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Editorial

IMPLEMENTATION OF NATIONAL PLANS FOR ACTION ON PRIMARY HEALTH CARE

Follow-up Proposal for Alma Ata Conference

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Alma Ata, Kazakhstan, U.S.S.R. (6-12 September 1978), was the site of an International Conference on Primary Health Care. The Conference, jointly sponsored by UNICEF and WHO, was attended by over 700 health workers and government representatives, who drew up a 10-point declaration and unanimously adopted 22 recommendations. (For a summary of the Conference, see Bull Pan Am Health Organ *12(4): 359-362, 1978). Six major considerations for follow-up are advanced.*

No conference, policy, or plan will make a difference unless it promotes a process of change. Primary health care may be brilliantly conceptualized, exquisitely researched, carefully planned, and systematically structured but still do little to improve the lives of people. The promises of the Declaration of Alma Ata will be fulfilled only if new patterns of health and health care are implemented for the millions of village people around the world.

The World Conference on Primary Health Care demonstrated a wide base of international consensus. National leaders have returned home recognizing that they can be part of an international movement. As they undertake innovative programs reorienting health care in their countries to ensure coverage of the rural and urban poor, their resolve will be strengthened by knowing that the new emphasis works and is being applied in many other countries, both developing and developed. They will have a framework of principles and practical experience on which to build their local adaptations.

However, all the cumulative effort and collaborative impetus may fail unless a deliberate process is started for following up on the decisions and commitments of Alma Ata. Practical measures need to be defined so that national leaders will know what steps are required in order to meet the new challenges and where to turn for help, internationally, in adapting past traditions of health care as part of a continuing process of planned change.

In his opening address, Dr. Halfdan Mahler, Director-General of WHO, rightly referred to the need for each country to develop its own Plan for

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Action. To do this, WHO, UNICEF, and other international agencies should develop a general framework for implementation within which each country and agency can formulate its own Plan for Action.

1. National Commitment and Political Will

The crucial action which the momentum from Alma Ata should do most to encourage is the stimulation by national political and administrative leaders of a public commitment to the new definition of primary health care. This will require a tidal shift in emphasis so that coverage will reach out to all the people, especially the poor and neglected in rural areas and urban slums, with emphasis on community participation and on health as a component of development. The new orientation, while recognizing the importance of hospital-based health care in supporting primary care, will focus new investments in health services at the periphery. Courageous legislative and administrative decisions will have to be taken to reverse the apparently inexorable drift to increasingly specialized, high-technology overmedicalization that promotes dependency on the health system.

The first step in national plans, then, is to promote policy decisions as a basis for action. A massive communication effort is needed that includes prompt and widespread mailing of conference reports and arrangements for the Declaration of Alma Ata to be printed in local languages in a one-page format that can be placed on the wall of every health ministry office, health center, and doctor's office in every country that decides to mobilize public support. This effort might well be coordinated by UNICEF.

2. Prompt Implementation of a Redesigned National Health System

Experience with successful projects in almost every country shows that national services for primary health care can be effectively expanded through adaptation and general implementation of principles that are already known. The health system must be reorganized to promote decentralization and to emphasize the needs of people without access to services.

Some legislative and organizational changes should be nationwide; in particular, rigid regulations need to be altered to permit flexibility in working out new role allocations among members of the health team so that primary care can be delivered within as close range as possible of those in greatest need. New efforts are required to integrate the few preventive and curative functions which most effectively concentrate resources on appropriate technology for the greatest cost-effective impact. New mechanisms will need to be worked out to find locally appropriate supportive services—including training and retraining, supportive supervision, mobilizing and equalizing the distribution of manpower, and technical resources—and to balance categorical and integrated services and evaluation and feedback for progressive improvement.

In efforts to implement the concepts of primary health care that came together at Alma Ata, one of the most important issues will be to sort out

relationships with the various vertical programs that have been and still are being promoted internationally. Obviously, the balance of relationships depends mostly on the stage of development of various services in a country. In many developing countries the only services that have successfully reached the rural poor have been vertical programs directed against specific diseases or health problems. Rather than lose the advances that have been made in such programs, primary health care should begin to build integrating relationships among them. However, the vested interests of these separate activities now represent one of the greatest obstacles to effective implementation of comprehensive care.

In vertical programs the priorities are set nationally or, more likely, internationally. A continuing problem in trying to phase vertical programs into general health services is that each one assumes that it should provide the base from which general health care should evolve. Present experience suggests that only if primary health care is given the responsibility and authority to put together locally appropriate mixes of the most effective preventive measures from various vertical programs will this kind of territoriality be overcome.

Community participation introduces the further complexity that health services must be responsive to local wishes and realistic appraisal of local priorities. Primary health care can all too easily be diverted into another vertical program providing simple and inadequate medical care, since this is what the people usually want as their first priority. This attitude is supported by the vested interest of the medical profession, which will continue to promote doctor-based care in preference to getting minimal coverage promptly to all the people. Promoting the necessary planning and management skills to carry out the complex endeavor of overcoming these obstacles is one of our greatest challenges.

