1. Background

At the Alma Ata Declaration in 1978, Primary Health Care was articulated as a set of guiding values for health development, a set of principles for the organization of health services to reach all communities, and a range of approaches for addressing priority health needs and social determinants of health. The declaration broadened the concept of health to include social, cultural and economic factors and therefore acknowledged the contribution of non-health sectors including civil society organizations towards health improvement. Access and equity to health care and efficiency in service delivery were overarching goals.

1.1 The beginning of Primary Health Care in Vanuatu

Vanuatu adopted the PHC Strategy following Alma Ata Declaration. The PHC philosophy, its values and principles convinced local leaders and policy-makers that PHC was a logical and meaningful way of addressing health issues to improve health and well-being. Subsequently, a PHC policy was developed in 1984, its intention was to provide direction for promoting health and prevention of diseases.

Early pioneers in the implementation of PHC quickly learned the art of community mobilisation, community participation and multi-sectoral community development. Planning for health revolved around peoples’ needs and their social environment. It became increasingly apparent that the social determinants of health are influential factors in health and well-being for which PHC must address. The establishment of village health committees was a sign that health workers and communities were into real partnerships. Not only was water and sanitation and the prevention of malaria important to local Vanuatu communities, the PHC movement also created interest in income-generating projects that addressed basic community needs related to food and shelter.

A number of best practices based on the values of primary health care were implemented and some still have their mark today – for example: development of the public health unit; establishment of new rural health facilities such as dispensaries and aid posts; and the village health worker programme.

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<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1978</td>
<td>Alma-Ata Declaration of Primary Health Care (PHC)</td>
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<td>1984</td>
<td>PHC Policy in Vanuatu</td>
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<td>1986</td>
<td>Otawa Charter</td>
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<td>1980s-1990s</td>
<td>Evolution of PH approach</td>
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<tr>
<td>1995</td>
<td>Healthy Islands Vision</td>
</tr>
<tr>
<td>2000s</td>
<td>Period of slow development</td>
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<tr>
<td>2008</td>
<td>PHC Revitalisation</td>
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<td>2009</td>
<td>HI Revitalisation</td>
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Figure 1: Historical development of PHC in Vanuatu
The Ministry of Health, in its quest to implement PHC, established mechanisms for human resources development and deployment to communities. PHC prompted the establishment of new units, created new positions and expanded the scope of Public Health programme within the Ministry of Health. The Community Health Programme was established in mid 1980’s under the responsibility of a medical officer whose primary role was to support the implementation of the PHC approach. The reorganization of health services saw the creation of several new posts and reshaped health services and programmes.

A PHC module was developed and taught in the nursing school to ensure that graduating nurses apply PHC philosophy in the field. For doctors training, the Fiji Medical School was also teaching a PHC-oriented training programme. In response to the apparent need to decentralise services, new categories of health workers were trained including nurse practitioners and nurse aids. More community-based midwives and public health nurses were trained, also taking advantage of PHC-oriented training courses made available at the Fiji School of Nursing.

Increasing access to health services also required that facilities became closer to where people live. The early PHC movement in Vanuatu saw a number of community-based dispensaries being upgraded to health centre category while more aid posts were established by communities to help improve access to basic PHC services such as maternity services, immunization, treatment of endemic illnesses (eg malaria) and common illnesses.

The next few years saw PHC thrive in many provinces and communities in Vanuatu as approaches of community participation, health promotion and multi-sectoral partnership became part of community health. Village health committees were established to coordinate and lead community involvement in health initiatives. The main entry points for PHC to reach communities revolved around the malaria programme, environment health, and water and sanitation programme. Early community priorities in included clean water supply, toilets and preventive measures against malaria. Community-based initiatives included income-generation projects such as cash crop farming, piggery, poultry and cattle farming to support basic family needs. This participatory approach attracted communities to buy-in to the PHC model. The impact of PHC were beginning to surface – such as reduction in deaths from malaria and TB, improvement in infant and child mortality, and improved maternity care.

1.2 The decline of PHC

However, the enthusiastic early phase of PHC was short-lived. Within 10 years (mid 1980’s to mid 1990’s), it started to lose focus and lost its vigour. It almost disappeared unnoticed although its values and principles stood strong. The questions of what happened, why it faded away, what went wrong, why it took a long time to revive PHC – these questions lingered in the minds of many but were not fully explored at the time. Shortfalls in establishing clear policy directions to guide the necessary actions and actively mobilise different actors in the health development agenda provided some explanation to these questions.

Many people believe that the decline and fall of PHC was unintentional. A number of circumstances contributed to this. Firstly, the noble vision encapsulated in the PHC policy was not adequately translated into operational plans for implementation, resourcing, continuous support and monitoring. Secondly, there were inadequate long-term plans for continuity of initial investment in PHC staffing and facilities. Thirdly, there was insufficient dialogue among planners and implementers at every level of the health delivery system on the application of PHC. This affected the effectiveness of the referral system to link primary and secondary care. In addition, the 1990’s saw a shift of global and regional focus to disease-oriented interventions (such as HIV, malaria, TB) which somewhat diverted health resources to particular areas and left PHC poorly funded. This formed part of the explanation in the decline of attention for PHC.
Despite the recession of PHC, its name, values, philosophy and principles as outlined in Alma Ata remained strong. A number of early initiatives left long-term impact while others still exist today. PHC has resulted in the establishment of the public health division with well defined primary health package of services – MCH, Immunisation, Family Planning, water and sanitation, malaria control and other endemic diseases, health promotion, nutrition, essential drugs and treatment of common illnesses and ailments. These programmes resulted in improved health outcomes such as better infant and child health, maternal health, improved nutritional status, reduced incidence of malaria and TB, and better water and sanitation methods.

