SERIES

Renewing Primary Health Care in the Americas

No. 1

Primary Health Care-Based Health Systems

Strategies for the Development of Primary Health Care Teams

Pan American Health Organization

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Area of Health Systems & Services HSS-SP

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INTRODUCTION / BACKGROUND

Primary health care (PHC) is recognized as a key component of health systems. Evidence of the impact of PHC on the health and development of the population supports this assertion. Moreover, the experience acquired in developed and developing countries has demonstrated that PHC can be adapted to different political, social, and cultural contexts. The demographic, social and epidemiological changes that have occurred since the Alma-Ata Conference entail the need for an in-depth review of the PHC strategy so that it can respond to the health and development needs of the world population.

PAHO's proposal for the renewal of PHC is based on Resolution CD44.R6,[1] of September 2003, which invited Member States to adopt a series of recommendations to strengthen PHC. The Resolution also urged PAHO to: consider the principles of PHC in technical cooperation activities, particularly those related to the MDGs; evaluate different PHC-based systems and identify and disseminate good practices; propose a strategy for training health workers on PHC; and support PHC models at the local level. In response to this mandate, in May 2004, PAHO/WHO established a working group (WG) to make suggestions on future strategic and programmatic orientations on PHC. This process was directed by the office of the Assistant Director (AD) and coordinated by the Health Services Organization Unit of the Technology and Health Services Delivery Area (THS/OS). The first objective of the WG was to prepare the PHC position paper based on the legacy of Alma-Ata, the lessons learned in PHC, and the experience acquired in the reform processes. The position paper benefited from comments and suggestions by experts from within and outside the Region. In July 2005, the Regional Consultation was held in Montevideo, Uruguay, with the participation of representatives from 30 countries, who prepared the draft of the Regional Declaration on PHC. On September 29, 2005, the 46th Directing Council[2] ratified the Regional Declaration. The position paper focuses on the renewal of PHC and outlines human resources requirements in the design of a PHC-based health system:

- Universal coverage requires a significant number of professionals trained in primary care.
- Human resources planning must be consistent with the population's needs.
- Human resources training must be sustainable and respond to health needs.
- Policies on the quality of personnel performance must be implemented.
- Staff capacities (profiles and competencies) must be outlined and each worker profile tailored to serve a specific task.
- Mechanisms for continuous evaluation are required to enable health workers to adapt to new scenarios and address the population's changing needs.

- Policies must support a multidisciplinary approach to comprehensive care.
- The definition of health workers must include staff working in information systems, management, and administration of services.

Concurrently, the Human Resources Unit (HSS/HR) organized the Seventh Regional Meeting of the Observatories of Human Resources in Health[3] in Toronto, Canada from 5-7 October 2005. This meeting approved the Toronto Call to Action, which proposes five major challenges:

- Define long-term policies and plans to help prepare the workforce for changes in the health system and to develop institutional capacity to define these policies and revise them periodically.
- "Place the right people in the right places" – to achieve an equitable distribution of health workers across different regions so that workers match the specific health needs of target populations.
- Regulate migration and displacement of health workers to ensure access to health care for the entire population.
- Create and sustain relationships between the health workforce and health organizations to promote positive work environments in order to foster commitment to the institutional mission and guarantee quality health services for all.
- Develop cooperation mechanisms between training institutions (universities and schools) and health services to ensure that workforce training reflects a universal and equitable model of quality care that meets the health needs of the population.[3]

These five challenges are directly associated with the PHC strategy and with the development of teams in various areas of health systems and services. Consequently, joint work by the PAHO human resources and health services areas to define the organization, structure, and profiles of PHC teams was necessary.

This led the THS/OS and HSS/HR units to organize the Workshop on Development of PHC Teams that was held in Costa Rica in 2005. The activity was a first step toward a collaborative project.

During the workshop, the development of health systems and services competencies for PHC teams, from a human resources management perspective, was identified as a critical area.

In June 2006, the proposal to define competencies was submitted to a group of experts for consideration at a workshop held in Honduras. The group undertook the initial work to define the core competencies of PHC teams. At the same time, a regional capacity building process to increase the responsiveness of PHC teams was initiated.

During the II International Seminar on Primary Health Care – Family Health held in Fortaleza, Brazil, on 5-6 September 2006, an expert meeting on the competencies of multidisciplinary PHC teams addressed the following objectives:

- Present the progress in the development of the Regional Initiative to strengthen the competencies of PHC teams.
- Analyze the proposal of the core competencies of PHC teams.
- Establish the basis for the development of a project to strengthen the capacities of PHC teams.
- Define specific strategies for implementation in the Region of the Americas.

The present document is the result of the aforementioned meeting.

PHC TEAMS

Teams as the Basic Work Unit

The team is a particular form of work organization rather than a subject that can be learned about in a course. In the health sector, as in other sectors, specific training activities have been used to bring about the consolidation of work teams. Such interventions can contribute knowledge, but they cannot replace the development of attitudes with regard to teamwork. Attitudes can only be changed in practice, through work experience and interactions at work with colleagues, not in hypothetical spaces.[4]

For a group to become a team, the following conditions are important:

- Performance is the main objective. The team is a means and not the end.
- Managers strengthen teamwork through the creation of a team performance ethic.
- The cultural tendency toward individualism should not curb team performance.
- Discipline within the team and organization allow for enhanced team performance.
- Team performance is associated with the quality and comprehensiveness of their work in a changing area such as health.
- The team has a wide range of knowledge from different professions that enables it to interpret reality, approach problems from different viewpoints, and develop integrated and comprehensive responses.[4]

Three different concepts about teamwork have been identified. Each concept highlights the results and the relationship between the disciplines.

- Multidisciplinary team
- Interdisciplinary team
- Transdisciplinary team

The Multidisciplinary Team

The new concepts of work organization described by most authors are based on teamwork. The team is defined as:

- A limited number of persons with complementary skills that are committed to a common aim, performance goals, and a proposal they consider themselves to be mutually accountable for.[5, 6]
- Multidisciplinary teams are based on the principle that skills contributed by different professionals increase group creativity, foster innovation, and promote open thinking by team members, with comprehensive responses.[7]
- Although the composition of the team may change over time, the greater the stability of team members the greater the results.[4, 8]

Interdisciplinarity

A discipline is a set of techniques based on a theory or image of the world. Practice of a discipline requires study and concentration, and focuses on one aspect of reality. The interdisciplinary approach refers to the ways in which different disciplines interact and become the object of interdisciplinarity.[9, 10]

Transdisciplinarity

Transdisciplinarity occurs when several disciplines interact by adopting one or more disciplines, or other resources such as languages and linguistics, which operate as analytical nexuses. Such disciplines may include logic, mathematics, and others. The discipline adopted is referred to as a discipline, diagonal science, or transdiscipline.[11]

Teamwork

Teamwork is a dynamic, open, and participatory process of technical, political, and social development of health work in the context of a new care model.

