CURRENT CONCERNS
ARA Paper number 7

PRIMARY HEALTH CARE CONCEPTS AND CHALLENGES IN A CHANGING WORLD
Alma-Ata revisited

E. Tarimo
E. G. Webster

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This document is dedicated to the late Dr Duane Smith, a former staff member of the Division of Strengthening of Health Services, who worked diligently and conscientiously on the first draft before his untimely death.

This document was previously printed by the Division of Strengthening of Health Services under reference WHO/SHS/CC/94.2. The Division of Strengthening of Health Services was disestablished and the Division of Analysis, Research and Assessment (ARA) established on 1 June 1996.

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Acknowledgements

In addition to staff members of the Division of Strengthening of Health Services, the authors are particularly grateful to the following persons in WHO programmes in Headquarters and Regional Offices for reviewing draft material in detail and suggesting revisions.

Dr A. A. Abdullatif, Regional Adviser, Primary Health Care Support, Regional Office for the Eastern Mediterranean
Mr H. Benaziza, Division of Health Promotion, Education and Communication
Dr V. Boulyjenkov, Hereditary Diseases Programme
Dr G. Fernando, Director, Health System Infrastructure, Regional Office for South-East Asia
Dr J. Goicoechea, Regional Adviser, Primary Health Care, Regional Office for Europe
Dr H. R. Hapsara, Director, Division of Epidemiological Surveillance and Health Situation and Trend Assessment
Dr C.-C. Heuck, Health Laboratory Technology
Mr J. T. Jones, Health Education and Promotion
Dr F. K. Käferstein, Chief, Food Safety
Dr I. Kickbusch, Director, Division of Health Promotion, Education and Communication
Dr H. King, Diabetes and other Noncommunicable Diseases
Dr A. Kochi, Programme Manager, Global Tuberculosis Programme
Dr J. W. Lee, Director, Global Programme for Vaccines and Immunization
Dr P. Lowry, Health Services Development, Regional Office for the Western Pacific
Dr L. J. Martinez, Programme Manager, Programme on Bacterial, Viral Diseases and Immunology
Dr S. K. Noordeen, Action Programme for the Elimination of Leprosy
Dr J. M. Paganini, Director, Health Services Development, Regional Office for the Americas
Dr E. Pupelin, Chief, Rehabilitation
Dr L. Savioli, Division of Communicable Diseases
Dr Than Sein, Director, Planning, Coordination and Information, Regional Office for South-East Asia
Dr K. Tankari, Health Infrastructure, Regional Office for Africa
Dr B. Thylefors, Programme Manager, Programme for the Prevention of Blindness
Dr P. Travis, Short Term Professional Officer, Division of Strengthening of Health Services
Dr J. Tulloch, Director, Division of Diarrhoeal and Acute Respiratory Disease Control

The authors also thank Mr J. Polling for editing the draft document and Mrs A. Pollinger for preparing the document.
PREFACE

Since the concept of primary health care (PHC) was defined and given international recognition at the Alma-Ata conference\(^1\) in 1978, primary health care has become the main focus for the promotion of world health. The vision of PHC elaborated at Alma-Ata (see Annex 1) grew out of a synthesis of ideas and experiences from various geographical regions and marked the dawn of a new strategy to improve the health of the peoples of the world.

Sixteen years after this historic turning-point, the experience of many countries in implementing primary health care has brought further development of the concept and raised new questions and challenges. In the process of implementing primary health care under widely varying national circumstances, it was inevitable that differences in interpretation should arise, and these differences have been a subject of heated debate. Several calls for clarification of the principles of primary health care have been made, to ensure their validity in the 1990s and beyond.

The Alma-Ata conference defined primary health care in terms of both a "level of care" and an "approach". Primary health care is often used to refer to the level of health services closest to communities and to the set of activities performed at this point of first contact between health workers and individuals. This meaning antedates the Alma-Ata conference, and refers principally to medical care services. While mention of "primary", "secondary", and "tertiary" care continues to be useful in describing various levels of care within the health system, it should not be confused with the broader meaning of primary health care as it is used today, which refers to a specific approach to health development.

The PHC approach embodies several explicit principles and values that provide the philosophical and conceptual underpinnings for primary health care strategies. The resulting strategies have major implications for the entire health system and for its interactions with the broader economic and social development structures.

The two different meanings associated with the term "primary health care" have been a source of divergent perceptions of PHC ever since. We use the term "primary health care" throughout this paper to mean the PHC approach.

In Chapter 1, we summarize the main features of the primary health care approach and the implications of this approach for health care systems. Then, in Chapters 2-6, pages 10-60, the bulk of the paper, we shall review the specific recommendations made at the Alma-Ata conference in the light of the experience of the past 16 years and discuss the major factors responsible for hindering the implementation of primary health care.
Are we any nearer the goal of health for all than we were 16 years ago? Chapter 7, pages 61-87, examines how the principles of Alma-Ata should be revised in order to adapt them to new realities and concerns that have emerged over the past 16 years. The chapter also identifies four key areas where substantial revision of strategy is essential for achieving the goal of Health for All.
CHAPTER 1

THE PRIMARY HEALTH CARE APPROACH

Four basic principles underlie the primary health care approach - (i) universal accessibility and coverage on the basis of need, (ii) community and individual involvement and self-reliance, (iii) intersectoral action for health, and (iv) appropriate technology and cost-effectiveness in relation to the available resources.

*Universal accessibility and coverage in relation to need*

The fundamental aim of primary health care is to ensure universal accessibility to available resources and services in order to provide adequate coverage of the most important health needs of populations.

This means not only securing additional resources for health, where possible, but also reallocating existing health and social resources to those whose needs are greatest.

The economic crises of the 1980s have increased the disparities in health status between the "haves" and the "have-nots" in many countries, giving rise to concern about the slow progress being made towards meeting health-for-all goals.2

At the international level, primary health care is inevitably linked with concerns for economic equity, balanced world development, and international peace. A more even distribution of resources among the nations of the world will advance primary health care.

Effective primary health care makes an important contribution to greater social justice and equity by reducing the gap between those who have access to an appropriate level of health care and those who do not, by reducing the gap between those who have sufficient food and safe water and those who do not, and by reducing high infant, child, and maternal mortality and morbidity rates.

*Community and individual involvement and self-reliance*

The improvement of the health status of a population involves much more than simply delivering health services. The people themselves must become key actors in the process. Primary health care therefore empowers communities for greater self-reliance and more active and responsible involvement in improving their own health.

This concept of community empowerment and involvement has two important aspects. The first is a political issue. The more democratic and socially accountable governments
are to their people, the greater is the potential for real community involvement, in health as in other matters. Decentralization of decision-making allows for greater social control and better implementation of action for health at various levels of the health system.

The second aspect of community involvement recognizes that if individuals are to realize their potential for self-reliance, they must take greater personal responsibility for their own and their families' health. This means adopting changes in behaviour and life-style and understanding and controlling, as far as possible, their social and physical environment. A supportive political and social milieu can greatly facilitate the development of local responsibility and initiative.

The public must be informed and motivated in order to enhance community involvement. Therefore it is crucial that the health system inform communities of the basics of the primary health care approach, of its implications for their own role, and of the technological tools at their disposal for taking appropriate health action. Health staff should also do their best to motivate the community to adopt the approach.

*Intersectoral action for health*

The third component of the primary health care strategy involves making health goals a high priority in the overall development process. The primary health care philosophy recognizes that the health of a society is closely related to its overall socioeconomic situation and the extent of poverty within it. Important determinants of health include the availability of land and food; the existence and accessibility of social infrastructure and services such as water, schools, and health facilities; and the level of literacy, particularly of women.

The practical application of the primary health care approach requires the fullest consideration of health matters whenever general economic developments are being planned. Evidence must be gathered to sharpen people's awareness of the health benefits of alternative economic development policies and to determine the costs of these alternatives. What, for example, would be the net health impact of a rise in food prices, a new factory, an irrigation project, or a social security scheme? Who benefits and who loses? The choice of interventions is important, since resources are limited. The most dramatic health benefit might be achieved, for example, by an adult literacy campaign for women.

Another practical implication of the PHC approach is that the health care system must be enabled to coordinate its actions with other sectors at the appropriate level. For example, a health centre responsible for a defined population would need to work closely with the agricultural services in many ways: to identify nutritional problems and find appropriate solutions, to analyse seasonal relationships between agricultural labour demands and disease incidence, and to mitigate environmental health hazards from resettlement programmes or irrigation schemes.
At the community level it may not be necessary to set up special health structures to facilitate intersectoral collaboration, if health matters can be dealt with effectively by existing social organizations such as village development committees. An understanding of cultural factors influencing behaviour and health is essential for the success of many health interventions. Moving towards the centre, the separation of sectors becomes inevitable, and special mechanisms are needed to maintain the links between the activities and objectives of the health sector and those of other sectors.

**Appropriate technology and cost-effectiveness**

Cost-effectiveness involves the allocation of resources in such a manner as to yield the greatest benefits. Benefits are measured by the extent to which the health needs of the largest number of people can be met. This requires the use of appropriate technologies - appropriateness being defined principally in terms of maximizing efficacy and minimizing cost. The focus on strengthening preventive services and health promotion within PHC is derived directly from this principle.

The use of appropriate technology and cost-effective strategies also implies efficiency in the use of resources. For example, the tasks given to the various levels of health personnel should be delegated in such a way that most problems are handled by the least trained person capable of handling them (as opposed to having colds, for example, treated by specialist physicians). In the area of transport this might imply making greater use of public transport, motorcycles, and bicycles rather than providing cars for a few. Another example of appropriate, cost-effective technology is the limitation of drug procurement to a restricted list of "essential" drugs, purchased through a competitive tendering process.

Increasing the cost-effectiveness and efficiency of health services also requires a shift in public resource allocation away from hospitals, with their costly specialist services, towards more peripheral levels of the district health system, including community health centres.

The extent of redistribution of health resources according to these principles has been referred to as the "litmus test of political commitment". It is an indication that a country has gone beyond merely thinking about primary health care and is seriously taking action. One difficulty lies in measuring how far the pattern of resource allocation is actually changing, because few countries have an accounting system that indicates how much money is being spent on different health care functions. The establishment of such an accounting system is a first step in the process of political commitment to reallocating resources.
Misinterpretations of the meaning of PHC

Before looking further at the implications of the primary health care approach for contemporary health systems, it may be helpful to review some of the ways in which primary health care is misunderstood. Some of these misunderstandings represent incomplete, and others erroneous, views of the basic tenets of primary health care.

1. **Primary health care is only community-based health care.** While this view is firmly based on the principles of community involvement, it represents only a limited conception of the far-reaching changes at all levels of the health system that are required for the full implementation of primary health care. The creation of community-based programmes alone, without changes in the supporting health structures and institutions, such as clinics and hospitals, as well as in the basic patterns of allocation of health resources would not be sufficient to make substantial progress towards health for all.

2. **Primary health care is the first level of contact of individuals and communities with the health system.** This statement is, in fact, contained in the definition of primary health care in the Alma-Ata Declaration. The distinction between "primary", "secondary", and "tertiary" medical care is firmly enshrined in our health vocabulary and was widely used long before Alma-Ata so greatly enriched the meaning of the term "primary health care". While primary health care in this sense most commonly summons up a picture of a community health worker in the developing countries, the primary level of health care for many people in both developing and developed countries may be a physician, or nurse, or even a clinical specialist. However, the fact remains that to understand primary health care as principally the first level of health care is essentially to miss the broader meaning of primary health care and its underlying principles. This sense of the word is an anachronism, though it remains very useful in describing the organization of the health system, and levels of referral within it. Perhaps a different term such as "primary medical care" or "primary care" should be used to describe the first level of contact, leaving the term "primary health care" to be used as defined at Alma-Ata.

3. **Primary health care is only for poor people in developing countries, who cannot afford real doctors.** It is certainly true that the primary health care approach arose, mostly, out of the experiences of a number of poor countries, which demonstrated that its application could result in quantum leaps in health development, as in China’s health revolution. However, the principles outlined at Alma-Ata are increasingly being seen as bringing great benefit to richer and more technologically advanced societies. The challenges of life-style-related illnesses such as cardiovascular diseases or AIDS increasingly demand the kind of individual empowerment and intersectoral action that were found to be effective in the first large-scale experiments with primary health care. The need to make difficult choices about resource allocation is now on the forefront of the agenda of even the richest countries. With the exponential increase in the demand for health care services, greater consideration must be given to cost and effectiveness in trying to satisfy that demand.
4. **Primary health care is a core set of health services, often referred to as the eight (or nine or ten...) essential elements of primary health care.** This view of primary health care is embraced by the Alma-Ata Declaration, and establishes a *minimum* range of essential activities to be pursued by any health system.¹ This is an important feature of primary health care, and one that has been largely lost to advocates of a "selective" approach, who, in the name of cost-effectiveness, exclude crucial elements of health care such as the provision of essential drugs and the treatment of common illnesses. However, it is worth remembering that even the most comprehensive range of essential primary health care services encompasses only a part, albeit an important one, of the primary health care approach.

5. **Primary health care is concerned only with rural areas, simple, "low-tech" interventions, and health workers with limited knowledge and training and is opposed to doctors, hospitals, and modern technology.** It is important to emphasize that primary health care is concerned largely with a more equitable use of resources; it is not inherently biased for or against any type of personnel, institution, or technology. A concern for equity leads almost invariably to a consideration of the poor, who bear by far the highest proportion of the burden of preventable diseases yet often lack access to the most basic care. Primary health care attempts to redress what are often described as "imbalances" in health resource allocation, such as the situation in which up to 80% of national health expenditure is consumed by large hospitals accessible to less than 20% of the population. The accusations of an antitechnology bias arise from related situations, since "high" technology is frequently associated with high cost.

The primary health care approach recognizes the value of technology, particularly when it can contribute cost-effective solutions to common problems, such as the cold-chain temperature indicators now in wide use. It also recognizes the important role to be played in the health system by hospitals and other specialized referral and support services. However, equally important is the need to make appropriate choices as to the relative amounts of resources to be provided for expensive care for rare conditions and cheaper care for more common conditions, which may be low in unit costs but much higher in the aggregate.

6. **Primary health care is cheap.** Sixteen years ago, primary health care was often promoted as a relatively inexpensive way to develop a health system, particularly among the poorer countries. Given the lessons of the intervening years, the word "cheap" no longer applies. A more appropriate term might be "cost-effective", which suggests that an investment in a health system based on primary health care will yield greater positive effects than an equivalent investment in an alternative system. While there is no definite evidence that primary health care is more cost-effective, the idea has widespread credence. However, it is also true that in the developing countries we often began with a situation in which a very large proportion of the population had virtually no access at all to any modern health services. With such a starting-point, even a very small *per capita* investment, multiplied by a high proportion of the population, may constitute a strikingly large total. Thus it is no surprise that in the currently difficult economic
climate in which many of the poorer countries find themselves, even the cost-effective PHC approach is often found to be a major economic burden, the more so when a major share of that cost is being borne by the government itself.

**Implications of the PHC approach for health system development**

Thus far, the focus of this review has been to reiterate the principles of primary health care and to clarify several common causes of confusion. On a more practical level, these principles must be translated into changes in existing health systems before benefits can be realized. Some of these required changes are summarized below.\(^4\,5\)

The redistribution of existing resources for health is a key change and may be effected with or without legislative and regulatory changes.

Existing human resources for health may require reorientation to new goals and tasks in pursuit of the PHC approach. The majority of existing health workers do not possess the appropriate skills or conceptual awareness of the PHC approach. The training they received often emphasized clinical skills, rather than work within communities. Then, too, the skills required for PHC at all levels go well beyond technical competence. For example, if health is understood in broader terms, health workers will be able to identify the social and economic factors that are the main contributors to ill health in a given situation or among particular groups, for example, young children of families in certain occupational groups. They should be able to communicate with community leaders and other sector professionals in the search for solutions. Skills are required in management, community development, and epidemiology, as well as in integrating different programme tasks.

The way service within communities is viewed among health workers must be changed. In government service, rural posts are often perceived as a punishment. Changing attitudes and increasing motivation will require appropriate incentives, new selection criteria for trainees and their teachers, and political enthusiasm for PHC at the highest levels of the health system. While some of these goals may entail added costs, there is much that can be done within existing structures, given sufficient leadership and commitment.

The relationships between health workers both horizontally and vertically need to be rethought in the light of PHC objectives. Rational analysis of the tasks to be performed and the resources available may mean developing new categories of human resources and retraining existing ones. In the long term the PHC approach should be incorporated into all basic training programmes of health workers.

Finally the design, planning and management of the health system will often require improvement. The PHC approach, which calls for greater community involvement, intersectoral collaboration, and the application of alternative technologies, will need more flexibility and a certain degree of decentralization. Technical planning functions
will need to be more effectively integrated with the political decision-making process, and with planning in other developmental sectors. New institutional arrangements may be required for this. Health plans will need to incorporate specific equity goals from the start - for example, in the use of resources. New styles of management will be called for.

The concept of decentralization of the management process towards the periphery of the health system has led to a growing interest in the district health system as the operational unit for health development. This will be necessary if greater responsibilities are to be assumed by both local health professionals and local communities.
CHAPTER 2

ALMA-ATA RECOMMENDATIONS: A CRITICAL REVIEW - I

STRATEGIC APPROACHES

The Alma-Ata Declaration (see Annex 1) is widely considered to be a concise statement of the principles of PHC. A less well-known product of the Alma-Ata conference is a set of 22 recommendations for change within health systems needed to translate these principles into practice (see Annex 2). What has happened to the recommendations adopted by the conference? We have regrouped them under five headings: strategic approaches; developing health systems based on primary health care; primary health care elements; human resources; and international support for primary health care. Each of these new groupings of recommendations will be reviewed in this and the next four chapters. We shall try to highlight the current state of implementation of each recommendation, analyse various problems encountered, and indicate ways forward for the current decade and beyond.

The socioeconomic realities of the 1990s are radically different from those existing at the time of the Alma-Ata Conference. But while the recent economic crisis has made existing problems of health systems worse, it will be clear in the review that many of the problems currently faced by health systems are almost identical to those of the 1980s.

The first group of recommendations - strategic approaches - are considered in the following sections.

Health and development (Recommendation 1) and Coordination of health and health-related sectors (Recommendation 4)

The two recommendations call on governments to incorporate primary health care into national development plans, ensure that health plans take full account of national inputs from other sectors, and coordinate the health activities of different sectors, using institutional arrangements already established for this purpose as much as possible. Behind these recommendations is the recognition that improvements in health result mainly from activities outside the health sector (Fig. 1). Health improvement developments related to nine issues are summarized below. It will be observed that a number of issues that were not fully dealt with by the Alma-Ata Conference, like environment, food and nutrition, and rapid population growth, have since received considerable attention.
Fig. 1. Determinants of health

- Education
- Agriculture
- Water/sanitation
- Housing

- Work
- Environment
- Employment

- Socioeconomic development
- Social organizational network
  - Living conditions
  - Family size

- Health care
  1. Resources
  2. Organization and management
  3. Delivery and accessibility
  - Quality
  - Use

- Age
- Gender
- Genetics
- Life-style
Incorporation of PHC into development programmes

The incorporation of PHC into development programmes has not been easy. The health sector in many countries is reported to be weak and unable to influence socioeconomic development policies. Indeed, several studies indicate that action in support of PHC by health-related sectors has involved weak follow-up owing to the lack of political pressure. For example, a strong social consensus is required to persuade decision-makers of the necessity for healthy food policies, crop substitution for tobacco, the reduction of automobile emissions, the reduction of alcohol consumption, housing schemes for the homeless and many other development programmes. As long as some powerful groups are getting economic benefits from the existing system, changes will be difficult. In spite of this a number of countries, particularly Canada, have made spectacular progress in mobilizing health action in different sectors, and health issues have subsequently found their way into political debates.

Several factors account for the failure to implement these recommendations. One is the perceived threat to sectoral authority and resources posed by collaborative efforts. Similar problems have hindered rural development efforts in the past, when the agriculture sector has taken a dominant role to the detriment of participation from other sectors. Another is the lack of specificity regarding the role that other sectors are expected to play. The work of intersectoral committees must be focused on clearly defined problems or goals, such as the reduction of inequities in health, the promotion of healthy life-styles, and AIDS control. Experience shows that it is much easier to mobilize political support when the problems are sharply focused.

One reason why national health councils, PHC coordinating committees, and similar mechanisms set up by countries to coordinate health and health-related activities are not very effective is that intersectoral action does not often fit easily with the more compartmentalized approaches of most governments and international agencies. Many of these mechanisms are reported to function on an ad hoc rather than a formal basis, or to be non-functional. It should always be borne in mind, moreover, that a national health council or a rural development committee is not an end in itself.

The Technical Discussions at the Thirty-ninth World Health Assembly in 1986 provided a global forum to highlight some of the most important health-related issues that demand attention. These include equity in health and health care, food and nutrition, education, and the environment - all of which have to be viewed in the light of the widespread economic recession. Other relevant concerns are occupational health, urban growth, rapid population expansion, and the special needs of women and elderly people. Some of these issues are discussed below. The issue of equity in health and health care is discussed under recommendation 8.
The environment

The need for a more sustainable relationship between man and his environment has increasingly become a public preoccupation. Unmet needs in water supply and basic sanitation affect large populations - a third to a half of the global population. The recent cholera outbreaks in Latin America and a number of African countries is a reflection of poor sanitation. Pollution of the air, water, and environment, with the Bhopal and Chernobyl catastrophes as spectacular examples, is on the increase. Vigorous debate continues on the association between pollutants and chronic ill health - for example, DDT with breast cancer and cadmium, lead, and mercury with poisoning of the central nervous system. Deforestation, particularly in developing countries, results in the degradation of water catchment. Desertification and the depletion of the ozone layer, induced by the release of Freon gases from spray cans, refrigerators, air-conditioning, and the production of foam in plastic materials, are additional concerns. The greenhouse effect, caused by an increase in carbon dioxide concentration in the air due to the burning of fossil fuel, as well as acid rain, are other problems confronted in various parts of the world. Less educated, lower income groups, already in worse health than other groups in society, suffer disproportionately from the risks associated with these environmental changes.

