

This booklet explains what WHO is doing throughout the world to promote comprehensive health systems based on primary health care.

Part I outlines the present situation

Part II describes what is already being done and what it is planned to do.

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Introduction

Three dates have been important in stimulating the development of comprehensive health systems:

- 1977, the year in which the World Health Assembly launched its programme to achieve health for all by the year 2000 (the "health-for-all" concept);

- 1978, when the International Conference on Primary Health Care adopted the Declaration of Alma-Ata, in which primary health is seen as the best approach for implementing that concept; and

- 1981, when the World Health Assembly enunciated the strategy that such implementation would require.

This Global Strategy for Health for All by the Year 2000¹ calls on countries to develop health system infrastructures based on the primary health care approach.

The Strategy spells out the international action that should be taken to reinforce the national action, namely: exchange of information; encouragement of research and development; technical support; training; promotion of coordination both within the health sector and with other development sectors; and fostering of the essential elements of primary health care in the various countries.

The general aim of this programme of organization of health systems based on primary health care, as defined in WHO's Seventh General Programme of Work (1984-1989).² is:

"to promote and support the appropriate organization and effective operation of comprehensive health systems that provide the essential elements of primary health care to entire populations, along with referral and specialized support, when necessary, and that involve communities and health-related sectors in responsible and coordinated ways."

Health System

"The health system infrastructure provides the human and material means for delivering health care, but its impact on health depends on the substance of what is delivered" (7th General Programme of Work).

A health system can be presented in the form of five boxes - see figure 1. The first box, by far the biggest, comprises individuals, families and communities. There is increasing awareness of the crucial role that these individuals, families and communities can play in health promotion through adopting healthier life styles and in other ways. Several types of groups - self-help, alternative care, mutual aid, religious, women's and youth groups - are organized with explicit or implicit health goals.

The next box consists of frontline (basic health) personnel, usually full-time, working from dispensaries, health centres, hospitals, outpatient departments and other facilities. Community health workers, who are in some countries selected and supported by communities, form a link between boxes 1 and 2.

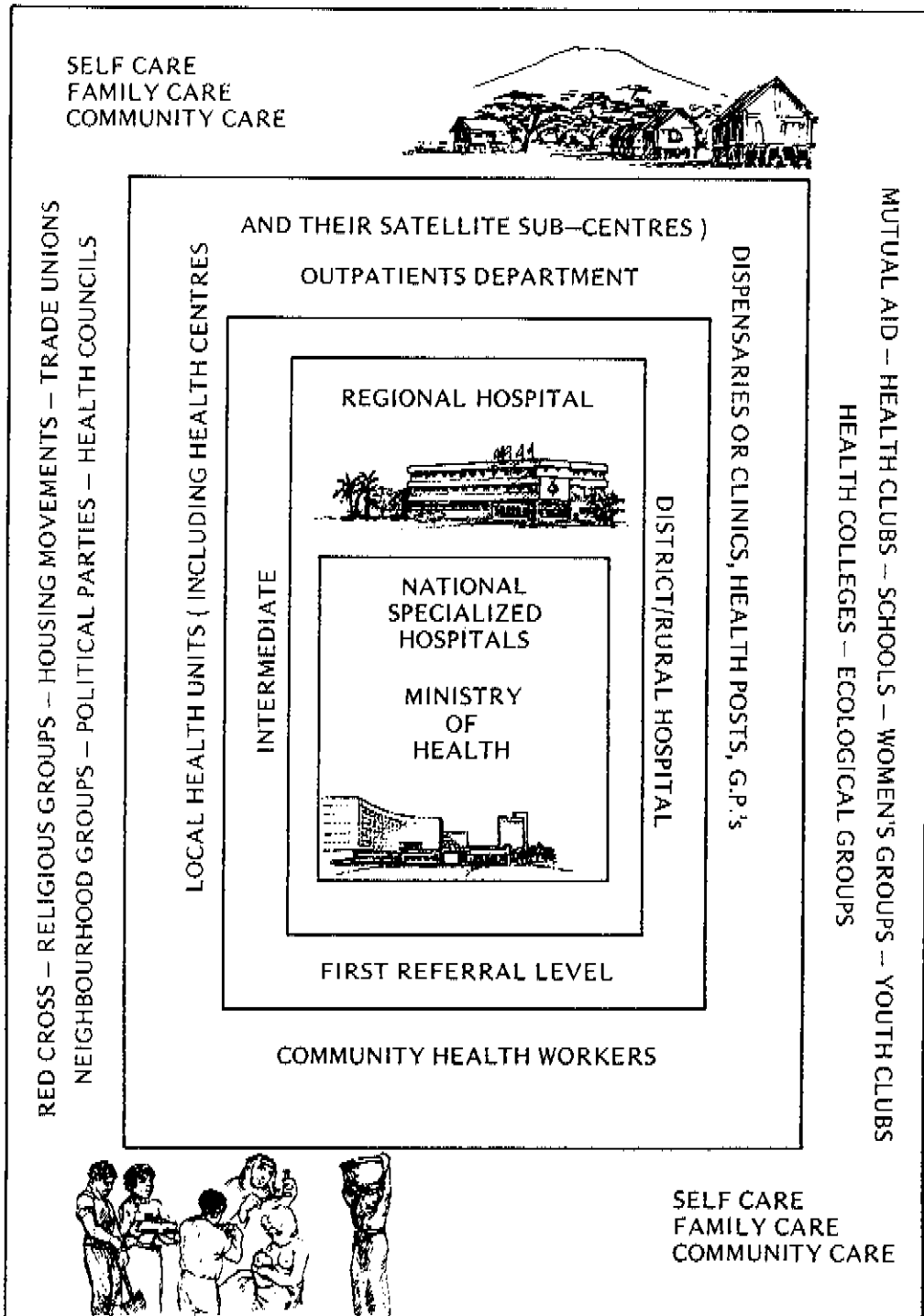
The intermediate level (first referral level) - box 3 - provides the main and direct support to the frontline workers. The national level institutions (tertiary care) provide more specialized care than regional ones.

The activities being carried out to implement the strategy are grouped under three headings:

- (1) strengthening of the national capabilities that will enable the country to organize its health system, modify its policy when necessary, introduce the requisite structures and mechanisms, and allocate adequate resources for implementing the primary health care approach (part II, section 1);

Figure 1

THE FIVE BOXES OF THE HEALTH SYSTEM



- (2) provision of primary health care to the entire population by way of a reorganization or reorientation that will make the health system both more efficient and more effective, proper emphasis being given to strengthening the first-line hospitals (part II, section 2);
- (3) development of local health systems in which the community plays its part alongside the health-related sectors; by which programmes can be planned to meet the priority health needs of that community; and through which can be created a suitable infrastructure for the delivery of those programmes (part II, section 3).

Section 1 provides an overview of the situation in countries.

I. THE PRESENT SITUATION

Towards the end of 1982, countries began the review of their health situations, using a common set of indicators. The findings formed the basis of a report that was reviewed by the Thirty-seventh World Health Assembly in May 1984 (the "global monitoring" report).³

THE PICTURE THAT EMERGES

What were those findings? On the positive side, it may be said that the political will to attain the goal of health for all undoubtedly exists in the large majority of countries. Many of them are indeed taking action to achieve full coverage of their population by primary health care. The right of people to take part in developing the national health system - and their duty to do so - has gained wide recognition. The intersectoral activities required for health development are being encouraged. Key areas in the delivery of primary health care are being strengthened. There is certainly progress in the necessary training or retraining of health workers. And there is a growing trend towards greater intercountry cooperation, especially the sharing of information and technical know-how and towards agreement on ways of solving priority problems.

* * *

THE DIFFICULTIES ENCOUNTERED

What problems came to light? The picture is not entirely rosy. Many countries are still without well-defined plans of action that specify targets and objectives, indicate the time-frame, and include a financial masterplan. Many technical and managerial problems are still unsolved - as is, indeed, the all-important question of financial resources. Some countries do not even know how much they are spending on health in general, let alone on primary health care. Moreover the data required for many of the social, economic and health indicators to assess progress are not always available. The creation of health system infrastructures based on the principles defined at Alma-Ata raises practical problems, not least of which is the need to make people more aware of the decisive role they can play in maintaining their own health. There is also the difficulty of reorienting the training of health workers towards those matters that are of most concern to the people they are to serve. Increased recourse to various types of auxiliary health worker, and to health workers who themselves have been selected by the community, is vital for extending coverage. Yet health systems are currently organized in a way that precludes optimal utilization of such workers.

The health systems of many countries were never conceived in terms of levels of care, where the first (peripheral) level serves as the basis of the system, the other levels providing technical and administrative support. First-line or district hospitals may not have the operational capacity required for effective first-level referral.

Coordination - both within the health sector and between the health and other sectors - needs improving. There is also the problem of integrating "vertical" programmes into the general system.

Management of services is often weak, and the information on which it depends is frequently not obtainable. One management problem increasingly encountered is the shortage of drugs. The cost of transport, and the distances between health units, hinder supervision.

Despite extensive promotion of community involvement over the last decade, the orientation that would enable health workers and health services to implement the concept is far from satisfactory. Health institutions are geared towards providing services to those who ask for them - instead of reaching out to find a solution to the health problems of the community as a whole.

Little emphasis has hitherto been placed on the ability of health systems to influence health-related behaviour, i.e., lifestyles.

In many countries the economic recession is curtailing the resources available for health work. In the 40 poorest countries, which in 1970 had a per capita income of less than US \$200 but an aggregate population of approximately 1200 million, the annual growth rate during the early years of the decade was only 1.1%. Inflation has further exacerbated the situation. As a result, the real income of large numbers of people in most developing countries has declined even further - and so have the resources for their health services. It is true that in the oil-producing and newly industrialized countries those resources have increased considerably, but more effective ways of deploying them have still to be found.

In the developing countries particularly, it is obvious that the health budget receives only a modest share of national resources, especially governmental resources. However, even in those developed countries where health-related activities traditionally receive privileged treatment (8% to 10% of the gross national product), the level of health is not always fully satisfactory; nor is there any noticeable correlation between the resources allocated and the resultant health situation.

In the great majority of countries where long-term trends have been investigated, the financial requirements of the national health system are found to be increasing faster than the gross national product - a differential growth in the order of between 2% and 10%, depending on the country and the year. Projections based on the modest differential of 4% per annum show that even to maintain the status quo would by the year 2000 require an allocation to health work of a proportion of the gross national product nearly twice the present allocation. But even this forecast is too optimistic, since the aging of the population will increase requirements and hence average per capita costs. Urbanization, and the tendency for the nuclear family to replace the traditional extended family, will further swell those costs. Allocations to health work would therefore more than double, merely to continue the present services. It would be difficult for even a wealthy country to allocate 15% to 20% of its gross national product to health-related activities; and certainly no developing country could afford to do so.

The present inappropriate use of resources is therefore a matter for concern. Most countries, developing and developed alike, continue to devote a large proportion of their resources to sophisticated and expensive curative technology that benefits only a small segment of the population. Considerably less attention is given to those basic care and prevention programmes that can be carried out with well-known and

readily available technology. Moreover the needs of the urban poor are ignored by health institutions, and that at a time when the rapid growth of cities makes it imperative to reorganize urban health services.

Nothing short of a different strategy will permit developing and developed countries alike to achieve greater social justice in health matters and to keep the relevant expenditure within bounds.

II. ACTIVITIES AND TRENDS

1. Organization and Development of National Health Systems

STRENGTHENING OF MINISTRIES OF HEALTH

Implicit in the health-for-all strategy is the strengthening of ministries of health as the focal point for national health development. A WHO/DANIDA workshop in 1982 examined the organizational options for these ministries. Participants from eleven countries⁴ discussed their national experiences, related their organizational successes and failures, and considered various solutions. The ground covered included: planning for primary health care, both horizontally and vertically (with special attention to resource allocation); manpower development; decentralization of ministry of health activities; internal coordination; intersectoral collaboration and its mechanisms; and structuring of the ministry of health to enhance its capacity for handling primary health care. The resulting guidelines were being adapted and used in 1984-1985 at regional and country level. If extrabudgetary funds are forthcoming, at least two regional workshops will be held - one for Latin American countries, the other for the French-speaking countries of Africa. Two or more institutions will carry out analytical studies and develop a training programme. National initiatives (including orientation seminars/workshops for key staff) are being supported. A synthesis of the information obtained from these and related activities will be disseminated.

