

REPORT ON THE  
**REVIEW  
OF PRIMARY  
HEALTH CARE  
IN THE AFRICAN  
REGION**

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REVIEW OF PRIMARY HEALTH CARE  
IN THE AFRICAN REGION**



REGIONAL OFFICE FOR

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## Acronyms

AFRO	WHO Regional Office for Africa
AMREF	African Medical and Research Foundation
CBHC	Community Based Health Care
CBOs	Community Based Organizations
CDD	Control of Diarrhoea Diseases
CEDHA	Centre for Educational Development in Health Arusha
CHWs	Community Health Workers
DHMBs	District Health Management Boards
DHMTs	District Health Management Teams
DMO	District Medical Officer
DPT	Diphtheria, Pertussis and Tetanus
FCEA	Central African French Francs
FGM	Female Genital Mutilation
FHI	Family Health international
FP	Family Planning
HCMTs	Health Centre Management Teams
HIPCs	Heavily Indebted Poor Countries
IDPs	Internally Displaced People
IMCI	Integrated Management of Childhood Illness
IRC	International Red Cross
LGAs	Local Government Areas
NIDs	National Immunization Days
PHMTs	Provincial Health Management Teams
RDC	Rural Development Committee
RHMTs	Regional Health Management Teams
UNAIDS	Joint United Nations Programme on HIV/AIDS
VHCs	Village Health Committees
VHWs	Village Health Workers





## EXECUTIVE SUMMARY

With the adoption of the Alma-Ata Declaration in 1978, which identified Primary Health Care (PHC) as the strategy for health for all, countries embarked on implementing PHC in the last two decades. Since then, there has been considerable diversity in country experiences in PHC implementation. Dissatisfied with progress, and with pressure from international institutions, most countries embarked on implementing health sector reforms such as decentralization in order to provide an enabling environment for PHC implementation. While useful lessons can be drawn from country experiences, it is evident that none of the countries has fully achieved health for all.

Recognizing that major interventions are needed in the 21st century to refocus on PHC, the World Health Organization (WHO) has identified the need to carry out a global review given the institutional, socio-economic, and other changes that have occurred since the Alma Ata Declaration. Each WHO Region would undertake a review that would be used to contribute to the global report. The purpose of the review would be to examine the implementation of primary health care and identify strategic interventions needed to cope with the new challenges facing the health systems, as a contribution to developing an agenda for strengthening PHC in the 21st century. In particular, the review would address the following:

- i. PHC policy formulation: How was the PHC policy formulated?
- ii. PHC policy implementation: How have the PHC policies been implemented?
- iii. PHC resources: What resources are available for PHC implementation?
- iv. PHC monitoring and review: How are the PHC policy and strategies being monitored and reviewed?
- v. Health trends: What are the health trends in countries of the WHO African Region?
- vi. What is the way forward?

The Primary Health Care review process, in the African Region, started with a two-day meeting (3-4 July 2001, Harare, Zimbabwe) whose objective was to determine the process and content of the contribution of the African Region to the global review of the PHC Policy. The participants that supported the review in the Region included officials from WHO/HQ and from all the technical divisions of AFRO as well as representatives of the three resource institutions, namely Centre for Educational Development in Health, Arusha (CEDHA), Iringa PHC Institute, Iringa (IPHCI), both in Tanzania and Institut de Santé et Développement (ISED), Dakar, Senegal). Specifically the meeting proposed a process for PHC implementation review and identified five relevant review areas in the African Region. These were Health Trends, PHC Policy Formulation, PHC Policy Implementation, PHC Monitoring and Review, and PHC Resources.

It was agreed that all the 46 countries of the Region would be involved in the review to assure political ownership. The Division of Health Systems and Services Development (DSD) of WHO African Regional Office, collaborating with the three resource institutions, worked out a guideline for the

country review of PHC. The countries were requested to identify an expert who would work closely with the Ministry of Health to undertake the review and produce a country report. Meanwhile the resource institutions undertook a thorough desktop review on countries and examined inputs from the country reports. Financial support to the institutions and the countries for the assignment was provided by WHO. CEDHA and PHCI-Iringa conducted the review in English-speaking countries, while ISED covered the French-speaking countries. The review relied on documented literature from various countries and available literature from online libraries of the WHO, UNICEF, World Bank and universities, among others. The final report is based on the reports produced by the resource institutions, review of other reports available in AFRO and other UN organizations, as well as seventeen individual country reports on PHC policy review. Using the information, AFRO then undertook the final review and synthesis of the report.

The review found that PHC policy formulation had been well articulated in the national health policies by most countries. Five principles and the eight elements of PHC were addressed, although the extent to which PHC policies encompassed equity, community participation, inter-sectoral collaboration and affordability is still questionable. Although all countries say that they are committed to PHC implementation, the process has lagged behind due to a combination of factors. These include weak structures, inadequate attention to PHC principles, inadequate resource allocation and, in most cases, inadequate political will. Periodic monitoring and evaluation of PHC activities in most countries is either lacking or done irregularly and, as a result, most country PHC policies have no allowance for feedback mechanisms.

Some health trends that showed initial improvements over time have regressed. The pace of improvement has been slow, as shown by infant and child mortality rates. There has also been a regression as shown by the high maternal mortality rates and declining life expectancy at birth in some countries. This is associated with falling GDP per capita over the years, coupled by the high debt burden, declining production and deteriorating terms of trade. Financial resources allocated to health and, especially, to PHC have declined. In addition, the social situation has deteriorated due to the rising number of conflicts and the resultant displacement of people as well as severe food shortages resulting in negative health impact on the communities, such as increased malnutrition, particularly among the children. Furthermore, the population has been growing disproportionately to the provision of basic social services.

The key recommendations of the review highlight that

1. There is need to look into ways of harmonising the health sector reforms with the PHC in order to ensure that the initiatives promote both equity and quality of health services.
2. For a common understanding of the Regional Health Policy, it would be appropriate to bring all the countries in the Region together for briefing on the orientations and strategies of Agenda 2020 or other regional strategies before embarking on development of country policies and strategic plans.
3. The Regional Health Policy should be discussed at the highest level of the State and shared widely with all national and international partners in the health sector in the country.
4. There is need to promote more inter-sectoral collaboration among, and coordination with,

the diverse stakeholders involved in PHC implementation, especially at the district level where PHC implementation is being advocated. For attainment of better inter-sectoral collaboration, the necessary interactions of the health system with other systems should be better and properly defined and appropriate mechanisms for inter-sectoral collaboration clearly designed on a country-by-country basis.

5. Future efforts should be made to address challenges such as effective involvement of the community in health planning and decision-making through the establishment of effective linkages, like boards and committees, between health facilities and community structures. In addition, this involvement needs to be strengthened in areas such as problem identification, priority setting, data collection and analysis, evaluation, and planning.
6. Financing policies and strategies should aim at improving equity and fairness in order to improve service coverage for the poor.
7. Resource allocations to PHC should be reviewed and ways of sustainable financing of PHC should be sought. In addition, greater efforts should be made in the countries to increase efficiency in the utilization of the meagre resources available.
8. Countries should be supported to address their particular human resource needs through clear articulation of human resources policy and plans, development and strengthening of national management systems and employment policies.
9. There is urgent need to support countries to identify and put in place mechanisms for attracting and retaining health personnel.
10. Intervention at inter-country level or even at the level of the African Union is required to address the brain drain problem.
11. There is need to reform health sciences education and reorient health workers education and practice to incorporate emerging trends and equip major stakeholders with skills in planning, financial and personnel management, which is important in promoting PHC and community home-based care.
12. WHO should facilitate the development and adoption of guidelines and methods on Primary Health Care monitoring and evaluation for use by the countries. This should be integrated into the monitoring of progress towards achieving the Millennium Development Goals.
13. WHO should strengthen its support to member countries to institutionalize on-going good practices and effective measures before introducing new initiatives.
14. WHO should support member countries in capacity building that will enhance implementation of health programmes and actions through PHC and within the framework of Health for-All policy for the 21st century in the African Region: Agenda 2020.



# CHAPTER 1:

## INTRODUCTION

By introducing the Primary Health Care (PHC) strategy, the Alma Ata Declaration in 1978 proved to be a turning point in the history of health care policy. PHC was defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of development in the spirit of self-reliance and self determination”. PHC was expected to form an integral part of both the country’s health system, of which it is the central function and main focus, and the overall social and economic development of the community. It would be the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people work and live, and constitute the first element of a continuing health care process. PHC comprises eight elements: (i) education concerning prevailing health problems and the methods of preventing and controlling them, (ii) promotion of food supply and proper nutrition, (iii) adequate supply of safe water and basic sanitation, (iv) maternal and child health care, including family planning, (v) immunization against major infectious diseases, (vi) prevention and control of locally endemic diseases, (vii) appropriate treatment of common diseases and injuries, and (viii) provision of essential drugs.

The ideology and principles behind PHC closely match what was and has since been advocated in human development such as social justice, equity, human rights, universal access to services, giving priority to the most vulnerable and underprivileged, and community involvement. At Alma Ata, it was recognized that the promotion and protection of the health of the people is essential to sustained economic and social development and contributes to better quality of life and to world peace. Attainment by all peoples of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life (Health for All) was identified by the Thirtieth World Health Assembly in 1977 as a main social target of governments, international organizations and the community and, it was reaffirmed by the International Conference on Primary Health Care at Alma Ata in 1978 that PHC was the key to attaining the target.

Since the Alma Ata Declaration, Member States commitment in the PHC process has been evidenced in the development of health policy documents and development plans. These prioritized PHC as the main strategy for achieving health for all. Despite this commitment and 25 years on, not much has been achieved. PHC in the 21st century is, and will continue to be, challenged by complex scenarios in the Region, such as rapid urbanization; the emergence and re-emergence of both communicable and non communicable diseases, especially the high prevalence rates of HIV/AIDS; and the declining national economic performance accompanied by high debt burden and deteriorating terms of trade. Moreover, the social situation has continued to deteriorate with increased disparities in access to basic social services among the urban and rural population. In addition, increased conflicts and exceptional food crises have resulted in a lot of resources being diverted to address emergencies and hence exhausting the resources originally earmarked for PHC. It is against this background that AFRO commissioned the Centre for Educational Development in Health, Arusha (CEDHA) and Iringa Primary Health Care Institute (IPHCI), Tanzania, to conduct a regional review in English-

speaking countries and the Institut de Santé et Développement (ISED), Senegal, to conduct in French-speaking countries. The objective was to identify the strengths, weaknesses, opportunities and threats in PHC implementation. Further, the outcome of the review would be used to guide WHO on the way forward in supporting Member States on PHC implementation in the 21st century.

The main motivating factor for reviewing PHC policy implementation in the Region was the great concern by all stakeholders and partners involved in health sector development to find appropriate ways to strengthen PHC implementation in order to deal with current and anticipated health and health-related challenges.

The purpose of the review was to examine the implementation of primary health care and identify strategic interventions needed to cope with the new challenges facing health systems, as a contribution to developing an agenda for strengthening PHC in the 21st century.

The main issues addressed by the review were:

- PHC policy formulation: How was the PHC policy formulated?
- PHC policy implementation: How have the PHC policies been implemented?
- PHC resources: What resources are available for PHC implementation?
- PHC monitoring and review: How are the PHC policy and strategies being monitored and reviewed?
- Health trends: What are the health trends in countries of the WHO Africa Region?
- What is the way forward?

The report presents the methodology used for the review, describes the economic, social and political environment since Alma Ata, and provides the review findings on PHC policy formulation and implementation, its resources, monitoring and evaluation, as well as health trends, challenges and consequences. It ends with conclusions and recommendations for the future.



# CHAPTER 2:

## METHODOLOGY

Taking the opportunity offered by the global PHC policy review, initiated by the Director General of the World Health Organization, a meeting was held in Harare on 4 – 5th July 2001 to define the Region's contribution. Participants were drawn from all the technical divisions in AFRO, WHO/HQ, and the institutions identified to support the review process, namely CEDHA, Tanzania, PHCI-Iringa, Tanzania and ISED, Senegal. Following this meeting the institutions, working together with the team at AFRO, discussed the process for the PHC Policy Implementation Review in the African Region and agreed to conduct the review at two levels, namely country-specific reviews and a regional review. To ensure consensus on issues for review, a framework for PHC review in countries (see Annex 1) was provided. It described the process and provided guidelines for the interviews, analysis, focus group discussion and gave an outline of reports to be produced. These were disseminated to all countries. The countries were also given an opportunity to identify a consultant that would work closely with the WHO country office and authorities in the Ministry of Health to carry out the country review, with funding from AFRO. Meanwhile, CEDHA, PHCI-Iringa and ISED were contracted to carry out the regional review. This consisted of a desk review, based on analysis of available regional documents, country-specific review reports and, where necessary, case studies of countries with best practices. Both CEDHA and PHCI-Iringa were contracted to cover the English-speaking countries and produce a report. Similarly, ISED was to cover French-speaking countries and the countries having Portuguese as working language.

### 2.1 MAIN OBJECTIVE:

The general objective for carrying out the review was to examine the implementation of primary health care policy implementation and identify strategic interventions needed to cope with the new challenges facing health systems, as a contribution to developing an agenda for strengthening PHC in the 21st century.

### 2.2 MAIN ISSUES TO BE REVIEWED

Five broad areas were identified for review. These are:

1. **PHC policy formulation:** How was the PHC policy formulated? What was the process of formulating PHC policy, the content of the PHC policy etc..
2. **PHC policy implementation:** How are the PHC policies being implemented? Aspects to examine include advocacy and marketing, actors and partners, structures and processes etc..



3. **PHC resources:** What resources are available for PHC implementation, for example human and financial resources, as well as PHC physical resources and structures.
4. **PHC monitoring and review:** How are PHC policy and strategies being monitored and reviewed?
5. **Health trends:** What are the trends of the main health and health-related challenges?

## 2.3 PROCESS

The process of reviewing PHC at the regional level was carried out at two levels, country and regional.

At country level, seventeen of the forty-six countries<sup>1</sup> in the Region reviewed their own experiences in PHC implementation and submitted reports for inclusion in the regional report. Data for the review was also obtained from the following sources:

- Unstructured interviews with interviewees/informants that have intimate knowledge of PHC implementation, such as policy makers, implementers at all levels, other sectors involved, WHO and other partners.
- Discussions with a wider audience of people who have intimate knowledge of PHC implementation. These included policy makers implementers, NGOs, private sector, health-related institutions, WHO and other partners
- A desk analysis of available documents and reports specific to the country and extensive analysis of all available published and unpublished documents and materials.

At regional level, both CEDHA and PHCI-IRINGA produced a review report while ISED produced only an inception report. The departure of the Director of ISED from the institution caused a breakdown in the compilation and analysis of the review in the French-speaking countries and countries with Portuguese as the working language. Though this was subsequently rectified, it was too late to fully complete the task in this group of countries.

Consequently, documented and online literature on PHC from, for example the WHO, UNICEF, World Bank and universities, Internet searches, and individual country reviews from the seventeen countries were used to complete the review and the final report. However, this was further constrained by the inadequate information received on the issues under review in all countries.

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<sup>1</sup> Algeria, Botswana, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Congo, Democratic Republic of Congo, Kenya, Liberia, Madagascar, Malawi, Mauritania, Niger, Sao Tome & Principe, Togo and Zambia

# CHAPTER 3:

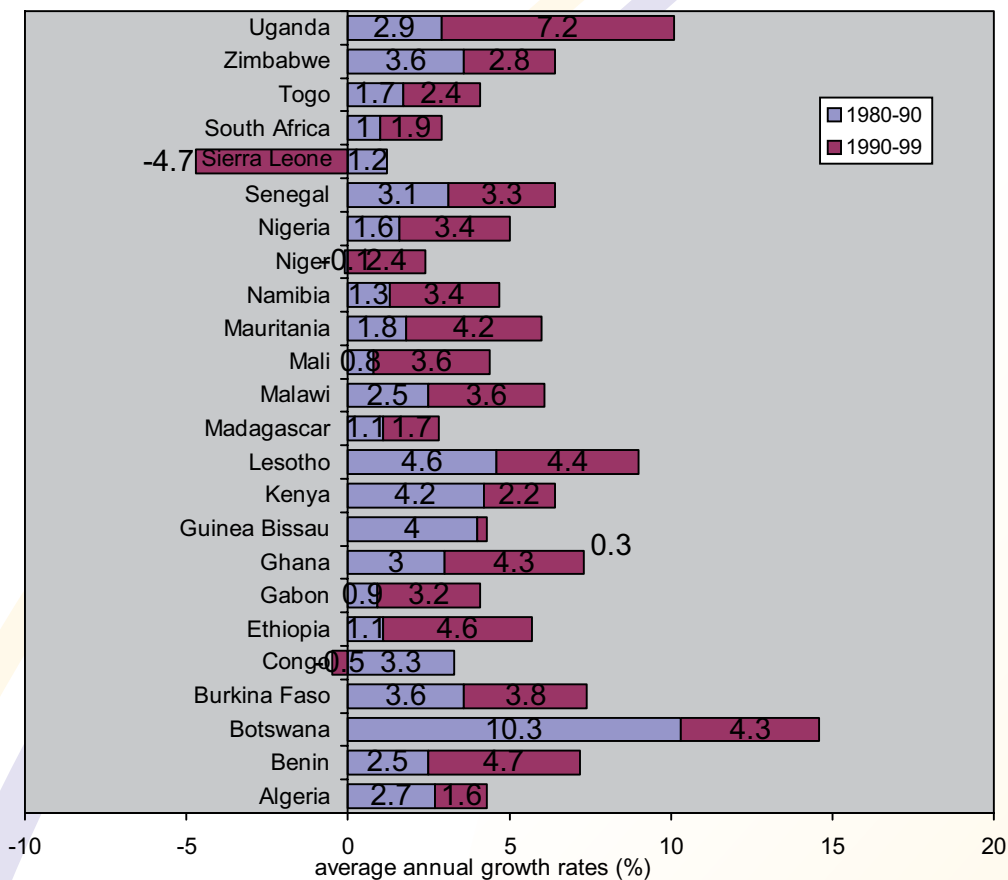
## ECONOMIC, SOCIAL AND POLITICAL ENVIRONMENT SINCE ALMA ATA

### 3.1 Economic Environment

The implementation of PHC assumed good economic performance. Unfortunately, most economies in sub-Saharan Africa have not performed well.

*Declining economic growth.* Economies in sub-Saharan Africa have been performing poorly during the 1980s to the early 1990s when some positive growth was registered (fig.1). GDP growth increased in 1994 to reach 1.6 percent from a low 0.8 percent recorded in 1993. It continued to 2.2 percent and 4.7 percent in 1995 and 1996 respectively (World Bank & UNDP data series). Improved macroeconomic management and more favorable external conditions helped sub-Saharan Africa to achieve significant high growth levels in 1996 (Irish Aid, 1998). Then since 1996, falling commodity prices and, especially, world oil prices progressively slowed the growth from 4.7 percent to 3.5 percent in 1997, further declining to 2.1 percent in 1998 (World Bank, 2000). The 1997-99 oil crises continued to depress economic activities in most countries in the year 2000, as non-oil commodity prices continued to decline. In the year 2000, the Africa Region average growth accelerated to 2.7 percent from 2.1 percent in 1998-99.

In terms of proportion of GDP dedicated to health, there are variations between countries. However, it is clear that health spending remains critically low as a percentage of GDP in the Region compared to other regions in the world. For instance, in 1997 and 1998 the average percentage of GDP devoted to health in the African Region was 4.1% and 4.2% respectively (WHO, 2001). The highest was 10.3% in South Africa in 1997 and 9.2% in Zimbabwe in 1998 while the lowest was in the Democratic Republic of Congo at 1.6% in 1997 and 1.7% in 1998 (WHO, 2001).

**Fig. 1: GDP Average Growth Rates, 1980-99 (Selected African Countries)**


Source: World Bank, 2001

*Poor performance of the main economic sectors – agriculture, industry, manufacturing and service.* The poor performance of the agricultural and industrial sectors, which form the backbone of African economies, has been challenging the sustainability of growth and development of most countries. Most of the sectors including agriculture, industry, manufacturing and service declined over the periods 1980-1990 and 1990-1999 (see Table 1) and very few countries showed positive improvements. Manufacturing output dropped in most countries due to a combination of factors including low levels of investment, high production costs and inherent structural weaknesses. During the period 1999 to 2000 countries like Kenya, Sierra Leone, Zambia and Zimbabwe continued to experience industrial declines and excess capacity, among others. The declining agriculture growth resulted in declining per capita food production and this trend threatens Africa's food security. Low exports prices coupled by increasing world oil prices, and the subsequent diminishing market share of African produce, especially in the 1990s, resulted in deteriorating exports earnings. Conflicts, floods and low commodity prices have again held back economic growth in Africa and it is evident that most countries did not match their major sectors output in the 1990s as compared to the 1980s. Even for countries like Malawi, Namibia, Lesotho and Uganda that are registering increased growth for some sectors, the growth has been very minimal.

