

Rural health around the world: challenges and solutions*

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Despite the huge differences between developing and developed countries, access is the major issue in rural health around the world. Even in the countries where the majority of the population lives in rural areas, the resources are concentrated in the cities. All countries have difficulties with transport and communication, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas. Many rural people are caught in the poverty–ill health–low productivity downward spiral, particularly in developing countries. Since 1992, WONCA, the World Organization of Family Doctors, has developed a specific focus on rural health through the WONCA Working Party on Rural Practice. This Working Party has drawn national and international attention to major rural health issues through World Rural Health Conferences and WONCA Rural Policies. The World Health Organization (WHO) has broadened its focus beyond public health to partnership with family practice, initially through a landmark WHO–WONCA Invitational Conference in Canada. From this has developed the Memorandum of Agreement between WONCA and WHO which emphasizes the important role of family practitioners in primary health care and also includes the Rural Health Initiative. In April 2002, WHO and WONCA held a major WHO–WONCA Invitational Conference on Rural Health. This conference addressed the immense challenges for improving the health of people of rural and remote areas of the world and initiated a specific action plan: The Global Initiative on Rural Health. The ‘Health for All’ vision for rural people is more likely to be achieved through joint concerted efforts of international and national bodies working together with doctors, nurses and other health workers in rural areas around the world.

Keywords. Family practice, primary health care, rural health.

Introduction

The year 2000 has passed and clearly we have not attained Health for All. Nowhere is this more evident than in the rural and remote areas where most of the world’s people live. This article begins by outlining some of the challenges facing rural health around the world before reviewing the Health for All target, reflecting on its non-achievement and on the potential role of family practice. It then describes the lead role of WONCA, the World Organization of Family Doctors, in tackling these issues, before introducing the World Health Organization (WHO)–WONCA Collaborative Rural Health Initiative.

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Rural health status

Around the world, the health status of people in rural areas is generally worse than in urban areas. In South Africa, infant mortality rates in rural areas are 1.6 times that of urban areas. Rural children are 77% more likely to be underweight or under height for age; 56% of rural South Africans live >5 km from a health facility; and 75% of South Africa’s poor people live in rural areas.¹

Critical factors in the relationship between poverty and health are population and environmental health issues. Eighty percent of the poor in Latin America, 60% in Asia and 50% in Africa live on marginal lands of low productivity and high susceptibility to degradation. This tends to encourage migration from rural areas to the cities. However, in the world’s cities, more than one billion people live without facilities for garbage disposal or water drainage, and breathe polluted air.² There are Healthy Cities policies and programmes aimed at addressing these problems. At times, it seems to be assumed that eventually everyone will move to the cities. MK Rajakumar, the great family practitioner/philosopher,

former WONCA President from Malaysia, points out that, in the totality of human history, cities are a very recent and potentially ‘unnatural’ phenomenon. He suggests that this helps to explain why so many urban people feel more at ease, somehow ‘at home’, in the rural areas. It does raise the notion that there should be programmes which actively seek to reverse the rural–urban drift.

With the concentration of poverty, low health status and high burden of disease in rural areas, there is a need to focus specifically on improving the health of people in rural and remote areas, particularly if the urban drift is to be reversed. The WHO International Development Programme has highlighted this, with specific objectives for policies and action which promote sustainable livelihoods including access for people to land, resources and markets, as well as better education, health and opportunities for rural people. These objectives seek to contribute to lowering child and maternal mortality, and to improve basic health care for all, including reproductive services. Achievement of this is linked to protection and better management of the natural and physical environment.

The emphasis on poverty as well as other social and economic factors has led to a tendency to focus on those issues rather than directly addressing health issues. The 10/90 Report on Health Research, 1999 presents an alternative view: “The global community should recognise that good health is a way out of poverty. It results in a greater sense of wellbeing and contributes to increased social and economic productivity. The impact of ill health on productivity affects not only the poor, but societies and economies as well”.² Drawing these points together, there is a particular need to focus on the health and wellbeing in rural and remote areas so as to break out of the poverty–ill health–low productivity downward spiral.

The low health status and variable patterns of illness and injury in rural areas are related not only to poverty. In general, the rates of avoidable deaths in rural and remote areas are higher than in the cities. Generally, work injuries are more serious and more severe in rural areas, which to some extent follows from the stoicism and the ‘too tough to care’ mindset particularly amongst farmers and agricultural workers.³ In fact, in Australia, the tractor is the most dangerous machine with which people work. Forty percent of work injuries are associated with tractors, even though only 5% of the workforce actually work with tractors.⁴ Similarly, there are dangers in other rural pursuits such as mining, fishing and timber work. In countries with established highway systems, country people spend a lot of time driving at high speed and tend to have more serious injuries from motor vehicle accidents.

The specifics differ from country to country; however, there are always some illnesses which are peculiar to living and working in rural areas. These include zoonoses, such as hydatids and leptospirosis, as well as other illnesses with animal vectors such as mosquitoes.

