

The Review

Primary care and international health links:

should GPs get more involved?

Dr Cath Taylor, a GP in South Wales, says:

'It has been an immense challenge being involved with this link, which has developed my skills and deepened my understanding in all sorts of areas.'

Cath volunteers with the PONT Mbale (www.PONT-mbale.org) link and chairs their primary care committee which is embedded in a community to community partnership between Rhondda Cynon Taf in South Wales and a district in Uganda called Mbale. Since 2005, PONT have trained 60 operational level health workers (OHWs) across three non-governmental organisations (NGOs), 450 community health workers (CHWs) across five NGOs, and distributed 10 000 insecticide treated bed nets. Cath is enthusiastic about the Department for International Development's (now UKAID) £5 million annual investment in the new International Health Partnerships Scheme, which was announced last year.¹ This is a real opportunity to consider the history, impact and future direction of the International Health Links movement.

INTERNATIONAL HEALTH LINKS

Dr Taylor is unusual among health workers involved in international health links. Most of our UK health links are embedded in hospitals, often led by academic clinicians, both here in the UK, and in their partner countries. The Tropical Health and Education Trust (THET) set up by the inspirational Sir Eldryd Parry in 1988, has been an invaluable source of leadership, encouragement and good practice guidance and has brought together many of the UK links. These all have laudable aims and much activity. Most are focused on partnership in training and education of higher level health workers (doctors, medical students and nurses); often delivered through short visits of UK hospital staff to train staff in an African hospital setting. It is not always clearly stated but presumably the training is designed to cascade down to the community and primary healthcare level.

PRIMARY CARE AND HEALTH SYSTEMS

Global health policy has seen a resurgent interest in primary health care, with the WHO Report 2008 setting the scene.² In the recent past it has often been oversimplified,

particularly in low income countries, where 'essential care packages' have been a poor substitute for the full primary health care that many richer countries benefit from. We prefer definitions of primary health care that are based on person-centred care and acknowledge its complexity. As originally defined by the Institute of Medicine, the core characteristics of primary care are that it is continuous, comprehensive, coordinated, provides universal coverage and is the first point of contact for most healthcare needs.³

We looked at the characteristics of the current international health partnerships in the UK, to see how many reflected these primary healthcare characteristics. There is a searchable register of institutions and individuals involved in health links in the UK and overseas. In an audit we did in January 2011, we found that only five of 67 institutions had included the category 'primary care' in their profile and only six had included 'public health/ community health'. There were some links which had begun in, or moved into, community or primary health care. In their self-descriptions in the directory of international health links, some links mention working with partners in district health centres or primary health care or with community health workers. A few mention out-of-hospital midwifery, environmental health, or public health. Very few are involved in wider links, such as twinning arrangements between communities or multiple organisations in both partner countries. One link describes a specifically primary healthcare partnership between a network of GP clinics in Scotland and Malawi (www.Malawiclinics.org) and PONT describes its model of a primary care link embedded in a community twinning partnership.

So how do links best help build capacity in developing countries public health systems? How do we reach the most rural and poor areas where there are few doctors and nurses? Are we targeting the right workforce? Is it doctors or mid-level health workers or is it primary and community health workers we should be investing in?

In Wales, the Wales for Africa Health Links Network (<http://www.wales.nhs.uk/sites3/home.cfm?orgid=834>) emerged in 2007 to bring together and support more than 20 health links in Wales with sub-Saharan Africa. We have found that we have taken a slightly different approach because most of

our links have a stronger emphasis on community twinning, primary health care and public health. We believe that the interventions that are likely to make the greatest impact in poor countries are those that address the wider determinants of health, such as reducing poverty and increasing access to sanitation and to education for women. Healthcare services can make a contribution, having the most impact through preventive measures, and primary health care, especially when these are focused on maternal and child health.