**Table 1: Growth of Output (1980-1999) – Selected African Countries**

Country	Agriculture Average annual % growth		Industry Average annual % growth		Manufacturing Average annual % growth		Services Average annual % growth	
	1980-90	1990-99	1980-90	1990-99	1980-90	1990-99	1980-90	1990-99
Algeria	4.6	3.0	2.3	1.0	3.3	-5.7	3.6	2.7
Benin	5.1	5.3	3.4	3.8	5.1	5.6	0.7	4.4
Botswana	3.3	0.3	10.2	2.8	8.7	3.9	11.7	6.3
Burkina Faso	3.1	3.3	3.8	4.0	2.0	4.2	4.6	3.6
Congo	3.4	1.7	5.2	-0.2	6.8	-1.9	2.1	-1.4
Gabon	1.2	-1.9	1.5	2.6	1.8	0.6	0.1	4.5
Ghana	1.0	3.4	3.3	2.4	3.9	-4.5	5.7	5.8
Guinea Bissau	4.7	3.4	2.2	2.3	-	4.1	3.5	-7.3
Kenya	3.3	1.4	3.9	1.9	4.9	2.4	4.9	3.5
Lesotho	2.8	2.0	5.5	6.3	8.5	7.9	4.0	5.2
Madagascar	2.7	1.5	0.9	1.9	2.1	0.6	0.3	1.9
Malawi	2.0	7.5	2.9	1.2	3.6	-2.7	3.3	3.5
Mali	3.3	2.8	4.3	6.5	6.8	3.2	1.9	2.7
Mauritania	1.7	5.0	5.9	2.6	-2.1	-0.9	0.4	4.7
Namibia	1.9	3.8	-0.6	2.5	3.7	4.3	2.3	3.4
Niger	1.7	3.6	-1.7	1.8	-2.7	2.3	-0.7	1.6
Nigeria	3.3	2.9	-1.1	1.7	0.7	2.0	3.7	2.8
Senegal	2.8	1.4	4.3	4.4	4.6	5.0	-2.7	-10.8
Sierra Leone	3.1	1.0	1.7	-4.6	-	3.7	2.8	3.6
South Africa	2.9	1.0	0.7	0.9	1.1	1.1	2.4	2.4
Tanzania	-	3.2	-	2.5	-	2.3	-	2.4
Togo	5.6	4.5	1.1	2.5	1.7	2.4	-0.3	0.6
Uganda	2.1	3.7	5.0	12.7	3.7	14.2	2.8	8.1
Zambia	3.6	9.4	1.0	-3.9	4.0	0.7	0.5	0.3
Zimbabwe	3.1	4.6	3.2	0.7	2.8	0.7	3.1	3.5

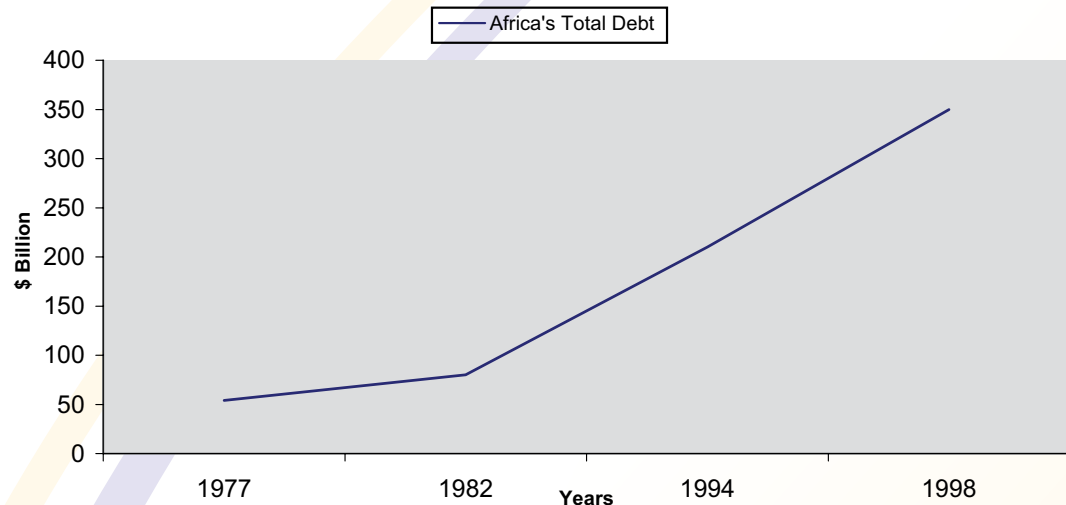
Extracted from: World Bank (2001), *World Development Indicators 2001*

*High external debt burden.* High external debt remains a severe obstacle to economic development. By 1998, the total external debt owed by sub-Saharan Africa rose to about US\$ 350 billion, compared to 1994 and 1982 when the total debt burden was US\$ 210 and US\$ 80 billion respectively (see figure 2). Many African countries are still borrowing more than they can repay and debt servicing now exceeds 30 per cent of the exports earnings for most countries (UNDP, 2001). This limits the amount of resources available for allocation to basic social services. The high debt burden has had a significant negative impact on health spending in Africa, with most countries allocating less than US\$10 per person per year to their health budgets.

The effects of the heavy debt burden have resulted in worsening balance of payments, fiscal imbalances, rampant inflation, which makes it difficult for countries to invest in priority issues like health care, food production, housing and education. The \$13 billion annually repaid by African governments to Northern creditors for debt servicing represents more than double their spending

in health and primary education combined (World Bank, 1997). Most countries in the Region are spending less on health and allocating more resources to debt repayments. Uganda for example spends approximately \$2.50 per capita on health compared to \$30 per capita on debt repayments.

**Fig. 2: Africa's Total Debt (\$ Billion) 1977-1998**



Source: World Bank, 1996

In 1996, 33 of the 41 countries classified as “Heavily Indebted Poor Countries (HIPC)” were in Africa. In 1998, the HIPC initiative started to review countries for debt relief. However, it is notable that few countries including Uganda, Niger and Tanzania have qualified for debt relief. Whilst this initiative is commendable, the debt relief measures are still marginal and too limited.

*Low investments.* Africa has continued to see its share of the world’s market economy diminish and whenever there has been meaningful growth it has not been backed up with investment. This was partly due to high debts, high inflation, persistent droughts and significant reductions in development expenditures and savings. In addition, the HIV/AIDS epidemic is having devastating effects on economic growth (WHO, 2000a) and hence discouraging further investment. In South Africa, for example, the HIV/AIDS epidemic is projected to reduce the economic growth rate by 0.3 to 0.4% annually, resulting, by the year 2010, in a gross domestic product (GDP) of 17% lower than it would have been without AIDS and wiping US\$ 22 billion off the economy (UNAIDS, 2000a). Further, projections show that, although Botswana has the highest per capita GDP in Africa, AIDS will slice 20% off the government budget, erode development gains, and bring about a 13% reduction in the income of the poorest households in the next 10 years (UNAIDS, *ibid*).

*Adverse external conditions.* Adverse external conditions in most countries have continued to negatively affect regional development, by stagnating external resource flows and decreasing commercial lending. Official bilateral and multilateral assistance accounting for the bulk of resource flows to most countries has also declined over the years. Irish Aid 1998 notes that the share of the Official Development Assistance (ODA) in Sub-Sahara Africa declined from 40% in 1989 to about 34%

in the late 1990s. Inadequate budgetary allocations coupled with poor governance, crumbling infrastructure, and pilferage of public resources has adversely affected investor confidence and reduced external funds to most countries. This has contributed to high poverty levels, with about 50 per cent of the population living below the poverty line, and has adversely affected the delivery of basic social services to the poor, especially children and women.

### *Poverty*

Poverty is one of the major constraints in all human development processes in Africa. It has been clearly established that there is a “cycle of causality between being poor and poor health, confining the individual in a spiral of poverty” (Fairbank et al. 2001). Poverty is both a hindrance to health development and a consequence of poor health and lack of access to health services.

Sub-Saharan Africa has the highest proportion in the world of people living in poverty, with nearly half of its population below the international poverty line of US\$ 1 a day. Between 1990-1999, the number of the poor in the Region increased by one quarter or over 6 million per year. Much as economic measures were taken in countries in the Region to fight against poverty and reduce inequities, it appears that the Region’s weak economic performance during the 1980’s and early 1990s as noted above hindered the success of these efforts.

## **3.2 Socio-political Environment**

The social situation has continued to deteriorate in sub-Saharan Africa. This has been attributed to the inequity in access to basic social services, increasing food shortages leading to high malnutrition levels, rising conflict levels and influx of refugees overburdening countries which already have high population growth rates. The section below briefly gives an overview of the social situation in the countries during the period under review.

*Access to basic social services.* The Region continued to face inequalities in access to services such as health facilities, housing, safe water and sanitation, with more than 50 percent of the African population lacking access.

Data from many countries indicate that the rural population is seriously disadvantaged in terms of access to health and health-related services. The result is the spread of infectious diseases, including childhood diarrhoea, which are major causes of malnutrition.

Each year, dehydration due to diarrhoea claims the lives of 2.2 million children under five years of age in the developing countries (UNICEF 1998).

Access to safe water and basic sanitation remains limited though there was some improvement between 1982-1985 and 1990-1996. Whereas access to safe water ranged from 14% in Benin to 52% in Zimbabwe in 1982-1985, in the period 1990-1996 it ranged from 29% in Madagascar to 77% in Zimbabwe. As for basic sanitation, access ranged from 9% in Burkina Faso and Niger to 60% in Malawi in 1982-1985, compared to 9% in Congo to 77% in Kenya in 1990-1996. However, in 13 of the 23 countries in table 2 below, less than 50% of the population had access to basic sanitation.



**Table 2: Selected Social Indicators in Selected Countries**

Country	% of population with access to improved water source		% of population with access to sanitation		% 1-year old fully immunized		Contraceptive prevalence rate (%)
	1982-85	1990-96	1982-85	1990-96	Against TB	Against Measles	
	1982-85	1990-96	1982-85	1990-96	1997-99	1997-99	1995-2000
Algeria	-	-	-	-	97	98	52
Benin	14	50	10	20	100	92	16
Botswana	-	70	36	55	98	74	-
Burkina Faso	25	-	9	18	72	46	12
Congo	-	47	-	9	39	23	-
Gabon	-	-	-	-	60	30	-
Ghana	-	56	26	42	88	73	20
Guinea Bissau	-	-	-	-	25	19	-
Kenya	27	53	44	77	96	79	39
Madagascar	31	29	-	15	66	46	19
Malawi	32	45	60	53	92	90	22
Mali	-	37	21	31	84	57	7
Mauritania	37	64	-	32	76	56	-
Namibia	-	57	-	34	80	65	29
Niger	37	53	9	15	36	25	8
Nigeria	36	39	-	36	27	26	6
Senegal	44	50	-	58	90	60	13
S. Africa	-	70	-	46	97	82	69
Tanzania	52	49	-	86	93	78	18
Togo	35	63	14	26	63	47	24
Uganda	16	34	13	57	83	53	15
Zambia	48	43	47	23	87	72	26
Zimbabwe	52	77	26	66	88	79	48

Source: Extracted from: World Bank, *World Development Indicators 2001* & UNDP, *Human Development Indicators 2001*.

*Increasing food shortages.* Sub-Saharan Africa has been experiencing exceptional food emergencies. About 17 countries face difficult weather conditions, persistent civil strife and insecurity (FAO, 2001). Unusually dry weather conditions that characterized most African countries over the years have caused huge crop losses throughout and have affected cereal production, resulting in reduced access to food for large segments of the population. In countries like Botswana, South Africa, Zambia and Zimbabwe, the maize output, which accounts for over 90 percent of the sub-region's total cereal production, is estimated at 13.7 million tons in 2001, 26 percent lower than in 2000 and below average.

*Increased levels of malnutrition.* Most countries have witnessed increased levels of malnutrition due to declining food per capita. This has continued to weaken the coping mechanisms of most communities and increase vulnerability of women and, especially children, to diseases, child labour and early

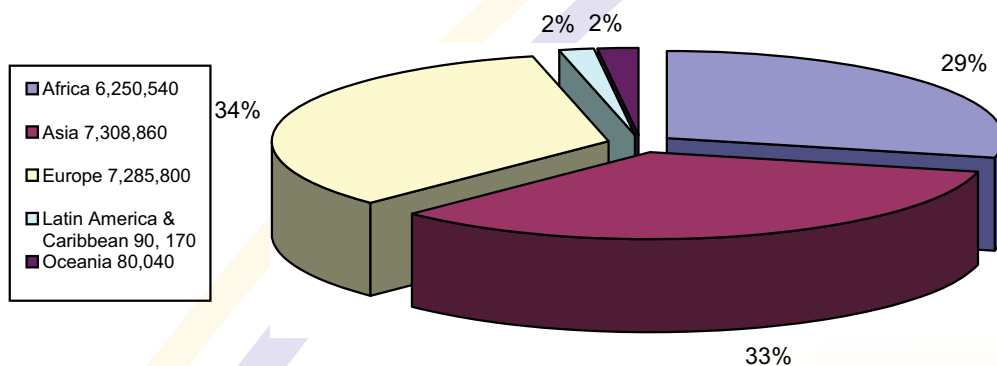
marriages. The declining food per capita has resulted in increased basic food prices, with the poor bearing the brunt of the burden. Malnutrition has increased in most countries as evidenced by the high percentages of malnourished children during the period 1995-2000 (UNDP, 2001) as follows: Benin (29%), Botswana (17%), Burkina Faso (36%), Burundi (37%), Central African Republic (27%), Democratic Republic of Congo (34%), Kenya (22%), Mauritania (23%), Namibia (26%), Niger (50%), Nigeria (31%), Rwanda (27%), Tanzania (27%), Uganda (26%) and Zimbabwe (15%). Slow government response to food deficits and inadequate allocation of funds for timely food purchases for, or transport to, the needy areas has caused serious suffering in most parts of these countries. This has eroded coping mechanisms among the most vulnerable communities. Thus the number of children in need of special protection (CNSPs) has grown rapidly due to increased vulnerability of many African households. Nefarious traditional and cultural practices such as Female Genital Mutilation (FGM) have also overburdened the girl child and subjected them to serious health consequences. Countries like Kenya and Sierra Leone have recorded FGM rates above 50 percent (WHO, 1998a).

*Increased conflicts and political crises.* Africa's social situation has continued to deteriorate with increased armed conflict and political crises in countries like Nigeria and Sierra Leone. In addition, countries like Kenya, Tanzania, Uganda, Zambia and Zimbabwe are recording increased influx of refugees from neighboring countries, namely Burundi, the Democratic Republic of Congo Eritrea, Ethiopia, Rwanda and Sudan. These countries have thousands of internally displaced persons who have sought refuge in neighboring countries, thereby increasing the burden on food requirements of the host countries. UNHCR (2000) global refugee statistics indicate that Africa shares a large proportion of the world refugees (29%) (see Fig. 3). Conflict escalation and ongoing civil wars have disrupted production and health delivery in countries already without adequate structures, experiencing persistent drought and famine. In most of the war-torn countries, health posts and health personnel have become targets of savage attacks by rebels and terrorists groups, thereby hampering efforts in health care delivery.

WHO estimates that the number of civilian losses in current conflicts borders on 90 %, the majority of which are women and children. Violence against women and children and the damage that results from it are unacceptable. These conflicts increase all forms of violence including sexual violence, resultant unwanted pregnancies, forced displacements and famine. These armed conflicts are now major challenges confronting PHC, a major means of achieving Health For All.



**Fig. 3: Global Refugees Statistics, 2000 Estimated number of persons of concern, by region**



Source: UNCHR (2001), *Refugees by Numbers 2000 Edition*

Education levels. The worsening economic crisis has jeopardized progress achieved in the social sectors especially in education, with about 110 million primary school-age children in developing countries out of school (World Bank, 2001). Adult literacy levels have varied from country to country. In the period 1985 to 1990, adult literacy in Africa was below 30 % in 8 countries; between 30 % and 50 % in 4 countries; between 50 % and 70 % in 10 countries and above 70% in 5 countries (WHO, 1994a). The rate of adult literacy, which was very low in the 80s, improved sharply, especially in the 90s. It was, on average, 46 % for males and 25 % for females in 1980 and by 1995 it had reached 60 % for males and 39 % for females. Poor families have had to bear the added burden of the introduction of cost-sharing facilities, and hence have limited access to education, especially for girls. Low literacy levels among women have severely affected the nutritional status of the children.

It should be noted that education and literacy levels have a great influence on peoples knowledge, skills, aptitude and attitudes and hence behaviors, which are very important health determinants.

*Population growth rates.* The African population growth has continued to rise over the years (Table 3), with almost two-thirds of the countries having rates above 3 percent.

**Table 3: Population Growth in Countries of the African Region, 1980-1999**

Country	Millions of people											Average annual percentage growth		
	1980	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	75-84	85-89	90-MR
Angola	7.02	9.23	9.59	9.94	10.29	10.63	10.97	11.32	11.66	12.00	12.35	2.7	2.8	3.3
Benin	3.46	4.74	4.88	5.03	5.18	5.33	5.48	5.63	5.79	5.95	6.11	2.9	3.2	2.9
Botswana	0.91	1.28	1.31	1.35	1.39	1.43	1.46	1.50	1.53	1.56	1.59	3.6	3.5	2.6
Burkina Faso	6.96	8.88	9.09	9.31	9.53	9.76	9.99	10.23	10.47	10.73	11.00	2.4	2.4	2.4
Burundi	4.13	5.46	5.60	5.75	5.89	6.02	6.16	6.29	6.42	6.55	6.68	2.5	2.9	2.3
Cameroon	8.66	11.47	11.80	12.13	12.47	12.823	13.18	13.55	13.92	14.30	14.69	2.8	2.9	2.8
Cape Verde	0.29	0.34	0.35	0.35	0.36	0.37	0.38	0.39	0.40	0.42	0.43	1.0	1.9	2.5
Central African Republic	2.31	2.94	3.01	3.08	3.15	3.22	3.29	3.35	3.42	3.48	3.54	2.4	2.4	2.1
Chad	4.48	5.75	5.89	6.06	6.25	6.46	6.71	6.89	7.09	7.28	7.49	2.4	2.4	3.0
Comoros	0.34	0.43	0.44	0.46	0.47	0.48	0.49	0.50	0.52	0.53	0.54	-	2.6	2.6
DRC	27.01	37.36	38.60	39.87	41.16	42.49	43.85	45.25	46.71	48.22	49.78	3.1	3.4	3.2
Congo	1.67	2.22	2.28	2.35	2.42	2.49	2.56	2.63	2.71	2.78	2.86	2.9	2.9	2.9
Cote d'Ivoire	8.19	11.64	12.00	12.37	12.75	13.13	13.53	13.89	14.21	14.49	14.73	3.9	3.4	2.8
Eq. Guinea	0.22	0.35	0.36	0.37	0.38	0.39	0.40	0.41	0.42	0.43	0.44	2.4	3.4	3.5
Eritrea	2.38	3.14	3.22	3.31	3.39	3.48	3.57	3.67	3.77	3.88	3.99	2.6	3.0	2.7
Ethiopia	37.72	51.18	52.95	54.79	53.30	54.89	56.53	58.23	59.75	61.27	62.78	2.8	3.2	2.3
Gabon	0.69	0.96	0.99	1.02	1.05	1.07	1.10	1.13	1.15	1.18	1.21	3.2	3.4	2.6
Gambia	0.64	0.92	0.96	1.00	1.04	1.08	1.11	1.15	1.18	1.22	1.25	3.1	4.1	3.6
Ghana	10.74	14.87	15.31	15.76	16.20	16.64	17.08	17.52	17.98	18.46	18.95	2.3	3.5	2.7
Guinea	4.46	5.76	5.93	6.10	6.26	6.43	6.59	6.76	6.92	7.08	7.25	1.7	2.8	2.6
Guinea Bissau	0.80	0.97	0.99	1.01	1.03	1.06	1.09	1.11	1.14	1.16	1.18	3.7	2.3	2.2
Kenya	16.63	23.55	24.28	24.98	25.66	26.31	26.92	27.54	28.16	28.79	29.41	3.8	3.7	2.5
Lesotho	1.35	1.72	1.76	1.80	1.84	1.89	1.93	1.97	2.01	2.06	2.11	2.5	2.5	2.3
Liberia	1.88	2.44	2.48	2.54	2.60	2.66	2.73	2.81	2.88	2.96	3.04	3.2	2.3	2.5
Madagascar	8.87	11.63	11.89	12.20	12.55	12.92	13.30	13.72	14.15	14.59	15.05	2.6	2.8	2.9
Malawi	6.18	8.51	8.74	8.99	9.24	9.49	9.76	10.02	10.28	10.53	10.79	3.2	3.4	2.7
Mali	6.59	8.46	8.70	8.95	9.20	9.45	9.71	9.99	10.29	10.60	10.91	2.2	2.7	2.9
Mauritania	1.55	2.03	2.08	2.14	2.20	2.26	2.33	2.39	2.46	2.53	2.60	2.5	2.8	2.8
Mauritius	0.97	1.06	1.07	1.08	1.10	1.11	1.12	1.13	1.15	1.16	1.17	1.4	0.8	1.1
Mozambique	12.10	14.15	14.42	14.69	15.01	15.42	15.82	16.23	16.63	16.95	17.26	2.7	1.0	2.2
Namibia	1.03	1.35	1.39	1.42	1.46	1.50	1.54	1.58	1.62	1.66	1.70	2.7	2.8	2.9
Niger	5.59	7.73	7.99	8.26	8.54	8.84	9.15	9.47	9.80	10.14	10.49	3.3	3.2	3.4
Nigeria	71.15	96.20	98.98	101.88	104.89	108.0	111.27	114.50	117.68	120.82	123.9	3.1	3.0	2.9
Rwanda	5.16	6.95	7.15	7.35	7.54	6.23	6.40	6.73	7.90	8.11	8.31	3.3	3.0	1.4
Sao Tome & Principe	0.09	0.12	0.12	0.12	0.13	0.13	0.13	0.14	0.14	0.14	0.14	1.5	2.8	2.6
Senegal	5.54	7.33	7.50	7.69	7.90	8.11	8.33	8.56	8.79	9.04	9.29	2.9	2.8	2.7
Seychelles	0.06	0.07	0.07	0.07	0.07	0.07	0.08	0.08	0.08	0.08	0.08	1.4	0.7	1.5
Sierra Leone	3.24	4.00	4.09	4.19	4.29	4.40	4.51	4.63	4.75	4.85	4.95	2.0	2.2	2.4
S. Africa	27.58	35.20	35.93	36.69	37.47	38.28	39.12	39.91	40.67	41.40	42.11	2.3	2.5	2.0
Swaziland	0.57	0.77	0.79	0.82	0.85	0.87	0.90	0.93	0.96	0.99	1.02	3.2	3.2	2.9
Tanzania	18.58	25.47	26.28	27.10	27.94	28.79	29.65	30.49	31.32	32.13	32.92	3.2	3.2	2.9
Togo	2.62	3.51	3.64	3.75	3.87	3.99	4.11	4.23	4.35	4.46	4.57	2.8	3.0	3.0
Uganda	12.81	16.33	16.89	17.46	18.03	18.60	19.17	19.74	20.32	20.90	21.48	2.4	2.6	3.1
Zambia	5.74	7.78	8.02	8.26	8.50	8.74	8.98	9.21	9.44	9.67	9.88	3.4	3.0	2.7
Zimbabwe	7.01	9.75	10.02	10.28	10.53	10.78	11.01	11.24	11.47	11.69	11.90	3.1	3.3	2.3

Extracted from: World Bank (2001b), *African Development Indicators, 2001*.

During the last three decades, fertility rates decreased sharply worldwide, save for sub-Saharan Africa. The 22 French-speaking countries in the Region had, for example, an average growth rate of 5.27% in 1999. The highest was in Niger (6.6%) and the lowest in Mauritius (1.9%). Young people constitute the majority of the population in these countries, with those below the age of 18 years, on average, making up 52.8% of the population.

This trend has continued to threaten the ability of countries to provide for their population, given the disproportionate slow growth in GDP. The high population has been attributed to persistently high levels of fertility, which show no sign of abating, due to early childbearing, low literacy levels and low levels of contraception use (see table 3). The increased influx of migrants from rural areas to urban centers, coupled with the high influx of refugees from neighboring countries, has also contributed to increased burden on the social services. As a result, many countries have recorded increased disease outbreaks, especially waterborne diseases due to inadequate sanitary facilities and unsafe drinking water.

However, the annual growth rate of the 1990's has declined in some countries. This is partly explained by the high HIV/AIDS prevalence rates, with about eight African countries having at least 15 percent of adults infected. The increasing HIV prevalence rates are envisaged to further reduce the population growth rates. However, as a large proportion of the population of most developing countries is in peak reproductive years, the number of children born each year will continue to increase, albeit at a lower percentile rate than in previous years. This disproportionate population growth compared to the availability of basic social services has continued to challenge the provision of PHC.