3. Progressive Research and Adaptation for Emerging Problems

Current thinking about primary health care is evolving rapidly as interactions among groups and organizational units take unexpected turns. New problems constantly emerge in this process. Mechanisms are needed to systematize the search for solutions; experience in several situations suggests the desirability of setting up research and training areas and centers in parallel with general programs for implementation. In a defined population unit, or in a center that has access to various population units, solutions to new questions can be worked out. The whole national service does not need to be subjected to trial and error experimentation whenever there is new leadership that wants to get credit for trying something different. In these centers innovative ideas can be tested and adapted, management procedures optimized, shifting priorities monitored, and tough long-range problems faced forthrightly. As new procedures are worked out, the area or center can be used for training or retraining service personnel. By filling such research and development functions, educational and research institutions can be brought into the center of the primary care implementation process. The most essential feature will be effective two-way commu-

nication of problems and solutions between the health system and such centers.

4. Community Participation and Intersectoral Involvement

The two current approaches that make today's thinking about primary health care different from previous efforts to strengthen basic health services are the focus on community participation and the importance being given to intersectoral involvement. Much remains to be learned about how these goals can be translated into realistic interactions. Practical mechanisms must be experimented with: community incentives, recognition and education for effective community leadership, enlistment of busy agricultural workers and teachers, etc. These potentials will be realized only within a dynamic process of intersectoral development that creates new relationships among the ministries.

5. Evaluation and Progressive Improvement

Implementation of primary health care will never be definitively achieved, but a process of change must be started. Simple evaluation procedures should establish baselines, monitor progress, and suggest new and dynamic improvements. Evaluation methods should be related to surveillance of high-risk groups to identify those in greatest need. In keeping with the fundamental principles of social justice and human rights, the measurement process must focus especially on whether benefits are reaching the poorest people. Monitoring of local achievements is especially needed as responsibility is turned over to community leadership in order to ensure that benefits are not co-opted by the local elite in traditional patterns of exploitation.

6. International Commitment

Just as those who have access to benefits within countries must now assume responsibility for ensuring care to those who have been neglected in the past, those countries that have and use the most resources must face their obligations to the poorest ones. To make a reality of the rhetoric, large new allocations of funds and technical cooperation will be needed. These should be coordinated by interagency mechanisms that establish systematic communication and collaboration.

There are three areas in which international collaboration is needed to promote the new emphasis on primary health care. Rather than having a single mechanism to meet all three purposes, a linked combination of arrangements would probably be best. Rather than setting up entirely new mechanisms that would be excessively time-consuming, it will probably be best to build on and modify existing capacities. This is especially true because primary health care should not be a separate international endeavor. It will be successful only inasmuch as it is able to support and mobilize the strength of existing national capabilities and organizational units.

Major Funding for Service Activities

It is likely that fairly sizable new funds are going to be available, mainly from bilateral donors. In fact, some of the money that has been going into vertical programs for services such as family planning and nutrition will probably be channeled into efforts to promote integration.

Some effective means of communication between potential donors will be needed to facilitate the best use of resources. One possibility is a special emphasis under the Development Assistance Committee (DAC) of the Organization of Economic Cooperation and Development (OECD), but this does not include representation of the developing countries. A more useful mechanism might be to develop an interagency committee bringing together the types of representation that meet in World Bank-sponsored country consortia. This would be facilitated if the World Bank were to enunciate a new health policy. Obviously WHO, UNICEF, other UN agencies, the bilateral donors, and possibly nongovernmental organizations could be members of such a group, together with appropriate representation from developing countries.

Promoting National Plans for Action and Training in Planning and Management

The steps 1 to 5 outlined above require consistent stimulation and communication at the international level. WHO is probably the agency with the best country contacts to promote both the development of national plans and the necessary training. A major internal process of restructuring is already under way in WHO to improve working arrangements between Headquarters and the Regions. If these relationships can become facilitating mechanisms rather than barriers, the decentralization process will strengthen inputs at country level. WHO should build this new restructuring around the goal of making implementation of primary health care effective. In the past the structure of WHO was designed mainly to promote vertical programs, but now it should demonstrate the feasibility of integration by showing how it can be done within its own system without losing technical expertise and management skills.

A basic key to the success of this endeavor has to be the massive expansion of training programs for planning and management. A network of institutional linkages is needed in which specialized centers in developed countries commit themselves to enhancing the capacity of regional and national centers. Such an undertaking requires central coordination, which could probably best be carried out by a subunit within the new organization at WHO Headquarters, with branches in the Regional Offices.

Health Services Research

The WHO Advisory Committee on Medical Research has identified health services research as one of its three main priorities. The regional

committees are appointing task forces to actively promote such research in country studies. These beginning mechanisms need to be specifically promoted by being given a significant percentage of all new money for primary health care. The training of research workers and the evolution of new research methods are particularly urgent. The former should be related to the group that is responsible for training in planning and management, and, since all training and research should be mutually reinforcing, perhaps a single mechanism at WHO should be set up for these activities, with appropriate representation and control from such other agencies as UNICEF and the World Bank.