Interregional seminars on primary health care were held in China (June 1982) and in Sri Lanka (August 1984).⁵ Ministers of health and senior health administrators, together with high-level representatives of other sectors discussed inter alia :

- action for social development, including the participation of women in health development, improvement of their status, and extension of literacy;
- role of food and related subsidies in improving the health status of the population;
- primary health care as related to the health needs of mothers and children;
- development of manpower for the management of primary health care.

Political commitment to primary health care is exemplified in the South-East Asia Region, where all countries have formulated health-for-all strategies and most of them have signed the regional Health Charter.

That political decisions in the African Region are beginning to be translated into practice is clear from the nature of national programmes and the trend in budget allocations. Dialogue between the Regional Office, political leaders, heads of state, ministers of foreign affairs, and ministers of health is continuing with a view to ensuring the primary health care approach. WHO support will be given in formulating action. A high-level seminar on the training of

intersectoral teams in primary health care development was held in July/August 1984; nine ministers and 12 directors of health services were involved.

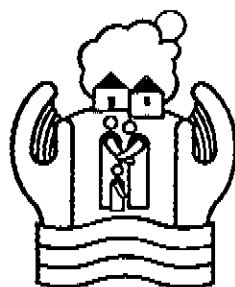
In the Eastern Mediterranean Region teams are visiting countries to develop on a national basis the WHO support programmes necessary for attaining Health for All. They have also introduced a comprehensive training programme for senior managers in all aspects of the managerial process for health development, including reorientation of health systems based on primary health care.

The rising level of commitment in the Western Pacific Region is shown by the number of countries that have reallocated resources to finance health-for-all programmes. The increased provision will be used to acquaint health workers with community participation, and workers in other sectors with health development; and to strengthen different levels of the health system, e.g., in relation to health care delivery; hospital planning and design; and peripheral and intermediate health facilities. The constraints are related to intersectoral coordination, management practices and skills, and shortage of resources (both manpower and money). They are compounded by adverse socioeconomic conditions in many countries of the Region, which hamper long-term development. Nevertheless, the following programmes are noteworthy:

- In China, since 1982, a study tour was organized for senior provincial health administrators to Thailand, the Philippines and Japan; and a group of senior administrators from Capital Hospital, Beijing, has visited the United Kingdom and the United States of America to study modern management techniques and the redevelopment of older hospitals.
- In Kiribati, a National Health Services Programme Plan for 1982-1986 was formulated in 1982, with the participation of sectors other than health, and representatives of the community.
- In Laos, a programme review was conducted (June 1983) along with WHO and UNICEF. Among other things, agreement was reached on a five-year primary health care project involving 50 districts and 100 communes.
- In Papua New Guinea, a reorganization of the National Department of Health (1983) led to a reduction in size in keeping with its new, principally advisory, role as part of the decentralization policy. In line with this policy, WHO and UNICEF supported the development of primary health care and management training courses at district and provincial level. A resource utilization review was completed in April 1983.
- In the Philippines, the Ministry of Health prepared its five-year plan for 1983-1987 following the principles of primary health care; undertook the training of some 9000 midwives; and embarked on studies of intersectoral action for health and strengthening of district hospitals. After a successful trial, a scheme for integrating district hospitals and rural health centres has been applied nationwide.
- In Samoa, WHO was advising (1984-1985) on a reorganization of the Ministry of Health that involves a restructuring of district health services based on primary health care.

* * *

UNICEF/WHO SUPPORT
TO IMPLEMENTATION
OF PRIMARY HEALTH
CARE



As recommended by the Joint Committee on Health Policy in 1979, UNICEF/WHO workshops have been held to help developing countries in formulating and implementing health-for-all policies. These workshops have proved useful for the exchange of experience on how to tackle the constraints, which fall roughly into three groups: (i) inadequate appreciation of the primary health care approach at policy level, (ii) inadequate support for that approach, and (iii) inadequate resources. It was recommended that all priority health problems should be tackled intersectorally; that there should be a permanent national mechanism to strengthen capabilities for planning, management, training and research; and that there should be continuous collection of information that would indicate a shift of resources to primary health care.

Such workshops have so far been held in Mozambique (1980), Senegal (1981), Ethiopia (1982), Mali (1983) and The Gambia (1985), twenty African countries being involved. Each participating country sent a team composed of a senior health official directly responsible for developing primary health care; an official at the same level of responsibility from a relevant non-health sector; the UNICEF representative; and the WHO programme coordinator. Each team had previously investigated policy, programming and implementation in accordance with a common framework of pre-established research modules.

The purpose of the workshops is to mobilize national and international staff to deal with the concrete information required to make primary health care a reality.

A working group in the African Regional Office (December 1983) took into consideration the recommendations made in the Ethiopian workshop and experience gained in organizing similar activities (especially those activities undertaken with 10 French-speaking countries and culminating in the Mali workshop). The following points emerged:

- (1) Primary health care reviews by countries are essential, since they provide countries with valuable information on their own situation (what has been accomplished, what still needs to be done, and where the disparities lie).
- (2) The presence of resource people from other countries of the region not only acts as a catalyst but is instrumental in suggesting options and outlining country-specific preparatory activities.
- (3) Their presence is necessary during the entire survey/review period. (In the case of the 10 French-speaking countries mentioned above, the resource people left before the survey was undertaken; as a result, whereas some countries went ahead with the surveys, others did not.)

The working group recommended that each country should take stock of the progress it had made; should carefully document any breakthrough achieved, the solutions found to problems, and the results of action research in critical areas, especially those identified at the Ethiopian workshop, namely: experience in integrated development, allocation of resources and costing, evaluation of community health workers and information on their training and utilization (in particular, remuneration) and coordination with nongovernmental organizations.

It proposed the following preparatory activities and methodology:

(1) A multisectoral team should be formed by each country (a team including representatives of nongovernmental organizations) to work out the specific steps to be taken. A resource person from the region would be there to give support to the national team.

(2) Surveys/reviews should be undertaken by each country, the tools used being adapted to the country's situation. Privileged, less privileged, and underserved areas should be represented in any sample taken.

(3) Resource persons and WHO staff should be involved in the conduct of the survey.

(4) Countries should be requested to document the sharing of progress on the issues identified at the Ethiopian workshop.

Support has been provided by UNICEF and WHO to national workshops, to work out concrete plans for primary health care development. An example is the workshop held in Djibouti (February 1982).

A further area of collaboration between the two organizations is their joint support of selected countries in the implementation of national strategies. At its 1981 session, the Joint Committee on Health Policy recommended:

"the provision of substantial assistance, over the necessary periods of time, to those countries with clear and continuing national commitment to put the primary health care approach into practice".

Such joint support entails an estimation of the involvement of UNICEF and WHO in certain selected countries⁶ to ensure that the support by the two organizations is effective. The main support will be given to activities that are unequivocally a national endeavour and are carried out by national personnel. Hitherto support has taken different forms, depending on the country's needs and its health pattern. But on the whole progress has been slow.

In addition to such support, and to the action of countries, the following activities are envisaged by UNICEF/WHO:

(1) analysis of whatever up-to-date information is available on the development and implementation of health policies in certain selected countries and on their infrastructures and technological programmes; and preparation of country profiles showing progress in implementing the primary health care approach since 1978, the year of the Alma-Ata Conference;

(2) collaboration with countries to pinpoint the critical areas for further country action and support, using the above-mentioned country profiles as a guide;

(3) preparation of plans for follow-up action by countries and for the supporting role of UNICEF/WHO.

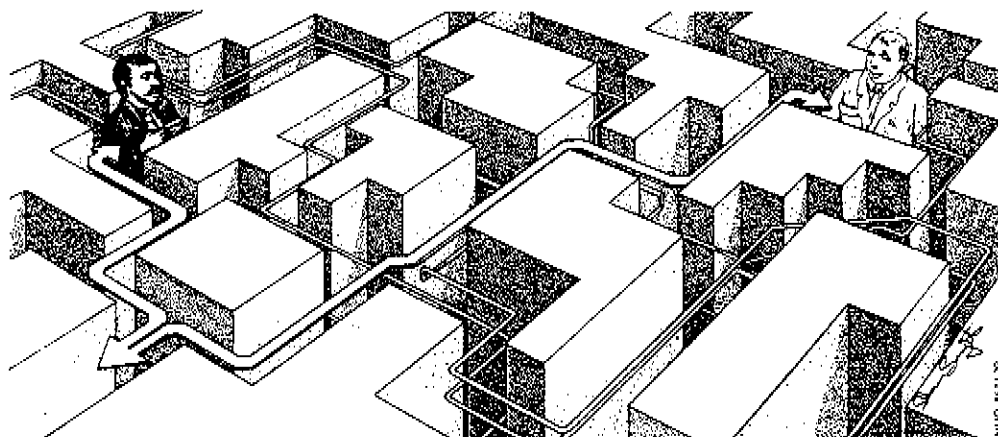
These activities were agreed on at a consultation in Jamaica (July 1984)⁷ in which key nationals and UNICEF/WHO staff participated. The consultation found that, although governments have made some progress in extending the primary health care approach to neglected areas, there were still major obstacles to its full realization. Among them was the fact that in many countries responsibility for implementing primary health care rests too exclusively with the formal health sector, the broad multisectoral implications being little realized. Moreover there are organizational

and managerial constraints: linkages within the health sector are often weak, decentralization to middle and local levels is limited, and managerial skills are lacking. As for resources, the consultation found that not only is there an absolute shortage of financial and human resources, but that what resources there are have yet to be qualitatively adapted to the primary health care approach. It noted the need for more active participation by communities, and for a change in attitudes and behaviour, particularly among professional health workers. It stressed that external aid, including UNICEF/WHO inputs, must be fully in accord with national priorities.⁸

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NATIONAL HEALTH
DEVELOPMENT
NETWORKS

Ministries of health are currently concerned with establishing or strengthening the mechanisms that will give political and technical support to their policies and ensure more effective coordination within the health sector itself, with other development sectors, and with individual communities. Among such mechanisms are the national health development networks, which besides giving technical support to ministries of health, health councils (see below) or similar bodies, can provide the necessary linkage between the technical and the policy level. The networks are seen as consisting of existing national institutes, departments, schools and organizations. Support to their development has been given by WHO in the form of missions, consultants, and financing of certain activities.



A consultation in Sri Lanka (November 1982) grouped 13 countries with experience in organizing such networks.⁹ It made recommendations on their structural features; the leadership role required of ministries of health; the areas for specific technical cooperation (both between countries, and with WHO or other international agencies); and the action to be taken by the countries participating.

These recommendations are being followed up. The experiences of participating countries and the constraints they encounter are being collected for information purposes. Support will be given to other countries wishing to establish similar networks. And promotional action will be carried out under various programmes (e.g., intersectoral action for health, health systems research, and orientation of health systems) in order to encourage the action of

national decision-making bodies. A publication will be prepared and distributed describing the mechanism, the issues involved, the experience of different countries, and the action needed to establish a network.

- In Sri Lanka itself, for example, the National Health Development Council, under the chairmanship of the Prime Minister, has provided clear policy guidelines for health development; monitored the progress of the national health development network and its six standing committees; and evolved an extensive coverage by both modern and traditional systems of health care, the physical infrastructure of which is well developed. (In Sri Lanka modern medicine meets about 75% of total requirements in basic health care, while the indigenous system of medicine - limited to curative services and operating through a network of dispensaries and eight ayurvedic hospitals - covers the remaining 25%.)

WHO, UNICEF, SIDA/SAREC, DANIDA, and others, provided assistance to Angola, Ethiopia, Democratic Yemen, Sri Lanka, Tanzania, and Zambia during 1984. Although each country has its own specific programme, the activities carried out by the networks and by collaborating institutes have included among others:

(1) Training and orientation, which includes workshops to prepare certain types of health personnel for primary health care work, e.g., community health workers and traditional birth attendants (Tanzania), those who do the training (Ethiopia), community health workers (Zambia), and district health managers (Sri Lanka and Democratic Yemen). Also included are symposia, seminars, and orientation sessions for managers and decision-makers at various levels; a consultation with parliamentarians (Sri Lanka); a symposium on health development (Ethiopia); and a meeting of regional medical officers (Tanzania).