# CHAPTER 4:

## PHC AND NATIONAL HEALTH POLICY FORMULATION

PHC policy formulation in Africa has been stimulated by three important events: (i) the adoption in 1977 by the World Health Assembly of “Health for All by the Year 2000”<sup>2</sup>, (ii) the adoption of the Alma-Ata Declaration<sup>3</sup> by the 1978 International Conference on PHC in which “Primary Health Care” was seen as the strategy for achieving “Health for All”, and (iii) the adoption in 1981 by the World Health Assembly of the “Global Strategy for Health for All by the Year 2000”. Most African countries’ health policy documents and national development plans indicate having addressed some, if not all, elements of the primary health care approach, and this was done much before its formal introduction and adoption in 1978 by the international community.

### *National Health Policies and PHC*

A review of the governments’ policy documents and national development plans indicates that the adoption of PHC strategies has been given priority. In Botswana, the country’s five-year national development plan clearly sets the goal of achieving health for all through the primary health care strategy. Burkina Faso adopted PHC as a core strategy for health development, and PHC was an entry point for the national health development plans developed in 1986-90 and 1991-95. In Kenya, the government’s commitment in reinforcing PHC was emphasized in the development plan (1980-84) as well as in subsequent plans of 1984-88 and 1989-93. In particular, the Kenya 1989-93 national development plan provides a general framework for PHC development. The effective launch of PHC in the Democratic Republic of Congo took place in 1985, while the PHC approach in Malawi was emphasized in the country’s development plans. The country’s national health plan (1986-1995) integrates the PHC approach as the main strategy of achieving health for all. In 1984, the Ministry of Health in Guinea developed a National Health Policy adapting PHC to national and regional specificity. The Republic of Congo initiated the PHC approach in 1979 and emphasis on the essential PHC components was expressed in the health plan for 1982-1986. In Namibia, the PHC approach was clearly articulated in the health policy documents and the launch of the PHC/CBHC guidelines in 1992, increasingly indicate the government’s commitment to PHC. The Tanzania health policy is commensurate with PHC and this is clearly indicated in its long-term development plan for 1980 to 2000.

### *Policy formulation process*

The level of commitment in formulating PHC policies in most countries of the African Region has been high.

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<sup>2</sup> In May 1977, the thirtieth World Health Assembly adopted resolution WHA 30.43 in which it decided that the main social target of governments and of WHO in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life, which is popularly known as “health for all by the year 2000”.

<sup>3</sup> International Conference on Primary Health Care held in Alma-Ata, U.S.S.R., 6-12 September 1978

In Zambia, for example, initial attempts in policy formulation started by establishing the National Coordinating Committee which drew members from the United National Independence Party, the churches' medical association, and relevant government ministries such as Agriculture and Water Development; Education; Information and Broadcasting; Finance; and Community Development (Kasonde et. al. 1994). Although this process failed, the government's commitment in developing dialogue in policy formulation was evidenced in the formation of the Primary Health Care Committee, which spearheaded the process. Health personnel at national and provincial levels were chosen to initiate the process.

Following the Alma Ata Declaration in 1978, the government of Burkina Faso adopted in 1979 the strategy of PHC as the means for health development. Adhesion to the strategy was manifest by the development in 1979 of the national 5-year strategic health plan (1979-1981) that took into account the PHC strategy which has, among other principles, community participation in the organization and management of health services and inter-sectoral collaboration. In September 1993, within the framework of Bamako Initiative implementation, they developed a national document on strengthening PHC. Real technical decentralization started with the creation of 53 health districts and provision of autonomy for the management of hospitals and peripheral health facilities. The National Health Policy of 1980 served as the reference framework for PHC implementation for a period of 20 years. A new one was developed in 2000 to guide the management of PHC

Kenya launched a pilot project in Kakamega in 1977 in order to assess the potential for community participation in health care delivery. Drawing on experiences of the pilot project, it concluded that community participation was a feasible approach of formulating and implementing PHC. The communities can be actively involved in decision-making concerning their priorities in health promotion and disease prevention. By 1986, the Ministry had started CBHC projects in 14 districts and established a CBHC unit within the Ministry to coordinate all the CBHC activities in Kenya.

At the Regional Committee Meeting in Bamako, Mali, in 1987, the Ministers of Health adopted an innovative strategy for intensifying PHC. The Bamako Initiative (BI) aimed at revitalizing primary health care at the district level. It focused on four issues, namely (i) the need for PHC self-financing mechanisms at district level; (ii) encouragement of social initiative to promote community participation in policies on essential drugs and child health; (iii) ensuring regular supply of essential drugs of good quality at lowest cost in support of PHC; and (iv) introduction of self-funding mechanisms at district level, especially by setting up revolving fund for essential drugs.

In Namibia, the first step in formulating PHC policies was through holding the first inter-sectoral workshop in Oshakati in February 1991. The workshop adopted a participatory approach to reaching a consensus on the concepts, processes and implementation of PHC at national level, raising awareness of decision makers on the conditions of communities in rural areas; developing action plans for the regions and districts; and developing a draft guideline for the implementation of PHC/CBHC (Ministry of Health and Social services (MOHSS), Namibia, 1992). The follow-up regional and district workshops held in Rundu, Oshakati, Windhoek and Okakarara sought to develop a shared understanding of PHC concepts at the regional and district levels. In addition, the workshops managed to train a total of 217 trainers (TOTs); developed training curricula and modules for TBAs and HCWs; and designed district plans of action for the implementation of PHC/CBHC programmes.

## *Marketing process*

Virtually all countries have made considerable effort to market the PHC policy formulation process as indicated in the health policy documents. Commitment in formulating and marketing the PHC policy has been witnessed in most countries through extensive consultations with national officials, regional health directors, district health managers, NGOs and private providers. Extensive public consultations were held at the beginning and during the policy formulation process. Major actors involved in the consultation process have included ministries of, for example, health, planning, water, education, finance and community development. The ministries of health also liaised a lot with other major stakeholders such as the communities, regional and international organizations active in the field of PHC, for example AMREF, Aga Khan Foundation, International Red Cross (IRC), UNDP, UNICEF, WHO etc.. One of the commendable achievements of these consultations is the formation of PHC committees at all levels, in the communities and at the national level.

Regional and district workshops and consultations have provided countries the opportunities to examine the PHC policies and make appropriate recommendations. They have also raised inter-sectoral awareness. International agencies like WHO, UNICEF and SIDA gave support to ministries of health in most countries in the organization of series of workshops for consensus building on PHC policy formulation. These workshops have brought together a wide range of experiences of stakeholders, including the private and public sectors, NGOs, donors and the communities. The recommendations emerging from these consultations are providing the basis in developing and improving guidelines for the implementation of PHC.

## *Incorporation of PHC principles and elements*

Following the Alma Ata Declaration in 1978, most countries reviewed their national health policies, and the review of national development plans indicate that these countries have incorporated the principles and elements of the PHC approach. Kenya was noted to have introduced and integrated two additional elements to make a total of ten namely, mental health and dental health.





# CHAPTER 5:

## PHC STRATEGY IMPLEMENTATION

The adoption of the PHC strategy meant that attention should be given to the principles of universal access, equity, community participation, appropriate technology and inter-sectoral coordination as important considerations in developing health systems. Although countries developed their respective national guidelines for the implementation of PHC, literature review points to a discrepancy between policy formulation and implementation. Making PHC the central function and the main focus of health systems has remained a big challenge for most countries (Macdonald, 1993). Macdonald further points out that the challenge presented by PHC was so great that almost as soon as the approach was declared and programmes to implement it were launched, opposition to it became institutionalized and ‘selective PHC’ was born.

### Principles of PHC.

#### *Universal access:*

Many countries developed a two-, three- or four- level hierarchical health care system. A common hierarchical health system structure is presented in figure 4. The structure comprises the ministry of health as the tutelage structure, teaching or referral hospitals, regional/provincial hospitals, district hospitals and health centres. The ministry of health sets policies and directs the strategic health system management. The provincial/regional level acts as the intermediary between the central level and the districts. The provincial/regional health management teams and boards (PHMTs/PHMBs) were constituted to oversee the implementation of health programmes in the province. The district health management teams and boards (DHMTs/DHMBs) were constituted to oversee health activities in each district. The district level is the main PHC operational unit, led by the district medical officer (DMO) who spearheads the DHMT. The health centres, dispensaries and village health posts support PHC implementation at the local level. In most countries, the structures for working with the communities are the village health committees (VHCs) and health centre management teams (HCMTs).

Countries have set different guidelines for establishing health centres and district hospitals. In some cases, the health centres are established such that each serves a specified population like 5 000 to 10 000 people or people within a radius of eight kilometers, or such that people within the catchment area can reach the health centre within one hour travel time. District hospitals are set up such that each serves a district or a population varying between 100 000 and 500 000.

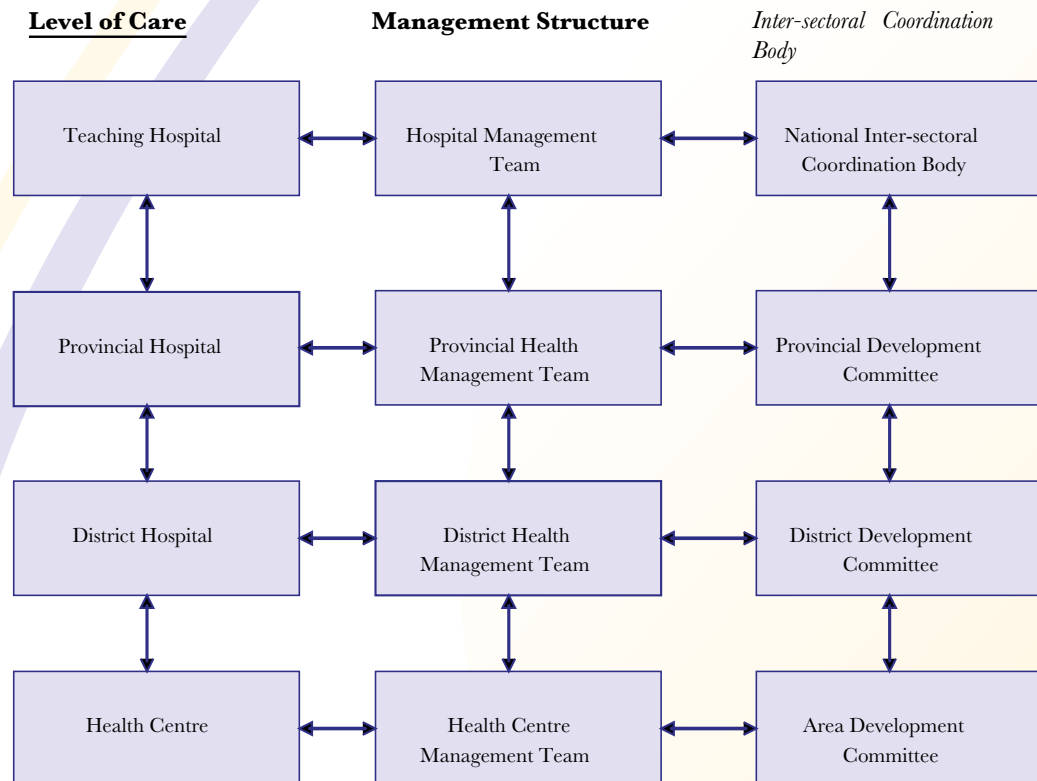
In order to ensure cost effectiveness, there is a strong advocacy for use of the referral system, right from the most peripheral level (community level) or primary care level (health posts and centres), through the intermediate level (district, regional or provincial) to the central level.



Service delivery was expected to be in an integrated manner in all health facilities, ranging from treatment of common ailments to disease control, antenatal care, care of the sick child to immunization and other preventive care. It was meant to ensure that there would be no missed opportunities. This has presented special challenges in terms of the need for health workers with generalist skills, especially at health centre and district levels.

However, it is evident that ministries of health in the countries did not share the same vision. While some viewed PHC as providing for service delivery through the already existing referral structures, others viewed it as a vertical programme that had to be implemented in parallel to other existing programmes and coordinated by PHC committees at the ministerial, provincial, district and local levels. However, these PHC coordinating structures have been criticized as having resulted in unnecessary duplication of efforts.

**Fig. 4: Hierarchical Health Care System**



## *Equity:*

Equity in health was understood to mean fair share of, and opportunities in, distribution and access to health resources and services. This was especially pertinent, considering the inequitable health systems most countries had inherited at independence. Countries developed national health policies stating equity as one of the objectives and indeed the infrastructure development initiatives focusing on the rural areas were meant to operationalize this objective. Unfortunately, it meant a reallocation of limited resources, which led to taking away resources from the already under-funded services serving the urban elite, who were the new decision makers. The equity policy objective was therefore not fully implemented.

There are huge disparities in allocation of resources between the rural and urban area, access to services is similarly skewed and the health outcomes as shown by infant and maternal mortality rates confirm the disparities.

In some countries, indigenous NGOs have been set up such as EQUINET and the Health Systems Trust in Southern Africa to spearhead the equity agenda.

Though countries indicated commitment to equity, this has not been realized and a lot more needs to be done.

## *Community participation*

Community participation was seen as a process of involving the community by promoting dialogue with, and empowering, communities to identify their own problems and solve them. Participation of the community in PHC was evidenced in most countries through the formation of community health committees, village health committees and health centre or area health committees and the selection of community health workers for training. Furthermore, community representatives were included in health facility or inter-sectoral management structures such as district health boards, district development committees and hospital management boards.

The management committees represent a very important element in the institutional setting of the system in regard to their main role in planning, management and control of health services. They form an interface between the health system and the population and hence represent and promote the people's participation and ownership. Unfortunately in some countries, as was the case of Mauritania, less than 10% of these committees were found to be operational. This problem may be associated with the way in which the members of the committee were chosen, which was often based on criteria other than consideration of the required expertise. More often than not, the chairperson of the committee is the political leader who may not even be staying in the locality.

A major challenge with community participation has been the capacity of the community representatives and relevant national structures to support it. Some countries responded by developing guidelines on what was expected of the communities and committed to train and support the communities. Nonetheless, community involvement, beyond paying for services and providing labour for work carried out at health facilities, has been one of the most challenging and difficult aspects of PHC implementation (Jarret and Ofosu-Ammah, 1992).

Community health workers (CHWs) have contributed significantly to programme effectiveness in many community-based programmes. Despite the structures in place to manage the work of CHWs, their operation has been hampered by the weak managerial capacities of the community and the high illiteracy rates. Although community participation has been argued as the core of PHC policies, it has largely remained problematic, calling for more review and definition.

Whilst the role of community health workers in achieving greater and quicker service coverage is well recognized, the village health worker programmes in many countries have disintegrated. The concept of traditional birth attendants (TBA) still exists but is still not widely promoted, given the new emphasis on the need for skilled attendants.

Besides, the role of the traditional health practitioners, who are providing a lot of services to the community, does not seem to be well integrated into national health systems.

Although ensuring qualified personnel-assisted deliveries is one of the pillars of the Safe Motherhood Initiative, the contribution of unassisted deliveries to maternal mortality still remains significant. The promotion of the traditional birth attendants programmes was launched in the 1970s, supposedly as a transitory measure. However, qualified personnel to assist deliveries are limited and, often concentrated in big cities. Studies have shown limited capacity to detect signs that predict unwanted outcomes of pregnancy by traditional birth attendants. It was also noticed that the antenatal care provided was not of adequate quality. Subsequently, it is not surprising to notice enormous disparities in the maternal mortality rates between the urban and rural populations. Some countries are significantly dependent on community health workers (CHWs) and traditional birth attendants to assist childbirth, especially in rural areas.

In revisiting community participation, David et. al (1998) highlight three main difficulties with the conceptualization and evaluation of community participation. These are (i) the great variety of health indicators using community participation as a strategy, (ii) the complexity of community participation and (iii) what community participation itself is understood to mean. The same authors recommend the need to develop community structures that take into account the needs, resources, social structures and values of the community.

### ***Inter-sectoral collaboration***

The need for the health sector to play a leading role in health and to coordinate and establish synergic relations with other sectors that have an impact on health was seen as one of the major contributions of the PHC strategy in health development. This was because there were no existing institutional mechanisms to guarantee that health objectives were prioritized and made an integral part of policies and programmes in other sectors.

Review of national development plans of all countries now show that inter-sectoral collaboration is being widely advocated as one of the key principles of PHC implementation. In Botswana, for example, the Rural Development Councils (RDC) were organized with the objective of promoting greater inter-sectoral collaboration by integrating other sectors such as planning, rural development, finance and development planning.

The development committees set up at different levels in most countries had the same objective. However, WHO (1994b)<sup>4</sup> notes that the envisaged inter-sectoral collaboration has remained non-functional partly due to lack of funds as well as lack of clarity of roles and responsibilities. In Malawi, inter-sectoral collaboration both within the public sector and with the private sector has been extensively explored for two main reasons, namely (i) dwindling resources and increasing demands on the sector, and (ii) realization that the dual health care provision system is promoting inequities by leaving large areas underserved by “free” public facilities introduced at independence.

In general, it is evident that most countries have established national health councils and primary health care committees at all levels to promote both inter-sectoral and intra-sectoral collaboration. Despite these committees, however, collaboration has been done in an ad hoc basis rather than in a formal way with clearly designated structures and well-defined motives. As a result, there seems to be a lack of general understanding among the different stakeholders of their roles in PHC. WHO (ibid) evaluation cited important constraints in inter-sectoral collaboration in health to include the following (i) the lack of a permanent multi-sectoral collaboration in the field, (ii) close organizational structures and the specialized nature of public health services, (iii) low financial resources, (iv) underestimation by health care authorities of the potential of other sectors in addressing health problems (v) increasing social and economic difficulties (vi) frequent political instabilities and (vii) the differing donor expectations and requirements.

### *Appropriate Technology:*

Adherence to the principle of using appropriate technology of proven effectiveness and safety was intended to be a cost-containment measure. Limited success was reported in this area. Perhaps the greatest achievement is the incorporation of generic drugs concept into national drugs policies. Other examples include attempts at standardizing equipment purchased for use in health institutions, use of the cheapest but effective technology like basic radiological units, use of locally-prepared sugar and salt solution for treatment of diarrhoea and, recently, the development of rural or bush ambulances using donkey draught power, bicycles and motorcycle engines.

Despite these developments and, perhaps, due to pressure from the global pharmaceutical industry, medical equipment manufacturers, the health professions and indeed the populations at large, countries have had to spend large sums of money on highly sophisticated technology when cheaper options are available. This challenge continues to grow especially as globalization takes root and health profession’s education, training and practice continues to be driven by the medical model instead of the health model

### *The Bamako Initiative*

Disappointed by progress towards Health for All, African health ministers adopted the Bamako Initiative in 1987 as a strategy for accelerating PHC implementation (WHO/UNICEF/Government of Mali, 1999) and ensuring access to essential health services to the majority of the population.

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<sup>4</sup> See WHO (1994b), Implementation of the Global Strategy for Health for All by the Year 2000. Eighth report on the world health situation.

The initiative placed emphasis on (i) the promotion and implementation of a minimum package of services; (ii) access to drugs at affordable cost; (iii) cost-sharing between government and users and, (iv) effective participation of the community in the local management of the health system.

The implementation of this initiative gave a second breath of life to the PHC implementation process. It allowed, in all countries where it was applied rigorously, to scale up PHC implementation, resulting in a net improvement in the availability of resources and, consistently, its more effective functioning. For example, in Central African Republic, 65.2% of the population had access to health services within a radius of 5 km in the year 2000 as compared to 45% in 1995 (RCA 1994-1995), though leaving approximately 20.4% of the population having to travel more than 10-15 km to reach a health facility.

Experience from the Bamako Initiative or similar numerous projects, such as the cost-sharing scheme in Botswana, Ghana, Kenya, Niger, Nigeria, Tanzania, Zambia and Zimbabwe, have been diverse. The report on the review of Bamako Initiative implementation in Africa held in Bamako, Mali, in 1999 indicated that countries were at different stages of implementation. While certain countries applied BI in all their districts, the others were able to expand to only some districts of the country. Eighteen of the 22 French-speaking countries in the Region, which benefited from the support of UNICEF in 1991 to implement the BI, covered only 34 % of 1048 districts. Except for Benin and Guinea, the other countries took long to start implementation of BI. The government of Guinea, in collaboration with UNICEF, WHO, World Bank and the Italian Government, initiated in 1988 the implementation of Bamako Initiative in order to strengthen PHC. Burundi, Cameroon, Mali, Mauritania, Senegal and Togo integrated BI only in 1991 (UNICEF, 1992). Other French-speaking countries like Côte d'Ivoire, Central African Republic and Congo Brazzaville were able to effectively start only in 1992.

The user fee system received most attention as an alternative source of financing, due to its perceived role in mobilizing resources, promoting efficiency, fostering equity, increasing decentralization and sustainability. Some surveys (Nolan & Turbat, 1993) indicate that most countries in Africa that tried to offer free health services later introduced some form of fee system for government facilities, for example Kenya, Tanzania and Zimbabwe.

A survey of health insurance in 23 African countries between 1971 and 1987 indicated that only seven countries (30 %) had formal health insurance systems (Vogel, 1990; Shaw and Griffin, 1995). A recent study on fifteen countries reveal that health insurance coverage ranges from less than 10% of the population in most countries to about 15 % in Burundi and 25% in Kenya (Nolan and Turbat, 1993).

Achievements with the Bamako Initiative have been notable in the following areas: promotion and implementation of a minimum package of activities (MPA); revitalization of health centres, constant availability of essential drugs at affordable cost; cost sharing; and an effective participation of the population. The availability of essential drugs at an affordable cost in Kenya, for example, was achieved by the sale of essential drugs through community pharmacies, which clearly reduced both financial and geographical barriers to access (Kara & Mcpake, 1993).



## *Health Sector Reforms*

In order to meet growing health needs and supported by institutions like the World Bank as part of the economic structural adjustment programmes, countries have embarked on health sector reforms. Much effort targeted rationalization of the ministry of health, decentralization of the planning, management and implementation of health services to the districts, introduction of new mechanisms for health care financing and recognition of the role of the private sector, NGOs and other actors in health care provision.

The WHO Regional Office for Africa (AFRO) has tried since 1978 to help Member States implement PHC, based on the district health systems approach. It organized several orientations on the subject and developed many documents to popularize, orient and give methodological guidance in order to promote the implementation of the approach in the countries of the Region.

AFRO also facilitated dialogue among actors in the health sector, putting at their disposal manuals, brochures and guidelines on the PHC approach. WHO's leadership in PHC promotion was never found to be wanting. However, innovative measures were sometimes introduced too frequently to countries such that their health systems had problems in applying them correctly.

In the early 1990s, Ghana began taking a series of actions towards restructuring its health sector, including developing a basic minimum package of services; refocusing emphasis on PHC including reproductive health; decentralizing greater management and financial responsibility to districts; de-linking health service delivery from the Civil Service; and reviewing the organizational structure of MOH to reflect a shift from vertical systems to a more functional horizontal system (Dovlo, 1998). In Zambia, the main streams of decentralization involved decentralization to local governments as part of the public health sector reform programme and the second stream of decentralization policy is specific to the health sector as set out in the government health reforms (Chongo & Milimo, 1996).

