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IMPLEMENTING PRIMARY HEALTH CARE

An Introduction and Overview for the
1981 Global Review of Progress in
Primary Health Care

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SUMMARY

Primary health care, as the key to attaining the goal of Health for All by the Year 2000, has evolved out of country experiences and socio-political movements at the international level. A general model of primary health care is the subject of international agreements and has attracted support in principle from countries and agencies of the international cooperation community.

Each country must give that general model of primary health care an operational definition according to its traditions, situation, aspirations and resource potentials. Particularly subject to national determination are PHC's calls for community involvement and for intersectoral collaboration to make health improvement an integral part of socioeconomic development.

National formulation and implementation of primary health care policies will often be constrained by ideological, political, and organizational factors in the health sector. Difficulties in effecting linkages and collaboration among social and governmental sectors, deficiencies in management capabilities, and absolute shortfalls in infrastructure and funds will also constrain PHC implementation.

Overcoming such constraints and achieving primary health care goals will require a strong political commitment. Political, social and managerial processes will be called into play in the formulation of policies and the development of strategies. Primary health care, by definition, puts a premium on broad participation and consultation among interested and affected parties.

Every aspect of primary health care is beset with problems of uncertainty and inexperience. Action research and evaluation can help solve these problems over time. The value of such efforts can be magnified by the systematic exchange among countries of knowledge gained from study and experience. The succeeding papers in this Global Review of primary health care seek to contribute to that exchange and to improve the prospects for successful outcomes.

INTRODUCTION

With the approval of virtually all governments of the 1978 Declaration of Alma-Ata and by resolutions of the World Health Assembly in 1979 and 1980, "Health for All by the Year 2000" became a national and international goal.

Implementation of the concept of primary health care is seen as the key to attaining the goal of Health for All. The Declaration of Alma-Ata defined primary health care as:

...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...

According to Alma-Ata, primary health care should be the "central function and main focus" of national health systems and as an integral part of "the overall social and economic development of the community." While primary care is "the first level of contact...with the national health system," it is also connected with other parts of the health care system and with broader efforts to improve the quality of living.

I. EVOLUTION OF PRIMARY HEALTH CARE

The Road to Alma-Ata

Primary health care was not invented by an international conference. It is the culmination and crystallization of past national and international experiences -- some of them negative and painful -- as well as an expression of aspirations for the future.

Preceding the primary health care concept, numerous countries sought to bring basic health services to populations without access to care and suffering heavily from preventable diseases. Most frequently these were rural people, but as industrialization in developing countries increased urbanization, severe health care problems also developed in urban slums. One frequent strategy was to extend medically staffed health centers and hospitals by establishing health posts in remote rural areas. However, sometimes these efforts were separate from, and not well coordinated with the medically directed "mainstream" of the health sector. These "front-line" posts were usually staffed by auxiliaries whose functions and training varied.

Among difficulties experienced in these basic health service programs were:

- 1) inadequate and often inappropriate assignment of physicians in rural areas;
- 2) poor supervision of services and poor program management;
- 3) failure to integrate general health services with campaigns and programs aimed at particular diseases;
- 4) inadequate supply, transport, communications, and record systems;
- 5) fragmentary coverage;
- 6) poor linkages with more advanced care;

- 7) severe underfinancing; and
- 8) marked underuse of services.

Actual quantitative and qualitative shortcomings of services were but one reason for underuse. People often bypassed basic service posts to seek care at hospitals (especially in urban areas). Hospitals diverted resources from advanced care to problems that could have been solved more properly at the village or neighborhood level. In some situations people preferred traditional healers to whom they were culturally and socially accustomed. Moreover, basic health services were often perceived as imposed from "outside"-- sometimes by governments that were not trusted -- and unconnected with either the political structure or socioeconomic concerns of the communities. Finally, in virtually all countries, insufficient public awareness of the need for preventive and promotive efforts led to demand for more and more curative services as a result of high levels of disease and disability.

For both humanitarian and political reasons, leaders in developing countries were becoming increasingly concerned with the health needs of their people. On one hand, disproportionate investments in sophisticated technologies inappropriate to national needs and primarily serving few people (sometimes less than 10 percent of the population), impeded improvements in general health status. In addition, improved health generally was pursued in isolation from other economic and social development. On the other hand, it came to be understood that developing countries could not progress economically because of inadequate health and education. Some countries could not improve living standards because they were confronted with increasing population, ineffective production, and inadequate revenue flows. Governments ideologically devoted to improvements in social justice regarded inadequate health development as intolerable.

The global picture was not altogether bleak, however. A few countries were able to develop effective national basic health services systems which fought major killer diseases, were linked to the political structure, and involved community participation and responsibility. In several other countries, the malaria eradication apparatus was used to deliver home health services. Over the years a multitude of small experiments and demonstrations contributed to the knowledge and technology of primary health care. Their impacts, however, tended to remain localized and restricted to demonstration sites.

Meanwhile, two distinct but converging developments were taking place at the international level, one in international politics, the other among international cooperation agencies. These developments stemmed partly from disappointments with the outcomes of the (First) UN Development Decade of the 1960's.

In the political arena, the Group of 77 developing countries enunciated a New International Economic Order (also designated as the North-South Dialogues) pursued mainly through organs of the United Nations. This policy approach sought a more just distribution of resources among nations via substantial changes in commercial relationships and in financial and technological assistance. The developing countries asserted claims for more support, for greater powers to determine the types of support, and for elimination of what they considered to be invidious policies and practices of donor countries. The application of these concepts to health was reflected in the Declaration of Alma-Ata.

The political force of the New International Economic Order, expressed in bilateral and multilateral relations, complemented a questioning of existing patterns of technical assistance to developing countries by international agency secretariats. The essence of their ideas could be

summed up in four terms: comprehensiveness, responsibility, management, and parity. Deficiencies in these key areas seemed not only to diminish the impact of technical assistance but also do unintended harm.

Comprehensiveness implies overcoming two tendencies toward fragmentation. One is the distribution of each agency's resources so thinly (even down to the level of an isolated educational fellowship) as to preclude amassing sufficient resources to carry out meaningful projects, thus undermining comprehensive national development programming. The second tendency was inadequate coordination of efforts among cooperating agencies, each insisting that applicant countries adhere to its own policies, standards, and procedures. This led to poor countries having to deal with a multitude of often contradictory priorities and norms. These practices resulted in failures to reinforce the potential effects of external support by fostering fragmentation of national plans and programs within and between sectors.