(2) Research and development, to investigate critical areas in countries' health programmes but also to test innovative approaches to health delivery, e.g.:

- the detection and control of noncommunicable diseases (hypertension, rheumatic fever, diabetes mellitus, etc.) by primary health care - project involving 35 villages and carried out by the Ministry of Health, universities, and research institutes (Tanzania);
- the provision of additional quantities of selected essential drugs in order to obtain a measurable impact on certain priority problems (Zambia);
- also in Zambia, the launching of a malaria control programme based on surveys undertaken by the Ministry of Health and the Tropical Disease Research Centre;
- the trying out of different patterns for strengthening district management (Sri Lanka);
- the inclusion of health and nutrition data in the national household survey carried out jointly by the Ministry of Health and the Central Statistics Office (Ethiopia).

More recently, support has been given to Angola for the detailed planning of the research programme of the National Institute of Public Health (in health system coverage, community participation, health system management, and information systems).

In the Western Pacific Region, eight countries undertook research and development (R&D) projects in primary health care in the rural areas, of which the Philippines and Papua New Guinea were the earliest.

- The R&D projects in the Philippines and Papua New Guinea have provided the major basis for national policy formulation and management guidelines for primary health care development and implementation and have been very active in providing technical cooperation with the other developing countries. The Philippines completed the evaluation of its project, and the document produced is now being used to develop training materials. The Papua New Guinea project has just recently completed its implementation phase and the final evaluation is in progress which is expected to be completed at the end of 1985. Papua New Guinea has expanded its R&D areas to other provinces.

- In Papua New Guinea, the R&D project in New Ireland Province has developed a mechanism through which community effort can be systematically channelled in the implementation of primary health care at the periphery.

- In the Republic of Korea, the R&D projects in several functional areas of primary health care have been carried out. To name a few, the integration of primary health care in Saemaul Undong (new village movement) at the community level; R&D in the implementation of school health programme based on primary health care approach; and R&D in the integration of community health practitioner training in basic nursing curricula;

- Kiribati, the Lao People's Democratic Republic, and Malaysia continue to implement R&D projects, while a county in China, and two areas in Vanuatu, initiated new R&D projects in the rural setting;

- Fiji completed the evaluation of its primary health care, one of the most significant results of which is the recommendation to modify the training of the village health workers and to standardize the manuals. The R&D projects in New Ireland Province of Papua New Guinea and in Fiji have contributed significantly to the efforts of the other South Pacific countries by receiving visitors and utilizing field staff from other countries in the spirit of TCDC.

(3) Information and documentation is required on experience with national health development networks or analogous mechanisms, which will be particularly useful to countries that are trying to institute similar functional arrangements. A report based on such experience, and providing practical information, has been compiled and will be widely disseminated.¹⁰ National health development networks also have made it their responsibility to furnish information (e.g., on the results of research) to such groups as professional health workers, decision-makers, and the general public. Journals and newsletters have been published (Ethiopia)¹¹ and reports and pamphlets circulated (Sri Lanka, Tanzania and Zambia).

(4) Monitoring and evaluation. Commitment to full implementation of primary health care implies a parallel commitment to evaluate progress towards that goal. Reviews have been undertaken by Ethiopia, Tanzania, and Zambia to:

- measure the extent to which well-defined targets for improving the acceptability, utilization and impact of the health services have been attained;

- identify obstacles to continued progress, and pinpoint those elements of primary health care which are developing well and according to plan;
- validate the routine data obtained on the implementation of primary health care;
- gather data that does not normally enter a country's information system, for example data not easily codified;
- enable high-level programme managers to review with field staff matters of general policy regarding implementation and its constraints.

UNICEF has been involved in these reviews as have other bilateral agencies that provide support, e.g., DANIDA (in Tanzania), SIDA/SAREC (in Tanzania and Zambia) and the Netherlands (in Gambia). The report on each national review is published by the country concerned.

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NATIONAL HEALTH COUNCILS

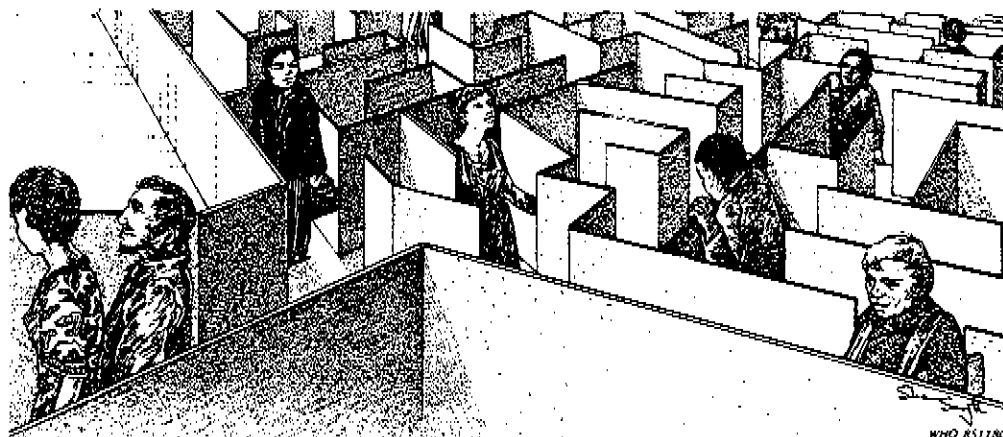
National health councils are encouraged as providing a forum for high-level multisectoral advice on a whole range of questions affecting health and development. The health development network brings to the health council technical support that is multidisciplinary and continuing in nature; it also develops the specific planning techniques and technologies required to translate broad policies into implementable plans. The national health council facilitates political decisions on health policy, strengthens the political commitment to primary health care, and provides intersectoral support for its implementation.

In countries of the South-East Asia Region, for example, a number of ad hoc bodies have been established - national health councils, national health development committees, and health-for-all committees with an interministerial composition. Some countries (e.g., India and Thailand) have specific targets in their national health plans for coverage of disadvantaged sections of the population. In Sri Lanka, the National Health Council is composed of nine ministers, with the Prime Minister as Chairman. Its role is to be the policy-making body under which there is a National Health Development Committee (NHDC) to provide high-level functional collaboration and intersectoral coordination. In order to obtain technical support for the NYDN, six Standing Committees have been created for various aspects of health development, including Health Manpower Development and Training, Primary Health Care, Health Research, Drug Policies and Management, Traditional Medicine, Technical Cooperation Among Developing Countries (TCDC), and Appropriate Technology for Health (ATH). The Standing Committees are guided by an "NHDC Secretariat" which is a special unit in the Ministry of Health. This process ensures that health concerns are safeguarded in all decision-making related to economic development. National seminars have been held for Members of Parliament and an interregional seminar¹² in August/September 1984 brought together high level participants from various sectors in twelve countries to learn together from the Sri Lankan experience.

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REORIENTATION OF
HEALTH SYSTEMS

Adoption of the health-for-all concept and the primary health care approach requires that the national health system be reoriented towards an appropriate infrastructure. This reorientation calls for fairly simple but scientifically sound and well-organized knowledge on the part of those responsible for system design at country level: they must be acquainted with the components of basic health systems, their structural and functional interrelationship, the political and economic conditions influencing them, and possible mechanisms for initiating and maintaining the reorientation process.



Studies recently undertaken have resulted in two reports: "National health systems and their reorientation towards health for all: Guidance for policy-making" and "health systems support for primary health care", based mainly on material collected for or resulting from the Technical Discussions at the 1981 World Health Assembly. Both reports were forwarded to WHO's regional offices to facilitate the continuing processes of review and reorientation of national health systems. They were recently used by the Advanced Research Institute for Health Services Systems in the Netherlands as a conceptual basis for the improvement of health systems in developed countries, and by the North American Group for Comparative Studies on Health Systems. They have also served as background material for a study group on the applied research needed for the reorientation of health systems.

There are several examples of such reorientation:

- In the European Region several countries, from all four subregions (North, South, East and West), have been intensively reorienting their health services to emphasize primary health care. Priority has been given to stimulating this development in the countries where certain problems demand immediate attention, namely: Algeria, Morocco, Portugal and Turkey. But there is still much to be done. For instance, the self-confidence of public health nurses and health visitors may be low; teamwork has not always been developed; collaboration among the various health-related sectors, particularly the health and the social services, may be deficient; nor is enough research being carried out. The guiding principles in the Organization's policy documents¹³ are being used in varying degrees, depending on the health status of the country concerned. In Morocco, for example,

major changes followed the adoption of a five-year plan and the carrying out of a primary health care project in two pilot areas. It is hoped to repeat this experience in Algeria, Turkey, and northern Portugal.

- In Bangladesh, as the result of a decentralization of authority, fresh enthusiasm has been aroused for strengthening the primary health care programme by means of the thana health-complex scheme. (Some 260 thanas were given increased administrative and financial authority and renamed upazillas.)
- In Bhutan, the Government in 1983 launched the national development strategy (the "Ezonglak Plan"), based on decentralization and self-reliance. Under this strategy, the basic health unit, which covers a population of 3000-5000, is the backbone of primary health care. In all, 53 basic health units have already been established, and there is a plan to convert all 40 of the country's dispensaries into such units. Between five and ten new units will be set up every year in order eventually to cover the entire country, depending upon the availability of manpower. The standard staffing of a basic health unit is: one health assistant, one basic health worker, and one auxiliary nurse-midwife.
- In Saudi Arabia, the health system is being reoriented by the establishment of a Department of Primary Health Care within the Ministry of Health; the development of regional primary health care units; and the planning of regional workshops.
- In Papua New Guinea, the health care delivery system has undergone the process of decentralization to reorient the system to effectively support the developmental activities at the periphery so that the essential elements of primary health care be delivered to the people as closely as possible;
- In the Philippines, the Ministry of Health has decided to implement the re-structuring of the health service delivery system in accordance with research findings in primary health care development in Leyte Province, and the study on hospital utilization. This implies decentralization of planning and financial control from the regional office to the provincial offices and the integration of the administration of curative and preventive health services at provincial and district level.

* * *

COLLABORATION
BETWEEN TRAINING
INSTITUTIONS

A matter of current concern to most countries is how to reorient various types of health worker, particularly at middle level, towards primary health care. A few institutes have developed training modules and have already conducted a number of short training courses.

A consultation hosted by the Andrija Stampar School of Public Health in Yugoslavia (1983) brought together 17 institutions with a view to exchange of information on training programmes and learning material, and discussion of primary health care in general. A plan of action was prepared that will enable institutes to keep in contact with one another and to share expertise and information on a continuous basis.

The participants in the consultation (notably the designated coordinators of activities) have since been implementing that plan and have kept WHO regularly informed. The object is: (a) to strengthen training institutions as regards management training for health workers, particularly those at middle level; (b) to maximize resources, both within and between countries, through the TCDC

process.¹⁴ Support will go to (i) strengthening of the training capabilities of the institutions; (ii) development of teaching/learning material; and (iii) research on the role of middle-level managers. Country workshops have been held to which participants from institutions in other countries have been invited in the spirit of TCDC. A meeting was held in Khartoum in December 1983 to revise educational modules for middle-level management in primary health care. This was followed by a meeting in New Delhi, hosted by the National Institute of Health and Family Welfare, in which institutions were encouraged to support each other with their relative expertise.

In the African region a conference is foreseen in 1985 that will bring together nurse teachers from both English- and French-speaking institutions with a view to strengthening professional links and collaboration.

The Regional Office for Africa will study in particular different health staff profiles; coverage; community perception of health (i.e., identification of needs, priorities, requisite knowledge, and sociocultural issues); the equitable sharing of financial resources; and a more rational design of health care facilities. Training institutions at all levels will be helped to include the elements of primary health care in their programmes.