Comparing the vertical decentralization of Zambia where only the health sector was decentralized with the holistic decentralization of Uganda, it has been concluded that neither form of decentralization has so far led to a clear and appreciable improvement in health services (Okunzi and Jeppsson, 2000). In Nigeria, the decentralization of health responsibilities within the three-tier system of government has facilitated distribution of human, material and financial resources.

These initiatives aimed to achieve greater equity of access to services, improved efficiencies in resource utilization, development of wider linkages with communities and other partners, as well as improved quality of health services. Yet, there has been no improvement in health systems performance. In fact, evidence available shows that in many countries the health status of the people has worsened.

## Elements of PHC.

### *Education on prevailing health problems and control and prevention methods*

Education on health problems and the methods for controlling and preventing them addresses the broad determinants of disease and ill-health in the Region, with the aim of promoting health. Countries have adopted varying mixes of health education and promotion approaches. According to a WHO survey,<sup>5</sup> out of 37 countries, 15 had health education; 11 had information, education and communication; 5 had health promotion; 2 had information, education and communication and health education; 1 had information, education and communication and social mobilization; while 2 had no specific approach.

Since 1986, WHO and her key partners have convened at least five global health promotion conferences. In the conference in Mexico, in June 2000, the participants from Africa called upon AFRO to develop a regional health promotion strategy adapting the Mexico framework for the development of health promotion within the African context. In response, the Regional Committee in 2001 adopted the health promotion strategy for the African Region. The strategy aimed to foster actions that enhance the physical, social and emotional well-being of the people and contribute to the prevention of the main causes of disease, disability and death.

### *Promotion of food supply and proper nutrition*

Many of the policies pursued by African countries during the 1970s and 1980s successfully achieved aggregate national food security but did not achieve adequate consumption by all individuals and groups within the country (FAO 1992e). To meet domestic demand, maximize food production and increase marketed supplies of food, many African countries embarked on food security strategies focused on achieving food self-sufficiency during the late 1970s and early 1980s, using policies designed to maximize domestic output of staple crops. (FAO 1997, Agriculture, food and nutrition).

Consequently, since the 1980s the availability of basic staple food for consumption has expanded by 30% for cereals and cereal products, 40% for roots and tubers, 35% for pulses, and 35% for oil crops. (FAO, 1995f). However, the estimated annual rate of population growth for the last three decades was about 3 percent compared to the rate of food production growth of around 2 percent (FAO 1995f).

Data from FAO show that the proportion of chronically undernourished people in Africa rose from 38 to 43 percent between 1969 and 1992. It is estimated that about 215 million people in sub-Saharan Africa suffer from chronic under-nutrition. Anaemia affects another 206 million people while 181 million and 52 million are at risk of iodine deficiency disorders and vitamin A deficiency.

<sup>5</sup> A questionnaire was sent to countries and these were the responses which were received by September 2000.

Healthy market places initiative was introduced in the Region to promote safety and wholesomeness of foods sold in the markets. A few countries like Tanzania, Nigeria and Mozambique are undertaking the initiative and it is to expand to other countries.

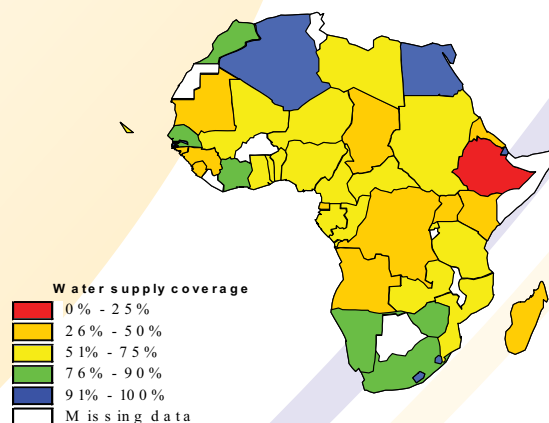
### *Adequate supply of safe water and basic sanitation*

Over the past twenty years water and sanitation coverage increased markedly from 32% water coverage in 1980 to 56% in 1999, and from 28% sanitation coverage in 1980 to 55% in 1999. However, there was a decline from 56% coverage in 1990 to 55% coverage in 1999 for sanitation (AFR/WSH/00.3).

Although all countries of the Region had some type of guiding policies for water and sanitation development, many did not have legal enactments or formal written statements for the sector. The majority of countries in the Region merely drew their water and sanitation policy guidance from general development policies, national development plans, or in some cases water Acts. However, during the International Drinking Water and Sanitation Decade (1981-1990), decade plans were prepared for water and sanitation planning in nearly all countries of the Region, setting out their national needs, priorities, goals and targets.

The map and the figure below show the water supply and sanitation coverage in Africa for 1990 and 2000.

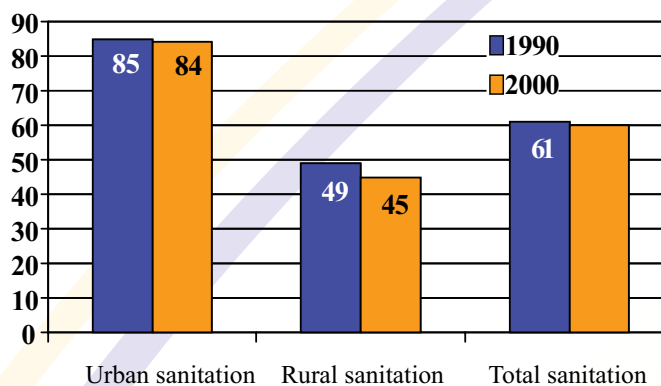
**Figure 5: Water Supply Coverage in Africa, 2000**



Source: *Global Water Supply And Sanitation Assessment 2000 Report. WHO and UNICEF Joint Monitoring Programme For Water Supply And Sanitation. 2000. Page 43.*

The major constraints for water and sanitation sector development in the Africa Region are, in the order of importance, as follows: limited funding; inadequate logistics; inadequate operation and maintenance; inadequate or outmoded legal framework; and inappropriate institutional framework



**Figure 6: Sanitation Coverage in Africa, 1990 and 2000**

Source: *Global Water Supply And Sanitation Assessment 2000 Report. WHO and UNICEF Joint Monitoring Programme For Water Supply And Sanitation. 2000. Page 43.*

### *Maternal and child health care, including family planning*

The maternal mortality rate (MMR) in the Region is the highest in the world, averaging around 1000 deaths per 100,000 live births, with disparities among countries and between urban and rural areas. The high MMR, combined with low contraceptive prevalence rate of 13% and high fertility rate—estimated at 5.6 children per woman, increases the lifetime risk of maternal death—estimated at 1:14. In some countries of the Region, 25 % to 27 % of first birth occurs among adolescents. Adolescent childbearing contributes significantly to maternal death risk, accounting for up to 40% in some countries. Lack of access to reproductive health services, including counseling and family planning, contributes to the high incidence of post-abortion complications.

The 47th session of the Regional Committee of WHO in September 1997, in the bid to accelerate reduction of maternal and peri-natal mortality and disability, adopted the Regional Strategy on Reproductive Health. The strategy focuses on critical issues, which include access to efficient antenatal care; provision of hospital-based treatment for pregnant women with life-threatening complications; transport and communication; and strengthening of the health care system. To address the adolescent health problems, the 51st session of the Regional Committee adopted the Adolescent Health Strategy for the African Region. The strategy aimed to identify and respond to the health needs of adolescents as well as promote their health development, through their involvement and that of their parents, families and communities.

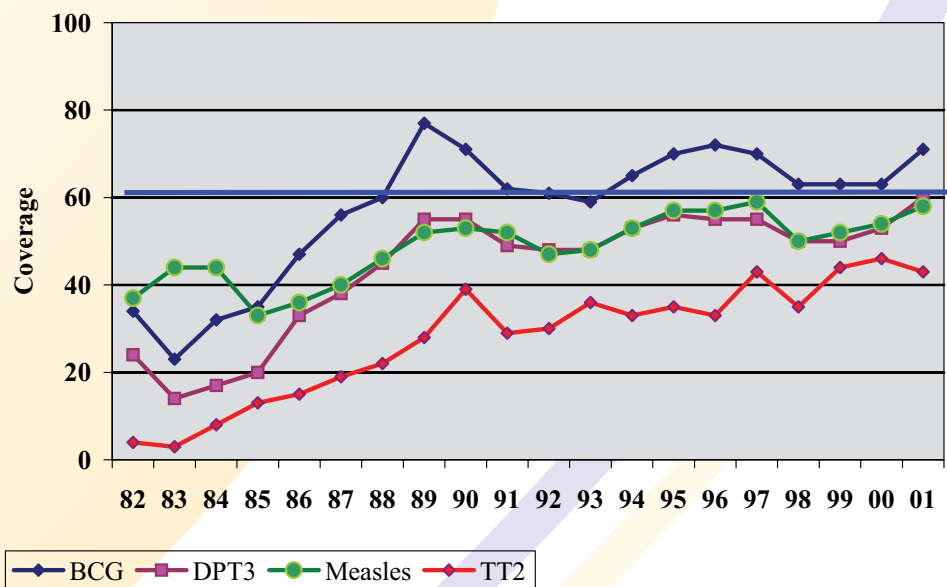
In addressing the high infant and child mortality rates, most countries including Benin, Botswana, the Democratic Republic of Congo, Ghana, Kenya, Madagascar, Malawi, Niger, Tanzania, Togo, Zambia and Zimbabwe, have adopted an integrated approach to child health programmes that address the overall health of a child. Recent measures and strategies adopted in the area of child health include the continuation of national immunization campaigns to eradicate major childhood diseases in all countries; promotion of breast feeding; formulation and implementation of a nutrition

policy; free health care for pregnant mothers and children under the age of six and free treatment for malnutrition and diarrhoeal diseases. The adoption of the WHO/UNICEF approach for an integrated management of childhood illness (IMCI)<sup>6</sup> is seen as a great achievement in reducing childhood death and illnesses.

### *Immunization against the major infectious diseases*

Child immunization coverage has increased remarkably in most countries, with the immunization of almost two-thirds of all children under one year of age. UNICEF (2002) notes that three million fewer children under five years of age now die each year, due largely to immunization programmes and the dedicated efforts of families and communities. Figure 7 gives the trend in the immunization coverage with EPI vaccines in the African Region from 1982 to 2001. The countries however exhibit different trends during the same period. Immunization programmes have improved accessibility to immunization through increased public education on the value of PHC. In addition, community health workers (CHWs) have been trained to promote immunization. Many countries have indicated that immunization is seen as a good way of introducing PHC and beginning to work with communities.

**Fig. 7: Immunization coverage with EPI vaccines in the African Region, 1998-2001**



Source: AFRO, 2002

Immunization against tetanus among women of childbearing age is far below expected coverage. For example in the Central African Republic, the coverage of pregnant women with 2 or more doses of tetanus toxoid during the period 1991 to 2001 ranged between 14% and 32% only (Enquête CV OMS

<sup>6</sup> Refer to WHO/UNICEF (1999), Integrated Management of Childhood Illness (IMCI) – WHO/CHS/CAH/98.1B

1990-1991; EDS 1994-1995; Enquête MICS 1996; Données de routine de 1997 à 1999; MICS 2000; Revue PEV 2002). In Niger between 1994 and 1999 it ranged from 27% to 42% (Rapports annuels d'activités DNPEV). Cases of neonatal tetanus therefore still exist. It was conveniently decided to use antenatal consultations to make these inoculations. The low rates of antenatal care visits to health facilities as well as late attendance further reduces the chances for immunization of women against tetanus. The failures of such programmes would in most cases be due to the dysfunction of health systems. These systems continue to suffer from serious gaps in their organization and management, as reflected in frequent shortages of vaccines, defective cold chain equipment, infrequent orientation of the staff charged with the responsibility for immunization (WHO, *World Health Forum*, Vol. 8, 1997).

### ***Prevention and control of locally endemic diseases***

In the past, the prevention and control of endemic diseases in the African Region largely focused on communicable diseases. But in the last decade or so, noncommunicable diseases like cardio-vascular diseases, cancers, and mental illnesses have been included.

The Regional Committee has adopted strategies for prevention and control of communicable and noncommunicable diseases with the aim of strengthening the capacity of Member States to draw up policies and implement programmes using comprehensive multi-sectoral approaches.

However, communicable diseases still account for a large proportion of the disease burden and various strategies and efforts have been made to address them. The African Region adopted a framework for implementation of Roll Back Malaria (RBM) in 2000. In 1996 the HIV/AIDS strategy in the African Region was adopted to combat the epidemic and a framework for its implementation was adopted in 2000. For control of tuberculosis, the directly observed treatment short course strategy (DOTS) is being implemented. The number of countries using DOTS has been increasing since the early 1980s reaching 41 out of 46 by 1998. Fifty-six percent of the countries have attained 100% coverage of their population. Technical, managerial and financial support was given to countries towards elimination of leprosy and measles, and eradication of polio and guinea worm disease. Through the Regional Strategy on Integrated Disease Surveillance adopted by the Regional Committee in 1998, and regional efforts to build capacity for epidemic preparedness and response in the countries, there has been improvement in priority setting, planning, resource mobilization and allocation, prediction and early detection of epidemics and monitoring and evaluation of intervention programmes. In addition, collaborating with countries and other partners, new and under-utilized vaccines like yellow fever, hepatitis B and pneumococcal meningitis vaccines have been introduced and are more effectively used to reduce mortality and morbidity in the Region.

### ***Appropriate treatment of common diseases and injuries***

WHO has continued to support countries to improve the diagnosis and treatment of diseases and injuries in accordance with improving technology and in the effort to improve the management of patients. Guidelines and tools to facilitate identification of standard equipment and other applicable technologies were provided to countries. Most countries have developed their standard treatment guidelines and, given the resource-limited context, have adapted the syndromic management approach in areas like sexually transmitted infections.

The Region has faced problems of multi-drug resistance in treatment of tuberculosis and resistance to first-line anti-malarial drugs. The DOTS approach has, to a great extent, ensured observed treatment and hence reduced the potential for multi-drug resistance for anti-TB drugs. A number of countries have had to revise their first- and second- line drugs for treatment of malaria.

### *Provision of essential drugs*

The “provision of essential drugs” was included as the eighth element of PHC at the Alma-Ata Conference on Primary Health Care (PHC) in 1978. In 1981, the WHO Director-General established the then Action Programme on Essential Drug in accordance with resolution WHA32.41.

Concerned with the continued problem of inequitable access to essential drugs, African ministers of health took measures aimed at improving access to essential drugs. One of the most important was the Bamako Initiative that was launched in 1987.

In order to further increase access and promote equity of access to essential drugs in the context of national health policies, WHO was requested to assist Member States in the formulation and implementation of comprehensive national drug policies. In response to this request, the document ‘WHO Guidelines for Formulating National Drug Policies’ was produced in 1988. These guidelines were first adapted for the African Region in 1993 and its current version (WHO/AFRO/EDP/01.5) was published in 2001.

Thirty-eight Member States have used these guidelines, with WHO assistance, to start the process of formulating or reviewing their national drug policies, and 33 of them have official national drug policies. Despite these efforts, over 50% of the population in some parts of the African Region do not have regular access to the most basic essential drugs, according to WHO estimates in 1999. The reasons for this include inadequate financing for health in general and for drugs in particular. Even when drugs are available, weak regulatory capacity may mean that they are substandard or counterfeit, and that they are not rationally used.

In view of the above and in response to resolution WHA54.11, the WHO Medicines Strategy 2000-2003 was developed. The strategy aims to save lives and improve health by closing the gap between the potential that can be offered by the drugs and the reality that they are unavailable or unaffordable for millions of people. The strategy addresses four objectives: policy, access, quality and safety, and rational use. Of these, the greatest emphasis is on securing access to essential drugs for priority health problems like malaria, childhood illnesses, tuberculosis and HIV/AIDS.

Access is the central pillar of the strategy and four factors are critical in ensuring and expanding access: rational selection and use, affordable prices, adequate financing and reliable procurement and supply systems, using approaches like generic and bulk procurement. It is expected that emphasis on access will make the greatest contribution towards achieving the first seven elements of Primary Health Care.

Traditional medicine maintains its popularity for historical and cultural reasons. In Benin and Sudan for example, 70% of the population rely on traditional medicine while, in Uganda, users of traditional medicine make up 30% of the population. In Ghana, Mali, Nigeria and Zambia, 60% of children

with fever were treated with herbal medicines at home in 1998. Some countries in the African Region are producing, locally and on a pilot scale, various plant-based preparations for chronic diarrhoea, liver disorders, amoebic dysentery, constipation, cough, eczema, ulcers, hypertension, diabetes, mental health and HIV/AIDS. Some of these medicines have been registered and included in the national essential drug lists. Furthermore, WHO has developed frameworks, guidelines and protocols for institutionalising traditional medicine in national health systems, and to facilitate the rational assessment of traditional herbal medicines.

# CHAPTER 6:

## PHC RESOURCES

### 6.1: Health infrastructure

A network of infrastructure to support service delivery in the area of PHC has been developed. Depending on the country, this includes health posts, dispensaries, rural maternities and health centers, which constitute the first level of the referral system. They play the role of interface between the population and the higher-level facilities like district and other referral hospitals. These structures serve about 80 % of the population but regrettably receive at best only 20 % of the financial resources of the health system (Diallo I; WHO, 1993). Figure 8, showing consolidated data from the national health accounts of some countries in eastern and southern Africa confirms this point. These primary care facilities cannot by themselves mobilize sufficient resources to operate well. They are very often short of equipment, qualified personnel and are unable to undertake appropriate management procedures. The dysfunction of these structures contributes significantly to the poor performance of the health systems noticed in almost all the countries of the Region.

Despite calls to governments to allocate more resources for primary care, it appears that more resources continue to be allocated to hospitals (1<sup>st</sup> and 2<sup>nd</sup> levels of care) in most countries of the Region.

It could be argued that donor and private resources (households and firms) compensate for the low allocation of recurrent expenditure by ministries of health to primary care. The available evidence from some countries in the Region, however, does not support this argument. Figure 9 below shows that even when total expenditure on health is distributed between all levels of care, the bulk of the resources in most countries continue to be spent at the hospital level. Though it could further be argued that hospitals also provide primary care, and are hence justified to receive more financial resources, it should be noted that most hospitals in the Region are located in the urban areas where only about 30 % of the population live.

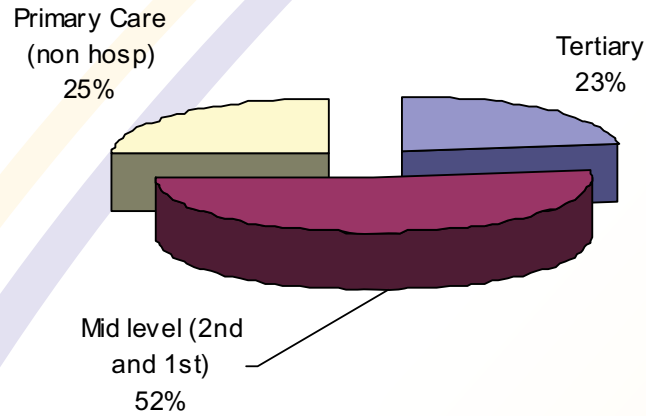
It is evident that financial resources have not kept pace with the increasing demands on health care as well as the intent of health policies regarding expansion of health services, especially primary care, to both urban and rural areas. However, when financial resources are available, allocation of resources are more biased towards urban areas and tertiary care hospitals and institutions. Although a number of alternative financing and cost-recovery schemes have to some extent yielded revenue, their effect on increasing PHC resources, promoting equity and accessibility is still not clear.

The importance of hospitals, which are part and parcel of the health system, needs to be underscored, nonetheless. Their key role in provision of referral care, development of human resources for health in terms of training and supervision, and information and research needs to be highlighted as a vital link with the lower levels in health care delivery. Despite seemingly consuming the greater share of health budgets, hospitals in the Region are commonly found to be dilapidated, without equipment, drugs and other essential supplies.



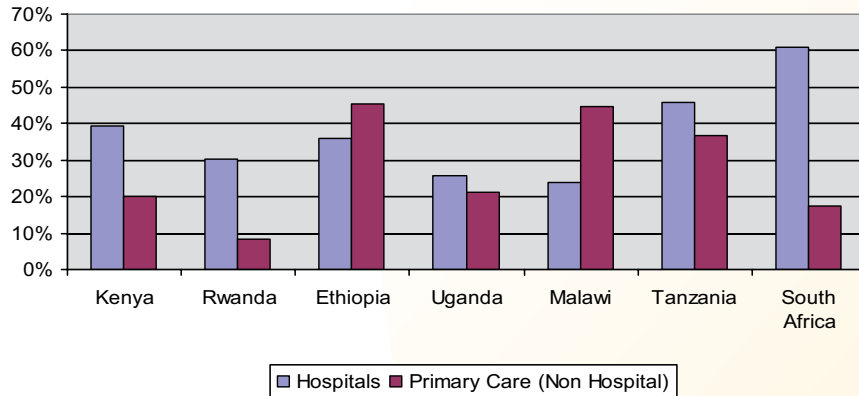
Human resources for proper hospital management are also lacking. Thus despite consuming around 70% of national health budgets, hospitals remain under-funded and fail to play their role effectively.

**Fig. 8: MOH recurrent health expenditure by level of care in the public health sector: 1997/98**



Source: Eastern and Southern Africa NHA Network (2001): National Health Accounts in Eastern and Southern African., A comparative Analysis (unpublished report)

**Figure 9: Allocation of expenditure by level of care: Hospital and non-hospital care, 1997/98.**



Source: Eastern and Southern Africa NHA Network 2001: National Health Accounts in Eastern and Southern African Africa: A comparative Analysis (unpublished report)



## 6.2 Human Resources

Health personnel constitute 50-75% of recurrent health budgets in most African countries in terms of salaries alone (WHO, 2003a). While estimates of health personnel have been difficult to obtain (WHO, 1998b), human resource development has remained a critical challenge in improving health care systems (Martineau and Martinez, 1998).

All countries in the Region have made primary health care the cornerstone of their goal of attainment of health for all. Yet, only 15 countries have prepared human resource development plans. Some of these plans are not comprehensive since they do not always articulate training, distribution and deployment of health workers in PHC at all levels in the hierarchical structure of the health system. Most of these countries, however, have trained and utilised community health workers (CHWs) and village health workers to promote the delivery of basic, cost-effective services to the majority of the people.

In spite of governments' efforts in developing human resources it seems to be inadequate at all levels, and particularly in PHC.

