GENESIS AND DEVELOPMENT OF PRIMARY HEALTH CARE STRATEGY

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During the late seventies it was recognized that the western model of provision of health care was failing. It did not adequately improve the health of the people in the less developed countries. Other alternatives were being searched. The concept of Primary Health Care (PHC) as one of the alternatives, was evolved at a meeting convened by the World Heath Organization (WHO) and the United Nations Children's Fund (UNICEF) held during 6th to 12th of September 1978 at Alma Ata in Kazakhstan in the former USSR.

This meeting was attended to by delegates from 138 governments (including Sri Lanka), 2 liberation organizations, representatives of 12 UN organizations and 49 Non-Governmental Organizations. At this meeting the goal of "Health for all by 2000 AD" (HFA 2000) was proclaimed and the concept of Primary Health Care (PHC) was conceived. PHC was to be a comprehensive strategy which would not only ensure an equitable, consumer centered approach to health, but would address the underlying social and political determinants of health.

Several models of PHC have been tried out in different countries in order to achieve the goal of HFA 2000.

Primary Health Care

* is essential Health Care which can differ from country to country depending on its perception of Health and Disease.
* must be practical.

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* must be based on scientifically sound concepts of essential care.
* must bo socially acceptable.
* must be accessible to all individuals and families in the community.
* must be developed with the community's full participation in a spirit of self reliance and self determination. The health worker should not only serve the community but should help the community work towards their goal.
* must be affordable by the community and the country at every stage of its development.
* must be an integrated part of the routine health service of the country.
* should be the first level of contact with the National health service of the country.
* should bring health care as close as possible to where they live and work.
* should constitute the fist level of a continued health care process.

What is the difference between the basic health care available and PHC?

Basic health care is a mainly curative service provided by the Health Ministry through technocrats and health personnel. In this instance people have to seek the services.

On the other hand PHC, emphasizes on prevention with a multidisciplinary and multisectoral approach with community involvement at every stage.

The components of Primary Health Care includes

1. Education concerning the prevailing health problem and the methods of preventing and controlling them.

2. Promotion of food supply and proper nutrition.
3. Adequate supply of safe water.
4. Maternal and child care including family planning.
5. Immunization against major communicable diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases and injuries.
8. Provision of essential drugs.
9. Mental Health

The delivery of PHC involves a system where there will be a primary health care complex covering the entire country with referral hospitals for tertiary care.

The well known diagrammatic representation of PHC is given in Figure 1.