The characteristics of teamwork include the relative autonomy of each type of professional (ensured by the legitimacy of the set of competencies of each of them); interdependence between the different professionals in the performance of actions; interdisciplinarity; horizontality; flexibility; creativity; and communicative interaction.[5, 10]

Health Teams

The creation of a health team is not achieved by the mere physical juxtaposition of its components and activities. Team members must accept common goals and establish functional bonds that facilitate harmonious development. A set of tasks should be established based on the functional division of labor and shared responsibilities should be defined in accordance with the technical training of the health professionals that form the team rather than a vertical hierarchical approach.[5, 7, 8, 12, 13, 14]

Interdisciplinary work and community participation facilitate the definition, development, and evaluation of comprehensive health care competencies on the local level, bringing about renewal and integration of the clinical and public health capacities of health teams.[4, 5, 8, 13]

Composition of PHC Teams

The composition of a primary health care team (PHCT) should adapt to the specific characteristics of the system and the community in which it provides care. Therefore, there are no universal models that can be used to prescribe a composition that is valid for all places and social contexts. A health team is not defined by the type of professionals that form the team or its qualitative relationship to the population, but rather by the organizational approach to adaptation of its structure and operation to meet the needs of individuals, families, and the community.[13]

Criteria for recognition of teamwork:[13]

- Intrinsic communication
- Common project
- Technical differences between specialized jobs
- Rationale for inequality of specialized jobs
- Specific characteristics of specialized jobs
- Flexibility in division of labor
- Independent technical autonomy

This proposal incorporates the idea of integrality of health actions in PHC-based systems. This articulation is defined by work situations where team members establish relations or coordinate with other levels and it demonstrates the links between the different health interventions.

Appropriate human resources, including providers (health services, social services, and others), community workers, managers, administrative personnel, and the population (individuals, families, and the community) are the foundation of PHC-based health systems. Although all human resources in the health system are part of the PHC strategy, PHCTs at the primary level of care are the essential element.

Team composition varies in different countries throughout the Region. Brazil, Costa Rica, and Cuba have reported successful experiences with the use of PHCTs for the provision of health services. In all of these experiences, the common denominators are the family physician and the nurse. Depending on the health system, other professionals are also present in the PHCT. For example, in Cuba the team was initially formed by the family physician and the nurse.[15, 16, 17] The emergence of new health needs and the desire to offer wide-raging and integrated quality services led to the creation of comprehensive family care groups (GAIF) which include dentists, social workers, and specialties from the secondary level of care (e.g., Internal Medicine, Pediatrics, and Gynecology-Obstetrics), as well as informal participation by community leaders. In Brazil,[8,18] in addition to the physician and the nurse, the teams include technical staff or nursing assistants, dentists, and community agents, which are community caregivers with a certain level of professional skills and training hired by the Unified Health System (SUS).[19, 20] In Costa Rica, the teams include nursing assistants, primary care technical assistants and, recently, medical record assistants.[21, 22]

Consequently, there is no uniform definition for the composition of the PHC team at the primary level of care. However, the minimum composition usually includes a physician (i.e., general or family physician), a nurse, and an intermediate-level technician that acts as an assistant or community technician, depending on the needs of the community.

PRIMARY HEALTH CARE (PHC)

The Alma-Ata Conference defined PHC as: "essential health care, based on practical, scientifically sound and socially acceptable methods and technologies made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[12, 23]

Renewal of PHC

"In the 25 years after Alma-Ata, the Region of the Americas experienced major advances. However, the increasingly large gaps in health equity and the chronically overloaded health systems threaten the achievements obtained and endanger the possibility of future progress toward improved health and human development."

"Renewal of PHC entails more than mere adaptation to the political realities of a given time; reforming primary care requires a critical examination of its meaning and purpose. The surveys conducted with health care professionals in the Americas confirm the importance of the PHC approach. They also demonstrate that there are widespread disagreements and prejudices with regard to PHC, even within the region."[24]

The perceptions of the role of PHC in the development of social and health systems often differ. In Europe and other industrialized countries, PHC is viewed for the most part as the primary level of care in the delivery of health services to the entire population. As such, it is usually referred to as "primary care." In the developing world, PHC has been mainly "selective" and the approach focuses on a few high-impact interventions targeting the most prevalent causes of infant mortality and some infectious diseases. Although some countries appear to be developing more integral approaches and many small-scale efforts are underway throughout the region, a more comprehensive national approach to PHC has experienced limited implementation.[25]

Renewal of PHC should contribute to the work conducted in all countries to strengthen health systems and achieve the global, regional, national, and local health objectives (e.g., MDG, 3 by 5 initiative). PAHO considers that the renewal of PHC should be understood as an integral aspect in the development of health systems. Furthermore, PHC-based health systems are the most appropriate means to achieve equitable and sustainable improvements in health for the populations in the Americas.

PHC-Based Health Systems

The new definition of PHC mimics the definition established at Alma-Ata. However, it focuses particularly on the health system as a whole, including the different public, private, not-for-profit, and for-profit sectors, and is applicable to all countries. The idea that PHC is defined by specific types of health workers has been ruled out, since PHC teams must be defined according to the resources available, cultural preferences, and evidence.

Each country must develop its own strategy for renewal of PHC in accordance to its resources, political circumstances, administrative capacity, and national health development.

