PRIMARY HEALTH-CARE SERVICES

PRIMARY LEVEL

ICRC

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This document was written by Pierre Perrin, chief medical officer of the ICRC. It was later reviewed by ICRC health staff (headquarters and field) and their comments and suggestions were incorporated into the final version. It was validated as an official ICRC thematic document by Hervé le Guillouzic, head of the ICRC health unit.

INTRODUCTION

Health systems comprise all services whose main purpose is to promote, restore or maintain health, defined as a state of complete physical, mental and social well-being and not simply as the absence of any illness or infirmity.

Health systems are complex structures that may be viewed from various angles:

- National health policies, which strike a balance between
  - preventive services, whose purpose is to prevent illnesses and which are usually located near population centres;
  - curative services, whose purpose is to treat patients, and which are usually provided in medical facilities such as community clinics or hospitals.
- Links with services that are not strictly speaking health services but are essential for maintaining health. These services deal with areas such as nutrition, water supply, environmental hygiene and living conditions.
- The allocation of available resources, especially human resources, most of which are assigned to hospitals.
- The influence of international norms such as the Alma-Ata Declaration.

For the sake of clarity, ICRC health interventions may be divided into three categories:

- Interventions in primary health-care services, i.e. all health services delivered directly to the population (immunization, outpatient treatment, provision of drinking water, nutrition) with a view to maintaining health, preventing illness and dealing with common medical problems.
- Interventions in hospital services (surgery, internal medicine, paediatrics, obstetrics, etc.).
- Interventions in services ensuring the continuity of care (hospital referral, follow-up care after dismissal from hospital).

Armed conflicts have repercussions on people's health (wounds, population displacements), on health systems (deterioration due to lack of human and financial resources, attacks on health facilities) and on access to health services (insecurity). These repercussions may be immediate or take effect gradually, over the years.

In health emergencies as in periods of stability, restoring access to primary health-care services is a priority in so far as many health problems can be dealt with by means of preventive care and conventional therapy. Depending on the context, the ICRC must often take action in this area, taking into account the level of emergency, the involvement of other actors, the possible evolution of the situation and the organization's operational strategies.

The purpose of this document is to help health coordinators understand the various procedures used by the ICRC for its primary health-care interventions and to define the role played by these interventions in an integrated approach to assistance activities and the ICRC's action as a whole.

A| ICRC PROCEDURES FOR INTERVENING IN PRIMARY HEALTH-CARE SERVICES

1. Analysing the health situation

Three types of analysis are involved.

1.1 Public-health analysis

The purpose of this analysis is to assess the match between people's health needs and the available services.

- As regards people's health needs, the aim is to determine the most prevalent health problems, their seriousness (mortality, morbidity, disability) and how willing people are to become involved in a health strategy.
- As regards the available services, the aim is to determine:
  - their capacity (can they cover needs, in particular when these needs are growing because of an influx of displaced people?)
  - their quality (are the services in line with national and international norms?)
  - their potential resilience to foreseeable political change (to what extent would they be able to operate in an insecure environment where, for example, part of the health staff would be driven to leave the area?)

1.2 Analysis of the role of the health actors involved

The number and types of health actors involved vary from one situation to another.

- It is important to assess a population's ability to grasp its health problems and to propose strategies for dealing with them. There is an anthropo-sociological aspect to this part of the analysis. While it is true that the health field lends itself to quantitative analysis, qualitative analysis can provide data on how people perceive health problems and how satisfied they are with the services delivered.
- Health ministries are responsible for providing people with appropriate health services. Although in some cases they may not have the means to do so, this does not absolve them from that responsibility. The purpose of analysing the role of health ministries, including their role in managing community health services, is to determine how willing and able the authorities are to shoulder their responsibilities. Considerable weight should be given to this aspect when drawing up the ICRC's intervention strategy.
- The National Red Cross and Red Crescent Societies are the partners with which the ICRC will most often be working. The criteria for entering into discussion on a form of cooperation with a National Society are its acceptability in a given context and its operational capacity and available human resources. The relevant frame of reference is the Seville Agreement.
- Some United Nations (UN) agencies may also be on the scene. World Health Organization (WHO) and United Nations Children's Fund (UNICEF) are the two agencies with which the ICRC may have contacts and, in some cases, work.
- A great many national and international NGOs carry out primary health-care activities, especially when massive population displacements occur. Some are specialized in emergency situations. Others may be involved in development or other projects when they have to respond to emergencies. The ICRC does not conclude framework agreements with NGOs. When needed, it makes ad hoc arrangements based on respect for its neutrality and independence.

1.3 Analysis of the political situation

This analysis focuses on the security problems that will have a strong bearing on the ICRC's intervention procedures and, in some situations, prevent the organization from acting, the main point here being to strike a balance between people's needs and the risks that the ICRC can afford to take.

It is essential for the ICRC to determine these parameters so that it can decide whether or not it should proceed to set up primary health-care services or support existing ones.

2. Planning an intervention

2.1. Define a strategy for maintaining or restoring access to primary health-care services

There are three possible strategies for the two types of situations that may arise.

