PUBLIC HEALTH PROGRAMMES, PACKAGES AND PROCESSES

Several recent submissions to the *SAMJ* have provided readers with insight into public health strategies, and the pertinent comments of the various authors have flagged both positive and negative aspects of these strategies. We refer specifically to the article by Mathews, van Rensburg and Coetzee on the syndromic approach to sexually transmitted diseases,[1] the comment by Zar *et al.* on the Integrated Management of Childhood Illness (IMCI),[2] and the paper by Chopra *et al.* on the implementation of primary health care (PHC).[3]

The common thread running through these articles is the need to identify and cost-effectively manage common local health problems (*affordable, accessible, appropriate* health care). Implicit in all the papers is also the recognition that at the coalface, this broad-based approach will often be dependent upon health care providers with fairly basic clinical skills and limited ability to differentiate between subtle variants of clinical processes. So, what we need are reliable systems or processes that are affordable, have acceptable specificity and sensitivity and ensure adequate management of the patient, while also dealing with preventive aspects at individual and community levels. Such systems obviously also require defined and reliable referral processes to ensure that every patient ultimately receives the right care in the right facility.

Most of the papers either refer or allude to paediatric intervention programmes that were promoted in the 1980s and were grouped together as the GOBI-FFF strategy. The focus of the strategy was on growth monitoring, oral rehydration therapy, breast-feeding, immunisation, family planning, food supplementation and female education, and it was hoped that these simple low-cost interventions would help to reduce the vast number of childhood deaths and to strengthen primary health care infrastructure, especially in the underdeveloped world.[4]

However, as pointed out by Zar *et al.*,[2] while specific interventions for diarrhoea, malnutrition and common childhood infections are effective,[5-7] a single focus for a sick child is often inappropriate as co-morbidities occur frequently, particularly in deprived and developing communities. For example pneumonia and diarrhoea are frequent complications in children who present with either measles or malnutrition.

The recognition among public health medicine experts that intervention must go beyond single presenting features and must address the patient fully and in the context of his/her community, has led to the development of the strategies and frameworks discussed in the various papers.[1-3] A question that arises is whether the targeted communities, most of which are clinically underserved, can realistically expect to be serviced by either multi-skilled individuals or by teams of health care workers who have both the time and the full range of skills, from pure clinical to comprehensive public health. The answer is that health system co-ordinators have generally recognised the clinical and human resource limitations, and have designed

Table I. Strengths and weaknesses of various PHC programmes

Programmes	Strengths	Weaknesses
Specific interventions[4-7]	Selective; targets problem areas Promotes clinical rigour and specificity	Does not address broader issues, e.g. socio-economic factors Tends to ignore co-morbidities Requires clinical skills
Syndromic approach to disease management[1]	Selective; targets problem areas Recognises and treats co-morbidities Does not require very skilled personnel	May lack specificity and sensitivity Risk of treatment protocols becoming screening tools (i.e. diagnosis by failure to respond) Does not address broader issues May become expensive as coverarge expands to cover full range of clinical possibilities
Integrated management of childhood illness[2]	Targets problem areas plus likely co-morbidities Addresses community issues and engages community Aims for cost-effective minimum intervention	Loses specificity Reduces clinical rigour Time-consuming
Core package of primary health care	Focuses on national need Involves communities, regional and central government Acknowledges roles of private sector and NGOs Promotes equity	May compromise on clinical sensitivity and specificity at level of individual Loses focus on local issues and problems (because it is a *national* package)

and/or adopted programmes that rely on pattern recognition, management algorithms and clinical pathways. Trade-offs that occur are described in Table I.

Table I, which presents the programmes as incremental strategies going from single disease to disease complex, and from isolated patient to patient in society, highlights the question raised by Chopra *et al.*,[3] viz. is primary health care a package or a process? The table would suggest that if sold as a package it might lose more than it gains. However, if implemented as a national process that empowers districts, focuses on relevant local problems and draws on one of the more comprehensive programmes to achieve its clinical and social goals, then the gains will almost certainly prevail, particularly if attention is given to the strengths of the selected programme, and every effort is made to eliminate the weaknesses.

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