In many developing countries there is a tiny health workforce which is struggling in the face of overwhelming need. Many people have little or no access to essential services. The WHO Kampala Declaration in 2008⁴ stated that, 'All people, everywhere, shall have access to a skilled, motivated and facilitated health worker within a robust health system'; but we are a very long way from this goal as evidenced by the follow-up Forum in Bangkok in January this year.⁵

Globally, we are realising that to build sufficient capacity in health systems to have a real impact on health outcomes, there must be universal coverage of primary health care. A review of preventable child deaths⁶ concluded that in the 42 countries that accounted for 90% of child deaths in the world, 63% could have been prevented by the full implementation of primary health care. This included addressing diarrhoea, malaria, HIV/AIDS, pre-term delivery, neonatal tetanus, and neonatal sepsis.

People in many African countries, especially the rural population, do not use hospitals or doctors. Ethiopia has less than 0.5 doctors, two nurses/midwives and two community health workers and 33 hospital beds per 10 000 people; 6% of births are attended by a skilled attendant. Uganda has one doctor, 13 nurses/midwives and four hospital beds per 10 000 people; 42% of births are attended by a skilled attendant.⁷ In many developing countries, there is a heavy concentration of doctors in cities and in private practice, so most people are just too far away or too poor to access them. De Maeseneer and Flinkenflögel reviewed the role of primary health care in Africa in this journal,⁸ and advocated the community-oriented primary care approach. They argue that primary health care can be a strategy for addressing the social determinants of health, health equity, and inter-sectoral action.

The complexity and perverse incentives of international development aid have sometimes made this situation worse. The massive drive of the 'single disease' programmes for HIV, TB, and malaria have had successes. However, the impacts are levelling off and they may have had high opportunity costs and sometimes unintended negative outcomes. In 2008, The World Organisation of Family Doctors (Wonca) in collaboration with Global Health through Education, Training and Service (GHETS), with The Network: Towards Unity for Health, (The Network: TUFH), and the European Forum for Primary Care (EFPC), issued a call to funding organisations, such as the Global Fund, the World Bank, the Bill and Melinda Gates Foundation, and the World Health Organization (WHO), to assign primary health care a pivotal role and to support its development in a systematic way.⁹ They launched the '15 by 2015' campaign to advocate that:

'... by 2015, 15% of the budgets of vertical disease-oriented programmes be invested in strengthening well-coordinated, integrated local primary healthcare systems and that this percentage would increase over time. Such an investment would improve developing nations' capacity to address the majority of health problems through a generic, well-structured, comprehensive primary care system.'

In the same year, WHO's World Health Report called for *Primary Health Care: Now More Than Ever*² and this approach is indeed being increasingly supported by the major donors and NGOs. So why has this shift not been reflected in the UK International Health Links movement?

HOW CAN INTERNATIONAL HEALTH PARTNERSHIPS DO IT BETTER?

In the global context, international health links in the UK are very small with small impact. However, they can be powerful beyond their individual link's work, through advocacy and demonstrating good practice and also through influencing the future leaders of health systems in developing countries.

We therefore need to harness the most appropriate skills and knowledge among those in the UK. These include essential generalist clinical skills, organisational skills, community engagement, human resource management and teaching at all levels. In addition, many GPs, community nurses and midwives, health visitors and other health workers in primary health care

have themselves had experience of working in developing countries — how do we continue to use their skills to make a real difference when they are back in the UK? Why are so few of them involved in health partnership working?

BENEFITS OF LINKS TO THE UK

There is evidence of benefits to the UK, in particular to the NHS, of mutual learning through health links. These are well summarised in the report by Sir Nigel Crisp in 2007: *Global Health Partnerships: the UK Contribution to Health in Developing Countries*¹⁰ and the *Framework for NHS Involvement in International Development*,¹¹ and other resources provided by the International Health Links Centre. Many of the skills gained are 'soft skills', in leadership, management, communication, teaching and team working. The NHS invests significantly in developing these in its workforce and involvement in international links may be a more cost-effective method of achieving the same outcomes as formal organisational development and leadership programmes.

At a time of huge financial pressure on the NHS, involvement with an international health link can improve staff morale and problem-solving skills at relatively low cost and will support the UK government aims for international development.

IF PRIMARY HEALTH CARE IS THE SOLUTION, WHY ARE HEALTH LINKS BETWEEN HOSPITALS?