* * *

HEALTH CARE FACILITIES

Support has been given to a number of countries for studies on health facilities. The reports on those studies were discussed at national meetings, which produced recommendations for practical improvements in the participating countries. Case studies have been completed for Algeria, Cuba, Senegal, Sudan and Venezuela. Volume 4 of the publication Approaches to planning and design of health care facilities in developing areas is now available.¹⁵ Volume 5¹⁶ is entirely devoted to a cross-national analysis of the above studies, and blends the experience of countries with basic concepts of health care systems.

To facilitate self-reliance and development of skills in this area, support is being given to a network of national training centres (following the recommendations of a WHO interregional seminar held in London in October 1983). A loose-leaf kit of material for use by the centres has been produced by WHO, in collaboration with the Medical Architecture Research Unit of the North London Polytechnic and other institutions.

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LOGISTICS



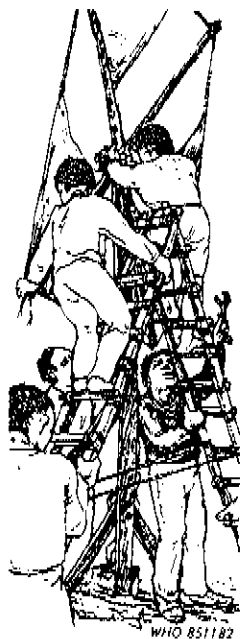
WHO's 1984-1985 programme and plan of action for logistics in support of primary health care is intended to foster national efforts to establish a well-organized logistic system that will ensure that the right items are available in the right place, at the right time, and at the lowest possible cost, starting with community-based facilities and working up through intermediate, central and international level. The target is that, by the end of 1989, 50% of developing countries should have formulated clear plans for a well-organized and well-maintained system of logistic support.

In 1984 work was directed towards information, training and research. The aim was to ensure the provision of drugs and equipment, maintenance of that equipment, and maintenance of the appropriate facilities. A study on logistic needs for primary health care support, particularly at district level (including transport and radio communications) has been initiated. It involves the preparation of a

dual-purpose problem-solving module (guide) on logistics for use in self-evaluation; a joint WHO/country evaluation in selected areas/districts; and an information document (guiding principles) on radio communication and transport in support of primary health care that can be of use to national decision-makers. The work will culminate in an interregional meeting in 1985, which will set the scene for future effort.

* * *

APPROPRIATE TECHNOLOGY



A directory of organizations, institutions, groups and individuals concerned with the development of appropriate health and health-related technology is maintained by WHO. At present it comprises 418 entries from 83 countries. WHO's information system in this area is regularly updated; it includes a comprehensive bibliography on the subject from all over the world.

The ATH Newsletter is another instrument for disseminating information on appropriate technology. Judging by the increasing demand for it, the Newsletter is an effective way of increasing practical understanding of the primary health care strategy at all levels. It emphasizes decentralization of knowledge and resources; alternatives for community action; and community control of the technology used.

A study on the use and misuse of health technology has been undertaken (jointly with WHO's programme of health laboratory technology). The first step was a critical review of the use made in general of clinical laboratory methods.

In the African Region, a first conference on the technology of applied and operational research has been held for 15 French-speaking countries. It discussed (i) methods for developing applied research to solve priority primary health care problems; (ii) case studies of selected projects that demonstrate the use of research for decision-makers; (iii) resources for training in applied research and technical support for projects.

An information document on the selection, utilization and control of health technology has been finalized and will be widely disseminated. The intent is (i) to promote the global collection, elaboration and exchange of information on needs in health technology, and its assessment, selection, utilization and control; (ii) to support developing countries in adapting and utilizing methods for the selection and control of such technology with a view to increasing their self-reliance in this area and improving the cost-effectiveness and coverage of their health care systems.

* * *

WORKING WITH OTHER SECTORS

There is general recognition at national, regional and global levels of the need to involve key development sectors in health development. But intersectoral coordination and cooperation is a complex issue, and many countries are finding it difficult to implement. Nevertheless some breakthroughs have been made, both in individual countries and at regional and global levels.

The subject of the Technical Discussions at the 39th World Health Assembly in May 1986 is Intersectoral Cooperation in National Strategies for Health for All. Articles will appear in the monthly journal of the National Council for International Health (Washington, D.C.), dealing with central issues that are to be discussed at the Technical Discussions. An Announcement on the subject, outlining the critical issues that will be discussed, is available. The Background

Document will map out the broad linkages between health and other development sectors and analyze the impact on health of the policies and programmes of other sectors. Also included will be a synthesis of concrete country experiences, both positive and negative.



A fact-finding inquiry into the contributions of other sectors to health development led to a consultation in Kerala, India (1982), involving India, Jamaica, Norway, Sri Lanka and Thailand. Assessments carried out in various countries on the health component of integrated rural development projects culminated in a consultation in Nepal, also in 1982. Follow-up measures are being taken throughout the regions, as described below.

In the African Region, guidelines are required for policy analysis adapted to regional conditions. A meeting was held in Sweden (March 1984) between Dr Kaduma (Centre for Integrated Rural Development for Africa - CIRDAFRICA), Dr Dahlgren (Swedish Ministry of Health) and Dr Pannenberg (Netherlands Ministry of Health). Its purpose was to share methodology and to discuss a framework that could be used for policy analysis in three or four African countries.

The African Regional Office has prepared, with support from Headquarters, a document on health, entitled: "Health Development in Africa, an Addendum to the Lagos Plan of Action", which has been transmitted to the OAU for presentation to the Meeting of Heads of State and Governments in July 1985.

A high level meeting is being planned by AFRO involving seven countries (anglophone and francophone) from 9 to 11 October 1985. AFRO has invited OAU and ECA to co-sponsor this meeting. Ministers and decision-makers from key sectors will be invited.

As a result of the joint PHC Reviews, almost all countries have identified possible intervention strategies involving key sectors. One such country is Gambia where they would like to proceed immediately with formulating, together with some key sectors, a few critical interventions, to be implemented in some priority development projects and within primary health care.

An assessment of rural development projects in a group of countries in Africa has been undertaken with FAO, with a view to strengthening their health component. Health development was also included in the programme of a workshop organized by FAO in Zimbabwe (1984).

In the Region of the Americas, a working group made concrete proposals for accelerating work at country level. They include close work with the Latin American Institute for Economic and Social Planning (ILPES) in studying the impact of the economic crisis on the health sector. In addition PAHO has developed with ILPES, a proposal for a 3-year study of intersectoral action that will involve both institutions in an action research activity in Brazil, Panama and Venezuela, to examine in greater detail the linkage between the socioeconomic environment and health. The primary nature of this project is one of institution building; it is designed to strengthen government decision-making processes for better management of health aspects of development and improved planning methods. It also includes direct support, a pilot phase and direct training. A study on intersectoral action in relation to health and social development in Costa Rica has just been completed, in which a comprehensive analysis was made of the interplay of experiences in the non-health sector and their effect on patterns of health. The consequences for the health sector of macro-economic adjustments to meet the economic crisis were also studied. Attention was given to mechanisms for intersectoral coordination that have proved exceptionally effective.

The current economic crisis was also the subject of a working paper submitted to the Directing Council of PAHO: "The economic crisis in Latin America and the Caribbean and its repercussions on the health sector". The Directing Council adopted a resolution in this connexion.

A report¹⁷ on Coordination of Social Security and Public Health Institutions was approved by the thirtieth meeting of the Directing Council of PAHO in September 1984. This report summarizes the development of the coordination process and of the different coordination and integration mechanisms set up during the period 1979-1984 in 16 Latin American countries in which Ministries of Health and Social Security Institutions share responsibilities for the provision of health services.

The review made highlights central elements of the coordination process, the formulation of policy, the financing of health services and their delivery, and the coverage of these services; special emphasis is placed on the levels of coordination that will permit progressive implementation of national policies and strategies, and on the contribution of technical cooperation in the strengthening and furthering of the coordination process in order to carry out the national undertakings to provide health care for the entire population.

In the South-East Asia Region, the National Economic and Social Development Board of Thailand, in an attempt to combat the all too frequent hierarchical and sectoral approach to social development, in 1980 initiated a social development project that radically alters the character of planning and delivery of health and other social services throughout the country. The approach utilized by this project has been applied in Korat Province. It provides for intersectoral cooperation among several ministries (Public Health, the Interior, Education, and Agriculture and Cooperatives) at all levels of government; involvement of the public in the development process at village level; and the use of social indicators for planning projects and allocating resources.

The SEA Regional Office Planning Group on Primary Health Care has identified intersectoral action as one of the priority areas in primary health care. As a result, an inter-country meeting on the Role of Intersectoral Cooperation in Primary Health Care is planned from 30 October to 4 November 1985.

As a follow-up to a study undertaken by the Marga Institute in Sri Lanka,¹⁸ action research is being undertaken in districts. The relationships between the health and non-health sectors are being studied in connection with the causes and conditions of the prevailing health situations. Programmes of intersectoral action will then be introduced in two locations, rural and urban.

Short visits have been made by regional office staff to Bangladesh and Thailand to study integrated rural development. The study included assessment of current intersectoral action at national and district level, with a view to evolving a better mechanism.

At district and more peripheral levels support is given by organizing seminars or workshops and by assisting training and management in health and health-related fields. Support is also provided for establishing village health committees and for studies to strengthen both the role of community health leaders/workers and the self-reliant planning efforts at village level.

In the European Region, Sweden places emphasis on the relationship between health and such risk factors as the physical environment, housing and unemployment. Its work has been reported to other countries. Similarly, the Netherlands has been active in developing a methodology for making projections of alternative strategies for health development (the "scenario" approach).

Case studies on Inequalities in Health Care, being undertaken by the Nordic countries, are to be discussed during a meeting on Social Injustice and Health Care, in July 1985. This meeting is being organized jointly by the European Regional Office and the University of Leeds.

The Regional Office has undertaken research and development with a number of countries, culminating in a workshop in Copenhagen (December 1984) on the health burden of social inequalities.

The Nordic School of Public Health (Göteborg, Sweden) and WHO have organized joint workshops for nationals from both Nordic and developing countries. The outcome is reflected in a publication on intersectoral action for health.¹⁹ The Nordic School of Public Health is also co-sponsoring a meeting with the European Regional Office on Inequalities in Health and Health Care, in Gothenburg, from 28 to 30 August, 1985. This meeting will prepare for a meeting of Nordic politicians and researchers from various sectors that will be held on 19 and 20 November 1985. The main objective of this meeting is to discuss appropriate support for Intersectoral Action for Health.

At the same School of Public Health a seminar was held (January 1985) based on case studies from the five Nordic countries. It focused on national policies, factors making for differences in health status, and health care for certain population groups, and it came up with sound practical solutions. Participants with experience in the intersectoral dimension of health problems from other WHO regions also attended.

In the Eastern Mediterranean Region, experience drawn from the joint nutrition support programme in Sudan (Red Sea and Equatoria provinces), in which an intersectoral approach has been employed, will provide useful lessons. This is also true of Somalia, where coordination between the health sector and that of women's affairs is of particular importance. Intersectoral action for health was the topic of the 1984 Technical Discussions in the Regional Committee.

Democratic Yemen, reviewing national experience in primary health care, found that intersectoral collaboration and coordination were particularly weak at national level, although somewhat stronger at

governorate or more peripheral levels. An integrated socioeconomic development mission to the island of Socotra (November 1984) paved the way for a workshop in 1985 to acquaint non-health sectors with the primary health care approach and devise ways of strengthening intersectoral cooperation.

Two case studies are being undertaken - one in Bahrain, as agreed upon during the Consultative Meeting on Intersectoral Action for Health (29 April to 3 May, 1985), and the other in Pakistan.

In the Western Pacific Region intersectoral coordination is recognized as central to primary health care. Tonga is a good example of this approach. Coordination was required after the 1982 hurricane and was continued in the development of a nutrition programme, in which Ministry of Health initiatives met with a good response from other ministries. In 1983 there was multisectoral participation in a programme for the promotion of breastfeeding. There was similar multisectoral participation in the first national seminar on primary health care held in Tuvalu (August/September 1982). The island councils play a key role in community development activities, which include the health sector.