Responsibility concerns the "ownership" of projects and other efforts involving external cooperation. Too often, categorical projects were initiated by external advisers and agency staffs, sometimes with only nominal involvement of national authorities and community leaders. Projects were "in" countries, but not "of" them; sometimes such projects were merely ineffective, but at other times they distorted country priorities and neglected important national needs. Increased national initiative and responsibility were needed in international cooperative ventures.

Management refers to the realization that shortfalls in development projects and programs result from inadequate planning, implementation, and coordination as well as from inadequacies in funding and intervention technologies. Managerial deficiencies in health programs may be attributed to some extent to lack of training in program management for the physicians who run most health programs.

Parity implies a change in traditional donor-recipient relationships, enhancing mutuality of interests and benefits. Reciprocal status became a requirement for developing countries to assume their proper responsibilities and control their futures. Recognition of the desirability of reciprocity was symbolized by adopting the term "technical cooperation" in place of "technical assistance" in international communications.

These were some of the streams of national and international experience that converged and were articulated in the September 1978 International Conference on Primary Health Care at Alma-Ata, which received a Joint Report on Primary Health Care by the Director-General of the World Health Organization and the Executive Director of the United Nations Children's Fund. The Conference was attended by representatives of virtually all countries, international and bilateral agencies, and many nongovernmental organizations. It enunciated 22 sets of recommendations for future work in primary health care, as well as issuing the Declaration.

The Road from Alma-Ata

These recommendations were subsequently endorsed by the World Health Assembly, the Executive Board of UNICEF, the Economic and Social Council, and the General Assembly of the United Nations. The World Health Assembly called upon its member states to formulate national policies, strategies, and plans of action for primary health care. Most countries have submitted policy statements and general plans, including some of the developed as well as developing countries. WHO undertook to coordinate such plans into regional and global strategies.

Change has been felt both nationally and internationally. The linked concepts of primary health care and global commitment to health for all by 2000 have provided a common frame of reference for health to governments

and international cooperation agencies -- multilateral, bilateral, and non-governmental, whether directly or secondarily involved in health. Many of these agencies have made primary health care the leading priority in their health cooperation programs. Initial steps have been taken to develop an international mechanism to attract and coordinate information on bilateral and multilateral resources for primary health care. The emergence of the concept and goal influenced some agencies to include capital investment in national primary health care capacities in their funding programs.

Thus, the stage has been set for a renewed effort to further develop human health in the context of socioeconomic development. The major elements of international policy have been defined. Details will have to evolve, as will substantial shifts in the approaches and priorities of individual agencies. Significant political and strategic commitments to PHC have been made by some governments.

In most respects, however, events thus far constitute the prologue to the play. The play itself must take place in each country and in continuing interaction between national and international entities over the next two decades. In no country is either the development of primary health care or the attainment of the objectives of health for all (however each country defines those objectives) without problems and difficulties. Those problems are political, technical, operational, and managerial. They are also financial, if the health infrastructure is to extend and improve PHC in communities throughout each country of the world.

Some of the problems are unique to the political histories and systems of individual countries; many, however, are common problems whose solutions may be advanced by sharing information on experiences.

To organize and disseminate such information is the purpose of the series of papers which this document introduces. The following sections of this paper relate specific information to the whole of the primary health care concept.

II. NATIONAL APPROACHES TO PRIMARY HEALTH CARE

Problem: Operational Definition of Primary Health Care

While the Alma-Ata documents and subsequent elaborations provided a conceptual definition of primary health care, the Conference explicitly recognized that operational definitions would differ from country to country according to their stages of development, geographic regions, cultures, and political systems.

Arriving at the operational definition of primary health care in each country is likely to be an early problem, one that could frustrate or paralyze the implementation of the primary health care approach.

Such an operational definition can be thought of as the product of a process by which all "involved parties" -- another concept that requires operational definition -- would reach agreement on objectives for primary health care. To be useful, objectives must cover (1) the impacts desired from primary health care to serve the goal of health for all by the year 2000, (2) the services and activities that will compose primary health care, and (3) the structures and resources by which the activities will be carried out. In some countries, determining the process by which objectives will be set may be a further issue. Also, choices will have to be made in many countries as to whether objectives should include social changes beyond improvements in health status.

A groping for the operational meaning of primary health care preceded and entered into the Alma-Ata discussions. It persists in agency, national, and international dialogues on the subject. While arriving at

an answer to the question at the national level is critical, the international aspects are important to many developing countries: the definition of primary health care adopted by each international cooperation agency will provide criteria by which developing country proposals for support will be judged. Agency staffs and decision-makers are already grappling with the question of whether recent national proposals contain enough of the Alma-Ata characteristics to qualify for monetary and other support.

The concept of primary health care contains a dilemma which some would call a contradiction. On the one hand, PHC requires participation at all levels and therefore a high degree of self-determination by communities, regions and nations. On the other hand, primary health care seeks the most effective use of limited resources, which implies economies of scale, setting priorities, and some degree of standardization. Policy makers will need to seek a balance between the "efficiency of participation" and the "efficiency of standardization."

To meet this challenge, national analysts, planners, and decision-makers need to understand both the model of primary health care hammered out at Alma-Ata and the variations that might be considered in adapting that model to their own situations. It is likewise necessary for those involved in international cooperation to understand both the philosophy and the realistic possibilities for implementing the model.

The Primary Health Care Model

The product of a political dialogue, the primary health care model is expressed through 10 separate articles of the Declaration and 22 recommendations on implementation. The model embodies a complex system of concepts. Partly because of how it is expressed and partly because it is complex, discussions of primary health care bring to mind the fable of the blind men who tried to describe an elephant in circumstances where each of them could touch only one part of the beast.

Some emphasize the model's listing of eight (or nine) basic health services that constitute primary health care; others emphasize the need for intersectoral programming and integration with the whole of the national development process; others, the fundamental requirement for community participation and the potential of primary health care as a strategy for social change and the attainment of social justice; still others emphasize referral and articulation among levels of the health system; emphasis may also be given to research into the selection of appropriate technology or to the use of traditional healers. What is emphasized undoubtedly reflects the backgrounds and current roles of those who comment as well as their perceptions of their country's situation.

