ACHIEVING HEALTH FOR ALL BY THE YEAR 2000

MIDWAY REPORTS OF COUNTRY EXPERIENCES

EDITED BY
E. TARIMO & A. CREESE

WORLD HEALTH ORGANIZATION
GENEVA

Achieving Health for All by the Year 2000

Midway reports of country experiences

Edited by E. Tarimo & A. Creese
Division of Strengthening of Health Services,
World Health Organization,
Geneva, Switzerland

World Health Organization
Geneva
1990

WHO Library Cataloguing in Publication Data

Achieving health for all by the year 2000: midway reports of country experiences.

1. Health planning—organization & administration 2. Primary health care—organization & administration 3. National health programs—organization & administration 4. Health for all I. Tarimo, E. II. Creese, A.

ISBN 92 4 156132 7 (NLM Classification: WA 540.1)

TYPESET IN INDIA

PRINTED IN ENGLAND

89/8029-Macmillan/Clays-5500

Preface

Hiroshi Nakajima,
Director-General, World Health Organization

Fifteen mid-term accounts of progress — and setbacks — in the implementation of the vision of health for all by the year 2000, as expressed at Alma-Ata in 1978, make up this book. They make a mixed picture, reflecting the fact that, for most countries, the last decade has been one of continuing economic difficulties. It cannot be denied that prosperity and peace are important underpinnings for lasting improvements in health. Nevertheless, health services that are appropriately planned, funded, and managed are important in mitigating the effects of economic recession on the poorest members of the population, and in ensuring that economic growth is accompanied by widespread improvement in health.

Implementation is where the real challenges lie. The reports included in this publication show how individual countries have adapted the primary health care approach to meet their own special, and evolving, circumstances. There are no general blueprints here for other countries to select from, but there may be parallels, similarities, hints and lessons in these accounts which offer insights and suggest possible solutions to problems. The promotion of such an exchange of experience is one of the mechanisms used by WHO in working with countries towards health for all.

Contents

Introduction

The Alma-Ata Conference in 1978 was an important milestone in the struggle for health. The conference was organized in response to widespread dissatisfaction with existing health services. Despite great efforts by countries and WHO in the late 1960s and early 1970s to improve and extend services, large numbers of people, particularly in the rural areas of developing countries, remained with no access to health care. Primary health care was seen as the route to health for all.

What is the challenge? Primary health care as outlined at Alma-Ata calls for three developments: universal availability of essential health care to individuals, families, and population groups according to need; involvement of communities in planning, delivery, and evaluation of such care; and an active role for other sectors in health activities. Each of these developments has far-reaching implications for health services. To make essential care universally available, for example, calls for a more equitable and efficient use of health resources. The conference provided a green light for implementing primary health care, but passing resolutions is one thing, implementing them quite another. There can be a big difference between what is planned nationally and what is done locally. This book provides a picture of what has actually happened in 15 countries. The various chapters outline the evolution of policies and plans and describe their implementation and outcome, particularly at local level.

Several red lights have also been encountered. First there were questions asking, in effect: what is all this about? How does primary health care differ from what we are already doing? Is it second-rate care for the poor? By calling for more community participation and action, does primary health care enable governments to avoid difficult decisions on reallocation of resources? Will resources continue to be used in favour of certain population groups while governments preach self-help to the underserved communities? Or does the implementation of the principles create a force for change that makes it imperative for governments to provide more support to underserved communities?

Controversy on these issues has resulted in a better understanding of the unsatisfactory nature of existing health care programmes, which serves as a strong determinant to develop policies and plans to rectify the situation. Many countries have defined not only their targets but also concrete programmes to achieve them. The WHO European Region, which comprises mostly developed countries, is leading the way in this respect. This is a good indicator of the success of the primary health care movement, as serious reservations were initially expressed regarding its relevance to the developed countries. Experiences in four industrial countries with different socioeconomic settings —Canada, Finland, Hungary, and the Netherlands—are documented in these chapters. The light has changed from red to green.

The next serious check to primary health care is money. It has been said that from the point of view of a sound economy, the Alma-Ata conference could not have come at a worse time. Development efforts in many countries have been seriously affected by the burdens of interest on external loans, deteriorating terms of trade, deadlock in the North–South dialogue, decrease in rural agricultural production, economic adjustment policies, and poor management of the economy in general, compounded by rapid population growth. Reassessment of spending priorities has tended to turn attention away from the "social" sectors in favour of the "productive" ones. Given that the proportion of government resources devoted to health in poor countries is already small and not deployed in the most cost-effective way, the challenge in some of these countries is to maintain the levels of development already reached. New sources of finance and improvement in the use of existing resources hold out the hope of gains in primary health care without additional central government funding.