The mechanism for planning with attention on intersectoral and community representation received special attention for strengthening. To this end, a meeting was held in Manila on the development of intersectoral collaboration for the allocation of health resources. Five large countries participated, namely, the People's Republic of China, Malaysia, Papua New Guinea, Philippines and the Republic of Korea.

The above activities were followed up at global level through the Working Group on Intersectoral Action for Health, and a publication on the subject.²⁰

Work with other United Nations agencies (especially the ACC Task Force on Rural Development) has been particularly fruitful. An attempt has been made to replace the convening of meetings in capital cities by the promotion and implementation of practical action in communities, even though limited in scale. The United Nations Panel on People's Participation (ACC Task Force on Rural Development), for instance, is an increasingly useful vehicle for intersectoral action in health work. The Panel conducted a workshop in Arusha, Tanzania (October 1984) which discussed case studies²¹ of participatory rural development efforts involving health, agriculture, labour, women's organizations, etc. The workshop, and the subsequent fourth meeting of the Panel, agreed on a joint programme of action involving UNDP, UNICEF, IFAD, FAO, ILO, and WHO. To initiate the programme, Nigeria, Senegal, Uganda, and Zimbabwe have been selected - countries where WHO is successfully collaborating with women's organizations in health development. Following an interagency mission, work in two villages in Senegal is showing encouraging results.

* * *

HEALTH SYSTEMS
RESEARCH

WHO cooperates closely at country level in promoting health systems research and in strengthening national capabilities for such research. The regional offices provide direct technical support, while the global level concentrates on the collection, analysis, synthesis and dissemination of information; worldwide coordination; and selection and conceptual development of substantive research in priority areas.

The challenge for the future is to integrate health systems research into all health development programmes at all levels, with a view to adapting the infrastructure, and the science and technology, to

local conditions. WHO's Health Systems Research programme works along three main lines: (i) promotion, support and information; (ii) strengthening of national capabilities; and (iii) initiation of substantive research in priority areas.

To promote health systems research at country and regional level, WHO issued the publication The uses of health systems research in 1984.²²

A health systems research training package has been prepared that can be adapted to the needs of individual countries. It includes a guide for planning training programmes, a course manual, and a guide for administrators and trainers (developed by WHO/AFRO as part of the project for strengthening health delivery systems).

The training package was reviewed at an interregional consultation in Cameroon (July 1984), attended by 13 countries,²³ at which recommendations were made for:

- generating political and managerial support for health systems research and related training;
- encouraging administrative activities to promote such research;
- ensuring that training activities are reinforced by adequate training material.

As regards substantive research in priority areas, state-of-the-art reports have been made on primary health care in urban areas, and on social control of technology.

In the African Region a systematic effort is being made to help countries establish central departments that will have responsibility for: (i) health systems research; (ii) data analysis; (iii) planning, implementation, management, and evaluation of research projects; and (iv) coordination with other sectors. The national programmes being promoted focus on analysis of the existing health system, identification of community needs, appraisal of health care delivery and coverage in rural areas, and the fixing of research priorities in the light of these factors.

A study group specialized in health systems research was set up in 1980. It met in Antananarivo in February 1981 and Brazzaville in February 1985. The last meeting²⁴ recommended, *inter alia*, that a central HSR unit be set up within each country's department of health; that an HSR manpower training course be developed; and that Member States be encouraged to allocate part of the health budget on a regular basis to HSR activities. Institutions have been identified to support this undertaking.

The network of national research centres has been extended into Ethiopia, Ivory Coast, Kenya, Mozambique, Nigeria, Zaire, and Zambia.

A special effort has been made to strengthen national research capabilities. WHO contributed US \$100 000 to the launching, together with SIDA, of a three-year research programme in primary health care in Ethiopia. A network of subregional centres to back up the regional programme, and facilitate the choice of subjects for research of regional interest, will be put into operation within the next four years.

A training course on methodology was held in Ouagadougou (1980) and a multidisciplinary group⁸ met to study problems of evaluation, information systems, and financing (1981). Other national or intercountry workshops and courses, including courses on research

methodology and management for trainers, were arranged for participants from English-speaking and French-speaking countries of the African Region.

In the Region of the Americas, a health services research programme has started that emphasises the strengthening of local capabilities. The Organization is collaborating in various surveys and studies, notably on drug administration in hospitals, supply administration, infection control centres in hospitals, and appropriate technology for maintenance of health facilities. A regional workshop (Washington, 1981) was attended by specialists in health (including epidemiology), sociology, systems engineering, economics, administration, and research.

The Organization has cooperated with Peru and Uruguay (backed financially by the World Bank and UNDP respectively) in general surveys of health services and establishments with a view to reorganization. It has also provided technical and financial support for a study on utilization of health services covering 2000 households (about 8000 people) in Antigua, Dominica, Saint Christopher and Nevis, and Saint Lucia. In compliance with recommendations made by the regional ACMK, a survey on health systems research was undertaken in 17 countries (13 Spanish-speaking and four English-speaking Caribbean countries). It showed a general trend of sustained growth, the figures for research projects rising from 188 in 1974 to 392 in 1983, i.e., their number more than doubled. The results of the survey were discussed at a workshop on trends in health services research (Mexico, 1984), which made concrete recommendations covering definition of research priorities, suitable approaches, relevant methodologies, and strategies for the mobilization of resources.

In the South-East Asia Region a subcommittee of the regional ACMR established a conceptual framework for health systems research that has been widely distributed to Member States and is being used extensively in their meetings.

National focal points for health systems research were established in Bangladesh, Burma, India, Indonesia, Mongolia, Nepal, Sri Lanka, and Thailand, with focal points at state or provincial level in India and Indonesia. In collaboration with biomedical research institutions, and WHO's Health Literature, Library and Information Services (HELLIS), they have produced information on health systems research in most countries of the Region.

An intercountry consultative meeting was held to introduce the concepts, principles and methods of health systems research into the educational curricula of health and health-related personnel. Support was given to national meetings to promote awareness on the part of policy-makers, administrators, and scientists. In order to obtain maximum community participation, a scientific working group on behavioural research developed specific projects for certain high priority problems in primary health care. Research grants have been attributed for such subjects as nutrition, maternal and child health, health manpower development, immunization, health education, and financing of primary health care.

A regional plan of action (supported jointly by governments, WHO, and other agencies) was formulated for the period 1983-1985. It seeks to strengthen national institutional networks, promote collaborative research, and create the necessary multidisciplinary and multisectoral basis. One of the elements emphasized in the plan of action - research into health behaviour - was the subject of a national workshop in Nepal (January 1983).

In the European Region, the regional ACMR recommended that WHO should activate and support health services research wherever it was lacking in the Region. The Study Group on Health Services Research (Mürren, Switzerland, January 1983) reviewed previous work, analysed its impact, and studied factors hindering the development of a regional strategy, the role of such a strategy, and the targets to be set. The latter covered decision on health policy; budget allocations to health research; focal points at national level; research policy and funding; and the position of the research worker. The regional ACMR recommended that the Study Group should continue to identify targets that were relevant to community needs.

Equity in health has been accepted as a research priority of increasing importance, since it is recognized that unemployment and poverty, at least in socially vulnerable groups, are important risk factors for health. A programme on social equity and health started in 1982. An advisory committee on this programme met in October 1983 to review national experience.

Mechanisms for setting national research priorities were studied by a working group on the management and structure of health policy research (Rome, October 1983). An analysis of three countries - Austria, Czechoslovakia, and Denmark - was taken as a basis for examining the structure and management required to bring research more closely into line with the provision and practice of health care. Following a recommendation by the regional ACMR that a study should be made of theoretical models related to the scientific analysis of health and health care, workshops were held on the relevant paradigms, methodologies and organization (Berne, 1981; Paris, 1982; and Ulm, Federal Republic of Germany, 1983); proposals were made for investigations to fill the gaps in knowledge.

An international course on research in primary health care was organized for postgraduate research workers (Kuopio, Finland, 1980) and an international workshop on health services research methodology, relevant to both developing and developed countries, was conducted (November 1984) by the WHO collaborating centres for the classification of diseases (Moscow) and for primary health care (Alma-Ata). In recognition of the important role of the social sciences in health systems research, a European Society for Medical Sociology has been established, which will focus on the social aspects of the health-for-all strategy.

In the Eastern Mediterranean Region the emphasis is on research that will facilitate the implementation of national and regional strategies for health for all. A training course on the methodology of health services research was organized at the University of Nottingham, United Kingdom (1980), attended by 18 nationals from five countries of the Region. Support has been given to national courses on methodology, using learning material from earlier courses, and the guidelines prepared by the Regional Office for Africa and the project for strengthening health delivery systems in central and western Africa.

The establishment of a network of research and training institutes in primary health care is under way. The selection of the institutes, which will combine operational research with the training of different categories of health workers at intermediate and local level, has started in Jordan, Sudan, and certain countries of the Gulf Area.

To build up national expertise in managing research programmes and centres, a workshop (1981) was devoted to the organization of research at national and institutional level; research planning; evaluation of research proposals and scientific activities; staff development; research information; and management techniques.

Following the recommendation made by the regional ACMR that special emphasis should be given to research in primary health care, a task force was convened in October 1982 and defined four priority topics: (1) primary health care coverage; (2) mobilization of the community; (3) reorientation of health professionals; and (4) factors influencing the effectiveness and acceptability of primary health care workers at community level. The task force drew up a number of detailed research protocol outlines which by the end of 1983 were forming the basis of full-scale projects in Egypt, Jordan and Yemen.

In the Western Pacific Region a task force, and later the Subcommittee on Health Services Research of the regional ACMR, reviewed progress during the period of the Sixth General Programme of Work (1978-1983) and set priority areas for the Seventh General Programme, namely: health care organization and management; health care financing; legislation and policy-making; intersectoral and sectoral coordination; manpower utilization and training (including educational technology); design of health care delivery; community participation; and logistic support systems.

Malaysia, the Philippines and the Republic of Korea have completed research on which to base the further development of their hospital services in support of primary health care. A study on the functions and problems of health staff at the periphery has been completed in Papua New Guinea. The Korean Institute for Population and Health, Seoul, (designated as a WHO collaborating centre for research and health) was enabled to complete a health resources allocation model that will permit long-term forecasting of manpower and other requirements. In the Solomon Islands a thorough evaluation was made of the primary health care/village health aid programme. In Fiji an evaluation of the primary health care programme has started.

Support was given to the Republic of Korea for a national workshop (October 1980) to create awareness of health services research and develop the ability to carry it out; the participants were senior and middle-level public health workers. In the Philippines a national workshop on biomedical and health services research methodology was conducted (August 1982) and in Fiji a subregional workshop, for South Pacific countries, on health services research in family health programmes (July 1983). In China a national training course on research methodology and information analysis was held for the staff of the four WHO collaborating centres on primary health care and for staff of health administrations in other countries (October 1983).

Support was given to the Republic of Korea to evaluate the roles and functions of the community health practitioners, and the efficiency and effectiveness of the programme in relation to primary health care coverage and consumer satisfaction. The study further attempted to assess the curriculum management of the training programme and educational input.

In the Philippines, support was given to assess the performance of the public health nurses in primary health care delivery and to assess the adequacy of the training programme in primary health care for basic nursing.

A register of health systems research programmes, started in 1977, is being periodically updated. A bibliography on this type of research has been developed in collaboration with the Medical School, University of Singapore, and arrangements are being made for its updating. New Zealand has drafted a guide to health services research that has been distributed to other countries for possible use in developing their national registers.

The challenge for the future is to ensure that health systems research becomes an integral part of all health programmes. Three lines of development will be followed:

(1) Promotion and support, which will entail:

- planning on the part of countries for a coordinated development of health systems research, e.g., determining the location, structure and functions of the agencies responsible for the research; and formalizing the requisite infrastructure of human, technical and material resources;
- improving the interaction between decision-makers, researchers, and professional bodies by way of bilateral exchanges, sharing of information, and the assessment of priorities and feasibility;
- establishing effective administrative strategies for carrying out research policies at management, intersectoral, institutional, and operational level;
- introducing mechanisms to ensure that funds are allocated in the budget, are properly used, and are forthcoming for as long as is needed to bring the research to its final stage, i.e., utilization of results;
- evaluating the results of research and translating them into policy options;
- emphasising the feedback of research results to health professionals, to policy-makers and care providers at various levels, to trainers of health personnel, and to the public;
- exploring the possibilities of, and the limits to, transferring the results of research from one country to another.