In the form of a series of statements, the primary health care model provides that:

1. The national health system has an important role in the process of socioeconomic development. The outcome or product of the health system is a rising level of health. As health embraces physical, psychological, and social factors, the health system consists of the activities of the health sector and those of other sectors that affect determinants of health.

These include agriculture and animal husbandry, food, industry, education, housing, public works (particularly with regard to safe water, sanitation, and safety), and communications. To maximize effects on health of scarce resources, effective intersectoral coordination must be established. These mechanisms will help assure that health improvements contribute to national development processes. Coordination is required in the formulation of policies, strategies and plans, and in the implementation of the objectives these plans embrace.

2. While the health sector performs promotive, preventive, curative and rehabilitative functions, most countries need to emphasize the application of the first two of these functions to the entire population. Appropriate health technology that people can use and afford should be available close to or within the home and workplace. Further, because of limited resources, priorities should be accorded to (1) the main health problems and (2) populations at greatest risk, such as women, children, workers exposed to hazards, and the most impoverished and isolated populations.

3. To contribute to social well being and to help assure the acceptability and use of health and related services, local and other communities should participate in the planning and implementation of programs. Community efforts should make full use of local resources, with national support, fostering community and individual self-reliance and responsibility for health. Necessary and appropriate educational processes should be used to develop the capacities of all community groups to participate. Decisions and actions pertaining to health should be integrated into the political, social and economic processes of the community.

4. With respect to health care services, primary health care strategies should provide for, at the minimum:

- education on prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- adequate supply of safe water and 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.

Such basic services should be reinforced and sustained by integrated, functional, and mutually supportive referral systems, linking primary and more advanced health services "leading to the progressive improvement of comprehensive health care for all."

5. These objectives and approaches imply the use of a broad spectrum of resources. Human resources for primary health care include properly educated professional, paraprofessional, auxiliary, and community workers. In some countries, traditional practitioners will also be involved. Primary health care requires competent management and necessary support services, including coordinated information support. Health services research is essential to the selection, development, and evaluation of technology, personnel and other resources.

6. National governments and administrations should:

- define and establish their political commitments to primary health care as an integral part of national development;

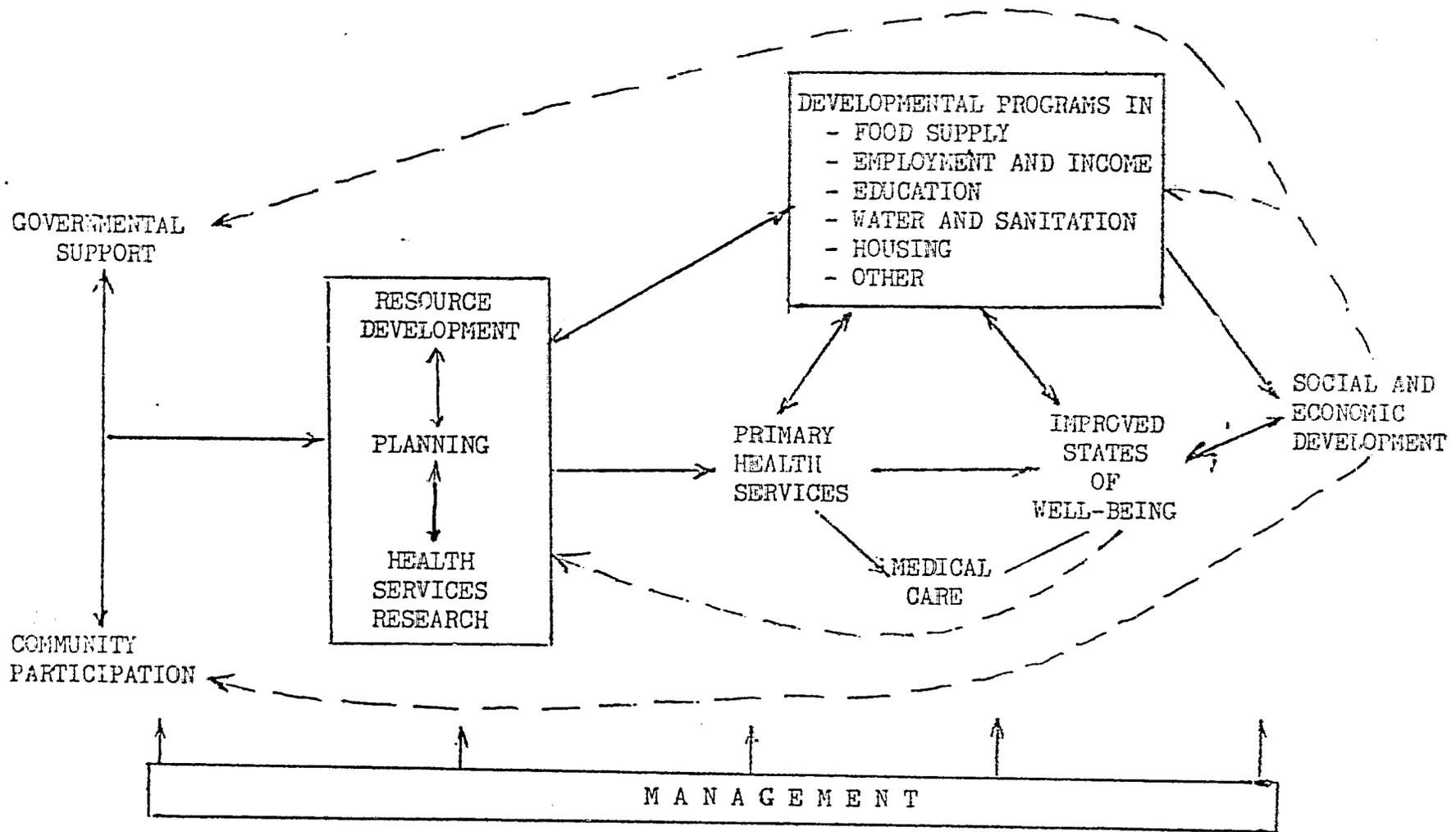


Fig. 1 - PRIMARY HEALTH CARE AS AN INTEGRAL PART OF NATIONAL SOCIOECONOMIC DEVELOPMENT

- give it priority in funding allocations;
- use a broad range of financial measures to support it;
- coordinate intersectoral planning and program implementation;
- strengthen administrative delegation and support; and
- facilitate and foster community participation.

