PRIMARY HEALTH CARE (PHC)

Description

This chapter gives an overview of the role of Primary Health Care (PHC) in humanitarian emergencies. It can also serve as an aid for implementing emergency PHC at the district level.

Learning Objectives

- To review the primary health care concepts and their relevance to humanitarian emergencies.
- To characterise a functioning district-level health system in developing countries.
- To compare the emergency health care and primary health care strategies.
- To define the steps for implementing primary health care in relief programs.

Key Competencies

- To describe the importance of the PHC approach to humanitarian emergencies.
- To define the components of a district-level health system.
- To understand the similarities and differences between emergency health care and PHC strategies.
- To design an emergency PHC program.

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Introduction

The primary responsibility for the care of a large displaced population falls on the government authorities in the host country where a displaced population has "settled." If the host country is unable to meet the health needs of the affected people, the host government authorities should invite humanitarian organisations to strengthen the local emergency response. The health needs of large displaced populations are not any different from the everyday health needs of many urban or rural communities in developing countries. Once the crisis is over, the displaced population is likely to return to an environment with limited resources for health care. It would be inappropriate to get them used to a standard of health care that cannot be achieved with their local resources. Therefore, humanitarian assistance should be delivered within the Primary Health Care (PHC) framework so that whatever skills the displaced population gains through community participation, health education, nutrition, and preventive health measures, can enable them to take responsibility for their health and rebuild their future.

OVERVIEW OF PRIMARY HEALTH CARE

Primary Health Care (PHC) is defined as:

> *Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made 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 in the spirit of self-reliance and self-determination.* (Health for All by the Year 2000, WHO 1978, Alma Ata)

Table 8-1: Terms and Definitions

Basic Health Facility	The first level of health care in the health system. Offers mainly ambulatory care, outreach and referral services. It is usually staffed by medical assistants, nurses, and auxiliary staff.
Community Participation	Involving families and communities who, rather than being mere beneficiaries of health care, share the responsibility of caring for their health. This promotes individual involvement and self-reliance.
Decentralisation	Transferring authority or responsibility in planning, managing resources and/or decision-making from the central level of government to the district and local levels.
District	The smallest, well-defined, administrative and operational unit of a central government. Represents the level where qualified personnel from different sectors can work directly with the community and other agencies.
District Health System (DHS)	A health care system set up for delivering primary health care to a population within a well-defined geographical area. It includes all concerned health care agencies, which are organised and co-ordinated by district health authorities. Managing a DHS requires involvement of multiple sectors as well as the community.
Equity	Providing equal health care to all groups of people according to their needs. Concerned with ethical aspects of service being delivered: giving highest priority to those with greatest health needs.
Health Workers	Physicians, medical assistants, nurses, auxiliaries, community health workers (CHWs) and traditional healers functioning within the health care system.

Principles of Primary Health Care

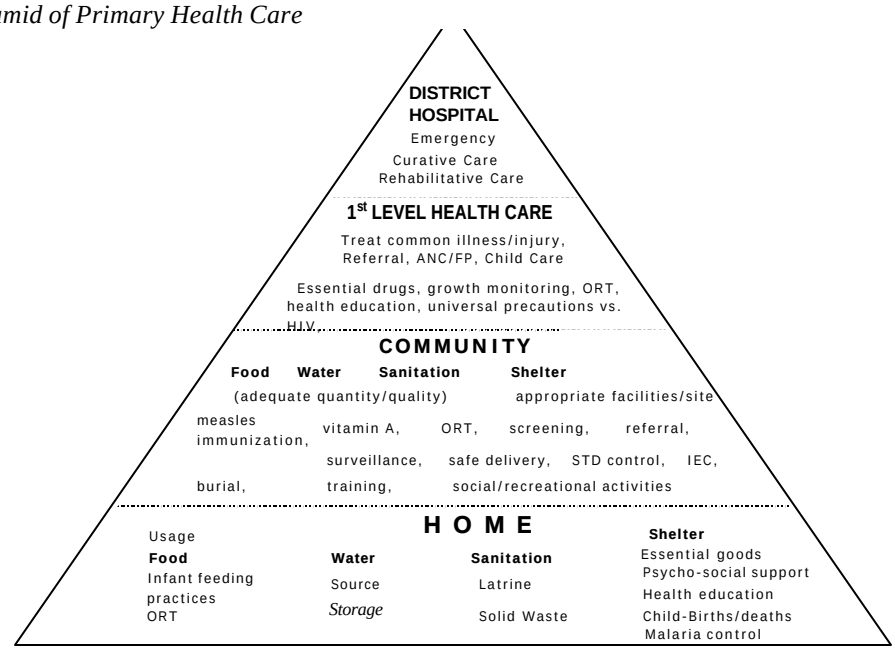
Primary health care is based on five main principles:

1. **Equity** — Services should be physically, socially, and financially accessible to everyone. People with similar needs should have equal access to similar health services. To ensure equal access, the distribution of resources and coverage of primary health care services should be greatest in those areas with the greatest need.

2. **Community Participation** — In addition to the health sector, families and communities need to get actively involved in taking care of their own health. Communities should participate in the following:
   - creating and preserving a healthy environment
   - maintaining preventive and promotive health activities
   - sharing information about their needs and wants with higher authorities
   - implementing health care priorities and managing clinics and hospitals
3. **Inter-Sectoral Approach** — PHC requires a co-ordinated effort with other *health-related sectors* whose activities impact on health e.g., agriculture, water and sanitation, transportation, education, etc. This is necessary to achieve social and economic development of a population. The health sector should lead this effort. The commitment of all sectors may increase if the purpose for joint action and the role of each sector is made clear to all concerned.
4. **Appropriate Methods** — An increasing complexity in health care methods should be observed upward in the PHC pyramid, (see Figure 8-1 below). Care-givers should be trained to deliver services using the most appropriate and cost-effective methods and equipment for their level of care.

   Note: *Appropriate technology does not necessarily mean low technology.*

Figure 8-1: Pyramid of Primary Health Care



5. **Health Promotion and Prevention —** PHC requires a comprehensive approach that is based on the following interventions:
   - **Promotive** — addresses *basic* causes of ill-health at the level of society.
   - **Preventive** — reduces the *incidence* of disease by addressing the immediate and underlying causes at the individual level.
   - **Curative** — reduces the *prevalence* of disease by stopping the progression of disease among the sick.
   - **Rehabilitative** — reduces the long-term *effects* or complications of a health problem.

   Comprehensive PHC combines facility-based health services (curative and rehabilitative) with multi-sectoral public health interventions (promotive and preventive). Because this approach is more effective in sustaining the overall well-being of a population, it should be supported by the community. The following table shows how the comprehensive framework of PHC services can be used to address common health problems.

Table 8-2: Comprehensive Framework of Primary Health Care

DISEASE/ INTERVENTION	PROMOTIVE	PREVENTIVE	CURATIVE	REHABILITATIVE
Diarrhoea	Safe water, basic sanitation, food security, health education, child care	Education (on personal hygiene), breast feeding, measles immunisation	Oral rehydration, nutrition support, (drug therapy)	Nutrition rehabilitation, special ORS
Pneumonia	Good nutrition, adequate shelter, clean air, health education	Immunisation, breast feeding, vitamin A supplement	Drug therapy	Nutrition rehabilitation
Measles	Good nutrition, ventilated housing, health education	Immunisation	Drug therapy, nutrition support	Nutrition rehabilitation
Malaria	Good nutrition, vector control, health education	Mosquito nets, drug prophylactics	Drug therapy	Nutrition rehabilitation
Anaemia	Vector/parasite control, Good nutrition, health education	Screening, Iron/folate prophylactics, de-worming	Dietary supplement, blood transfusion, nutrition support	Nutrition rehabilitation (iron-rich food)
Tuberculosis	Good nutrition, ventilated housing, health education	Immunisation, contact tracing	Drug therapy, family counselling, nutrition support	Social integration

Comprehensive PHC requires health workers to identify solutions that involve the community, as follows:

1. It is not enough to provide oral rehydration solution and medical treatment to a sick child with diarrhoea. Maintaining the health of the child also requires providing family education on child care and environmental hygiene, as well as improving access to food.
2. In addition to counselling on breast-feeding, growth monitoring, nutrition rehabilitation, and child care, a nutrition program should promote weaning foods that are available locally.
3. PHC services for healthy people (e.g., pre-natal care, immunisation, health education) should be established as soon as possible through community-based health interventions.