(2) Strengthening of national capabilities, which will require:

- development of guidelines on the planning of training programmes and on training material that can be adapted to the needs of the individual country;
- training of teams of trainers who can develop national capabilities for health systems research;
- introduction of the concepts and methodologies of such research into the curricula of training programmes for other health or health-related disciplines;
- further exploration and implementation of the concept of institutional networking, since few institutions individually can provide all the disciplinary inputs that will be required;
- creation of training opportunities in disciplines (e.g., social and behavioural sciences, or economics) that are of growing importance in health care;
- training that forms part of the carrying out of research, each research project being used as an opportunity for such training;

- linking of research training programmes to the realities of service (this applies both to basic training and to further training in a system of continuing education);
 - introduction of a research function into the role of the various professions; and establishment of the career profiles, contracts, and tenure that will encourage a permanent commitment to health systems research;
 - development of mechanisms by which the work of orientation and training can be monitored.
- (3) Promotion of substantive research in priority areas (including innovative methodologies) that will cover:
- research on health-promoting behaviour and lifestyles;
 - research on the economic aspects of health care;
 - crucial areas in the health-for-all strategy (e.g., intersectoral action, community involvement, social equity, social control of technologies, primary health care in urban areas), where the most essential research findings are still lacking;
 - new methodologies, e.g., participatory research, scenario-writing;
 - the potential of disciplines such as political science, sociology, anthropology, geography, social psychology, and communications science.

2. Intermediate Level Support for Primary Health Care

DISTRICT HEALTH MANAGEMENT

The increase in the activities undertaken by village and community health workers makes many new demands on existing health centres and referral facilities. If the necessary technical and material support is to be forthcoming, it will often be necessary to modify both the patterns of work and the attitudes of health workers. They must be more involved in health promotion and preventive work, more sensitive to community needs, and better equipped for motivating the community, and workers outside the health sector, to undertake health action.

Changes must be carefully adapted to each country's culture and health system. A variety of innovative efforts are therefore being supported in selected districts of a number of countries. A framework for analysis and action to improve primary health care support at district level and below has been prepared. A number of countries (e.g., China, Ethiopia, Mongolia, Sri Lanka, Tanzania, Thailand, Zambia, Zimbabwe) are undertaking situation analysis, planning of action, management training, and practical field studies to improve programme effectiveness. An essential step is to involve workers at health centres and district hospitals, community representatives, and others in the process. A number of such workers from a dozen countries met in Zambia in late 1983 to exchange early experience, review progress, and discuss further action, including the dissemination of the practical lessons learned.

Several countries (among them Tanzania and Zambia) are working on improved health recording and reporting systems, and are testing them in selected districts.

Comprehensive management development is being undertaken in a number of countries in the Western Pacific (including China and several Pacific islands), with particular attention to the intermediate level.

The Regional Office for South-East Asia has assisted group educational activities in district health management in India (Gujarat), Mongolia, Nepal and Sri Lanka over the past few years. Fellowships have been provided so that middle-level health managers can attend the short courses organized periodically by ESCAP. Botswana, India, Papua New Guinea and Sri Lanka are decentralizing responsibility for planning and management to district level and improving the capacity for local management by means of in-service training. In Sri Lanka, although physical facilities for health services are satisfactory, there are difficulties in manning those facilities owing to the continuing brain drain. WHO's main task has therefore been to support the development of health manpower at all levels. Since the greatest need is at the intermediate level, priority has been given to training middle-level health managers.

In China, after the visit of a team from the Regional Office for the Western Pacific, a project for developing six model health "counties" was established in 1983, financed by UNDP.

In the Solomon Islands, attention has been given since 1982 to the leadership role to be played by the provincial and area council. A first primary health care workshop and a management course for provincial health officials were conducted in early 1983. By 1984-1985 support was being given to strengthening the health administration at provincial level. Promotional activities are being continued by way of primary health care workshops. Also at provincial level the strengthening of management is receiving support in Laos, where health infrastructure and primary health care is being developed in 50 districts and 100 communes.

* * *

THE ROLE OF
HOSPITALS AT THE
FIRST REFERRAL
LEVEL AND HEALTH
CENTRES

As experience accumulates in the implementation of the PHC approach in various countries, the need for health system support for PHC is becoming increasingly apparent. Taken up by the Aga Khan/WHO sponsored conference on the "The Role of Hospitals in Primary Health Care", Karachi, Pakistan, November 1981, this concern continued to be reflected in the main topics of the International Conference on "Hospitals and Primary Health Care" organized by the Indian Hospital Association under the aegis of the International Health Federation in New Delhi, January 1985, and the 24th International Hospital Federation Congress in San Juan, Puerto Rico, May 1985.

Hospitals constitute a major part of the health system's infrastructure and appear to have an exceptional importance at the first referral level which is the main interface between peripheral local health services and the national health system. As a result of an informal planning meeting held in Geneva in June 1984 on "The Role of the First Referral Level in Support of PHC" the title of the proposed Expert Committee for 1985 was changed to "the Role of Hospitals at the First Referral Level" and focused on hospital support for primary health care. This Expert Committee was held in Geneva, December 1985, following preparatory meetings in February and July 1985.

In the Eastern Mediterranean Region, concern with health service management and the role of hospitals in health systems based on primary health care led to an intercountry workshop in Nicosia, September 1985, on "Health Management in Hospitals as Referral and Supportive Centres to PHC Services". A follow-up workshop for 1986 on practical and country specific solutions is planned.

Translating PHC principles into practice, the European Regional Office is moving from concepts and philosophies to organization and functions and in 1984 has appointed a Medical Officer for Hospitals in Primary health Care. A Consultation held in February 1985 assessed the

present situation of hospital related activities and prioritized foreseen activities of EURO/WHO's hospital programme. It proposed to include strengthening interactions between the hospital and PHC services as a substantial part of this programme next to direct hospital related issues such as cost-effectiveness and information systems.

A workshop on "The Establishment of Social Medicine Division in Hospitals" was held in Athens in March 1985, and three working groups were convened on: (1) The impact of medical decision-making on costs (London, November 1985); (2) Planning methods for the hospital sector (Kiel, FRG, November 1985); (3) Impact of demographic morbidity and social changes on the functions of hospitals (Stockholm, December 1985).

In the South-East Asia region, a seminar in Ulan Bator, Mongolia (August 1984) provided an opportunity for Bhutan, Indonesia, the Democratic People's Republic of Korea, Mongolia, Nepal and Thailand to exchange information and to analyse (a) the organization and management of the health infrastructure, and (b) intersectoral collaboration at community, health facility, and first referral levels. A visit was made to the WHO-supported model primary health care project at Huvsgul Aimak, which started in 1983 with training, service, and research components. Mongolia intends to extend the Huvsgul Aimak project to other areas of the country.

Following the 1984 Resolution SEA/KC.37/R3, "Strengthening of Referral Systems for PHC", SEARO is promoting and supporting the provision of PHC to entire populations through reorientation, reorganization and more effective functioning of health service systems with emphasis on strengthening of first-line hospitals. Through the regional programme in PHC, technical cooperation was provided by developing a conceptual framework of comprehensive referral support systems for PHC. An informal consultation formulated country actions - cum - research plans for 1986. District hospitals in Bhutan were improved and expanded to enhance referral support for the basic health units, and a model design for an integrated district health system was developed there.

Specific activities included a Regional Conference on PHC networks in New Delhi, January 1985, where reorientation of health systems for referral support and intersectoral coordination was a main topic of discussion. Support for participants to the International Health Federation sponsored a conference on "Hospital and PhC" in New Delhi, January 1985, and an informal consultation on "Referral Support for PHC in New Delhi, August 1985. This was followed by preparation of country action-research and support for implementation.

Several countries (including the Philippines and Sri Lanka) are integrating hospital and community health services that were previously separate. The integration of district hospitals and rural health centres in the Philippines will be monitored in 1985. A review of the role of hospitals in support of primary health care at intermediate level has been initiated.

In the Western Pacific region, between October 1983 and February 1984, an assessment was made of Fiji's long-term needs for tertiary care at a national referral hospital, and of the physical facilities and potential for expansion of the Colonial War Memorial Hospital. A master plan was submitted for re-development of the hospital, along with guidelines for any new development.

A series of workshops were conducted in the People's Republic of China, Malaysia, Papua New Guinea, and the Republic of Korea to improve and develop the technical and administrative support systems for primary health care by strengthening the various levels of health facilities which include planning, design, management and maintenance of health facilities and equipment.

The role of the provincial hospital in primary health care was identified as the focal point for technical training and as a backstop measure in patient care in the primary health care infrastructure in Papua New Guinea and the Philippines.

To help overcome the deficiencies in expertise in the field of biomedical and hospital engineering, the intercountry project on hospital management, design and maintenance collaborated with 14 countries in the repair and maintenance of medical equipment and implementation of an in-service training programme in the Western Pacific Region.

Special attention is given to improvement/development of the first referral level including support for training courses for health and hospital administration and management, especially at district level; integration of curative and preventive services and the strengthening of referral and supervisory services to support further PHC development as well as re-development of older hospitals and application of modern management techniques.

Hospital utilization studies and courses in hospital planning and management were conducted. The National Institute of Hospital Services in the Seoul National University Hospital was designated a WHO collaborating centre in 1984.

In 1986-1987 WHO's objectives will be: to determine the further activities needed to clarify the support role of the first referral level; to find the most appropriate ways of providing support for governments and district authorities in readjusting the functions of that level; to help institutions to carry out the necessary reorganization and training; to collect, analyse and make available such country and district experiences as emerge from findings of the expert committee mentioned above.

* * *

PRIMARY HEALTH CARE IN URBAN POPULATIONS

Since a main raison d'être of primary health care is to ensure equitable distribution of health resources and health coverage of populations in their entirety, the programme naturally focuses on the plight of underserved urban populations.



A framework has been produced for identifying needy groups and analysing the related information. Preparations have also been made for a study of the structure, functions, and managerial processes of municipal health departments.

Following preliminary discussions in 1980 and a consultation on the subject in January 1981, attention was given to the preparation and organization of intercity workshops. Subsequently, UNICEF and WHO jointly reviewed urban primary health care and in July 1983 held a meeting on the subject in Geneva. The reactions to the report of this meeting were presented in a preliminary compilation of information at the end of 1983.

Joint UNICEF/WHO activities provided a basis for updating this compilation and for a state-of-the-art report on primary health care in urban areas by the end of 1984. The two documents describe intra-urban health differentials and what innovative action has been taken to eliminate problems and reduce the gap. They were reviewed at a joint consultation in Guayaquil, Ecuador (October 1984), which also reviewed experience of how urban health systems have extended primary health care into low income areas, and suggested follow-up action for countries, UNICEF, WHO, and other organizations.²⁵ In 1985, cities will be visited to determine the concrete possibilities for cooperation with persons and institutions in implementation of the UNICEF/WHO plan of action, and at the same time find institutes that can prepare case studies on problem identification, organization, and financing of primary health care in urban areas.