Another red light has to do with weak management. Even if additional health resources were made available to the health budget from inside or outside the country, very little improvement in primary health care would be realized if they were used in the same way. Most health resources go to providing unnecessarily sophisticated curative health care which is becoming more and more expensive to those who have access to it. Little money is left for health promotion, disease prevention, and the provision of curative care to the rest of the population.

The litmus test for commitment to primary health care is the willingness to try to improve this situation. Some strategists claimed that primary health care called for too many things to be done. Priorities should be chosen. Who should be left behind? The children? The old? As the debate continued some even suggested that priority should be given to selected disease problems rather than to individuals. The challenge was to ensure that strategists and health workers were attuned to the principles of primary health care and guided by them in their analysis of problems, the setting of priorities, and the implementation of programmes. How was this to be achieved? How were leadership and managerial skills, accountability and monitoring at the central and local levels to be developed? Indeed, how were the health workers themselves to be motivated and their continuous support assured?

Despite these problems the "locomotive" moves on. This is the general conclusion of a meeting convened by WHO in Riga, USSR, in March 1988. The theme of the meeting was "From Alma-Ata to the year 2000: a midpoint perspective". The meeting found that levels of health as measured by mortality rates have improved in all countries. Improvements in some of the indices used, such as the number of children under five who die per 1000 live births, have been spectacular in the industrial countries and also in some developing countries. Predictions to the year 2000 show that the improvements will continue. But a worrying geographical rift came into focus. Africa and southern Asia are not keeping pace with the rest of the world. Some 40 countries in these two regions will still have under-five mortality rates of over 100 per 1000 at the end of the century unless special measures are taken. Concurrent with the organization of the Riga meeting it was decided to invite public health experts in 15 countries to write an account of their experiences in the application of primary health care. The countries chosen were representative of the various stages of development to be found in the different regions. They were Burkina Faso, Canada, China, Egypt, Ethiopia, Finland, Hungary, Indonesia, Malaysia, Mozambique, the Netherlands, Nigeria, Papua New Guinea, Sri Lanka, and Thailand. Of these, Burkina Faso, Ethiopia, Mozambique, and Papua New Guinea are among 40 developing countries with very high child mortality.

In order to make the accounts as lively and realistic as possible, it was suggested that, besides indicating the broad

national strategy and achievements, the authors should focus on practical experience at district level, placing that experience in the context of national developments and policy. The contributors were also requested to put more emphasis on implementation and outcomes, rather than on intentions and processes. The concluding section attempts to distil some general lessons from these reports.

WHO's hope is that the publication of this selection of country achievements and prospects, together with appraisals of underlying factors facilitating (or inhibiting) successful implementation of primary health care, will serve several purposes. Information of this kind provides an idea of the present global health situation and the problems being encountered, as well as of the corrective activities being undertaken and their impact. It could also be useful in the identification of areas of primary health care needing intensified global action. Perhaps most important of all, the innovative activities described might stimulate action in other countries.

Burkina Faso: building on the successes

B. Michel Sombié
Director of Studies and Planning, Ministry of Health and Social Action, Burkina Faso

Burkina Faso is one of the least developed countries in the world, with a per capita gross national product of about US$ 210. The population numbers 8 million, of whom 85% are engaged in a largely traditional kind of agriculture heavily dependent on the rains, which have been very erratic in recent years. The soils are lateritic and poor, supporting a savanna vegetation. Most of the watercourses are seasonal.

Industry is not well developed, and the proportion of children attending school in 1985 was less than 25%. Many schools have been built in the five years since the revolution, and a dual-vacation system has recently been adopted to make the best use of the places available. Adult literacy campaigns in the three main national languages have reached 20 000 people.

In the economic crisis that has affected all developing countries, Burkina Faso has been faced with enormous difficulties even in maintaining the health service it inherited from the colonial power, despite the declared intention of every government since independence to safeguard the people's health, especially in the rural areas. The current health situation in Burkina Faso is far from satisfactory, yet a comparison with the situation in 1978 shows that significant progress has been made.

The health situation in 1978

In 1978 the population was estimated at 6 million. The annual report of the Ministry of Public Health for that year stated that there were three main public health problems — communicable

diseases, nutritional deficiencies, and lack of clean water and sanitation.