The International Conference on the Environment in Brazil in June 1992 was a landmark in the mobilization of greater national and global efforts for a healthy environment. Agenda 21, Chapter 6, of the Rio Declaration on Environment and Development specifically discusses the relationship between the environment and the protection and promotion of human health. It outlines five programme areas relevant to health needs, among which the reduction of health risks from environmental pollution figures prominently. Agenda 21 reflects a global consensus and political commitment at the highest level on cooperation to achieve a better environment. Its successful implementation is first and foremost the responsibility of governments. National strategies, plans, policies, and processes are crucial in achieving this. International cooperation should support and supplement such national efforts. The challenge now is one of implementation.

There is an indication that in the West a shift in public opinion in favour of ecologically friendly policies is occurring. A number of organizations, such as Greenpeace and Friends of the Earth, which have pioneered action for a healthy environment, are now taken seriously by governments and the media.

An area of Agenda 21 that has received much less attention is housing. The links between housing and disease are often overlooked. The homeless and people living in overcrowded and damp houses have a high risk of many diseases, including tuberculosis, bronchitis, skin diseases, as well as alcohol and drug-related diseases.
Occupational health

Working conditions still account globally for 90,000 injuries with 400 deaths every day, totalling 32.7 million occupational injuries and 146,000 deaths per year.\textsuperscript{14}

In the more industrialized countries, the effectiveness of health monitoring and protection and the comparatively well-developed machinery for industrial relations have greatly reduced gross physical hazards to health in most work settings. But their place has been more than filled by stress-related problems such as peptic ulcer, cardiovascular disease, and hypertension, and behavioural difficulties related to alcoholism and drug abuse.

Surveys in the less industrialized countries show continuing and possibly growing health problems from chemical and physical pollution of the working environment. Between 7\% and 30\% of miners have been found to have pulmonary problems resulting from the inhalation of silicon dust. Between 5\% and 30\% of cotton workers have been found to suffer from similar problems consequent on the inhalation of cotton fibres. A survey in a Latin American country has shown 5.6\% of farm workers to be affected by neurotoxins in pesticides, while a country in South-East Asia has reported over 1000 deaths from poisoning with the same class of chemical. Loss of hearing has been demonstrated in up to 67\% of workers in textile mills and other noisy workplaces. A prevalence of contact dermatitis ranging from 17\% to 86\% has been found in chemical workers.

The occupational risks of cancer and damage to the reproductive system are causing new concern. It has been estimated that at least 5\% of cancers in the world result directly or indirectly from exposure to hazards in the working environment. Chemical and radiation risks to pregnant women are coming under closer scrutiny - particularly in the industrial countries, where women are increasingly employed in the workforce.\textsuperscript{2}

The National Institutes of Occupational Health convened a meeting in Helsinki in June 1990 on the initiative of the US National Institute for Occupational Safety and Health and the Finnish Institute of Occupational Health, with the purpose of identifying the global needs of occupational health in the 1990s and of finding ways in which the national institutes could expand their individual and collaborative efforts in a more systematic way to contribute to the objectives of the WHO Workers’ Health Programme.\textsuperscript{15}

Food and nutrition

With regard to food and nutrition, enough is known to ensure household food security. The real problem is one of inequity between and within countries. The situation is favourable in Latin America and the Caribbean and somewhat better in Asia than in Africa. Many Africans across the continent exist on a dietary energy supply of less than 2000 calories per day. On the whole, the statistics on Africa have not improved over time. In 1980, a daily consumption rate of less than 1900 calories per person was found
in eight countries. In 1985 there were nine countries in this category.\textsuperscript{16} Globally, low birth weight shows little improvement during this period: 7.4\% to 6.8\% in developed countries, 15\% to 13\% in Africa, and 20\% to 19\% in Asia. Protein-energy malnutrition and micronutrient deficiencies (vitamin A, iron and iodine) are still common in a number of countries. The World Summit for Children held at the United Nations, New York, 1990,\textsuperscript{17} adopted two important targets: universal salt iodization in countries where iodine deficiency is a public health problem; and 80\% vitamin A coverage for all children under the age of two in endemic areas by 1995. Obesity shows an upward trend worldwide but is decreasing in the developed countries.

The potential of food production to match future population increases has been questioned. The year 1994 is seen as a watershed year, one marking the transition from an era of rapid growth in food production to one of much slower growth. One author has concluded that the world's farmers can no longer be counted on to feed the prospective additions to the population, and that achieving a balance between food and people now depends more on family planners than on farmers.\textsuperscript{18}

Food safety is another important area. Although the Declaration of Alma-Ata recognized that the provision of food and proper nutrition are essential elements of primary health care, unfortunately many countries, particularly the poor ones, have given marginal importance to the safety aspects of the food supply. Diseases due to contaminated food have remained a major public health problem. It is estimated that of the 3.2 million children who die annually as a result of diarrhoea, 70\% of the cases are due to contaminated food (including drinking water).

The International Conference on Nutrition in Rome in 1992 crystallized awareness of the causes and consequences of malnutrition, and of the ways in which the international community can combat them.\textsuperscript{19} It stressed the importance of incorporating nutrition objectives into development programmes and issued recommendations on seven major nutrition strategies. These include: improving household food security; protecting consumers through improved food quality and safety; caring for the poor and nutritionally vulnerable; preventing and managing infectious diseases; promoting appropriate diets and healthy life-styles; preventing specific micronutrient deficiencies; and assessing and monitoring nutritional status.

The conference pointed out that if agriculture policies focused on increasing production alone, the underprivileged could be worse off in the end unless the policy provided for adequate distribution of the extra food. Macro-economic policies, particularly measures associated with structural adjustment, should make special efforts to meet the needs of underprivileged populations.

The World Declaration and Plan of Action for Nutrition, emanating from the International Conference on Nutrition in Rome in 1992, demonstrates the desire of countries to address the foregoing nutritional issues. It asserts, "we also commit
ourselves to revise or prepare our national policies and actions based on principles and programmes enunciated.\textsuperscript{20} Once more, the challenge remains one of implementation.

\textit{Urban growth}

The ongoing process of urban growth has outstripped the capacity of municipal governments to provide essential services relating to health, such as housing, water supply, and waste collection and disposal. Air pollution caused by road traffic, industrial activities, and other sources is on the increase. An additional matter of great concern is the increasing number of poor living in urban slums, squatter camps, and shanty towns, now common features of cities throughout the less developed countries. A series of strategies proposed by the WHO Commission on the Environment delineates the areas most in need of attention.\textsuperscript{21} Countries should take action to reduce urban population growth rates through a national population policy, to include health in urban development plans, and to establish the use of specific indicators to monitor progress. Finally, development programmes should emphasize the establishment of collaborative links and activities between cities, the education of the public, and the strengthening of community participation in urban projects.\textsuperscript{22-27}

On the whole, urban areas receive more resources from governments than do rural areas. The challenge, therefore, is one of achieving greater equity in the distribution of resources in urban areas. Priority should be given to health programmes in the peri-urban areas in developing countries and the inner cities of industrialized countries.

\textit{Rapid population growth}

Rapid population growth has been a continuing concern, with broad implications for both health and socioeconomic development.\textsuperscript{28} A number of developing countries have made considerable progress in the area of family planning. Several studies show that most of the needs for family planning in Latin American and Asian countries have been met, much as they have in the developed countries. With a few exceptions - Botswana, Egypt, Kenya, Tunisia, and Zimbabwe - the demand for family planning is much lower in the African countries, and efforts need to be intensified.

Some writers have called for draconian measures to tackle rapid population growth. They ask that more attention be given to family planning rather than to public health measures, which save lives and thus lead to population increases.\textsuperscript{29} While there is certainly reason to look more seriously at this issue, the abandoning of public health activities appears neither ethical nor politically feasible as a solution to the problems of population growth. More pragmatic approaches must be sought.

The International Conference on Population and Development in Cairo in September 1994 built on the 1984 Mexico Conference and had a broader mandate than previous conferences, reflecting the growing awareness that population change, inequality, patterns
of consumption, and threats to the environment are so closely interconnected that they should be considered together.

**Education and literacy**

The first edition of *World education report*, published by Unesco in 1991, provides a good summary of global developments in basic education and literacy. The report follows on from the World Conference on Education for All, which met in Jomtien, Thailand, in March 1990. The Jomtien Declaration and Framework for Action set the stage for the exceptional moral and material effort required to ensure that all people have the opportunity to expand their personal horizons while contributing to the general well-being of society. In the follow-up to Jomtien and the International Literacy Year (1990), Unesco has once more begun to take stock of progress worldwide towards the objective of education for all.

School enrolment rates have increased over the period 1985-90 in all the world's regions and for each of the three age-groups - primary, secondary, and tertiary. Worldwide, an estimated 80% of the 6-11-year age-group, 55% of the 12-17-year age-group, and 20% of the 18-23-year age-group are enrolled in school.

The global figures conceal considerable variation, however. In the non-Arab African countries, primary-age enrolment made little headway owing to population surges: the level remained at about 50%. While females continue to have less access than males, the gap between males and females narrowed over the period in most of the world's regions in terms of primary education. Less change was seen at the secondary and tertiary levels. In Africa (excluding Arab states), the gap actually widened at the tertiary level from 7 to about 9 percentage points. In the Arab states, the gap in enrolment for primary education narrowed from 17% to 14%, but from only 18% to 16% for secondary education.

Adult literacy has similarly shown improvement over the period. The proportions of illiterates declined in each region, for both men and women. The decline in percentage points between 1985 and 1990 was greater for women than for men, though from higher initial levels. It was greater also in Africa than in the other regions, again from higher levels. The absolute number of illiterates in the world also declined between 1985 and 1990, namely from 949.5 to 948.1 million. While the difference may be the result of different estimation methods, the trend is probably significant.

On the basis of recent trends, Unesco's projections indicate that the total number of illiterate adults in the world will fall over the course of the present decade to around 935 million by the end of the century, even though in some regions, notably sub-Saharan Africa, the Arab states and southern Asia, the numbers are still rising because of the continuing influence of low school participation rates in the past. These projections do not take into account the strong policy commitments to reduce illiteracy made by many countries during International Literacy Year (1990).
Numerous studies have shown the clear relationship between literacy, family planning, and falling infant mortality. Illiteracy, especially among women, thus continued to be a serious obstacle to health development. Closer contacts between ministries of education and health would be needed to develop mutually supportive education and health policies.

**Gender issues**

Gender issues have become increasingly important in the last decade. While "sex" is used to refer to the biological attributes of men and women, "gender" is understood here as a social construct, referring to the distinguishing characteristics of men and women.

The implications of gender differences and the nature of the discrimination and disadvantages that women face permeate their social, productive, and reproductive roles in all societies. The results can be seen in numerous areas. Women lag behind men on virtually every indicator of social and economic status. They constitute a larger proportion of the poor in all societies and they are relatively powerless to improve their health and quality of life.

The 1992 Technical Discussions on "Women, health and development", which took place during the Forty-fifth World Health Assembly, was an important event. Discussions were organized around the following themes:

- morbidity and mortality patterns affecting women of all ages, and factors that have an impact on women's health status;

- worldwide health care needs of women, including information, counselling, access to services, and legislative support of essential care services.

An important resolution on women, health and development (WHA45.25) was adopted by the World Health Assembly. It outlines the steps to be taken by Member States, both individually and in unison through WHO, to promote the health of women and to establish a Global Commission on Women's Health. *Women's health: across age and frontier* was published to serve as a background document for these Technical Discussions. It provides factual data on a spectrum of issues affecting women.

The Fourth World Conference on Women, which is to be held in Beijing in September 1995, will build on the 1985 Nairobi meeting. The meeting is expected to be a "platform of action" to deal with eight main concerns - inequality in the sharing of power and decision-making; insufficient mechanisms to promote advancement of women; lack of awareness of, and commitment to, internationally and nationally recognized women's rights; poverty; inequality in women's access to banks and loans; inequality in access to education, health and employment; violence against women; and the effects of warfare on women.
The elderly

Progress towards the goal of health for all implies increasing survival: it is the aspiration of countries that by the end of the century more of their citizens should live longer. A consequence of this increased survival and of the successes achieved in reducing fertility is that the proportion of the elderly in the total world population is increasing very rapidly. By the year 2000 there will be some 600 million elderly persons (aged 60 years or more) in the world, two-thirds of whom will be living in the developing countries.

Cross-national studies on the needs of the elderly in developing countries from three continents have consistently shown that their main problem is lack of financial resources. This prevents large numbers of people from satisfying many of their basic needs and limits their access to health care. These studies emphasize the importance of the informal support system provided by families and the community. But as families become smaller due to the success of family planning programmes, and as young family members increasingly move from rural to urban areas, the traditional support system is weakening. This scenario has a greater adverse affect on country-dwellers. Unlike those living in towns, who retire from their employment and receive a pension, the rural elderly are mostly retired farmers, dependent on their children or their own savings. The incidence of AIDS is exacerbating these problems, particularly in developing countries, because the death of thousands of young people leaves the elderly without support. Instead, they face the additional burden of having to care for orphaned grandchildren.

Compounding the problems of poverty is the fact that the elderly have the highest prevalence of disability in a population. Addressing disabilities in this age group would increase or maintain their independence.

Many countries have emphasized the need to integrate health care for the elderly into the social services, on a par with maternity benefits, children's day care, home helps, and family allowances. Israel passed a nursing insurance law in 1986 that facilitated the care of the elderly in the family and community by subsidizing the services they needed for their personal care. Other countries including Uruguay have followed suit. But there is another side to such approaches: the burden of increasing costs. For example, Scandinavian countries that adopted a series of benefits for ill and disabled patients several years ago, when they were more prosperous, are now finding that they cannot easily afford them. Thus the aging of the population presents an increasing challenge to the health and social services.

Community participation in primary health care (Recommendation 2)

In its second recommendation, the Alma-Ata conference called on governments to "encourage and ensure full community participation through the effective propagation of relevant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families, and communities can assume responsibility for their health and wellbeing." This emphasis on community
participation represents an enormous change from former approaches, which viewed communities as passive recipients of services planned and provided by others.

While there is general agreement on the importance of community participation in health development,\textsuperscript{35,36} much remains to be done to implement the concept. Studies carried out in all WHO Regions show that passive participation, in which the public utilizes the health services and contributes money, materials, and labour, is fairly widespread.\textsuperscript{37} Yet, active community involvement, in terms of the planning and management of health activities, is still uncommon (Fig. 2). Five sets of problems besetting popular participation in health development have been advanced.

**Fig. 2. A continuum of community participation**

<table>
<thead>
<tr>
<th>Degree of Participation</th>
<th>Community Participation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Has control</td>
<td>Organization asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish goals.</td>
</tr>
<tr>
<td></td>
<td>Has delegated power</td>
<td>Organization identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.</td>
</tr>
<tr>
<td></td>
<td>Plans jointly</td>
<td>Organization presents tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more subsequently.</td>
</tr>
<tr>
<td></td>
<td>Advises</td>
<td>Organization presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.</td>
</tr>
<tr>
<td></td>
<td>Is consulted</td>
<td>Organization tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.</td>
</tr>
<tr>
<td></td>
<td>Receives information</td>
<td>Organization makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.</td>
</tr>
<tr>
<td>Low</td>
<td>None</td>
<td>Community told nothing.</td>
</tr>
</tbody>
</table>

First, conventional public health planning is not conducive to community participation. It tends to be a top-down process, with a group of experts identifying priority health problems and then deciding on programme activities to resolve them. Community participation is precluded when health priorities and solutions, including the types of health workers and services needed, have been determined at the central level. Decentralization of responsibility to communities and local health authorities runs counter to the perceived self-interest of most health decision-makers. An analysis of the struggle with decentralization in Papua New Guinea and various other countries is revealing. It reminds us that "it is the nature of the animal to increase its power rather than willingly forego the loss of any power."38

Another aspect of the planning problem has surfaced in the course of the current economic crisis. For many countries in Africa, the crisis has meant a decrease, or at least a levelling, of the real resources allocated to health activities. In these circumstances, outside donor agencies have funded most health development activities in recent years. Many donor agencies require tangible results in a short time if they are to continue to fund projects. The tendency, therefore, has been to see community self-reliance as secondary to activities that the agencies feel can yield immediate results. This problem can only be resolved through better dialogue between governments and donor agencies.

Second, problems exist within communities themselves - lack of cohesion, the scattered nature of populations in rural areas, and social stratification. There are often reactionary forces within communities that try to maintain existing power relations, making community participation difficult. These problems tend to be exaggerated by outsiders. Such conundrums manifest themselves even in simple tasks, such as the selection of village health workers. However, given time, communities are able to overcome them; while the wrong village health worker may be chosen the first time, it is unlikely to go on happening.

Third, the frequent lack of organizational structures, such as village councils and clubs, is an obstacle to community participation. Where such structures do not exist, they usually have to be developed before any genuine participation can begin. The scope and content of community participation will vary from country to country. For example, while the social control of the health services may be possible through political structures in some countries, it may not be possible or desirable in others.

Fourth, problems have been encountered in the autonomous and sometimes paternalistic attitude of health workers and other professionals. Highly trained health workers, especially physicians, often feel that their task is to prescribe treatment and medication to junior health staff and patients, who are expected to accept it without question. Services tend to be organized in a way that is convenient to health workers rather than to clients. Thus it is very inconvenient for a mother who has walked 8 km to bring a child to a clinic to be told that if she wants advice on family planning she must come back in three days' time. For true participation, communities need to be better informed.
on alternative choices and their implications. For this, literacy is helpful. Health workers must acquire a better understanding of approaches that promote community participation. It is often asked whether one should start with the health workers or the community in order to build community involvement. If one starts with health workers, there is a risk that they will practise community manipulation. Many effective small-scale programmes have begun by working in communities, with or without the involvement of local health facilities and workers, but in practice it appears that the most sustainable and effective programmes are the result of communities and health workers cooperating in mutual respect.

Finally, community participation may entail risks to governments, particularly nondemocratic ones. The current wave of global democratization offers an opportunity to build genuine community involvement. However, even in open societies there are many vested interests. In such cases, wide public involvement in decision-making is often neither easy nor efficient, particularly when there is no clear social consensus on key issues. Much remains to be done and learnt in the practice of community involvement. Experience from the community development movement is useful in the practice of community involvement but has not been exploited fully. The World Conference on Human Rights, Vienna, 1993, confirmed the centrality of individual rights in all population and development activities. The conference adopted the Vienna Declaration and Programme of Action.

The decentralization of power which is discussed further under recommendation 3, page 31, is crucial for community participation.

Vulnerable and high-risk groups (Recommendation 8)

On the whole, despite the existence of this recommendation, few programmatic strategies to alleviate the specific problems of vulnerable and high-risk groups have been developed. Immunization is an exception; practical cost-effective technology has cut across socioeconomic and geographical barriers to reach a large and growing proportion of the target populations. In this case, the social determinants of increased health risk, such as poverty, unemployment, landlessness, remoteness, and urban slum environments, have been largely circumvented by well-organized and sharply targeted special infrastructures existing on the fringes of formal health systems. This success, however, needs to be qualified. Some studies have shown that even with increased immunization coverage among all population groups, inequities between social groups remain or may even increase. Apparently, it is only when the coverage of the affluent groups approaches 95% that inequalities begin to narrow. Gaps in levels of health between population groups have not improved much. In Africa, health differentials continue to follow the patterns that emerged in the colonial era. There is no doubt that structural adjustment programmes, which invariably cut funding for social welfare programmes, result in deterioration of the living and health conditions of vulnerable groups. The World Bank report acknowledges that this has happened in a number of cases.
Health improvement for vulnerable and high-risk groups requires approaches designed to tackle the complex web of economic and political marginality that they face. A multisectoral approach and active local involvement are called for. The empowerment of these populations is a prerequisite to their obtaining access to health services, clean water, and food. A number of projects supported by nongovernmental organizations, particularly in Bangladesh, have reported considerable success in this direction. Canada has adopted the goal of achieving equity in health, and most of the provinces have developed policies emphasizing consumer participation and community-based care through a more highly devolved system. The Janasaviya programme in Sri Lanka and Mexico's national programme of solidarity are working to alleviate economic uncertainty among the poor, demonstrating that an improvement in the health of the poor first requires the attainment of the means to subsist. In the Janasaviya project selected poor families are given a grant of Rs 1458 a month ($35.50) for two years, in the form of food and other goods, which roughly doubles or even trebles their normal income. From this amount they are encouraged to save Rs 458 a month. Every participating family also has access to a bank loan of up to Rs 25 000 ($610), payable without collateral when the family selects a viable project that will earn money. The idea behind the Janasaviya project is to lift the burden of poverty from families for a sufficiently long time to enable them to achieve sustainable self-employment or to become accustomed to regular work.

In Mexico the national programme of solidarity was started in 1989 to meet the health needs of extremely poor populations. The government obtained funds for the programme by reducing its financial contribution to the Mexican Institute of Social Security, leaving most of the financing to the Institute to the participating employees and employers. There are now three systems of care: one for the poorest population using the scarce public resources of the Ministry of Health, a second one under social security with more resources, and the private sector with abundant resources. Questions have been raised as to the appropriateness of targeting resources to the poor while abandoning previous commitments to expand social security to a single national health system providing universal access. The percentage of GNP expenditure on health has declined from 1.8 in 1980 to 1.4 in 1989. The question must therefore be asked whether the national programme of solidarity has resulted in a lower priority for health care.

The World Summit for Social Development, March 1995, mobilized action to improve the wellbeing of marginalized population groups. The core issues for the summit were: the alleviation of poverty, the expansion of productive employment, and the enhancement of social integration, particularly of the more marginalized and disadvantaged groups.

**Appropriate technology (Recommendation 12)**

As used at Alma-Ata, the term "technology" means machinery and equipment (hardware) as well as knowledge, organizational procedures and human skills (software) that are combined to produce benefits. Many technological issues are discussed under particular programmes, for example MCH and essential drugs. In terms of hardware, progress has certainly been made. Oral rehydration therapy, vaccine development, immunization
technology (including the cold chain), and improvements in community water supplies have all contributed to health. Collaboration between NGOs, interested countries and WHO has made the provision of items such as low cost spectacles, and the local small scale production of eye drops, possible. Examples of recent advances in food production and processing include fermentation technology. Safe application of this process at household level is considered to have the potential to prevent food borne diarrhoea, particularly in socioeconomic settings where facilities for safe storage and cooking of food are not available. Less is known of progress with "soft" technologies such as local monitoring, home deliveries, lay reporting, and the promotion of self-reliance among communities. One should not, however, overlook the considerable amount of work being done by nongovernmental organizations and training institutions in the development of teaching materials and manuals for community development activities.