Challenges to Primary Health Care

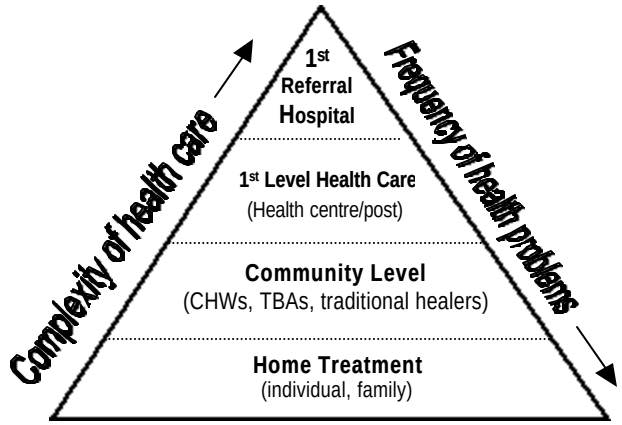
Large gaps may be observed when planning and implementing comprehensive Primary Health Care (PHC). Some of the current challenges to PHC include the following:

- Improper translation of PHC as *primary level of care* (first level health care in the pyramid), which ignores the overall integrated nature of PHC.
- The community may not be willing to take responsibility for the health care system.
- Drugs may not be available at lower levels of the PHC system. Therefore, patients will go directly to hospitals.
- Prolonged delays in health worker salaries may result in hostile attitudes towards patients.
- Referral system may not be functioning well.
- Lack of supervision and training may result in poor quality of services.
- Different sectors may not be used to working together.

Translating Primary Health Care

PHC is based on the fact that most health problems can easily be handled outside the hospitals. Therefore, to provide the best possible care for the greatest number of people, certain health care functions should be transferred to lower levels in the PHC pyramid as illustrated in Figure 8-2 below:

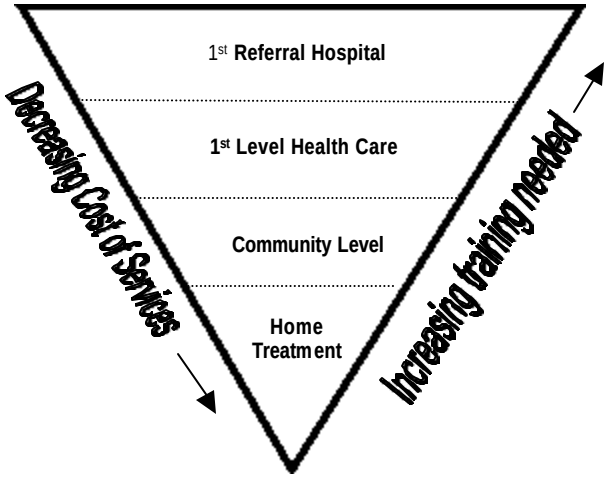
Figure 8-2: Functional Levels of Primary Health Care



Note: *The second referral (provincial or regional hospital) and third referral levels (national hospital) do not fall under PHC.*

Because resources for health care are always limited, health planners should first focus on strengthening health centres and medical posts rather than referral hospitals. Providing basic level health care at health centres and health posts or dispensaries is more cost-effective, whereas services at referral hospitals are more costly since they are delivered by personnel with more advanced training (refer to the inverted pyramid in Figure 8-3 below).

Figure 8-3: Resource Needs for Different Levels of Health Care



Even though first referral hospitals are expensive to run, they should be supported within the PHC framework because they provide care for serious medical conditions and injuries that cannot be adequately treated at the lower levels of the PHC system.

THE DISTRICT-LEVEL HEALTH SYSTEM

A health system where the central authorities within the Ministry of Health (MOH) are responsible for running the health services for the entire nation is known as a *centralised health system.* Primary health care is best implemented in a *decentralised* system, which transfers the authority and responsibility for planning, managing resources and/or decision-making from the central MOH to the district and local levels. Transferring management functions closer to the local health authorities gives the local communities a louder voice in determining how clinics and hospitals can improve the quality of health care being provided.

Defining the District-Level Health System

The following table defines the characteristics of a well-functioning district health system:

Table 8-3: Characteristics of a Well-Functioning District Health System

A district health system is based on primary health care. It serves a well-defined population living within a clearly delineated administrative and geographical area. It includes all relevant health care agencies in an area (government, private, professional or traditional) which co-operate to create a district system and work together within it. The district health system contains a variety of inter-related elements that contribute to health in homes, schools, work and communities, and is multi-sectoral in orientation. It includes self-care and care provided through health care workers and facilities, including the hospital, with supportive services (laboratory, logistical, etc.) It needs to be managed by an individual with public health and curative responsibilities in order to combine the elements and institutions into providing a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities, and to monitor progress.

