VI PROGRAMME AREAS

A. PRIMARY HEALTH CARE

UNICEF's policy in health, which is closely related to the Basic Services Approach, is to support the PHC Strategy adopted at Alma Ata in 1978*. This represented a radical shift in health policy internationally: it recognized that health for the majority could not be achieved through continuing to develop conventional health systems based on sophisticated hospitals and training of high level workers on the assumption that benefits would eventually "trickle down" to reach the poor. Nor were the mass vertical style disease control programmes the answer for the complex interrelated health problems. What was needed was the involvement of people, both in their own health care and in managing health services; the integration of health goals and actions as part of overall economic development; and radical changes in the organisation and delivery of health services, involving shifts in allocation of health resources towards meeting the health needs of those whose needs were greatest.

1. Underlying Principles

The PHC Strategy gives expression to some fundamental values or principles in health development. These are firstly equity and justice. Health Care is a basic human right and not just for those who can afford to buy it. PHC is concerned with the equitable satisfaction of health needs, reducing gaps in health status, and distribution of resources in relation to priority health needs.

* Alma Ata 1978 Primary Health Care, WHO, Geneva 1978.

This refers not merely to health care resources but also to other resources to which an individual must have access in order to maintain health,(land or job, food, education, water, etc.). This leads to the second tenet of the underlying philosophy, which recognises that health is the outcome of a complex set of socio-cultural, economic, environmental and biological factors. Health will only be realised in the context of a pattern of development which balances the priority of social goals with economic ones.

Thirdly, there is the principle of self reliance and self realisation. People must be given the opportunity to exercise control over their own lives and their environment. They must be supported to take responsibility for their own, and their families health, as well as contribute collectively to the supervision and management of health and health-related services.

2. The PHC Strategy

It is to be expected that the variety of circumstances pertaining in countries would result in differences in interpretation of PHC. Because of the radical nature of the changes involved, high level political commitment is needed and because the PHC approach is by definition, a process of change, it is inevitable that there be opposition, evasion and misconceptions, and slow progress. It is much easier to define PHC as a level of health care to be tacked onto the periphery of an existing (unchanged) health care delivery system (as a number of countries have done). In some countries PHC has become synonymous with training large numbers of village level health workers, which is accompanied by the rhetoric of "community involvement" because communities "select" the workers.

Unfortunately, where there is no re-orientation of health delivery systems, communities and their community health workers remain unsupported by the health system and programmes are in danger of losing credibility with the people, with health professionals, and ultimately with politicians and governments. For this reason, it is important to define clearly the characteristics of health systems which are based on the PHC Strategy in order to define PHC goals and policies.

Characteristics of a Health System based on the PHC Approach

Four "A"'s provide the main characteristics of a health care system based on PHC. Health Care should be Available, Accessible Acceptable, and Appropriate to health needs. Health Care can be available but not accessible. The latter involves not only geographical access but also social and economic accessibility. This is related to acceptability and appropriateness or relevance, which requires community involvement. If people are involved in decision-making about the services they need, if they are informed and consulted, if the health care and resources allocated are seen to meet felt needs and concerns, then the system conforms to PHC principles.

There is sometimes a misconception that PHC means less than high quality of health care because it is basic. The reverse is true. Effectiveness is not necessarily based on high technology interventions, but on the application of known, and often simple, appropriate technologies for prevalent and serious conditions.

PHC ensures that these simple technologies are applied effectively and in a timely manner at the appropriate level of the system. It also ensures that the more technologically sophisticated interventions are applied for those who need it, because another characteristic of a PHC orientated health system is that there is a functional integration between the community level activities and the supportive infrastructure of the rest of the health system hierarchy. A PHC health care system allocates national or government health care resources in such a way as to ensure that the 80% of the population who need primary level care receive it and the other 20% who really need secondary or tertiary care can also receive it.

The principle of cost effectiveness and efficiency is fundamental to the PHC concept, i.e. resources are allocated in such a manner as to achieve the greatest benefit (as measured by the extent to which health needs of the majority are met) at the lowest cost. This implies a dynamic concept of a health system which a country can afford because it uses the resources (which may be very limited at present) wisely and efficiently. Cost effective use of resources involves more efficient use of health personnel, re-allocation, even of roles and functions, and re-training programmes. It involves more efficient use of drugs, of transport and improved management of the system as a whole. The PHC process can also involve radical re-organisation and restructuring of health care institutions and infrastructure to achieve the goals of accessibility, relevance, cost effectiveness and efficiency.