"Major emergencies"

When the population's vital needs are not covered by existing health services, the ICRC usually adopts a strategy based on **emergency medical/health interventions (EMHIs)**, the aim being to cover these needs as soon as possible and to provide the primary health-care services immediately required to preserve the foundations of health (food, water) and reduce morbidity (communicable-disease control, immunization campaigns, treatment of common medical problems). In such cases we speak of the **minimum package of activities**, which are often planned, set up and managed by humanitarian organizations, with relatively little input from the target population. EMHIs are typical of public health emergencies in IDP and refugee camps. Their basic features are:

- a rapid analysis of health problems
- a generally very low degree of involvement of the population
- the primacy of immediate effectiveness over sustainability
- the predominant role of humanitarian organizations in setting up primary health-care services
- a mode of action based on substitution
- health objectives defined in relation to needs (mortality) and service coverage
- health services based on international norms (Sphere, WHO norms, etc.)
- just the amount of coordination needed to avoid any obvious duplication of efforts
- the absence of any exit strategy, at least during the initial period
- a follow-up system for monitoring the population's health and the growing involvement of WHO in running the services and thereby ensuring a form of coordination

In acute health crises, the speed at which victims obtain access to primary health-care services is a key efficiency factor. The ICRC's decision-making process must be very swift and rely on the expertise of the organization's health staff.

Stable situations

Stable situations are situations in which the imbalance between health needs and health services does not lead to high mortality/morbidity rates. In such cases it is possible to adopt a classical **"primary health-care" (PHC) strategy,** the purpose being to ensure that the population plays a substantial role in identifying health problems and in managing – and if possible funding – the primary health-care services, which must be of good quality, accessible to all and affordable.[1]

This approach is geared to development and requires more time. It is preceded by in-depth negotiations with the population and the health authorities.

ICRC interventions within this strategic framework are characterized by:

- a detailed analysis of existing health problems
- the participation of the population
- the integration of the ICRC's intervention into a national health policy
- formal partnership agreements
- a mode of action based on support for existing primary health services
- long-term commitment

When a PHC approach is adopted, the speed of the decision-making process is not an efficiency factor. What is essential is to carry out a thorough analysis of needs and of the ICRC's interactions with the other actors involved, especially the target population and the health and political authorities.

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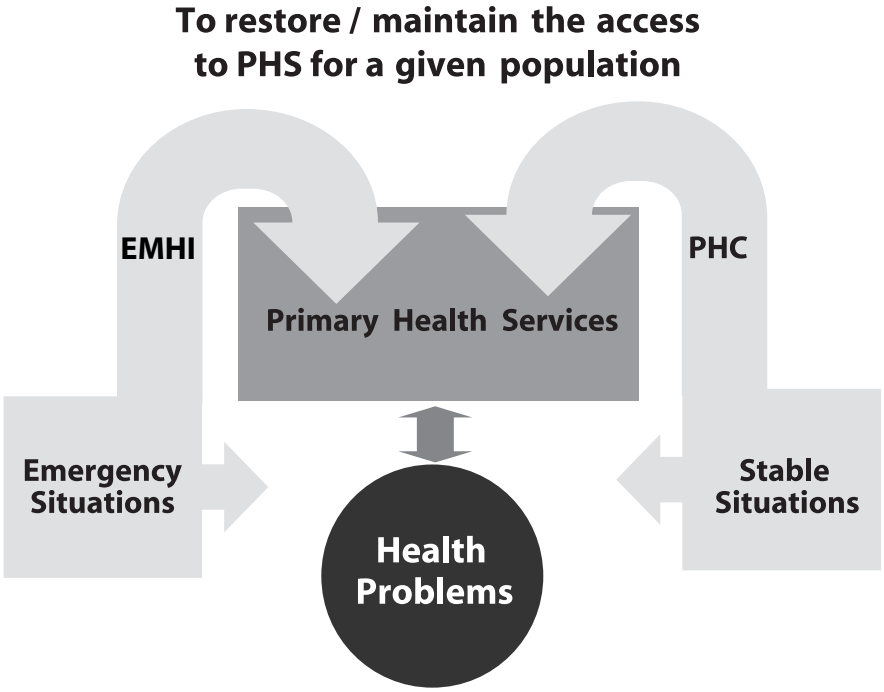
[1] "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is 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 live and work, and constitutes the first element of a continuing health care process." Declaration of Alma-Ata, point VI, in Alma-Ata 1978 – Primary Health Care, WHO, Geneva, 1978.

The mobile-clinic strategy consists in delivering primary health services by means of clinics that are not fixed but travel from one area to another. It is the ultimate strategy for reaching communities with poor access to health care. The criteria for establishing mobile clinics are given in the ICRC document entitled "Mobile health units: Methodological approach" (2006).

What are the ICRC's criteria for determining its strategy?