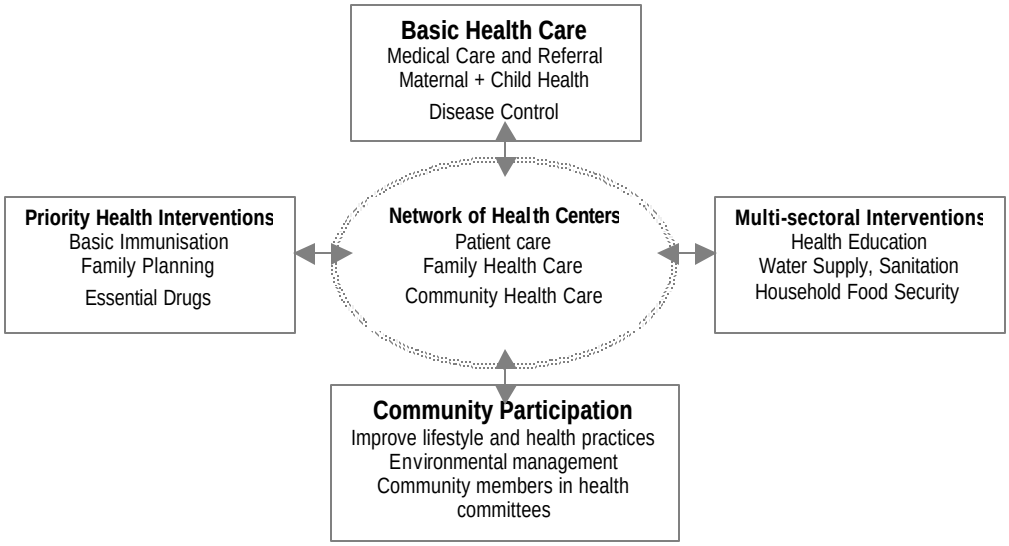
Expected benefits of a well-functioning district health system include:
- a rational and unified health system that meets the basic health needs
- flexible management of health services, with minimum logistical and administrative delays
- more equitable health services to the entire population
- improved management of resources
- co-ordination and integration of health care with activities of other sectors
- a means for facilitating community participation and accountability to the community
- better performance through an efficient and motivated workforce

Because **health centres** are often the first contact the community has with the formal health system and most of the district level health workers are based there, health centres should be equipped to function as the focal point for comprehensive PHC. Resources should be readily available at this level to maintain adequate and stable levels of staffing and supplies.

Health centres should function in the following ways to reflect their important role:
- the centre for community participation
- the base for preparing community health programs (e.g., health education, immunisations, sanitation).
- the focal point of inter-sectoral teamwork within the district-level health system.

The figure below illustrates the central role of health centres:

Figure 8-4: The District-Level Health System



Key Issues of a District-Level Health System

The following key issues should be addressed to ensure a well-functioning district health system:

1. Co-ordination

The highest authority in the district-level health system should be made responsible for organising and co-ordinating comprehensive PHC services for the entire population. However, coordination depends on adequate logistical financial support and training from the central authorities.

2. Health Management Teams

In a district-level health system, decision-making is shared among the central MOH, the district health offices, the health facilities, and the community. This can only be achieved through formation of health management teams at every level of health care, for example:

- District health management teams should include the medical superintendent, the senior nursing officer (matron), the hospital secretary, and elected community leaders.
- At the health centre level, the management team may include the clinical officer or the nurse in charge, other staff, and members of the community.
- At the community level, a health committee may include the health auxiliary, the community health worker, and the village elders.

Local authorities from other health-related sectors, representatives from NGOs and other interested groups may be included in these health management teams. Each team should be given advisory roles and regulatory powers for managing the PHC services (immunisation, maternal health/pre-natal care, water and sanitation, treatment of tuberculosis/leprosy, clinical services).

3. Community Participation

Community participation may be interpreted in various ways. It may range from district authorities informing community leaders about what the health sector has planned to community leaders being actively involved in making decisions (e.g., determining health priorities or strategies). The level of participation may greatly depend on the community leaders in local health committees: how they were selected, their capacity to mobilise community action and to demand accountability, and the amount of social and political support they can rally. The community should be encouraged to join forces with other sectors, organisations and groups when planning comprehensive PHC programs.