A summary of recent technological developments in genetics, human reproduction (including artificial insemination and in vitro fertilization), control of tropical diseases, control of noncommunicable diseases, clinical care, and laboratory services, is available elsewhere.\(^2\) Considerable effort is currently being made to find low-cost effective technologies that could be used in environmental sanitation programmes, where they could be more or less imposed. The effects would be dramatic because even the disadvantaged population groups would have access. Examples include the "green technologies", such as vehicles and machinery that produce minimal air pollution. The switch from the use of chlorofluoro-carbons (CFCs) in aerosol propellants has been rapid, but these substances continue to be used in refrigeration technology, which is by far the greatest source of CFCs in developing countries. But where such technologies cannot be imposed, as is the case with many diseases, their social aspects need attention.

Three areas of technology need further attention in developing countries. First, people in developing countries need to be given knowledge to enable them to make informed choices among technologies, and their ability to assess such information needs to be strengthened. Secondly, more attention should be paid to the maintenance of health equipment. There is very little investment in this area. Efficiency losses from the poor selection and maintenance of medical equipment are very large. WHO estimates that less than half the medical equipment in developing countries is usable. Thirdly, there is considerable scope for South-South collaboration and the transfer of technology between countries.

Research and development effort to assess existing technologies, and to develop new ones, needs to be strengthened in developing countries.

**Laboratory services**

Access to medical technology varies greatly. The availability of efficient and reliable laboratory services is essential for diagnosis and treatment.\(^4\) The use of laboratory services to test blood to be used for transfusions is especially important, in view of the prevalence of Hepatitis A and B, and AIDS. Increasingly, in many developing countries,
efficient and reliable laboratory services are becoming available at the local level. Some countries, however, still over-emphasize the development of central laboratories to support second- and third-level care, leading to delays in treatment at the more peripheral levels.

Thus, in terms of "hard" technologies, one of the greatest challenges in future is to develop rapid diagnostic tests for health centres in developing countries for malaria, AIDS, typhoid and other important diseases.

Radiology services

Although radiotherapy and nuclear medicine facilities exist in many developing countries, approximately 70% of people lack access to the most basic diagnostic radiology services. Existing facilities are often concentrated in the cities, and it is estimated that 30-60% of equipment in developing countries does not function. The basic radiographic system (BRS) is relatively inexpensive and is as effective a diagnostic and therapeutic tool as much more costly equipment.50-52 Yet only 700-800 of these units are installed worldwide. It is a paradox that a system conceived for the developing world is more widely used in developed countries, due to value-for-money criteria.

Access to diagnostic techniques, such as magnetic resonance imaging and computed tomography scanners, varies a great deal in developed countries. Not all use is appropriate. For example, while access to these techniques is limited in Canada compared to the USA, patients with immediate and serious needs rarely have to wait for services. Canada has made efforts to regionalize high technology units and to ensure that each has a sufficient volume of work to allow quality care.53

Few countries, developed or developing, have yet instituted bodies for technology assessment.

Conclusions

Countries have had great difficulties in implementing recommendations on strategic approaches. Progress has been slow.

A number of important issues that were not addressed adequately by the Alma-Ata conference have since received considerable attention. Thus international conferences have been organized on food and nutrition, rapid population growth, sustainable relationships between man and the environment, and education and literacy. These conferences and many other activities referred to in the paper have been proposed and organized by different agencies and are not necessarily linked to the Alma-Ata recommendations.

Two areas, occupational health in developing countries and the plight of vulnerable and high-risk groups, need more global attention. The World Summit for Social
Development has mobilized greater interest and action to deal with the second area. It is highly regrettable that many international conferences dealing with closely related issues are organized by different agencies and do not harmonize with each other. The World Summit for Social Development provided a unique opportunity for addressing various issues in a holistic manner.

The Alma-Ata recommendations and those of other conferences - with the notable exception of Agenda 21 - are fairly silent on resource requirements. Where is the money to implement these recommendations going to come from? This issue will be taken up later under Recommendation 17, page 28 (Resources for PHC) and Recommendation 22, page 57 (International support for PHC).
CHAPTER 3

ALMA-ATA RECOMMENDATIONS: A CRITICAL REVIEW - II

HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE

National commitment (Recommendation 18)

There is little room to doubt the strong verbal commitment of all countries to the principles of primary health care. This commitment has been expressed and translated into practice in a variety of ways by individual countries or groups of countries. Such expressions include "Healthy People 2000" in the USA, 54 the "New Perspectives on the Health of Canadians", 55 "Targets for Health for All" in the European countries, 56 "The Health of the Nation" in the United Kingdom, 57 and the "African Health Development Framework" in the African countries. This Framework, adopted in Lusaka in 1985, sets forth the main issues for defining health policies and reinforcing cooperation among people, their governments, and their international agency partners. To these may be added health development "charters", which have been adopted by all WHO regions and by many groups of countries (e.g., the Caribbean, the Andean countries, and Central America). Invariably, the Declaration of Alma-Ata serves as the cornerstone. However, an assessment of the effect of this commitment must be based on the extent of actual PHC achievements to date, in the context of health development strategies backed up by the allocation of financial and human resources for their implementation. Many nongovernmental organizations, including national and international public and medical associations, have played a part in stimulating interest in PHC and in mobilizing action. However, it must be observed that relatively few countries have adopted enabling legislation to enhance the implementation of "charters" and other expressions of commitment to PHC.

National strategies (Recommendation 19)

Virtually all countries have strategies for health for all. With a few exceptions, however, they have been drawn up solely by health planners. A number of countries have adopted targets to deliver health improvements, such as a specified improvement in service provision to disadvantaged groups. 58,59 While the achievement of these targets calls for coordinated sectoral action, many countries have not developed them jointly with health-related sectors. In other instances, clear goals and targets have not been defined, and the costs of the strategies have rarely been determined. Realistic plans, including estimates of possible resources from the public and from other sectors, are needed. Generally, there is a notable lack of information on the expenditure of other health-related sectors, especially the private sector. Few countries have developed clear
objectives and resource requirements to achieve health for all. Another deficiency has been the lack of regular revision and updating of the Health for All strategies in response to changing needs.

Reports on progress in countries have been over-optimistic. Many country reports have tended to give the impression that all is well when there is very little concrete improvement on the ground in such areas as resource allocation, organization, and delivery of programmes.

Under the slogan of health sector reforms, many countries have in the last five years introduced a series of organization, managerial and/or financial reforms of various degrees. These changes are discussed under relevant sections.

**Resources for PHC (Recommendation 17)**

The most important health resource, which is often overlooked, is the people themselves. Thus better information to the public on what to expect from health services and on what they can do themselves is essential. This matter is discussed under recommendation 5.

A systematic look at the way countries accord priority to health development must encompass several considerations. An obvious first is the *proportion of overall government expenditure allocated to the health sector*. The government expenditure on the health sector as a percentage of the GNP has increased on most countries.\(^6\) What is striking is the low levels of this percentage in poor countries. On average, the least developed countries spend 2.4% of the GNP for public expenditure on health. But the corresponding figures for Mali, Sudan, Nepal, Rwanda and Myanmar are 0.5, 0.3, 0.7, 0.6 and 0.8 respectively. However, these figures are of limited value in assessing financial priorities within the health care system, because they do not indicate whether the expenditures are for hospitals in the capital city or for a more equitable distribution of resources to meet the priority needs of the whole population. A closer scrutiny may tell us *what proportion of these expenditures actually go to local health services*. While the percentage of national health expenditure devoted to local health services has been increasing in developed countries, it has been stagnant in developing countries, and has decreased in the least developed countries.\(^14\)

Another important resource allocation issue is the *division between staff and other costs*. With few exceptions a large portion of health budgets in Africa - 80% and more - goes to salaries, leaving very little money for drugs and operating costs. For mission hospitals in Africa and for many East Asian countries, 40-50% of the recurrent budget goes to salaries. The tendency in Africa and Latin America has been to set up costly institutions, medical schools, and hospitals similar to those in the West. The cost of professional education is considerably higher in these regions compared to countries in Asia. Costs of first-level care in Africa are twice those in Asia, and costs of hospital care five times greater.
In the world as a whole, aging populations, the emergence of new diseases and technologies, and increasing urbanization are making new demands on the health care system. Even in growing economies, the resulting pressures of rising costs are beginning to push health expenditure to levels that give rise to concern about national economic competitiveness. In countries where real per capita growth is stagnant or negative, these pressures simply accelerate the recent deterioration of the quality, accessibility and relevance to people's needs of publicly provided health care.

The political orientation of the health system in many countries has been influenced by concerns with liberalization, decentralization, and privatization. These influences affect the health sector in ways that depend on each country's level of development and on the structure of its health care system.

Central government financing of health care is giving way to decentralization and to a separation between financing and service provision. But transactions between providers and consumers of health care differ significantly from those between producers and purchasers of ordinary goods and services. A degree of regulation of the health care market is needed to ensure that consumers' interests are protected in their dealings with health care providers, who often hold a near monopoly of both information and access to treatment. At the same time competition among providers of care is needed to improve better the quality of care. Public agencies, for their part, need effective mechanisms to control costs. The term "managed competition" has emerged in recent years to describe these arrangements, which attempt to combine the efficiency of the markets with the equitable distribution of resources provided by the public services. Health sector reforms based on these principles have been introduced in an increasing number of countries, including the Netherlands, New Zealand, and the United Kingdom. A widely shared recent finding is that central government regulation and legislation should be confined to a selected set of strategic activities, such as budgeting for total public sector spending on health. In this context, government budgeting can be an effective way of controlling health costs (notably at the hospital level), as revealed by Abel-Smith's study on the 12 European Community countries. On the whole, however, government regulations to date have tended to be too prescriptive and directive: more could have been done to negotiate changes through improved incentives.

The whole question of the public/private mix has been debated during the last three years, thereby setting the stage for considerable rethinking in the future. The private sector is able to provide several complements to government health resources.

- It can mobilize finance and certain managerial skills. Sizeable traditional sectors in many countries constitute actual or potential complements to public sector services.

- It can provide choice for some health care consumers, and offer a high standard of service and continuity in dealing with patients.
It offers greater flexibility. The private sector frequently plays an innovatory role and is active in areas where governments have not yet developed capacity or are unable for political reasons to become involved.

There is also, however, a potential for conflict, for the following reasons.

- The public and private sectors often compete for the same resources. The problem is particularly serious when the competition is for human resources, but other inputs may also be affected.

- The private sector's objectives, particularly those of the for-profit sector, while not necessarily purely financial, are narrower than those of the public sector. In many cases, the private sector provides only the more remunerative services, which tend to be easier to provide and most in demand, leaving responsibility for the poor, for emergency care, and for training, to the government.

- Because access to the private for-profit sector is determined by ability to pay, it is likely that any expansion of the private sector will create increasing inequity in the health care system unless it is carefully controlled.

- Governments may have little control over some aspects of private sector activity, such as cost and price trends, which affect public sector operations.

- Without careful planning and monitoring, the private sector may lead to duplication and waste.

Policies to increase the role of the private sector have often been initiated by governments in times of financial strain. Yet there is an inherent tension in this approach. The successful promotion of private sector providers depends upon adequate income levels in order to pay for such health care. Private sectors flourish mainly during prosperous times, or at least among rich communities. Two countries, Chile and Malaysia, are distinctive in that they have not promoted privatization measures as a response to financial crisis. Chile began privatization in 1973, before the onset of economic decline; it came as a result of political, rather than economic changes. A closer examination of Chile's experience would be extremely useful to countries contemplating similar policies. Malaysia retains the belief that health is a government responsibility, and should be provided free to all who cannot afford it. However, it also believes in a free market system and, despite a well-respected public health care system,
is actively promoting the private sector. Moreover, it is doing this in resource rich times: GNP growth has remained strong during the past few years. A WHO Study Group has carried out an extensive review and evaluation of the recent changes in the financing of health services.  

The development of clandestine markets of dubious quality is becoming a feature of health services in a number of developing countries. These markets are being encouraged by limited opportunities and high capital costs in the private sector on the one hand, and by low salaries and shortage of drugs in the public sector on the other.

Health services in many of the least developed countries have deteriorated rapidly in the last 10 years or so. The economic recession, together with the restructuring these countries have had to adopt, has resulted in a marked decline in real terms of government budgets, particularly those of ministries of health. As noted above, these countries spend a very small percentage of their already low GNP on health and have a high population growth. The challenge to these countries is how to arrest the deterioration of services. But even if additional health resources were made available to the health budget from inside or outside the country, little further improvement in health would result if these resources continued to be deployed as at present. Most of the least developed countries are therefore carrying out various types of reforms, including those outlined above. It is particularly important for these countries to monitor the impact of these reforms. For example, there is evidence that user charges are keeping vulnerable population groups away from services. There is a fear that some of the ongoing health reforms, rather than improving efficiency, may increase bureaucracy and inequities. Monitoring will help in the revision of levels of user charges and exemption policies.

**The role of national administrations (Recommendation 3)**

Where decentralization of power has occurred there has been a significant delegation of responsibility and authority to intermediate and local levels. Strengthening of the management capability of local services, as called for in other recommendations (see recommendations 6 and 7 below), is a precondition for effective decentralization, and such strengthening can create pressure from below. However, few governments have taken such action and the health services managed by local authorities have deteriorated. Some ministries of health are now advocating recentralization of responsibility and authority.

Available data show clearly that despite statements of commitment to decentralization, central authorities retain most control over financial decisions. For most developing countries central governments are responsible for over 90% of social sector expenditure and 85% of total expenditure. The corresponding figures for industrialized countries are 75% and 60%. Donor agency support tends to go mostly to the central level and therefore has a centralizing effect. A number of initiatives, some of which are supported
by donor agencies, provide finance directly to districts and communities. Experiences are encouraging.

It must be recognized that decentralization is not a panacea, and decentralization of responsibilities without provision of concomitant resources and authority to the local level is unlikely to improve the functioning of health services at the central or peripheral levels. Of course, some health programmes may benefit from a greater degree of centralized direction than others. The challenge is to establish an appropriate balance between centralized guidance and local adaptation of policy to operational realities.

Support of PHC within the national health system (Recommendation 7)

WHO has published a number of guiding principles on this subject, including the report of the Technical Discussions in 1981.

With respect to overall national health systems, several steps have been taken during the past 16 years to reorient existing infrastructures in terms of facilities and human resources. Large numbers of seminars, workshops, and conferences have been organized to educate health workers at all levels in the PHC principles and approach. However, some health workers have not been involved. It is only recently that attention has been directed to hospital workers. WHO has carried out a series of activities in this area including the organization of an Expert Committee, a Study Group on the Role of Hospitals, a technical meeting, and the commissioning of a number of technical papers. New cadres of PHC workers have been trained, notably through community health worker programmes. A great number of these programmes, however, have withered away through lack of support from health leaders and health centres. New organizational structures for PHC were designed to facilitate the implementation of PHC activities at the central and local levels. The concept of the district focus, introduced by WHO in 1986, has helped to mobilize countries to improve their local health systems. Yet the number of countries where district health systems are functioning fully and effectively is still limited. Emphasis on improving the performance of health centres is a recent development that can further facilitate the implementation of the district focus concept.

Comprehensive PHC at the local level (Recommendation 6)

The advocacy of selective PHC on the lines discussed later under recommendation 5 has made the implementation of the above recommendation difficult. Because funds allocated to health services have decreased in real terms in all the least developed countries, the only programmes that are able to expand are those funded by donor agencies. Often donor agencies want the programmes they support to be single-purpose in order to facilitate accountability. A few countries, with WHO support, have made attempts to integrate a number of vertical programmes - MCH, tuberculosis, leprosy, malaria, and vector-borne diseases - but a lot more needs to be done. However, concern about the sustainability of projects is increasing the interest of donor
agencies in supporting more comprehensive programmes. WHO is currently working in a number of countries on the allocation to health centre staff of tasks that are integrated and based on local needs. These efforts are being documented and could be the basis for developing methods of priority-setting for comprehensive PHC.

Administration and management for PHC (Recommendation 15)

Owing to its complexity, the management of district health systems has been given particular attention. A district health system consists of a large variety of interrelated elements, covering governmental, private, and traditional services. These elements must be well coordinated by an assigned officer in order to allow for the provision of a fully comprehensive range of promotive, preventive, curative, and rehabilitative health activities.

In general, the management of primary health care requires further refinement; the sharing of experiences within and between countries should go a long way towards bringing about the rationalization of monitoring and evaluation methods.

Logistic support and facilities (Recommendation 13)

Developing countries continue to face enormous problems in providing logistic support for health services. Logistics is an area characterized by neglect, haphazard operations, and crisis management rather than planned intervention. Central warehouses and medical stores are often physically inadequate and poorly managed, and there are delays in the handling and distribution of critical supplies, resulting in spoilage and other losses. Problems with the maintenance and repair of equipment and vehicles can also cause considerable waste.

Weak communications systems impose a further constraint on logistics in developing countries. People in remote areas, such as mountainous terrain and islands, often suffer from a lack of trained local personnel and have limited access to care. Simple problems, such as a lack of petrol or broken vehicles, hinder the supply of medical materials and equipment to second- or third-level referral services even in accessible areas. Lack of telephones means that emergency advice cannot be readily obtained.

Health sector logistics is inextricably linked with the overall level of development of the country. However, within the constraints of underdevelopment, several notable successes have been achieved in the areas of immunization, essential drugs and the control of diarrhoeal diseases.

Many developing countries accept whatever equipment they can get but efforts should be made by both donors and recipients to ensure compatibility of new equipment with that already to hand. More effort is needed in the standardization of equipment such as X-ray machines and vehicles. These issues point to the main problem causing
logistical constraints, namely shortage of funds. Should a specified percentage of the budget, say 5-10%, be earmarked for this neglected area?

Health services research and operational studies (Recommendation 16)

In the initial enthusiasm generated by Alma-Ata, many people mistakenly thought that since PHC used simple methods its implementation would be straightforward. However, many difficult problems have been encountered in the implementation of PHC and some of them will be solved only with the help a wide range of health and health-related institutions.

Health systems research is recognized as an important tool of innovation because it can provide crucial inputs into the decision-making process. Considerable progress has been made in health systems research, not least in the development of the skills needed to conduct the research. Momentum is growing in terms of the development of training materials and the provision of training, and there has been an enormous increase in the number of health systems research studies carried out in recent years. They have not, however, had the success that might have been expected and one reason for this has been the absence of a national health policy and of a health systems research strategy to underpin it.

Moreover investment in health systems research remains relatively weak, and this is reflected in the poor planning and management of research projects. Then, too, the discipline requires refining and strengthening in the areas of the compilation and analysis of reliable information. In many countries, the research findings are not utilized by decision-making cadres because of the tendency of health systems research to concentrate on narrow technical issues and academic problems. The challenge for health systems research in the future will be to develop practical methods for dealing with the problems of decision-makers and for improving health. One such success is the development of the method of cognitive mapping used to resolve the problems of health care leaders. National health development networks, which are mechanisms that link, coordinate, and mobilize the efforts of those involved in health development and health systems research, have appeared in a number of countries.

Multifactorial studies need more attention. Subjects for such studies would include the various factors involved in referral in health care, the linking of public and private systems, and the optimum mix of curative and preventive services. Studies on this topic are particularly needed at the local level. For example, there are very few studies on micro-level-integrated health care. Studies of this nature would provide information on cost-effective ways of linking the various elements of health care.
Conclusion

Formal commitment has been made to health for all by most countries, many nongovernmental organizations, and many health institutions. A forceful HFA movement has been set in motion.

However, less effort has been made to define clear PHC objectives and targets. A few countries, particularly in Europe, have taken a lead in this respect but most activities of this kind remain almost exclusively within the health sector. Little progress has been made in introducing necessary changes based on PHC principles in resource allocation, the organization of health systems, the delivery of programmes and supportive legislation. The successful implementation of comprehensive PHC requires the rethinking of current approaches to the setting of priorities.

Some progress has been made in mobilizing interest in health systems research and in developing the necessary skills. The challenge is to intensify the effort, but an even more urgent need is to make health systems research more relevant to decision-makers.

Fresh efforts must be made to stimulate technical cooperation among developing countries at the operational level so that they can learn from each other on a continuing basis.
CHAPTER 4

ALMA-ATA RECOMMENDATIONS: A CRITICAL REVIEW - III

PRIME*ARY HEALTH CARE PROGRAMME ELEMENTS

Content of primary health care (Recommendation 5)

The recommendation that PHC should include "at least" eight elements in order to provide comprehensive care has created heated discussions. There are some who have felt that other programmes like mental health and oral health, should be added to the list, while others have contended that the list is too long for countries with limited resources and have advocated "selective" PHC implementation. Many have vehemently disagreed with this stand, and a WHO consultation was devoted to the subject. While selective implementation threatened PHC in the first years, it is gradually being abandoned even by its strong advocates. At any rate, the debate is less heated.

A well-developed primary health care system has to address "at least" a specified number of programmes, but this may be done in stages within a planned package and time framework. However, the phased implementation of PHC activities must be planned at the outset.

It is ironic to note that while the Alma-Ata conference listed eight essential elements to emphasize that primary health care was comprehensive (one or two successful programmes do not constitute primary health care) the same list has been used by some agencies for selecting programmes that they favour, which is exactly what was being discouraged. The two important words "at least" have been completely overlooked.

In retrospect, was it a mistake to introduce the list?

Examples of progress in coverage of populations with the essential elements of health care and some of the health technologies in use are given below. Fig. 3 summarizes achievements between 1983-85 and 1988-90.

Health promotion and education

The term 'health promotion' incorporates both individual and societal action for improved health. The term has been used since the 1920s. However, following Alma-Ata, international conferences in Ottawa, Adelaide and Sundsvall have helped determine the scope of health promotion, and develop strategies for action. The three principal interrelated strategies have been advocacy for health, building alliances and social
Figure 3. Percentage of the population covered by PHC activities in the developing countries, 1983-85 and 1988-90

1983 – 1985

- Local health services
- Pregnancies attended
- Deliveries attended
- Tetanus: pregnant women immunized

1988 – 1990

- Infants attended
- Infants Immunized:
  - DPT
  - measles
  - polio
  - BCG
- Safe water supply
- Excreta disposal

Coverage (%)
support, and empowering people to act in ways that promote health.\textsuperscript{108,109} The Sundsvall conference focused on supportive environments in the broadest sense, recognizing that health, the environment and human development cannot be separated. Health education is a part of the overall approach, and was listed in the eight essential elements of primary health care.