The country was divided into 10 health sectors, each managed by a chief medical officer who coordinated all health activities. The infrastructure comprised two national hospitals, three regional hospitals, 39 medical and health centres at the area level, 156 district health centres and maternity centres, 167 dispensaries, and 31 maternity centres. The health staff in service during that year comprised 101 doctors, 5 dentists, 15 pharmacists, 74 health assistants, 338 state nurses, 736 registered nurses, and 165 midwives. Table 1 shows the number of cases of various diseases. An estimated 50% of the children examined by health personnel suffered from some degree of malnutrition.

To combat these major endemic diseases, health services were made available from treatment centres, and vertical programmes were administered by mobile units (mass immunization teams and units for maternal and child health care, surveys, and leprosy control), but all these activities worked in isolation from each other.

Immunization campaigns, for example, reached small numbers of people because information about them was distributed through administrative channels. There was very little public education, and the population was simply requested to take

Table 1. Cases notified by the health facilities, 1978

Disease	Number of cases
Malaria	371 730
Measles	9 213
Onchocerciasis	8 359
Schistosomiasis	15 080
Trachoma	13 070
Leprosy	48 005
Meningococcal meningitis	1 359
Trypanosomiasis	62
Treponematosis	2 327
Diarrhoea	149 828
Intestinal parasitic diseases	47 044
Tuberculosis	426[a]

Source: Ministry of Public Health

[a] Probably an underestimate, since 1060 cases had been notified in 1977.

advantage of the services that were being provided free of charge. The figures for immunizations in 1978 were as follows:

smallpox	682 746
measles	109 257
BCG	235 600
yellow fever	184 196
DPT	669
tetanus	202 549
poliomyelitis	47 375

The figures do not specify how many subjects completed the vaccination courses requiring more than one dose.

Table 2 provides an estimate of mortality rates per 1000 population, by age group, for the principal diseases.

As regards water supply, between 12% and 17% of the population had reasonable access to water. In 1976, approximately 1.75% of the population had running water in the home and 1.1% used stand pipes.

Because of this worrying health situation, the Government enthusiastically welcomed the primary health care approach adopted at the international conference at Alma-Ata in September 1978.

Table 2. Mortality rate per 1000 from the principal diseases, by age group, 1978

	Age group (years)						
	0–1	1–4	5–14	15–44	45–64	65+	Overall
Measles	26.1	26.1	4.6	0.4	0.1	–	5.7
Malaria	40.5	4.9	0.5	0.6	1.8	6.0	3.2
Diarrhoea	19.2	13.4	2.1	2.3	7.4	17.8	5.6
Pulmonary diseases	11.2	1.4	0.3	1.9	8.0	16.0	3.1
Abdominal diseases	7.8	2.1	0.6	1.0	2.8	–	1.8
Meningococcal meningitis	4.5	1.8	1.1	1.1	1.1	2.5	1.4
Heart disease	2.6	0.7	0.3	0.7	2.9	5.0	1.1
Pertussis	11.9	1.8	0.3	0.1	0.2	0.7	0.9

Source: Ministry of Public Health

Health policy since 1978

Even before the Declaration of Alma-Ata the Government had asked WHO to provide technical assistance in the preparation of its national health programme, and primary health care was chosen as the strategy for health development. The programme, covering the period 1980–90, was approved by the Council of Ministers on 14 March 1979.

To provide health coverage for the population, the programme provided for the progressive establishment of a five-tier health service comprising:

— one primary health post in each village,
— one health and social action centre for every 15 000 to 20 000 inhabitants, serving a maximum radius of 20 km,
— one medical centre for every 150 000 to 200 000 inhabitants,
— ten regional hospitals, and
— two national hospitals.

This health development strategy has been continued by subsequent governments. In a policy speech of 2 October 1983, the health and social service objectives were summarized as follows:

— access to health care for all,
— the establishment of maternal and child health care,
— stepping up of immunization campaigns to combat communicable diseases,
— health education for the masses.

It was also stated that these objectives could be met only if the people themselves were committed to them. The scene was therefore set for a more equitable distribution of health resources and a more conscious participation by the community.

Structure of the health service

The adoption of the primary health care strategy was followed by a reorganization of every level of the health service in Burkina Faso.

The Ministry of Health is in charge of government health policy. It comprises eight boards dealing with administrative

and financial affairs, research and planning, vocational training, health supplies and the traditional pharmacopoeia, health and sanitation education, promotion of immunization, epidemiological surveillance, and maternal and child health.

The Ministry of Health is also linked with the Occupational Health Office, the National Pharmaceutical Supplies Association, national organizations such as the Red Cross, intercountry organizations such as the Onchocerciasis Control Programme, and the *Organisation de Coordination et de Coopération pour la Lutte contre les grandes Endémies* (OCCGE), and international organizations including WHO.