- There is a project in Seoul, for example, for the preliminary collection of baseline data on two urban populations, of contrasting socioeconomic characteristics, living under different environmental conditions, and consequently presenting differences in health status and in access to health services. The project is a necessary first step in the process of strengthening the health service infrastructure; and it confirms yet again the need to disaggregate information when characterizing a population if services are to be designed that are in line with people's demands and needs.
- At the other end of the spectrum is the report from Metropolitan Manila, where the reorientation of urban health services, initiated in 1982 in four low-income areas of the city, has been gradually extended to other low-income areas and is heading towards total city coverage. The Philippines convened a national workshop on primary health care which was attended by the city health officers of major cities of Metro Manila. The Manila experience is now being used as a basis for health development in other urban areas of the Philippines.
- The Guayaquil (Ecuador) programme for low-income urban areas started in 1980 in a limited area with 42,000 people, now covers 170,000, and is expected by 1985 to cover 300,000 out of the city's 600,000 urban poor. Its main feature is the development, testing, and wide replication of low-cost service modules, in which the community health workers (health promoters) have the key place. They belong to the community; and they are entrusted with promotional, preventive, simple curative and referral functions, and with the responsibility for describing and continuously monitoring the health characteristics of that community.
- The projects in the Cono Sur pueblos jovenes of metropolitan Lima started in 1978 and at present cover 500,000 low-income people out of the 2,500,000 living in marginal areas (50% of the city's total population). The projects are firmly multisectoral, being managed by an executive coordination committee that includes

representatives of the health, labour and education sectors. Among the projects' achievements is the elaboration of working tools for the community health worker who must carry out family education and follow up the health of the infant risk group (0-5 years). One such tool is a growth and development chart for children, which has been adapted for use not only on the projects but in all health establishments, at first, second and third level of health care. Another achievement has been to provide health education for preschool children that covers 90% of what is a large group at risk. Notable in these projects have been (a) the extensive degree to which the community participates in planning, programming, and evaluation (not only through health promoters but through leaders at all levels); and (b) the impressive intrasectoral coordination.

- Addis Ababa is a city with immense and complex problems, since its poor population is large. The city's primary health care programme has been in operation since 1983 and includes all the main elements of such programmes. It is based on a precise set of targets, to be achieved by 1987, which include: improvement of the infant mortality rate from 150 per 1000 to 75 per 1000, and of child mortality from 92 per 1000 to 50 per 1000; mastery of oral rehydration techniques by 90%-100% of mothers; growth monitoring of 90% of children up to three years; immunization coverage of 80%; and availability of solid waste management to 70% of the population (the present level is 34%).
- In the large low-income population of Guatemala City (240,000 people out of a total of 1.3 million) the infant mortality rate can be as high as 113 per 1000 (the average rate for the country as a whole is 65 per 1000). In general, the risk of disease and death is great. Respiratory infections, gastroenteritis, certain immunopreventable diseases, perinatal mortality, and malnutrition are all highly prevalent. Social and environmental conditions are well below the average for the city. The Government and a number of collaborating organizations are stepping up their effort in these low-income areas, the emphasis being on maternal and child health, community action, and multisectoral/multiagency collaboration.
- The Government of India, recognizing the growing problem of slums and shanty towns, has recently decided to strengthen the primary health care services and infrastructure in cities that have a total population of more than 100,000 and where the proportion of low-income population is 40% or more. Every effort will be made to identify high-risk communities and groups. The basic unit of service is the "health post", staffed by a woman voluntary worker for every 2000 people, an auxiliary male nurse/nurse midwife and a male multipurpose worker for every 10 000, and a nurse supervisor and a female medical officer for every 25,000 to 50,000. It is proposed that private medical practitioners, voluntary organizations, industry management and unions, education personnel, and engineering and agriculture departments should become actively involved in the programme.
- In Brazil, the current health policy is to give priority to those in greatest need in the big cities. This policy entails the reorientation of existing services and institutions towards primary health care objectives and the merging of new initiatives into the present system. The programme has been established at national level but is expected to be adopted by state and municipal authorities.
- In Colombia, there has been considerable expansion of primary health care projects in large and medium-sized cities. The main object at present is to reduce inefficiency and improve effectiveness. One recent success has been the countrywide

vaccination campaign, organized in conjunction with a national radio network and a newspaper: it achieved a 20% increase in immunization, and gave substantial stimulus to community participation. Current strategy emphasizes 10 basic targets (the "ten enemies of health"). Among the obstacles to further progress are the absence of a political decision to reallocate funds from tertiary to primary care, and the lack at health centre level of a local programming process, i.e., the authority and the information to make intelligent use of available resources.

In the Philippines, the projects of the Davao Medical School Foundation in Davao City (island of Mindanao) and of Alay Kapwa Kilusang Pangkalusugan Inc. in Quezon City (Luzon) are examples of what nongovernmental, non-profit-making organizations can accomplish in collaboration with religious organizations and the government. The emphasis is on careful and systematic preparation at community level as a way of gaining people's confidence, learning about their needs, and preparing them to take over the management of affairs; basic and continuing training of community health workers; provision of essential services; and monitoring of progress. Voluntary service is emphasized.

Another project in the Philippines is unusual in that it specifically concerns the disabled in a deprived urban community. In 1981 the Philippine National Commission concerning Disabled Persons, as part of the national effort during the International Year of Disabled Persons, initiated a series of city-level rehabilitation activities. In Bacolod City (Negros), a group was organized, the Volunteers for the Rehabilitation of the Handicapped. Together with the National Commission and with assistance from UNICEF, it initiated a survey of the disabled that led to a pilot project based on the WHO approach to community-based rehabilitation. This programme maximizes the self-reliant roles of community and family in relation to the physical, emotional, mental and social needs of their disabled. Service to the disabled begins with trained local volunteer supervisors and the family, systematically seconded by out-of-community support services. It can be an effective solution to the problem of disabled children in a low-income urban community.

3. Primary Health Care at Local Level

HEALTH WITH
THE PEOPLE
(COMMUNITY
INVOLVEMENT)

There are two tendencies that must be closely monitored, namely: (1) to think of community involvement as the panacea for all problems of scarce resources; and (2) to confine community involvement to time-limited action directed towards a single problem. Such tendencies may be useful as entry points, but they are not enough to promote self-sufficiency and self-reliance. Often indeed they have the opposite effect.

WHO has undertaken a comprehensive series of activities to strengthen community involvement by way of information, education, training, organization, and research. Its present work is focused on:

- (1) promotion and support of research into community involvement in order to ascertain the crucial issues and find solutions;
- (2) support to countries in developing or reviewing their policies, programmes, and experience in community involvement;
- (3) support in evolving structures and processes to facilitate community involvement, including mechanisms to bring in specific groups;
- (4) support in enabling the community to diagnose its problems and mobilize its resources, including health education and organization.



During 1984-1985 the regional aims were:

- in the African Region, to increase community capabilities for planning, implementation and evaluation through dissemination of experience, training programmes for personnel at every level, and national and intercountry meetings;
- in the Americas, to evaluate and adapt experience in primary health care, giving special attention to projects in health education and to community participation;
- in South-East Asia, to ensure community involvement in the planning, implementing and evaluating of primary health care by training health workers in the concepts and methods of the behavioural sciences;
- in the European Region, to review and evaluate the potential of consumer movements for self-help and self-care, and develop community involvement by studying existing mechanisms, and evaluating the relevance both of community-oriented educational programmes and of projects for strengthening social and community structures;
- in the Eastern Mediterranean, to promote the development of community-managed institutions;
- in the Western Pacific, in continuation of the national seminars and workshops that have laid a solid foundation for community action, to enhance the self-reliant attitude of communities through such bodies as village welfare groups and women's committees or organizations.

The following examples from individual countries are worthy of note:

- In Burma, political and community leaders play a direct role in implementing and monitoring the People's Health Plan. Committees for implementing primary health care have been formed in various townships and village tracts. Township medical officers are responsible for preparing plans of action for their respective areas. Monitoring and assessment of achievement is carried out periodically. Involving the community in the management of the

primary health care programme has mobilized more resources and has motivated communities to strengthen the network of health units. Station hospitals, health centres, aid posts for voluntary health workers, and hospital wards have in the main been built thanks to public donations and community labour.

- In Mongolia, specific conditions (a widely scattered population and a long cold season) call for an approach suited to an isolated population. To achieve self-management in health care, the prerequisite is maximum community participation and the training of community activists. The Huvsgul Aimak model (mentioned above) is suitable for Mongolia and it could also be a model for other countries with scattered populations.
- In the Caribbean area, a workshop in Antigua (June 1984) discussed and adopted the first Caribbean strategy and plan of action for community participation and community health education.

At global level, WHO has supported the International Council for Adult Education in producing a popular booklet on community involvement in primary health care intended for medium-level adult educators and community health workers. It is an outcome of the Council's study of adult education programmes that have been successful in promoting community involvement.

A bibliography of essential published documents on community involvement in primary health care was published early in 1983.²⁶ Material describing experience with such involvement is being disseminated in the African Region, where the setting up of village health committees will be promoted. A study will be made on the behavioural aspects of the way a community perceives its priority health needs.

* * *

COMMUNITY HEALTH WORKERS

Community health workers, their activities, their relations with the community, and their effectiveness and impact, are the subject of an interregional study that began in 1979. It has so far covered 13 countries and it has included in-depth studies in individual countries, with periodic workshops to compare results (Jamaica, 1980; Philippines, 1983). The next phase will be to:

- (1) help countries to analyse the functioning of community health workers, identify the shortcomings or weaknesses, and take the necessary action to strengthen their performance;
- (2) support them in developing a monitoring and evaluation process for continuous appraisal of such workers;
- (3) strengthen health centre staff and supervisors so that they can give more effective support to the community health workers by means of supervision, training, and utilization of simple management tools;
- (4) support health centre staff in motivating and mobilizing communities and in utilizing their community health workers to best advantage;
- (5) disseminate widely the experience of countries with community health workers, stressing in particular the critical issues and the options that are open.

The countries originally participating in this research and development activity will continue.²⁷ Others will join them. Support will be given to enable each country to:

(a) assess the support given by health centres to community health workers in two selected districts per country;

(b) undertake the training of supervisors (10 supervisors per country);

(c) strengthen the performance of community health workers by means of the health centre staff (all community health workers in the specified two districts, and covering a population of approximately 10 000).

- In 1984-1985 the Regional Office for Africa was collaborating with countries that wish to organize reorientation courses for community leaders, or training courses for community health promoters/trainers.
- In the Solomon Islands a first national seminar on primary health care (October 1977) gave impetus to the training of village health workers. After an evaluation of the primary health care programme in 1982, promotional activities were intensified and primary health care workshops were introduced at provincial level.
- Bhutan has introduced a programme for voluntary village health workers, and it is now in operation in five districts. The workers are selected by the community and are given three weeks' training in health promotion and simple first-aid techniques, including the use of oral rehydration salts. Efforts are being made to evolve a mechanism to form the link between staff of the basic health unit and the community health activities.
- In Papua New Guinea, the selection, training and supervision of aid post orderlies is being improved. More volunteer village aides will be trained to provide essential health care for the population in remote areas.
- In Burma, there are now 227 townships in which primary health care is being implemented as a planned programme. Coverage of new townships has expanded to nearly 100%, and there is at least one community health worker on duty in each village tract. Another type of volunteer, the "ten-household health worker", was recently instituted to supplement the work of the community health worker. The number of community health workers trained has increased so much that the distribution of kits for them cannot keep pace.
- In India, the retraining of health personnel under a multipurpose workers' scheme has been completed in 329 districts and is continuing in a further 47. WHO assistance is being provided to strengthen the basic training programme for community health volunteers, multipurpose workers, and health assistants; the Organization is also helping with the procurement and distribution of kits for primary health centres. A revised training programme for multipurpose health workers is being implemented in all basic training schools. A programme of continuing education for community health volunteers (through correspondence courses) has been launched on an experimental basis. Training material and visual aids have been developed.

* * *

EPIDEMIOLOGICAL
TECHNIQUES AT
THE PERIPHERY

Reports from several countries show that even workers with limited education and little medical training can use basic epidemiological tools effectively. The experience in this field of a number of countries (Burma, Botswana, Ecuador, Indonesia, Iran, Malaysia, Morocco, Niger, Philippines, Sudan, Tanzania, Thailand, and Zambia) is described in a WHO publication.²⁸

- In the African Region a mechanism was being developed during 1984-1985 for the effective supervision of peripheral health centres.
- In Ivory Coast a pilot project was launched in 1984 to test information processing methods (including microcomputers) intended to provide data on the eight components of primary health care at the periphery, data which is needed for planning national programmes.