When determining what strategy to use, it is important to:

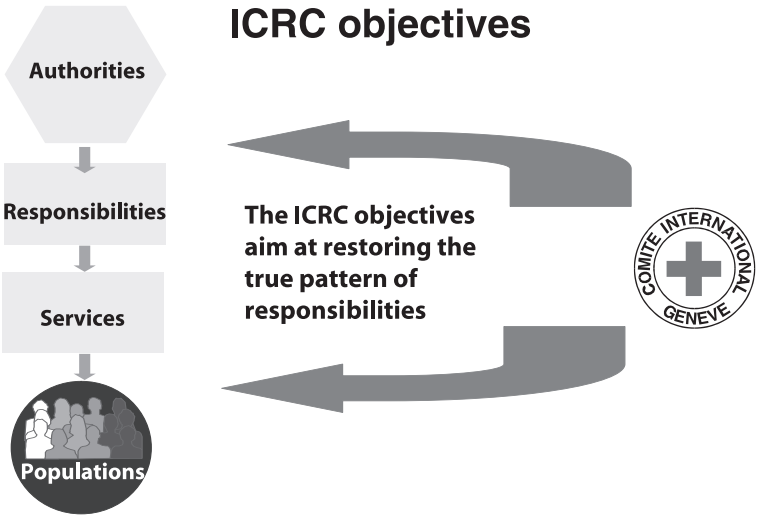
- Define primary health-care services in terms of the priority health problems within the population.
- Put the emphasis on preventive measures.
- Use an appropriate and scientifically sound technology.
- Have a dynamic vision of the health system facilitating a multi-sectoral approach to health (diet, nutrition, water, environmental hygiene, preventive and curative care).
- Have a permanent vision of the role and work of the other actors in this field.
- Ensure that the procedures for setting up primary health-care services are consistent with the national health policy:
  - in a PHC strategy, such consistency is indispensable and a precondition for implementation;
  - in an EMHI strategy, consistency is desirable but not necessary, especially if it would delay implementation.
- Be able to discuss a framework agreement, in particular with the health authorities, when a sharing of responsibilities is being considered.
- Have the target community take part in the entire procedure for devising and carrying out the health activities:
  - essential in a PHC strategy
  - important in an EMHI strategy



2.2. Set clear objectives

A general objective is set with regard to a particular health problem faced by the population; specific objectives may be set with regard to the coverage of services. It is important to always be able to establish the general objective to which specific ones are linked. For instance, building a community clinic is a specific objective that contributes towards the general objective of providing the population with primary health-care services.

As regards the need for the authorities to shoulder their responsibility for managing primary health-care services, objectives are set on the basis of the perceived motivation and commitment of the authorities and of the qualitative and quantitative analysis of the health services actually provided for the population.



2.3. Select the primary health-care services concerned and draw up a plan of action

2.3.1. Choice of primary health-care services

Different primary health-care services are targeted depending on the situation. In major emergencies, the selected services will be those with a potential for immediate impact on what are usually common medical problems such as the risk of measles, diarrhoeal illnesses, lung infections or malaria. Such services might include mass immunization campaigns, outpatient consultations in quickly set up clinics, etc.

In stable situations the range of services is often wider. Depending on the context, the ICRC might propose setting up services that screen for chronic illnesses, for example.

Non-exhaustive list of services:

- Provision of clean water
- Provision of food
- Mother and child care
- Immunization
- Prevention of contagious diseases
- Hygiene promotion
- Treatment of common illnesses
- Provision of essential drugs
- Reproductive health
- Mental health
- Outpatient curative care
- Inpatient curative care

2.3.2. Drawing up a plan of action for each primary health-care service

- The plan of action for each primary health-care service must include the target population, the tasks involved in setting up the service and the order in which they will be done. In the case of outpatient curative care, for example, it will be necessary to:
  - build/rehabilitate the facility
  - train the staff
  - set up a system for providing drugs
- The plan must also define the criteria that will be used to evaluate the service's work.
- It must describe how responsibilities will be shared between the various actors involved in setting up and managing the service.
- It must specify how the various health services will be coordinated.
- Finally, it must stipulate how the services will be monitored, describing the chosen indicators, the methods to be used for gathering these indicators and the role of the indicators in decision-making processes.

B | ROLE OF PRIMARY HEALTH-CARE INTERVENTIONS IN AN INTEGRATED APPROACH TO ASSISTANCE ACTIVITIES AND THE ICRC's ACTION AS A WHOLE

1. Role of primary health-care interventions in an integrated approach to assistance activities

1.1. Link with hospital sector

Primary health-care services must be linked to the hospital sector, whether the ICRC is active in this sector or not. The decision to work in hospitals will depend on the analysis that the ICRC has made of the entire health system. It must be taken at the same time as the decision to intervene in the primary health-care services.

1.2. Integrated approach to assistance

This approach is formally described under point 4.2 of the "ICRC Assistance Policy." In practice it means:

- joint analysis of new situations by the three assistance units
- plan of action taking into account the need for consistency between the services provided by those three units, for example between water and health or between nutrition and health
- integrated monitoring of the interventions carried out by the three units

2. Role of primary health-care interventions in ensuring respect for personal and community integrity

Primary health-care services are by definition community services. As such, they provide the ICRC with a unique possibility of being in direct contact with the population. In practice, this means that health interventions will be based on expressed needs and on the participation of the population in drawing up and implementing a plan of action – within the limits mentioned above – and that they will be adapted to local cultural specificities.