7. To best serve the universal goal of health for all by the year 2000, mechanisms are needed to exchange knowledge and expertise and to channel financial and other resources among countries.

The model's main points may also be expressed graphically (Figure 1). The diagram depicts a national system of socioeconomic development, emphasizing the place and role of primary health care. Reciprocal and interactive relationships (symbolized by the double-headed arrows) pertain to health sector processes and development process between sectors. The broken lines of feedback show how these processes are modified by knowledge gained from experience and by progressive accomplishments. It should be noted that primary health care is represented by the diagram as a whole, while primary health services constitute but one component of the system.

National Variations

Operational definitions of primary health care and its goals and strategies will be influenced by each country's resource situation and by the character of its main health problems. For example, in the poorest countries, limited resources need to be used to reduce endemic or epidemic infectious diseases and poverty-linked diseases. In rich countries with low communicable disease prevalence, the targets of primary health care will be the "diseases of affluence" whose causal factors lie in the industrialized and social environment, the age structure of their populations, and patterns of human behavior. Between these extremes, the great variations in national needs and capabilities

defy precise classification. Some of the developed countries contain areas where health care needs resemble those of poor countries, while in some poor countries, industrial and agricultural development efforts have led to rapid environmental deterioration and new disease problems. Strategies of some of the least developed countries show an awareness of the long range dangers to well-being and health that are arising from the rapid destruction of forests and contamination of water resources in pursuit of short-term agricultural and industrial development.

National political and economic structures are a second source of variation in defining primary health care. "Planning" and "development" have different meanings and manifestations, and countries differ in how their governments and communities can affect economic and social factors. A country with a highly collective structure can undertake more direct strategies than a country structured on individual and group autonomy, where governmental policies may be confined to the manipulation of private sector incentives. Nations are open in different ways to external influences and ideals. Beyond such structural differences, nations vary in the ways in which ideals of equality and distributive justice are represented in their political systems.

The size, composition, and organization of each country's medical care resources, both human and material, are a third source of variation. Countries differ as to what resources are needed, how they can be distributed and retained, and the manner in which they can be obtained. Resource development targets will differ in their extent and nature. If a country needs to create resources, its health sector targets will differ from those of a country whose main need is to reorient existing resources.

One question of definition has a different significance for national governments and for international agencies: How much of the model must be included in a national policy if it is to be considered primary health care? For example, does an extension of existing coverage of basic rural health services meet the definition? Must there be intersectoral involvement? Community participation?

Governments answer such questions within their own sovereign powers and according to how they perceive their external interdependencies. Their latitude for choice is wide and multidimensional: They may implement the primary health care model fully, partially, or not at all and still label their policies as primary health care.

For the members of the international cooperation community, however, the question is more acute and difficult. Each organization seeks to be consistent and fair in dealing with countries, and it must have clear policies and criteria to guide its decisions. Difficult as that is, differences in each agency's mission and interests may impede the development of common policies and coordinated actions toward health for all. The challenge to the international cooperation community is substantial.

III. OBSTACLES TO IMPLEMENTATION

As countries state their intentions of achieving health for all by the year 2000 through the implementation of primary health care, what obstacles to the realization of such goals are likely to be encountered? What constraints can be expected to impede the process of translating health and social aspirations into reality? Some common obstacles found in experience to date follow.

Health Ideologies

The primary health care model contains explicit and implicit challenges to the relevance and sufficiency of scientific* and traditional medical practice. It clearly says that medicine by itself is not a sufficient means to achieve social and personal health.

Scientific medicine* competes with interventions that may be more important and useful. The PHC attitude toward traditional practitioners differs somewhat, in recognizing that the social role of such practitioners among key target groups can help stimulate community participation in and acceptance of primary health care. Still, the model implies that traditional practitioners are to extend their skills and to alter the quality of their activities.

Opposition can be expected from both these groups. PHC challenges the intellectual beliefs and social role of physicians and paramedical

*This term is one of convenience. It is recognized that many schools of traditional medicine are based on scientific approaches, reasoning and evidence. On the other hand, what used to be called "Western medicine" is now so firmly established in all countries that the use of that term is both obsolete and biased.

practitioners, quite aside from its implications for their economic status and potential. Medical and allied education foster a paramount belief in the medical model of health and disease; while that model includes concepts of prevention and significance of host factors, medicine in the past 70 years has given predominant attention -- and rewards -- to research and clinical practice involved with pathology. For the clinician -- who often plays social roles beyond that of consultant -- the primary aim is to bring a high order of diagnostic and therapeutic skills into play against "the presenting symptoms." Prevention usually follows far behind and, again, is often limited to medical techniques. The prevailing answer of medicine to health needs has been more and better physicians supported by improving knowledge of disease and progressively advanced intervention technologies.

Primary health care, by proposing alternative interventions and resources, may be seen as a threat to the central role and the "ownership" of the health enterprise by physicians -- or, at least, by physicians who strictly follow the medical model. Others than physicians might control the national health effort, and where there are insufficient numbers of physicians or where physicians are poorly distributed (as in most countries), the threat may be perceived as acute. Physicians are likely to be uncomfortable with the call to accept auxiliaries and/or traditional practitioners for the delivery of elementary medical care. Discomfort may be increased when the use of such workers is justified on the grounds of the sociocultural affinity with the people they serve and by the integral leadership roles in their own communities.

Open opposition by medical communities to such policy approaches has taken the form of discrediting them as "witch doctoring" and "poor medicine for poor people," as well as threats of retaliatory actions. Covert medical opposition may well have influenced past governmental decisions not to proceed with approaches analogous to primary health care. In some basic health service demonstration projects involving use of auxiliaries, acute opposition has given way to chronic attritional warfare.

Often overlooked in such situations is the critical dependence of primary health care upon physicians who can function in other than the conventional mode. As well as requiring somewhat different clinical functions, primary health care requires many physicians to act primarily as scientific and managerial leaders, teachers, exemplars of proper health behavior, and persons who can bring medical and epidemiological insights to intersectoral and sectoral planning, policy formulation, and decision making.

