Promotion of Primary Health Care in Member Countries of WHO

HALFDAN MAHLER, MD

THE HEALTH ORGANIZATION of the League of Nations held an Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene in Bandoeng, Java (Bandung, Indonesia) in 1937. More than 100 delegates considered the topic of rural hygiene, and they proposed recommendations along four major lines—health and medical services, rural reconstruction and collaboration of the population, sanitation and sanitary engineering, and nutrition.

In a report of the conference, the introduction notes that the attendance by men of "diversified interests" was a positive indication that "those responsible for the medical services and health protection of the rural population realize that their work is made difficult if not impossible unless activities in the fields of economics, sociology, agriculture and education are carried out at the same time."

The delegates touched on many issues and drew a number of far-reaching conclusions. They noted "that the greatest benefit to the health of the rural populations, at the smallest cost, can be obtained through some process of decentralization." They recognized the importance of community development and organization and "urged the necessity for leading the rural peoples into the adoption, of their own free will, of plans for their betterment, rather than the imposition of such schemes on them by means of Government orders." The role of women in rural betterment was also discussed, and it was urged that "everything be done to ensure that women shall be given all opportunity to develop their activities in this important field."

The conference not only laid the basic framework for health as part of rural development, but it also elaborated the essential features for success. It described the kinds of health personnel required, as well as the essential features of their training. It stressed the importance of planning of intersectoral activities in a coordinated manner. It recognized the possibility that "the opening of public health work in rural areas can often be used as the entering wedge for the development of a broader programme embracing education, economics, sociology, engineering and agriculture." At the same time, it noted that such work must be based on "the cooperation of the people at the periphery."

Primary Health Care

In 1975 the 28th World Health Assembly adopted primary health care (PHC). In my paper to the Assembly (document A28/9), PHC was characterized by the following seven principles:

(a) Primary health care should be shaped around the life patterns of the population it should serve and should meet the needs of the community.

(b) Primary health care should be an integral part of the national health system, and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support.

(c) Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing, communications).

(d) The local population should be actively involved in the formulation and implementation of health care activities so that health care can be brought into line with local needs and priorities. Decisions upon what are the community needs requiring solution should be based upon a continuing dialogue between the people and the services.

(e) The health care offered should place maximum reliance on the available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are present in each country.

(f) Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

☐ *Tearsheet requests to Halfdan Mahler, MD, Director-General, World Health Organization, 1211 Geneve 27, Switzerland.*

Villager in Pilcoyou, Peru, volunteers to be a candidate for the post of health administration worker

(g) The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by workers most suitably trained for performing these activities.

I also emphasized that no single model of PHC exists which has general applicability. Each of the seven principles listed can be translated into action in countless ways; the important thing is that these ways should evolve from and reflect the *unique* aspects of national values, conditions, and lifestyles.

The similarity between these principles and the conclusions reached in 1937 cannot be denied. Clearly PHC is not "new." Therefore, why did WHO put forward these principles in 1975? Why did the World Health Assembly adopt them unanimously? Why have countries chosen to proclaim that they will *now* reorient their health systems to comply with these principles?

Why has it been necessary to resurrect ideas that were put forward decades ago? What happened between 1937 and 1975? Were the earlier recommendations not implemented? Have countries not moved forward as best they could in improving the health of all their people?