A PHC-based system implies a broad approach based on the lessons learned and identification of essential values in order to set national priorities and evaluate whether or not social changes respond to the needs and expectations of the population; principles that establish the foundations for health policies, legislation, evaluation criteria, production and allocation of resources for operation of the health system; elements that, in a PHC-based health system, constitute the organizational and functional components that facilitate organization of policies, programs, and services.[25]

Values, principles and elements of a PHC-based system

Source: Position Paper[25]

Essential Elements

The team competencies should correspond to the essential elements that define PHC-based health systems. Consequently, they should enable the team to respond in the following areas:

UNIVERSAL COVERAGE AND ACCESS

From the PHC perspective, universal access implies the elimination of geographic, financial, sociocultural, organizational, gender and structural barriers that prevent access to the health system and/or use of services according to the health needs of individuals, families, and the community.[26, 27, 28]

COMPREHENSIVE AND INTEGRATED CARE

Comprehensive and integrated care means that the range of services available should be sufficient to respond to the health needs of the population, including provision of promotional, preventive, early diagnostic, treatment, rehabilitative, and palliative care services, as well as support for self-care. The comprehensive approach is a function of all health systems. It includes prevention, primary care, secondary care, tertiary care, and palliative care. In order to provide integrated PHC, all levels of care in the health system must be coordinated.[25, 29]

Coordination is a component of health care. Lack of coordination leads to loss of longitudinality and hinders the provision of comprehensive services. Consequently, first contact has a merely administrative role. Coordination requires the harmonization of joint efforts or actions. The essence of coordination is the availability of information about health conditions and services used, and application of such information to establish current care needs.[30]

EMPHASIS ON PROMOTION AND PREVENTION

Health care interventions must take place as early as possible in the health-disease process and/or with regard to risk, health conditions, and sequelae. Such health care is provided for individuals, families, and the community. Health promotion and education actions at the individual level strengthen a person's disease prevention and self-care capacity. At the community level, PHC coordinates performance of preventive activities with other sectors.[25, 29, 31]

APPROPRIATE CARE

Appropriate care entails the use of measures, technologies, and resources that are qualitatively and quantitatively sufficient to ensure achievement of the proposed health objectives. As a result of appropriate care, the expected benefits should exceed the negative consequences of the disease process.[25]

When addressing appropriate care it is important to mention quality, or the extent to which current and potential health needs are covered adequately by health services. This takes into account current knowledge of distribution, identification, diagnosis, and management of health-related problems and aspects.[30] The foundations of quality are effectiveness, efficiency, optimization (balance between the costs and effects of care), acceptability, legitimacy, and equity. It includes the technical quality of the services provided as well as user satisfaction.

Although defining quality is a complex task, it can be described as the appropriateness of the health actions performed. Higher quality is achieved when actions are more appropriate (i.e., when actions are performed with the greatest effect, least inconvenience, and lowest cost allowed by professional skill, scientific knowledge, and technological development). [25, 32, 33]

FAMILY AND COMMUNITY BASED

PHC-based health systems are not based exclusively on an individual perspective. Rather, the public health perspective and community information are used to assess risks, identify problems, and prioritize interventions. The family and the community are considered to be the primary focus of planning and intervention.[25, 29]

ACTIVE PARTICIPATION MECHANISMS

PHC should be an integral part of national and local socioeconomic development strategies. Joint social participation is required in order to ensure transparency and accountability at all levels. This includes collaborative activities by PHCTs and the communities that promote healthy environments and lifestyles; foster self-care of individual health; stimulate community capacity to become active partners in identification, prioritization, planning, and management of community health problems; and encourage evaluation of the actions undertaken by the health sector, including the private and public sectors as well as civil society.[25, 34, 35]

LEGAL AND INSTITUTIONAL FRAMEWORK

It is extremely important to understand the legal and institutional framework that relates to the knowledge of health policies, plans, and programs. In addition, current standards and legal regulations associated with the technical and professional performance and work of team members must be understood.

National regulations often limit development of teamwork.

OPTIMAL ORGANIZATION AND MANAGEMENT

The structures and functions of a PHC-based health system require optimal organization and management. This includes a legal, political, and institutional framework that identifies and empowers actions, actors, and procedures, as well as legal and financial systems that enable the team to perform its specific functions in the decision-making process. In terms of operational activities, PHCTs require good management practices in order to facilitate improved organization and provision of care. Enhanced management ensures compliance with quality standards, offers attractive workplaces for team members, and responds to specific health needs of the community.[25]

PRO-EQUITY POLICIES AND PROGRAMS

Promotion of knowledge on pro-equity policies and programs within PHCTs reduces the negative effects of social inequities with regard to health, corrects the primary factors that cause inequities, and ensures that all people are treated with dignity and respect in the provision of health services.[25]

FIRST CONTACT

The existence of levels of care is an intrinsic aspect of the organization of health services. It is based on the notion that whenever the patient has a health problem there is a point of entry, and such a point should be useful and accessible.[30]

Primary health care is the gateway to the health system and social services, where health needs are addressed. A PHC-based system strengthens the first level of care, although its structure and operation are more complex.[29]

APPROPRIATE HUMAN RESOURCES

This element includes service providers (PHCT): community workers, managers, and administrative personnel. Their performance should reflect an appropriate combination of skills and knowledge. Ensuring the availability of human resources requires strategic planning, investment in training, employment, and incentives, as well as further development and strengthening of the current knowledge and skills of health workers.[25, 36]

ADEQUATE AND SUSTAINABLE RESOURCES

Resources must be determined according to the health needs and should be defined through a community-based health situation analysis. They include the resources and budget required to provide high-quality comprehensive care. They should be sufficient to achieve universal coverage and access, taking into account that availability may vary by country.[25]

INTERSECTORIALITY

Intersectorial actions are required to address the health determinants of the population and create synergistic relations with the actors and sectors. In order to have an impact on health and its determinants, close ties between the public, private, and non-governmental areas, both within as well as outside of the health services, are required.[29]

DEFINITION OF PHC TEAM COMPETENCIES

Why Competencies?

The systemic transformations introduced in health services have brought about significant changes in management models and practices, as well as care models. This shift has impacted the work context. In regards to performance requirements, new competencies have been developed at different levels of decision-making and care.

The continuing education perspective is characterized by a programmatic orientation that is based on everyday work; planning that takes into account the reality of health care work and an emphasis on performance improvement by highlighting the work competencies approach.

The notion of competencies is currently a human resources management concept and a strategy for human resources management that allows improved links between management, work, and education.