In addition, communities benefited economically from community-based income generating projects. A number of initiatives attribute their success to PHC – eg. small scale piggeries expanded to bigger cattle farming, cash crop farming expanded to economic scale, communities achieved better living conditions with reliable water supply and improved sanitation facilities. The establishment of village health committees still exists in many villages today, while a good number of PHC pioneers are still employed within the health sector or NGOs. Their retold stories are living testimonies of the benefits of the early phase of PHC. PHC has demonstrated that it works beyond health goals – helping to raise the standards of living and to curb poverty, thus contributing to the achievement of the MDGs.

1.3 Overview of Health Promotion

Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health status. The Ottawa Charter on Health Promotion was adopted at the first International Conference on Health Promotion in Ottawa in November 1986. The Charter was the means for action to achieve Health for All (HFA) by the year 2000 and beyond and builds on the progress made through the PHC declaration made in Alma-Ata in 1978.

The Charter identified healthy settings as an approach to further enhance health promotion. It comprises 5 action areas for moving into the future:

1. Building healthy public policy
2. Create supportive environments
3. Strengthening community actions
4. Developing personal skills
5. Re-orientating health care services towards prevention of illness and promotion of health
6. Moving into the future

1.4 The Healthy Islands Concept

The concept of Healthy Islands unifies efforts for health promotion and health protection in island settings based on the principles of the healthy settings promoted in the Ottawa Charter. It provides a framework within which health issues are analysed, prioritized, and implemented in island settings. The success of Healthy Islands initiatives, as reflected in improved health status, is strongly linked to community commitment and buy-in from other sectors. The concept, endorsed at the Health Ministers’ meeting in 1995 in Yanuca Island in Fiji was an attempt by Pacific health leaders to revive the PHC using the healthy settings approach to improve health outcomes among island countries.

The goal of Healthy Islands is to improve the health and quality of life of people in island settings. The application of the healthy settings approach aims to establish more effective working relationships between the health sector and other sectors with peoples’ participation to address health problems. This involves strengthening community education, health promotion and stakeholder mobilization.

Following Yanuca Declaration in 1995, the 1997 Rarotonga Agreement reinforced the Healthy Islands concept to address priority health issues in partnerships with communities, organizations
and agencies at local, national and regional levels. The health ministers meeting proposed that donors and development partners support and revive PHC applying the vision of healthy islands. However, the application process did not adequately materialize as envisioned. Nevertheless, Vanuatu continued to adopt the PHC approach despite low resources allocated for PHC.

1.5 The Revitalisation of Primary Health Care

The PHC Revitalisation agenda was the focus of the 2008 World Health Report, 30 years after Alma Ata. The report highlighted unacceptable levels of disparity in health status between rich and poor countries and within countries – an indicator of unequal distribution of resources and access to health services. Since health is a fundamental human right, WHO called on global action to address unequal access to health services and to reduce health inequity. The report called for a return to primary health care and to note the importance of addressing social, economic, and political determinants of ill health which contribute to inequity. The report also highlighted that primary health care was a model for strengthening health systems.

Vanuatu responded positively to the call for PHC Revitalisation and embraced the redirection for the way forward. In 2010, a series of PHC workshop were conducted as first steps in the revitalization process. Vanuatu also benefited from a number of regional meetings to help shape the revitalization process.

With an emphasis on local ownership, primary health care honours community involvement and mobilisation where communities take lead role in prioritising their needs and working together with other stakeholders in a multi-sectoral way to find solutions to health problems that they can afford and sustain. Primary health care is a guide to organizing the delivery of the full range of health care made available at the community level and linked to community-based health facilities, health centres and finally to secondary care in hospitals. Primary health care highlights the importance of
investing resources at every level of the health care system and regards preventive care as equally important as curative services.

In April 2010, a PHC seminar was conducted jointly by the Ministry of Health and WHO country office in Vanuatu to discuss the PHC philosophy and the rationale for revitalisation. At the 63rd World Health Assembly in May 2010, a pre-assembly forum on Healthy Islands expanded its concept in relation to primary health care. Further to this, the 61st WHO Regional Committee Meeting in October 2010 endorsed the Regional Strategy on Health Systems Strengthening based on the values of Primary Health Care.

In October 2010, the Ministry of Health fully endorsed PHC Revitalisation and conducted a national workshop on PHC Revitalisation – Healthy Islands as a vision for health-for-all agenda and PH/C as a tool for achieving improved health using health promotion principles. Then in February 2011, a workshop was conducted to develop a Healthy Islands Policy and Strategy. This document is the outcome of this workshop.

1.6 Linkages to Health Sector Strategy

The Health Sector Strategy (2010-2016) of the Ministry of Health was launched in August 2010. This is the policy document of the Ministry that defines its vision, mission and goals and provide the strategic direction for improving health services delivery and for achieving better health outcomes. The main strategic objectives of the Ministry are:

1. Improve the health status of the population
2. Ensure equitable access to health services at all levels of services
3. Improve the quality of services delivered at all levels
4. Promote good management and the effective and efficient use of resources

Primary Health Care is highlighted in this document as a tool for improving access and coverage of health services particularly in remote rural areas and outer islands. The health sector strategy adopts a systems approach and aims to address gaps in the health system in order to improve the effectiveness and efficiency of providing access to quality services. The six health systems components include:

1. Service delivery
2. Human resources for health
3. Health information
4. Health financing
5. Medical products, vaccines and technologies
6. Good governance and leadership

Figure 3: WHO framework for health systems strengthening