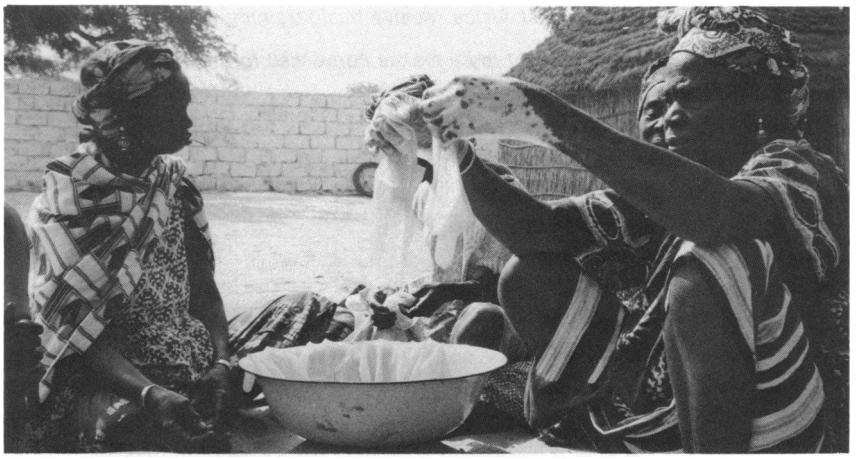
I believe that, with few exceptions, the recommendations of 1937 were not acted upon with the spirit with which they were framed. The commitment to an intersectoral approach to health founded upon an active involvement of the people was not adhered to. The reasons for this are many, and surely no one set of them will explain the failures and partial successes of the past decades. Perhaps there was a sincere belief by many that general development would take place rapidly enough to justify the preoccupation of the health sector with the delivery of medical care at the expense of health care. However, I do not feel this was the case. Even in the 1937 report, the seeds of failure had already been sown. This report also recommended that "Every country should, in the sphere of medical education, attain the highest scientific level of theoretical and practical training, which should include facilities and opportunities for research."

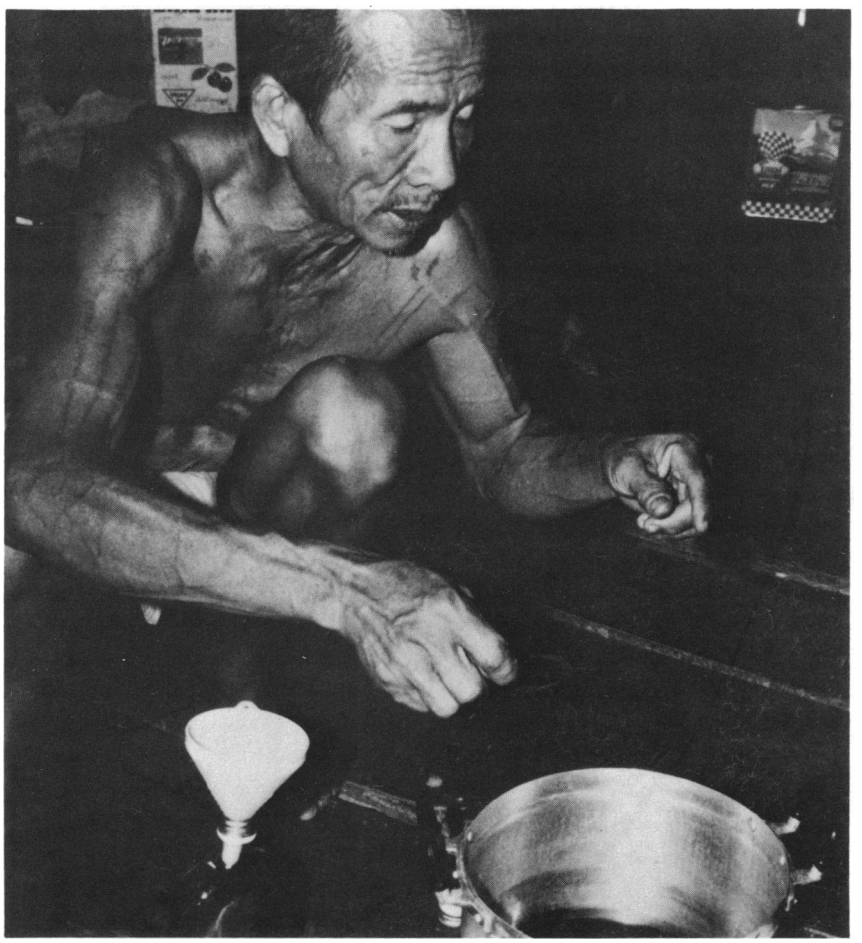
If the highest level of training were commensurate with the attainment of the highest level of health, matters may have taken a different course. Unfortunately, the opposite has been the case. The progress that has resulted has yielded benefits for only a relatively small proportion of the world's population. The more serious scourges of mankind have not been the focus of attention of the "facilities and opportunities for research" that have been created. Exotic, rare diseases and degenerative conditions have received attention disproportionate to their importance. No one can deny that such conditions need attention, but the health profession has been derelict in its duty to recognize that available resources are limited and that they should be applied in a manner to obtain the greatest improvement in health of all the people, not just a select few.