Generally speaking, the ICRC's health and other assistance activities are highly appreciated by the target population. As a result, a climate of trust is established between assistance staff and those whom they are seeking to help, and this trust will be all the stronger if it is grounded in respect and empathy.

Owing to their presence in the field and to the trust people place in them, health staff and all those in charge of assistance work are likely to receive information on violations of international humanitarian law that affect the security of individuals (ill-treatment, torture, disappearances) or entire communities (dispersion of families, forced displacements, discrimination). By collecting and passing on such information for use in specific activities (representations, Red Cross messages), they often play a major role in ensuring respect for personal and community integrity.

Health staff are also often the first to receive information related to incidents and other problems caused by mines or explosive remnants of war (ERW), which when passed on, can be used to develop appropriate preventive mine-action operations activities by the ICRC or other relevant actors.

C| MONITORING THE PROVISION OF HEALTH SERVICES AND THEIR INTEGRATION WITH OTHER ASSISTANCE ACTIVITIES AND WITH PROTECTION ACTIVITIES

A system for monitoring the performance of primary health-care services and the context in which they operate is set up at the start of the intervention. It covers both the activities carried out by these services and those pertaining to access to food, water and a healthy environment. In addition, a link must be established with activities focusing on respect for individual and community integrity.

1. Primary health-care services

1.1. Monitoring primary health-care services

The indicators to be used for monitoring each primary health-care service (immunization, outpatient medical care, etc.) should focus on:

- the quality of the service provided (monitoring of tools for improving the quality of the service)
- the coverage of the service

1.2. Monitoring the strategy for setting up primary health-care services

One must be able to answer the following questions:

- How do health priorities change during the course of the ICRC's intervention?
- Have the characteristics of the national health system changed?
  - new health policy
  - greater involvement of the authorities / responsibilities not shouldered
  - changes of persons within the health system
- Has the level of popular participation changed?

The indicators are:

- technical (changes in the specific morbidities already identified when monitoring the primary health-care services)
- political (attitude of the health authorities, which are monitored by means of regular, documented meetings with those in charge of the national health policy)
- sociological (the population's attitude towards health services, which may be analysed by means of group discussions)

1.3. Monitoring the ICRC's modes of action with regard to primary health-care services

Health interventions fit into an overall strategy based on the various modes of action described in the "ICRC Assistance Policy."

Changes in strategy regarding the authorities will depend on an analysis of the above-mentioned indicators. For example, the decision to go from substitution to support will depend among other things on:

- the evolution of urgent health needs
- the willingness and ability of the authorities to shoulder their responsibilities

2. Integration with the activities of other assistance units

When analysing several services and their interactions, it is important to have indicators specific to each and to compare them. For example:

- coverage of water projects and evolution of the rate of diarrhoeal illnesses
- immunization coverage and the rate represented by the number of cases observed in the clinics
- number of consultations in clinics and the rate represented by the number of patients referred to hospitals
- malnutrition rate observed in clinics and access to food or sharp increase in certain communicable illnesses

3. Integration with protection activities

Mine/ERW incidents,[1] ill-treatment, forced displacement and the dispersion of families are all indicators that may be monitored in the field by health staff in charge of running primary health-care services. The monitoring of these indicators may thus be considered as a factor of integration between health activities, on the one hand, and between health activities and those focusing on personal and community safety, on the other. The joint analysis of these indicators provides a basis for building a solid coordination process. It makes it possible to monitor not only the performance of primary health-care services, but also their integration with assistance activities and, more generally speaking, with the ICRC's action as a whole.

The plan of action adopted for each primary health-care service, the monitoring of the plan and the hypotheses that underlie it must be integrated into a logical framework.

D | *EXIT STRATEGIES*

Action plans include entry and exit strategies. An exit strategy is drawn up at the start of an intervention with all the actors concerned, at least when a PHC strategy has been adopted. This facilitates the community's involvement in and adherence to the programme from the outset and makes it possible to identify partners who could later take over the programme.

Exit strategies must be flexible. However, they must not be subject to the arbitrary decisions of successive programme managers but must be based on objective criteria. Indeed, when the ICRC launches a health programme it takes on a responsibility towards the community. Ethically, it is unacceptable to leave the community with no viable alternative to a programme that has had a positive impact on it. To prevent this from happening, the plan of action must therefore include:

- a written agreement whereby the partners pledge to take over the programme according to a set timetable. Later on, a certain amount of flexibility may be shown if the partners are unable to shoulder their responsibilities within the allotted time. Since the partners are, in fact, the authorities, this approach is in line with one of the ICRC's modes of action, which is to persuade the authorities to shoulder their responsibilities.
- a plan for monitoring the programme – not only the activities carried out (number of patients treated), but also the process of helping the partners who will eventually take over the programme to shoulder their responsibilities.

While exit strategies must be planned at the start of the intervention in stable situations, it is often more difficult to do this in major emergencies, which are characterized by political chaos and the unforeseen involvement of other health actors.

Exit strategies may also turn into emergency exits when security conditions no longer allow the ICRC to continue working, or when the authorities stop granting access to the target population.