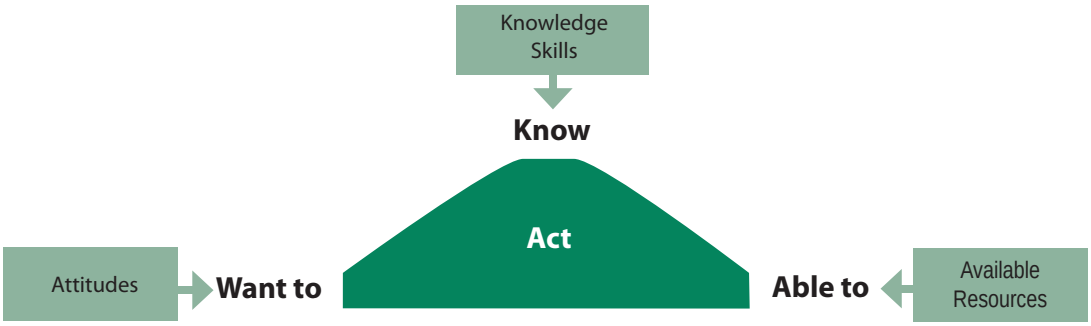
Consequently, competencies entail an integrated combination of knowledge, skills, and attitudes that lead to appropriate and timely performance in several different contexts.[37]

Concept of Competencies

The definition of competencies is an essential requirement for achieving improved work performance in different work contexts.[37]

A review of the literature suggests that competencies (e.g., knowledge, skills, and attitudes) are personal characteristics that become evident when a task is carried out or a job is performed. They are related to successful performance of an activity, work-related or otherwise. [37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49]

Actions undertaken with competence will result in successful performance and good practices. However, to achieve this, some elements are necessary: knowledge (to know it), ability to implement knowledge (to know how to do it), motivation and attitude (to want to do it), and the necessary means and resources (to be able to do it).



Classification of Competencies

- Generic
- Specific
- Humanistic

Generic Competencies

Generic competencies are essential for adequate performance or development of team tasks. They are common to and shared by all team members. Such competencies also allow professionals to adapt to new working conditions, stay up-to-date, and overcome problems in their respective jobs.[46, 50, 51]

The following generic competencies will be considered: communication, information management, resource management, and public health.

COMMUNICATION

Communication is considered the primary tool in PHCTs to improve relationships with patients and interaction with the community, political and management levels, across different levels of care, and between team members.

At the primary level of care, communication occurs during a consultation where care is provided for persons with health conditions in early stages of natural progression that are not yet well-defined. Therefore, there must be sufficient reasoning capacity to distinguish situations that are more complex in terms of severity and develop a more specific diagnosis based on a vague complaint.

Effective communication is essential to provide high-quality health services because it improves:

- Individual satisfaction
- Understanding
- Therapeutic adherence
- Community interaction and facilitates community participation
- Conflict resolution between team members
- General health outcomes[45]

In other aspects, communication between team members and individuals is also an element that contributes to increased levels of performance.

INFORMATION MANAGEMENT

Health information systems (HIS) allow the evaluation of the health status of the population as well as promotional, preventive, and health care activities.[29] In 1973, WHO defined HIS as a "mechanism for collection, processing, analysis, and transmission of information that is required for the organization and operation of the health services as well as research and teaching."[40]

Primary health care information is useful for:

- Individual and population-based clinical care
- Planning
- Management of health care centers and services
- Quality evaluation and control
- Training
- Research
- Legal requirements

The information required can be classified into three types: clinical, epidemiological, and administrative.

Clinical information

Basic documents are required to identify risk groups and facilitate clinical decision-making: medical history, morbidity registry, and office visit records. There are additional records that supplement the basic documents and are often used in PHC (e.g., records on referrals to secondary level of care, home care, use of diagnostic tests).[12]

Information management requires knowledge of health information systems and, specifically, use of registries and indicators for decision-making or research.[52]

Epidemiological information

There are four main applications of epidemiology in PHC: (a) analysis of community health status, (b) investigation of the risk factors of a disease, (c) evaluation of effectiveness of health interventions, and (d) evaluation of efficacy of diagnostic tests.[12, 53]

The health situation analysis is classified as the first activity that should be performed by the PHC team in the community. This analysis measures the health status of the population and identifies the health problems and vulnerable populations. Based on this information, community priorities can be outlined and an action plan can later be developed so that actions are taken accordingly.[12]

Administrative information

Administrative information refers to the planning and provision of health services, the evaluation of services in regards to the populations they are intended for, and the basic knowledge that facilitates the improvement of the provision of health services. In attempt to monitor the development of health service provision processes, traditional administrative functions require information acquisition and dissemination.

RESOURCE MANAGEMENT

Resource management is the ability to evaluate a specific problem encountered by the teams and determine rationally which resources will be required to provide the appropriate response. Resources from the primary level, as well as other health levels, or even other sectors, such as the social sector, may be required. Resource allocation is based on the health situation analysis and prioritization of problems.

PUBLIC HEALTH AND ITS ESSENTIAL FUNCTIONS

Public health is the component of the health systems that seeks to improve, protect, or maintain the health of populations. In order to strengthen public health, the coherence of its objectives should be considered in detail. In addition, to ensure the performance of the essential public health functions (EPHF), a group of professionals who posses an adequate level of proficiency in the competencies related to the EPHF is required.[54]

Essential public health functions

1. Monitoring, evaluation, and analysis of health status
2. Surveillance, research, and control of the risks and threats to public health
3. Health promotion

4. Social participation in health
5. Development of policies and institutional capacity for public health planning and management
6. Strengthening of public health regulation and enforcement capacity
7. Evaluation and promotion of equitable access to necessary health services
8. Human resources development and training in public health
9. Quality assurance in personal and population-based health services
10. Research in public health
11. Reduction of the impact of emergencies and disasters on health

The EPHF are the primary competencies of the National Health Authority (NHA) with regard to public health. The PHC teams are part of the NHA at the local level. Therefore, they should have knowledge of the EPHF; accept responsibility for management of prevention and promotion; and guarantee the access, quality, and orientation of personal and population-based health services.[55]

Identification of the competencies requires a frame of reference based on a classification that facilitates the functional transition from EPHF to competencies. A proposed classification is as follows:

Core competency

Such competency provides the fundamental understanding of what is public health and what is its significance. All public health workers should be proficient in this competency.

Transversal competency

This is the competency that contributes general and specific knowledge, aptitudes, and skills in areas that facilitate performance of one or more functions. Several categories of public health professionals and technical personnel should be proficient in this area in accordance with their respective responsibilities.

Critical competency

This type of competency provides the know-how, aptitudes, and skills required to fulfill an essential function, program, or a certain area of application. Its structure is based on the two previous categories. Work teams that are responsible for a specific essential function should be proficient in this competency.