The integration of traditional healers into primary health care presents somewhat different difficulties. Traditional healers may be required to assume new roles in another system or to alter their behaviors in their own system. Successful integration may offer major benefits in achieving coverage and penetration of the population, reducing hostility and competition, and increasing the versatility of the technological approach to health. Differences in traditional systems and their roles in each society will require distinct national approaches that may range from providing incentives and assurances, at one extreme, to negotiating "treaties" to settle scientific, technical, and theological differences, at the other.

Health Politics

By definition primary health care disrupts the politics of health, since politics concerns the distribution of power and the distribution of social benefits and costs. Primary health care, both in its intersectoral dimension and in its emphasis on community participation, calls for increasing the numbers and types of persons who participate in decisions about health actions. Power is not restricted to the upper levels of the health sector itself; even within the health sector, PHC implies changes in the configuration of decision makers.

Primary health care policies explicitly require changing priorities (and, therefore, resource distributions) for the health sector as a whole and among its parts. The concept requires reorientation of health workers at all levels. Because PHC gives priority to basic help to the many over delivering high technology to the few, its implementation may result in allocating more resources at the "front line" of villages and urban slums and relatively less in the hospitals. Such changes, in turn, involve relatively smaller flows of resources to the most highly trained providers. Such priorities may disrupt personal career plans and institutional aspirations.

Where PHC policies would change the status quo of health system governance and the sectoral pattern of activities, political opposition is likely. In some countries, opposition may be contained by economic, ideological and political imperatives. In others -- particularly where considerable governmental health funding subsidizes private provider incomes -- opposition could be well organized and strong.

Health Organizational Structures

Primary health care emphasizes decentralization of administration, effective linkages between front-line and advanced levels of health care, integration of categorical health programs/projects into comprehensive service delivery patterns, and intersectoral coordination of front line activities. Bringing this about may require substantial changes in existing structures within the health sector (including the structure of the Ministry of health) and in relationships between health and other sectors.

In many countries, developing and developed, governmental appropriations and other public funds (e.g., lottery proceeds) support multiple systems of medical care. Authorized by legislation passed at different times, such systems serve different population segments (often defined on the basis of occupation); the funds per capita available in each of these systems often varies considerably, with the Ministry of Health programs poorly supported. In some countries, the governmental health budget supports a large number of autonomous health and welfare organizations subject to neither program control nor financial accountability requirements, as is the case with private sector organizations and practitioners who receive substantial subsidies. This creates difficulties for governments and external agencies in finding entry points to stimulate community participation and problem-solving.

Although Ministries of Health are likely to be called upon to play the leading and coordinating role in primary health care, many of these organizations are themselves structured in ways that inhibit their ability to do so. Most Ministries of Health are internally organized according to technical functions (e.g. environmental health, hospital administration) and categorical disease problems (e.g. malaria, leprosy, family planning). Each of these entities may have its own "vertical" organization, consisting of counterpart units at

regional, provincial and local levels. The problem of coordinating such structures at each level of administration has been recognized for decades, but the technical and economic requirements of primary health care make the need for solution more urgent and important. (Part of the difficulty in achieving coordination, apparently stems from the fact that the greatest gains in changing health status that have been measured are those associated with the intensive categorical "campaigns", as in the instances of smallpox, malaria and family planning).

Coordination difficulties often derive from constitutional and legislative assignments of responsibilities to sub-national levels. Unitary governments may have this problem, and federal systems always will. PHC's need for intersectoral coordination at these several levels compounds the difficulty.

While organizational fragmentation of health responsibilities and resources presents difficulties for the coordination required by primary health care, such conditions may be helpful to the PHC requirements for decentralization. The division of responsibilities among governmental levels can provide a framework on which local adaptation and increased community participation may be built. Sometimes an autonomous health service organization may already be providing more coherent health care activities than the categorical programs and separate services of official health agencies.

In countries whose governing ideology is technocratic, the very presence of health organizations may constrain the development of community participation and responsibility. If social interventions are regarded as the exclusive domain of those who manage public and private organizations, without significantly involving those outside such organizations, then activities will continue to be delivered to people, rather than developed with people.

Whatever changes in organizational relationships may be required by the

primary health care policies of a country, implementation will involve both finding the "right answers" and negotiating their acceptance. Because organizational structures involve both assignments of responsibilities and authority and the definition of domains and roles--each with its economic and political interests--this constraint is formidable.

Resource Allocation and Development

The opposition of vested interests is likely to be felt most directly and acutely in decisions about the allocation of money and other resources. If, in the words of the Alma-Ata documents, a national primary health care policy is to give "priority to those most in need", through "the transfer of a greater share of health resources to the underserved majority of the population," in addressing "the main problems of the community," resource decisions may involve:

- a. allocation of more national revenues to health;
- b. "freezing" or slowing the rate of resource flows to groups presently receiving them, if not reducing such flows in absolute terms;
- c. investing in human and technological resources that are not in the "mainstream" of past development or in accordance with professional preferences.

When available funds are increased (or it proves politically feasible to effect substantial reallocations among health priorities), the development of the required "real" human and technological resources requires overcoming the constraints of negative attitudes and limited development capacity. Implementation can be expected to involve changes in existing resource development systems (educational and training curricula), as well as the creation of resource development capacities that may not exist. New projects may be needed to train front line primary health care workers,

educate health managers and produce supplies. In turn, executing such projects may be impeded as much by inadequate funding as by a dearth of managerial resources to make operational plans, select and refine technologies, specify operating patterns, and organize support systems.

Intersectoral Linkages

The difficulties of resource and organizational problems in primary health care are increased by the challenge to link health development with national processes of socioeconomic development, to merge attainment of the basic requirements for health with efforts to reduce disease. Meeting that challenge requires the coordination, if not the integration, of policies, programs and actions among sectors, primarily as they interact with the local community; effective local coordination requires coordination at higher levels of politics and administration.

While primary health care presents this challenge in terms of objectives of health, broadly defined, the problem of intersectoral coordination is hardly new. It represents a long-standing impediment that applies to all national development programming and to the primary responsibilities of government itself.

With some exceptions, modern nations fall short of attaining intersectoral coordination under conventional patterns of organizing their public administrations. Besides dividing the work of government, ministries represent the values of particular economic and social constituencies, various segments of the population, and different technologies and vocabularies. Ministers are often chosen from among the leaders of interest groups, and the survival of directors-general usually depends upon giving what is perceived as adequate service to those interests. The problem is more than political, however.