Finally, the ICRC may have to pull out because for various reasons – insufficient access, breaches of agreement by its partners, etc. – it can no longer maintain quality services.

[1] ERW: explosive remnants of war

CONCLUSION

Primary health-care interventions provide a means of dealing with the main health problems faced by communities. Technically, they are the fruit of numerous experiences in the field and of the intensive research that has been carried out in recent years and has given them true credibility. The procedures involved are very complex, however, and require a careful analysis of each situation. To ensure the implementation of a consistent and effective health strategy, health staff must be included at all levels of the decision-making process. Through their activities in the field, they can also take advantage of the direct contacts they establish within communities to further the ICRC's protection efforts. This is not a minor aspect of their work, but an integral part of their responsibilities.

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ANNEX 1 | DEFINITIONS

1. Health: an entity, a right, a responsibility

"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (…) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures[1]".

2. Health systems

In 2000 WHO defined a health system as a system that includes all actions whose primary purpose is to promote, restore or maintain health.

3. Primary health care (PHC)

For decades, health systems were centred around care given to patients in medical facilities. In the 1978 Declaration of Alma-Ata,[2] WHO defined an approach under which health systems should focus on essential services – including preventive services and those promoting health – and make them accessible to all. Today, this strategy is still the main foundation on which health systems are built.[3] Whatever the circumstances and political environment, the emphasis is on ensuring universal access to essential health services.

While still relevant, the PHC strategy must be adapted to new health problems (HIV/AIDS did not yet exist when the Declaration of Alma-Ata was drafted), to demographical changes (the elderly population poses specific problems in developed countries), to changes in national health policies, which are increasingly reliant on the private sector, and so forth.

4. Emergency medical/health interventions (EMHIs)

Natural disasters and armed conflicts affect entire communities and seriously disrupt primary health-care services. When health situations become critical, EMHIs can be used to deliver such services as quickly as possible. Since primary health-care services are not necessarily delivered in accordance with primary health-care principles, the PHC and EMHI strategies are described as two separate ways of reaching the same goal, which is to provide primary health-care services.

5. Mobile clinics

Mobile clinics are a strategy for reaching communities that have a permanent problem of access to primary health-care services.

6. Health services

Health services comprise specific activities such as immunization, health education and medical consultations, but also combined activities such as prenatal services, which include prenatal consultations, tetanus vaccinations, etc.

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[1] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 -22 June 1946.

[2] See below.

[3] At its 13th session, in January 2004, the WHO Executive Board reiterated its recommendations aimed at developing health systems based on the PHC principle.

7. Primary and secondary levels of health services

The primary level of health care is the first level of contact a community has with the national health system. The corresponding services are delivered either directly within the community or within acceptable reach of it.

The secondary level of health care comprises all hospital services.

In practice, this distinction is not absolute. However, it has the advantage of defining at what level(s) the ICRC should intervene. Furthermore, it corresponds to the operational structure of the ICRC health unit.

8. Logical framework

The logical framework is used to combine within a matrix the elements summarily described below.

- logic of the intervention:
  - overall objectives, i.e. those towards which the intervention is meant to contribute
  - specific objectives to be reached during the intervention
  - results: end product of the activities carried out, which together will make it possible to reach the specific objective
  - activities: work needed to obtain the results
- indicators, which are used to ascertain to what extent the objectives have been reached and to what degree the activities have been carried out in accordance with predetermined quality criteria
- the methods used for measuring the indicators
- the hypotheses on which the project is based; these involve external factors on which the intervention has no direct influence, but which themselves have a major influence on results and objectives.

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is 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 country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is 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 live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente- and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share. The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

ANNEX 2 | OPERATIONAL FRAMEWORK

1. Political analysis

Armed conflicts generally destabilize political, economic and socio-cultural institutions. It is important to measure what impact this has on the national health system, especially as regards the activities of national health personnel, the suitability of health policies and the degree of control that health authorities have over the establishment and distribution of health services.

If the primary health-care strategy is to work, health institutions must be relatively stable so that ICRC interventions can be integrated into national health policies. In chaotic situations, where health authorities lose control over their services or where certain population groups are denied access to those services, emergency medical/health interventions may be the only viable strategy.

2. Health crises in armed conflicts

The "ICRC Assistance Policy" gives a definition of health crises based on needs and the ability of health services to meet them.

- emerging crisis and pre-crisis situation: essential needs are still being met, but there is a risk that they will not continue to be met
- acute crisis: certain essential needs are not being met
- chronic crisis: essential needs are not being entirely met and an acute crisis could recur
- post-crisis situation: essential needs are being met by existing services, but these remain fragile

In armed conflicts, many factors contribute towards creating an imbalance or increasing one that already existed. Population displacements sever the link between communities and their health systems, for example. Other features specific to health problems in conflict situations include insecurity, the collapse of health systems and the flight of health staff.