The concentration on disease technology has not helped matters. Largely institution based, this technology has contributed both to the sharp inequities of available care and to the pressures to develop even more sophisticated and costly technology. I have characterized this as a technological explosion which has overemphasized the refinement of knowledge for the sake of knowledge and of the techniques for the sheer cleverness of them. I

have called, along with others, for the demystification of medical technology. But, more important is the necessity to reconsider the strategy that we have chosen. Rather than decry the sad state we are in, I believe we must work toward health as a social goal, and we must assess developments in the light of their ability to contribute to this goal. In characterizing primary health care the way we have, we are putting it forward as an alternative to the dominating trends of the past few decades. It is an alternative that has more than once been recognized as the best road to take, but somehow the choice has always been made for other ways. Now I believe it is no longer an alternative; it is an imperative.

The necessity to proceed with implementing primary health care is part of a wider necessity to seek social justice. The forces that confined progress in the health sector to a few persons have also ignored the many needs that require satisfaction if human well-being is to be achieved. The importance that primary health care gives to community involvement is part of a greater need for individuals, families, and communities to be the prime movers in all aspects of their own development, not just health. The failure to achieve equitable development has rested largely on the isolation of people from decision-making processes and on the erection of independent sectoral bureaucracies which have little contact with reality. Even the call for "community development" some 30 to 40 years ago became the work of the bureaucracy alone, rather than that of the people. Other sectors have come to similar conclusions and are pressing for similar programs in their respective areas of influence.