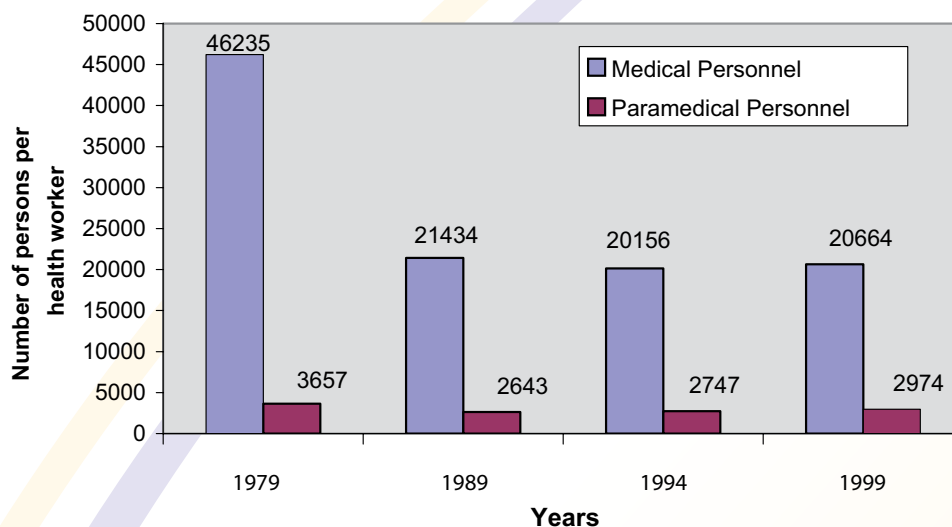
The PHC progressive philosophy has implications on health personnel training and health care practises. The PHC approach requires that health workers both adapt and change a range of traditional attitudes, expectations and opinions (Walker, 1995). Indeed, many health systems are still based on a disease-curing model of service, relying mainly on hospitals and technical health staff that try to resolve specific disease and illness events. As a consequence, training and education of health workers are elitist and hospital-focused.

Cadres are therefore primarily not appropriately equipped to deal with promotive and preventive care in line with PHC. There is clearly a need for a shift from the "medical paradigm" to a "health paradigm" which is more geared to promotion of health and well-being.

Although in some countries like Cape Verde, the human resources/population ratios for medical doctors and nurses can be considered good, the shortage of trained and qualified health human resources in Africa continues to be a major impediment to PHC development. The staffing required for optimum running of health units have not been met (see fig. 10 and table 4), and this has hindered the integration of activities. Another major drawback is the scarcity of health personnel in public health delivery systems, although African governments have tried to introduce policies to retain skilled staff. In Lesotho and Zimbabwe, for example, governments have implemented bonding whereby workers are obliged to stay in their positions for an agreed length of time, while Nigeria and Zimbabwe have raised public sector salaries.

The situation of migration within the Region and to abroad has reached crisis levels. For example, 60% of medical graduates from one country migrated within a few years after graduation. (Bundred P.E., Levitt C, 2000). A study done by the WHO Regional Office for Africa in 2002 (Awases M. et al., 2003) showed that 26 to 68 % of health workers interviewed intend to migrate to other countries. The main factors for migration were poor salaries, poor working conditions, lack of opportunities for professional development, unclear career paths, conflicts and wars. Migration of skilled health workers has contributed significantly to deteriorating access and quality of care in the Region.

**Fig. 10: Trend in the population to Health Personnel Ratios 1979-1999 in Burkina Faso**



Source: *Rapports annuels statistiques sanitaires, DEP/santé, Burkina Faso*

**Table 4: Evolution of doctor/population ratios in five African countries from 1970 to 2003**

YEAR	1970	1990	1995-1997	2000-2003
<b>COUNTRY</b>				
Burkina Faso	97 120	57 320	29 412 (1995)	27 200 (2001)
Mozambique	18 860	36 225	N.A.	25 200 (2000)
Niger	60 090	34 850	28 571 (1997)	35 600 (2002)
Rwanda	59 600	72 990	N.A.	20 100 (2002)
Uganda	N.A.	22 399	20 000 (1996)	44 300 (2002)

Source: *WHO-AFRO, 2001 and WHO-AFRO database*

In addition to the shortage of human resources for health, there is often inequitable distribution of available human resources in favour of urban areas. The situation of Central African Republic, shown in the table below, is a good example.

**Table 5: Health Personnel/Population ratios in the Public Sector in Bangui compared to the rest of the country**

Health Personnel	Bangui	Rest of Country
	Doctors	1/12,031
Senior Health Technicians	1/9,466	1/19,105
State Certified Nurses	1/4605	1/18,857
Midwives/Nurse Midwives	1/6,776	1/28,987
Traditional Birth Attendants	1/7,462	1/31,923

Source: MSPP / DEP 1995, RCA

In Niger, the breakdown by zone demonstrates the important disparities and confirms the concentration of health personnel in urban areas (see table 6). For example, 60% of all doctors, 50% of all midwives and 30% of all nurses in the country are found only in Niamey, the capital city of Niger.

**Table 6: Distribution of Health Workers by gender and by zone in Niger**

	Agadez		Diffa		Dosso		Maradi		Tahoua		Tillabéry		Zinder		Niamey		Total%	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
Urban	94	60	65	29	104	82	114	105	127	76	53	36	172	168	660	851	2796	65%
Country-side	26	37	43	22	134	89	191	76	163	93	160	146	222	132			1534	35%
<b>Total</b>	<b>120</b>	<b>97</b>	<b>108</b>	<b>51</b>	<b>238</b>	<b>171</b>	<b>305</b>	<b>181</b>	<b>290</b>	<b>169</b>	<b>213</b>	<b>182</b>	<b>394</b>	<b>300</b>	<b>660</b>	<b>851</b>	<b>4350</b>	<b>100%</b>

Source: *Développement des ressources humaines pour la santé, plan stratégique: 2000-2010, septembre 1999*

Attempts have been made to change the attitude of health personnel towards PHC. The district medical officers (DMOs) and the district health teams, who are charged with the responsibility of coordinating the PHC activities in the districts, have received more training in countries like Tanzania, Uganda, Kenya, Zambia and Zimbabwe. However, the majority of health workers do not possess the appropriate skills or conceptual awareness of the PHC approach (Tarimo and Webster, 1994). The existing human resource is therefore in dire need of reorientation in PHC approach. The efficient delivery of health services is dependent on the availability of professionally qualified and motivated personnel.

WHO (1996) notes that although many activities and training to promote better national health management have been undertaken in most countries of the WHO Region, no evaluations of their impact is available. Particular attention should be given to this issue to enable policy makers to design sound policies and plans for the development of human resources that are able to fully participate in achievement of PHC goals.

### 6.3 Financial Resources

The major source for financing health care goods and services in the Region is the general tax revenue from government, which contributes on average 42.6% of total health expenditure. Households, through direct out-of-pocket payments, are the second source contributing an average of 36.7% of the total health expenditure. Donors only contribute an average of 15% of total health spending (WHO 2002).

Total health spending remains critically low in the Region averaging US\$ 32 per capita in 2000. This comprises on average US\$ 12.5 government expenditure, US\$ 1.2 donor funds to government and US\$ 16.8 from private expenditure, which included out-of-pocket sources.

The total expenditure ranges from a low of US\$3 per capita in Liberia and Burundi to a high of US\$ 440 per capita in Seychelles in 2000. Only 10 countries spend more than US\$30 as recommended by the Commission on Macroeconomics and Health Report of 2001 for the provision of essential health interventions.

Much as there is inefficiency and inequity in resource allocation and utilization in most of the countries as noted by the few resources allocated to PHC, most countries' national health systems are suffering from absolute inadequacy of financial resources as can be seen from Table 7.

Most countries in Africa are currently facing an array of health care financing and management problems. Increasingly, countries have been found to rely on direct out-of-pocket payments as a means for paying for health care goods and services in the Region (an average of 36.7% of total health spending in 2000 ranging from a high of 73% of total health spending in Nigeria to zero in Algeria). Although such alternative financing and cost-recovery schemes have been implemented in many African countries, their effect on promoting equity and accessibility of PHC is still limited. Evidence shows that direct out-of-pocket spending dissuades the very poor from utilizing health care services (Creese 1990, WHO 2000a) and the majority of the people in the African Region are poor. In addition, 53% and 50.3% of total health expenditure on health in 2000 respectively, was provided through donor support in a few countries like Mozambique and Rwanda, which raises questions of sustainability.

Thus, unless massive resources are mobilised both from domestic and other sources, the poor health systems performance in the Region will continue and the achievement of the Millennium Development Goals will remain a dream.

**Table 7: Health expenditure in the African Region, 2000**

Country	Per capita total expenditure on health at average exchange rate (US\$)	Per capita general government revenue expenditure on health* (US\$)	Per capita external resources for health to government at average exchange rate (US\$)	Per capita private expenditure on health** (US\$)
Seychelles	440	278	17	146
South Africa	255	108	0	148
Botswana	191	118	2	71
Mauritius	133	73	2	58
Namibia	128	76	5	48
Gabon	120	78	5	38
Algeria*	64	19*	0	11
Swaziland	56	39	1	16
Equatorial Guinea	54	29	7	18
Zimbabwe	47	20	3	25
Cape Verde	30	16	5	9
Lesotho	28	21	2	5
Kenya*	28	3*	2	22
Cameroon	24	5	1	18
Angola	24	12	1	11
Congo	22	15	0	7
Senegal	22	10	2	9
Zambia	18	8	4	7
Côte d'Ivoire	17	6	1	10
Mauritania	14	6	5	3
Guinea	13	6	1	6
Comoros	13	5	4	4
United Republic of Tanzania	12	4	2	6
Rwanda	12	3	3	6
Benin	11	4	1	6
Malawi	11	1	5	6
Gambia	10	5	3	2
Mali	10	3	1	5
Ghana	10	4	1	5
Uganda	10	1	3	6
Guinea-Bissau	9	4	2	3
Eritrea	9	2	4	3
Mozambique	9	2	3	3
Democratic Republic of the Congo	9	6	0	2
Nigeria	8	2	6	0
Burkina Faso	8	4	2	2
Togo	8	3	1	4
Sao Tome and Principe	8	2	4	3
Central African Republic	8	2	1	4
Sierra Leone	6	3	1	2
Chad	6	2	3	2
Madagascar	5	2	1	2
Ethiopia	5	1	1	3
Niger	4	1	1	2
Burundi	3	1	1	2
Liberia	3	2	1	0
<b>African region (Population weighted average)</b>	<b>32.1</b>	<b>12.5</b>	<b>1.2</b>	<b>16.8</b>

Notes\* Does not include social security/social health insurance in Algeria at US\$33 and in Kenya at US\$1 per capita. The population-weighted average for social security/social health insurance in the Region is US\$1.6/capita.

\*\* Includes expenditure on health by Non-Governmental Organizations (NGOs), households (through direct out-of-pocket spending), private health insurance and firms/enterprises reimbursements to their employee and provision of health care in their own health facilities.

Source: WHO NHA Data Base 2002 (WHO, 2003b).



# CHAPTER 7:

## PHC MONITORING AND EVALUATION

Most countries have health policy documents emphasizing the importance of monitoring and evaluation of PHC. They outline the need to define clear health objectives and targets and the need for baseline surveys. Most countries seem to have developed monitoring systems at all levels of the health care system. However, the degree to which these systems monitor performance comprehensively at all levels, from the central level to the communities, is questionable. In many developing countries reliable data on health services are scanty and, when available, are often not used (Kipp et. al, 1994). Engelkes (1993) notes that most PHC projects have internal, sometimes vertical monitoring systems, and that comprehensive and functional health information systems were not present.

In Niger, the organs for follow-up, monitoring and evaluation envisaged in the health development plan of 1994-2000 include (1) the national health committee and the national inter-sectoral technical committee for health at national level, (2) two inter-sectoral organs at regional level, namely the Departmental Technical Committee and the Departmental Technical Committee for Health, (3) the District Health Committee and the technical committee at district level, (4) Health Management Committee at the health centre level and (5) the Village Health Committee.

Three PHC evaluations have been carried out in Botswana during 1985, 1991 and 1994 (WHO 1994b). Progress is monitored at the facility, health district or national levels. However, major problems inherent in the monitoring and review process in Botswana include:- (i) untrained staff in the research and statistical units; (ii) resignation or transfer of relatively well-trained personnel; and (iii) shortage of data management facilities at the facility, district and national levels.

A national health information centre has been in place in Nigeria at the federal level since 1988. This centre was developed by the Department of Planning, Research and Statistics. In addition, the Primary Health Care Department of the Federal Ministry of Health has set up a monitoring and evaluation division (WHO, *ibid*). The objectives of the monitoring and evaluation division include: (i) to assess current health status in all LGAs in the country; (ii) to develop the system of data collection for use nationwide, at the community, LGAs, States levels; (iii) to monitor progress in implementation of PHC in Nigeria; and (iv) to provide data to health sector decision makers for allocation of funds and running of effective programmes.

In Tanzania, PHC reviews have been done jointly with DANIDA, SIDA, UNICEF, SCF, and WHO (Information from Ministry of Health, Tanzania). The objectives of the reviews in Tanzania were: (i) to assess progress and present status of PHC implementation; (ii) to determine the relevance of the present health policies, plans and programmes; (iii) to identify the priorities for appropriate support of each sector to PHC and (iv) to determine the relevance of support from abroad. Apart from these reviews, it is evident that Tanzania does not have a PHC monitoring and evaluation system in place.



Literature review indicates that although countries have been carrying out reviews, in many instances they were initiated by international agencies such as the WHO (WHO, 1994b; WHO, 1996). The lack of systematic baseline data or information to conduct evaluations has also hampered the process. The literature review further indicates that WHO has developed guidelines for PHC reviews (Hammad and Smith, 1992).<sup>7</sup> However, the standard application of these guidelines in evaluating PHC is not evident.

Engelkes (1993) reviewed the lessons learnt from evaluating PHC projects based on three sources: a review of 83 evaluation reports from 18 donors; case study of three successive evaluations of one PHC project; and the author's own experience in evaluating PHC. From these he made the following conclusions:

- Evaluation team members were rarely described, as result no clear idea could be obtained of their background, expertise or nationality. In addition, representatives of the recipient country were included in the evaluation teams in only 11 of the 43 reports submitted.
- Many evaluators complained about a lack of baseline data, while project objectives were too vague or too ambitious to use as a criteria for evaluation.
- Few of the evaluated projects had inbuilt systems for evaluation and monitoring, although these had often been planned when the projects were formed.
- Donors usually draw most of the terms of reference for PHC evaluations and thus evaluation criteria are mainly donor-oriented. Evaluations have been too concerned with the format of reporting than with methodology. In addition, not all donors have guidelines for evaluations.

Key members of two major European bilateral aid agencies, which fund numerous evaluations of PHC projects in developing countries, revealed that it is likely that expensive, ill-designed and inappropriate health impact evaluations will continue to be implemented. This is due to political pressures, which ignore the conceptual and methodological problems associated with such evaluations (Screttenbrunner and Harpham, 1993).

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<sup>7</sup> Bindari-Hammad A. & Smith D.L. (1992), Primary Health Care Reviews. Guidelines and Methods. WHO Publication.

# CHAPTER 8:

## HEALTH TRENDS AND CHALLENGES

In the majority of African countries, health reforms have been implemented and decentralization has strengthened district-level capacity to manage health services. Participatory structures with community involvement have been created, and the concept of health care packages developed. Countries have achieved some results such as improvement to access to health services and in some health indicators such as life expectancy and under-five mortality. However, the socioeconomic environment such as the increasing poverty, growing impact of the HIV/AIDS epidemic, increased burden of care on the health system, communities and households, has not been conducive to achieving great success in the people's health status. In addition, lack of access to education, water, sanitation, and increased food shortages and social conflicts have resulted in worsening the health status of the people, particularly of women and children.

The efforts put in health sector reforms have yet to show substantial improvements in the delivery of services. Access to quality health services remains an overriding concern especially for poor households and rural communities.

The section below attempts to give a general overview of the health trends, including the leading causes of morbidity and mortality from both communicable and noncommunicable diseases, and gives some indicators related to the population's health status.

### 8.1 Disease-specific morbidity and mortality

The ten leading causes of morbidity in most countries are attributable to communicable diseases, some noncommunicable diseases and to peri-natal causes, most of which are preventable.

#### 8.1.1 Communicable diseases

While the number of reported cases for some diseases like measles, bilharzia, dracunculosis, leprosy, onchocerciasis and polio has decreased, significant increases were noted for malaria, HIV/AIDS, TB, cholera and other emerging diseases.

These increases are thought to be partly due to the weakness of the health system and unfavorable social, environmental and economic trends as well as armed conflicts and natural and man-made disasters. Consequently, communicable and highly infectious diseases still remain the leading health problem in Africa, accounting for nearly 70% of the disease burden (WHO, 2000a).<sup>8</sup>

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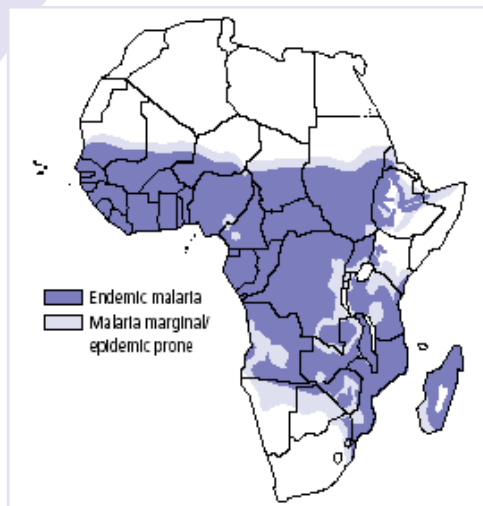
<sup>8</sup> See Annex Table 4 in WHO (2000), The World Health Report 2000. Health Systems: Improving performance.

This report focuses on the leading causes of morbidity and their trends. Although there are some variations from country to country, the leading causes of morbidity are malaria, HIV/AIDS, TB, cholera, respiratory diseases, diarrhoea.

## Malaria

Malaria remains one of the top two causes of mortality and morbidity in Africa, with more than 500 million clinical cases recorded annually. The disease kills one million people annually, mostly children and pregnant women

**Figure 11: Distribution of Endemic Malaria**



*Source: MARA/ARMA collaboration (Mapping Malaria Risk in Africa), July 2002*

About 90% of all malaria deaths in the world occur in Africa, south of the Sahara (The Africa Malaria Report 2003). WHO notes that malaria accounts for about 30-50% of fever cases, 30% of all outpatient consultations and 10-15% of hospital admissions in endemic countries (WHO, 2000b).

According to UNDP (UNDP 2001), malaria cases registered per 100,000 people in 1997 were as high as 37,458 in Zambia, 26,217 in Namibia and 11,941 in Ghana. According to the results of the Multiple Indicator Cluster Survey (MICS) in the Central African Republic (MPCI/UNICEF, Bangui 2001), the prevalence of malaria was 25.8% in 1996 and 31.8% in 2000 at the national level, while ranging from 24.1% and 42% from one health district to another. However, in rural areas with little access to adequate treatment, the rates might be even higher. Since the 1980s, there has been a notable increase in the number of cases and deaths caused by malaria, which is partly attributed to the emergence of new strains of the parasite that are resistant to drugs such as chloroquine as well as ineffective control measures.

As a result, chloroquine has had to be replaced with more expensive drugs such as Sulfadoxine/Pyrimethamine, thus taking treatment out of reach of the majority poor populations. This trend has continued to challenge countries' ability to tackle malaria, given the low levels of resources available for health. An analysis of data from 31 African countries during the period 1980 to 1995 showed that the annual loss of economic growth due to malaria was as high as 1.4 percent per year (WHO, *ibid*). In Africa south of the Sahara, the decrease in all-cause under-5 mortality seen in the 1970s and 1980s leveled off in the 1990s.

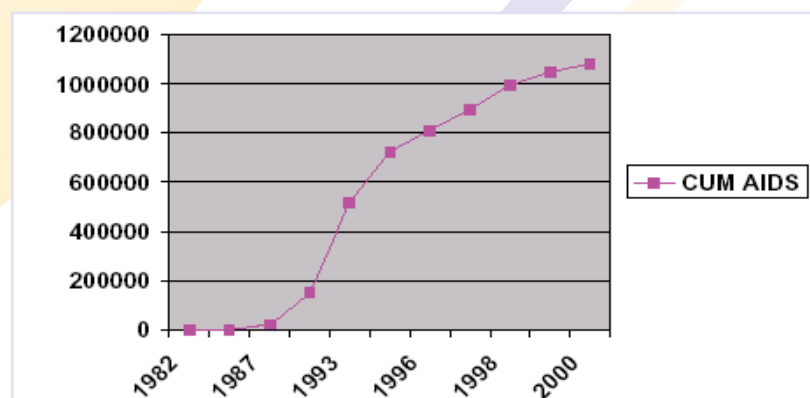
Countries such as Botswana, Kenya, Malawi and Zambia have updated their anti-malaria drug policy, while countries such as Democratic Republic of Congo, Namibia, Nigeria, Rwanda, Tanzania, Uganda and Zimbabwe are in the process of doing so (WHO, 2000c).

The increasing incidence of malaria cases and the resistant strains of malaria pose a big challenge in PHC implementation in African countries. Malaria has continued to produce considerable adverse impact on the health of the majority of the population and consumes a lot of government resources. Consequently, all countries in the Region are committed to the Roll Back Malaria programme, which aims to halve the malaria burden by 2010.

## HIV/AIDS

The outbreak of HIV/AIDS in the early 1980s drastically changed the epidemiological profile of countries in Africa, especially those in eastern and southern Africa, with the pandemic becoming an unprecedented threat to regional development. Currently, about 25.3 million adults and children in Africa are living with HIV/AIDS, out of the world total of 36.1 million (UNAIDS, 2000). Figure 12 shows the cumulative reported AIDS cases in sub-Saharan Africa during the period 1982-2000. Southern Africa (South Africa, Botswana, Zimbabwe, Malawi, Lesotho, Swaziland, Namibia and Mozambique) accounted for 38.3% of the infections in the continent in 1999, while Uganda, Kenya, Tanzania, Ethiopia, Rwanda, Cameroon and Democratic Republic of Congo contributed 37.8%, and Nigeria, Ghana, Cote d'Ivoire and Burkina Faso contributed another 16.9%.