Satisfactory performance of one or more essential functions is based on proficiency in a combination of the three categories of competencies.[56]

Specific Competencies

Specific competencies are those intrinsic to the functions that should be performed by an organizational unit such as the PHC teams. They are related to individual and collective contributions and processes that are dependent on knowledge and skills. Such competencies are inherent to each profession and the technical aspects predominate.[37, 41]

Humanistic Competency

Humanistic competency refers to the ethical values developed by professionals for application and use of the knowledge acquired. It is related to professional practice and social responsibility to the community (professional ethics).[55]

PHC Team Competency Matrix

Renewal of PHC is proposed as an essential mechanism for the reorientation of health systems. PHC-based health systems recognize the importance of values, are guided by principles, and are comprised of a set of key elements.

The essential values of the health system should reflect the values of the society as a whole, such as:

- Right to the highest attainable standard of health
- Health equity
- Solidarity

These are the values that should determine the motivation and skills of PHC teams and that are required, in addition to knowledge and skills, to perform successfully.

The elements are related to one another and form part of all levels of care and health system management. Such elements, which are defined in the PAHO position paper on renewal of PHC, were the starting point for preparation of the competencies matrix for PHC teams.

- For each of the elements, the most significant function to be developed by the teams has been identified.
- For each function, specific competencies (knowledge and skills) that facilitate improved performance in exercising the function have been defined.

The matrix, which includes the elements, functions, and competencies (knowledge and skills), is shown below:

PHC Team Competency Matrix

Essential elements of PHC	Structural function	Competencies	
		Knowledge	Skills
1. Universal coverage and access	Eliminate barriers to access	• Identify the barriers to access: ✓ Geographic ✓ Economic ✓ Organizational ✓ Sociocultural ✓ Gender, ethnic, age, social groups • Recognize and analyze actors for social dialogue with the community • Identify strategies that can extend social health protection toward universal coverage • Organizational accessibility (emergencies)	• Identify the populations with barriers to access • Apply strategies to reduce barriers to access and expand coverage • Interact, facilitate dialogue, negotiate, and achieve consensus to eliminate barriers and reduce inequities
2. Comprehensive and integrated care	Provide comprehensive and integrated care for the population Longitudinality	• Understand basic concepts of health promotion, disease prevention, treatment, rehabilitation, and palliative care • Be familiar with the prevalent health status and problems in the community • Understand techniques and procedures for disease prevention, health promotion, treatment, rehabilitation, and palliative care • Know techniques and procedures for inpatient and outpatient care • Understand the functional network of health services and mechanisms of referral and counter-referral for all levels of care • Know the individual and family life cycle • Know the basic concept of continuous care • Know alternative health care policies	• Identify the perceived and unperceived needs of individuals and families • Improve the capacity to respond to prevalent health problems in the community • Apply knowledge of each discipline (fields of knowledge) to address the individual and family life cycle and use evidence appropriately for problem-solving • Promote health self-care in the community according to the prevalent diseases

3. Emphasis on promotion and prevention	Health promotion and disease prevention	• Be familiar with the community health status, its distribution and determinants • Understand basic concepts of health promotion and disease prevention, and the differences between them • Know tools to apply, monitor, and evaluate health promotion and disease prevention activities	• Apply evidence-based health promotion and disease prevention strategies • Facilitate joint learning by the health team and the community • Establish intersectoral commitments and/or partnerships for social production of health • Participate in health promotion and disease prevention initiatives with other components of the health system and other agents • Design local programs for promotion and prevention based on community needs
4. Appropriate care	Serve the health needs of persons with an evidence-based approach using available resources with efficiency, effectiveness, and equity	• Have knowledge on good practices to respond to physical, social, mental, and health needs • Know, identify, and apply new technologies and appropriate methods according to the culture and the local resources • Understand how to apply good practices of clinical management • Promote the importance of health self-care in the community (autonomy, participation in clinical decision-making)	• Provide appropriate evidence-based attention to the different settings (inpatient and outpatient) • Apply timely and efficient procedures in the use of the health services network • Integrate knowledge of community health status with care priorities and assignment and availability of resources • Define the responsibilities of each team member in order to ensure appropriate care • Coordinate care
5. Family and community based	Plan for intervention, focusing on the family and the community	• Know and apply methodologies and tools to identify: ✓ Health status ✓ Health determinants ✓ Services network ✓ Financial resources ✓ Socioeconomic and cultural status ✓ Family situation • Define the service needs and establish care priorities • Be knowledgeable about participatory programming and planning	• Identify sources of information and key actors in the community • Collect, analyze, and use appropriate and relevant information • Define community health needs and their determinants in order to establish intervention priorities with community participation • Conduct family interviews • Conduct participatory and programmatic planning. • Use the comprehensive approach to promote self-care for individuals, families, and the community • Consider specific groups • Consider the individual as part of a family context • Manage and apply epidemiological tools in health planning

6. Active participation mechanisms	Facilitate and promote social participation in health	• Understand the techniques and methods used to analyze key agents and institutions • Identify consensus-building areas and participatory methods currently used in the health system and the community • Promote the importance of health self-care in the community • Have knowledge on methods for effective communication between team members and the community • Understand the role of the community in health development	• Promote active community participation in setting priorities, management, evaluation, and regulation of the health sector • Apply methodologies to optimize effective information, communication, and education • Use tools to identify the current community actors and institutions in order to conduct joint comprehensive health care work • Capacity of the team for joint work with the community • Develop cooperation and negotiation • Develop instruments for participation, advocacy, and adaptability • Establish mechanisms of team cooperation and shared responsibility with individuals and the community
7. Legal and institutional framework	Promote and strengthen public policies and the legal framework of the health sector	• Know public policies and the legal and institutional framework for health • Know: ✓ Health sector policies ✓ Health sector plans and programs ✓ Local public policies ✓ Current legal frameworks related to the health sector ✓ Social policies	• Analyze the coherence of policies, plans, and programs, and their relationship to multidisciplinary PHC work • Facilitate and advocate development of local and sectoral policies through citizen participation • Adapt policies and standards to local reality (critical reflection) • Conduct integrated critical analyses of social policies and their influence on the health sector • Evaluate public policies and their relationship to the health sector