3. Armed conflicts and health crises: a dynamic framework

The following aspects must be taken into consideration:

- There is a certain correlation between the dynamics of armed conflicts and the dynamics of health crises. When conflicts are acute, communities are more likely to face acute health crises than during the transition phase. However, health crises do not necessarily follow the "political" evolution of armed conflicts. The pre-conflict and chronic phases may sometimes be characterized by acute health crises.
- However severe a health crisis may be, health activities always have the same goal: to restore and/or maintain as broad and easy access as possible to health services with a view to treating and preventing health problems.

A combined analysis of the political and health situation is essential to enable the ICRC to decide on the need for a health intervention on the basis of its fundamental principles.

4. Choosing an overall strategy: the five modes of action

The ICRC strives to ensure that the authorities fully assume their responsibilities towards those affected by armed conflict. To this end it has developed a strategy based on five modes of action: persuasion, mobilization, support, substitution and denunciation.

Persuasion: The ICRC makes representations to the authorities in an effort to persuade them to respect their obligation to preserve the lives, health and dignity of individuals, groups and populations under their control.

Mobilization: The ICRC may mobilize third parties[1] who will endeavour to persuade the authorities to shoulder their responsibilities or, failing that, will strive either directly (themselves) or indirectly (by supporting others) to assist those affected.

Denunciation: In cases where credible information points to the existence of serious and repeated violations of international humanitarian law, the ICRC may, in accordance with its policy guidelines,[2] take steps to denounce those responsible.

Support for local structures/partners: The ICRC provides support for local structures and partners wherever it considers that they constitute a viable means of ensuring access by the group affected to basic goods and services. This mode of action is the best way of preserving existing structures over the long term. Furthermore, cooperation with local structures/partners enhances the ICRC's work and may provide the basis for an exit strategy.

Substitution/direct provision of services: The ICRC substitutes for the authorities and directly provides a service for those affected. The decision to do so depends on the urgency of the health crisis and the inability or unwillingness of the authorities to address it.

In practice several scenarios are possible. In the best of cases, the authorities fulfil their obligations and the ICRC simply monitors the situation to make sure that their "good conduct" continues. At worst, the authorities – or opposition groups, when they are in control of the population – are themselves responsible for violating people's rights, for example by denying access to health services or destroying health facilities. Between these two extremes, it is of course also possible that the authorities may be willing to shoulder their responsibilities but lack the means to do so, or that they have the means but lack the will. Whatever their attitude may be, the ICRC will adopt a strategy based on the best combination of modes of action for a given situation at a given time.

5. Choosing a strategy for setting up primary health-care services

As explained in the main document, choosing a strategy for setting up primary health-care services entails the following decisions:

- selecting the primary health-care services appropriate to the given situation
- determining a suitable health strategy (PHC or EMHI)
- choosing the practical means for delivering primary health-care services

Depending on the decisions made at these three levels, primary health-care interventions may take various forms.

[1] i.e. States, international or regional organizations and private firms or individuals.

[2] See DOCT/15, "Les démarches du CICR en cas de violations du droit international humanitaire ou d'autres règles fondamentales qui protègent la personne humaine en situation de violence."

6. Defining a general strategic framework

The general strategic framework for setting up primary health-care services will depend on the link between the overall strategy (modes of action) and the primary health-care strategy, each of which has its own requirements and constraints.

The five modes of action can be combined in such a way as to devise overall strategies for various contexts. Among other things, these contexts are defined by the attitude of the authorities or other actors responsible for delivering primary health-care services to the population.

The notion of responsibility for the health of the population is grounded in specific norms.

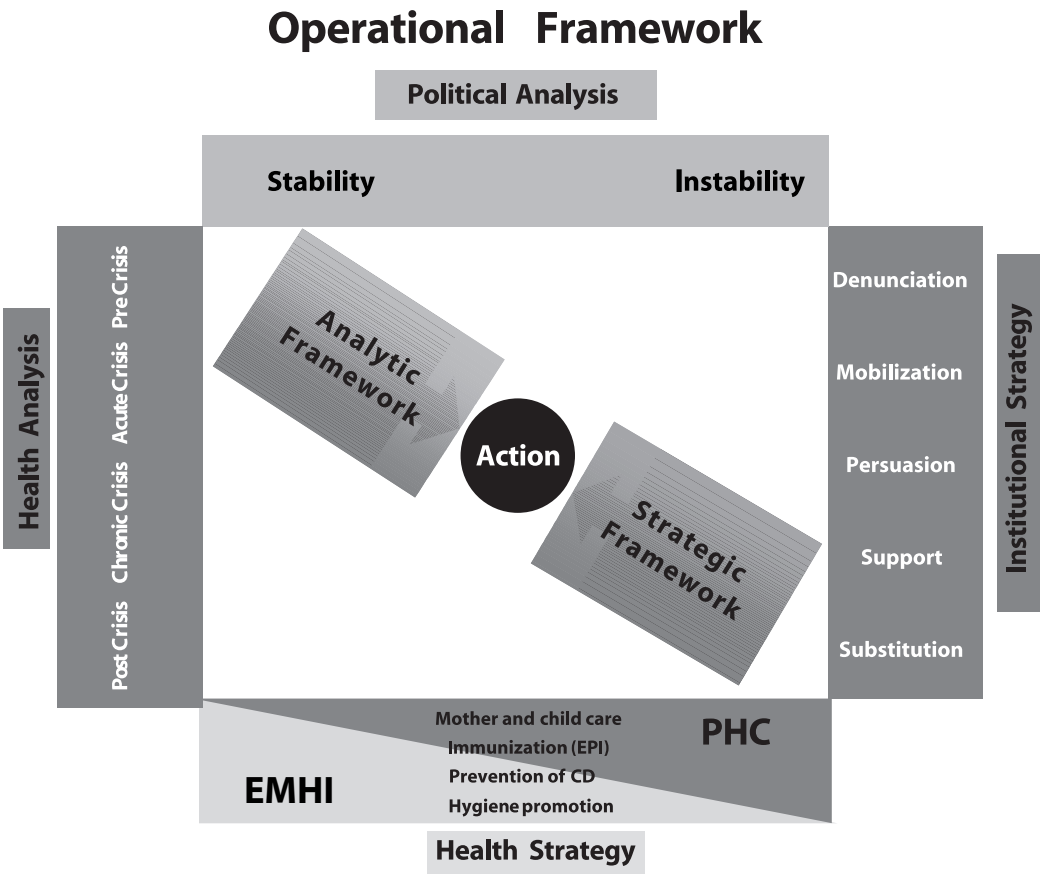
As stated in the Preamble to the WHO Constitution:

> "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."[3]

Likewise, the "ICRC Assistance Policy" asserts:

> "While circumstances may lead the ICRC to provide services for affected groups, it is not the organization's role to relieve the authorities of their responsibilities. The ICRC will continue to urge them to ensure delivery of those services and fully meet their obligations."[4]

Taken together, the analytical and strategic frameworks for health activities make up the operational framework in which such activities are carried out.



[3] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946.

[4] DOCT/49, "ICRC Assistance Policy," p. 9.

ANNEX 3 | STAGES OF THE ICRC'S DECISION-MAKING PROCESS
(explanation of the "ICRC Assistance Policy")

1. Decision-making stages

There are five stages to the ICRC's decision-making process:

- the ICRC decides to act in a given situation
- the ICRC decides to act on behalf of a specific population group
- the ICRC decides on an overall strategy based on the best possible combination of the five modes of action
- the ICRC decides on a strategy for its assistance programme
- the ICRC decides on a plan of action for implementing the programme's activities

"Assistance must always be regarded as forming part of an overall ICRC strategy. This necessarily entails close cooperation among all programmes and all levels of decision making." [1]

1.1. First stage: deciding to act in a given situation

Basis for decision

This is clearly an institutional decision to be taken on the basis of the ICRC's analysis of the political situation and how it fits in with the relevant law (international humanitarian law). The Seville Agreement and the potential evolution of the situation must also be taken into account.

The analysis made of the health situation plays an important role in this decision as well. As noted in Annex 2, there is not necessarily any direct correlation between health crises and political crises. For example, an acute health crisis may occur in a situation of chronic conflict. The existence of such a crisis would be a determining factor in any decision to make a long-term commitment in the health field.

Decision-making structures

The Directorate of Operations and the heads of delegation play a major role in making decisions at this level. They do so on the basis of the analyses made by the Health Services Unit and by health staff in the field.

1.2. Second stage: deciding to act on behalf of a specific population group

Basis for decision

Target groups are chosen on the basis of the following criteria:

- categories protected by international humanitarian law
- level of health crisis as defined in the "ICRC Assistance Policy" (including analysis of the capacities of the local health system)
- technical criteria for determining the feasibility of a health intervention (e.g. against tuberculosis)
- possible effects on the ability to act on behalf of other, less accessible groups.

Decision-making structures

The Directorate of Operations and heads of delegation play a major role in making decisions at this level. It is crucial for the Health Services Unit and health staff in the field to provide a professional analysis of the level of the health crisis, the ability of health systems to cope with it and the feasibility of an intervention.

[1] DOCT/49, "ICRC Assistance Policy," p. 9.

1.3. Third stage : deciding on an overall strategy

Basis for decision

Each mode of action is a strategy for improving the plight of the target population. For example, the purpose of persuading the authorities to change their attitude is to improve the situation of the population by putting an end to violations affecting physical safety or by improving access to primary health services. The relevance of each mode of action must be assessed in terms of its potential impact on the population. An overall strategy must give each mode of action its proper weight, allowing it to change over time.

While there are no standard combinations of modes of action, certain trends emerge from the analysis of past health crises.

When the authorities are willing to address an acute health crisis but lack the means to do so, the ICRC often adopts an approach based on substitution and support, while at the same time using persuasion and mobilization to restore responsibility where it belongs and, in the medium term, make it easier for the ICRC to withdraw.

When the authorities have neither the will nor the means to address an acute health crisis, and the ICRC does not have access to the target population, the initial strategy will be to secure access by means of persuasion and the mobilization of actors who could influence the situation. Subsequently, the strategy will be twofold. Substitution and if possible support (account being taken of the unwillingness of the authorities to meet the population's needs) will be used to restore access to primary health-care services. At the same time efforts will also be made to persuade the authorities to assume their responsibility for running the services. If the attitude of the authorities is hostile, then obviously it may take some time before these efforts bear fruit.