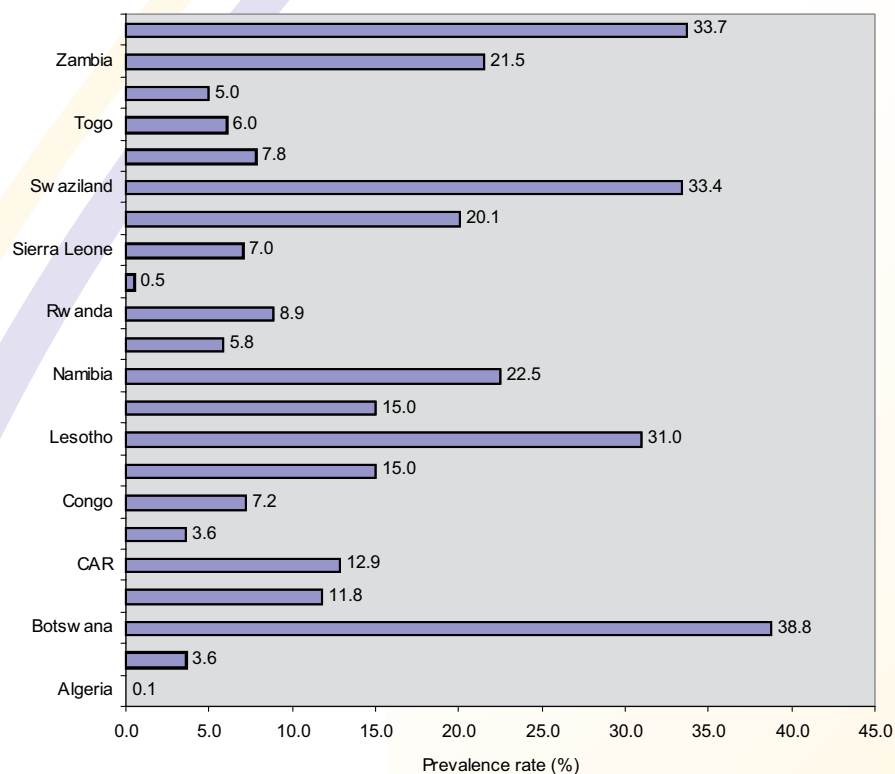
**Figure 12: Cumulative Reported AIDS Cases – Sub-Saharan Africa, 1982-2000**



Source: *HIV Surveillance Report for Africa 2000*, WHO/AFRO

Africa has also registered the highest adult prevalence rates in the world with countries such as Botswana, Zimbabwe, Swaziland and South Africa having higher prevalence rates averaging at around 38%, 34%, 33% and 20% respectively, as compared to countries in central and West Africa whose prevalence ranged from 0.1% in Algeria to 12.9% in Central African Republic (Fig. 13). HIV/AIDS has continued to have a substantially negative impact on a number of countries. Seventeen of the eighteen countries in sub-Saharan Africa (SSA) that experienced a declining or stagnating life expectancy during 1990-1995 were described to have a generalized HIV/AIDS epidemic, with HIV prevalence rate of more than 5 percent among adult population.

**Fig. 13: Adult HIV/AIDS Prevalence Rates 2001 in Selected Countries**

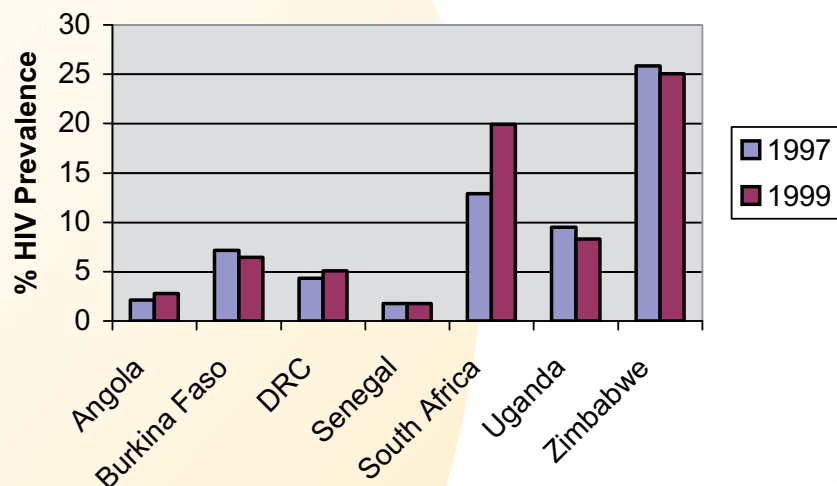


Source: UNAIDS, UPDATE 2002 by country

In the same year, about 530,000 HIV-infected children were born in sub-Saharan Africa, causing high child mortality rates. UNAIDS (ibid) estimates indicate that, by 2005-2010, infant mortality in countries such as South Africa will be 60 percent higher than it would have been without HIV/AIDS. In Zambia and Zimbabwe, 25 percent more infants are already dying than would have been the case without HIV and UNAIDS estimates indicate that by 2010, Zimbabwe's infant mortality rates would have doubled. However, countries such as Kenya, Senegal, South Africa, Uganda, Tanzania, Zambia, and Zimbabwe have developed and adopted national HIV/AIDS control programmes to ensure effective control and prevention of the spread of the virus. For example, Uganda, which had the highest HIV prevalence rate in 1993, has made commendable progress, with rates dropping from

30% in 1992, to 14% in 1995 and reaching about 8% in 2000, while Senegal has maintained the low rate of infection (UNAIDS, *ibid*). Figure 14 demonstrates the trend of adult (15-49 years) HIV prevalence in a selected number of countries in the Region between 1997 and 1999.

**Figure 14: Adult HIV Prevalence in Selected Countries, 1997 & 1999**



*Data source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic June 1998 & UNAIDS Report on the Global HIV/AIDS epidemic June 2000*

The results of the 2000 MICS survey in Central African Republic show that the prevalence of HIV/AIDS at national level was 14%; the rate among pregnant women varied from 5.3% to 22%; in Bangui it varied between 12% and 30%. Whereas studies conducted as early as the 1980s found HIV prevalence among sex workers to be over 30%, sex workers in Cote d'Ivoire had an HIV prevalence of 83.8% in 1992; those in Burkina Faso had HIV prevalence of 59.2% and 31%-55% in 1994 and 2000 respectively. In Benin in 1996 sex workers' HIV prevalence ranged from 38.5% to 85.4%. A UNAIDS multi-centre study in 1997/1998 found an HIV prevalence, among sex workers, in Yaounde, Cameroon and Cotonou, Benin of 33% and 57% respectively.

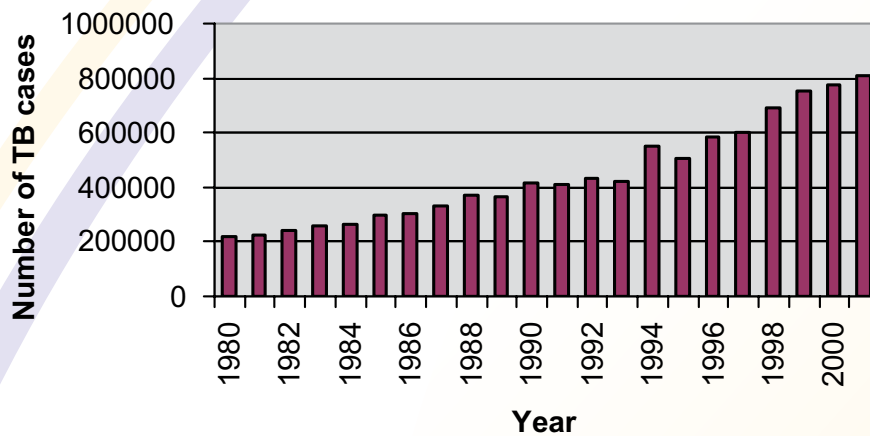
The increasing HIV/AIDS prevalence rates are threatening the commendable achievements of PHC. As over 80 percent of deaths have occurred among 20-49 year olds, the epidemic is offsetting decades of improvement in life expectancy in several African countries (UNAIDS, 1998). HIV/AIDS features now among the first two to three causes of morbidity and mortality in many countries. The chronic nature of the problem and lack of cure have posed a big problem to the health systems, which already are unable to cope with the management of acute infections. AIDS cases are a big worry for the services, staff, families and the communities. Measures to mobilize resources from different sectors and institutions should be targeted in order to control the epidemic. In this regard, AFRO advocates a multi-sectoral involvement through the HIV/AIDS Strategy in the African Region: Strengthening the health sector response. This is due to the realization that the health sector alone cannot cope with the burden.



## Tuberculosis

Tuberculosis has become a major opportunistic infection among people living with HIV infection, because HIV has been the main thrust behind the upsurge of tuberculosis incidence and mortality in developing countries in recent years (Path, 1999). Although tuberculosis was once regarded as virtually under control, reported cases in Africa have increased from 219,802 in 1980 to 811,172 in 2001, as shown in figure 15 (WHO Report 2003 Global Tuberculosis Control, WHO/CDS/TB/2003.316). The mortality associated with tuberculosis has reached about 3.1 million people a year (WHO, 1996).

**Figure 15: Reported TB Cases in Africa, 1980-2001**



*Data source: WHO Report 2003 Global Tuberculosis Control (WHO 2003c)*

Countries such as Kenya, Nigeria, South Africa, Tanzania, Uganda and Zimbabwe are among the 22 highest-burden countries in the world, accounting for 80 percent of all new TB cases. The dual epidemics of HIV and tuberculosis have added to the disease burden of people living with HIV/AIDS. Approximately 40 percent of all HIV/AIDS deaths in Africa result directly from tuberculosis. In Zambia, for example, tuberculosis admissions have doubled since 1994 due to its association with HIV infection (Kasonde, et.al 1994). It is also evident that countries that had high HIV/AIDS prevalence rates by 2001 (Fig. 13) also registered increased cases of tuberculosis per 100,000 people in the same year. For example, Namibia recorded 628 cases, Zimbabwe 437 cases while Botswana, Swaziland and South Africa recorded 619, 653, and 339 cases per 100,000 respectively. On the other hand, countries with relatively lower prevalence rates like Algeria and Senegal reported only 59 and 89 cases per 100,000 people, respectively. Incidence of resistance to drugs is challenging disease control measures. Concerted efforts are therefore necessary to address HIV/AIDS as well as tuberculosis in PHC implementation.



## Cholera

Cholera has re-emerged as a result of environmental degradation and breakdown of water and sanitation infrastructure.

Increasing outbreaks of cholera were noted in the 1990s in most countries such as Benin, Botswana, Burkina Faso, Comoros, Ghana, Kenya, Madagascar, Niger, Tanzania, Uganda and Zambia. In the year 2000, the global number of cases officially notified by African countries decreased by 42% compared to 1999 (WHO, 2000b). However, the same report notes that the officially notified cases do not reflect the overall burden of the disease, owing to underreporting.

The WHO epidemiological record shows decline in cholera cases reported from east African countries and, compared to 1999, and 85% decrease in cumulative cholera cases for Malawi, Zambia and Zimbabwe. While the number of reported cases remained stable in Guinea and the Democratic Republic of Congo, there was an increase in Comoros and Madagascar. South Africa, for example, which had not had an outbreak since 1987, recorded a major outbreak in Kwazulu-Natal, which started in August 2000.

## Acute Respiratory Infections (ARI)

Acute Respiratory Infections are one of the principal causes of morbidity and mortality among children below age of 5. At a prevalence of 15.4% in Central African Republic, according to the results of the Demographic and Health Survey of 1994-1995, ARI is one of the top causes of deaths among children below the age of 3. Children in rural areas are more affected (11.7%) compared to those in the urban areas (8.0%).

## Diarrhoeal Diseases

Diarrhoeal diseases are still among the top causes of childhood mortality and morbidity in countries in the African Region. The prevalence in the Central African Republic was 25.7% at national level, 27% in rural areas and 23.8% in the urban areas (MPCI/UNICEF, Bangui 2001). The level of use of Oral Rehydration Salts (ORS) in cases of diarrhoea was found to be very low, 32.4 % on average in the Region (15.1 % in Burkina Faso, 21.9 % in Cameroon, 22.7 % in Côte d'Ivoire, 17.1 % in Togo, 26.6 % in Senegal (Barrère et al. 1999).

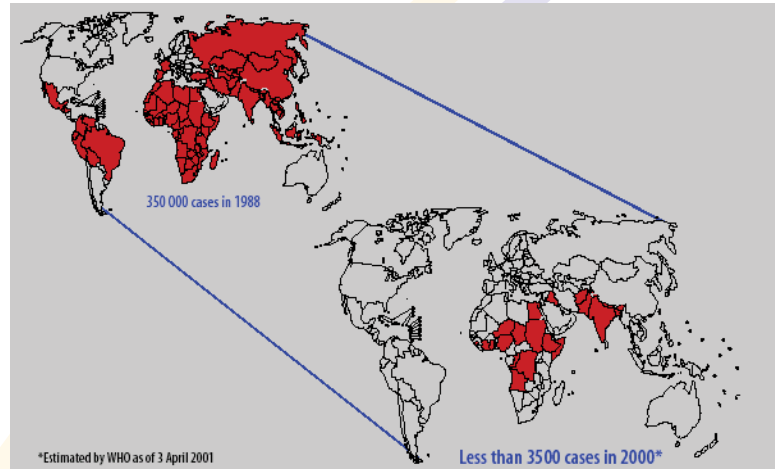
## Poliomyelitis

Considerable progress has been made in the control of poliomyelitis worldwide. In the African Region, the non-polio Acute Flaccid Paralysis (AFP<sup>9</sup>) rate, which is the proportion of AFP cases that are not caused by polio, improved from 0.3 in 1998, to 0.8 in 1999.

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<sup>9</sup> Acute Flaccid Paralysis refers to acute onset of focal weakness or paralysis characterized as flaccid (reduced tone) without other obvious cause in children < 15 years old. It is an index used to measure success of polio disease surveillance.

**Figure 16: Progress towards poliomyelitis eradication, 1988 – end 2000**



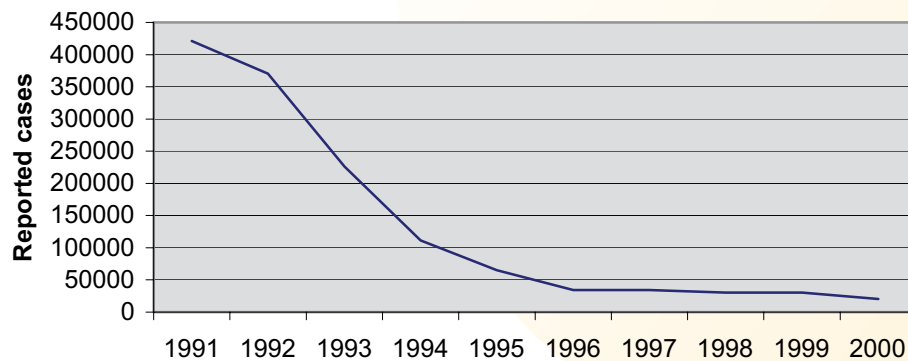
Source: *Global Polio Eradication Progress 2000, WHO/POLIO/01.03*

Thirteen of the 46 countries in the Region detected wild poliovirus in circulation in 2000, reporting 1,763 polio cases of which 144 had laboratory confirmation. By end of 2000, poliovirus circulation was confined to west and central Africa and the Horn of Africa, as shown in figure 16.

### Dracunculiasis (Guinea worm)

Countries in the African Region achieved an overall reduction in incidence of Guinea worm of almost 80% in the period 1992-2000 (see figure 17). However, in 2000 all reported cases were from sub-Saharan Africa, totaling 75,223 of which 20,333 were from the African Region. The most endemic countries in the Region remain Nigeria and Ghana.

**Figure 17: Guinea Worm Case Trend in the African Region, 1991-2000**



Data Source: *Weekly Epidemiological Record No.18. 2001,76*

## Emerging Diseases

Emerging diseases constitute a serious challenge to PHC implementation because their causes, mechanism of transmission, prevention and treatment are unknown. This therefore calls for a health system that can adjust rapidly in order to respond. Unfortunately, however, most national health systems are resource-weak, with dilapidated infrastructure, and unable to play their proper public health roles.

There have been epidemics of Ebola hemorrhagic fever in Côte d'Ivoire, Gabon, the Democratic Republic of Congo, the Republic of Congo, South Africa and Uganda. The epidemic in the Republic of Congo reached 143 cases by May 2003, including 128 deaths. The epidemic in Gabon in 1997 was 60 cases, including 48 deaths while the 2002 epidemic toll reached 60 cases, claiming 50 deaths; and between August 2000 and January 2001, a total of 396 cases with 150 deaths were reported in Uganda.

The other epidemic was meningococcal meningitis. The distribution of meningococcal meningitis cases is mainly limited to the “Meningitis Belt” of Africa, an area that extends from Senegal, on the West African coast, to Ethiopia in the Horn of Africa. In the last decade, it is estimated that over 700,000 cases of epidemic meningococcal disease occurred with an overall case fatality rate of over 10%. During the first 8 months of 2000, 36,194 cases were reported with the highest number of cases recorded in Burkina Faso (Communicable Diseases Epidemiological Report N° 0003 September, 2000, WHO/AFRO)

In 1989, Hepatitis C was identified as the most common cause of hepatitis following blood transfusion, which is estimated by WHO to be infecting up to 3% of the world population.

### 8.1.2 Noncommunicable diseases

Apart from the acute microbial and parasitic diseases, the health sector has been challenged by the rising burden of noncommunicable diseases, including injuries and accidents, mental disorders, cancer, cardiovascular diseases, respiratory diseases, diabetes and other degenerative diseases. This has been partly attributed to changing lifestyles in African countries combined with unhealthy living conditions, violence and wars, which have provided a solid base for increase in incidence rates. The increasing burden of NCDs has severely inflicted a great burden on PHC. AFRO (2000) estimates that if noncommunicable diseases are not contained, they will account for sixty percent of deaths in Africa by the year 2020, compared to forty-one percent in 1990 (WHO 2000d).

Cancerous pathology is also a public health problem in the Africa Region. Cervical, liver and breast cancers are common among women while liver, prostate and stomach cancers are common among men. Cancer of the lungs and esophagus are also frequent, especially in southern Africa, where they are linked to tobacco use.

Arterial hypertension is the most common form of cardiovascular disease, with prevalence rates exceeding 10%, in certain urban areas. One percent of the rural population and 2 to 3 percent of the urban population in some countries in Africa suffer from diabetes.

In Africa as a whole, rheumatic fever and rheumatic heart disease are major causes of premature mortality and account for one-third of all cardiac diseases admitted to hospitals.

The prevalence of malnutrition in West Africa averaged 17.91% among children under five years of age in 1998-1999 (Enquêtes démographiques et de Santé en Afrique de l'ouest, 1999; Senegal 1997). Interventions in this area are very limited and often cover only small portions of the population.

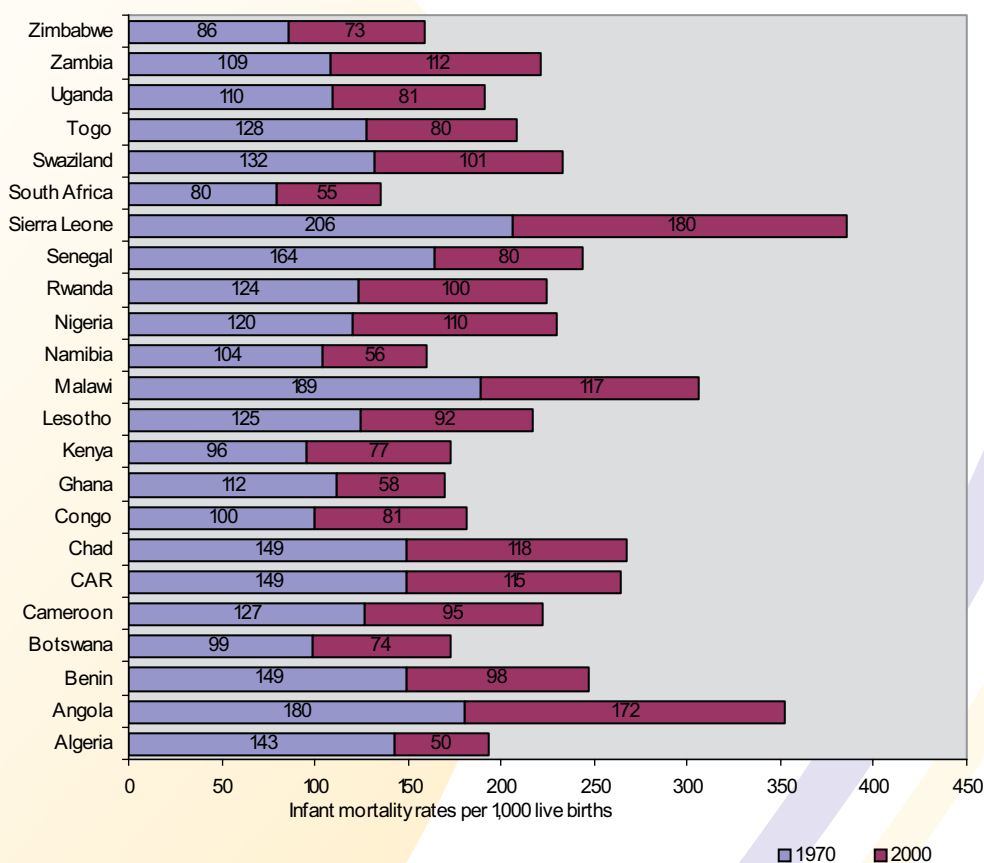
According to a draft paper "Africa Bureau Results Package: nutrition, October, 1998" produced by the Africa Bureau's Office of Sustainable Development (AFR/SD), it is currently estimated that malnutrition is an underlying cause of nearly two million child deaths each year in Africa. According to the same report, micronutrient deficiencies affect millions of sub-Saharan African men, women, and children. Approximately, 23 % of the total population was at risk of iodine deficiency disorders in 1997. About one-third of all children under-five, nearly 40% of all women in reproductive age, and half of all pregnant women suffer from anemia. Overall, malnutrition is also an underlying factor in three out of the five major causes of maternal death in Africa. Malnutrition increases illness frequency and severity, the need for health care, and subsequent mortality, especially when appropriate services and treatment are not available or utilized. The short- and long- term impacts of child malnutrition include unacceptable levels of disease and death, poor school performance, and stunted physical and mental development.

## 8.2 Health Status Indicators

### 8.2.1 Infant mortality

Health indicators in most countries have shown tremendous improvements with certain indicators such as infant mortality showing lower figures in 1999 compared to thirty years ago. Although the infant mortality rates have continued to drop over the years, the pace of decline has been lagging behind, compared with other Regions.