New styles of management which involve communities are characteristic of a PHC orientated health system, community involvement in the planning, administration and evaluation of health care services is fundamental to the PHC approach.

Finally, there is inter-sectoral collaboration. A health care system based on PHC has collaborative working relationships with other sectors at all levels. At the community level it may not be appropriate to set up special health structures where health issues can be dealt with adequately by a village development council or committee. As one moves towards the centre or national level, disaggregation of sectors becomes inevitable, particularly for allocation of resources. Special mechanisms are needed to develop and maintain links between health activities and objectives and those of other sectors, and to co-ordinate interventions and resource allocations in such a way as to achieve a balanced development which is health promoting rather than health threatening.

In summary, to realise PHC, countries must be involved in a process which includes: redistribution of resources; introduction of legislative reforms; re-orientation of health manpower; introduction of improved management planning; strengthening logistical support systems; and the use of appropriate technology. It also involves intensified communication and information programmes and the application of health system research in its widest sense.

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UNICEF gives high priority to supporting this PHC process. Following an international analysis of experience in PHC implementation,* the JCHP recommendation, endorsed by the UNICEF Executive Board in 1981 recommended, that UNICEF and WHO:

(a) support countries in developing relevant indicators and strengthen their health information systems;

(b) collaborate with countries in establishing and strengthening intersectoral mechanisms, mobilising and organising relevant institutions for training, research and development, and establishing inter-sectoral networks for promoting health policies and programmes;

(c) support countries in increasing national capability in planning, and especially in health economic analysis, health care legislation and budgetary planning methods to effect shifts in resource allocation;

(d) to assist in developing innovative approaches to and mechanisms for community involvement in planning, management and implementation of programmes and community monitoring,

* National Decision-making for Primary Health Care. A study by UNICEF/WHO Joint Committee on Health Policy, WHO, Geneva 1981.

(e) to assist countries to disseminate information and explanatory material for use in public compaigns, mass media and to all social channels of communication.

3. Primary Health Care Activities

The Alma Ata Declaration emphasised 8 essential elements of PHC. These are: education concerning prevailing health problems and the methods of identifying, preventing, and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water, and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health; and provision of essential drugs.

UNICEF gives highest priority to those activities which are directly related to the health of women and children, recognising that with limited resources there is a need for some selectivity, and that the priority population group to be reached with UNICEF resources are children, and those who are primarily concerned with their health, i.e. their mothers, and potential mothers. The priority is to support those interventions which are technically proven as effective, which address health problems which have a high mortality and morbidity and which have technologies which can be managed by people themselves, or by minimally trained health workers, and which are cost effective and feasible to implement in situations of underdevelopment.

These activities include the following priorities:

1) Nutrition activities, including breastfeeding and growth monitoring of young children, and promotion of appropriate weaning; 2) Immunizations; 3) Diarrhoeal disease control (including both oral rehydration and provision of safe water and sanitation; 4) Maternal Care. This includes TBA training and support for MCH supervision and referral with special attention to antenatal care, screening for risk and nutrition supplementation including iron and folate administration; 5) Family Planning; and 6) Control of other diseases which are major causes of childhood mortality and morbidity such as malaria, upper respiratory infections, tuberculosis, etc., which can be feasibly and cost effective managed through a PHC approach involving communities; 7) Ensuring regular and adequate provision of a limited list of essential drugs.

UNICEF policy is to promote and support these PHC activities as co-ordinated and integrated health care programmes as far as possible, recognizing that immunization, nutrition surveillance and diarrhoeal disease control are all components of MCH care, and that it is the combined impact of convergent services which will bring about health improvement in mothers and children. Integrated services are also more efficient and achieve broader coverage.

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This, however, does not mean that special campaigns selecting specific components of PHC, should not be given increased emphasis periodically in order to raise national awareness, to inform and motivate individuals, and to mobilize all resources to achieve specific limited goals. This may require an orchestrated national programme involving a number of sectors and NGOs as well as the national health delivery system. In order to achieve an impact, it may be necessary to focus on a more limited list of interventions than the national PHC programme provides. Currently, UNICEF is giving high priority to support these types of national campaigns especially for diarrhoeal disease control, growth monitoring, immunisation, breastfeeding, family spacing and selected targetted food supplementation for vulnerable groups such as undernourished pregnant and lactating women and young children during the weaning period.