There are many examples of implementation of the three strategies. Governments, communities, the media, research institutes, NGOs and international agencies are all understood to have important roles in advocacy for health. Their degrees of influence vary in different countries. An example of an intersectoral approach to advocacy and health education is the project 'Heartbeat Wales', aimed at reducing mortality from heart disease. An example of a broad government commitment to health improvement was seen in China, Sri Lanka and Kerala, where there was a government commitment to education, the provision of services essential to basic needs, and local involvement in the process. Much health promotion work has been done with school age children and young adults; some successful examples are the child-to-child programmes, the 'little doctor' programme in Indonesia, and health scouts in Colombia.

The importance of social support in enabling people to take actions to improve their own health has been increasingly recognised.\textsuperscript{109,111} For example, family planning programmes have been better accepted when they have been designed with an understanding of the external factors that determine peoples behaviour. Alliances between different agencies have contributed to this better understanding.

The importance of health promotion programmes based on community education and social change has been emphasized in recent years. The "new public health" is based on a five-part social change strategy:

- 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 supporting 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 wellbeing.\textsuperscript{112}

It is, however, increasingly realized that, as defined, the concept of new public health is weak in addressing environmental problems. The strategy of sustainable development is broader and is considered to be more appropriate.\textsuperscript{13}
Water and sanitation

Increasingly, the provision of water for personal hygiene is seen as equally important to health as the provision of safe water for drinking and cooking. Thus, the focus is shifting from drinking-water quality alone to one of overall environmental improvement involving water supplies, sanitation, hygiene education, and general community involvement in environmental management. The impact of this more holistic approach can be seen in the dramatic progress in controlling dracunculiasis.

While globally there has been an overall increase in the provision of clean water and sanitation, it has been inadequate to cope with population increase in many developing countries. There are great inequities between regions. Africa has the lowest coverage with safe water (44%), while Asia has the lowest coverage with environmental sanitation (20%).14

Maternal and child health care and family planning

Maternal mortality is an indicator of women's status in society and of their access to health care and other essential services. Inadequate care during pregnancy and childbirth, inadequate referral to higher levels of care when required, as well as poor health and nutritional status, inappropriate timing and spacing of pregnancies, and excessive numbers of pregnancies are the factors responsible for most maternal deaths, infant mortality, and serious morbidity among women and their children. The International Women's Decade (1976-85) helped to heighten awareness of the magnitude of these problems and the realization that they cannot continue to be accepted as inevitable in view of the feasible solutions that exist. Maternal health has received far less attention than child health.113 Table 1 shows maternal mortality rates by country groups.

<table>
<thead>
<tr>
<th>Country groupings</th>
<th>Maternal mortality per 100,000 live births, 1991</th>
<th>Number of Member States included, 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing countries</td>
<td>421</td>
<td>113</td>
</tr>
<tr>
<td>of which least developed</td>
<td>737</td>
<td>37</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>41</td>
<td>8</td>
</tr>
<tr>
<td>Developed market economies</td>
<td>34</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>370</td>
<td>146</td>
</tr>
</tbody>
</table>
The use of affordable and straightforward technologies, now available to all women, can cut maternal mortality in half. For example, family planning is crucial to avoid high-risk pregnancies, including those among women under the age of 18 and over the age of 35. It allows for births to be spaced two to three years apart and for the total number of pregnancies in a woman's lifetime to be reduced. From only 9% in 1960-65, contraceptive prevalence in developing countries has risen to an estimated level of 50% in 1990.14

However, about 300 million couples who do not want additional children are not using family planning methods, even though surveys in developing countries show that they are aware of the health risks to women and children posed by frequent pregnancy.

It is estimated that 13-14% of maternal deaths result from unsafe abortions. The proportion in developing countries is well over twice as high. Table 2 shows the current situation of legislation on induced abortion. Induced abortion remains a sensitive issue with cultural, social, political, and religious overtones that make it difficult for governments to decide on the matter. In both industrialized and developing countries, there is a move in the direction of liberation of abortion laws - although the change is slow in the latter.

Genital mutilation remains an important problem in a number of developing countries. A series of activities by nongovernmental organizations and the UN Commission on Human Rights culminated in the adoption by the Forty-seventh World Health Assembly in 1994 of resolution WHA47.10 urging governments to take measures to eliminate traditional practices harmful to the health of women and children, particularly female genital mutilation.114-118

Newborn and child health is strongly related to the social, economic, and health status of the mother. Most infant and under-five morbidity and mortality could be prevented through the provision of adequate water supplies and sanitation facilities, good nutrition for both mother and child, and access to first-level care, including immunization coverage. Table 3 shows that the provision of infant care by trained personnel has increased since the first evaluation in 1985 but also that there are still large differences between countries.
Table 2. Legislation on induced abortion

<table>
<thead>
<tr>
<th>Legal status of abortion</th>
<th>Number of countries</th>
<th>Percentage of global population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prohibited, unless the pregnancy is life-threatening</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td>Authorized on broad medical grounds</td>
<td>42</td>
<td>12</td>
</tr>
<tr>
<td>Authorized for social and sociomedical indications</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Authorized without specific indications</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>


Table 3. Provision of infant care by trained personnel, 1985 and 1991

<table>
<thead>
<tr>
<th>Country groupings</th>
<th>Infant care per 100 live births</th>
<th>Number of Member States reporting, 1991</th>
<th>Number of Member States included 1985</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1991*</td>
<td>1985</td>
<td></td>
</tr>
<tr>
<td>Developing countries</td>
<td>64</td>
<td>43</td>
<td>47</td>
</tr>
<tr>
<td>of which least developed</td>
<td>56</td>
<td>36</td>
<td>13</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>-</td>
<td>99</td>
<td>13</td>
</tr>
<tr>
<td>Developed market economies</td>
<td>100</td>
<td>98</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>60</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>71</td>
</tr>
</tbody>
</table>

* Based on values for 48 Member States and weighted by their respective number of live births.

The prevalence of breastfeeding, especially after three months, is highest in Africa and Asia and lowest in Europe and North America. However, its use has been rising steadily in industrial countries over the past 30 years, particularly among educated mothers. The fall in the prevalence of breastfeeding among disadvantaged mothers is one of several factors threatening the survival of babies. This is especially significant because, although infant and under-five mortality rates continue to decline worldwide (Tables 4 and 5), 9.2 million infants still die each year in developing countries. Projected under-five mortality rates are unacceptably high for Africa and Southern Asia (Table 5). Table 6 shows 26 countries whose under-five mortality is over 170.19
Table 4. Infant mortality rates, 1985 and 1991

<table>
<thead>
<tr>
<th>Country groupings</th>
<th>Infant mortality (per 1000 live births)</th>
<th>Number of Member States included, 1991</th>
<th>Number of Member States included 1985</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1991</td>
<td>1985</td>
<td></td>
</tr>
<tr>
<td>Developing countries</td>
<td>75</td>
<td>86</td>
<td>113</td>
</tr>
<tr>
<td>of which least developed</td>
<td>119</td>
<td>130</td>
<td>37</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>22</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>Developed market economies</td>
<td>14</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>76</td>
<td>146</td>
</tr>
</tbody>
</table>

Table 5. Global under-five mortality rates

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>World total</td>
<td>240</td>
<td>118</td>
<td>83</td>
</tr>
<tr>
<td>Industrial countries</td>
<td>73</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>Developing countries</td>
<td>281</td>
<td>134</td>
<td>94</td>
</tr>
<tr>
<td>Africa</td>
<td>322</td>
<td>182</td>
<td>132</td>
</tr>
<tr>
<td>Latin America</td>
<td>189</td>
<td>88</td>
<td>61</td>
</tr>
<tr>
<td>East Asia</td>
<td>248</td>
<td>50</td>
<td>28</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>244</td>
<td>111</td>
<td>67</td>
</tr>
<tr>
<td>Southern Asia</td>
<td>327</td>
<td>177</td>
<td>125</td>
</tr>
<tr>
<td>Western Asia</td>
<td>307</td>
<td>115</td>
<td>65</td>
</tr>
</tbody>
</table>
Table 6. The 26 countries with under-five mortality rates of 170 and over  
(per 1000 live births)

<table>
<thead>
<tr>
<th>Afghanistan</th>
<th>Mali</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Malawi</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Mauritania</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Mozambique</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Nepal</td>
</tr>
<tr>
<td>Burundi</td>
<td>Niger</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Rwanda</td>
</tr>
<tr>
<td>Chad</td>
<td>Senegal</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>Guinea</td>
<td>Somalia</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>Sudan</td>
</tr>
<tr>
<td>Liberia</td>
<td>United Republic of Tanzania</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Yemen</td>
</tr>
</tbody>
</table>

Immunization

The immunization coverage of children under one year stood at the 20% mark in 1980. The global achievement of the 1990 target of 80% immunization coverage among infants worldwide with BCG and measles vaccines, the third dose of DPT, and oral poliovirus vaccines represents a milestone on the way to universal childhood immunization. This progress in global immunization is directly attributable to the efforts of national governments, WHO, Unicef, and other bodies of the United Nations system, bilateral development agencies, and nongovernmental organizations such as Rotary International. The development of the capacity to achieve these levels of coverage of infants represents a major public health triumph for the decade of the 1980s.

The impact of routine coverage and special immunization activities on the target diseases has been impressive. One of the greatest achievements has been the virtual eradication of poliomyelitis from the Americas, with the last reported case in August 1991 in Peru. This dramatically demonstrates what can be accomplished when multiple governments, United Nations agencies, nongovernmental organizations, and international donors work together towards a common achievable goal. Globally, it is estimated that there has been an 81% decline in cases of poliomyelitis compared to pre-immunization levels. It is estimated that the incidence of measles has fallen 66% and measles mortality 88% compared to pre-immunization levels. Similarly, there has been an estimated 54% decline in neonatal tetanus deaths compared to pre-immunization levels. At current levels of immunization, it is estimated that some 2.9 million deaths are being averted each year due to measles, neonatal tetanus, and pertussis. However, 2.1 million deaths from these same diseases continue to occur. It is important to continue to improve surveillance to develop the capacity to monitor disease incidence routinely and
accurately, to identify risk areas and to direct immunization activities to areas of greatest need.122

Achievements in child immunization coverage, which in 1990 reached 80%, have largely been sustained. However, further improvements in global coverage have not been reported, and some countries have experienced decreases in immunization coverage. This is of concern because it suggests that:

- the sustainability of past accomplishments is being threatened;
- progress is being blunted in reaching the "hard to reach" populations, who bear a disproportionate burden of vaccine-preventable diseases, as well as other conditions preventable by primary health care.

While it is expected that progress will slow down once high coverage is achieved, it is important that countries should review policies aimed at reaching those who are not immunized. Countries in which immunization coverage has fallen should assess the reasons behind the reduction and take urgent corrective action. An example in the European Region is the situation in most Newly Independent States where a combination of lack of vaccines and weakened management of vaccination programmes had led, in particular, to an outbreak of diphtheria; the total number of cases in the Region rose from some 3000 in 1991 to some 17 000 for the first six months of 1994.122 Additional efforts are needed to reach countries - and districts within countries - that are still significantly below the global average and to accelerate activities to reach 90% immunization coverage.

In contrast to the coverage achieved with children, the immunization of pregnant women with tetanus toxoid vaccine has only increased from 39% to 42% globally. Much higher coverage will need to be achieved, especially in high-risk areas, to eliminate neonatal tetanus as a public health problem.123 In the African Region, for example, the estimated TT 2+ coverage has increased from 23% in 1987 to 50% in 1991. This increase may reflect efforts to extend the delivery of tetanus toxoid immunization services at childhood immunization sites, as well as improvements in assessing and reporting the actual coverage.

The World Summit for Children124 endorsed the joint WHO/Unicef health goals for immunization programmes in the 1990s, which are as follows:

- maintenance of a high level of immunization coverage (at least 90% of children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis and against tetanus for women of childbearing age;
by 1995, reduction by 95% of measles deaths and reduction by 90% of measles cases compared to pre-immunization levels as a major step towards the eventual global eradication of measles;

- elimination of neonatal tetanus by 1995; and

- global eradication of poliomyelitis by the year 2000.

_Treatment and control of diseases and injuries_

In this section some specific diseases are briefly reviewed. Those presented have been chosen because of the size of their present and future contribution to the global burden of disease, because there have been achievements in disease control, and/or because they illustrate problems common to several disease control programmes.

_Acute respiratory infections_

ARI, which causes about 3.4 million deaths annually in children under 5 years old, is currently the leading cause of childhood death and a frequent cause of morbidity. Its top position is partly a reflection of the decrease in mortality from diarrhoea and vaccine preventable diseases in the last decade. Pneumonia is the principal cause of death from ARI. Risk factors for pneumonia are malnutrition, low birth weight, indoor air pollution, exposure to cold and behavioural factors that influence maternal care. Standardised case management is currently the main strategy for reducing ARI deaths. WHO activities have included the development of technical guidelines for case management, training courses for all levels of health workers, and clinical, behavioural and health systems research. Fifty-five developing countries now have operational ARI programmes in at least some provinces. Nineteen countries reported in 1992 that they have national coverage on training, supervision, and supplies in first level facilities. In target countries (those with an Infant Mortality Rate over 40/1000 in 1990) access of the population to a trained health provider with a regular supply of free or affordable antibiotics was estimated to be 12% at the end of 1992. However, despite training many pneumonia cases are still not adequately treated.

_Diarrhoeal diseases_

Although there has been an important reduction of mortality due to diarrhoeal diseases in the last decade they are still a leading cause of death among children in developing countries. They caused an estimated 3.2 million deaths in 1990 (80% in the first two years of life). Approximately 50% of the deaths are due to acute watery diarrhoea, 35% to persistent diarrhoea, and 15% to dysentery. Risk factors for frequent, severe or prolonged episodes include a failure to breastfeed, malnutrition, measles and HIV. Each episode of diarrhoea contributes to malnutrition. Management of diarrhoeal diseases therefore involves several elements of PHC.
At the end of 1993, 129 countries had implemented plans of action for control of diarrhoeal diseases in children. Programmes have been aimed at appropriate case management, to prevent dehydration and reduce malnutrition, combined with efforts to reduce disease incidence through measles immunization, promotion of breast-feeding, and improved weaning and hygiene practices. WHO activities have included development of case management guidelines for use in health facilities, training packages for all levels of health workers including licensed drug sellers, research to develop improved rehydration fluids, and promotion of access to oral rehydration solutions.

By the end of 1992 the proportion of the global population with a regular supply of ORS in their community was 73%; 32% of mothers are estimated to know the three rules for case management in the home; approximately 19% of cases are now receiving increased fluids and continued feeding. However, this strategy is of limited value on its own when the child that has been treated for diarrhoea has to return to the same environment in which the disease was acquired. It is important to develop programmes for improving environmental sanitation, including safe supplies of water.

A need for more integration between health care programmes for under-fives has been recognized. A WHO-UNICEF training package *Management of childhood illness - a training course on case management and the organisation of work at health centres* is being prepared as the first phase of a broader approach to management of serious childhood illness. This provides training aimed at health workers at first level health facilities on management of the five problems that cause 70% of the deaths among young children: respiratory infection, diarrhoea, malnutrition, malaria and measles.

*Tuberculosis*

Tuberculosis today is the foremost cause of death from a single infectious agent; one-third of the world’s population is infected. It causes 25% of avoidable adult deaths worldwide.125 Eight million new cases and three million deaths occur each year. It is thus a major global health problem and is especially serious in the developing world, where 95% of cases occur. Eighty per cent of cases involve people who are in their most productive years (15-59).

Since 1985 the incidence of tuberculosis has started to increase in many countries. This is for four main reasons: demographic changes, poor quality TB programmes, HIV infection and socioeconomic factors. HIV is the greatest risk factor for tuberculous infection to progress to disease: of those co-infected with tubercle bacteria and HIV 50-70% may develop tuberculosis. By the end of 1990 more than three million people were dually infected, of whom 2.4 million were in sub-Saharan African countries.14

The current tuberculosis/HIV situation in some Member States in the South-East Asia and Western Pacific Regions is similar to that in Africa five to seven years ago. Two-thirds of the world’s tuberculosis-infected population is in Asia. Although current HIV
prevalence is small at present, it is increasing rapidly, and control of the TB epidemic is essential before the HIV pandemic proceeds much further, if large increases in mortality from TB are to be avoided. In Bombay, HIV seroprevalence among tuberculosis patients increased from 2% in 1988 to 10-15% in the past two years. In northern Thailand, where HIV seroprevalence in tuberculosis patients increased from 5% in late 1989 to 14% in early 1991, there is already some evidence that tuberculosis incidence is increasing. Fortunately, however, it appears that the increase in tuberculosis cases does not necessarily lead to increased transmission of the disease if an effective country-level control programme is in place.

A second major problem is the emergence of multi-drug-resistant bacilli. This is a direct consequence of ineffective or inappropriate TB control programmes and policies, and increases the threat of an incurable epidemic.

The Forty-fourth World Health Assembly (1991), recognizing the growing importance of tuberculosis and the potential for cost-effective control using currently available methods, endorsed a global tuberculosis strategy and established the following two objectives for global control. First, to treat successfully 85% of all detected smear positive (or infectious) cases, and second, by the year 2000 to detect 70% of such cases.126

In 1993, the Forty-sixth World Health Assembly adopted three types of action regarding tuberculosis.

- Member States are urged to strengthen their national tuberculosis programmes in accordance with a strategy involving four main components: passive case detection through sputum smear microscopy, directly observed short course chemotherapy, standard case registries and treatment evaluation, and reliable supplies of high-quality drugs to treatment centres.

- The international community is requested to continue support for improved tuberculosis programmes at all levels, both through increased funds, and training in management.

- The Director-General of WHO is requested to take action to further strengthen the capacity of the programme and reinforce support to Member States, to advocate the better use of existing resources, and to mobilize additional resources.

AIDS

The cumulative number of reported AIDS cases, as of 1 July 1992, was 501 272 from 168 countries. Over 95% of the reported cases were young or middle-aged adults. However,
the true cumulative total of adult AIDS cases in the world by mid-1992 was estimated by WHO to be approximately 1.7 million. Reasons for the discrepancy include inadequate diagnosis and incomplete reporting to public health authorities, and delays in reporting.\textsuperscript{127}

Nearly 90% of the projected HIV infections and AIDS cases for this decade will occur in the developing countries. In sub-Saharan Africa, where over seven million adults are already infected with HIV, the situation is critical. As many as a third of pregnant women attending some urban antenatal clinics are HIV-infected. Seropositive rates this high are also being seen outside cities. As a result, WHO now projects that 5-10 million HIV-infected children will have been born by the year 2000. By the mid-1990s the projected increase in AIDS deaths in children will begin to cancel out the reduction in mortality achieved by child survival programmes over the past two decades. In the African countries where the prevalence of HIV infection is already high, life expectancy at birth will actually drop by 5-10% by the year 2000 instead of rising by 20%, as was projected in the absence of AIDS. In Asia, where more than half the world’s population lives, the dramatic rise in seroprevalence between 1987 and 1991 in south and south-eastern countries may well parallel that seen in sub-Saharan Africa in the early 1980s. By the late 1990s more Asians than Africans will be infected each year. As of early 1992, Latin America and the Caribbean were estimated to have over one million HIV-infected adults.

Fears of a non-HIV AIDS epidemic have been shown to be unfounded. In all, only about 100 cases of an AIDS-like disease have been recorded, spread over a relatively long period of six years. Epidemic proportions have not been witnessed.

Endorsed in January 1992 by the WHO Executive Board, in May by the World Health Assembly, and in July by the Economic and Social Council of the United Nations, the 1992 update of the Global Strategy on AIDS sets out technically and ethically sound approaches of known effectiveness for meeting the pandemic’s new challenges:

- adequate and equitable provision of health care to the growing numbers of HIV-infected people falling ill;
- treatment for other sexually transmitted diseases, which increase people’s biological vulnerability to HIV infection;
- reduction of women’s social vulnerability to HIV infection by improving their health, education, legal status, and economic prospects;
- a more supportive socioeconomic environment for AIDS prevention;
• immediate planning in anticipation of the pandemic's socioeconomic impact;

• a greater focus on conveying effectively the compelling public health rationale for overcoming stigmatization and discrimination.\textsuperscript{121}

Subsidiary strategic approaches are focusing on women, children and AIDS. For both WHO and Unicef, the main strategy for reducing the impact of HIV/AIDS on women and children is the prevention of the sexual transmission of HIV. As more women are infected through heterosexual intercourse, more infants will be born already infected. Reducing sexual transmission of HIV requires behaviour change achieved through health promotion activities targeted at various groups, including those practising (or exposed to partners who practise) high-risk behaviours.\textsuperscript{129} In addition, activities are being focused on the avoidance of discrimination against HIV-infected people and people with AIDS and collaboration with nongovernmental organizations.

Much work is being done to define appropriate interventions for people most at risk. At the same time emphasis is being laid on clinical research and drug development, vaccine development, diagnostics, and epidemiological research and forecasting.

The same factors that originally fuelled the pandemic continue to impede prevention and care. These include ignorance about the nature of the disease, denial of the relevance of AIDS to the individual or to society, and complacency or paralysis in the face of the pandemic's magnitude. These are aggravated by the stigmatization of HIV-infected persons and those perceived as being at risk of infection; the subordinate social and economic status of women; traditional and cultural practices that facilitate transmission; and reluctance to discuss sexual matters frankly. As a result, there is still insufficient high-level political support for the prevention and control of the disease, and this is reflected in the inadequate human and financial resources allocated to combating it.

These factors make it imperative for a broad range of different sectors and agencies to contribute to a coordinated effort. A joint and co-sponsored United Nations programme on AIDS was approved by the World Health Assembly in May 1994 and by the governing bodies of other UN agencies has started recently.

\textit{Malaria}

The malaria situation has been static in many areas, but drug resistance of parasites and of vectors to insecticides is a big challenge. Globally, African countries south of the Sahara account for 80\% of all clinical cases and for nearly 80\% of the deaths per year related to this problem. The Ministerial Conference on Malaria held in Amsterdam in October 1992 reviewed the situation and adopted a global strategy.\textsuperscript{130} One certainty is that the development of a vaccine for malaria is still a long way off. The strategy adopted has four basic technical elements:
• to provide early diagnosis and prompt treatment;

• to plan and implement selective and sustainable preventive measures;

• to detect the disease early and contain or prevent epidemics; and

• to reassess a country’s malaria situation regularly, in particular the ecological, social, and economic determinants of the disease.