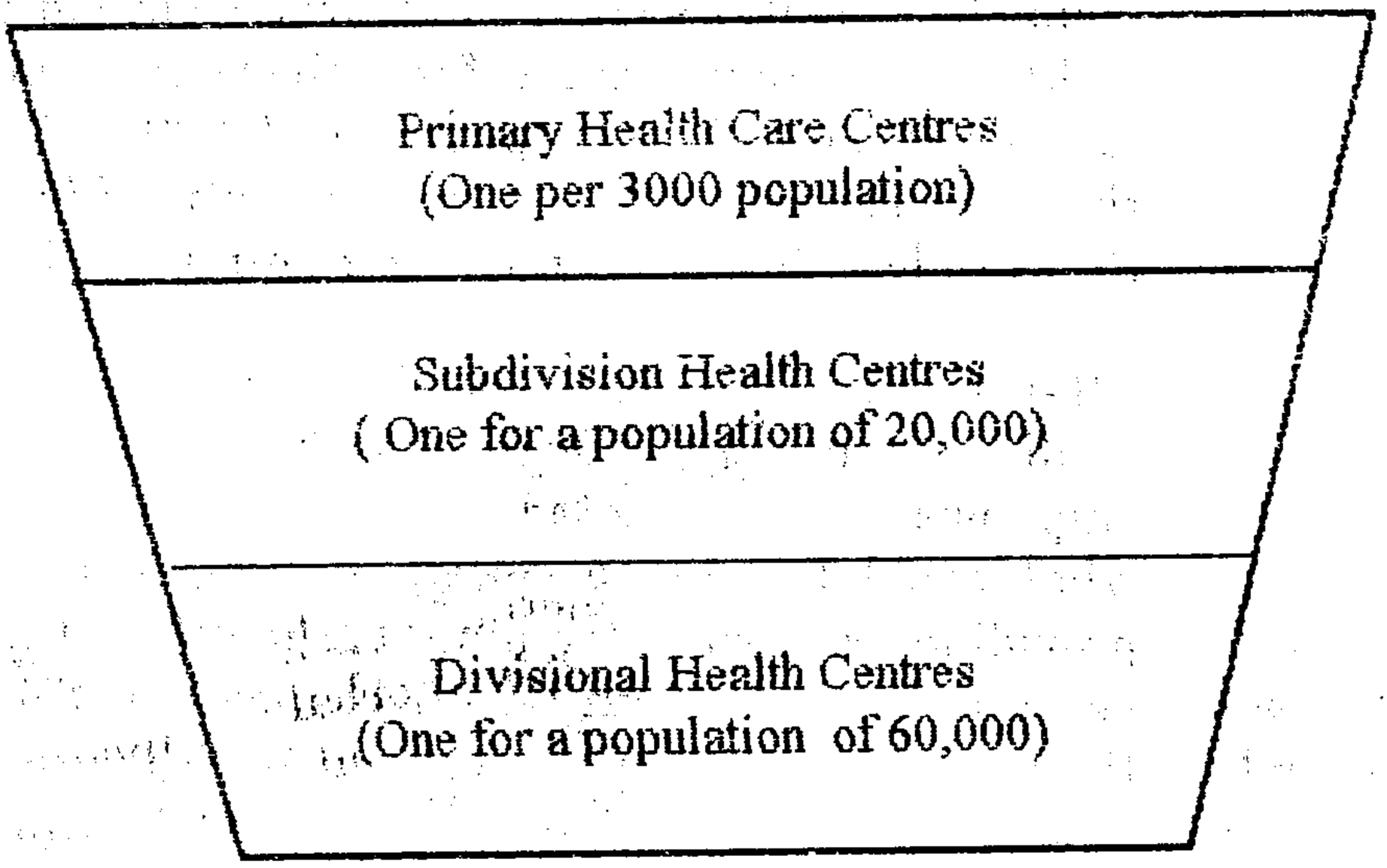

Figure 1: Primary Health Care complex

Participation of the people is not simply the contribution of resources to a health system managed by professionals, nor is Primary Health Care

a matter of providing Community Health Workers with inadequate training, isolated from the rest of the Health Care system, unsupported and unremunerated by the people they serve. It is not an inferior system, but rather a total system, permitting all people to have access to the level of care they require at a cost that is within the means of the country and the individuals concerned. It is not a "programme" to be implemented in isolation either from other technical programmes in the heath system or from other sectors out side the health system.

The concept of concentrating on grassroot level health workers rather than sophisticated hospitals was being practiced long before the Alma Ata conference.

The "barefoot doctors" of china is an example. These health personnel were neither "barefoot" nor were they "doctors" but most of the concepts of PHC were encompassed in this system of health care in china. The health services left over from old china were backward. In 1949 when China became free, there were only 505,000 professional health workers for a population of 500 million Chinese and most of them were concentrated in large cities [1] Most of the doctors and the elite left China when the communist regime took over.

After the establishment of the People's Republic, Mao tse tung, a medical man himself, left with a depleted health cadre, placed emphasis on training local personnel in the villages, teaching them what could be put to immediate use, conducting crash courses and providing refresher training to health activists, herbal doctors and peasant with a certain level of education. These peasant worked part-time as peasant and part-time as health workers. By 1981 there were 1,396,000 barefoot doctors and 2,591,000 aides and birth attendants

Thirty years after the introduction of the "barefoot doctors" China's Crude Mortality rate decreased from 25/1000 population to 6.2/1000 population and the Infant Mortality Rate dropped from 200/1000 live births to 12/1000 live births in the cities and 20-30 per thousand live births in the rural areas. The incidence of most parasitic diseases had

also decreased significantly. The life expectancy rose from 35 years to around 68 years. Although these changes cannot be solely attributed to the barefoot doctors, they have contributed immensely towards the improvement of the health status of the people of China.

