Primary Health Care in the 21st century
Atenção Primária em Saúde no século 21

Global health situation has improved remarkably in the last two decades of the 20th century. Since the meeting at Alma-Ata in 1978 when Primary Health Care (PHC) was defined by the international community and a call for Health For All by the Year 2000 (HFA 2000) was put out, a remarkable progress in global health indices has been achieved. It would be useful to put on record the stages and sequence of events through which progress has been made. At the time of independence during the 1950's and '60s many pre-colonial countries inherited health systems which were largely intended for the colonial administrators, the military, and the civilian elite. In no time their inadequacies became obvious, and the concept of Basic Health Services was developed to provide coverage with simple preventive/promotive services operating from health centres and satellite sub-centres using mainly health auxiliaries. The latter was a new kind of health worker and gave rise to much debate. Several countries along the eastern seaboard of Africa like the Sudan, Somalia, Uganda, Kenya, Tanzania, Malawi, Zambia, Lesotho and others like Papua New Guinea adopted the concept as part of national health planning. Their experience has shown that the medical auxiliary can become the backbone of a national health service. In the 1980's and '90s several of the more developed countries like New Zealand and Britain also adopted the concept.

In 1975 a joint World Health Organization (WHO) and United Nations Children's Fund (UNICEF) study estimated that only about a fifth of the rural population in the average developing country received basic health care on a regular basis. The study went on to describe alternative approaches to health planning in ten countries, and drew several conclusions from them. This was soon followed in 1976 by a study sponsored by the International Labour Organization (ILO) which estimated that almost two-thirds of the populations of developing countries were living in serious poverty, and 700 million people globally were destitute with incomes more than 50 per cent below the poverty line. The multiple deprivations suffered by such families were identified and their stunting effects on the potential for growth and development were decribed. Based on the study ILO advocated a 'Basic Needs Approach'.

The convergence of such new thinking regarding human development and alternative approaches in health planning evolved into the Primary Health Care (PHC) approach. Eight activities were identified as the elements of PHC as follows: 1) promotion of nutrition; 2) provision of adequate supply of safe water; 3) provision of basic sanitation; 4) maternal and child care including family planning; 5) immunisation against the major infectious diseases of childhood; 6) prevention and control of locally endemic diseases; 7) health education concerning the prevalent health problems; 8) appropriate treatment for common diseases, and injuries.

During the 1980's global economic recession prevented many countries from whole scale adoption of the PHC approach. Instead, a selective approach in which causes of childhood mortality were directly targeted came to be increasingly adopted by several countries as well as international donor agencies. One form of selective approach was promoted by UNICEF as a combination of growth monitoring, oral rehydration, promotion of breastfeeding, and immunisation under the acronym GOBI. Because of its cost effectiveness and practicality GOBI came to be widely adopted, and its impact was soon felt.

Encouraged by the success of the selective approach several diseases like onchocerciasis, dracanculosis, neonatal tetanus and poliomyelitis as well as nutritional deficiencies like xerophthalmia and iodine deficiency goitre also came to be targeted. In a similar vein the appalling high maternal mortality was made a focus of international attention, and the Safe Motherhood Initiative was launched in 1987. At the world summit for children heads of states from 140 countries agreed a number of milestones as progress towards HFA 2000. These milestones seemed achievable in the general optimism created by the rolling back of several killer diseases of children during the 1980's.

But the 1990's unfolded a different scenario. Economic recession and political turmoil around the world meant that in many countries a backslide in health gains had begun. The world summit goal of bringing down the under-five mortality to 70 per thousand is unlikely to be achieved, particularly in sub-Saharan Africa (under-five mortality rate 170 per thousand in 1997), and South Asia (under-five mortality rate 116 per thousand in 1997), which jointly house 43 per cent of the world's children under the age of five. For the developing

world as a whole where 89 per cent of the world's under-five population lives, the under-five mortality rate stands stubbornly at 96 per thousand.[1] The yearly toll of maternal deaths has reached almost 600.000.[2] Experience with PHC activities in the 1980's had demonstrated the crucial role of female literacy in the application of health promoting strategies at the family level. Female literacy rates are still below 50 per cent for sub-Saharan Africa (47 per cent in 1995), the Middle East and North Africa (47 per cent), and South Asia (36 per cent). New revised targets have now had to be set for the elimination of a number of highly preventable conditions like vitamin A deficiency, iodine deficiency, and trachoma.[3]

By its very nature, selective primary Health Care would be expected to slide back in the absence of a sustaining health infrastructure. Economic recession and political unrest in many countries held back reorganisation of national systems to be responsive to the needs of the poor rather than the demands of the rich. Political will may not be the whole answer for an efficient health system; but of all the ills that kill the vulnerable, none is as lethal as bad government.