This is a distinctly different approach from that of the old malaria eradication programme. But the worsening of malaria in many developing countries will call for a constant review of the efforts in malaria control.

_Leprosy_

The estimated global prevalence of leprosy in 1994 is 2.4 million cases. There is little information on the prevalence of disabilities due to leprosy, but a global estimate is 2 to 3 million. Countries where leprosy is endemic have adopted an elimination strategy involving multi-drug therapy. By 1994 54% of all registered leprosy cases were taking multi-drug therapy. The global prevalence of registered cases has decreased rapidly in the four years, 1990 to 1994, from 7 cases per 10 000 population to 3 per 10 000, suggesting that elimination of the disease as a public health problem (a prevalence less than 1 case per 10 000) is feasible. There are problems emerging with programme implementation, which require attention if progress is to be maintained. These include inadequate political commitment, programme coverage, drug supply at different levels, and availability of trained personnel.¹³¹

_Diabetes mellitus_

Diabetes mellitus is being recognized as an increasingly important problem to the public health of developing and developed countries alike. Its prevalence is known to be highest in some developing countries and among minorities and disadvantaged population groups in developed countries.¹³² Unless effective measures are taken the situation will worsen steadily as urbanization and population aging continue, since older people are more susceptible to the most common form of the disease. There are at least 60 million adults with diabetes in the world.

As the epidemic of diabetes develops, the greatest impact is likely to occur in developing countries owing both to the greater genetic susceptibility of their populations to the disease and to the lack of health care facilities to avert its complications. Diabetes is strongly linked with the adoption of a Western life-style. Treatment and management of cases is costly, and it is only recently that developing countries have been seriously
assessing the feasibility of national control programmes. A study in Tanzania has shown that the average annual direct cost of diabetes care for a patient requiring insulin is US$ 287; for a patient not requiring insulin it is $103. Tanzania has a GNP of $160-200 per capita, and expenditure on health is around $2 per capita. The paper concludes that "if African patients with diabetes have to pay for their treatment, most will be unable to do so and will die". An important finding in the study is that patients made an average of 3.8 visits to health units before diabetes was diagnosed. Earlier diagnosis and treatment would have reduced the cost.\textsuperscript{133}

Diabetes does, in fact, test all the components of the health system. It is a disease that requires maximum individual and family participation. It is a disease that requires the utmost commitment and motivation of health workers to provide repeated guidance to patients. Interactions are needed within the health system and with other sectors in such areas as logistic support to ensure the adequate and timely provision of services. In this respect diabetes control is a true and effective indicator of the level of functioning of the health system. As with the other major noncommunicable diseases, the factors most likely to be responsible include obesity, lack of physical exercise and inappropriate diet. Therefore, emphasis needs to be placed on prevention.\textsuperscript{14}

\textit{Onchocerciasis}

Onchocerciasis transmission has been virtually eliminated by the Onchocerciasis Control Programme in several African countries through large scale vector control. Increasing use is being made of ivermectin, which acts against the disease parasite in man for up to a year.

\textit{Disabilities}

Notable progress has been made in technology and programmes for the local management of disabilities,\textsuperscript{134} though the application of such approaches is still far from reaching all those who might benefit from it.

Information on the extent of disability worldwide is beginning to be collected in a standard manner based on the categories in WHO's international classification of impairments, disabilities, and handicaps.\textsuperscript{135} Estimates of the percentage of persons with disabilities vary depending on the types of questions used. Surveys using standardized screening methods show that up to 5% of the population may present disabilities; this percentage is higher where other screening methods have been used (mainly Europe and North America). But the relatively high levels found in developed countries are not due solely to a difference in methods; those countries contain a higher proportion of older people than the others.

Available data generally concentrate on the prevalence rather than the incidence of disability, and it is not easy to derive information on trends. Rates from diverse national collection sources are not fully comparable at present. However, the relationships found
between disability and other demographic or socioeconomic variables are fairly consistent - for instance, it is generally the case that disabilities are more prevalent among the poor.

Many developing countries are already in, or are soon to enter, a period of marked demographic and epidemiological transition.\textsuperscript{136,137} Their health services must assume the added responsibility for the prevention and management of chronic noncommunicable diseases such as cardiovascular diseases, cancers, mental illness and injuries, including the disabilities they cause. Some countries, such as Kenya and Zimbabwe, have begun to include rehabilitation within the PHC approach.

**Essential drugs (Recommendation 14)**

The Action Programme on Essential Drugs\textsuperscript{138,139} was established in 1978, with the objectives of (1) ensuring the regular supply of safe and effective drugs and vaccines of acceptable quality at the lowest possible cost and (2) promoting the rational use of drugs.

Much has been accomplished since 1978. Within 12 years 64 countries had installed operational essential drugs programmes, 28 were developing such programmes, and at least 68 had formulated national drug policies. Notwithstanding this progress, approximately two billion people still lack access to the most crucial drugs and vaccines.

The drugs bills for most health services are enormous, compounded by problems of wastage. Over 50\% of supplies may be wasted. Concentrating more on basic drugs could bring considerable savings. Medicine consumption per head in developing countries was estimated at $5.40 in 1985. Yet basic and essential drugs cost only about $1.00 per person, and an even more basic list could be provided for $0.25.

Many of the cheapest treatments are just as effective as the high-technology alternatives. The conventional treatment for diarrhoeal diseases is intravenous rehydration therapy. But oral rehydration is just as effective as intravenous, if not more so in some cases, and its use could cut costs by about 90\%.

Rationalizing drug purchasing policies could lead to further economies. Generic, rather than brand-name drugs, could be used. Buying could occur through a competitive bidding system. Sri Lanka saved considerably by centralizing the buying of pharmaceutical products through one state company. It obtained basic drugs at a half to a third of the price paid by the private sector.

There are instances of success in rationalizing the purchase of drugs (for example, in Bangladesh and Zimbabwe) and in joint bulk procurement (in the Caribbean) in the face of vested interests at both multinational and national levels. However, several drawbacks have also been encountered, among which are the dependency created by international support, inappropriate dispensing at the community level, and the persistent shortage of drugs in the least developed countries. Cost-sharing, as exemplified by the Bamako Initiative, requires appropriate management and close monitoring to determine its full
effects, particularly on utilization patterns. This issue is also discussed under recommendation 17.

There is great need for comprehensive national policies and for the formulation of criteria to allow countries to select medicinal plans for use by health services and in informal self-care. Such policies should emphasize the ways of reducing expenditure on imported drugs, thereby increasing self-reliance and ensuring cultural acceptability. Although these activities are being carried out in a number of countries, they have yet to be taken up by those where the need is greatest.\textsuperscript{140}

Quality assurance remains a problem for many developing countries because of inadequate capacity for quality assessment. Substandard and fake drugs have caused a number of deaths.

Conclusion

Considerable progress has been made in the implementation of a number of the elements of primary health care. Most notable has been immunization, especially when donor agencies have been willing to provide resources for poor countries, but further extension and maintenance of the present level of coverage will to a large extent depend on continued donor support. Achievements have also been recorded in the other elements of PHC but much more effort is needed. Maternal mortality remains high in some countries, and many mothers still have no access to advice on family planning. Maternal mortality in the least developed countries is about 20 times that of countries with developed market economies.

A number of endemic diseases such as diabetes mellitus and malaria are of increasing concern to developing countries. The global community "burnt its fingers" with the malaria eradication programme and has since been reluctant to put much money into control programmes. Much more needs to be done by the global community to avert the malaria havoc in developing countries.

The identification of the essential elements of primary health care unfortunately led to selective implementation, and the two words "at least", which precede the enumeration of the eight elements, have been systematically suppressed. The gain of one programme can be the loss of another; hence the need for strategies for balancing interventions at local level to ensure maximum cost-effectiveness and sustainability.

Some 26 countries will not be able to reach Health for All - at least as measured by under-five mortalities. These countries require special support. How best can global support to these and other poor countries be provided? This issue is taken up later, under recommendation 22, page 57.
CHAPTER 5

ALMA-ATA RECOMMENDATIONS: A CRITICAL REVIEW - IV

HUMAN RESOURCES FOR PRIMARY HEALTH CARE

Roles and categories of health and health-related manpower
(Recommendation 9)

Recommendation 9 called on governments to make full use of human resources by defining the technical role of health workers and by developing teams.

The period since the Alma-Ata conference has seen a considerable expansion in human resources, most notably at the paramedical level in developing countries. Community health workers are a prime example. Despite the overall global increase, a number of poor countries still have too few health workers to provide universal coverage with essential health care. For example, the least developed countries still have only one doctor for over 20,000 people and one nurse for over 4000 people. Ethiopia, Burkina Faso, and Mali have one doctor for over 50,000 people.

The main problems in human resources continue to be the maldistribution of health personnel and imbalances between various types of health workers. Finding the appropriate manpower mix to achieve the best response to changing needs has been difficult. While in some countries there is often an over abundance of specialists such as gynaecologists, there is a very limited supply of front-line staff such as midwives. This imbalance makes it difficult to implement public health programmes such as identifying and targeting support to high-risk mothers, the success of which depends on large numbers of front-line staff. But what constitutes an appropriate mix of doctors, nurses, midwives and other health workers is country-specific. The variation in the ratio of nurses to doctors in different countries is striking. The average value is 3:1 for industrial countries and 2:3 for the least developed countries. In Argentina, Bangladesh, Bolivia, Lebanon, and Pakistan, the ratio is 2:1. Over-supply of physicians is a reality, particularly in Asia and Latin America. Several solutions, including curtailment of medical enrolments, have been tried but with limited success.

On the whole, teamwork is poorly coordinated, while the skills and motivation of health personnel require strengthening in order to deal effectively with the nonmedical facets of health development. Greater involvement of traditional health practitioners in the health system is advocated in some countries. These personnel are already doing good work in their communities, and they have the ability to detect cases for referral to higher levels. More attention should be given to them and arrangements made for their supervision and collaboration.
Training (Recommendation 10)

Despite the considerable efforts made to expand training programmes and reorient them to the PHC approach, these programmes tend to retain an overly biomedical bias. Field work is required to provide health personnel with the necessary exposure and motivation to serve local communities. This is particularly the case in the training of doctors\textsuperscript{151} and nurses at the university but is less evident in programmes of instruction for community health workers. Community education remains weak, as does health training for development workers in other sectors.\textsuperscript{152} There is a need to develop networks of community-based institutions in order to create opportunities for the emergence of new problem-solving approaches and skills in epidemiology. The training of district health teams, especially in terms of leadership capacity, is another urgent requirement.\textsuperscript{153} Other development sectors should be included in such sessions. Some countries require field service, either as part of training or early on in a career, but such procedures need to be institutionalized and replicated in other countries and a variety of contexts. Insufficient provision is made in human resource development policies for periodic adaptation of training programmes. These must be able to respond to the changing needs of a population, and to the changing roles of health personnel.

Incentives for service in remote and neglected areas (Recommendation 11)

Retaining human resources at all levels is critical, because there is a tendency for health workers to move to the private sector or overseas. New strategies are needed to retain them in order to sustain service levels. In several countries, the national health services have attracted doctors by allowing them to carry out private practice under certain conditions. Other countries allow health workers to have a reduced service time to enable them to do further study. Individual and collective awards to recognize good performance is another commonly used incentive. But there is no blueprint to go by and each country has developed incentives suitable to its circumstances. Where community health workers serving on a voluntary basis have failed, governments need to take steps to review the situation and take measures which might include offering financial remuneration and opportunities for advancement. The debate on the role of community health workers and their remuneration has been extensive. Obviously, when community health workers spend many hours a day providing services, they have to be remunerated by the government, by the community or by individuals.

Technical cooperation in PHC (Recommendation 20)

Technical cooperation issues have been discussed under relevant recommendations.

Technical cooperation among developing countries (TCDC) is a continuing effort.\textsuperscript{154} It often takes the form of joint intercountry activities in the area of training or developing methodologies. At the operational level, however, virtually no such effort exists. Support by donor agencies for technical cooperation among developing countries remains
minimal. Consultants are increasingly engaged from institutions of developed countries, thus detracting from the inward flow of foreign exchange.

Thus, while the concept of TCDC is acclaimed globally, there has not been comparable enthusiasm for supporting its implementation. If it means that countries cannot learn from each other and so gain confidence in what to do and in what to demand from the global community, the policy of supporting individual countries is in danger of degenerating to the colonial approach of "divide and rule". Multilateral and bilateral agencies need to make greater efforts in supporting TCDC.
CHAPTER 6

ALMA-ATA RECOMMENDATIONS: A CRITICAL REVIEW - V

INTERNATIONAL SUPPORT FOR PHC

International support (Recommendation 21) and the role of WHO and Unicef in supporting PHC (Recommendation 22)

WHO and Unicef were required to carry out three tasks: to encourage and support national plans, to assist in the formulation of regional and national plans that promote mutual support between countries, and to mobilize international resources for PHC. The first two tasks have been carried out fairly well. As it will be noted later in this section, the third task has been difficult to implement. Immediately after the Alma-Ata conference, WHO prepared guiding principles to help countries prepare national and regional plans of action. The regional plans of action were approved by the WHO Regional Committees in 1980. In 1981, the global strategy, based on the regional plans, was adopted by the World Health Assembly (resolution WHA 34.36). A timetable for implementing the global strategy and a set of indicators to monitor and evaluate it were adopted by the World Health Assembly in 1982. Countries were asked to provide monitoring reports on their strategies every two years and evaluation reports every six years. Few governments have taken the process seriously, and attempts are being made to correct this situation. The Regional Office for Europe has developed 38 regional targets, the specificity of which has generated the interest and attention of many countries in other Regions.

Two important initiatives - the formation of the Global Advisory Council and Intensified Support to Selected Countries did not survive. The Global Advisory Council was to be an independent mechanism to monitor progress towards health for all and to determine the adequacy of the support provided by WHO, Unicef and other relevant agencies. The Council would suggest remedial action to the Director-General, and through him to the governing bodies of other organizations, but in the end it was feared that the Council would duplicate the work of the Executive Board. This matter is discussed further in the next chapter where specific recommendations are made for the future.

The objective of the Unicef/WHO project of intensified support to selected countries, which was launched by the Joint Unicef/WHO Committee on Health Policy in 1981, was to demonstrate that PHC can be effectively implemented given national political will and global solidarity. The project put emphasis on providing "the most effective support that WHO and Unicef could give jointly to governments". Ten countries were selected but eventually only seven - Burma, Democratic Yemen, Ethiopia, Indonesia, Jamaica, Nepal,
and Papua New Guinea - were involved. To obtain government agreement and high-level commitment, joint letters were sent from the Executive Heads of the two organizations to the heads of state or government in the countries identified. Joint Unicef/WHO missions were organized to support national task forces and working groups in reviewing relevant national experience, to identify critical issues requiring special attention and support, and to adapt WHO and Unicef cooperation to national PHC strategy. It soon became clear that the complexities of political commitment and cooperation in the face of a diversity of interests and of a range of political, economic, and social uncertainties had been grossly underestimated. Eventually the project narrowed its focus to a special study in Democratic Yemen and Indonesia on "Unicef/WHO complementarity in support of PHC". After the collapse of the joint Unicef/WHO effort, it was continued by WHO in five selected countries, again with limited success. Thus the idea that PHC can work through intensified global effort in selected countries within a short time frame seems to be false. The same conclusion has been reached by other technical cooperation programmes, such as the integrated rural development programme under FAO.

When one looks back, there is sadness that so much effort has on the whole resulted in very little betterment of the poor and underprivileged who need such betterment most.

How can the failure be explained? The reasons for failure are complex but include: gross underestimation of the time required to effect reforms in countries; reliance on experts who lack sufficient knowledge of the political, economic, and social contexts in which they work and who do not have the large amount of time necessary to complete their work; overreliance on decision-making at the central government level; inadequate attention to the building of national capacity and the institutionalization of reforms; and the lack of technical cooperation between countries. But the most important problem has been shortage of funds for intensified support programmes. There are many programmes providing technical support to countries and on the whole support in this area is adequate. Thus, unless intensified programmes have additional funds (mini-Marshall plans), they have not and will never succeed.

How far have the pledges made at Alma-Ata concerning the support of poor countries by rich ones been fulfilled? No increase in aid flows has occurred and only minimal action has been taken to tackle the indebtedness of the least-developed countries and improve their access to industrial markets. There is now a well-founded fear that Eastern Europe's need for finance may further reduce the resource pool available for the least developed countries.

It should also be noted that none of the many global health conferences organized in recent years have been followed by flows of money to implement recommendations. With the notable exception of the Rio International Conference on the Environment, there has been no assessment of resource requirements for implementing recommendations of conferences, and no attempt has been made to determine where the money should come from. During the preparatory period for the Alma-Ata conference,
a number of options were suggested for raising money to support follow-up activities in poor countries. One was that the more prosperous countries would allocate support to poor countries equal to at least 1% of their expenditure on health care. Eventually none of the options was discussed by the conference.

How much will it cost a developing country to provide the eight elements of PHC? This question, which preoccupied many agencies immediately after the Alma-ATA Conference, has resurfaced recently. A series of studies carried out immediately after the Alma-ATA Conference showed that there were no easy answers then or now. There are too many variables involved - standards of service chosen, level of training of staff, number of staff and staffing patterns, level of salaries, dispersion of population, level of private provision of services, technology adopted, etc. Thus the answer will vary from country to country. Relevant issues on resources for PHC are discussed under recommendation 17, page 28. It soon became clear that whatever the level of resource requirements arrived at, funds would not be available. This is partly because donor agencies are interested in supporting projects and countries of their choice. Some countries may also want to link aid to bilateral commitments, such as the purchase of military equipment. There are very few agencies that are willing to support comprehensive PHC. The other problem has been the large sums of money required, for which large increases in aid would be necessary at a time when many industrial countries were experiencing recession themselves.

At the Rio conference, resource requirements and mechanisms for supporting poor countries were worked out. Agenda 21 speaks of the need for an extra US$ 125 billion of concessionary aid each year between 1993 and 2000 to finance its recommendations for poor countries. In preparatory discussions for that conference, French representatives proposed that the European Union should put up US$ 3.8 billion to help pay for Agenda 21. The scheme vanished in a welter of argument within the Union.

Thus many questions remain about how best to mobilize funds for PHC from donor agencies. A more serious effort should be made to find innovative and effective ways of deploying donor support. This matter will be referred to again in the next section. Obviously it is not difficult to calculate what sums of money are required to do this or that. For example, estimates of extra funds needed for Rio follow-up activities on the lines indicated above and for cost-effective minimal health care packages in various countries have been worked out fairly easily. More thought, however, should be devoted to practical ways of obtaining the sums needed and commitment (or at least interest) on the part of those who will provide the money.

It is also important to be realistic about what outside agencies can do in solving national problems that are based on the totality of life in a country. Initial euphoria in launching top-down broad-based country initiatives so often leads in a few years to frustration and disillusionment on the part of those in the recipient countries, who are the losers in opportunity and other costs.
Conclusions

The gap between the acceptance of the principles of global solidarity at the Alma-Ata conference and other conferences and the implementation of those principles is enormous.

With regard to support by donor agencies to poor countries, aid has stagnated for over a decade. In this respect it can be said that the global community has let down the PHC movement. Many donor agencies want to benefit from their money. This may at times adversely influence the way in which projects are planned and implemented. Often it also means that there is little interest in providing broad support. More effort must go into exploring new ways of supporting poor countries.

On global solidarity in general, the PHC movement has depended almost exclusively on goodwill. The proposal of establishing a Global Advisory Council as a means of exerting pressure on various health-for-all partners to comply with their commitments has not been successful. The need for such a mechanism remains.
CHAPTER 7
ADAPTING PHC FOR THE YEAR 2000 AND BEYOND

Overview

Are countries any nearer to achieving the goal of health for all than they were at Alma-Ata 16 years ago? There is no composite measurement that makes it possible to give a "yes" or "no" answer. Some measures show improvements: others show deterioration.

Successes

On the positive side, the call for HFA and the concept of PHC have won widespread acceptance, among both governments and international and nongovernmental organizations. It has had considerable influence in promoting a more equitable distribution of health resources, in reorienting services, and in developing new types of health workers in many countries. There has been extensive expansion of coverage of several PHC elements (see Fig. 3 and Table 3). Health status has improved, as indicated by lower mortality rates in all countries (see Tables 4 and 5), although significant epidemiological variations and inequities are found both between and within nations. Considerable successes have been achieved, particularly when it is realized that a great deal of time is required for new concepts to be assimilated and for changes to be integrated into national health systems.

Epidemiologically, childhood diseases such as poliomyelitis, measles, tetanus, and pertussis have decreased owing to the rapid expansion of immunization coverage. This decrease has contributed significantly to the overall decline in infant and child mortality rates. However, few developing countries, particularly the least developed countries, would be able to maintain the high level of childhood vaccination without external support. Progress towards the achievement of global targets for eradication and control of selected diseases is encouraging. Cardiovascular diseases have decreased in males in developed countries, partly because of a decline in smoking.

A number of countries have had very rapid economic growth, moving from a developing country status to that of newly independent countries. The economic growth has been accompanied by overall improvements in social conditions.

Finally, the 16 years of experience gained in implementing PHC will be of help to individual countries and the global community in designing future strategies for dealing with health problems. The factors that have led to rapid improvements in health in a number of countries indicate the strategies that should continue to be emphasized. The dissemination of practical experiences in overcoming problems encountered in the
implementation of PHC is perhaps the most powerful tool that the global community has to foster progress. On the basis of these practical experiences case studies, methodologies, and guidelines have been prepared by countries, WHO and other agencies.

Failures

On the negative side, the various partners involved in the implementation of PHC, such as governments, health workers, and donor agencies, have demonstrated persistent weakness in the coordination of activities and resources. Little attention has been given to important management issues such as the setting of priorities, quality assurance, and operational research. In the area of priority-setting, there is a conflict of advice given to developing countries on how they should tackle their health transition problems. Then, too, national health services continue to devote considerable resources to diseases and conditions that do not affect large segments of the population. The global economic recession which set in after the Alma-Ata conference has destabilized the economics of many countries, particularly poor ones, resulting in large decreases in resources allocated to health and deterioration of health services. Finally, on the role of various partners, flow of funds from the North to support PHC in poorer countries has been at a very much lower level than expected at Alma-Ata.