What is the secret of China's achievement?

The most important factor was China's tremendous political commitment to the of task of improving the quality of life-especially among the rural population. Health Goals have been given top priority and this political commitment permeated to all levels of government and all social and mass organizations, ensuring sustained popular support.

The second important factor was high level of decentralization which permitted the integration of the health sector with all aspects of economic and social development, and has facilitated the peoples' involvement in the financing and management of Health Care.

Another factor was the concerted action in many sectors which resulted in equitable distribution to permit minimally adequate shelter, clothing and above all essential food at affordable prices, expansion of literacy and mass education, provision of public service such as water supplies, transport, and policies and programmes related to family planning. All these have contributed to the improvement of health status.

The development of the Chinese health care system in the past, starting with mass mobilization for prevention, followed by development of cooperative health centres, the emergence of the 'barefoot doctor', the combined use of western and Chinese medicine, the development of the commune and brigade network, with its cooperative medical insurance schemes is a concrete and living expression of what contributes appropriate technology.

The transformation of the intention of the Alma-Ata conference was left to the individual countries to translate the Declaration of Alma-Ata into better health for their people.

Much time has been devoted to international debate on whether PHC has been a success or failure. Some critics say that PHC has failed while others claim that it has still not started.

Primary Health care in Sri Lanka.

The constitution of Sri Lanka provides for the acceptance of Health as a fundamental right. Article 27 (2) C of the constitution provides for the realisation by all citizens of an adequate standard of living including food , clothing, housing, and health care [3]

In February 1980 this commitment was reaffirmed by signing the charter for Health Development to provide ' Health for all by the year 2000 AD' The five year plan for 1984-88 states "... it is envisaged that the health infrastructure system will be consistently strengthened by the extension of the programme to provide Primary Health Care"

National strategies for Health For All by the year 2000 were formulated and adopted in 1980. The main features of the strategies were

1. Establishment of a National Health Development network to ensure intersectoral coordination for health development activities.
2. To place greater emphasis on decentralization of health administration
3. Priority identification of PHC components and development of an implementation model for application on a national scale.

On the basis of the recommendations of the Alma-Ata conference the Standing Committee on PHC identified the following 17 areas of activity for development of PHC

1. Proper and adequate nutrition
2. Safe water
3. Basic Sanitation and hygiene
4. Maternal care
5. Child care (with emphasis on the infant and preschool child)
6. Family Planning
7. Immunization
8. Prevention and control of common communicable diseases
9. Prevention and control of common non communicable diseases
10. Appropriate and early management of common ailments and emergencies
11. Simple rehabilitation
12. Mental Health
13. School Health
14. Oral Health
15. Occupational Health
16. Prevention of Blindness and visual impairments.
17. Health Education and community organization for PHC

The main plan of action proposed in the early 1980s for implementation of the PHC strategy included [3]

* Generation of political leadership through seminars and conferences for ministers, members of parliament and members of local authorities
* Establishment of health sub committees at district and divisional levels
* Mobilization of more resources to raise the percentage of health expenditure. In 1993,4. 5% of total expenditure (Rs. 7140 million) was spent on health [4]

* Formulation of programmes of infrastructure development and referral hospitals
* increase the capacity of training facilities for critical categories of health manpower.
* Develop and improve essential support system to provide essential drugs, logistics support and storage facilities in the content of PHC .

With implementation of the Provincial Councils Act of 1989 the Health services was devolved resulting in the Ministry of Health and Women's Affairs at the national level (Figure 2) and separate provincial ministries of health at provincial level (Figure 3) in the 8 provinces [4] With the creation of the District secretariat in 1992, further organization changes were made in the Health Service with a Provincial Director of Health Services being appointed (Figure 2 & 3).