The economic and technological complexity of modern governments

hinders coordination among sectors through the ministerial collective -- the cabinet -- or by the office of the prime minister. The experience of some developing countries indicates that coordination is even more difficult when the government is politically unstable, when bureaucratic organization proliferates, and as socioeconomic development occurs.

In many countries, the national health authorities are among the least likely entities to spearhead programs based on multi-sectoral coordination, because of the emphasis given to specialization, professionalism and high technology. Often sectoral leaders disdain "politics" and resist the powers of general government, much less those of other sectors, in decision-making about medicine. Primary health care policies that require common action with other sectors will often call for drastic changes in thinking and preferences and for raising the health ministry's customarily low political status, in order to carry forward the definition and execution of strategies.

Infrastructure Deficiencies

Primary health care is itself a response to the realities of physical and economic infrastructure deficiencies. It emphasizes appropriate (and by implication, simplified) technology, use of indigenous front-line resources, and community self-reliance and involvement. Thus it responds to the most prevalent and urgent needs of underserved populations and involves strategies that adapt to deficiencies in transportation, communication, high technology, and administrative organization. But such adaptations cannot fully compensate for all of these infrastructure deficiencies and the attainment of PHC objectives of coverage and equity may have to be limited or delayed for the short term. For example, articulation of basic services

with other levels of health care "leading to the progressive improvement of comprehensive health care for all," may not be feasible in regions where roads are inadequate and seasonally impassable; closely linked management systems are unrealistic in areas where the best available communication system is one-way broadcasting to people's transistor radios. Even the introduction of relatively simple technologies may be restricted, as with immunizations, until the "cold chain" requirements for certain vaccines can be met. While drug lists may be cut to the essentials, program administrators must either be able to resupply frequently or find the money to pay for sizeable inventories at a multitude of distribution points. At national or regional levels, ways have to be found to produce and maintain the requirements for the technologies that have been chosen, or expensive reliance on foreign suppliers will continue.

Countries vary not only in their states of physical and economic infrastructure, but also in their capacity to meet the social infrastructure requirements for primary health care. The levels of education and literacy may impose critical limitations upon primary health care strategies. So may traditions and behaviors with regard to cooperative community action and mutual assistance among individuals and families, although some relatively developed countries may be poorer in this regard than some of the least developed.

The force and character of customs, the strength of localism, popular attitudes toward government, professionals and outsiders -- these factors of social infrastructure require careful attention in formulating and carrying out primary health care strategies. Yet PHC strategies need not be purely

reactive, for although strategies must conform to infrastructure constraints in the short term, health improvement efforts can be linked more closely than in the past with progress in infrastructure development.

Management Capacity

The primary health care concept implies a management capability to perform numerous functions as a country formulates and implements strategies for health development. These functions include the ability to:

- identify needs, feasible tactics and appropriate interventions and responses;
- charter, direct, and utilize health services research to determine and evaluate appropriate technology, delivery patterns, and effects;
- design and develop support systems;
- plan and carry out resource development and mobilization;
- specify and properly use information in support of program and service control;
- justify, obtain, and administer required funding;
- foster community participation;
- develop and maintain linkages among elements of the health care system and among the intersectoral elements of the larger health system;
- carry out required supervision of personnel and activities;
- design management systems and develop the human resources to implement them at every level of the program; and
- monitor the system to determine needed adjustments and changes, and to effect them.

Further, primary health care implies that management be more attuned to the realities of the national situation than to general canons and conventions of traditional management. It expects that management for social change will be given primacy over hierarchical or technocratic approaches.

Few countries have such a health management capability, and some countries lack even the "seed" resources in their health management personnel and practices. The low quality of health system management may be exceptional, or it may be typical of the entire public administration. It is not unusual to find national administrative systems -- either indigenous or inherited from a colonial period -- in which the major emphasis is on the control of transactions rather than on the management of programs, and which are so centralized that no transaction is too small to require review and approval in the national capital.

In such circumstances, primary health care strategies will need to give explicit attention to the means by which such immediate constraints can be altered or bypassed. Such tactics, however, do little but help clear the way for actions addressed to the more fundamental need to develop appropriate managers and PHC management systems. Neither the importance of overcoming this obstacle nor the difficulty of doing so should be underestimated. Except for a lack of political commitment to health development, no other facilitating factor is more crucial than managers who are capable of pursuing changes in other constraints.

IV. IMPLEMENTATION REQUIREMENTS

In addition to modifying and adapting to constraints, the implementation of primary health care requires positive, developmental actions. If we think of both types of actions as problems to be solved, it can be said that more is known at this stage about the problems than about the solutions. Indeed, the purpose of the papers that follow in this series is to examine some of the problems in greater detail and to report on some of the approaches that have been taken toward their solution. The following overview discussion of the problems recognizes that possible prescription is limited not only by a lack of experience-based knowledge, but also by the differences in national situations. It assumes one common characteristic of such countries, however: that an initial commitment to primary health care as a national policy has been made by some segment of national leadership.

While the discussion of problems is presented in a sequence that follows the rational planning model, the intention is not to suggest either that the issues should be attacked one-by-one or in this sequence. The interrelationship of the requirements, as well as the particulars of country situations, would make that application dysfunctional.

Political Commitment

1. Required political commitments. What commitments are needed from the high political levels of government; from key ministries; from political parties, health sector and economic organizations, religious leaders, the mass media; from workers and farmer organizations? To what extent are commitments of positive support needed rather than commitments not to block or oppose?

2. Timing of commitments. Which commitments must be obtained before definitive planning can take place? Which follow upon planning? Which come later on in the course of program development? Which can be timed to coincide with major developments such as extending coverage into additional regions? Can a schedule of such promotional activity be drawn up, subject to modification along the way?

3. Policy roles. What are the roles in the policy process of governmental bodies, non-governmental organizations and local communities? With respect to various types of decisions, what are their respective functions--advising, informing, , deciding, endorsing? How are various actors in the process to be prepared for their roles? How organized? What kinds of information should flow regularly in one direction or another? For what functions should different interests be brought together? For which should they be consulted separately? How shall roles be assigned to central, intermediate and peripheral levels?

Primary health care requires a long-term political strategy to assure that the initial authorization and resource decisions will lead to continuity in PHC development. In some countries political strategies may radiate outward from the health sector; in others, it may be necessary to exert political pressure on the health sector. The wide participation of various types of communities may be the key to success.