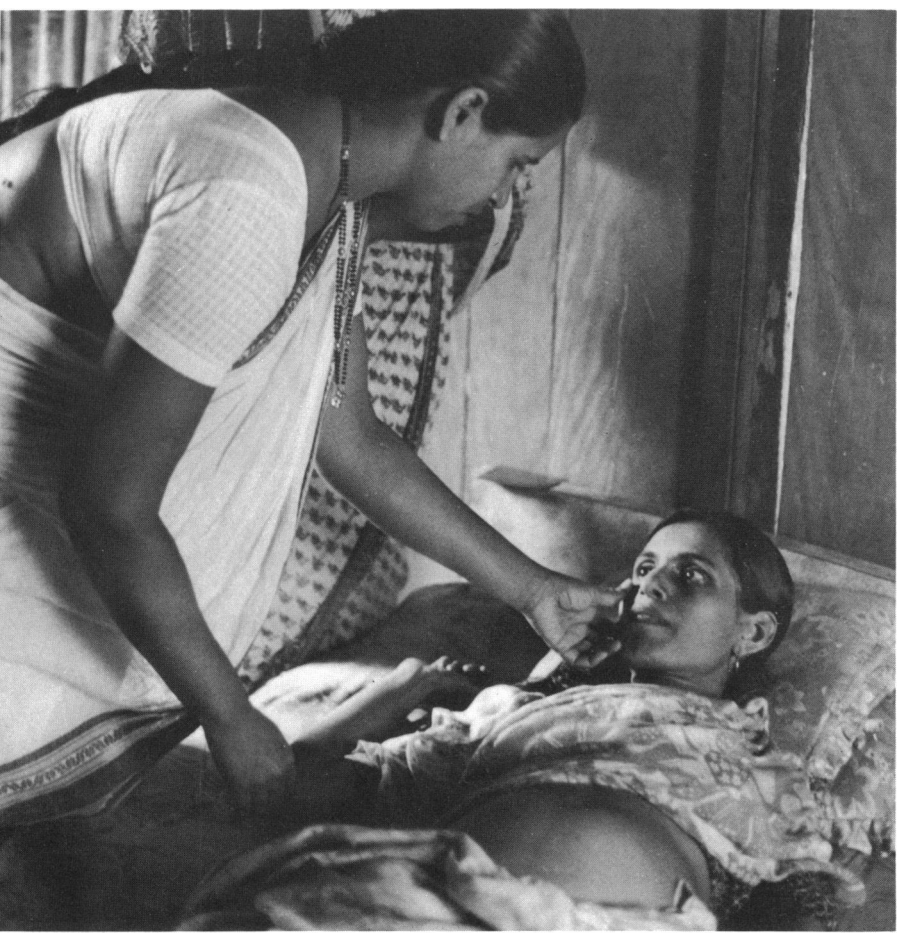


Midwives at rural maternity center in Touba Toul, Senegal, cleanse materials used in delivering babies

Thai "village health volunteer" prepares cough syrup using juices extracted from bark of a tree

Village health assistants in West Africa receive basic training course

Community health worker in rural India makes home visit to provide prenatal care



WHO's Role in PHC

The role of WHO is to promote, through various forms of technical cooperation, the development of primary health care in all Member Countries, with priority attention being given to the least-served and poorest populations. Activities are being undertaken within countries, among countries, and at the global level.

WHO is stressing the need for each country to establish clear national health policies in support of the PHC principles and to develop a nationwide program for its implementation. In collaboration with a number of Member States, the Organization has developed the process of "country health programming" (CHP) as a commonsense planning process for specifying more precisely which programs are required and deciding upon the order of priority for their implementation. Where such a process has been applied and where the need for PHC has emerged as a priority program, a more detailed program formulation has been undertaken. This step invariably has led to the identification of a number of critical activities; for example, mobilization of public opinion, strengthening of community organization, developing training programs for community health workers, evolving infrastructure support to health measures and activities undertaken at the community level, and coordinating intersectoral support of PHC.

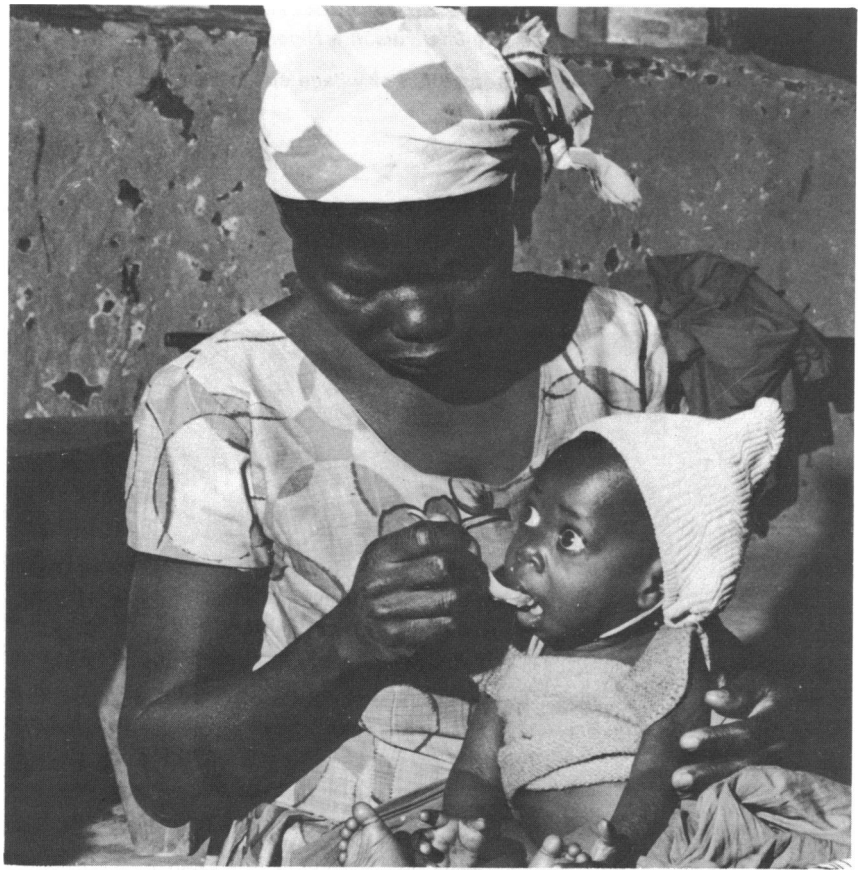
To facilitate the formulation of PHC programs, the Organization is preparing technical guidelines which can be adopted and adapted for national use. These guidelines illustrate, in concrete terms, what can be done. A manu-