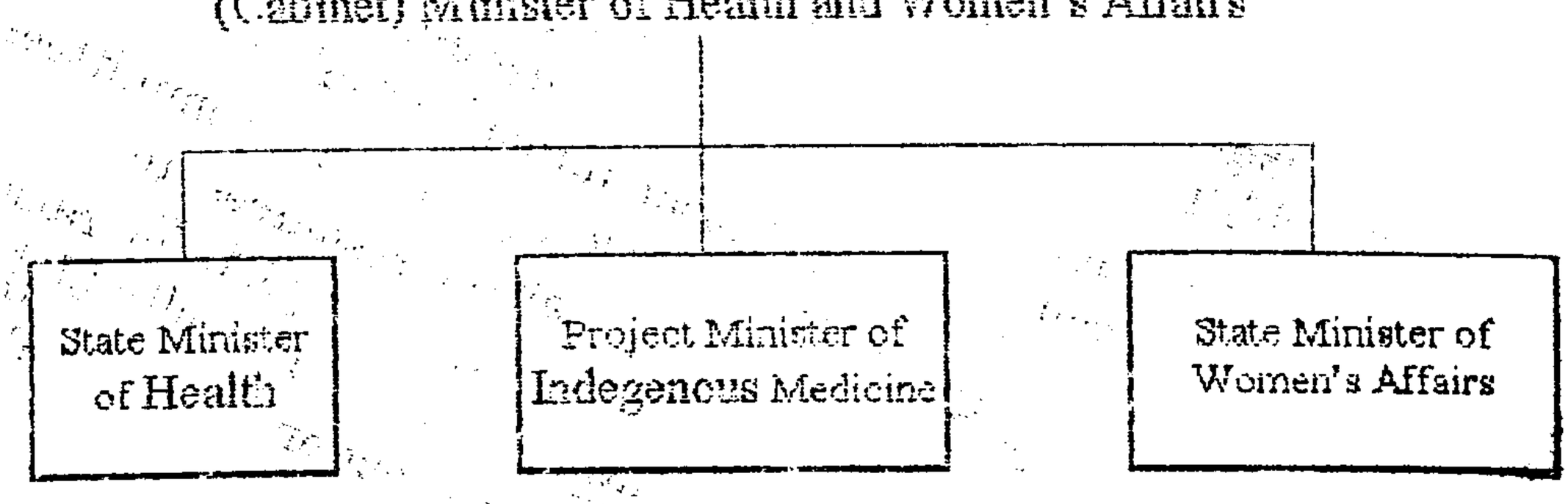

Figure 2. Health Care Services at National Level

Responsibilities of the Minister of Health & Women affairs were

- Laying down of Policy guidelines.
- Medical and Paramedical education.
- Management of medical Institutions involved in medical and paramedical education.
- Bulk purchase of medical requisites