In pre-crisis situations, the ICRC does its best to prevent a humanitarian disaster by supporting the existing health system or mobilizing other actors to take action.

When faced with a chronic health crisis, the ICRC strives to find sustainable solutions and to ensure that its programmes can be taken over by the authorities – whose capacities it strengthens to this end – or, if not, by others. In specific cases where it has residual responsibility,[2] the ICRC continues its action.

The right combination of modes of action for a given population will depend on:

- the needs of that population
- the capacities of the national health services and the health services provided by others
- the attitude of the authorities, which may go from contempt for the rights of the population to a willingness to fully assume their responsibilities

Experience is the key factor at this level of decision-making.

Decision-making structures

Delegations define and implement the combination of modes of action best able to optimize the ICRC's activities. In any particular situation, for example, the respective weights given to persuasion, substitution and support depend largely on how severe the health crisis is. Health staff therefore have a determining role to play in devising the combination on which the strategy is based and in monitoring the situation so that this strategy can be adapted to any changes observed, in particular as regards the attitude of the authorities.

1.4. Fourth stage: deciding on a strategy for the relevant programme (economic security, water and habitat, health services)

Basis for decision

Strategies for assistance programmes are determined on the basis of the "ICRC Assistance Policy" and various documents specific to each unit. At this stage of the decision-making process, the present document on primary health-care services is the main reference.

Decision-making structures

It is obvious that Assistance Division staff must be responsible for making decisions at this level. Their task will be easier if they have a thorough knowledge of the situation as a whole and if the heads of delegation are sufficiently well informed about assistance programmes. This is the level at which the intersection between the "blue line" and the "red line" is clearest.

[2] The ICRC has a residual responsibility towards those whom it assists during a conflict, and more specifically towards those who would be endangered if it ended its programmes and those towards whom it knew, when it launched its activities, that it would have a lasting commitment. See DOCT/61, "L'action du CICR en période de transition."

1.5. Fifth stage: drawing up a plan of action for implementing the programme's activities

Basis for decision

"ICRC Assistance Policy"

- Water and habitat (WATHAB)
- Economic security (ECOSEC)
- Health services

Technical references

The relevant references are the technical guidelines established by the ICRC (immunization, malaria, prenatal care, tuberculosis, etc.) and those issued by normative organizations such as WHO (guidelines for cholera control, etc.).

Decision-making structures

Assistance Division staff are responsible for making decisions at this level. They do so mainly on the basis of the technical guidelines, whose applicability depends on the context.

2. Decision-making process

2.1. Dynamics of the decision-making process

The final decision to intervene in primary health-care services is the result of a decision-making process that integrates the four facets of the operational framework. Thus:

a. The ICRC's decision to intervene in a given situation depends both on its analysis of the political and legal situation and on the severity of the health crisis. The pre-conflict phase has a different meaning for the ICRC depending on whether there is an acute health crisis or no crisis at all.

b. The choice of overall strategy depends on the severity of the health crisis and on the attitude of the other actors involved. In acute crises, the most appropriate modes of action for restoring access to health services are usually substitution and support. However, various factors such as the hostility of the authorities to an ICRC intervention or one carried out by other humanitarian actors must be taken into account.

c. The choice of a health strategy based on emergency medical/health interventions (EMHIs) or primary health care (PHC), as well as the choice of the relevant health services, depend on the severity of the health crisis, the capacity of the target population to become involved in the programme, the national health policy and the chosen combination of modes of action.

2.2. Using the proper reference framework

While the ICRC's mandate plays a crucial role in identifying situations that fall within the organization's scope of action, it is of no avail when it comes to choosing health activities: **for that purpose, the health situation must be analysed in relation to the "ICRC Assistance Policy."**

2.3. Coordination/integration of the decision-making process

It is essential for health services to be properly coordinated. Access to clean water and communicable-disease control are interdependent. Likewise, when the ICRC is working in the hospital sector, coordination is needed for transferring and monitoring patients referred to hospitals by primary health-care services. This coordination is based on a structure in which:

- decisions regarding the establishment of services in the three traditional fields of assistance are taken together
- information on these services is systematically exchanged
- data is analysed on the basis of common health indicators (morbidity, mortality).

The coordination of health activities with so-called "protection" activities (i.e. those focusing on personal and community integrity) enables the ICRC to enhance the effects of its activities in these two areas through the exchange of information provided by the communities that are covered by its health services.

It is absolutely essential to ensure that everyone's responsibilities are clearly defined at each stage of the decision-making process.

The head of delegation has overall responsibility for coordination.

On the basis of the analyses carried out, the ICRC is able to take the following decisions:

- **Decision 1** : should the ICRC take action in a given situation?
- **Decision 2** : what population groups should be targeted by ICRC health interventions?
- **Decision 3** : on what combination of modes of action will the overall strategy be based?
- **Decision 4** : what strategy should be followed in setting up its assistance programme?
- **Decision 5** : how should the programme's activities be implemented ?

When the ICRC decides not to act, it must do so on the basis of solid arguments.