If we want to know how to engage a wider spectrum of UK health workers in international health links, we could consider the following:

1. It is more difficult to start a link which is based in communities outside hospitals. There are issues of how to establish points of contact, how to get a movement together in your own neighbourhood, how to find a partner. There is limited capacity in a poor country to organise and find a primary healthcare partner in the UK.
2. There is a lack of understanding in the health links movement of the role of the community setting in training health workers. Links activity has largely been driven by universities and training institutions and by hospital doctors. Even though more and more training and teaching has been shifted to the community in the undergraduate curriculum here in the UK, this has not been fully reflected in links.
3. There is a lack of proactive support from

the links movement to engage health workers outside hospitals in existing links or to encourage new links to start from outside hospitals. The independent contractor status of GPs is a barrier to gaining support from the NHS, and also to harnessing the benefits they can bring back.

4. The policy environment in international development is tolerant of the links movement but tends to favour larger recipients of funds, such as large NGOs that have the capacity to make grant applications and deliver major projects. UKAID works through country Ministries of Health and struggles to deal with small and diverse organisations, although it has a number of grant schemes that are geared to smaller NGOs.
5. There is a lack of consensus of what primary health care is, in this context. Many doctors in developing country public health systems are probably working in a role more similar to that of a UK GP than a UK hospital doctor (particularly in the way described as community-oriented primary Care, where public health combines with primary care). In contrast, many UK health links describe some of their activity as being 'primary health care' when most UK GPs would probably describe these activities as outreach secondary care.
6. The existing grants specifically for international health links tend to set criteria based on existing links, and therefore tend to favour large, hospital-based, single-focus projects that are strong on teaching high level health workers. They are not easily accommodating of the more diffuse approaches that primary health care uses. The bidding process tends to favour institutions that have the capacity and experience in applying for grant funding, which is much more easily found in a hospital or university.

SO, WHAT'S TO BE DONE?

The essence of international health links is partnership working, and that means equality in decision making. The partner in the low income country should be leading in the assessment of their local needs and the UK partner should be guided by this and not by the skills they happen to have. It is hard to believe that so many low-income countries would actually prioritise investment of their staff time in such activities as setting up specialist orthopaedic or ophthalmology centres, however useful these no doubt are.

Supporting country, regional and local health plans is more likely to benefit from the skills of health service managers, midwives, GPs, environmental health officers and public health practitioners. We are encouraged by the appointment of Professor Sir Andy Haines to the Chairmanship of THET. He is professor of public health and primary care at the London School of Hygiene & Tropical Medicine and was previously their director. We hope that he will understand and actively support the widening of the workforce involved in international health links working.

We need to think about how we can do the following three things:

1. Encourage existing links to focus on true needs assessment, working with their partners to identify public health priorities and then seeking out the required skills from UK staff both from within and outside their own institution, therefore enabling the greatest impact in return for the time invested by the partner.
2. Encourage the implementation of robust monitoring and evaluation systems within link activity to enable link partners to assess the effectiveness of interventions and develop ongoing link activity appropriately.
3. Encourage the building of new models of links embedded in the NHS, which are focused on wider partnerships and not single specialities, and are therefore more responsive to partner's needs, more sustainable and with greater impact.

This requires us to scale up links activity and mainstream the support for it. It needs us to move on from the 'enthusiastic amateur' approach to one that is based on matching overseas partners' needs with the most appropriate resources here in the UK — and this will include more of the skills found in primary health care and public health.

Kathrin Thomas,

Consultant in Public Health, Public Health Wales and Coordinator for Wales for Africa Health Links Network.

Geoff Lloyd,

Coordinator, PONT and GP, Pontypridd.

Cath Taylor,

Healthlinks Coordinator, PONT; GP, Pontypridd; board member for Wales for Africa Health Links Network.

ADDRESS FOR CORRESPONDENCE

Kathrin Thomas

Public Health Wales, Preswylfa, Hendy Road, Mold, Flintshire, CH7 1PZ, UK.

E-mail: kathrin.thomas@wales.nhs.uk

Sally Venn,

Primary Medical Care Advisor, Public Health Wales and General Practitioner, Abertillery.

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