4. Resources for PHC

Implementing PHC requires resources to be readily available, particularly at the health centre level. Adequate and stable levels of staffing and essential supplies need to be maintained. In addition, district health authorities should encourage all levels to make maximum use of resources available locally. Sometimes these resources are not available because of logistical, financial, or managerial problems. In such situations, appeals for funding may be sent to donors that are interested in strengthening the district health system infrastructure. Otherwise, local NGOs and existing community groups may be supported to extend services to outlying areas.

5. Health Information

Indicators for monitoring the PHC program should be defined for all essential PHC services. Information from monitoring these indicators can be used for making decisions and setting policy. The following table gives examples of PHC indicators:

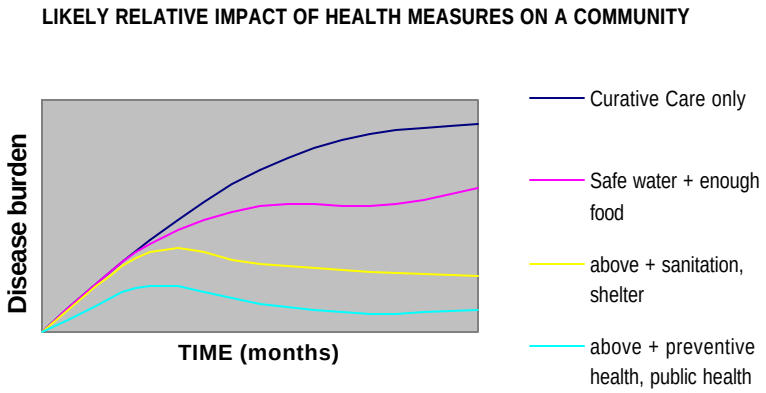
Table 8-4: PHC Indicators, Target Group, and Optimal Coverage

PHC SERVICES INDICATOR	TARGET GROUP	OPTIMAL COVERAGE
No. of under-five children weighed per month	All children aged 0-59 months	100% of under-5/month
No. of women provided ante-natal care per month	All pregnant women	50% of pregnant women/month
Number of assisted deliveries per month	All deliveries	1/12 of total group/month
No. of children immunised against measles per month	All children aged 9-12 months	1/12 of total group/month
No. of OPD consultations per month	4 per person/year	0.33 per person/month

RELATING PRIMARY HEALTH CARE TO EMERGENCY HEALTH CARE

Many acute emergencies are characterised by a large displaced population living under crowded, unhygienic and often unsafe conditions. A significant proportion of the displaced population may lack access to basic needs, including health care. Under these conditions, setting up curative services alone is unlikely to improve the health of the majority of the displaced population. Long-term recovery of the sick and injured may be hampered by constant exposure to communicable diseases, poor health practices, and malnutrition. Transmission of chronic diseases such as tuberculosis and HIV/AIDS, may increase because the normal life-style and customs have been disrupted. It is only through a *combination* of curative care, preventive and public health interventions that significant reductions in the disease burden of a displaced population can be maintained. This is clearly shown in the following graph.

Figure 8-5: Impact of Health Measures on a Community



Humanitarian assistance for large, displaced populations is usually characterised by the following emergency health measures: providing food, water, sanitation, shelter and curative health care for the injured and the sick. After the acute phase, the emergency health care should typically shift toward Primary Health Care (PHC). This shift to PHC occurs more rapidly in sudden-impact disasters than in famine or refugee situations. How effective the emergency health care will be in alleviating the suffering of displaced people and promoting their recovery may depend on how closely the emergency health care strategy reflects the PHC strategy.

The table below shows how the components of emergency health care programs are similar to those of Primary Health Care:

Table 8-5: Similarities Between Primary Health Care and Emergency Health Care

Components of Primary Health Care	Emergency Health Care Priorities
• Promoting good nutrition	• Provision of food rations and selective feeding programs
• Access to safe water and basic sanitation	• Access to potable water and waste disposal systems • Protection against cold (shelter, blanket, clothes)
• Improving maternal and child health care, including family planning	• Maternal and child clinics; later reproductive health programs with family planning
• Immunising against major infectious diseases	• Immunisation against measles, sometimes meningitis
• Preventing and controlling locally endemic diseases	• Control of communicable disease outbreaks including control of vectors and surveillance
• Fostering education on common health problems, their prevention, and control measures	• Health education based on a community health workers program
• Treating common diseases and injuries	• First level health services and a referral system
• Access to essential drugs	• Provision of essential drugs

Emergency health care is built on the principles of PHC. Because resources for health care are always limited, both strategies reflect the basic needs approach toward addressing the priority health problems of a population. As a result, benefits of both strategies become clear when a large fraction of the total population has access to *comprehensive* health services on a regular basis (curative, preventive and promotive), and when those most in need are cared for.