Epidemiological transition has continued in developing countries, with cardiovascular diseases and cancer rates progressively replacing infectious and communicable diseases. There is a pressing need to deal actively with both.

Tropical diseases and AIDS have spread extensively. Cholera has spread to the Americas for the first time in the century, the malaria situation continues to deteriorate, and yellow fever, dengue, schistosomiasis, trypanosomiasis, and leishmaniasis now affect larger numbers of geographical areas and persons. The incidence of AIDS cases is increasing rapidly, while tuberculosis is also on the rise, owing partly to combined infection with HIV.

Diabetes is increasing everywhere. Lung cancer in females is increasing rapidly, and in some developed countries has replaced cancer of the breast as the leading cancer among women. Alcohol-related diseases, mental illness, and drug addiction are also causes for concern. High rates of maternal mortality continue to be reported from developing countries.

Undoubtedly the most serious finding is that inequalities in health and health care between different social, ethnic, gender, and occupational groups show little decrease and sometimes even an increase. This situation appears to apply even in the newly industrialized countries. Unemployment is increasing in most countries. Many of the health reforms that have been introduced have been concerned with improving efficiency, with inadequate attention to equity issues. All these factors contribute to the increasing
social tension and insecurity around the world, which manifests itself in ethnic, racial, and religious strife, as well as violence and crime.

While a number of countries have had spectacular success in reduction of mortality, levels of morbidity have either remained high or even increased. Several explanations have been advanced to explain the phenomenon, including effects of population aging.\textsuperscript{158}

\textit{Contextual factors}

The achievement, or prospect, of peace in some countries enhances the outlook for health for all. Prolonged civil and military strife in Afghanistan, Angola, the Balkans, the Caucasus, Cambodia, Mozambique, Nicaragua, Northern Ireland, Palestine, South Africa and other countries has greatly hindered health development in the past. Prospects of lasting peace are greater now in some of these countries than they have been for a long time. A number of issues remain unclear. The end of the cold war gave rise to considerable optimism that the North-South dialogue on development, frozen during the 1980s, would resume. But recent developments in Eastern Europe have imposed a more urgent global agenda. Questions are raised about the effects such developments will have on the availability of funds to finance development in other parts of the world. Will external aid remain at the present low level? Will aid continue to be allocated for programmes selected by donor agencies or will it be channelled in response to local priority needs?

The process of democratization is now almost universal. On one hand, it represents an opportunity to realize the Alma-Ata call for participatory development in health. On the other hand, it has the danger of giving rise to religious and ethnic wars and even anarchy, as a few examples have shown recently. But it is unrealistic to expect instant success in all countries. The process of democratization has taken years in the West.

Another important issue is whether the developing countries will continue to face trade barriers. A leading economics journal has made the point that a better way for the rich world to help the poor is to buy the poor world's goods. "At present the rich give aid with one hand and use the other to impose impoverishing trade tariffs and quotas. On one estimate, if rich countries abolished all their barriers to Third World goods the increase in developing nations' exports would be worth twice what they receive in aid."\textsuperscript{159} The effect of the recent GATT trade agreements to developing countries is uncertain.

The permanent threat of natural and man-made disasters, including earthquakes, floods, prolonged droughts (in the Sahel region and other areas), and outbreaks of new diseases (such as Ebola Haemorrhagic Fever in Zaire), with their devastating effects on health, are an additional source of uncertainty.

Finally, people's expectations are increasing everywhere and are also becoming more varied, as evidenced by growing interest in alternative therapy.
Looking to the future, many of the problems that have beset PHC implementation in the 1980s are likely to continue to the year 2000 and beyond. The economic situation seems unlikely to improve much in many of the least developed countries in the coming years. Population growth will continue to erode the limited economic gains that may be achieved in many of the poorer countries. Urbanization is projected to accelerate, with corresponding increases in city slums and degradation of the environment. Differences in priorities and approaches to PHC between countries, donor agencies, and international organizations seem likely to continue, with the consequent inability of all concerned to chart a clear path for health development.

But, with the exception of the poorest countries, lack of resources is unlikely to be the main problem in the implementation of the PHC approach. The real problem will remain the lack of political commitment and courage to make the decisions required for PHC.

Whatever the type or extent of problems to be faced, PHC will be relevant to the year 2000 and beyond. Continued efforts will be required in line with the recommendations outlined above. Specific suggestions have been made under the review of each recommendation regarding the areas requiring more intensive efforts or a reorientation of approaches. Special attention is given to several critical areas, such as population growth, the environment, and urbanization. There remain, however, a number of areas where a more substantial revision of strategies and action are required if the problems remaining after the past 16 years of effort are to be overcome.

Areas for substantial revision of strategy

The remainder of this chapter will be devoted to elaborating four key areas for health development: (a) partnership towards a new social contract and code of ethics; (b) special efforts to reach the underprivileged in the pursuit of equity; (c) renewed attempts to raise the quality and effectiveness of the health services, both public and private; and (d) rethinking priority setting.

Partnership towards a new social contract and code of ethics

The Director-General of the World Health Organization has on several occasions called for a new health partnership - a partnership that would involve all countries, communities, and individuals and both government and civic society in sharing resources and responsibilities to ensure health for all in a spirit of justice and mutual respect. To achieve this goal, four issues are of primary concern. How can global support be generated and maintained? How can fragmentation of HFA action be avoided? What complementary actions should be carried out by the various partners in a new social contract? What should be the code of ethics for the social contract?
Generating and maintaining global support

While the vision laid down at Alma-Ata remains valid, the PHC philosophy and approach have been misunderstood by many, and there is a need for continuous promotion and dissemination of information on the concept of PHC, couched in terms that are acceptable in the national cultural context. Several strategies, including more extensive use of the media, have already been suggested. The World Health Organization has a clear leadership role to play in this area on the lines indicated in the Ninth General Programme of Work.162

Three other strategies for generating and maintaining global support, namely, selection and use of appropriate slogans, legislation and health summits are outlined below.

A publicity theme using various slogans would help in promoting PHC, and such slogans might best be focused on practical, innovative examples of PHC implementation. The slogan "HEALTH FOR ALL NOW" has much to commend it. Banners bearing this message would emphasize the urgency of action. It has been suggested that a new, more realistic target date beyond the year 2000 should be chosen, and the year 2020 has attracted a lot of interest, but that raises the dangerous possibility that politicians could use the concept of health for all as a tactic to delay controversial decisions until after the year 2000. The impression should not be given that it is acceptable to wait until the year 2000 before taking action. If changes must be realized, why not now? Let us remember that the "life expectation" of ministers of health in many countries is less than two years! Other relevant slogans have been mentioned earlier on page 38 and include "sustainable development",13 "new public health",112 and "sustainable human development".163,164 These slogans and many others have been proposed by different agencies to promote development from their own points of view. It is unfortunate that there is little or no collaboration between various agencies in the development of these slogans. The potential for confusion is great, as new slogans do not link with old ones and give the impression that short-cuts to existing problems have been found. For example, the "new public health" has generated heated debate among academic disciplines, with some people contending that the slogan has nothing new and that it is a repetition of old-style stubborn tactics that will lead to a new academic downfall.165 The slogan of "sustainability and equity", which was first used by the Canadian Public Health Association in its position paper on primary health care in 1990, is also a good one. An analysis of the meaning attributed to several other slogans shows great similarity. The choice of a suitable one has therefore to depend not so much on the meaning of a slogan, but its political value and potential to mobilize health effort. Given the current impatience for action, the first slogan "Health for all now" is much better than the others. This slogan also represents some continuity with the past slogan of "Health for all". Action to implement the slogan will include constitution of mechanisms to identify countries that have achieved the health for all targets and those that still have large numbers of people waiting outside the HFA door. Possible mechanisms are discussed later, page 77.
One important tool for enhancing and maintaining the health-for-all movement in countries is legislation to support the various strategies used. At present the PHC movement is essentially driven by the good will of individual countries and of the global community.

The starting-point of a legal framework is the acceptance by individual countries and the global community that access to essential health care is a human right. It is important to note that while health is acknowledged as a human right in most countries and in the WHO Constitution, health care is not. Debates must be encouraged in all countries leading to the identification of suitable national and international regulatory and supervisory mechanisms.

WHO has some experience - albeit limited - in the drafting of laws relating to this area, particularly in relation to the use of breastfeeding substitutes and essential drugs. The experience of ILO, IMO, and UNEP may be of help to WHO.\textsuperscript{166}

A suggestion for maintaining global support is the convening of health summit meetings once every four or five years. WHO governing bodies have decided to convene a conference of health leaders in 1997. It will be useful if the conference is not a one time event, as was the Alma Ata Conference, and that follow-up health summits are envisaged at intervals of four or five years.

Avoiding fragmentation of HFA action: the district health system

One of the major deficiencies of the Alma-Ata recommendations was the failure to define the specific relationship between them. Do points of convergence exist? Is there a common thread linking them? This deficiency was one of the factors responsible for the rise of selective primary health care.

It was only in 1985 that the district health system approach, alternatively referred to as "the catchment area focus" (EMRO), "tipping the balance" (EURO), or the "small area" or "intermediate group" approach, was advanced as the point of convergence. Its creation represented a major breakthrough. The district health system is a basically self-contained segment of the national health system. It provides a geographical focus for the strengthening of the health infrastructure, which is a precondition for the creation of sustainable primary health care programmes. By defining population bases that are "manageable" in size and coincide with an administrative area, the organizational, planning, and monitoring functions are facilitated.\textsuperscript{167} The district health care system includes all facilities up to and including the hospital at the first referral level, diagnostic centres (such as laboratories), and logistic support services, as well as the personnel that staff them. This system provides a focus to channel regional and global health-for-all information to the local population, and to generate pressure for reform.

A sound district level infrastructure will help ensure that a balanced mix of preventive, curative and rehabilitative programmes will be planned in response to changing local
needs. Neglect of the role of the district health system has in some cases led to failure to implement the Alma-Ata recommendations and in some cases it has allowed the recommendations to be implemented "vertically", producing short-term, achievements that prove to be unsustainable. The piecemeal implementation of recommendations results in the duplication of programmes and training efforts. Health workers have to attend separate training for each disease programme, which causes confusion and wastes time while health managers are left to wonder whether their staff will have the time to work. Clearly, sustainability of an activity is not only a matter of the availability of resources; the institutionalization of activities in the local infrastructure is equally important.

The role of the district health system has yet to be fully realized and made concrete. At present, it is in danger of being misappropriated by groups dealing with the technical components of district health systems, such as information systems and management. The challenge is to strengthen its functioning in order to empower local communities, health centres, underprivileged groups, and local leaders. In this respect it is essential to strengthen the role of health centres as the driving force for action at community level. Operational research on ways of improving the performance of district health systems should be emphasized.

At the same time it must be recognized that the district health system is part and parcel of the national health system and has to be seen within its framework. While much remains to be done to improve the performance and quality of district health systems, the infrastructures now in existence make it possible to conceive accomplishments in health promotion and disease control that go far beyond what most categorical programmes have been able to achieve or would be able to achieve within any realistic estimation of available resources. Despite the recognition of the importance of district health systems by most countries, the strategies of few global programmes have been modified. There are, however, a few exceptions. Notably, the programme for control of tetanus has established district-based targets. This has the potential of enabling technical programmes to make full use of improvements in district health systems. A similar district focus might enable the planners of malaria control programmes to appreciate the extensive developments that have taken place in local health systems since the failure of the malaria eradication programmes in the 1960s. Such an appreciation might convince malaria programme managers and others of the need to go for much more ambitious targets.

District focus will also enable programmes to deliver health care in a way that is cost-effective, integrated, and convenient to clients. Support activities, such as the supervision and training of staff, can also be provided jointly or in a coordinated manner by different programmes.

Donor agencies should seriously consider setting aside a portion of the funds they provide for categorical programmes as district "infrastructure tax". In addition to providing supplementary finance for this neglected function, such a contribution would
remind donors of the longer-term considerations involved in developing effective health programmes. It is also suggested that an item such as "implications for district health systems" should feature on health conference agendas in order to facilitate discussions on the practical aspects of follow-up action. Health conferences need to create strategies whose implementation can be initiated by different institutions, individuals, communities, and districts. Experience shows that it is a mistake to rely only on government initiatives for follow-up action.

*The role of the various partners in a new social contract*

Eight partners in the social contract, each with different levels of knowledge, responsibility and resources, are identified below. What are these responsibilities? How well have they been carried out? What further action is needed?

*The government.* Health for all requires the assumption of responsibility by governments for providing the necessary conditions to ensure that essential health care is delivered. Yet, at present, the primary participants in discussions on PHC policies are ministry of health staff, who often lack the political power to carry out extensive reforms. The government as a whole should institute an overall national strategy for health for all, which should include inputs from all the health-related sectors. In particular, attention should focus on creating a legal framework to institutionalize the goals of health for all.

This matter is discussed further below in the section on code of ethics for a new social contract.

*Ministries of health.* Several critical functions of ministries of health, which should be kept intact, irrespective of other efforts towards privatization and decentralization are discussed below.

Ministries of health are charged with the task of *developing policies, strategies, and plans* that provide direction for national health care systems. The many challenges and sometimes contradictory demands on governments and ministries of health call for a sense of purpose and a plan of action. Planning has been discredited in a number of countries because of its preoccupation with theoretical issues. Classical planning becomes difficult in situations of zero budget growth. In many developing countries, planning is about doing with fewer resources. The aim of planning in these circumstances is to adopt a long-term perspective that goes beyond short-term interests. Ministries of health should decide what they can achieve and how.

Such policies, strategies, and plans will help a great deal in mobilizing and coordinating the activities of the private sector, the nongovernmental organizations, and the donor agencies. Unfortunately, few countries have well-developed health plans, with targets and financial implications. Many health plans have not been updated in response to changing needs and challenges. It is strongly recommended that ministries of health carry out in-depth reviews of their plans at least once every five years. The review
should also include appraisal of the adequacy of the organization, structure and resources of ministries of health to fulfil their functions. Experience shows that where ministries of health do not take the initiative to carry out these reviews into their own hands, others will, putting the ministry of health on the defence. Support mechanisms, such as health boards and annual reports, which have faced neglect by many ministries of health, need to be regenerated.

The task of ensuring access to quality care for all falls squarely on the ministry of health. Large numbers of people remain with no access to essential health care, even in developed countries. Approximately 37 million people in the USA have neither public nor private health insurance. Problems of low income and adverse selection can mean that markets for health insurance simply do not exist for some of the most vulnerable groups in society, namely the poor and the chronically ill. Providing adequate finance for the health care of such people should be the government's responsibility. Besides financial problems, two other sets of barriers to access to health care must be overcome - individual barriers, which include attitude, culture, and lack of awareness of the need for health care, and health-care-system barriers, which include long waiting periods, unfriendly and uncaring behaviour on the part of health workers, and the low status of some health facilities. The two sets of barriers may explain, at least partially, the finding of many studies that the poor, particularly in the developing countries, underutilize health care. Even in developing countries where services are provided free, there is often a failure to achieve an equal distribution of health care utilization as other mechanisms related to the two sets of barriers, take over the rationing, and the end result is as if prices had been charged; the richer consume much more than the poor.

Ministries of health must mobilize resources. New sources of money and alternative ways of financing health care must be identified. The Alma-Ata conference emphasized the reallocation of resources for PHC, although in practice it is difficult to reallocate resources where there is no growth. The ministry of health and other institutions need to press actively to obtain more resources, and at the same time they must examine alternative ways of financing health care, whether through government taxation, insurance, user charges, or community financing by means of revolving funds. It also falls to the ministry to play an active role in coordinating support from external agencies. This task is facilitated when the ministry's priorities and plans are made clear. Past experience shows clearly that many donor agencies have a tendency to push for conditions and grant arrangements that work in their favour. Ministries of health therefore need to take these negotiations into their hands and ensure that the support provided is of maximum use to the country.

Promoting and marketing public health is an important responsibility of ministries of health. At present public health is being bypassed by health care reforms that focus on financing options and cost containment. An example of an area that needs much more attention than at present is public health in suburban areas. The failure to provide reasonable levels of essential services, including sanitation and housing, is creating the
need for expensive services - health care, welfare, justice, etc. Similarly, public health action against injuries and for healthy life-styles needs more attention.

The role of ministries of health in mobilizing intersectoral action for health remains a big challenge at national and international levels. One action that might help at the international level is to extend participation in the World Health Assembly beyond ministry of health representatives. It would be useful to include a number of other partners, e.g., nongovernmental organizations, on a more organized and regular basis. Unlike ILO, which is a tripartite organization, WHO is an intergovernmental organization. Ideally, it would be useful to make WHO a multi-partner organization, although it will take a very long time to achieve this. But individual ministries of health can make improvements in their representation immediately.

Standards for service safety and quality must be set by ministries of health, even if they choose to exercise such controls through professional bodies. Regulations may be necessary to ensure compliance with set standards. Incentive structures may have to be adjusted.

Ministries of health, especially those in countries with high population growth rates, must spearhead the formulation of effective policies on population, the environment, and urban health development. The aim should be to make family planning services available to all, along with other health improvement measures. In this respect, it is important to improve the status of women. As it was stated in one report: "The task is indeed formidable, but the consequences of inaction can be disastrous."70

The encouragement of innovation and experimentation is another important responsibility of the ministry. Learning-by-doing needs to be a permanent feature of all future efforts. Experimentation, such as studies in selected geographical areas, allows changes in health care provision to be tested before they are introduced on a countrywide basis. Health systems research should be strengthened and applied in a greater number of countries.

It is fair to point out that by trying to do everything during a time of economic stagnation, ministries of health in poor countries have lost authority in two ways. 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 on the lines indicated above.
Individuals and communities. To increase participation in health project planning and execution by individuals and communities, action is required on several fronts. The top-down planning approach adopted by many agencies has detracted from local initiative and responsibility. Too often, the objectives, strategies, and organization of health projects depend on the priorities of the agencies. Also, while calling for community participation, agencies promote and finance piecemeal health projects that result in uncoordinated and confusing demands on communities. Enthusiasm must be rekindled by adopting a planning process that invites individuals and communities to define their common needs and problems. Communities should be encouraged to make individual and group plans and to share in carrying them out by using their available resources, as well as government and other support.

Existing local leadership, both formal and informal, as well as other community structures must be identified and supported. The tendency is for health workers to select new village leaders for health projects and set up new structures to implement them, overlooking the existing village development committees, which could not only implement the projects but also undertake the coordination of health activities. Health workers, particularly in local health facilities, must work more closely with local nongovernmental organizations, churches, synagogues, mosques, schools, clubs, and other social structures or groups.

Then, too, an effort should be made to demystify health knowledge and to find more effective ways of communicating such knowledge to individuals and communities. Studies have shown that many health problems can be prevented, managed, and treated by communities when they are given adequate information. Communities should promote healthy life-styles and behaviour.

A major flaw in the implementation of PHC has been an almost exclusive preoccupation with ministries of health and other bureaucracies, rather than with people and communities. This flaw is a major challenge for all countries. Health care, even in the small front-line units, has become incredibly bureaucratized, with unnecessary paperwork and delays, resulting in frustration for the public.

The role of community health workers (CHWs) and volunteers must be more precisely defined. In a number of countries, the CHW movement has attracted young village people who have not found other employment. Only in a few countries has the movement been able to attract locally respected adults. In some instances, the community health worker can be a person who works as a part-time health motivator or one who provides full-time curative care in areas lacking a static health facility. The training needs and remuneration of these two groups are quite different. Few governments have clear policies on community health workers, and such policies should be developed in order to enhance their performance and retention.

Health workers. Five matters demand urgent attention. First, a large number of health workers have not received training and continued education in the PHC philosophy to
allow them to work effectively in their communities. Such training should be provided and an attempt made to coordinate various training projects in order to avoid duplication. Special attention should be given to the review and updating of the curriculum for PHC training programmes.

Second, attention must be given to providing incentive and motivation, including improved remuneration. A number of suggestions are made by various countries.62,63 Without such action, the brain drain of health workers from poor to rich countries, as well as to other sectors, will continue unabated. Admittedly a number of basic manpower issues have to be tackled, including decisions on the number of personnel that can be properly remunerated.

Third, there is a marked weakness in district-level management in many developing countries. In retrospect, it was probably wrong to advocate relying on one individual, the district medical officer, to spearhead PHC development. It is essential to mobilize additional district leaders for PHC. These can include district officers in charge of agriculture, education, public nursing, community development, and environmental sanitation. The development of appropriate leadership programmes will facilitate their participation.

Fourth, public health leadership in general requires strengthening. While Departments of Community Medicine have the primary responsibility for developing both national and middle-level leadership in many developing countries, experience shows that this is not enough in itself. While schools of public health are now appearing in increasing numbers in developing countries to produce the needed cadres of public health professionals, the numbers required are very much greater than are being produced at present - perhaps by a factor of twelve.172 The move to establish institutes of public health should be complementary to the efforts currently being made to reform medical schools, nursing schools and other health professional schools, to make them more community-oriented.173

Fifth, a related but potentially more serious problem is the fact that many developing countries use the public health institutes of developed countries, particularly the USA, as models. However, these institutions often focus on theoretical knowledge to the detriment of field application, and this kind of training is inappropriate for developing countries. The public health institutes in developed countries also tend to be individualistic, with each school guarding its own identity and responsibility. A number of initiatives are being undertaken in developing countries to correct these deficiencies, such as the creation of a network to link the various types of PHC training and health development centres, including public health schools. Such complementarity is more likely to meet the public health leadership requirements at the national and intermediate levels.

Donor agencies. Several areas of concern emerge from a review of the performance of donor agencies. The need to re-emphasize national capacity-building is evident. The series of short missions, which offer the expertise of international consultants, supported
by donor agencies, are of little use to developing countries. In any case, these nations now have large numbers of skilled personnel in different health areas. New ways of collaboration need to be explored. Thus support to recipient countries to develop those institutions without which activities cannot be sustained should be a priority for donor agencies. The duration of donor supported projects is an area that needs serious attention. Many donor agencies are increasingly agreeing to longer durations for projects - 10 to 20 years instead of 2 to 3 years is often the case.

Few agencies are interested in promoting and supporting technical cooperation among developing countries. This is unfortunate, as learning from one another is one of the best ways of facilitating the implementation of PHC in the developing world. Developing countries themselves need to press for improvements in this area. Unfortunately, the power of structures meant to promote the interests of developing countries, like the non-aligned group of 77 and regional groupings, has been seriously eroded.