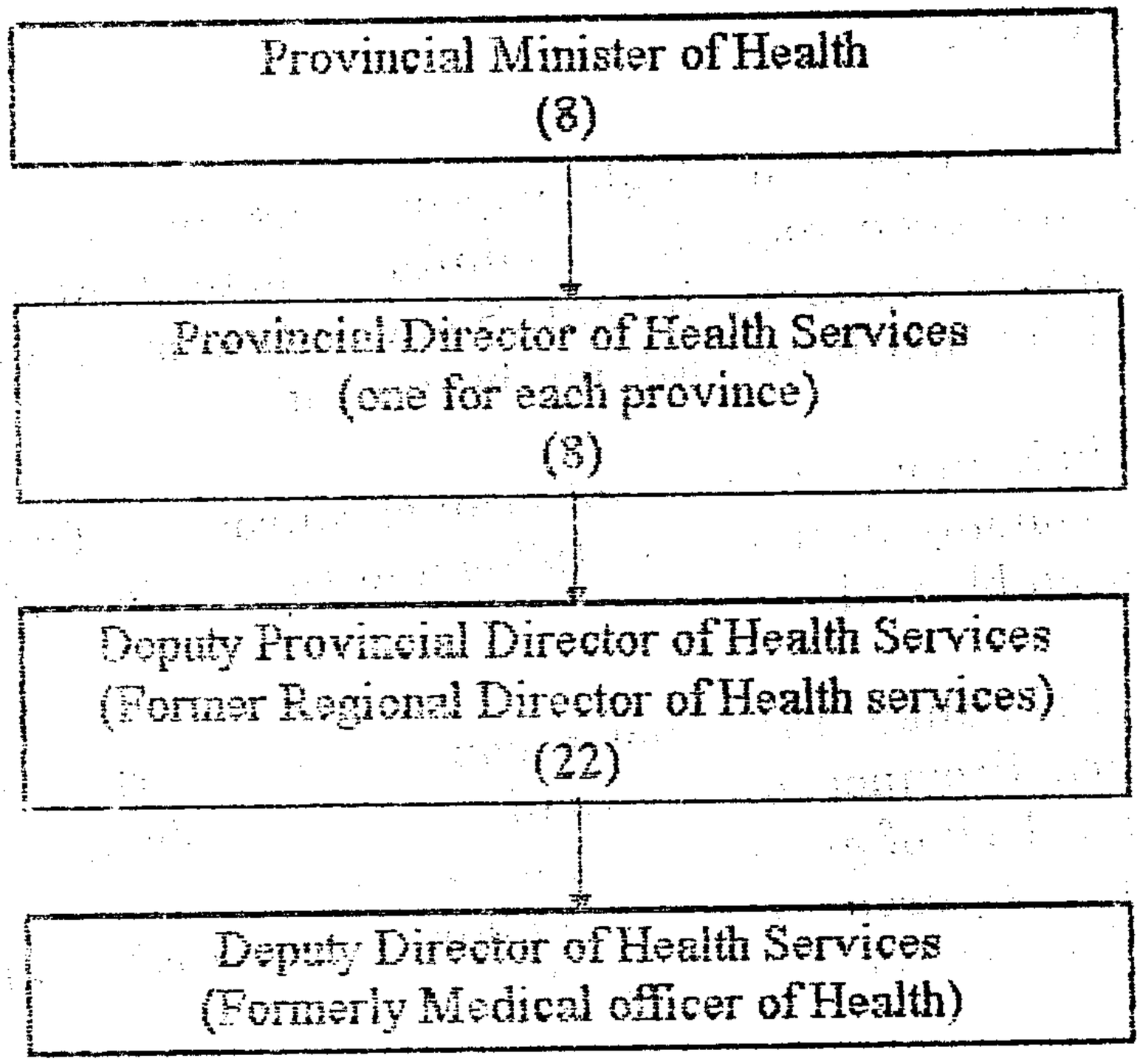

Figure 3: Health Care Services at Provincial Level

The Deputy Director of Health Services would be responsible for

- comprehensive Health Care to a population of 60,000-80,000.
- co-ordination of curative and preventive services
- administration of curative institutions including district hospitals and below.

In 1993, curative care was provided by 504 hospitals having 48949 beds distributed through Sri Lanka. The least number of beds per 100,000 population is in the districts of Manner, Vavuniya, Mullaitivu and Trincomalee [4].

Preventive health care is carried out by 215 health units by Medical Officers of Health.

The grass root level workers in primary health care are the Public Health Midwife (family Health worker) and the Public Health Inspector. The FHM provides domiciliary services to mothers and children and maintain a link between the Health Services and the community. The PHI is primarily responsible for environmental sanitation and the control of communicable diseases.

Progress with PHC

Today, 17 years later, the high expectations of the Alma Ata conference has not been met. It is painfully clear, that the goal of Health for all is growing more distant. Some critics say that PHC has failed. Others claim that it has still not been tried.

The experience in Zambia [4] has not been encouraging. The steep fall in he Zambian economy in the post -1970s and the neglect of the rural economy have been blamed.