8. Optimal organization and management	Apply appropriate management practices	• Know policies and the legal and institutional framework for health • Understand the stages of administrative management • Know the human resources competencies in different areas: labor, trade associations, unions, levels of care, administrative, etc. • Identify the social organizations and trade associations and their agents, and understand the role that they play • Be familiar with the registries defined and established in the PHC system • Know management evaluation tools	• Use information: develop strategic planning, operational research, and performance evaluation • Monitor the administrative management process, which implies: diagnosis, negotiation, performance, evaluation, and control • Negotiate with recognized leaders • Use specific and up-to-date registries for PHC • Use management evaluation instruments for the team • Capacity to negotiate with the community and the highest levels • Capacity to define (individual and collective) incentive and performance systems, including motivation
9. Pro-equity policies and programs	Include equity criteria in program proposals	• Understand the current limitations in health sector policies, plans, and programs that limit equity • Recognize and analyze current inequities in the community • Know the strategies used for tackling health inequities and their political and legal framework	• Include social participation in resolution of inequities • Identify and act on health inequities and promote strategies to reduce them
10. First contact	Promote access and use of services Establish first contact	• Establish a gateway to the health system • Promote strategies to ensure access to health services • Know the role of the team as a whole and each of its members in order to provide appropriate guidance for individuals • Conduct interviews to recognize and evaluate health problems or other problems (e.g., economic, social) that have an impact on the health-disease process	• Provide decent and respectful treatment • Prioritize health needs and interventions • Include the individual/family/community and their health system demands, and provide longitudinal care • Develop good communication with the individual/family/community that requests health care or any other type of care • Organize services to ensure access • Determine the target population and geographic area • Develop areas of mutual cooperation between caregiver, persons, and groups (individuals, family, and community) • Respect and promote the autonomy of individuals, families, and communities

11. Appropriate human resources	Teamwork	• Know and define team roles and responsibilities • Know about training processes and continuing education • Understand and apply the Code of Ethics to the team and the community • Know about the health care services network in the health system in order to mobilize resources • Capacity to recognize and identify the need to maintain knowledge up-to-date through continuing education • Know the qualification and recertification needs of workers on the team • Know the methods used to evaluate performance	• Support and participate in the continuing education process of team members • Analyze the team profile and health needs of the population with a participatory approach that includes the team and the community • Negotiate working conditions (team staffing, financing requirements) • Prepare, develop, and participate in teamwork processes: ✓ Communication ✓ Collaboration ✓ Coordination ✓ Conflict negotiation and resolution ✓ Participation ✓ Decision-making ✓ Shared responsibility
12. Adequate and sustainable resources	Rational use of resources	• Identify the resources required for health situation analysis with information from the community • Know the resources available: ✓ Community health care facilities ✓ Staff ✓ Equipment ✓ Supplies (current supplies and needs) ✓ Drugs (consumption and consumers) ✓ Financial resources ✓ Information systems • Know the self-evaluation and accountability methods used to measure rational use of resources and ensure sustainability	• Make rational and efficient use of available resources • Generate useful and detailed information about health needs and resources that enable decision-makers (political authorities for the health system) to plan services • Produce new knowledge for primary health care • Develop health indicators and establish goals for appropriate management of the health needs of the population • Promote self-evaluation and accountability of resources and ensure their sustainability

13. Intersectoriality	Links between all sectors in order to produce health	• Know the different sectors that have an impact on the health process and/or its determinants • Share and define actions in collaboration with different sectors in order to act on community determinants of health • Identify the responsibilities and limits of each agent and/or sector in the intersectoral approach process • Coordinate intersectoral promotion and preventive actions to produce health	• Lead, participate in, and support intersectoral actions • Mobilize intersectoral resources and community resources to be responsive to health needs • Interact with national authorities and the community
14. Emergency and disaster planning	Establish organizational plans to prevent and mitigate emergencies and disasters	• Understand common and uncommon risks, disasters, and emergencies in the region • Know the response mechanisms, care network, and disaster prevention and emergency actions • Know the institutions, protocols, and mechanisms of national, regional, and local coordination that intervene in the response to disasters and emergencies • Know the human development indices (e.g., poverty, public policies) in order to organize intersectoral work	• Communicate the required information and identify evacuation routes, safe places, shelters, etc. to mitigate the effects of emergencies and disasters

ANNEX I: GLOSSARY OF TERMS

Acceptability: Extent to which a service is compatible with the cultural needs, values, and standards of a community.

Accessibility: Absence of geographic, financial, organizational, sociocultural, gender and/or structural barriers to participation in the health system and/or use of the health services and other social services. It is essential that people can receive health services in accordance with their needs.

Accountability: Process that requires actors to be responsible for their actions. For governments, this includes the obligation to submit and disclose their aims, principles, procedures, relationships, results, income, and expenditures on a regular basis in a coherent and detailed manner to all interested parties that are directly or indirectly involved in such a way that they can be evaluated by the interested parties. This includes the need for transparency on the degree of success in the health of the population and adaptation of the mechanisms to achieve success.

Active participation mechanisms: Mechanisms (appropriate for each community) that are designed to achieve accountability and representation of community interests at the local and national levels.

Appropriate and effective care: Application of measures, technologies, and resources that are qualitatively and quantitatively sufficient to ensure achievement of the proposed goals. The health benefits expected as a result of implementation of a procedure should clearly exceed its negative consequences. Effectiveness implies that the approaches used to improve health have the intended impact on the population.

Appropriate human resources: Competent health workers that have the required knowledge and skills and who are located and distributed geographically in accordance with the need for implementation of PHC. This concept usually implies the availability of a wide range of health care professionals (i.e., medicine, nursing, pharmacy, physiotherapy, social work, administration and management, and community-based management) related to health promotion, prevention, treatment, and ongoing care of individuals, families, and communities.

Appropriate resources for needs: Resources should be sufficient to meet the needs of the population (i.e., prevention, promotion, treatment, rehabilitation and intersectoral actions), including the resources required to improve the health status of the most disadvantaged persons at a rate greater than or equal to that of the general population. On the local level this requires adequate facilities, staff, supplies, and operating budgets.

Community-oriented primary health care: A continuous process by which primary care services are provided to a specific community based on evaluation of its health needs through planned integration of public health practice and primary care services.

Comprehensive care: Extent to which the essential services required by all persons are provided by PHC, even for the uncommon needs of the population. Services that are not available are provided through the PHC coordination and reference component. This implies provision of services such as promotion, disease prevention, treatment, rehabilitation, and physical, psychological, and social support in accordance with the majority of the health problems in a given population.

Continuity: The presence of mechanisms in order to ensure the uninterrupted succession of health care events in the health system. Continuity occurs over time when a health condition is present that involves two or more visits and is problem-oriented. Through the continuity of care, the individual's health is monitored on an ongoing basis. A close relationship between the physician and the patient is not required.