**Fig. 18: Infant Mortality Rates (per 1,000 live births), 1970 and 2000 - Selected African Countries**



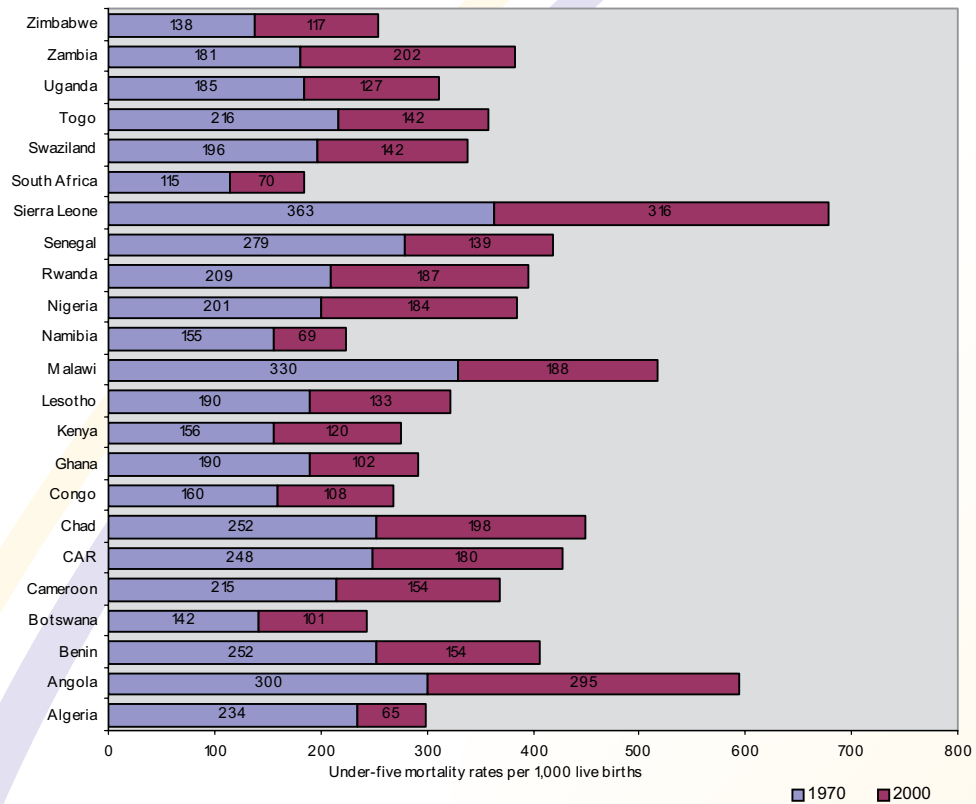
Source: UNDP, Human Development Indicators, 2002

Infant mortality rates are still high and averaging above 100 per 1,000 live births in countries like Malawi, Nigeria, Sierra Leone and Zambia. The above trends could be partly explained by poor environmental conditions, scarce resources for care during pregnancy and childbirth and the high prevalence of communicable diseases. WHO (ibid) estimates that HIV/AIDS is likely to negate any significant progress made in infant mortality reduction. In countries like Malawi, South Africa, Zimbabwe, Tanzania, Uganda, and Zambia, the estimated infant mortality rates have increased by 40 percent as a result of HIV/AIDS (UNICEF, 1998).

### 8.2.2 Under-five year old mortality

The most noted improvement is the decline in mortality among the under-fives in the majority of countries over the years. This could be attributed to increased coverage of immunization programmes, enhanced environment programmes such as safe water and sanitation and other health-related aspects.

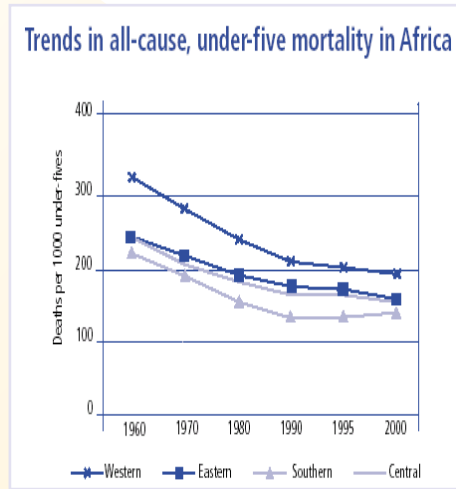
**Fig. 19: Under-five Mortality Rates (per 1,000 live births), 1970 and 2000 - Selected African Countries**



Source: UNDP, Human Development Indicators, 2002

Between 1970 and 2000 there is no significant improvement in reduction of under-five mortality in Sierra Leone, Angola and Rwanda while, for the same period, countries such Algeria, Benin, Congo, Ghana Kenya, Namibia and South Africa have experienced some progress and their under-five infant mortality has dropped significantly.

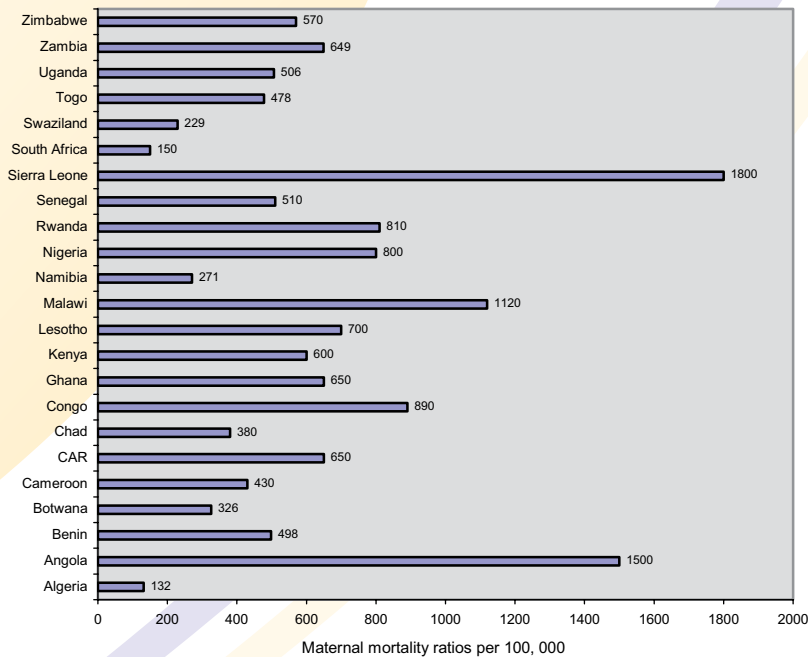
**Figure 20: Trends in all-cause, under-five mortality in Africa**



The most important decline in under-fives mortality is observed in southern Africa, followed by the Central and Eastern Regions. Even though, there is an improvement, the rates are still high and unacceptable.

### 8.2.3 Maternal mortality

**Figure 21: Maternal Mortality Ratios reported (per 100,000 live births) for 2001**



Source: MOH of Member States, Update 2001



Maternal mortality rates either remained the same or increased in all sub-Saharan African countries. Countries like Sierra Leone, Angola, and Malawi have a maternal mortality ratio per 100,000 of up to 1,000 (1800 and 1500 respectively for Sierra Leone and Angola). Only few countries (Algeria, South Africa, Namibia, and Swaziland) have less than 300 deaths per 100,000 live births).

Despite recent gains such as the decline in fertility and increase in contraceptive use prevalence rate in many African countries, reproductive health eludes many women in the continent. The high maternal mortality is essentially due to complications related to pregnancy and childbirth such as hemorrhage, sepsis, eclampsia, obstructed labour, unsafe abortion, anemia, etc. Shortage of qualified health workers, basic supplies, equipment and drugs limit ability of health facilities to provide effective services, especially in handling obstetrics complications. In addition, access to youth-friendly services is limited. The reproductive rights of women and youth continue to be hindered by harmful traditional practices in many African countries. Female Genital Mutilation is a major hindrance to the empowerment of women.

### 8.2.4 Life Expectancy

The poor health investments are mirrored in the low life expectancy in the African Region. The average life expectancy in sub-Saharan Africa is only 48.7 years although the numbers vary significantly (Sierra Leone 39 years, Cape Verde almost 69 years) and it is over 50 years in a few countries, for example Ghana 57, South Africa 56, Benin 54, Kenya 52, Lesotho, Congo, and Swaziland 51, Cameroon 50, according to the UNDP Human Development Report, 2001. According to the same report, life expectancy has declined most dramatically in Zimbabwe falling from 56 to 43 years since the end of the 70s. Botswana and Zambia have experienced declines of nine and seven years respectively, while smaller reductions are evident in Namibia, Burundi and Malawi. The main factor for falling life expectancy is, of course, HIV/AIDS.

The objective of 60 years life expectancy at birth, that was to be realized in every country in 2000, was achieved only in Cape Verde and Algeria (WHO, World Health Report 2000).

The implementation of PHC certainly contributed to the reduction of some of the disease burden in a significant way, but this reduction remains still very insufficient and, in some cases, has been reversed. Most of the health indicators have not achieved the HFA targets for the year 2000, and infant, child and maternal mortality are registering high figures.

Recognizing the challenges that the health sector is facing in the countries of the Region, a Health-For-All policy for the 21st Century in the African Region: Agenda 2020 was adopted by the 50th session of the Regional Committee. Its vision was to overcome diseases related to poverty, exclusion and ignorance within a context of good governance and autonomous development of a pro-active health system for decent and worthy living, by the year 2020. Achieving this vision is a big challenge for the African Region.

## 8.3 Constraints and Opportunities

Although the PHC approach has led to many interpretations in policy development and its implementation, it is evident that the initiatives have not been well integrated. The review demonstrates that countries are facing similar constraints, regardless of the development of PHC policies or the institutional frameworks in place. The section below briefly discusses some of the constraints and opportunities that are evident in the development and implementation of PHC.

### *Constraints*

There seems to be a general lack of shared understanding of the PHC concepts among the policy makers, health workers and the community at large. Despite the existence of PHC policy formulation mechanisms in most countries, no common front has been evolved for the implementation of the strategies. In some cases, there were no institutionalized legal frameworks governing PHC policy formulation that required participation of the health and all health-related sectors.

The successive crises of the 80s and 90s aggravated the capacities and limitations of the public sector to respond to the needs of the populations. It thus became inevitable to identify other partners in health care delivery, notably the non-profit private sector, whose know-how, determination, ingenuity and flexibility made them to accumulate spectacularly positive results. The involvement of other partners however did not go without problems. The NGOs, for example, though very dynamic in the health sector, very often did not have the required resources and had limited capacity to influence the decisions of political and technical authorities.

Despite governments' commitment to implement health sector reforms, such as decentralization of health services, the decentralization of resource allocation and planning to the districts has not been fully achieved, leaving the lower structures as mere recipients of guidelines and instructions.

The right to health mentioned in the constitutions of the concerned countries were very often confused with free health care. One of the fundamental responsibilities of any government is certainly the setting up of a health system able to guarantee universal access of the population to quality health care. This does not however mean that the care has to be free. Worse still, the regulations in force in these countries required that money collected by and from State structures be paid back to the treasury and that expenditures were to be from approved budgets. In these conditions, revenue locally generated could not be used directly at the point of collection.

Despite having developed mechanisms for inter-sectoral collaboration within the ministries, poor coordination among different health providers such as donors, NGOs, private sector and the communities remained evident. Furthermore, collaboration with other ministries such as environment, water, and agriculture, was not fully realized, resulting in fragmentation of efforts through many vertical programmes.

Although donor agencies contributed in implementing PHC, sometimes their efforts were not well coordinated. In some countries the donors 'dictated' their involvement in health work and, more

often than not, were seen to drive selective PHC. The concentration on a few selective elements of PHC contributed to failure to promote the comprehensiveness of PHC.

Often if different donors supported a programme, there were risks of a slow down or even abandonment of efforts in the programme in favour of another, even where a national plan and/or a stakeholders' coordination committee existed. Upon arrival of new programmes with substantial resources and benefiting from particular attention of national and international decision-makers, the earlier programmes were often neglected.

Lack of effective ownership of PHC projects in host communities is common, probably because these communities were not properly involved in the decision making process. The PHC policy formulation process did not clearly seem to have involved people's participation at grass-root levels and managers of lower structures in the health care hierarchy. This top down approach weakened the policy formulation content and jeopardized the effective ownership of PHC projects by the communities. Although most countries have in place community structures such as the village health committees (VHCs), their operation and linkage to the overall health structures is often weak and sometimes informal.

It is evident that both human and financial resource allocation priorities are not in accordance with the PHC objectives both at the national and district levels. More human and financial resources have continued to benefit the larger health institutions, which are often found in the urban areas, leaving the rural population underserved.

Health services for common childhood illnesses, namely respiratory infections, diarrhoeal diseases, malaria and malnutrition and, of recent, AIDS-related illnesses are hampered by the ineffectiveness of health systems of most countries. The advent of HIV/AIDS has had considerable negative impact on resources and their utilization in the health sector. Health facilities are filled more and more with HIV/AIDS and AIDS-related cases like tuberculosis, at the expense of the other common ailments. These cases consume the larger portion of the meagre budgets of health facilities and have led to burnout of the health personnel that attend to these cases. This also means that fewer and fewer resources are available for essential medicines and supplies.

### *Opportunities*

It is important to summarize the real opportunities that have arisen in PHC implementation, as these opportunities can be of great value in promoting PHC.

Major stakeholders including governments, NGOs, private sector, international organizations and community-based organizations (CBOs) are keen to contribute to address current health challenges. This large network of actors is a great asset for addressing the health challenges of, and expanding health services to, the majority of the population.

The current WHO/UNICEF approach of promoting Integrated Management of Childhood Illness (IMCI) is a broad strategy, encompassing interventions at home and in the health system. It advocates for an integrated approach to management of major childhood illnesses thus removing the need for vertical programmes. This lesson could be replicated.

Current initiatives by most countries to strengthen district health systems through decentralization are a great opportunity for implementing PHC. The structure, mode of functioning and resources of the operational level have been defined. The district is declared to be the operational unit for PHC, which presupposes a real decentralization of decision-making authority to the level of the districts.

Many structures including the PHC committees have been formed at all levels of national health systems, in the regions, districts and villages. This is a very good framework, if strengthened and monitored, for facilitating decision-making, implementation and monitoring of PHC activities at all levels.

A number of health programmes utilize community resource persons, such as community drug distributors, community health workers, traditional birth attendants, and traditional practitioners. The possibility of building on such a long tradition of community organizations is a great opportunity in mitigating health problems. It is therefore possible to strengthen the links with community structures. However, the dangers of reinforcing internal links within the communities without developing relations or links with the rest of the main stakeholders should be avoided.

The African Region has a wide range of institutions such as universities, research and training centres. These institutions can be utilized to enhance capacity building of key stakeholders in PHC and research. Through research, interregional cooperation among member states should be encouraged to share PHC intervention packages; research findings and best practises.



# CHAPTER 9:

## CONCLUSION

It is evident that PHC policy formulation and implementation has been a highly complex issue. PHC strategy implementation requires fulfillment of the five principles of equity, community participation, universal access, appropriate technology and inter-sectoral collaboration. PHC introduces a management challenge of combining central policy direction with significant degree of decentralization.

The health systems in the Region have undergone major reforms in management, administration and financing, including their decentralization. However, these reforms have not been sustained due to the implementation of structural adjustment programmes and the decline in socio-economic development that characterized the period after Alma Ata. Consequently, low health spending in association with poor and inequitable access to basic social services like water, sanitation and housing, and high population growth rates, have aggravated the vicious cycle of poverty and ill-health.

Most countries have made considerable achievements in developing a health care system based on the PHC model. A review of the national development plans of countries in the Region indicates that the countries have addressed some, if not all, of the elements of PHC. Despite this effort, there has been a discrepancy between the PHC policy and its implementation. Implementation of PHC has also varied across countries. Whereas all countries made considerable effort to integrate PHC principles and elements into their health systems, the broad-based PHC approach of ensuring that PHC was the central function and main focus of the health systems had been abandoned in most cases in favour of “selective PHC” in form of vertical disease-specific programmes.

There are emerging opportunities in promoting the development of structures and systems in line with the implementation of some PHC principles. The adoption of the Bamako Initiative and other community health fund approaches and the creation of health boards are some of the good initiatives that are creating an environment for the promotion of community participation. Decentralization to the district levels, currently being implemented through health sector reforms, is envisaged to promote bottom-up approaches and contribute to the mobilization of additional resources for PHC. Most of these initiatives however are still in their infancy and the extent to which they can fully mobilize support for PHC on their own is still to be seen. In addition, multi-sectoral collaboration has been largely neglected in the planning and implementation of programmes.

The period of the late 80s and early 90s saw the breakdown and dysfunction of the network of health infrastructure that had been established. This contributed significantly to the poor performance of health systems noticed in most countries of the Region.

Financial resources have not expanded to cope with the increasing demand for health care. Total health spending remained critically low with only 10 countries in the Region able to spend more than USD 34, the minimum figure recommended by the Commission for Macroeconomics and Health Report of 2001 for the provision of essential health care package. It is clear that unless



massive resources are mobilized both from internal and external sources, the poor performance of the health systems will continue and the achievement of the Millennium Development Goals will be threatened.

Since the 1990s the problem of shortage of human resources for health has become a significant factor in the performance of health systems in the Region. There has been a high attrition rate of health workers as a result of death or migration in search of better remuneration and terms of service, further reducing the capacity of health systems to deliver health care to the population.

Although in most countries, the implementation of PHC has involved community health workers, human resource policies in the countries have not taken community health workers into account in terms of organization, management, integration in the health system and in terms of consideration of proper procedures for selection, career development, motivation and remuneration, and supervision. They are not yet seen as partners and hence their involvement in health care delivery is not adequately promoted.

Very few countries defined clear policies or mechanisms and procedures for collaboration with the private sector in health services delivery, in general and in particular, in the application of PHC. The involvement of the private sector and all community interest groups in PHC suffers mainly from lack of coordination, integration, regular follow-up and evaluation.

Yet, the involvement of the lucrative private sector presents certain potential advantages. The offer of good quality curative care in private hospitals in the big capitals can allow the State to divert its attention and resources to the care for the poor and deprived. Their large-scale involvement in health services delivery and PHC in particular requires a definition of new roles for the State, which would consist especially in directing, regulating, monitoring and quality control more than direct involvement in the delivery of services.

Health committees exist at the level of each health facility in the districts in most countries of the Region. In certain countries, their organization and operation was given huge importance such that they were instituted by presidential decree. Nevertheless, determination of their membership, internal structures, and relationships with health services and staff motivation posed a number of problems. The voluntarism that was there initially seemed to have waned.

The review shows that periodic monitoring and evaluation of PHC is either lacking or erratic and that the extent to which most countries have progressed in implementation has largely remained unknown. This has limited critical review in this area. Reliable data on health services is scanty and, more often than not, there are no comprehensive and functional health information systems in place. The problem is compounded by shortage of appropriately trained personnel to handle and interpret data.

The 1970s to mid-80s witnessed achievements in terms of quality of life as evidenced by the reduction in infant and child mortality rates. There has also been considerable progress made towards eradication of polio and guinea worm diseases. However, subsequent period has been associated with deteriorating health trends, decreasing life expectancy at birth, high maternal mortality rates, and increasing health challenges. There has been emergence and re-emergence of both communicable



and noncommunicable diseases, increasing poverty, food shortages as well as inadequate access to basic social services.

The adoption by Member States of the Health for All Strategy in the 21st century, Agenda 2020, provides a framework for development of health systems respecting the principles of PHC adopted in Alma Ata and the implementation of health packages that respond to current and changing needs of the populations in the countries.



# CHAPTER 10:

## RECOMMENDATIONS

Given the above, the recommendations are as follows:

1. There is need to look into ways of harmonizing health sector reforms with PHC in order to ensure that the initiatives promote both equity and quality of health services.
2. For a common understanding of the Regional health policy, it would be appropriate to bring all the countries in the Region together to be briefed on the orientations and strategies of Agenda 2020, or any other regional strategy before embarking on the development of country policies and strategic plans.
3. The Regional health policy should be discussed at the highest level of the State and shared widely with all national and international partners in the health sector in the country.
4. There is need to promote more inter-sectoral collaboration and coordination with the different stakeholders involved in PHC implementation and, especially, at the district level where PHC implementation is advocated. For the attainment of better inter-sectoral collaboration, the necessary interactions of the health system with other systems should be better studied and defined, and appropriate mechanisms for inter-sectoral collaboration should be clearly defined on a country-by-country basis.
5. Efforts should be made in future efforts to address challenges such as effective involvement of the community in health planning and decision-making by establishing effective linkages between health facilities and community structures, such as boards and committees. In addition, community involvement needs to be strengthened in areas such as problem identification, priority setting, data collection and analysis, evaluation, and planning.
6. Financing policies and strategies should aim at improving equity and affordability in order to improve service coverage for the poor populations.
7. Resource allocations to PHC should be reviewed and ways of sustainable PHC financing should be sought. However, it is important that greater efforts be made in the countries to increase efficiency in the utilization of the meagre available resources.
8. Countries should be supported to address their particular human resource needs through clear articulation of human resources policy and plans, development and strengthening of national management systems and employment policies.
9. There is urgent need to support countries to identify and put in place mechanisms for attracting and retaining quality health personnel.
10. The brain drain problem requires intervention at inter-country level or even at the level of the African Union.
11. There is need to reform health sciences education and reorient health workers education and practice so as to incorporate emerging trends and equip major stakeholders with skills in planning, financial and personnel management, which are important in promoting PHC and community home-based care.

12. WHO should facilitate the development and adoption of guidelines and methods in Primary Health Care monitoring and evaluation for use by the countries. This should be integrated into the progress-monitoring framework for the Millennium Development Goals.
13. WHO should strengthen its support to member countries to institutionalize ongoing good practices and effective measures in application before new initiatives are introduced.
14. WHO should support member countries in capacity building that will enhance implementation of health programmes and actions through PHC and within the framework of Health for-All policy for the 21st century in the African Region: Agenda 2020.

# ANNEX 1:

## PHC Review: Country Framework

Taking the opportunity offered by the global PHC policy review, requested by the Director General of the World Health Organization, the contribution of the Region was defined at the meeting held in Harare on 4 – 5th July 2001. The review of the policy in the African Region will focus Region-specific PHC implementation issues, involve all countries, though countries themselves will review their own PHC. WHO will provide technical and financial support.

The African Region contribution to the global PHC policy review will give high attention to how to strengthen implementation of PHC within the overall framework of the Health for-All Policy for the 21st Century in the African Region.

A Primary Health Care Review is being undertaken at the regional level in response to many institutional, economic, social and other changes that have occurred in the world since Alma Ata. The PHC review is intended to address three core questions, namely:

- What should be the main strategy for implementing PHC in the new context?
- What roles should WHO play in supporting Member States to implement primary health care?
- What resources and capacities will countries and WHO need in order to play those roles?

### 1.0 MAIN OBJECTIVE:

The general objective for carrying out this review is to identify major issues concerning PHC implementation in order to formulate pertinent recommendations on the way forward.

### 2.0 MAIN ISSUES TO BE REVIEWED

Five broad areas are to be reviewed both in the country reports and in the regional analysis. These are:

1. **Health trends:** What are the trends of the main health and health-related challenges in the country?
2. **PHC policy formulation:** How was the PHC policy formulated in the country? Other issues include the process of formulating PHC policy, content of the PHC policy, review of policy formulation and so on.
3. **PHC policy implementation:** How are PHC policies being implemented in the country? Aspects to look at should include advocacy and marketing, actors and partners, structures and processes, and so on.
4. **PHC resources:** What are the resources available for PHC implementation in the country? (Human and financial resources, PHC physical resources and structures)

5. PHC monitoring and review: How are PHC policies and strategies being monitored and reviewed? (Information system for PHC implementation, research activities, utilization of available information, monitoring and evaluation systems)

## 3.0 PROCESS

### 3.1 Principles

The main principle governing the review of PHC implementation is that it has to be as representative of the Region as possible and based on ownership by countries. This will be ensured using several approaches. All Member States in the Region will be included in the review, active involvement of stakeholders in countries will be ensured, and validation and dissemination of the review report by countries will be carried out.