Nutrition Activities

Regular growth monitoring of young children using calendar type weight charts, or other anthroporetic measurements, carried out on a community basis, provides a focal point for bringing mothers and children together for nutritional education, screening for nutritional risk cases, and an opportunity to provide preventive health measures such as immunisation and malaria prevention. Although use of growth charts has been an important component of MCH Programmes supported by UNICEF, more efforts are needed to promote the correct use of the charts as an educational tool particularly outside the formal health system, e.g. through women's groups, etc. Mothers, whose children's weight is faltering, can

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be given intensive educational support such as a home visit by a health worker, and if necessary food supplementation. Promotion of breastfeeding is a major component of nutrition programmes and food supplementation to selected pregnant and lactating mothers should be given when necessary. Attempts should be made to reach all pregnant women through TBA and MCH Programmes to identify malnourished cases and provide food supplementation to those at risk. The effectiveness of this strategy can be measured by its impact on birth weight. It has been shown that babies with birth weights of over 2,500 grams have a neonatal mortality rate which is one-quarter of that of babies with birth weights below this figure.

2. Immunisations

UNICEF gives high priority to supporting immunisations against the six childhood diseases, as a component of integrated MCH Care. It participates with WHO in the Expanded Programme of Immunisation. The policy is to support the management and organisation of supplies and logistics; improvement and strengthening of the cold chain; the training of health workers in techniques of immunisation and the provision of vaccines; and support for vaccine production. UNICEF also gives priority to management training, communication and information research and programmes, and provision of the necessary supplies.

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3. Diarrhoeal Disease Control*

UNICEF supports the WHO Control of Diarrhoeal Diseases (CDD) programme, in light of the proven effectiveness of oral therapy. It assists with the supply and distribution of ORS through health systems, ensuring their availability at the community level for use by community health workers, other community level workers and, if possible mothers. Part of this effort involves support to production of ORS both nationally, and at the cottage industry level. As part of this effort, UNICEF places high priority on promotion of home therapy using simple household remedies, such as salt and sugar solutions, rice water, etc., for prevention of dehydration in early childhood diarrhoea. A concerted effort is needed in the area of communication, information and education, through all available channels, guided by relevant social science research on attitudes, practice and behaviour. Surveys on marketing and distribution and the economics of local production are also supported by UNICEF.

Promotion of sanitation, improvement of water supply, personal and food hygiene are also promoted and supported as a contribution to diarrhoeal disease control, as well for the prevention of other water and food borne diseases and other developmental goals.

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* At present, a policy statement on CDD is being prepared to be issued jointly by both WHO and UNICEF. This, which is under review at present, is hoped will clarify in more detail an agreed joint policy by both agencies. It should be finalised by end January 1983.

4. Maternal Care. This includes antenatal care and supervision of childbirth consisting of the following specific priorities: training and supervision of traditional birth attendants (TBAs); the establishment of a good screening and referral system between TBA and basic health services; antenatal care tasks carried out by TBAs or CHWs*, using simple effective interventions for the priority complications of pregnancy (i.e., according to local epidemiology and resources); identification of malnutrition and nutrition supplementation (including iron) for pregnant and lactating women; tetanus immunisation and, where relevant, malaria prophlaxis, and treatment of other common infections which affect the outcome of pregnancy.

5. Responsible Parenthood and Family Planning

UNICEF policy on Family Planning is based on 3 important considerations. First is the impact of population trends on society with the interrelated problems of inadequate food and nutrition levels, rural and urban poverty, and the inadequacy of resources for education and health services. Second is the health implications for mothers and children. This concerns: the serious negative health impact of frequent pregnancies on both mothers and children; the problems of increased risk to mother and baby of high parity: pregnancies in the young and older age groups; and the importance of child spacing to ensure adequate care of the child during the weaning period, and allowing time for the nutrition and health status of the mother to be restored.

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Third, is the effect of family planning on family and community life. Having fewer children enables families and communities to provide each child with a substantially larger portion of basic requirements, such as home space, clothing, food and parental attention. In addition, parents have more time to spend on income generating activities which would improve the quality of life of children.

UNICEF endorses the integration of family planning activities with other basic and welfare services. It seeks to make it part of an educational process to stimulate grassroots participation in decision making in matters related to family and community life and to explore the integrated interdisciplinary approach to provision of family welfare services. It is recommended that provision of family planning services be integrated into MCH services as a part of PHC. The use of community health workers and trained TBAs, and the strengthening of the supporting health care delivery and referral systems could provide opportunities for relevant family planning programmes. Appropriate technologies and training programmes for health workers need to be designed and methods for promoting greater community involvement will need to be found. Information, education, and communication is also given high priority. Information and education is promoted through the mass media, informal and formal education systems and involves NGOs and local social and political organizations. Support for family planning involves a wide range of multisectoral and inter-disciplinary approaches and collaboration with other multi and bilateral agencies.