Each province of Burkina Faso has a Provincial Health Board responsible for the planning, organization, implementation, supervision, and evaluation of health activities.

The Provincial Health Board comprises 10 departments dealing with maternal and child health, epidemiological surveillance and immunizations, health and sanitation education, health supplies and the traditional pharmacopoeia, nursing and obstetrics, primary health care coordination, occupational health, school and university health, statistics, and administrative and financial affairs.

The health services are financed mainly from the national budget, which pays all wages and salaries and ensures that the services operate. Apart from the allocation of certain amounts to the Provincial Health Boards, management of the national budget is centralized. The operational budget is divided among the provinces according to a quota based on population size. The provinces express their needs to the Administrative and Financial Affairs Board, which acts accordingly. Allocations for fuel and spare parts are managed directly by the Ministry of Finance.

The national budget returns 75% of the income from medical charges to the Ministry of Health, and that sum, too, is distributed among the Provincial Health Boards. Some Provincial Health Boards have initiated money-earning activities such as traditional pharmacopoeias, and others benefit from external finance donated by nongovernmental organizations or arising from bilateral or multilateral aid. The population itself makes an appreciable contribution.

Information support has developed considerably since 1985. Under the auspices of the Research and Planning Board, the old data-gathering media have been adapted to meet information

requirements. The Research and Planning Board summarizes and analyses reports produced by the Provincial Health Boards. It gives training in health statistics to personnel working in the provinces and supervises them in the field. The recent computerization of the service should improve health information and lead to more rational management of the health service.

Each province plays its part in operating the five-tier health service defined by the national health programme. This structure was revised in 1984, when staffing levels and the capacity of health units were reduced in accordance with the country's resources.

Primary health posts. These are to be found in every village. Each is run by a village health worker and a traditional birth attendant, both chosen from the community they are to serve and trained in the nearest health centre. Although volunteers, they are given some support from their community through its health committee. The post is provided with drugs, equipment for deliveries, a wheelbarrow and shovel for sanitation, and a bicycle. These workers carry out simple activities such as the treatment of malaria and diarrhoea, the application of dressings, normal deliveries, and giving advice on hygiene.

Health and social action centres. These comprise a dispensary with two beds, a maternity unit with four beds, and a room for educational activities. Each serves a population of 15 000 to 20 000. It should be run by a team of five, but this is rarely the case in practice. Each centre conducts preventive, curative, and promotional activities, taking into account the eight components of primary health care, and supervises the primary health posts within its area. A number of simple dispensaries and maternity units will be expanded into health and social action centres in the course of the 1986–90 five-year plan.

Medical centres. There is a medical centre in the main town of every province, serving a population of 150 000 to 200 000. At this level there are a number of specialist services such as laboratories and dental clinics, and a doctor should be available, but the medical centres are not all staffed as yet. Each centre has 12 beds for general patients and 8 beds for childbirth and is equipped with a utility vehicle, motorcycle, or ambulance for transferring patients.

Regional hospitals. Ten regional hospitals are planned for the whole country, each serving a group of provinces with a total population of 500 000 to 600 000. A regional hospital has 140

beds and serves as a referral centre for patients from the medical centres and the health and social action centres. It offers mainly treatment and a number of specialist facilities such as surgery, ophthalmology, and laboratory testing.

National hospitals. There are two national hospitals, one in Ouagadougou, the capital, and the other in Bobo Dioulasso, the second largest town. They are the referral centres for all the health units in the country, and all medical specialities are available there. They are also training centres for doctors and paramedical personnel.

It is by constant improvement of this system that progress, however modest, has been made.

The progress achieved

In order to provide health facilities where people can reach them, the construction of health and social action centres in rural areas has been given priority over the construction of large hospitals (see Table 3). Planning of the infrastructure has enabled us to avoid and correct regional disparities. Since it has been impossible to satisfy the demand for construction of health and social action centres owing to shortage of human resources, each province has been allotted a quota in proportion to its population. At the end of the five-year plan in 1990, each province should have one health and social action centre for every 16 000 inhabitants.

The policy of setting up one primary health post in every village brought essential services to the population. In the primary health post, people receive simple treatment for malaria, diarrhoea, and coughs, assistance with childbirth, and advice on hygiene. In recent years there has been a redistribution of the limited human resources in order to improve the efficiency of rural health units. Each province now has at least one doctor, one pharmacist, and one midwife—categories that had previously been concentrated in the towns.

On completion of training, all health personnel must serve for at least two years in a rural area, and the Government has increased the allowances for rural service. It is also pursuing a policy of providing acceptable accommodation for all administrative personnel in rural areas and urban fringe areas, by