Coordination: Process by which PHC facilitates access and integration of more complex care when such care is not available at the local PHC level. It refers to the extent to which the care required by a person is arranged by the appropriate staff across the organization and over time. It also refers to the links between the different services, including community resources and their rational organization.

Element: A component part or condition, which is usually basic or essential.

Emphasis on promotion and prevention: Health care provided as early as possible in the chain of events that links risk, health problems, and sequelae. Such care is provided at the individual as well as the community level. At the individual level, it includes health promotion and education to increase prevention and self-care. At the community level, PHC coordinates performance of essential preventive primary care activities with other sectors.

Equity of health services: The absence of differences in access to services for equivalent health needs (horizontal equity) and increased access and/or resources for socially, demographically, or geographically defined populations with greater health needs (vertical equity).

Essential public health functions: These include: i) monitoring, evaluation, and analysis of health status; ii) public health surveillance, research, and control of risks and threats to public health; iii) health promotion; iv) social participation in health; v) development of policies and institutional capacity with regard to public health planning and management; vi) strengthening institutional capacity to regulate, monitor, and control public health; vii) evaluation and promotion of access to required health services; development and training of public health human resources; viii) quality assurance for health workers and health services in accordance with the needs of the population; ix) public health research; and x) reduction of the health impact of emergencies and disasters.

Family and community based: PHC conceives care in the broader context of the family and environment. Social and health services that fulfill the needs of the population are based on local information. Practices should consider the health conditions of individuals in the context of their family, social and cultural networks, and work environment. This implies effective understanding of the circumstances and facts in the person's life as well as his or her culture, living conditions, family dynamics, work situation, and health conditions.

Financial sustainability: Availability of sufficient financial resources to cover the costs of the health system and its mid- and long-term operation by taking into account future expenditures, regardless of political, social, or economic developments.

First contact: The extent to which primary care is the place where health conditions are first encountered and care is provided (with the exception of emergency care), and decisions regarding health and other types of needs are made.

Health: WHO defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease." This definition has been criticized as unrealistic, since according to this concept most people would consider themselves to be unhealthy. Health has also been defined as a dynamic condition, a form of (or deviation from) homeostasis, and as a continuum with positive and negative poles. At the population level, health can be conceived of as a social, economic and political issue as well as a human right. The Ottawa Charter for Health Promotion defined peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity as prerequisites for health.

Health equity: Absence of systematic differences with regard to one or more aspects of health (or its determinants) in socially, demographically, or geographically defined groups.

Health promotion: The process of empowering individuals to increase control over the determinants of health and, consequently, improve their health. It involves the population as a whole in the context of their everyday life. Moreover, it seeks to act on the determinants and causes of health rather than focus on the risk of contracting specific diseases.

Health system: WHO defines a health system as the "sum total of all the organizations, institutions and resources whose primary purpose is to improve health." A health system can also be characterized according to its main actors: the government or professionals that structure and regulate the system; the population, including patients, that individually or collectively pay for the health system (through taxes or other mechanisms) and receive services; financing agents, who collect funds and allocate them to providers or purchase services at the national level and other lower levels; community and local organizations (e.g., volunteers, health committees, private initiatives) that assist with organization and logistic support, provide direct or indirect financing, and in some cases provide services; and service providers, which can also be categorized in different ways. Health systems can also be defined according to their main functions: management (or supervision); financing (collection, pooling, or procurement); and delivery or provision of services.

Human development: "Process of increasing the options available to persons by expanding their capacities and functions. The three essential conditions for human development at all levels of development are: the capacity to have a long and healthy life, access to knowledge, and acceptable standards for living with dignity. The field of human development extends beyond the aforementioned: the options highly valued by persons range from social, economic and political opportunities for creativity and productivity to self-esteem, sense of empowerment, and belonging to a community." The human development index is used to measure the level of human development in a country by measuring levels of health (life expectancy), knowledge (complete primary education), and living standards (per capita GDP).

Integrated care: A type of care that combines information about events that impact the health of a person and occur in different places and at different levels of care throughout a person's life. It is related to longitudinality, which is an orientation of health services towards individuals (not diseases) throughout their life span. It is often accomplished in a defined area and with health information systems that are integrated at both the family and community levels. Integrated care refers to care

provided over time by a single professional or a team of health care professionals ("clinical follow-up") as well as effective and timely communication of information about clinical events, risks, advice, and patient referral to different levels by a wide range of health care professionals ("record follow-up").

Intersectorial actions: Actions that mobilize all sectors that are determinants of the health of the population (e.g., data collection and analysis, provision of services or information). The role of the health system in such actions depends on the cause and magnitude of the problem, the availability of resources, and other mechanisms of coordination.

Intersectoriality: The extent to which PHC is integrated in its efforts to intervene in the determinants of health that are outside the health sector, such as water, sanitation, housing, education, coordination of development, and the implementation of a wide range of public policies and programs that affect and involve non-health sectors. The intersectoral approach requires close links between public, private, and non-governmental sectors such as employment, education, housing, production of food, water and sanitation, and social services, both within as well as outside traditional health services, that have an impact on health status and access to health care. Such an approach mobilizes the resources of society in the sectors that have an impact on health.

Longitudinality: Care provided by the health care professional to the individual throughout his lifetime (over time). The difference between continuity and longitudinality of care in the health services is that longitudinality entails a patient-physician relationship and care regardless of whether or not there is a health condition.

Millennium Development Goals (MDG): The Millennium Declaration is a framework for countries to work together and improve their development. It recognizes freedom, equality, solidarity, tolerance, respect for nature, and shared responsibility as essential values for international relations in the 21st century. In 2000, the Millennium Development Goals were developed within the framework of the international agreements included in the Millennium Declaration. Its goals include: eradication of extreme poverty and hunger; achievement of universal primary education; promoting gender equality and empowerment of women; reducing infant mortality; improving maternal health; combating HIV/AIDS, malaria, and other diseases; ensuring environmental sustainability; and establishment of a global partnership for development.

Optimal organization and management: The capacity to predict the future (strategic planning), adapt to change (change management), and perform continuous monitoring and evaluation of system performance (evaluate the impact of changes and performance-based evaluation). It also entails the use of criteria to allocate resources (e.g., equity, cost-effectiveness, opportunity) and the selection of appropriate strategies to achieve equitable health gains. It requires a stable legal, political and institutional framework that defines the legal and financial actions, actors, procedures, and systems that allow PHC to perform its specific functions, link with other components of the health system, and work across sectors to intervene in the determinants of health.