During the 1990's economic disparities between countries and within countries have grown. Some 700 million people currently live in the 42 highly indebted poor countries (HIPCs). A new creativity and a new partnership between the rich and the poor is needed if these 700 million people (projected to rise to 1,5 billion by the year 2030), as well as the extremely poor in other parts of the world are to have a better future. Economic aid is not the only answer. A better approach would be for the wealthy governments to enable the grossly under financed United Nations (UN) institutions to become more vibrant and active partners of human development. In this respect the failure of the United States to pay its UN dues is surely the most flagrant violation of international obligations. Leaving aside the chronic shortage of resources resulting from it the lowering of morale amongst the UN agencies has been very damaging.

Against this background ten new targets are being proposed for HFA in the 21st century. These targets fall into three broad groups viz.

1. Improvements in health indices and outcomes.
   1. 1 Improved survival as measured by life expectancy, maternal mortality, and child mortality.
   1. 2. Equitable health services.
   1. 3. Reverse global trends in five major pandemics: malaria; tuberculosis; HIV/AIDS; tobacco related diseases; violence and trauma.
   1. 4. Eradicate and eliminate certain target diseases: leprosy and Chagas's disease; measles; filariasis; trachoma; vitamin A and iodine deficiency by year 2020.
2. Addressing main determinants of health.
   2. 1. Improving access to drinking water, sanitation, food and shelter.
   2. 2. Promoting health enhancing lifestyles and taking action against health damaging ones.
3. Encouraging development of sustainable health systems.
   3. 1. Promoting national policies in support of HFA, as well as their translation into action through good management as well as institutional and legal framework.
   3. 2. Improve access throughout life to good quality comprehensive health care based on essential public health functions with a life-span approach.
   3. 3. Appropriate local and national surveillance and health alert systems.
   3. 4. Research policies and institutional mechanisms at global, regional and country level.

The target set are desirable with measurable yardsticks in the case of many.[4] Clearly, a great deal of effort has gone into developing them. Yet there are several glaring omissions which cannot go unchallenged. Child growth monitoring has been identified as one of the major activities for target 1.1 with the objective of achieving *"the percentage of children under five years who are stunted should be less than 20% …"* The maximum period of growth that an individual experiences is in foetal life. There are countries where rates of low birth weight (< 2.500g) are as high as 33% (India) and even 50% (Bangladesh). Yet there is no mention of ensuring optimal foetal growth. Clearly such a high prevalence rate of low birth weight indicates that it is a public health problem of major concern. At present UNICEF is the only international agency to recognise the situation as one of "foetal malnutrition". Much of the high prevalence rate of low birth weight stems from social factors, and serves as a reliable indicator of the social status of women in the society. Addressing the problem would well fit into the objective of equity set for group one targets. A focus on foetal and neonatal health is even more desirable in the light of group three targets where a life-span approach has been described *"… acknowledging that many factors in early life have a cumulative impact on health in later life"*. Low birth weight and inadequate growth in the first year of life have been linked to hypertension,[5] coronary heart disease,[6] diabetes,[7] and

several other non-communicable diseases in adult life.[8]

The role of breastmilk in ensuring the survival of the newborn and the infant in the overcrowded disadvantaged communities is well established, and proven by experience with the GOBI programme. It is very likely that breastmilk helps to ameliorate some of the adverse effects of suboptimal growth in foetal life. Yet it receives no mention, leaving one to wonder whether there would be a need for GOBI - markII to make up for the omissions in HFA - 21st century.

Another very significant area left out is that of mental health. Almost half the world's children are now living in urban areas. In the giant cities of Africa, Asia, and Latin America 40 per cent of the children are growing up in slums, shantytowns, and *favelas* amidst squalor, family break-ups, violence and social strife. Mortality rates due to violence are shockingly high amongst school children, adolescents and adults in these communities demanding urgent intervention. Does the international community have nothing to offer for the promotion of mental health in the world of tomorrow?

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