



IMPLEMENTATION OF PRIMARY HEALTH CARE — PACKAGE OR PROCESS?

After establishing the commitment of the government to comprehensive primary health care (PHC), the Department of Health and provinces are now faced with the challenge of implementation. An important response has come with the recent proposed 'core package of primary health care services'.¹ After consultation with national, provincial, district and facility health managers, various 'core packages' of services to be delivered at community, clinic/mobile and community health centre levels have been proposed. For example, undernutrition, which affects more than 1 in 4 young South African children,² is to be dealt with through treatment protocols, clinic-based growth monitoring and marketing messages about breast-feeding. The core package initiative seems to offer a pragmatic approach with its outlines of tasks and timetables and has been justified as a 'planning tool to move towards comprehensive services'.¹ In contrast, we believe there is a danger that it may have the opposite effect.

SELECTIVE PRIMARY HEALTH CARE

The proposed core package approach is reminiscent of the response of many international health agencies and governments to the demands of comprehensive PHC as set out in the 1978 Alma Alta Declaration. It was argued that the adoption of certain selected interventions, such as growth monitoring, oral rehydration therapy (ORT), breast-feeding and immunisation (GOBI), would be the 'leading edge' of PHC, ushering in a more comprehensive approach at a later stage.^{3,4} The shift of emphasis away from equitable social and economic development, intersectoral collaboration, community participation and the need to set up sustainable district level structures suited the prevailing conservative winds of the 1980s. It gave donors and governments a way of avoiding the fuzziest and more radical challenges of tackling inequalities and the causes of ill-health.⁵ The result was the enthusiastic initiation of selective interventions that received generous funds to the detriment of the more comprehensive approaches.⁶

Partly in response to criticism of its structural adjustment programmes, the 1993 World Bank World Development Report⁷ instigated a more elaborate version of the selective PHC approach. One of the main struts of its health policy includes a limited public health and clinical package, with the content determined by what are regarded as cost-effective interventions. New activities such as de-worming and vitamin

A supplementation were added to the above selected technologies, which governments should be aiming to provide. The identification of core packages became a mechanism to ration the cost of health services provided by the State as other activities were to be taken up by non-government organisations. This fitted in neatly with the Bank's wider economic policies of strict monetary controls, encouraging the privatisation of health care delivery and the cutting back of State services.

Proponents of the selective approach point to the impressive increases in immunisation coverage, declines in infant mortality in many countries and the successful eradication of polio from the Americas. However, 15 years after the adoption of these packages the health of many children has not improved,^{8,9} and there is evidence that immunisation coverage rates have stagnated¹⁰ and that infant mortality rates have risen in many sub-Saharan countries.¹¹ In addition, instead of dying in infancy of diarrhoea, for example, survivors are suffering the effects of undernutrition¹² and often perishing later in early childhood.¹³ Questions have been raised about the sustainability of mass immunisation campaigns,¹⁴ the effectiveness of health facility-based growth monitoring¹⁵ and the appropriateness of ORT when promoted as sachets or packets without corresponding emphasis on nutrition, water and sanitation.⁷ A recent review has even pointed out the lack of evidence for the effectiveness of directly observed therapy for tuberculosis (DOTS) in the absence of a well-functioning health service and community engagement.¹⁶ Evaluations at both national and provincial levels have found that it is only when these core service activities are embedded in a more comprehensive approach (which includes paying attention to health systems and human capacity development) that real and sustainable improvements in the health status of populations are seen.¹⁷⁻¹⁹

COMPREHENSIVE PRIMARY HEALTH CARE

The Government's White Paper on Health defines comprehensive PHC as the 'provision of preventive, promotive, curative and rehabilitative care'.²⁰ The inclusion of preventive and promotive aspects is welcome and points to the importance of intersectoral collaboration and the centrality of active community involvement for effective health interventions. All the major health problems facing South Africa, viz. HIV, TB, diarrhoea, malnutrition and mental ill-health, to name but a few, are clearly rooted in poverty, social inequalities and disempowerment. This is why, after only partial successes with previous approaches, the comprehensive PHC approach has been promoted as the most appropriate and effective strategy for South Africa.

For example, in contrast to the narrow range of activities specified in the package, the national Integrated Nutrition Policy²¹ explicitly recognises the wider determinants of



undernutrition and has outlined a more comprehensive approach. Health centre activities, such as growth monitoring and treatment of severe undernutrition, are important components of such a programme, but they are situated within a broader approach that also includes community-based programmes. In our attempts to implement the policy in a poor rural district in the Eastern Cape²² the challenge has been one of increasing the capacity of district health workers to facilitate an assessment of the local health problems and then to formulate multi-faceted interventions with multi-sectoral teams and local communities. It is also situated in a broader bottom-up district health systems development project.²³ The South African core package approach proposes instead the implementation of health sector-based activities that have already been agreed upon by health professionals and academics.¹

The core package approach has been an important reason for the failure of comprehensive PHC to take root in many countries. Local capacity development has been undermined through a reliance on centrally devised, health facility-based solutions with an emphasis on disease (as opposed to the underlying determinants of ill health). In addition, community participation has been distorted into a conduit for the delivery of the core package.²⁴ Thus one of the fundamental benefits of a district health system — the capacity of district health management teams to plan the delivery of health services in a way that is locally appropriate and optimal — has been critically undermined. In the absence of a strategy to broaden the PHC approach, the 'leading edge' has become instead the focus of health services, and the past 15 years have witnessed an erosion of painstakingly created community health infrastructures and deterioration of the health services in many developing countries.

We certainly do not deny that certain curative and preventive technologies are known to be effective and should be provided as a minimum at all levels of health care. However, as Klein²⁵ has remarked, there is little point in setting out the menu if we do not pay attention to what is going on in the kitchen. The history of fragmentation of the South African health services has already aggravated a top-down vertical programme approach. District health systems are struggling to become established. We fear that the core package approach, with its allure of a ready-made basket of services will, like the selective PHC approach, lead to the neglect of the (admittedly difficult) processes fundamental to the implementation of a more appropriate, effective and sustainable comprehensive approach to South Africa's pressing health problems.

The authors of the Core Package report are to be congratulated on tackling a very difficult but important issue, and have outlined some activities that should be a part of all health services. However, as a recent review of health sector reform in Africa has commented, 'WHO defines a package comprehensively as including a mix of health care, management and organisational interventions, as packages of

health care interventions alone run the risk of being developed into vertical programmes'.²⁶ We believe the priority for the health service should be one of developing and implementing a vision of a district health system in which local health managers, in collaboration with local communities and other sectors, have the capacity to develop and implement comprehensive PHC programmes. It is within this context that core activities are introduced and prioritised.

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