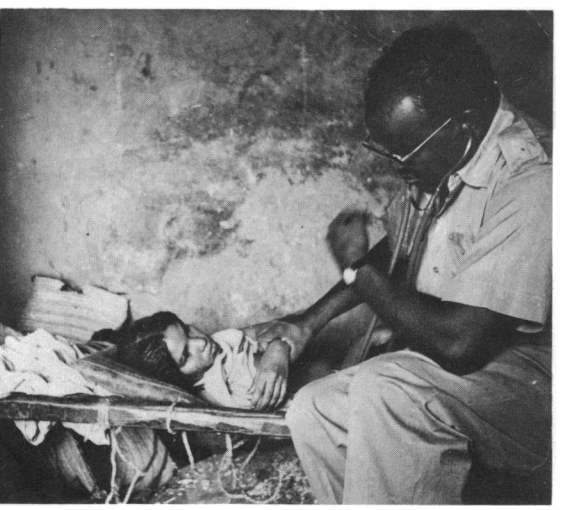
al, "The Primary Health Worker," identifies the many activities that can be undertaken by suitably trained health workers of the community. This manual has inspired many nationals to compile their own manuals and others have translated and adapted it for their use. Another manual, "Oral Rehydration," provides an excellent example of a technology that is appropriate in all the aspects desired: efficacy, cost, ease of application, and ease of learning. Other guidelines illustrate how communities might be mobilized and encouraged to take the initiative in developing simple health measures on their own, such as finding local solutions for drinking water supplies and waste disposal, the protection of houses against insects and rodents, and the provision of elementary health care. Still other guidelines point to the means whereby traditional healers and local midwives can, at moderate expense, be trained to provide adequate and acceptable health care under suitable supervision. Such training might include personal hygiene, mother and child care (including family planning), nutritional guidance, immunization against the major infectious diseases, elementary treatment of all age groups for the common diseases and injury, and a basic understanding of sanitation and environmental hygiene.

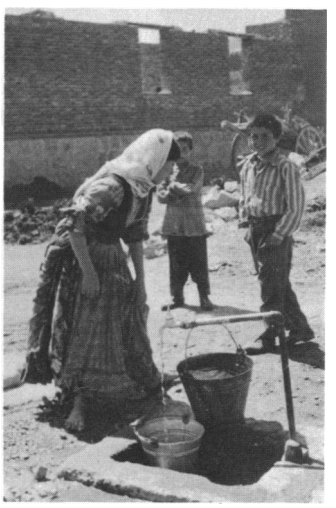
In parallel with country health programing, the Organization is also encouraging each Member State to determine the implications of primary health care for its own national situation. WHO has helped a number of countries organize national workshops in which key national decision makers discuss these implications and plan for establishing national policies, where these have been lacking, and for initiating the

Medical helper treats patient with conjunctivitis in a Niger village

Rural nurse in Yugoslavia seeks cooperation of village elders in maintaining regular vaccination of children







Zambian baby thrives on regular diet of protein-fortified porridge obtained at nutrition center

Malaria patient being tended by medical assistant in Sudan

A protected well, with piping and concrete basin constructed according to instructions from health worker in village of Khariz, Iran

steps necessary for implementation. Such national dialogs have stressed the intersectoral nature of primary health care by actively involving representatives of other sectors such as agriculture, housing, and education. They have also brought together representatives of the nongovernmental organizations that deliver care to the people.

In the development of PHC, one should not forget that it is first and foremost a concern of communities. If this is forgotten, the history of 1937 to 1975 will repeat itself. There is the danger that primary health care can be abused by either being allocated minimum resources in a condescending manner or being taken from the communities and made the exclusive concern of the "infrastructure." This will not happen if communities are fully engaged in developing the care that is appropriate for them.