The situation in Sri Lanka too is not encouraging and the progress in the North-Eastern Province of Sri Lanka is positively discouraging. The main reason is lack of grassroot level health workers. Table 1 and Table 2 give the requirement and availability of PHMs and PHIs categories of staff in Sri Lanka and NEP.

Category	Requirment	Availability (1993)	
		Sri Lanka	NEP
PHM	88	24.8	10.0
PHI	10	5.0	2.8

Table 1: Key Health Personnel for PHC (per 100,000 population)

Category of Staff	Requirment	Availability (1993)
Public Health Midwives(PHMs)	967	370(42.7%)
Public Health Inspectors(PHIs)	260	110(42.3%)

Table 2: Requirments and availaility of PHC workers in North East Province

In Sri Lanka 75% of the PHMs and 50% of the PHIs needed are available. In the NEP only 42.7% of the required PHMs and 42.3 % of the required PHIs are available. It is of interest to note that out of the 370 PHMs in the NEP 35% are in the Amparai district In the Jaffna District only 30% of the PHMs and 28% of the PHIs needed are available. Even among the PHIs a majority are re-employed or are on the verge of retirement. The present situation is the end result of inadequate training. Although the Nurses Training School at Jaffna has a capacity to train 50 PHMs every year [6], only 45 have been trained during the past 10 years.

What are the ingredients for success of PHC The WHO consultative committee on primary Health Care Development identified the following criteria [2]

- persisting national political, social and financial commitment with clear policy and administrative guidelines that reach to the periphery.
- strong management capabilities that can implement the programmes, including management information systems that track equity and effectiveness and point towards those who are especially at risk.
- health personnel oriented and trained as to understand and have their own commitment to the implementation of Primary Health Care.

- decentralization to district and sub district levels so that management decisions can be made with close relevance to local conditions.
- community participation with active involvement in local decision about Primary Health Care planning and implementation.
- sustained financing, preferably with community input to the extent that it will engender a sense of ownership but without inhibition of usage.
- Primary Health Care programmes that bring life-saving technologies to individual families at costs that are affordable even in the midst of poverty.

What are the causes of our failure to achieve the target.

1. Although hundreds of volumes have been written on PHC there is no true commitment on the part of the politicians or the Administrators.

In countries like Sri Lanka which is predominantly agricultural, the political base is mainly rural. A policy of health Care sustained by the people in rural areas is seen to be fraught with political danger [7]. Therefore politicians are reluctant to campaign or force PHC.

There is a tendency to build sophisticated hospitals and intensive care units staffed by highly qualified personnel, with the hope of expanding them progressively as resources increased until the entire population was covered. The consequences of this type of thinking has been quite contrary because resources are limited and funds are not available to even maintain the very expensive equipment in these institutions.

2. In Primary Health Care, when resources are limited, priority should be given to undeserved areas and to high risk groups in

the population. One major problem area is the lack of trained manpower at grassroots levels for PHC. Training grassroots level workers for Tamil speaking areas has been severely neglected although facilities are available at the Nurses Training schools in Jaffna and Batticaloa. The training of the paramedicals should be decentralized to the provincial level.

3. In order to have an effective Primary Health Care system decentralization is essential. In Sri Lanka although "lip service" is given to decentralization, in effect there is very little decentralization, as most Health Administrators are reluctant to give away their hold on the peripheral administration.

4. The medical professions is also partly responsible for this failure. It has failed to organize public and political support for PHC. It has been suggested [7] that the medical profession should organize themselves into a consortium of people from Universities, National and International Institutions and Professional bodies - a sort of Global NGO giving political leadership in favor of PHC, thus supporting the WHO and member states.

What is the future of PHC in NEP ?

The health care situation in the NEP (especially the North Province) today is somewhat similar to the situation on China in the early 1950s. Hospitals are broken down or closed. Senior doctor have left the country. Doctors who graduate are leaving. In short, the health service is deteriorating rapidly and we are on the verge of a major crisis.

Is PHC the answer to our present situation or are there any other alternatives?

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