Financial support from donor agencies has been severely curtailed over the past 10 years due to world recession, and increased levels of monetary support are needed. While the response to such a request is not likely to be encouraging, one innovative strategy might be for donor agencies to assume responsibility for selected recurrent costs in several countries. An example would be the provision of a few essential drugs to a number of the least developed countries over long periods. The areas selected should particularly be those involving foreign currency and those in which project management and accountability are not difficult. The suggestion being made here is that donor agencies should identify jointly with national authorities the areas most suitable for external support. However, this suggestion is rather controversial because some donor agencies like to support activities with immediate results, like the training of community health workers. This emphasizes the crucial need for a national health plan as a basis for discussion on what will be financed by local funds and what will be financed by outside funds.

The coordination of financial assistance between governments and various donor agencies demands attention. Indeed, international rivalries and lack of coordination of donor projects and governmental initiatives often result in wasteful duplication. Then, too, problems are created by the fact that donors often prefer to specify programmes for resource allocation and tend to avoid channelling funds in response to locally defined priority needs. The issue of poor countries that do not at present figure on any agency's list of countries eligible for assistance is a difficult one. The criteria for the development of the lists vary between donor agencies but are mostly political considerations. Donor agencies need to review this matter with a view to finding ways in which countries that need support and can benefit from it are not excluded. UNDP's 20-20 proposal, which calls for donor agencies and recipient governments to devote at least 20% of overseas development (compared to 5-7% at present) and of domestic expenditure to the social sector, needs strong support.60
**Nongovernmental organizations.** The role of nongovernmental organizations (NGOs) in the health sector is becoming more pronounced. National nongovernmental organizations are likely to grow from the present level of about 7600 to about 9600 by the year 2000. International nongovernmental organizations are likely to remain at their present level of about 300.\(^{174}\)

An increasing proportion (now about one third) of rich country development financing goes to NGOs. The situation has led to high levels of competition among NGOs in developing countries for the newly available funds. The danger exists that under these circumstances, NGOs may lose their strength and base within communities. This is an issue that should be addressed by the NGOs in the developing countries and their supporters in the richer countries. Two additional areas requiring attention are capacity-building and improvement of the monitoring skills of NGOs in poor countries.

**Private for-profit providers.** There is a wide diversity of for-profit providers: private doctors, nurses, midwives, paramedics, nursing homes, hospitals, and traditional practitioners.

Some countries have consciously encouraged private providers to flourish. Others, until recently, have discouraged or virtually banned them. It is now acknowledged in practically all countries that the private sector brings additional resources for the provision of health care, thus alleviating pressure on the already overburdened government systems. Such complementary services are beneficial as long as governments provide both regulations and incentives to ensure maximum efficiency. Experience shows that the most useful approach by ministries of health is to involve the private sector right from the planning stage of programmes.

The private sector has, however, to reform itself in a number of areas. For example, as a partner in the Health For All social contract, the private sector has to be more sensitive to the need to avoid environmental pollution or the manufacture of harmful products. The private sector needs to act in a responsible way both through goodwill as well as through legislation.

**Universities and health for all**

A major challenge to the health system is to bring advances in biomedical, socioeconomic and managerial areas to bear on the development of primary health care. In 1984 the Technical Discussions at the Thirty-seventh World Health Assembly addressed the issue of the role of universities in the strategies for health for all. It was noted at the time that many Universities all over the world were actively exploring new relationships with communities, industry, government and other institutions, new structural forms within the university itself, and changes in traditional education, research and service programmes.\(^{175}\) In Resolution WHA37.31 member States were urged to support universities in orientating the education and training of workers in health and related fields towards the attainment of health for all.\(^{176}\) Universities were invited to provide the
kind of education and training for students and postgraduates in the health and related
disciplines that will prepare them technically and attune them socially to meet the health
needs of the people they are to serve. They were also encouraged to conduct
biomedical, epidemiological, technological, social, economic and behavioural research
required to prepare and carry out strategies for health for all.

Medical and health professions have increasingly been required to break out of their
traditional boundaries to encompass emerging developments: increased emphasis on the
humanization of care, integrated care, more consumer participation, equal access to care,
assessment of technology, cost containment, consideration of the population perspective
in planning health care, protection of the environment, promotion of health lifestyles,
etc.\textsuperscript{177}

The implication of this challenge is that health must from now be regarded as a crucial
factor in human development and as a potent indicator of social justice. Health
technology must be made to respond more meaningfully to social problems, taking into
account the culture, ethos, value systems, and lifestyles of societies. The uneasy
relationships of suspicion and disdain as between universities and government ministries
must be improved if HFA is going to have any chance of realization.

Society at large, consumers and students, numerous health insurance agencies, hospital
and community councils, medical professional organizations - all interrelate with medical
academic centres. Ultimately the straight lines of these relationships take the form of
a triangle - an often turbulent but closely-knit entity - University - Society - Government.
This triangle will have a different shape in different countries.\textsuperscript{178}

Further emphasis on this approach was given in a WHO Study Group (October 1992),
which stressed the importance of extending problem-based learning beyond limited
clinical confines into social and community issues if it is to realize its full potential.
Although educational experience could undoubtedly be enhanced if teaching institutions
assume new responsibilities in health care organization and service, this is beyond their
traditional mandate and they will therefore need to build up new alliances and
partnerships with professional associations, service organizations and the community.\textsuperscript{179}

Attempts are also being made to identify those elements which define the quality of
educational experience.\textsuperscript{180} Similarly, efforts are being made to understand the factors
which facilitate change, and to establish common criteria so that monitoring of
improvements in medical education and practice can be carried out globally. Four issues
of a new bulletin, \textit{Changing medical education and medical practice}, were distributed
during the 1992-93 biennium as well as a revised edition of the WHO guide for teachers
of primary health care staff.

WHO has been supporting a Network of Community-Oriented Educational Institutions
for Health Sciences comprising some 40 medical schools. They place special emphasis
on primary health care in their education, research and health care activities. The
Network is an independent organization governed by an Executive Committee chosen by the medical schools. Half the schools are in developing countries and the other half in developed countries.\footnote{181}

To build on the work of the 1988 World Conference on Medical Education,\footnote{182} the World Federation for Medical Education, with support from WHO, UNICEF, UNESCO, UNDP and the World Bank, organized a further major conference in Edinburgh (August 1993) on the theme of societal changes and their implementations for medical education. The conference considered such issues as the new skills being demanded of physicians, the economic impact of medical decisions, the importance of better communication with the community and individuals, and the growing consensus that radical reform is required to ensure that the skills of graduates who will practise in the 21st century will be relevant to the needs.\footnote{183}

The global trend of separation between provider of health care and purchasers has potentials for improving the relevance of medical education. By defining clearly the product they are prepared to purchase, ministries of health and other institutions can influence the curriculum of medical education. However, for the potential to be realized further dialogue and consultation mechanisms between purchasers and providers need to be strengthened.

**Code of ethics for a new social contract**

The term 'code of ethics' is used here to mean a set of rules of conduct among partners in the social contract. The promotion of ethical values at all levels should be a feature of the contract. Codes of ethics are needed to provide guidance for procedures for achieving the goals of the contract. Such procedures might include definitions of how the eight partners ought to act in relation to each other. Provision should be made for assessing compliance with ethical standards.

What should be the code of ethics for the social contract for health for all? What is wanted is now fairly clear: (i) a health care focus on the underprivileged and a reduction in inequities in health and health care systems; (ii) an overall improvement in health, with reduced infant and maternal mortality rates, an increased life expectancy, and an improved quality of life; (iii) health care that satisfies individuals, families, and communities and in which they themselves participate; and (iv) development and satisfaction of providers of care. A number of countries have, or are in the process of developing national social contracts of various kinds. Experience from these countries is of global interest. The Malaysian government is moving towards a new social contract between the people and itself under the slogan of "Malaysia Incorporated". The main feature of this and similar contracts is liberty for all. A major goal is the resolution of inequalities in society so as to ensure the wellbeing of all.

Reference has already been made to the need for a legal framework to enhance health for all. Interventions should be designed to comply with basic ethical considerations,
such as that interventions should at least not harm other partners in the social contract, or that all involved in an intervention should actively participate in its planning and execution. The precise scope of obligations of individual partners need to be worked out. For example, a donor agency that fails to analyse the needs of a country properly and rushes to support projects that are not viable or sustainable should be admonished.

The HFA contract should also impose certain constraints on each country. It might, for example, be expected to show evidence of preferential allocation of resources to underprivileged population groups. Periodically, each country should monitor its own progress and its compliance with HFA aspirations. Supplementary audits might be carried out by an independent body at regional and global levels with access to data from official country reports, nongovernmental organizations, and commissioned studies. Such audits may disclose glaring failings by countries in meeting their obligations to implement HFA. Disclosure can exert powerful pressure on countries to intensify their efforts. The International Labour Organisation has developed such a mechanism. The conference committee on the application of conventions and recommendations publicly debates these findings. Countries may also consider establishing similar independent mechanisms at the national and regional levels.

While a number of countries have updated their national HFA strategies, many others have not. Consideration should be given to using the framework of the 22 recommendations formulated at Alma-Ata for updating HFA strategies at regional and global levels.

A conflict of responsibilities, duties and rights between the eight partners in the social contract is inevitable. It is not possible that one or two partners will be absolute winners - a compromise will always be necessary.

The creation of an independent global mechanism, such as a Global Advisory Council or Global Commission, is essential, in order to enhance the revision of strategies and provide overall supervision for HFA. The proposal for such a body was first proposed and then rejected in 1981. Since then the need for a mechanism of this nature has been alluded to by various bodies, including a subcommittee of the Executive Board.

Targeting the underprivileged

Despite considerable improvements in the levels of health in all countries, the gap between developed and developing countries has not changed significantly over the past 20 years and is unlikely to do so by the year 2000. In fact, the opposite trend can be expected. While the under-five mortality rates in developing countries were four times greater than those in the industrial countries in 1950, by 1980 they were seven times greater. Projections hold that mortality rates will be 7.23 times greater by the year 2000 (see Table 5).
This section focuses on the gap in the levels of health care available to various socioeconomic and ethnic groups, as well as to different geographical areas within countries. It is noted with concern that at present there is little global interest, data, skills or political will to reduce the gap. Possible strategies for redressing the situation are then discussed. The section ends with a contention that the problem of inequity in health and health care has proved to be intractable and that serious consideration should be given to establishing special programmes to address it.

The present situation is of concern for several reasons. Although great progress has been realized in improving health on the whole, significant differences within countries still exist. Such differences are masked by the fact that few countries keep adequate records of the health of underprivileged groups. Where such data are available on both developed and developing countries, the gaps are found to be stable or increasing. This throws doubt on the effort of countries' support for health for all, the objective of which is to ensure that everyone has access to essential health and health care. Concern has also been expressed that, owing to trends in economic liberalization, health care will be less and less accessible to poor people. The identification of underprivileged groups and the targeting of support to them must therefore be a top priority for the year 2000 and beyond.

Few countries seem to have a clear idea of the policies and strategies needed to improve the health of the underprivileged, and in others there is a great deal of inertia to undertake fundamental reforms to address the needs of vulnerable groups. This inertia is evidenced by the fact that some countries do not recognize the existence of health inequities. Political will can go a long way to ameliorate the situation. A number of countries - China, Costa Rica, and Sri Lanka as well as the Indian State of Kerala - have achieved a significant improvement in the health of all population groups. What inspiration and strategic options can be drawn from the effort of these and other countries for future action? Several elements for success have been identified: equity-based health policies and strategies, active involvement of the poor in their own health development, equity-based financing, increased access to essential services including health care, monitoring for equity in the distribution of incomes and social services, and making every effort to ensure that essential health care continues to be provided to the poor in times of financial reductions.

Governments must take the lead in formulating equity-based health policies and strategies. In developing health policies, it is important to distinguish between differences in health and health care. Reduction of differences in health status requires broad-based government action involving all sectors. Government macroeconomic adjustment policies, stabilization programmes, and pricing reforms have important effects on the health of the underprivileged. Measures needed for health care improvement lie within the mandate of the health sectors. Specific effective strategies for improving the health of the underprivileged have included: the provision of cash and food subsidies to families; the creation of employment opportunities; the augmentation of educational opportunities, particularly for women; improved access to essential health care; and the
promotion of healthy life styles. Policies should establish targets for the improvement of the health of underprivileged groups. WHO's European Regional Office has considerable experience in the development and use of such indicators.\textsuperscript{192-193}

Equity-based financing aims at ensuring that underprivileged population groups are not excluded from health care for economic reasons. Firstly, resources should preferably be allocated according to need rather than for services actually delivered. Secondly, prepaid health plans, including national health insurance, by removing economic barriers at the time of use of services, make services more accessible to underprivileged populations. Cost recovery and other privatization reforms of the health system, unless carefully designed and monitored, may end up excluding large numbers of poor people.

Involvement of the underprivileged in the effort to improve their own health is crucial. Given that poverty discourages cooperation and encourages a primary commitment to self and family, what strategies can be used to inform and mobilize the poor? Schools in underprivileged areas may be an entry point. What participatory methods and approaches could be adopted? What links should be established with NGOs and grassroots organizations? How can governmental and other agencies support efforts at the local level? These questions remain to be answered.

The provision of health care must begin with a systematic assessment of the needs of subgroups and of the health risks they face in order to target corrective action. Data on the health situation in communities will be needed. At present, the routine information provided by health facilities is inadequate. Local reporting systems should be designed so as to highlight differentials between population groups by age, sex, domicile, work, ethnicity, etc. Surveys can assist in this, and a system should be established for the independent monitoring of the progress made in improving the health of the underprivileged.

A challenge faced by many countries is how to safeguard health and health care for the underprivileged in adverse circumstances, such as the adoption of economic adjustment policies. It is essential for ministries of health (and the ministries dealing with other sectors) to identify essential services which the government should fund as a priority. The most effective use possible should be made of existing manpower, which represents the most costly component of the recurrent budget. Retraining and redeployment may be necessary. Finally, inequities in health and health care must be brought from obscurity into the spotlight of national debate. The challenge centres on reforming information systems at the local level to ensure that data on health and health care are disaggregated according to various population groups. Data of this nature are essential for local surveillance of inequities.\textsuperscript{194} The potentials of using sentinel communities, districts and tracer conditions also need to be considered.\textsuperscript{195}

For most industrial and many developing countries, the challenge is one of political will. For the 26 countries that have been bypassed and left behind by the health-for-all movement, special support is needed. The emphasis should be on mobilizing additional
resources for them and supporting them to learn from each other (TCDC). But as mentioned in discussions under recommendation 20, much more effort is needed by all parties involved to move from lip-service to practical support for TCDC. It is often asserted that one cannot pursue equity objectives in the very poor countries. It must be recognized that the present situation in these countries can be improved if resources are directed to the provision of essential health care to everyone, while sophisticated care is rationed. It is important to note that a number of poor countries have managed to improve equity while a number of richer countries have not.

Many least developed countries spend too small a portion of their GNP and government budget on health care. With a per capita expenditure of US$ 1 to 4, it is difficult to provide universal coverage. A major effort is therefore needed to mobilize more money from inside and outside the country to fund health care. The option of rationing utilization by introducing user charges does not extend care to the underprivileged: the opposite may be true.

The wisdom of establishing special programmes for the poor is a matter of controversy. Experience shows that such a policy is crucial to ensure that the underprivileged do not have to wait for resources to "trickle down." On the other hand, the danger exists that where two programmes are in place, one for the poor and one for the rich, the one for the former is likely to be second rate. That danger has to be accepted as we cannot rely on overall improvement in the efficiency of the health system to reach the underprivileged and reduce inequities in health and health care. Special programmes aimed at improving equity have to be organized along with general programmes.

Ensuring the quality of health services

Reviews and evaluations of PHC implementation indicate that countries are encountering enormous difficulties in the assurance of quality. In some reports the concept of quality is equated with sophistication and thus seen to be opposed to the national effort to extend health care to underprivileged populations. But when quality is seen correctly as complying with desired standards, its relevance to all health systems becomes obvious.

Quality assurance in health care warrants considerable attention in the 1990s and beyond. Many developing countries have achieved considerable expansion of their health services. The provision of health centres, hospitals, outreach programmes and community-based activities has been greatly expanded. In the future, ministries of health will need to make more serious efforts to consolidate existing services and ensure that the care provided is of good quality. Innovation will be required in defining what quality care entails.

The focus of quality assurance has expanded extensively in recent years from concern with hospital patients to concern with the total health system, and from an inspection/control activity, monopoly of the provider health professional, to responsibility for all health workers and the public.
Debate continues on a number of familiar issues, such as whether to adopt traditional quality assurance or total quality management, how to determine the appropriate balance between health care standards set locally and those set elsewhere, and whether reliance should be placed between self-assessment or inspection. Answers to these and related issues can be obtained only through "learning by doing". There is no need to spend a lot of effort, time and resources looking for the perfect quality assurance programme. A start can be made by mobilizing the interest, skills and creativity of various health workers faced with local realities. Undoubtedly, the biggest challenge is to ensure effective leadership, which creates confidence and enables health workers to be truly committed to the objectives of health services and of quality assurance. A global working group on quality assurance recently established by WHO will help in mobilizing and coordinating activities.

Total quality management implies that priorities should also be set in terms of comprehensive system improvements. All facets of a health system will require attention, including health facilities, equipment, supplies, human resources (in terms of both numbers and training), logistics, information systems, efficiency, and productivity. System priorities will vary in different countries and groups of countries. Many of the least developed countries, such as Afghanistan, Chad, Haiti, and Somalia, have very poor infrastructures. The challenge for them is therefore to build the necessary infrastructure and improve performance at the same time. About half of the LDCs - countries at the level of Ghana and the United Republic of Tanzania - have reasonable health infrastructures in terms of facilities and workers. The challenge in these countries is to improve supplies and performance. Ministries of health should establish a new or existing group as a focal point to facilitate quality assurance developments, including the adoption of appropriate policies. Professional associations can help in the development of standards, tools, and the training of staff.

Rethinking priority-setting in poor countries

Scarcity of resources has given new impetus for attention to priority-setting. It is noted below that existing priority-setting methodologies are based almost exclusively on the extent to which various interventions can reduce morbidity and mortality. It will be argued that there are potential conflicts and trade-offs between the goals of reducing disease morbidity and mortality and other health care objectives such as: reducing inequities in health and health care; establishing a sound infrastructure; decentralized decision-making; and addressing the health transition. Various ways of reducing the conflict are also discussed. It is concluded that considerable rethinking and operational research is needed in this area.

A number of methods for selecting priority diseases, based on the extent of morbidity, mortality, and the feasibility of control, have been suggested recently. Using these methods, diseases in developing countries have been divided into three groups. Group I contains the infectious diseases, such as measles and diarrhoea, that cause most of the preventable illnesses and deaths. Groups II and III contain health problems that are less
pressing or more difficult to control respectively. It has been recommended that health interventions concentrate on Group I diseases, while investment in Groups II and III illnesses focuses on research and development of less costly and more effective methods of prevention and therapy.\textsuperscript{101}

Shortcomings of such selective approaches to the provision of health care, which in the past have invariably led to the creation of vertical programmes, are well known. Vertical programmes to deal with important diseases, such as malaria, yaws, tuberculosis, venereal diseases, sleeping sickness, smallpox and trachoma, predominated the 1950s and 1960s. While these programmes were useful in the short-term in controlling the targeted individual diseases, three problems emerged. First there were serious overlaps and redundancies between the multitude of vertical programmes, while at the same time there were no resources for other health problems and diseases. Secondly, while vertical services were popular with providers, they were inconvenient to consumers who were constantly required to leave work and travel long distances to receive piecemeal services. At times, the instructions they received conflicted. Thirdly, soon it became clear that for the continued success of the vertical programmes a basic health service infrastructure was essential. This need stood out as the reasons for the failure of the Malaria Eradication Programme were investigated in the late 1960s. The attack phase consisting of environmental reconnaissance, house-to-house spraying with residual insecticides and other activities was effectively carried out by special malaria teams. The maintenance phase, when all new cases should be diagnosed and treated as they occurred, failed because the basic services did not have adequate coverage. Thus, in the 1970s development of basic health services infrastructure and integration of programmes became the focus of policy. The Alma-Ata Conference reaffirmed the relevance of this policy, but, as indicated in discussions under recommendations 5 and 6, debate on selective versus comprehensive primary health care resurfaced soon after the conference.

A quantitative tool that has recently been developed permits a comparison of the cost-effectiveness of various health interventions.\textsuperscript{199} The tool is similar conceptually to the quality-adjusted-life-years (QALYs) approach which has been used in industrialized countries.\textsuperscript{199} The process begins with a measurement of the burden of disease in a country in units of disability-adjusted-life-years (DALYs). Next, the cost of achieving one additional DALY is computed. A health intervention that is able to achieve more DALYs per dollar has greater priority.\textsuperscript{44} Debate continues on several aspects of DALYs, such as whether it is ethical to use age as one of the parameters in priority-setting. It is generally agreed that chronological age limits should not be applied for priority-setting in medical care.\textsuperscript{200} The observations below are limited to one disadvantage of DALYs.

Attribution of numbers is eye-catching and gives the tool a precision which the selective PHC approaches of classifying diseases to groups I, II and III does not have. The tool also makes it possible to include in the priority list important interventions to deal with aspects of Groups II and III diseases.
A serious disadvantage with the methodologies mentioned above is that they are based on only one concern, reducing morbidity and mortality, and thus have the drawbacks of selective PHC approaches and vertical programmes outlined above.

There are other equally important health care objectives that have to be considered by decision-makers in priority-setting, particularly in poor countries.

It is submitted that each of the five goals mentioned below need to be considered in its own right, along with the extent of morbidity and mortality from different causes, in establishing priorities in health care. In other words, one should not just start with identifying important diseases and cost-effective interventions and then, and only then decide on how the other objectives should be achieved.