The concern of national dialogs must be twofold. First, as just implied, this concern must be to reorient present programs so that they meet the needs of communities through strengthening the capacity of communities to handle their problems with their own resources, human and otherwise. Second, national dialogs should lead to a better understanding by all participating agencies, organizations, and sectors of how they can best coordinate their respective supportive activities of PHC. Ideally, these two concerns together should lead to local coordination and integration of all the elements required for the successful implementation of measures and activities needed to improve the quality of life of the people.

Although the emphasis of the Organization's work is at the country level, it is recognized that much can be obtained through

encouraging an exchange of experiences and ideas among countries. A range of activities are possible—extending from encouraging technical cooperation among countries, in particular among developing countries, to the formal mechanisms of workshops, seminars, and conferences.

One conference is of particular importance to the further development of primary health care. At the request of the World Health Assembly, WHO, with the cosponsorship of UNICEF, is organizing an International Conference on Primary Health Care. This conference will take place in Alma-Ata, U.S.S.R., September 6–12, 1978. Three or more participants from each Member State are expected to attend, as well as participants from other United Nations agencies, nongovernmental organizations, and donor agencies participating in activities related to primary health care. It is hoped that at such a forum the importance of primary health care as a developmental strategy will be highlighted in a manner that will encourage all participants to strengthen their commitment to this approach to health.

A number of preconference activities have taken place that will lead to a more complete accounting of national experiences as well as a better understanding of primary health care. Nearly all of the Regional Offices have organized regional workshops, conferences, and other special intercountry meetings designed to bring together national experiences and understanding. Also, one WHO-sponsored conference emphasizing the importance of primary health care in industrialized nations was organized by the New York Academy of Sciences and held in New York in December 1977. Another WHO-sponsored conference emphasizing the role of nongovernmental organizations in implementing primary health care is being organized by the World Federation of Public Health Associations and will be held in Halifax, Nova Scotia, in May 1978.

In addition to regional and international conferences, WHO is using films and literature to promote a wider understanding of primary health care. It was through such promotional means, especially the publication of "Health by the People," that the earlier statements on PHC obtained wide exposure. Although printed materials still remain the major informational activity, an increasing number of national authorities are obtaining similar information through visits to PHC projects and through reexamination of their countries' experiences that have emerged in light of the renewed interest in primary health care.

The increasing interest in primary health care is influencing health expenditures of all kinds. Investments in isolated, high-cost technologies that serve only a few are being put to severe tests of appropriateness before they are implemented. The day when such outlays serve the narrow interests of shortsighted politicians is passing as more and more programs recognize the futility of capital investments which put in place buildings and equipment that either cannot be maintained or serve the needs of only a small minority at great expense. This day is being replaced by investments in those activities essential for the early development of a nationwide PHC program and for strengthening the health infrastructure which reaches the people through support of community-based health care.

Challenge for the Year 2000

In 1976 I chose to present to the Regional Committees the objective "Health for All by the Year 2000." The Thirtieth World Health Assembly in May 1977 took up this challenge by adopting a resolution urging "that the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

The purpose of this challenge is not to proclaim that all diseases and illnesses can be eliminated by the year 2000. Such a possibility is unimaginable; the vicissitudes of life are too great for anyone to dream of such a Utopia. No, this challenge is aimed at focusing world attention on the grave inequities that exist today and on the possibility of attaining an acceptable level of health, equitably distributed through the world in one generation's time. This is a realistic goal only if urgent action is initiated now. Primary health care is a viable alternative toward bringing about this objective. That we have made such little progress between 1937 and now should not be taken as evidence of the impossibility of the task. This heritage hangs heavily upon us. But I believe that this generation is up to the task of making the decisions necessary to correct this injustice.

If each individual country has the political courage both to reorient its internal health priorities according to their social relevance for the total national population and, simultaneously, to espouse the cause of international solidarity for global health promotion, then I have not the slightest doubt that we shall reach this goal before the year 2000.