There are notable differences between primary health care and emergency health care strategies. For example, emergency health care has not greatly focused on social and economic development. This is because displaced populations are expected to return to their pre-disaster origins relatively soon after a disaster. Unfortunately, many complex humanitarian emergencies have extended beyond ten years (Mozambique, Sudan, Palestine, etc.). It is now clear that disaster-affected communities should be more involved in planning the relief response and identifying activities that can promote their future development. Table 8-3 below summarises the main differences between primary health care and emergency health care strategies:

Table 8-6: Differences Between the Two Methods of Health Care

	Primary Health Care Strategy	Emergency Health Care Strategy
Goal	To achieve a level of health for all people that will permit them to lead a socially and economically productive life.	To alleviate suffering related to the disaster and support durable recovery of the affected population.
Future Prospects	Long-term operation.	Short term operation. No continuity after relief operation is complete.
Funding/Support	From government, agencies, community (labour, finances).	Mainly external funding and local institution support.
Community Participation	Significant, leading to eventual self-management.	Minimal, affected population lacks resources for full involvement in program management.
Health Improvement	Gradual, focus on comprehensive approach.	Fast (in weeks!), focus on high priority activities.
Need for Security	Insecurity not a major problem.	High priority to ensure access to services.

In conclusion, emergency health care should be implemented within the PHC framework, and based on the district-level health system. At this level, implementing PHC is most efficient.

PRIMARY HEALTH CARE IN RELIEF PROGRAMS

Goal of PHC in Emergencies

Primary health care in emergency relief programs aims to do the following:

- Reduce morbidity and mortality rates of the displaced population to regional norms.
- Build on existing knowledge and skills of the displaced community to improve overall health.
- Link emergency relief to rehabilitation, reconstruction, and development by building the capacity of the affected population. This will make it possible to sustain resources.

Lessons in PHC Planning

Planning and implementing PHC into reality in relief programs can be a slow and challenging process. Reasons for this include centralised decision-making, administrative delays, lack of supervision, and insecure professional health workers. The following lessons have been learned over the years about how a PHC program should be planned:

1. PHC can be adapted to all types of situations, including complex emergencies, provided the long-term goals are clear.
2. Factors that may influence planning PHC in emergencies include the political support of the host country, the historical experience of the health care system, the capability of the affected community, and the presence of NGOs and donors.

3. Decentralised planning helps to make relief programs more relevant to the needs of the displaced population rather than responding to the wants of the leadership.
4. When setting priorities, encourage active support and communication with the displaced community. This will lead to a consensus. The methods used will depend on the existing political structure.

Establishing an Emergency PHC Program

The type of emergency health services set up depends on several factors, including:

- the health system of the host country
- the available resources
- the context of the disaster
- the health needs of the affected population

Providing hospital-based care alone is appropriate only where a displaced population is concentrated within a limited space and the facility is accessible to all (located near a road or at the centre of the camp). Setting up a field hospital is only justified when access to a referral hospital for surgical and obstetric emergencies is difficult or delayed.