Participation: The extent to which a person participates in and shares decision-making with regard to his or her own care. "Self-care" is a similar concept that entails provision of information to community members so that they are enabled to care for themselves and know when they need to seek professional care. Social participation is the right and the capacity of the population to participate effectively and responsibly in health care decisions and implementation of such decisions. Social participation in health is an aspect of civic participation, a condition inherent to the exercise of freedom, democracy, social control over public action, and equity.

PHC-based health systems: This system is a broad approach to the organization and operation of health systems. The main goal is to provide the right to the highest attainable level of health services while maximizing equity and solidarity. Such a system is guided by the PHC principles of responsiveness to the needs of the population, quality orientation, government accountability and responsibility, social justice, sustainability, participation, and the intersectoral approach. A PHC-based health system consists of a set of functional and structural elements that guarantee universal coverage, access to services that are appropriate for the population, and promote equity. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and ensures the first user contact with the system. Planning and action are based on families and communities. A PHC-based health system requires a legal, institutional, and organizational framework as well as adequate and sustainable human, financial, and technological resources. It uses optimal organization and management practices at all levels to achieve quality, efficiency, and effectiveness, and develops active mechanisms to maximize individual and collective participation in health. A PHC-based health system promotes intersectoral actions in order to address other determinants of health and health equity.

Population-based approach: Unlike the clinical or individual perspective, this approach uses information about the population to make decisions about health planning, management, and geographic location. Such an approach seeks to improve the effectiveness and equity of interventions, and to achieve improved health and distribution of health in the population. This is achieved in the context of the culture, health status, and health needs of the geographic, demographic, or cultural groups represented by a population.

Prevention: Prevention is traditionally considered on three levels: primary prevention refers to management of disease before it occurs; secondary prevention takes place after the onset of disease; and tertiary prevention occurs when the disease progresses. It also includes the notion of "primordial prevention," which is related to changing the underlying conditions that initially lead to exposure. Primordial prevention integrates approaches that create health and modify the conditions "that generate and structure inequitable distribution of exposure to health hazards, susceptibility, and the protective resources of the population."

Primary care: Level of a health system "that provides entry to the system for all new needs and conditions, with a person-centered rather than a disease-centered approach, over time. It provides care for all conditions, except those that are uncommon or rare, and coordinates or integrates provision of care in other locations or by others."[5] Use of this term is believed to date back to 1920, when the Dawson Report was published in the United Kingdom. This report mentioned the proposed "primary health centre" as the key element of regionalization of the services in that country. In 1940, the term "community-oriented primary care (COPC)" originated in South Africa. The COPC approach is still considered today to be one of the important forerunners to the Alma-Ata conception of PHC.

Primary health care (PHC): In 1978, the Declaration of Alma-Ata defined PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain. It forms an integral part of the country's health system as well as the economic and social development of the community, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health process."

Principle: A foundation, law, doctrine, or generating force that other elements are based on.

Pro-equity programs and policies: Proactive and systematic efforts to reduce unfair health inequities and access to health services.

Quality-oriented: The extent to which health services for individuals and populations increase the likelihood of achieving the desired health outcomes and are compatible with current professional knowledge. The foundations of quality are: effectiveness, efficiency, optimization (balance between the costs and effects of care), acceptability, legitimacy, and equity. It includes technical quality as well as user satisfaction with services.

Relevance: The extent to which the common needs of the entire population and a specific population group are met. Services are adapted to fulfill such needs based on objective evidence. This is a measure used to set priorities that consider the most important problems to be addressed.

Responsiveness to peoples' health needs: The care required to achieve the health and equity of the population in accordance with the highest attainable level at a given level of knowledge and social development. Such care focuses on the person rather than specific organs or symptoms, applying the concept of "person-centered care" to the population and considering the physical, mental, emotional, and social dimension of persons. Responsiveness is also defined as care with the following characteristics: holistic approach to persons, professionals with knowledge of persons, caring and empathy, trust in physicians, appropriate care for the patient's needs, option of shared decision-making between physicians and patients.[1]

Right to the highest attainable standard of health: The Constitution of the World Health Organization and international treaties on human rights recognize the right to "the highest attainable standard of health." This right emphasizes the links between health status and human dignity, non-discrimination, justice, and participation. It comprises the freedom to control (e.g., one's own reproductive decisions) and the freedom to defend (e.g., the right to health care and healthy living conditions). The rights-based approach entails obligations and accountability by the responsible agents (e.g., governments) to ensure that citizens exercise their health claims. The right to health implies ethical behavior and responsibility by health care providers, researchers, and decision-makers. Some international treaties define the rights of citizens as: the right to freedom from conditions that interfere with the highest attainable standard of health; to defend one's right to health care and healthy living and working conditions; and fulfillment of one's expectations with regard to standards of ethical conduct in provision of services and research. The obligations of the State include the obligation to respect (refrain from interfering with enjoyment of good health), protect (establish measures to prevent third parties from interfering with the citizens' right to the highest attainable standard of health), and guarantee (adopt the legislative, administrative, budgetary, judicial, promotional and other measures required to ensure full attainment of the right to health).

Social justice: An ethical concept based on social contract theories. Most variations of the concept identify governments to be instituted by the people for the benefit of the people. Governments that are not oriented towards the well-being of citizens are not fulfilling their part of the social contract and are therefore unjust. This concept usually includes, but is not limited to, defense of human rights. It is also used to refer to the justice of a society as a whole, in its divisions and distribution of rewards and obligations.

Solidarity: Common interests, aims, and affinities by members of a society in order to create the conditions required to improve social situations. Solidarity is exercised by active participation, individually as well as collectively, in efforts organized with other members of society. It implies working together to achieve aims that cannot be achieved individually. It is facilitated by common interests that develop as a result of intense and frequent interactions among group members. It is characterized by the promotion of common group aims within the framework of their own rights. For some, an adequate level of social solidarity is essential for human survival.

Sustainability: The capacity to meet present needs without compromising the ability to fulfill future needs.

Universal coverage: Financial and organizational arrangements to cover the needs of the entire population, eliminating the capacity to provide payment as a barrier to accessing the health services.

Value: The social principles, goals, or standards supported or accepted by an individual, class, or society.

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