Policy Formulation

Each country's political system and situation will determine the policy process for primary health care. In some a comprehensive, long-term strategic approach to PHC development can be formulated, based on extensive planning and consultations; experience may then lead to revisions and refinements of a grand design that embodies a strong, clear political commitment. In other countries, the policy approach may develop in steps over some years. Initial formulations may be limited and then progressively widen and deepen.

Whatever the feasible policy process, a problem for leadership is to define the nation's goals and objectives for primary health care, provide a capacity for planning and management, obtain authorizations and financing, and establish the ground rules for further development.

Critical Issues in Primary Health Care

1. Strategy Planning

Planning of strategies provides a link between policies and their actual implementation. Policy directs, authorizes, and sets limits to strategies. Strategy development identifies the resources and operations needed to attain policy goals.

All development planning is beset with uncertainties and incomplete data. It is a difficult and complex process. Additional complications may pertain to the planning of primary health care programs because of the need for community participation in planning and action and for intersectoral collaboration. Exceptional use of consultation and negotiation techniques, some of which can be anticipated and built into the planning process, may be employed at each stage of the process.

If community participation in planning and implementation is to be constructive, ways need to be found to:

- define ways in which participation can be fostered,
- establish the limits within which participation can occur, and
- specify opportunities and means for participation to take place.

Analogous decision rules will be needed to achieve intersectoral collaboration.

While isolated and spontaneous initiatives may occur, deliberate provisions for strategy planning and its costs need to be made if programs are to be relevant, acceptable, affordable, and effective.

2. Relating to Existing Systems

A major difficulty that has seldom been resolved in the health development experience of many countries is the isolation of planning from the existing systems of service operation. Because health planning has often failed to involve administrators and clinicians, plans were not understood or proved to be unworkable.

Primary health care may accentuate the danger that existing service systems will be bypassed in the planning process if planning is concentrated on front-line, elementary services. One problem is how to plan for that need and yet provide for integrated and linked services in the health sector and with agencies in other sectors.

Another problem is to link primary health care with the system of general public administration. While national level planning and programming may easily involve political and administrative leaders, this may not ordinarily be the case with sub-national levels of administration: regions, states, provinces, districts and municipalities. Yet agencies and officials at those levels can be powerful allies in effecting

intersectoral coordination and in fostering community participation in their jurisdiction, quite aside from the benefits of avoiding their antagonism. A similar problem exists in countries where resources of a private sector of medical care have to be involved to achieve primary health care objectives.

3. Decisions on Technology, Services, and Resources

The problem facing those responsible for primary health care, is more complex than an exercise in health planning, difficult as experience has shown that to be. Strategy formulation involves choices on such broad issues as the roles of physicians and other personnel categories, essential drugs, arrangements for intersectoral collaboration, and the functions of various institutions and organizations. If the strategy statement is to guide resource development and actual operations, it must also specify just how a new or reformed system is to perform, how and by when it is to be phased in, and the means by which program resources are to be developed. To be specified are the program's impact and service objectives, its service patterns, its support and management systems, and its resource requirements for both the developmental phase and continuing operations.

The magnitude of the problem represented by these requirements will be recognized by those familiar with the history of developmental health planning. That record is mixed. The major successes have been achieved in the planning of categorical disease campaigns and in those comprehensive programs that were localized at the provincial and district levels. Primary health care's imperatives for community participation and intersectoral programming further magnify the challenge to planning and planners. It is an aspect of primary health care that would benefit from inter-country exchanges of experience.

Health services research may provide useful information on distribution of problems and needs and on costs and effectiveness of various interventions, resources, tactics and patterns of service delivery.

4. The Role and Functions of Physicians in Primary Health Care

The earlier discussion of health ideologies identified the critical role of the physician. Reorienting physician preparation and performance is critical to developing realistic strategies. To specify the functions of physicians in various primary health care roles may require attention to logistical considerations of physician distribution, remuneration, and operational supports as well as the curricula for basic and continuing education. In some developing countries, a basis for obtaining the collaboration of medical educators and the leaders of organized medicine already exists as a result of long-standing concerns about the lack of congruence between traditional medical curricula and the actual health needs of the country.

5. Motivation of Personnel and Communities

Primary health care's effectiveness over the long term depends on the continuing functioning of personnel, some of whom will have to function autonomously in remote or detached locations for long periods. Experience suggests that meeting this critical requirement can be aided by personnel system provisions by training and by features of the operating strategy itself. These might include provisions for remuneration (some of which might come from the community), opportunities for career growth, and intangible forms of recognition. Strategy characteristics that have proven useful are avoiding overloads in direct effort or in the area or population to be covered, the recruitment of

personnel indigenous to communities, and supervisory and support arrangements that help assure quality and give symbolic importance to individual efforts.

An analogous problem is stimulating and sustaining the motivation of communities to participate in and contribute to PHC development. Solution of this problem indeed is not only critical to success in primary health care but can assist in solving the problem of staff motivation at the front line of action.

6. Integration of Health Programs and Services

The linking of primary care with more advanced levels implies a clear delineation of relationships among programs and organizations within the health sector and especially within the Ministry of Health structure. To integrate categorical program activities and resources in the community into comprehensive primary health care services presents the problem of appropriately relating program leaders at all other levels, while assuring that program activities fit local needs and preferences. The problem, therefore, involves working out agreements on organizational relationships, resource assignments and operating procedures, as well as specifying how service units are to interact with community leaders in working out local plans and activities.

7. Time Phasing the Strategy

Developing a comprehensive schedule that provides guidelines and establishes deadlines for implementation is an intricate technical problem with political aspects. Just when a district obtains services, or even pilot projects or demonstrations, is of concern to citizens and politicians. Technically, time factors will interact with decisions about strategy: a

strategy with a relatively rich service mix that emphasizes professional activities implies a schedule different from that of a strategy to establish rapidly many development nuclei, each initially providing minimal services to small areas, from which expanded coverage and services could proceed.