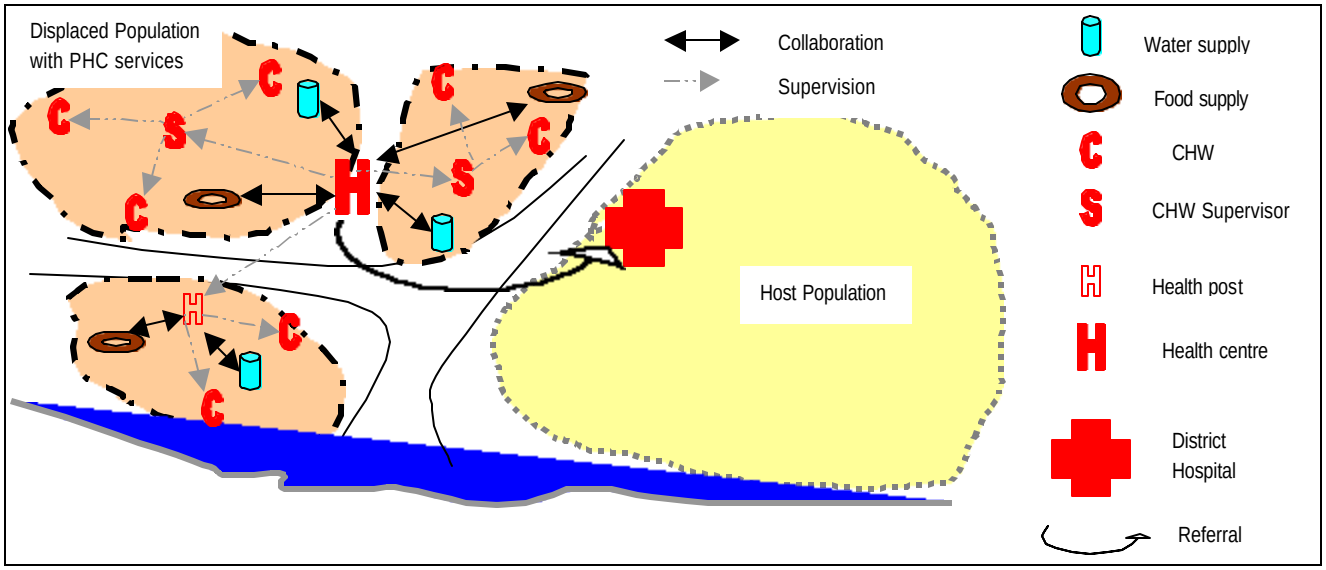
To ensure a more cost-effective and sustainable program, relief agencies should establish an emergency PHC program within the framework of a district-level health system. This program should be:

- Based on the policies, standards and treatment protocols of the host country and integrated within the national health system.
- Functioning in a decentralised manner that reflects the community's identified health needs and priorities.
- Comprehensive, involving all components of the health and other health-related sectors).
- Having clearly defined decision-making authority and responsibility for each level.
- Balanced in terms of the distribution of resources between curative, preventive, and promotive health programs.
- Sharing health information and promoting co-operation between all levels of the health system, and with other sectors and the community.

Relief agencies should aim at strengthening the existing public health infra-structure (basic health facilities, community health network, the local referral system and water supply, disease control, etc.) and at limiting dependence on external resources.

To establish emergency PHC services, first set up the health centre to function as the focal point for all PHC services in the area and establish a network of CHWs to extend services into the community. Community participation and inter-sectoral teamwork should be promoted from the beginning. Peripheral health units or dispensaries may be set up later, if necessary. All levels of the PHC system, from the home and community level to the district hospital, should be provided with essential resources (for example, staff, equipment, drugs) and logistical support. This will ensure PHC services are equitable and increase access to care. The map on the next page shows the health centre functioning as a focal point of the district-level health system.

Figure 8-6: Health Facility Level Map



Emergency PHC services should be co-ordinated within a functioning referral system so that the lowest skilled workers with minimum training provide the appropriate care at lower levels of the PHC system. At the same time, these workers must screen for conditions that require referral to higher levels of the system for care by more skilled PHC workers. Supervision should be arranged for all levels, carried by supervisors from the next higher level of the health system. For example:

- One auxiliary nurse-midwife based at a peripheral maternity unit may supervise ten traditional birth attendants within the community.
- A nurse-midwife at the health centre can supervise the auxiliaries at peripheral health units.
- Senior health workers based at the first referral hospital may supervise health centre staff.

This approach to supervision will ensure that a larger number of people receive quality health care more efficiently than when all patients are required to see only the most highly trained health workers.

Each level of health care should also form a health committee in order to be accountable to the communities they serve. In addition, training community health worker teams to report their findings to different levels of referral system can greatly promote the effectiveness of PHC services at the peripheral health units.

Division of Responsibilities

Implementing PHC for emergency situations requires the community and other sectors to be involved in decision-making, and on-the-job training and supportive supervision to be organised for all levels of the emergency PHC system. A unified approach for making referrals to other sectors or levels within the PHC system can be developed in the following way:

- all field workers understand the PHC system: their responsibilities, functions of neighbouring levels, and the procedures for co-operation.
- each sector sets its own targets for services in terms of quality and coverage to make the system more effective.
- collaboration within the referral system is promoted to maximise the use of resources and labour, and to provide the appropriate level of care.