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6. Control of Diseases

UNICEF supports disease control programmes as an integral component of PHC. Some prevalent conditions which affect children are acute respiratory infections, malaria, tuberculosis, leprosy, schistosomasis, and intestinal parasites. In the past, UNICEF supported vertical programmes in an attempt to eliminate or dramatically control these diseases. With newer technologies becoming available and with the development of PHC infrastructures and community involvement, it is possible to support control measures as part of the PHC programme. In some countries, well developed vertical programmes have already been established and it will be necessary to support a gradual integration into PHC. This is true of leprosy, TB and malaria control programmes in particular.

Acute respiratory infections is perhaps the most important cause of death in children. Strategies for its prevention and management are currently being researched by WHO. However, a PHC programme which provides essential primary care using appropriate antibiotics for respiratory infections close to home, combined with simple preventive measures to keep young children warm in cold weather remains the most effective strategy.

TB Control through BCG immunization, early diagnoses and continuous supervision and treatment over the necessary 1-2 years, can be carried out through strengthened PHC programmes.

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One of the most effective aspects of a TB programme is improved management at local and sub-national level, to strengthen record keeping systems and monitoring progress of all diagnosed cases to prevent spreading of the disease.

For schistosomiasis the basic control methods advocated are selective chemotherapy with new and highly effective drugs, although these are expensive. This is supported by water and sanitation programmes and by health education, specifically aimed at the younger age groups in whom prevalance is highest.

Lastly, intestinal parasites, which are debilitating but not a cause of mortality in children, are largely controlled by improved sanitation and hygienic practices. In some situations, mass chemotherapy for the child population may be appropriate at regular intervals. This can be done at the community level as part of the PHC programme.

7. Provision of Essential Drugs

UNICEF and WHO are jointly engaged in an action programme to support countries in the provision of essential drugs for PHC. The objective is to ensure the regular supply of the most effective and safe essential drugs at a reasonable cost to all people. This involves strengthening national capability for formulating and implementing the necessary drug policies and regulations governing the importation, production, distribution and sale of drugs; and the use of generic rather than brandname drugs.

It also involves strengthening national capabilities in the areas of procurement, packaging, storage, distribution, and management; support to local production of essential drugs; and quality control. The UNICEF/WHO essential drugs programme also provides for the availability of a few basic drugs in sufficient quantities to the least developed countries through multi and bilateral donors. These drugs include an antibiotic, multi-malarial, iron and folate for aneamia, antihelmintics, aspirin or other analygesic/antipyretics, ORS and antibiotic eye ointment. Support for appropriate use of traditional remedies is also included in the policy on essential drugs.

8. Childhood Disability

At least one child in ten is born with, or acquires, a serious physical or mental impairment. Today, 80 percent of the estimated 140 million disabled children in the world are living in developing countries without access or rehabilitation services of any kind. Because most of the physical and mental impairments suffered by children in developing countries can be prevented (being due mainly to inadequate nutrition, faulty child-bearing practices, preventable diseases and accidents) UNICEF's main efforts regarding childhood disabilities are directed towards better preventive measures involving greater support for maternal and child health services, health education, disease control and the improvement of nutrition.

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These activities, within the framework of basic services and primary health care, are a very important part of ongoing country programmes. Some of these are specific such as the prevention of xerophthalmia, endemic goitre and accidents; the control of trachoma and other communicable eye diseases; and immunization against poliomyelitis and measles.

Since most impairments which occur do not have to develop into serious disabilities, a secondary level of prevention lies in the detection and treatment of such impairments when they appear, again through existing health, education, nutrition and welfare services, with active community participation.

Rehabilitation procedures for many physically and mentally disabled children can be done by families and others in the community, if they have the right information and support: in this way, these children can develop their potential and find a useful place for themselves in the community. Such procedures must be relatively simple, practical, inexpensive and utilize local resources, with the main attention being on preserving the normal development of the disabled child (an interruption of this process can result in a more serious handicap than the direct consequences of the disability). Although UNICEF is generally concerned with the disabled children globally, because the situation of these children is unfortunately worse in the urban slums and poor rural communities of developing countries, preference will be given for the introduction of innovative, low-cost prevention and rehabilitation projects in these areas.

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While some support for the training of specialized personnel concerned with the integration and rehabilitation of disabled children continues, UNICEF assistance will now be increasing a great deal for the further training and orientation of other categories of personnel within a country (and especially community-level workers, who are in contact with individual families, and their supervisors) on the problems of childhood disabilities and their prevention and rehabilitation.

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