Other principles include:

- The review process will be thorough and systematic.
- Review will be based on:
  - Involvement of actors with extensive knowledge of PHC implementation.
  - Definition of the way forward for PHC implementation and,
  - Allowance, as much as possible, for global comparability, using the format provided.

### 3.2 Consensus on and selection of issues for review

To ensure consensus on issues for review, internal WHO/AFRO meeting(s) will be convened to refine issues/questions for each stage of the review and discussions held with countries (e-mails & telephone).

#### Method of conducting the review:

The process of reviewing PHC in the African Region will be carried out at two levels, country and regional levels.

#### Country-specific reviews:

Each country will review its own experiences in PHC implementation and submit a report for inclusion in the regional report. For each country, a consultant will be identified to carry out the review and prepare the country review report. The consultant will work closely with the WHO country office and authorities in the Ministry of Health.

Data for the review will be from the following sources:

- Unstructured interviews with interviewees/informants with an intimate knowledge of PHC implementation. These could comprise policy makers, implementers at all levels, other sectors involved, WHO and other partners.

- Discussions with a wider audience of people with intimate knowledge of PHC implementation. The following could be involved: policy makers implementers, NGOs, Private sector, health-related institutions, WHO and other partners
- A desktop analysis of available documents and reports specific to the country. An extensive analysis of all available published and unpublished documents and materials will also be undertaken.

The discussion of the consultant's report will be based on a compilation and analysis of data from the above-mentioned sources. The conclusions on PHC implementation and way forward will be based on logical judgments/assertions derived from the data. The report will be reviewed and discussed by a wider national audience in order to:

- further substantiate the findings.
- gain consensus and validate the information presented in report
- foster ownership of the report
- ensure the use of the recommendations of the review

### Regional review:

Three institutions, CEDHA, PHCI-IRINGA and ISED will be contracted to carry out the regional review (refer to the ToRs). A desktop review, based on a compilation and extensive analysis of available regional documents, country-specific review reports and, where necessary, case studies of countries with best practices will be done. The conclusions on PHC implementation and the way forward will be based on logical assertions/assertions derived from the data.

Both CEDHA and PHCI-IRINGA will cover the English-speaking countries and produce one report while ISED will be responsible for producing a report based on PHC review of French-speaking countries and countries with Portuguese as a working language.

## 3.4 Suggested format for country and regional reports.

The following format may be followed in writing country and regional review reports. Ensuring close follow up of the format will ensure comparability of both types of reports at regional and global levels.

### I. Introduction

1. Historical background of health systems in the country
2. Goal and objectives of the review

### II. Implementation of the review

1. Methodology used
2. Process of data collection and analysis



### III. Findings and discussions

1. Health trends in the country
  - Health challenges
  - Health-related challenges
2. PHC policy formulation
  - Process of formulating the PHC policy
  - Content of the PHC policy
  - Review of policy formulation
3. PHC implementation
  - Advocacy and marketing
  - Actors and partners
  - Structures and processes
  - Opportunities
  - Constraints
4. PHC resources
  - Human resources
  - Financial resources
  - PHC physical resources and structures
5. Monitoring and reviewing
  - Information system for PHC implementation
  - Research activities
  - Utilization of available information
  - Monitoring systems

### IV. Major conclusions and recommendations

References

Annexes

#### 3.5 Dissemination of the PHC review:

A programme of communication and briefing within WHO, with Member States and other international agencies to disseminate the outcomes of the review will be made. At the regional level, the review report will be put on the agenda of ongoing meetings with different health stakeholders, starting from November 2001. At country level, a half-day meeting will be convened to review and endorse the consultant's report. Opportunity will be taken to also disseminate the country and regional reports during on-going meetings in the countries.

#### 4.0 TERMS OF REFERENCE FOR COUNTRY CONSULTANTS

##### Objectives of the Consultancy:

The objectives of the consultancy are to

- Review the experiences in PHC implementation in the country
- Compile the country report on PHC implementation review.

## Scope of Work:

The consultant is expected to:

- Carry out a review of documents and reports on the country experiences in PHC implementation. The review should look at all relevant documents concerning health trends, PHC policy formulation and implementation, PHC resources, and PHC monitoring and review. This should not be restricted to experiences in the public sector or experiences under the Ministry of Health. It should include all key actors and stakeholders.
- Hold in-depth interviews with professionals and people with extensive knowledge and information on the major aspects of PHC policy and implementation in the country.
- Analyze the data and information gathered as well as prepare a country PHC review report.
- Facilitate a national meeting to gain consensus on, and validate, the country PHC review report.

## Period of Work:

The assignment will cover the period from August to September 2001.

## Reporting:

It is expected that a draft country PHC review report will be presented to a national meeting in order to gain consensus and validation.

The final report, which should incorporate discussions at the national meeting, should be submitted, not later than the last week of September 2001, through the World Health Representative to AFRO with a copy to the respective institute overseeing the review in the specific country group. English-speaking countries will be under CEDHA and PHCI-Iringa, Tanzania, while French-speaking countries and countries with Portuguese as working language will be under ISED, Senegal.

## Mode of Payment:

40% down payment will be made at the beginning of the assignment and the remaining 60% upon acceptance of the final report.

## Qualifications and experience

The consultant must have a wide experience in research and PHC implementation. He/she should also have a good exposure to health policy development and evaluation methodologies. He/she should have a good working relationship with the Ministry of Health.

## Languages

The consultant should be fluent in English or French or Portuguese, as required.

## GUIDELINES

### IN-DEPTH INTERVIEWS WITH INTERVIEWEES/INFORMANTS

The target interviewees/informants for this review are persons in the country in the best position to provide interviewers with adequate and precise information on major aspects of the PHC policy and implementation in the country. They may be director-generals or heads of departments, divisions, and other services of the MOH, or coordinator of NGOs involved in health or health-related activities, or partners of MOH, multi- and bi- lateral agencies (WHO, UNICEF, UNDP, USAID etc.).

The proposed guidelines have been developed to assist the reviewers in the review process and, particularly, in the interview component as well as in writing the report. Its proper utilization will also facilitate a comparison of all country reports. The guidelines, nevertheless, have to be considered as simply a “guide” that aims to facilitate the interviewer’s work and not as a complete and perfect set of directives to be rigidly followed. A good understanding of the goal and objectives of this review and the reviewer’s own ability is the best guidelines for this work.

### GENERAL RECOMMENDATIONS

Proper utilization of the current guidelines for interviewing people/informants requires necessary interview skills by the interviewer. Here are some of the essential elements to be remembered when conducting the interview. (1) The interviewer should adopt a careful step-by-step approach and decide on how and when to record the essential information received from the interviewee/informant. (2) The interviewer must always bear in mind that the interview aims to draw out knowledge, opinion or judgment of the interviewee/informant on major issues related to PHC policy and particularly its implementation in the country. (3) The interviewer should know how to appropriately prevent interviewee selective recount of information and also know how to draw the interviewee/informant back to the subject matter if he or she is deviating. (4) The interviewer should find ways and means to engage the interest of the interviewee/informant in the subject matter in order to get maximum valuable information and should find ways to have him or her accept to spend enough time on the interview. (5) The interviewer must avoid making any judgment, implicitly or explicitly, on what the interviewee/informant is saying; and at all times (6) show courtesy and openness throughout the interview period.

## GUIDELINES FOR CONDUCTING THE INTERVIEW.

MAJOR AND RELATED AREAS FOR INVESTIGATION	COMMENTS
<p><b>HEALTH TRENDS</b></p> <p><b>What are the trends of the main health and health-related challenges in the country?</b></p> <ul style="list-style-type: none"> <li>■ Emerging and re-emerging diseases,</li> <li>■ Economic conditions (poverty),</li> <li>■ Demographic problems,</li> <li>■ Other epidemiological problems,</li> <li>■ Social conflicts etc.</li> </ul>	<p>This section aims to capture the major health or health-related challenges of the country in the past, now and in the foreseeable future. The focus should be on the ways they have or might influence the development of PHC in the country. This section also makes use of the judgement of the interviewee/informant regarding the situation in the country.</p>
<p><b>PHC POLICY FORMULATION</b></p> <p><b>1. How was the PHC policy formulated in your country?</b></p> <ul style="list-style-type: none"> <li>■ What are the major actors?</li> <li>■ People/institutions involved in the process? (NGOs, private sector, civil society, communities)</li> <li>■ Influences of its establishment?</li> <li>■ Principles, evidence used?</li> <li>■ How commitment in the formulation of the PHC policy can be demonstrated? (level of participation, marketing strategy, soliciting ideas from different stakeholders, meetings, ownership, etc.),</li> <li>■ To what extent does PHC policy address the structures, resources and legislations of health and health-related systems?</li> </ul> <p><b>2. Does the country review the formulation of its PHC Policy?</b></p> <ul style="list-style-type: none"> <li>■ What is the trend regarding the major policy decisions on PHC in the last five years?</li> <li>■ Is there a structure/procedure for reviewing?</li> </ul> <p><b>3. What is the country's policy on PHC?</b></p> <ul style="list-style-type: none"> <li>■ What is the country policy statement on PHC?</li> <li>■ To what extent did the PHC policy address the main challenges?</li> <li>■ What are the main programmes?</li> <li>■ To what extent does the policy model address comprehensiveness of health issues?</li> <li>■ What is the relationship with other on-going reforms?</li> </ul>	<p>The concern here is to get the maximum information on the process undertaken to develop and review the PHC policy in the country. It aims also to determine the extent to which the PHC policy has addressed the challenges.</p>

## GUIDELINES FOR CONDUCTING THE INTERVIEW (CONTD).

MAJOR AND RELATED AREAS FOR INVESTIGATION	COMMENTS
<p data-bbox="315 392 823 421"><i><b>PHC POLICY IMPLEMENTATION</b></i></p> <p data-bbox="315 460 916 529"><b>How are PHC policies being implemented in the country?</b></p> <ul style="list-style-type: none"> <li data-bbox="315 568 669 597">■ Who are the major actors?</li> <li data-bbox="315 617 785 646">■ How was it advocated and marketed?</li> <li data-bbox="315 666 993 764">■ Strategies for overcoming resistance, barriers and constraints for PHC implementation (related to structures, resources, politics etc.)?</li> <li data-bbox="315 784 993 852">■ Does the implementation focus on the 5 principles and the 8 components of PHC?</li> <li data-bbox="315 872 993 940">■ To what extent was resources and capacity appropriate for PHC implementation (human, financial, physical, etc.)?</li> <li data-bbox="315 960 993 1058">■ To what extent does the implementation focus on involving other partners such as the civil society, private sector, NGOs, other partners in health development etc?</li> <li data-bbox="315 1078 993 1146">■ To what extent has PHC implementation promoted practice and development of traditional medicine?</li> <li data-bbox="315 1166 993 1264">■ To what extent and how have external agencies influenced PHC policy and strategy implementation (UNICEF, WHO, World Bank, bilateral and multilateral)?</li> <li data-bbox="315 1283 993 1381">■ How are PHC policy and strategies being implemented at the different levels of the health system? How are these levels connected (referral system/ continuity of care)?</li> <li data-bbox="315 1401 993 1499">■ To what extent did PHC implementation bring changes in integration, decentralization and financing of health care?</li> <li data-bbox="315 1519 993 1685">■ How have other major initiatives improved the health care system (Bamako Initiative, poverty reduction programmes, Safe Motherhood/Making Pregnancy Safer, etc.)? To what extent are these in line with PHC principles and components.</li> </ul>	<p data-bbox="1024 392 1347 597">The aim is to identify all approaches, methods and activities used in the country to implement PHC policy and strategies as well as the major difficulties, constraints and resistances encountered and strategies to overcome them.</p>

## GUIDELINES FOR CONDUCTING THE INTERVIEW (CONTD).

MAJOR AND RELATED AREAS FOR INVESTIGATION	COMMENTS
<p><b><i>PHC RESOURCES</i></b></p> <p><b>What resources are available for PHC implementation in the country?</b></p> <ul style="list-style-type: none"> <li>■ • To what extent are resources appropriate and adequate for sustainable implementation of PHC policy and strategies?</li> <li>■ • What major approaches are used to mobilize and reallocate resources to PHC policy implementation?</li> <li>■ • To what extent is the development of human resources including community health workers (policy, planning, training, management, etc....) in line with PHC principles?</li> <li>■ • What structures (responsibilities, relationships, procedures and culture) of the health system and the facilities are used to operationalize PHC policy and strategies (hospitals, health centers, dispensaries, health huts, rural maternities and training institutions, including universities)?</li> </ul>	<p>The aim is to identify the resources available in the country and the way they are being mobilized and allocated for effective and sustainable implementation of PHC policy and strategies.</p>
<p><b><i>PHC MONITORING AND REVIEW</i></b></p> <p><b>How are PHC policy and strategies being monitored and reviewed?</b></p> <ul style="list-style-type: none"> <li>■ • Strategies and approaches for monitoring and reviewing PHC policy implementation?</li> <li>■ • Outcomes and their application, if any?</li> <li>■ • Actors at different levels?</li> <li>■ • How is the relationship with the overall management of the health system?</li> <li>■ • How are research activities and the health information system supported and used to review and improve PHC implementation?</li> <li>■ • To what extent are the monitoring and evaluation results being used to set priorities in PHC activities?</li> </ul>	<p>The objective is to identify the systematic approach (if any) that exists in country to monitor, evaluate and review periodically the implementation of PHC policy and strategies.</p>

## GUIDELINES ON REVIEW OF DOCUMENTS AND REPORTS

### 1.0 Possible sources of information

The following are the main sources of information that may be used in the PHC review process:

- Individuals, groups, and organizations;
- Published information (books, articles, indexes, abstract journals); and
- Unpublished information (other research proposals in related fields, reports, records, computer databases)

### 2.0 Identifying the different sources

Different sources of information can be consulted and reviewed at various levels of the administrative system within the country.

#### Community and district or provincial levels

- Local surveys, annual service reports
- Statistics issued at provincial and district levels
- Newspapers, books, articles, mimeographed reports, etc.

#### National level

- Articles from national journals, books identified during literature searches at university and other national libraries, WHO, UNICEF libraries, etc.
- Special collections, e.g., newspaper clippings, archival records, library.
- Documentation, reports and raw data from:
  - The Ministry of Health (e.g. 5-year plans)
  - Central statistical offices
  - Other ministries
  - Non-governmental organizations

#### International-level information

- Bilateral and multilateral organizations (e.g., IDRC, USAID, UNICEF, WHO, WB);
- Computerized searches for international literature (from national library or international institutions).

Some agencies will assist with literature search, if requested by telephone or in writing. The request, however, should be very specific. Otherwise you will receive a long list of references, most of which will not be relevant. If you are requesting a computerized search, it is useful to suggest key words that can be used in locating the relevant references.



### 3.0 Accessing the sources of information.

***You need to develop a strategy to gain access to each source and to obtain information in the most productive manner. It may include the following steps:***

- Identifying a key person (researcher, decision maker or community member) who is knowledgeable on the topic and ask if he or she can give you a few good references or/and names of other people you could contact for further information;
- Looking up the names of speakers on your topic at conferences might be useful;
- Contacting and requesting relevant references from librarians in universities, research institutions, and the Ministry of Health and newspaper offices;
- Examining the bibliographies and reference lists in key papers and books to identify relevant references;
- Looking for references in indexes (e.g. Index Medicus) and abstract journals; which are available in libraries either as hard copies or in computerized form.
- Requesting a computerized literature search (e.g. Medline).

### 4.0 Possible biases in reviewing documents and reports.

Bias in the review of documents and reports is the distortion of the available information such that it reflects opinions or conclusions that do not represent the real situation. It is useful to be aware of various types of bias in order to have a critical approach in considering existing literature. If you have reservations about certain references or if you find conflicting opinions in the literature, discuss these openly and critically. Such a critical attitude may also help avoid biases in your own study. Common types of bias in literature include:

- Playing down controversies and differences in one's own study results;
- Restricting references to those that support the point of view of the author; and
- Drawing far-reaching conclusions from preliminary or shaky research results or making sweeping generalizations from just one case or small study.

### 5.0 Ethical considerations

The types of bias mentioned above would put the scientific integrity of the responsible researcher in question. Moreover, careless presentation and interpretation of data may put readers who want to use the study's findings on the wrong track. This may have serious consequences, in terms of time and money spent and it may even lead to wrong decisions affecting people's health. A similarly serious act, for which a researcher can be taken to court, is the presentation of research results or scientific publications from other writers without crediting the actual author (s). Therefore, appropriate referencing procedures should always be followed in research proposals as well as in research reports.

## INTERVIEW GUIDE FOR INTERVIEWERS

### 1.0 HEALTH TRENDS

What are the trends of the main health and health-related challenges in the country?

- Emerging and re-emerging diseases,
- Economic conditions (poverty),
- Demographic problems,
- Epidemiological problems,
- Social conflicts etc.

### 2.0 PHC POLICY FORMULATION

#### 2.1 How was the PHC policy formulated in the country?

- Who are the major actors?
- People/institutions involved in the process? (NGOs, private sector, civil society, communities)
- Influences of its establishment?
- Principles, evidence used?
- How can commitment in the formulation of the PHC policy be demonstrated? (level of participation, marketing strategy, soliciting ideas from different stakeholders, meetings, ownership, etc.),
- To what extent does PHC policy address the structures, resources and legislations of health and health-related systems?

#### 2.2 What is the country policy on PHC?

- To what extent did the PHC policy address the main challenges?
- What are the main programmes?
- To what extent does the policy model address comprehensiveness of health issues?

#### 2.3 Does the country review the formulation of its PHC Policy?

- What is the trend regarding major policy decisions on PHC in the last five years?
- Is there a structure/procedure for reviewing?

### 3.0 PHC POLICY IMPLEMENTATION

#### 3.1 How are PHC policies being implemented in the country?

- Who are the major actors?
- How was it advocated and marketed?

- Strategies for overcoming resistance, barriers and constraints to PHC implementation (related to structures, resources, politics etc.)?
- Does the implementation focus on the 5 principles and the 8 components of PHC?
- To what extent were resources and capacity appropriate for PHC implementation (human, financial, physical, etc.)?
- To what extent does the implementation focus on involving other sectors such as traditional medicine, civil society, private sector, NGOs, other partners in health development etc,
- To what extent do external agencies influence the implementation of PHC policy and strategies (UNICEF, WHO, World Bank, bilateral and multilateral)?
- How are PHC policy and strategies being implemented at different levels of the health system? How are these levels interconnected (referral system/ continuity of care)?
- To what extent did PHC implementation bring changes in the integration, decentralization and financing of health care?
- What other major initiatives have improved the health care system (Bamako Initiative, financial, planning, quality of services, equity etc.)? To what extent are these in line with PHC principles and components.

## 4.0 PHC RESOURCES

### 4.1 What resources are available in the country for PHC implementation?

- To what extent are resources appropriate and adequate for sustainable implementation of PHC policy and strategies?
- What major approaches are used to mobilize and reallocate resources to PHC policy implementation?
- To what extent is the development of human resources, including community health workers (policy, planning, training, management, etc....) in line with PHC principles?
- What structures (responsibilities, relationships, procedures and culture) of the health system and the facilities are used to operationalize PHC policy and strategies (hospitals, health centers, dispensaries, health huts, rural maternities and training institutions, including universities)?

## 5.0 PHC MONITORING AND REVIEW

### 5.1 How are PHC policy and strategies being monitored and reviewed?

- Strategies and approaches for monitoring PHC policy implementation?
- Outcomes and applications, if any?
- Actors at different levels?
- What is the relationship with the overall management of the health system?
- How are research activities and the health information system supported and used to review and improve PHC implementation?
- To what extent are the monitoring and evaluation results being used to set priorities in PHC activities?

## GUIDE FOR COLLECTING INFORMATION FROM DOCUMENTS AND REPORTS

The proposed guidelines have been developed to assist reviewers in the review process and, particularly, in conducting the interview and writing the report. Its proper utilization will also facilitate a comparison of all country reports. The guidelines, nevertheless, have to be considered as simply a “guide” that aims to facilitate the interviewer’s work and not as an exhaustive set of directives to be rigidly followed. The best guidelines are a good understanding of the goal and objectives of the review and the ability of the reviewer to effectively achieve them.

Information from documents and reports may be collected and sorted using the format outlined below. Guiding questions are presented below each area. Data from documents and reports may be extracted to answer these questions.

**1. HEALTH TRENDS: findings and conclusions**

What are the trends of the main health and health-related challenges in the country?

**2. PHC POLICY FORMULATION: findings and conclusions**

How was the PHC policy formulated in the country?

What is the country policy on PHC?

Does the country review the formulation of its PHC Policy?

**3. PHC POLICY IMPLEMENTATION: findings and conclusions**

How are the PHC policies being implemented in the country?

**4. PHC RESOURCES: findings and conclusions**

What resources are available for PHC implementation in the country?

**5. PHC MONITORING AND REVIEW: findings and conclusions**

How are PHC policy and strategies being monitored and reviewed?

# GUIDELINES ON GROUP DISCUSSION/MEETING ON COUNTRY PHC REVIEW REPORT AND ITS RECOMMENDATIONS.

The target participants for this meeting is any person in the country in the best position to provide intimate, adequate and precise information on major aspects related to the PHC policy and its implementation in the country. They may comprise of the Director Generals or Heads of departments and divisions, and other services of the MOH, coordinator of NGOs and private sectors involved in health or health related activities, partners of the MOH multi and bi lateral agencies (WHO, UNICEF, UNDP, USAID, WB).

The proposed guidelines have been developed to assist the reviewers in the process of conducting a meeting to discuss and validate the country PHC review report. The guidelines, nevertheless, have to be considered as simply a “guide” that aims to facilitate the interviewer’s work and not as a complete and perfect set of directives to be solely and completely followed. The best guidelines are a good understanding of the goal and objectives of the review and the ability of the reviewer to effectively achieve them.

Format to be used to guide the meeting.

The following format may be used to guide the discussions of the meeting.

**1. HEALTH TRENDS: findings and conclusions**

What are the trends of the main health and health-related challenges in the country?

**2. PHC POLICY FORMULATION: findings and conclusions**

How was the PHC policy formulated in the country?

What is the country policy on PHC?

Does the country review the formulation of its PHC policy?

**3. PHC POLICY IMPLEMENTATION: findings and conclusions**

How are the PHC policies being implemented in the country?

**4. PHC RESOURCES: findings and conclusions**

What resources are available for PHC implementation in the country?

**5. PHC MONITORING AND REVIEW: findings and conclusions**

How are PHC policy and strategies being monitored and reviewed?

**6. RECOMMENDATIONS AND WAY FORWARD**

The reviewer will be the facilitator of the discussions, guiding the discussion based on the areas listed above. He/she will ensure exhaustive discussion and conclusion of each topic. Each topic will end with recommendations that will be compiled and utilized to map out the way forward. The way forward should aim at strengthening PHC implementation in the country.

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