Specific responsibilities that may be defined for each of the following are described below:

- *Central level*
- *District level*
- *Relief program level*
- *Relief worker level*
- *Community level*

Central Level

For PHC to be effective, the central Ministry of Health must be committed to its role of coordinating the emergency health system, mobilising resources and encouraging district-level decision-making. The main functions at this level should include the following:

- Making policies on emergency PHC operations and drawing formal agreements or memoranda with relief organisations and other providers.
- Regulatory authority for monitoring the level and quality of emergency PHC services and supplies.
- Promote inter-sectoral co-operation and inter-agency collaboration within the defined geographical area.
- Restrict relief organisations from setting up emergency PHC programs without considering the overall health needs of the affected community, in order to avoid duplication of services.
- Give formal support in the training of emergency PHC service providers.

District Level

The function of the district level should include:

- Co-ordinating health services in all PHC facilities in the district (including the referral hospital), based on the local budget and available resources.
- Encouraging all sectors to work well together.
- Initiating dialogue in the community and promoting active community participation in planning the district-level health system.
- Ensuring that community health workers have enough support and supervision.
- Collecting, compiling, and regularly forwarding health information to the central government.

If the administrative capacity of the district level health authorities is weak, relief organisations may strengthen it by providing on-the-job training in PHC principles, district-level management, information systems, supervision, and health-related support. Training should target all senior managers from the district health office, the implementing agency and other health-related sectors who need to broaden their skills.

Relief Program Level

Every relief sector (e.g., food and nutrition, water and sanitation, basic health care, etc.) should organise on-the-job training for its staff in the following:

- Comprehensive PHC using problem-solving techniques that emphasise integrating preventive and promotive health interventions with the hospital-based curative and rehabilitative care.
- Developing and reinforcing standard ways of delivering services in order to improve the quality of the service. Standard methods should be adapted to the local situation and regularly reviewed.
- The planning process so all staff members will understand the program goals and objectives, their roles and duties, and the available resources.

Relief Worker Level

In any emergency operation, field workers are recruited in order to implement the PHC program. However, they must change from being the major "providers" of PHC services to becoming "enablers." Many field workers may be unwilling to take over new responsibilities since they, like many health workers, are only trained to *deliver* services to the beneficiaries rather than to make decisions about the program. Therefore, field workers need training in the following:

- How to increase the community's awareness of the association between poor health and poor living conditions or unhealthy behaviour. This will help strengthen active community support for multi-sectoral actions.
- How to meet regularly with the community to build support for the PHC program and to strengthen community participation.
- How to involve community representatives in determining priorities and in planning, implementing, and monitoring relief programs.

Note: *It is very important to recruit staff from among the displaced community. Recruiting an adequate number of female CHWs will increase access to individuals and households with the greatest need.*

Community Level

A partnership should be forged involving everyone who can improve the well-being of the community. This includes social groups, community groups, and traditional practitioners.

Getting communities to actively participate in decision-making on the emergency PHC program takes time and effort. They need to learn how to identify health priorities and the importance of co-operating and participating in PHC activities to improve their overall health. The most important role of the community is to give regular feedback to the relief agency about the delivery of PHC services in terms of the following:

- equity in how services are provided
- access to care
- relevance between the services offered and the needs of the affected population

In some situations, the local power structure may have to be readjusted to ensure satisfactory community participation. This can be achieved by including members from different social groups, such as women, youth, traditional healers, and school teachers in the health committees. This will ensure that the interests of the displaced population will be represented.

REFERENCES AND SUGGESTED READINGS

Collins, Charles. Management and Organisation of Developing Health Systems. Oxford University Press, 1994.

International Federation of the Red Cross and Red Crescent Societies. Emergency Response Unit (ERU) Basic Health Care Unit Manual on Primary Health Care.

Mills, A et al. Health System Decentralisation: Concepts, Issues and Country Experience. Geneva, World Health Organisation, 1990.

Monekosso, GL. A Minimum Health-For-All Package: For District Health Systems. Lesotho, WHO Regional Office for Africa.

Perrin, Pierre. 1996. Handbook on War and Public Health. Geneva: International Committee of the Red Cross.