THE EVOLUTION OF PRIMARY HEALTH CARE IN FIJI

This summary is based on Working Paper 6 by Joel Negin, Graham Roberts and Dharam Lingam

PHC re-emerges as a global priority
Primary health care (PHC) is back on the global health and development agenda more than 30 years after the Alma Ata Declaration of 1978. Stronger health systems are crucial to achieving health goals and PHC is increasingly recognised as one of the most effective ways to organise and allocate health resources, especially within local health systems. Fiji, as well as other countries in the Pacific, developed a strong PHC model that was widely implemented in the years after 1978. A study of PHC’s history in Fiji provides insights into its place in current health policy.

Methodology for this study
This study was conducted during 2009 using qualitative research methods. Empirical data were collected from current and historical documents through review of published and grey literature.

This was supplemented by semi-structured interviews with key informants, including senior representatives of government, multilateral and bilateral development partners, academics and experienced health consultants.

Origins of PHC in Fiji
The initial implementation of PHC in Fiji can reasonably claim to have successfully improved a number of key health indicators (see figure). It built upon earlier decentralised attempts to provide health care in the 1960s through outreach patrols and dispersed nursing stations. World Health Organization (WHO) leadership and funding introduced new PHC concepts including collaboration between health and other ministries and the training of community health workers (CHWs) with a strong linkage to village culture. There was general agreement that through the 1980s PHC became embedded in health policy and practice.

![Figure: Primary Health Care Indicators and policy trends in Fiji, 1975-2008](image-url)
PHC decline and shifts in emphasis

Formal reviews and all interviewees agreed there was a steady withdrawal of PHC from the national policy agenda after the late-1980s. But explanations differed as to why this took place, including:

- PHC was seen to have succeeded;
- WHO community funding ceased;
- Lack of government policy and funding;
- Domestic instability;
- Cultural changes in Fijian villages;
- Short attention span of global actors;
- The emergence of 'health promotion'.

From the mid-1990s, Ministry of Health descriptions of community level health initiatives began to replace descriptions of health service delivery with those oriented to community health education and health promotion – enshrined in the uniquely Pacific Yanuca Island Declaration. While some saw this merely as a redirection of PHC, others viewed it as a weakening of PHC, especially as a pattern for health care provision.

Some models of PHC were seen in this period, but often as standalone projects, such as the Fiji-AusAID funded Kadavu Rural Health Project. This successfully integrated comprehensive PHC with strong community voice into provincial council decision making.

From 2000, there was an emphasis by government and external donors on health sector reform, but the initial decentralisation was reversed and the reform agenda did not always prioritise PHC concepts. This period also saw the rise of disease-specific initiatives driven by external development partners that have detracted from both PHC and national priority setting. Political uncertainty and relative declines in health funding have seen a loss of PHC practitioners and reduced PHC resources.

Implications for national and international health policy

Primary health care is being discussed as a priority for the Fijian health sector and it is critical to extract lessons from history. Past PHC initiatives can provide models to help meet the many challenges to health resource allocation and service delivery.

Modern Fiji needs health services that reach urban poor (especially squatter settlements) as well as rural populations, and that address chronic diseases (especially the high rates of non-communicable diseases). Rather than a new health service paradigm, much of this may be achieved through a revitalisation of PHC, making use of PHC models from Fiji and elsewhere, and addressing PHC’s financial and human resource needs.

The loss of momentum in PHC over the past 30 years also demonstrates two trends in global health policy:

- External imposition of policy that is not fully owned by country governments;
- Inconsistency of policy direction with shifts in external funding priorities.

Pacific Aid Effectiveness Principles are now generally agreed and demand more thorough in-country consultations to support national priorities. Reaching national health goals depends on local health systems, based on the principles of primary health care.

To provide comment, download the full paper or to get further information please contact: www.ni.unimelb.edu.au noting “Working Paper 6”.

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