*Establishing a sound infrastructure.* The importance of a basic health infrastructure has been referred to above. The first concern of decision-makers in poor countries, many of which usually have poor infrastructure, is to expand it. Emphasis in the expansion of health infrastructure is on establishing front-line facilities consisting of health centres of different types and training of staff to man them. And yet most methodologies being advocated for priority-setting in poor countries make little or no attempt to relate to health centres or even health infrastructures in general nas the context in which priority-setting is carried out. Preoccupation with morbidity and mortality as the sole concern in priority-setting has often led to the establishment of piecemeal, unsustainable disease control programmes in poor countries, invariably through pressure and support from donor agencies. Fortunately, a number of donor agencies are increasingly recognizing that there are trade-offs between the establishment of a sound health infrastructure, which is essential for sustainability of health programmes, and setting up programmes for the control of individual diseases. It has even been suggested that donor agencies should consider halting their aid to programmes until they have successfully helped to develop a sound infrastructure without which programmes cannot be sustained. How can the potential conflict between the objective of developing a sound infrastructure and that of reducing morbidity and mortality be lessened? First is by developing an infrastructure that is organized in a cost-effective way, and secondly, by putting emphasis on improving capacity through training and provision of guidelines, as discussed under decentralization below.

*Reducing inequities in health and health care.* A serious problem with using morbidity and mortality or health gain for priority-setting is the emphasis given to efficiency at the expense of equity. It has been pointed out above that inequities in health and health care are either stagnant or increasing in most countries. Underprivileged population groups need to be identified and selective support provided to them. Since underprivileged populations are likely to have diseases which can be prevented or treated easily, it might appear that targeting intervention would result in relatively big health gains. In practice, however, it is difficult and costly to identify and reach underprivileged populations, particularly in developing countries where special infrastructure or outreach
programmes have to be established. Where the costs of reaching the poor are high, there can be trade-off between efficiency and equity.

Ways of decreasing conflict between efficiency and equity in priority-setting is to begin by identifying geographical areas that may need priority attention (for example, areas with scattered populations and therefore not easy to provide service), difficult areas, urban slums and areas with poor environmental conditions such as unfertile soil, and population groups at risk, including ethnic groups, scheduled castes, migrants, handicapped, expectant mothers, etc. Morbidity and mortality can then be assessed in the various geographical areas and population groups.

**Decentralized decision-making and community involvement.** There is universal agreement that health care should be provided in decentralized ways with the participation of many decision-makers. Most decision-makers have accepted the concept of a district health system as the unit for implementing PHC and balancing health interventions to achieve maximum health benefit. The decision-maker expects to see district plans with clear objectives and targets within a national framework. The district plans should be based on systematic, epidemiologically informed assessment of the health needs of local populations. Such assessment can be carried out adequately using simple tools. Health workers at sub-district levels in health centres are expected to do the same.

In practice, however, priority-setting in health care is mostly a top-down process, carried out by a few experts at the global and national levels. Thus health and health care priorities and targets have been decided upon by a series of recent summits and conferences. These global priorities are decided while decision-makers at various level of health services have established their own priorities, thus making a mockery of calls for decentralization and participatory approaches in health care.

It is claimed that non-professionals would not be able to understand the many quantitative approaches, technical tools and data that are generated in priority-setting. But in fact the challenge is for experts to make their data understandable to the public and to have the humility to initiate an open informed discussion of priorities with the public. The Oregon project is interesting in two ways. First, it shows that the public is able to understand stakes in priority-setting and secondly, involvement of the public calls for considerable rethinking and modification on priorities established by experts. Is it now time that an attempt is made on building global priorities, bottom-up, from districts.

How can the objective of decentralized priority-setting be reconciled with centralized priority-setting?

Centrally prepared guidelines based on value as well as cost can influence both the type and quantity of health care interventions in districts in several ways. Guidelines on staffing patterns, equipment and supplies, drugs, training, and technical guidelines will influence the type and quantity of health care interventions to be carried out under each
of the four headings. The power of guidelines of this nature for priority-setting and rationing of health is enormous but is often not recognized.

Technical guidelines will, among other things, indicate how various diseases, e.g., malaria, tuberculosis, and diabetes, should be handled at health centres and hospitals, and will provide practical guidance on how various diseases and problems can be dealt with. For example, in the poor countries where epidemics of non-insulin-dependent diabetes mellitus are occurring, largely due to unhealthy life-styles, particularly involving the consumption of food with high unsaturated fats, reduced physical activity, increasing obesity and social stress, \textsuperscript{204} technical guidelines will provide information on messages that should be an essential component of health education by community health workers and nurses in MCH and other programmes. Information for the preparation of such studies can be obtained from routine sources of special studies which might include some of the tools referred to above.

\textbf{Organization and management.} Poor countries have over the years struggled with the issue of how to organize resources to ensure that essential health care is available to all population groups in a way that is convenient to them. Essential health care in most developing countries can be grouped under four headings. First is clinical care provided at the community level, health centres and hospitals. Second is MCH services, which include immunization, growth monitoring; food supplements; family planning; treatment of diseases; chemoprophylaxis; and health education. Third is the control of diseases. Interventions here deal with health promotion, control of epidemics, control of communicable diseases, control of noncommunicable diseases, environmental sanitation, occupational health and mental health. These three groups of services are provided under the same roof and by a team of staff in an increasing number of countries. Examples are the "supermarket" clinics in many countries in Africa, particularly eastern and southern Africa, and the "poshyandos" of Indonesia. Although school services may also be provided by MCH staff, they are organized separately. Fourth is outreach programmes including health visits to families and communities. Clearly, there are many ways in which health services can be grouped. The point being made here is that a grouping which is both sustainable and efficient needs to be identified.

Researchers need to move from their preoccupation with assessing the health impacts of individual health interventions to assessing the impacts of \textit{existing} mixes or groupings of health care interventions, like those of an integrated MCH programme. As budgets are usually allocated according to such groups of health care interventions, their cost analysis becomes easier. The priority-setting tools referred to above usually end up with findings such as that mass chemotherapy against tuberculosis, immunization in districts, and integrated management of sick children are priorities, but that treatment diabetes mellitus and cancer are not. Such findings are not of much practical use. The information may be of use in the development of guidelines for districts at the central level. However, the information would have been of more use if researchers developing
priority-setting tools would make more effort to know and build their studies and methodologies on existing forms of organization of services in poor countries.

**Addressing the health transition.** An important challenge in priority-setting is to find the right mix of interventions that will enable countries to attack aggressively today's main killers and at the same time lay a foundation for overcoming tomorrow's emerging problems. To the decision-maker, once staff have been employed and services organized, priority-setting is essentially concerned with the efficient use of health workers' time. Studies show that health workers in most health centres in the least developed countries are under-utilized and are capable of carrying out additional interventions that do not require further investment in equipment or supplies. Thus health promotional activities, like those for diabetes and cancer prevention, can be carried out with very little additional cost to health services.

The main message from the above observations is that the overstating of the objective of disease (morbidity and mortality) reduction in priority-setting has undermined other equally important objectives in health care which have become neglected or related to secondary places. As there may be trade-offs between health care objectives, these have to be examined individually and in combination to arrive at the best way of organizing quality health care for all citizens. An example of a question involving a combination of concerns is what form of organization of services at health centre level is able to ensure maximum impact of programmes, sustainability, reduction in inequity and consumer satisfaction? Admittedly, this becomes a complex question needing to examine synergism of programmes and other factors. Thus the question is dealt with pragmatically using both qualitative and quantitative data. There seems to be no short cut and the current search for a tool that will lead to decisions needs to be re-thought in this context.

Clearly there is need to evaluate and experiment with alternative systems of priority-setting in poor countries. But to be of maximum and practical use, such evaluations and experiments have to be thought of and developed in the context of the existing situation in these countries and should aim at achieving several health care objectives concurrently. For priority-setting is about choosing appropriate mixes (see Fig. 6). The first International Conference on Priorities in Health Care, which is sponsored by WHO, will be held in October 1996 in Stockholm, Sweden, and will provide an opportunity for taking stock and exchange of information on various experiences.
Fig. 6. Choices that must not be made

- Choices must not be made between the eight elements of primary health care. The aim must always be to provide essential activities for each of the eight elements within the constraints of available resources. The issue is how much of each?

- Similarly, choices should not be made between preventive and curative services, basic and applied research, disease control programmes, hospitals and front-line health units, or infrastructure and programmes. Again, the issue is to choose an appropriate mix.
CHAPTER 8

SUMMARY

The Alma-Ata primary health care principles have had considerable influence in directing the global effort towards achieving the goal of health for all. Six major misinterpretations, namely, PHC is only community-based health care, PHC is first-level of contact in health care, PHC is only for poor people in developing countries, PHC is a case of eight elements, PHC is concerned with "low tech", and PHC is cheap, are clarified.

While the Alma-Ata Declaration is widely known, a less well discussed product of the Alma-Ata Conference is a set of 22 recommendations for changes needed in health systems to implement PHC. It is clear from the Alma-Ata recommendations that a number of areas, particularly environmental health, urbanization, rapid population growth, the role of women and the economic crisis (which was then in its infancy), were not addressed adequately. The deficiency has since been more than rectified through a series of activities, including international conferences on these issues organized by different agencies. It should be noted, however, that the potentials of these conferences in enhancing the achievement of the PHC/HFA goals are not fully exploited.

Like Alma-Ata, most of the international conferences have given little attention to action at the local level. They rather call for national commitment, strategies and activities to implement conference recommendations, and plans of action. The recommendations invariably speak of "people-centred development", "people-friendly markets", "democratization", etc. But it is unrealistic to rely exclusively on top-down implementation - it is too much like expecting poachers to lead game conservation measures. Supplementary strategies for action at district and community levels need more visibility at both national and international conferences. To be of maximum use to countries and to avoid confusion, the themes and action programmes of these conferences should build on one another. An even more serious deficiency of these conferences is their silence on where funds will come from to implement recommendations.

From initial euphoria with the privatization of health services and with user charges, a more balanced and cautious approach that calls for concurrent equity measures is emerging. A massive task of human resources development confronts the health sector, particularly in developing countries. Incentives for health workers in these countries remain inadequate, resulting in brain drain and poor performance. The situation is getting worse but in many of these countries everybody seems powerless.
The present situation, 16 years after Alma-Ata, is truly mixed. Considerable improvements in health and the expansion of care globally and nationally are documented in the paper. To celebrate now is premature - the battle is not yet over. Behind the global and national average achievements are distortions, inequalities, and unsustainable developments. A number of the least developed countries have been largely bypassed by the PHC movement. Emphasis in all countries should go to raising awareness about health and enhancing popular participation. There is a danger that many of the ongoing health reforms focusing on improving efficiency may worsen the current inequities in health and health care. Close monitoring of inequities, particularly at the local level, is essential.

Global organizations need to have a greater feel for the true country situations. Such a feel is difficult to acquire in short country missions. Most countries now have extensive knowledge and skills needed to implement PHC and carry it through successfully, if they have the determination and political will to overcome resistance and problems. The industrial countries and many of the developing countries have adequate resources to provide essential health care to all citizens. The least developed countries will not be able on their own to achieve the HFA goals in the near future. Well over 40% of the population in these countries has sunk into abject poverty. A sense of despondency and personal uncertainty about the future is widespread. These countries need special global support. The sense of personal uncertainty makes any type of outside help welcome. Inflated expectations by the global community in the past have resulted in constant frustration. The global community needs to learn from these errors. The need to intensify cooperation and collective self-reliance in the South is recognized although support for such cooperation does not arouse much enthusiasm.

Besides the need to avoid inflated expectations, three other lessons can be drawn from the experience of global programmes for the least developed countries. First is the power of the "demonstration effect" and hence the need to promote and support collaboration and exchange of experiences between these countries. Second is the value of using national experts in globally supported activities. These nationals, properly motivated, are more cost-effective than outside experts, who have difficulties in getting the "feel" of the country. Third is the fact that additional monies are necessary. The right local arrangements need to be in place to ensure that money is used well, but it is unrealistic to demand that additional funding will be provided only when there is proof that all available resources are being used in a cost-effective way.

The last part of the paper calls attention to four key areas for health development where substantial revision of strategy is necessary. These are: partnership towards a new social contract and code of ethics; special efforts to reach the underprivileged in the pursuit of equity; renewed attempts to raise the quality and effectiveness of the health services, both public and private; and rethinking priority setting. It is contended that priority-setting in health care involves balancing trade-offs between health care objectives. Research and development is essential to improve the quality of priority-setting processes.
In summary, based on a critical review of the implementation of the Alma-Ata Declaration and recommendations, the paper presents creative ways of promoting PHC to the year 2000 and beyond, together with suggestions on institutional changes needed at subnational, national, and global levels for adaptation.
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ANNEX I

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a stage of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of
governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

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.

VII

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 most 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.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country’s resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world’s resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.
The International Conference on Primary Health Care calls for urgent and effective primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.
ALMA-ATA RECOMMENDATIONS

1. Interrelationships between health and development

The Conference, recognizing that health is dependent on social and economic development, and also contributes to it,

RECOMMENDS that governments incorporate and strengthen primary health care within their national development plans with special emphasis on rural and urban development programmes and the coordination of the health-related activities of the different sectors.

2. Community participation in primary health care

The Conference, considering that national and community self-reliance and social awareness are among the key factors in human development, and acknowledging that people have the right and duty to participate in the process for the improvement and maintenance of their health,

RECOMMENDS that governments encourage and ensure full community participation through the effective propagation of relevant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families, and communities can assume responsibility for their health and well being.

3. The role of national administrations in primary health care

The Conference, noting the importance of appropriate administrative and financial support at all levels, for coordinated national development, including primary health care, and for translating national policies into practice,

RECOMMENDS that governments strengthen the support of their general administration to primary health care and related activities through coordination among different ministries and the delegation of appropriate responsibility and authority to intermediate and community levels, with the provision of sufficient manpower and resources to these levels.
4. **Coordination of health**

The Conference, recognizing that significant improvement in the health of all people requires the planned and effective coordination of national health services and health-related activities of other sectors,

RECOMMENDS that national health policies and plans take full account of the inputs of other sectors bearing on health: that specific and workable arrangements be made at all levels - in particular at the intermediate and community levels - for the coordination of health services with all other activities contributing to health promotion and primary health care; and that arrangements for coordination take into account the role of the sectors dealing with administration and finance.

5. **Content of primary health care**

The Conference, stressing that primary health care should focus on the main health problems in the community, but recognizing that these problems and the ways of solving them will vary from one country and community to another,

RECOMMENDS that primary health care should include at least: education concerning prevailing health problems and the methods of identifying, 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; promotion of mental health and provision of essential drugs.

6. **Comprehensive primary health at the local level**

The Conference, confirming that primary health care includes all activities that contribute to health at the interface between the community and the health system,

RECOMMENDS that, in order for primary health care to be comprehensive, all development-oriented activities should be interrelated and balanced so as to focus on problems of the highest priority as mutually perceived by the community and health system, and that culturally acceptable, technically appropriate, manageable, and appropriately selected interventions should be implemented in combinations that meet local needs. This implies that single-purpose programmes should be integrated into primary health care activities as quickly and smoothly as possible.
7. Support of primary health care within the national health system

The Conference, considering that primary health care is the foundation of a comprehensive national health system and that the health system must be organized to support primary health care and make it effective,

RECOMMENDS that governments promote primary health care and related development activities so as to enhance the capacity and determination of the people to solve their own problems. This requires a close relationship between the primary health care workers and the community and that each team be responsible for a defined area. It also necessitates reorienting the existing system to ensure that all levels of the health system support primary health care by facilitating referral of patients and consultation on health problems; by providing supportive supervision and guidance, logistic support, and supplies: and through improved use of referral hospitals.

8. Special needs of vulnerable and high-risk groups

The Conference, recognizing the special needs of those who are at least able, for geographical, political, social or financial reasons, to take the initiative in seeking health care, and expressing great concern for those who are the most vulnerable or at greatest risk,

RECOMMENDS that as part of total coverage of populations through primary health care, high priority be given to the special needs of women, children, working populations at high risk, and the under-privileged segments of society, and that the necessary activities be maintained, reaching out into all homes and working places to identify systematically those at highest risk, to provide continuing care to them, and to eliminate factors contributing to ill health.

9. Roles and categories of health and health-related manpower for primary health care

The Conference, recognizing that the development of primary health care depends on the attitudes and capabilities of all health workers and also on a health system that is designed to support and complement the frontline workers,

RECOMMENDS that governments give high priority to the full utilization of human resources by defining the technical role, supportive skills, and attitudes required for each category of health worker according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and, where applicable, traditional practitioners and traditional birth attendants.
10. **Training of health and health-related manpower for primary health care**

The Conference, recognizing the need for sufficient numbers of trained personnel for the support and delivery of primary health care,

RECOMMENDS that governments undertake or support reorientation and training for all levels of existing personnel and revised programmes for the training of new community health personnel; that health workers, especially physicians and nurses, should be socially and technically trained and motivated to serve the community; that all training should include field activities; that physicians and other professional health workers should be urged to work in under-served areas early in their career; and that due attention should be paid to continuing education, supportive supervision, the preparation of teachers of health workers, and health training for workers from other sectors.

11. **Incentives for service in remote and neglected areas**

The Conference, recognizing that service in primary health care focused on the needs of the under-served requires special dedication and motivation, but that even then there is a crucial need to provide culturally suitable rewards and recognition for service under difficult and rigorous conditions,

RECOMMENDS that all levels of health personnel be provided with incentives scaled to the relative isolation and difficulty of the conditions under which they live and work. These incentives should be adapted to local situations and may take such forms as better living and working conditions and opportunities for further training and continuing education.

12. **Appropriate technology for health**

The Conference, recognizing that primary health care requires the identification, development, adaptation and implementation of appropriate technology,

RECOMMENDS that governments, research and academic institutions, non-governmental organizations, and especially communities, develop technologies and methods that contribute to health, both in the health system and in associated services; are scientifically sound, adapted to local needs, and acceptable to the community; and are maintained by the people themselves, in keeping with the principle of self-reliance, with resources the community and the country can afford.
13. Logistic support and facilities for primary health care

The Conference, aware that the success of primary health care depends on adequate, appropriate and sustained logistic support in thousands of communities in many countries, raising new problems of great magnitude,

RECOMMENDS that governments ensure that efficient administrative, delivery, and maintenance services be established, reaching out to all primary health care activities at the communities level; that suitable and sufficient supplies and equipment be always available at all levels in the health system, in particular to community health workers; that careful attention be paid to the safe delivery and storage of perishable supplies such as vaccines; that there be appropriate strengthening of support facilities including hospitals, and that governments ensure that transport and all physical for primary health care be functionally efficient and appropriate to the social and economic environment.

14. Essential drugs for primary health care

The Conference, recognizing that primary health care requires a continuous supply of essential drugs; that the provision of drugs accounts for a significant proportion of expenditures in the health sector; and that the progressive extension of primary health care to ensure eventual national coverage entails a large increase in the provision of drugs,

RECOMMENDS that governments formulate national policies and regulations with respect to the import, local production, sale, and distribution of drugs and biologicals so as to ensure that essential drugs are available at the various levels of primary health care at the lowest feasible cost; that specific measures to taken to prevent the over utilization of medicines; that proved traditional remedies be incorporated; and that effective administrative and supply systems be established.

15. Administration and management for primary health care

The Conference, considering that the translation of the principles of primary health care into practice requires the strengthening of the administrative structure and managerial processes,

RECOMMENDS that governments should develop the administrative frame-work and apply at all levels appropriate managerial processes to plan for and implement primary health care, improve the allocation and distribution of resources, monitor and evaluate programmes with the help of a simple and relevant information system, share control with the community, and provide appropriate management training of health workers of different categories.
16. Health services research and operational studies

The Conference, emphasizing that enough is known about primary health care for governments to initiate or expand its implementation, but also recognizing that many long-range and complex issues need to be resolved, that the contribution of traditional systems of medicine calls for further research, and that new problems are constantly emerging as implementation proceeds,

RECOMMENDS that every national programme should set aside a percentage of its funds for continuing health services research; organize health services research and development units and field areas that operate in parallel with the general implementation process; encourage evaluation and feedback for early identification of problems; give responsibility to educational and research institutions and thus bring them into close collaboration with the health system; encourage the involvement of field workers and community members; and undertake a sustained effort to train research workers in order to promote national self-reliance.

17. Resources for primary health care

The Conference, recognizing that the implementation of primary health care requires the effective mobilization of resources bearing on health,

RECOMMENDS that, as an expression of their political determination to promote the primary health care approach, governments, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to under-served communities; encourage and support various ways of financing primary health care; including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximize the efficiency and effectiveness of health-related activities in all sectors.

18. National commitment to primary health care

The Conference, affirming that primary health care requires strong and continued political commitment at all levels of government, based upon the full understanding and support of the people,

RECOMMENDS that governments express their political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health system within overall socioeconomic development, with the involvement of all sectors concerned; to adopt enabling legislation where necessary; and
to stimulate, mobilize, and sustain public interest and participation in the development of primary health care.

19. National strategies for primary health care

The Conference, stressing the need for national strategies to translate policies for primary health care into action,

RECOMMENDS that governments elaborate without delay national strategies with well-defined goals and develop and implement plans of action to ensure that primary health care be made accessible to the entire population, the highest priority being given to under-served areas and groups, and reassess these policies, strategies, and plans for primary health care, in order to ensure their adaptation to evolving stages of development.

20. Technical cooperation in primary health care

The Conference, recognizing that all countries can learn from each other in matters of health and development,

RECOMMENDS that countries share and exchange information, experience, and expertise in the development of primary health care as part of technical cooperation among countries, particularly among developing countries.

21. International support for primary health care

The Conference, realizing that in order to promote and sustain health care and overcome obstacles to its implementation there is a need for strong, coordinated, international solidarity and support, and

Welcoming the offers of collaboration from United Nations organizations as well as from other sources of cooperation,

RECOMMENDS that international organizations, multilateral and bilateral agencies, nongovernmental organizations, funding agencies, and other partners in international health acting in a coordinated manner should encourage and support national commitment to primary health care and should channel increased technical and financial support into it, with full respect for the coordination of these resources by the countries themselves in a spirit of self-reliance and self-determination, as well as with the maximum utilization of locally available resources.
22. Role of WHO and UNICEF in supporting primary health care

The Conference, recognizing the need for a world plan of action for primary health care as a cooperative effort of all countries,

RECOMMENDS that WHO and UNICEF, guided by the declaration of Alma-Ata and the recommendations of this conference, should continue to encourage and support national strategies and plans for primary health care as part of overall development.

RECOMMENDS that WHO and UNICEF, on the basis of national strategies and plans, formulate as soon as possible concerted plans of action at the regional and global levels that promote and facilitate the mutual support of countries, particularly through the use of their national institutions, for accelerated development of primary health care.

RECOMMENDS that WHO and UNICEF continuously promote the mobilization of other international resources for primary health care.