* * *

COVERAGE

The public health literature contains few empirical studies of coverage by authors from developing countries. WHO has emphasized the importance of monitoring and evaluating such coverage. The situation of some countries has been analysed in a collaborative study, which inter alia provides a conceptual framework for analysing coverage, its effectiveness, and its efficiency. Recently certain programmes have been particularly active in trying to measure the coverage of their work, e.g., in immunization, and in maternal care. The plan of action to support this analysis/research has the following objectives:

- (1) to collect and disseminate examples of measurement and analysis of coverage;
- (2) to disseminate information on methods for such measurement and analysis;
- (3) to support countries in carrying out measurement and analysis of coverage at all levels and, through this "learning by doing", to increase capabilities in this area;
- (4) to strengthen the planning, implementation, monitoring and evaluation of national and local processes for extension of coverage and of their component parts;
- (5) to promote and support national research related to coverage, e.g., research on its determinants and differential trends, and on its effects and economic efficiency.

The results of the study are now available.²⁹

In Nepal, a programme of integrated community health services, especially geared to the needs of rural people, has made steady progress. It is under the direction of a Board headed by the Secretary of the Ministry of Health and is supported by WHO technical and financial input. The coverage of the project is being expanded from 23 districts to 27 (out of the country's total of 75). By the end of the sixth development plan (1980-1985) it is hoped to bring the remaining 48 districts into the programme.

Recently collaboration has expanded at global level (oriented towards the developing countries) in the matter of quality assessment and assurance, and integrated organization of health care delivery at the periphery.

- The European Regional Office has for some time concentrated on the matter of quality assurance.³⁰ The most recent synthesis of thought on the subject was the outcome of a meeting in Barcelona, Spain (May 1983).



4. Review of Progress

GLOBAL REVIEW
OF DEVELOPMENTS
IN PRIMARY
HEALTH CARE

In 1982 WHO undertook its first substantial review of primary health care development since the adoption of the Declaration of Alma-Ata. The review describes the efforts of no less than 70 countries to attain health for all. It highlights both the positive trends and the problems encountered. It aroused great interest and considerable comment in the world press.

In the next phase of this activity, it is planned to take a closer look at those "highlights" with a view to isolating those experiences that show the most promise.

* * *

ASSESSMENT OF
PROGRESS IN
COUNTRIES

As countries move on from policy and planning to action, they are increasingly concerned with monitoring the progress of primary health care and evaluating the results.

With the growing experience of combined reviews (e.g., in immunization, maternal and child health, and other elements of primary health care) and the interest of countries in the different types of special review being requested by programme managers, an effort has been made to refine and validate a form of review for primary health care that is acceptable, economical, and broad-based. In January 1984, a scientific working group was convened in South-East Asia to discuss the methodology of such reviews, calling on experience both within and outside the Region. A detailed evaluation of primary health care and the expanded programme of immunization was carried out in Mozambique and Thailand during 1982. A more comprehensive review, in Zambia, included assessment at community level. Eleven other countries in the African Region have, with WHO support, undertaken broad reviews, using a draft set of guidelines and prototype questionnaires adapted to each country's priorities. The process is proving invaluable to countries that wish to identify weaknesses and introduce the necessary changes in time. On the basis of the experience from Africa, and from other regions, an examination of available material was made at the end of 1984 with a view to revision, wider dissemination and, ultimately, use.

In 1984-1985 the Regional Office for Africa was collecting and disseminating information on assessment for the benefit inter alia of course organizers, teachers, directors of health services, and planners. A guide will also be prepared for evaluating the extent to which primary health care is being implemented.

Periodical assessment of primary health care is carried out in the Eastern Mediterranean Region, among others. An example is the assessment carried out in 1982 in Cyprus, Somalia and the Yemen Arab Republic.³¹ Such assessments lead not only to improved reorientation but also to a more realistic use of evaluation indicators. It is thus easier to keep track of primary health care implementation in the operational sense: one example is the three-year plan (1983-1986) of the Yemen Arab Republic, and the "milestones" developed for monitoring implementation in that country.

A microcomputer-based information bank to store data on innovative activities was set up at programme headquarters in Geneva, in 1984. The information will provide a basis for publicizing new ideas and disseminating descriptions of successful experiences by way of periodical publications. These will include the present ATH Newsletter, modified as necessary. The information bank can also be used to promote financial or technical support to countries by facilitating a linkage between innovative programmes (particularly those in the least developed countries) and interested international, bilateral, or nongovernmental organizations.

5. Integration of Health Care Delivery

MOVE TOWARDS INTEGRATION

Countries are increasingly aware of the need not only to maximize their resources but also to make those that are available go as far as possible. This means that in practically all countries there is a move towards providing integrated health care programmes. Integrated programmes or services (e.g., daily comprehensive maternal and child health services) not only are more cost-effective but are more convenient for the community.

Despite widespread acceptance by decision-makers of the idea of integration, there has been difficulty in making the transition from semi-autonomous "vertical" programmes, coexisting with a general health service, to an integrated infrastructure capable of effectively providing both general and specialized health care. The operational difficulties experienced by countries are often compounded by the continuing international debate on the vertical versus the integrated approach, and by the preference of some donor agencies for specialized programmes with an autonomous infrastructure that can be insulated from the demands of the general health services and thus concentrate on a single set of activities.



An interregional consultation was held in New Delhi (June 1984)³² to examine the specific experience of countries in making this transition, and in general to explore better ways of improving the coverage, range, and effectiveness of health systems. The report of the meeting, which also recommended a number of follow-up activities, will be widely disseminated.

* * *

METHODS AND SKILLS REQUIRED

A plan of action has been drawn up for introducing the methods and skills that will facilitate the organization of integrated health care delivery at different levels of care and by various institutions. The objectives are: (a) to further develop methods for easing the integration of varied technical programmes into the infrastructure of a health care system based on primary health care; and (b) to promote the collection and exchange of experience in the matter by disseminating a suitable methodological approach and by suggesting specific integration plans that will increase the national capability for organizing integrated local delivery of care while at the same time protecting the technical quality of specialized services.

The outcome of the plan should be: (a) to get the processes for local integration started in a growing number of countries, or advance them where they already exist; and (b) to increase coordination between infrastructure and technological programmes in WHO itself.

* * *

ADVANTAGES OF INTEGRATION

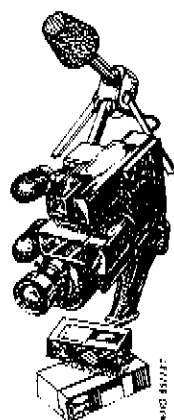
The integration process is expected to lead to:

- more extended coverage of the population in essential services;
- increased economic and administrative efficiency;
- improved effectiveness of the health care teams, since they will be able to take into account, as a whole, the priority health problems of each individual, family or community;
- greater decentralization of resources and of decision-making, and hence increased opportunities for community involvement;
- last but not least, greater convenience for people, since to obtain services from an integrated service takes less time than recourse to fragmented care.

6. Information Dissemination and the Media

PRESS

The review of primary health care development (see beginning of section 4, above) served as the basis for a press kit which was distributed worldwide at the end of 1983, and which elicited interest on the part both of the general public and of donors. It was further taken up by the International Planned Parenthood Federation,³³ the Christian Medical Commission,³⁴ and other organizations.



One conclusion of the media seminars on health for all through primary health care, held in the Philippines and the Republic of Korea (April 1983) was that the primary health care approach was in itself newsworthy, but that information was in short supply. It was desirable for journalists to be acquainted early on with a country's strategy and its implementation. WHO must play an active role in these and other media-related activities.

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FILMS

The four short films prepared for the International Conference on Primary Health Care in Alma-Ata have been consolidated. The resultant film is now available - by purchase or on loan - from WHO's Division of Public Information and Education for Health.

* * *

TELEVISION

The first international health seminar concerned with television, "Health messages on TV screens", took place in Moscow (September 1984). It considered critically the advantages and drawbacks of television, including its direct impact on health status, especially that of infants and young children. It also attempted to define how the potential offered by the medium could be optimized to form part of comprehensive national programmes of health advocacy; broad guidelines for future action to that effect were drafted.

It was decided to promote the involvement of media specialists (in particular television producers), along with health educators and public health staff, in the development of health systems based on primary health care; and to implement the follow-up action recommended by the seminar at national, regional and global level whenever opportunities arose.

7. Financial Resources for Health Work

The new approach to health cannot be implemented without a reallocation of resources. Primary health care requires financing mechanisms in keeping with a community-oriented approach.

An informal consultation on the economic aspects of primary health care (Geneva, March 1982) was followed in 1983 by a further consultation on the appropriate ways of helping countries to finance primary health care and make the necessary reallocations in their health budgets. Discussion centred on the various sources of community financing, ways of coordinating them with government financing, and the impact they had on primary health care.

A manual on planning the finances of the health sector³⁵ has been used in several meetings on health financing (e.g., Manila 1982; New Delhi 1983) and its practical application is now more widely accepted.

Guidelines for costing the development of primary health care were prepared and used as the background document for an informal meeting on that subject (Nazareth, Ethiopia, December 1983). Twelve African, two Latin American, and two Asian countries took part. The report has been widely circulated.³⁶ It contains a summary of the experience of the participating countries in costing primary health care and also methodologies for collecting data on such costs. Follow-up analyses are either being carried out or are planned in a number of the participating countries with the support of the regional offices. Preparatory work for a similar consultation for French-speaking countries in West Africa has started.

Preparations are under way for joint activities with UNICEF for support to countries in this area of cost and financing.

WHO has contributed to the work of the European Advisory Committee on Health Economics Programme and a study group on health economics training. For planners and statisticians, a training course on costing primary health care is in preparation. Among those participating will be a management training institute in Tanzania and the Centre for Development Studies, Swansea, United Kingdom.

Collaboration has started with a number of institutes in organizing training/orientation courses on the costing and financing of primary health care for planners, economists and statisticians. A draft curriculum has been prepared by the above-mentioned Centre for Development Studies.

The Health Resource Mobilization group has been carrying out reviews of the way resources are utilized, as a step toward planning and financing the strategies for health for all. The countries concerned are Bangladesh, Benin, Bhutan, Democratic Yemen, Ecuador, Gambia, Guinea-Bissau, Lesotho, Malawi, Nepal, Papua New Guinea, Sri Lanka, Sudan, and the Yemen Arab Republic.

Information on successful community health financing schemes is being collected from selected countries in all regions. It will be published in 1985 in the form of illustrative case studies.

References

1. WHO "Health for All" Series, No. 3 (1981). All nine numbers of this series can usefully be consulted.
2. "Health for All" Series, No. 8 (1982), pp. 61-62.
3. Document WHA37/1984/REC/1, Annex 3.
4. Chile, Finland, Ghana, India, Mozambique, Philippines, Sri Lanka, Sudan, Thailand, Turkey, and Yemen.
5. Jointly organized by UNDP, the World Bank and WHO.
6. Burma, Democratic Yemen, Ethiopia, Jamaica, Nepal, Nicaragua, and Papua New Guinea.
7. WHO document SHS/84.7, Geneva, 1984.
8. The recommendations of the consultation were submitted to the Joint Committee on Health Policy in January 1985, as part of a progress report on joint support to primary health care development in countries.
9. Colombia, Ethiopia, Finland, Jamaica, Republic of Korea, Malaysia, Sri Lanka, Sudan, United Republic of Tanzania, Thailand, Yugoslavia, Zambia and Zimbabwe.
10. "National health development networks in support of primary health care" (WHO document in preparation).
11. See The Ethiopian Journal of Health Development, Vol. 1, No. 1, July 1984; Update, Vol. 2, No. 1, 1984 (both journals published by national health development networks).
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27. Botswana, Democratic Yemen, India, Liberia, Nepal, and Thailand.
28. World Health Organization. The place of epidemiology in local health work, Geneva, 1982 (WHO Offset Publication No. 70).
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30. See Vuori, H.V. Quality assurance of health services: Concepts and methodology. Copenhagen, World Health Organization, 1982 (Public Health in Europe, No. 16).
31. See WHO document EM/PHC/19, Alexandria, 1983.
32. Participants came from Brazil, Ethiopia, Finland, India, Indonesia, Kenya, Malaysia, Philippines and Saudi Arabia.
33. It appeared in a jointly (IPPF/WHO) sponsored special issue of the magazine People (excerpted from Volume 10, issues 2 and 3, 1983).
34. See Contact, Number 76, December 1983.
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36. WHO document SHS/84.2, Geneva, 1984.