8. Support System

The extensive coverage and community penetration that is expected of primary health care will put a premium on effective support arrangements: supplies and drugs; transportation of patients and materials; communications between service sites and administrative centers; maintenance of vehicles, equipment and buildings; and recording and reporting essential epidemiological, service and utilization information. Too often health planning has given inadequate attention to these requirements, with consequent breakdowns in service programs. Even if a primary health care strategy is based on simpler technologies than traditional medical care, the numbers and distances involved will present a substantial problem in support requirements. It is possible that intersectoral collaboration in primary health care can result in the better utilization of existing resources and systems in the cooperating sectors.

9. Flexibility in Planning and Evaluation

Many country experiences demonstrate that the costs of health planning, coupled with the needs of administrators and organizations for stability, have often made such planning a one-time-only process whose products are declared to be final. Several characteristics of the primary health care approach, including community involvement and emphasis on learning from

experience, suggest the need for repeated evaluation and replanning. One problem is how to meet the costs in resources and "instability"; another is how to arrange the information flows and analyses to make replanning useful.

Evaluation

Evaluation can play a major role in the implementation of primary health care policies. The purposes it can serve are:

- to clarify problems and needs on a continuing basis;
- to assess alternative technologies and strategies for their effectiveness, relevance, and utility;
- to determine progress toward objectives of impact, coverage and resource development
- to identify and analyze problems in program implementation as an aid to management control and replanning, and
- to systematically develop information for further decisions on policies, resource allocations and program strategies.

The evaluation approach might include the periodic evaluation of the system by community leaders, as well as by the administrative structure, with orderly processes for the use of community information by regional and national leaders of the PHC system. Valid and systematic evaluations do not occur spontaneously; the problem is to plan, design, staff and support them with adequate information. Some of the developmental tasks are:

1. Identifying the purposes and needs to be served by evaluation, both ongoing and periodic.
2. Selecting the criteria to be used in assessments and decisions, from among those found in the objectives and milestones stated in policies and plans and those required for management purposes. The types of criteria

of progress and accomplishment may cover service provision, utilization, equity, and outcomes, the last of which reach beyond health status to include indices that reflect changes in the socioeconomic situation.

3. Specifying information needed to support evaluations, including data to be collected in the course of PHC operations and data to be collected through special or periodic efforts.

4. Scheduling evaluation activities and reports, including those to be used by various levels of program administration for purposes of management control.

V. RESOURCE DEVELOPMENT

Resource development is a continuing function of primary health care which seeks to serve resource needs for start-up, for progressive extensions of coverage, and for resource replacement and system improvement. "Resources" embraces (1) personnel needed to provide services and facilitate community efforts, (2) tangibles such as buildings, equipment and supplies, and (3) intangibles such as technology, plans, authorizations, agreements, commitments to self-help and information and management systems.

Resource Development Planning

Planning for resource development is properly guided by an explicit strategy that defines resource requirements and establishes deadlines for resource development. Resource development planning then defines detailed objectives, operational activities, responsibility assignments, operating budgets, and schedules to synchronize the activities. The problems of resource planning and management are both technical and administrative, the latter involving the coordination of many participants and the establishment of continuing relationships among them to avoid wasting scarce resources. Since most ministries have their own training and planning capabilities, and since educational institutions relate to the Ministry of Education, coordination is likely to be intersectoral in character.

Manpower Development Processes

Developing human resources for primary health care presents special difficulties: the requirement for large numbers of personnel who can function with a considerable degree of autonomy at dispersed locations, and the requirement for qualitative change in conventional patterns of

clinical and administrative practice. The problems to be solved in human resource development include:

- a) Definition of personnel categories and the functions, tasks and relationships of each, including the formal management structure and community leadership and residents. *relationships in with*
- b) Personnel selection, with due regard to constraints on professionals and to community participation and commitment in the process. *to a great extent, of research for public sector activities, much due regard to career uncertainty*
- c) Training, including development of mechanisms to prepare personnel who cannot be trained through existing programs, and modification of existing curricula and programs. There are technical and managerial problems here as well as problems of obtaining funds for the design, development, testing and evaluation of courses and materials; this burden can be reduced to some degree by inter-country sharing of experiences and materials.
- d) Assignment, maintenance, evaluation and upgrading of personnel.

Support System Development

The importance and severity of the problem of support system development is demonstrated by breakdowns in both traditional and innovative health care programs that are traceable to the neglect of crucial logistical requirements. Often the emphasis has been on construction of facilities and acquisition of equipment with little attention to maintenance or systematic replacement of capital goods.

While PHC technologies initially may involve relatively simple material resources, supplies must be delivered and replenished over substantial distances, patients and workers must move, equipment must work, and information about health and service problems must flow. Limited resources for primary health care suggest that supply, communication and transportation functions

can be integrated with clinical and information collection tasks at the level of basic service and first-line supervision, even though specialists may be required at higher levels to perform large critical support tasks.

The problem of designing and developing support systems, beyond its inherent intricacy, is the need for close coordination with agencies responsible for government-wide finance, procurement, custodial and communications functions, as well as those that oversee provincial and regional levels of government.

Management Development

Successful development of appropriate support systems would contribute substantially to capable management of primary health care. However, the full range of management capabilities identified earlier requires further development of management systems and personnel. Because of primary health care's decentralized character, management involves the actions of front-line workers and clinicians, as well as those of system leaders whose roles are mainly managerial. The dual problem, then, is to design and specify management and supervision systems, giving due regard to interfaces with community roles and actions, and to prepare different types of personnel to carry out needed activities.

Community Development

Perhaps the most difficult of the PHC requirements to implement will be community participation in planning, conducting and monitoring socioeconomic development activities, including health development actions. Variations in country social systems limit the validity of generalizations as to needs and responses. In some countries, the problems to be solved are not only to specify community roles in detail with appropriate involvement of

community leaders, but also to devise the means by which communities can be prepared and induced to participate.

Technical Cooperation among Developing Countries (TCDC)

The New International Economic Order promotes the concept that more technical cooperation should take place among developing countries, since clusters of developing countries have similar needs, experiences, and characteristics. These similarities potentially make the indigenous models and systems of each country more relevant to other countries of the group than the models and systems of developed countries. Making the concept operational, however, is a problem shared by developing countries and international cooperation agencies alike. Some ^{of these are} are well known: conferences, consultations, observations, inter-country pilot projects, study exchanges, and exchanges of publications and documents. The current challenge is to make TCDC efforts intense and systematic, to overcome past tendencies toward randomness in developing and disseminating knowledge, expertise and experience.