As a generalization, lifestyle-related illnesses are more common in the rural areas. The peaks and troughs

of the economic cycle tend to impinge more directly on rural communities, with economic downturns often placing severe pressure on these communities. Consequently, there are significant levels of stress in a situation where generally counselling, support groups and other mental health services are limited if available at all. Commonly, in rural areas, there is a higher alcohol and tobacco consumption, and standards of nutrition vary when compared with the cities.

Rural cultures

There tend to be clear cultural differences between rural communities and urban centres and, in many countries, there are significant cultural differences from community to community in rural areas. There is a strong feeling in rural communities that they are different from, and have special qualities not found in the cities. Sociologists describe this quality as ‘*gemeinschaft*’. Relationships are seen as personal and enduring; unlimited and unspecified in their demands and imbued with a strong sense of loyalty not only to friends and relatives, but to the community and its members. Particularly in smaller communities, there is a community conception of being part of ‘one big happy family’.⁵ By way of contrast, the city and government are seen as distant and antagonistic. Sociologists describe this concept as ‘*gesellschaft*’. The city is seen in many respects as bad and inferior, while the small rural community is good and superior.

Another aspect of the sociology and psychology of rural communities is the clear sense of behavioural norms which translate into community views of social roles and functions of various members of the community. In many countries, the social roles and functions are supported by a long tradition and specific religious practices. People in rural communities often value very highly self-sufficiency, self-reliance and independence, coupled with a stoicism which comes primarily from the farming culture. There is very much a focus on getting the job done. Consequently, health is given a very low priority which often translates into the view that medical services and hospitals really are the last resort.

In most developing countries, the vast majority of the people are in rural areas, whereas in mostly developed countries the rural population is a relative minority. In all countries, accessibility to rural and remote communities is affected by the physical topography, with mountains, deserts and jungles creating difficulties for transportation, at times complicated by varying climatic conditions. Consequently, in some areas, at least some of the time, there is no means of transportation, and evacuation of critically ill or injured patients is impossible. The standard and quality of communications between different rural and remote areas and between those communities and the urban centres is also very variable.

Rural health services

Despite the substantial differences between developing and developed countries, the key themes in rural health are the same around the world. Access is the major rural health issue. Even in countries where the majority of the population lives in rural areas, the resources are concentrated in the cities. All countries have difficulties with transport and communication, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas.

People in rural communities need to know that if they are unlucky enough to be seriously ill or injured, then the system is there to 'save' them. Generally speaking, in the cities where there are hospital emergency departments and ambulance services, this emergency response is assumed to occur. In rural and remote areas, this cannot be taken for granted, and people tend to be focused on their security need. Often, the way in which this felt need is expressed is through the community's primary focus on recruiting and retaining a doctor or doctors and having a hospital in the area.⁶ Generally speaking, people in rural and remote areas very much prefer to be cared for in their local environment.

The provision of health services in rural and remote areas is significantly affected by limited funding and other resource constraints. As mentioned already, in developing countries, there is considerable poverty and limited facilities and resources available for health care. In many developed countries, there has been a trend towards the reduction of funding and infrastructure support for health services in rural and remote communities. This is occurring in rural communities against a background of changing practices in major rural industries such as agriculture, mining, fishing and forestry, combined with wider social and economic changes causing considerable upheaval often described as 'the rural decline'.⁷ At the same time, economic rationalist policies have led to reduced infrastructure in rural communities, with the closure of schools, hospitals, government offices and banks. Many rural and remote communities bear the cost of global change without the commensurate benefits.⁸

All of these issues are accentuated in the context of often serious shortages of doctors, nurses and other health service providers in rural and remote areas.⁹ Rural health services require sufficient numbers of doctors and other health care providers who have the necessary skills to work effectively and comfortably in these areas. Sustainability of these services is dependent on adequate health service infrastructure and availability of specialist support.

Drawing together the various aspects of rural morbidity and mortality patterns, and the rural context, it is clear that the development and delivery of health services in rural areas must be specific to the rural context and different from that in the cities. Unfortunately,

urban-based policy makers and health service planners often seem to think that the country is just like the city but with a different population distribution, and that it is possible simply to transplant modified urban health services to rural areas.

The problems with primary health care

Returning to the theme of 'Health for All'. The Health for All programme was enunciated through the Declaration of Alma Ata in 1978. In part, the Declaration said "that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity; that health is a fundamental human right; and that the attainment of the highest possible level of health is a most important world wide social goal".¹⁰

The Declaration of Alma Ata went on to say: "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. . . . Primary Health Care is the key to attaining this target as part of development in the spirit of social justice. Primary Health Care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first level of a continuing health care process. Primary Health Care addresses the main health problems in the community providing promotive, preventive, curative and rehabilitative services accordingly".

The Declaration of Alma Ata outlined a grand vision of primary health care which has not yet been achieved. It clearly has a strong public health emphasis and is much more than primary medical care. In retrospect, there have been a series of problems with the interpretation and implementation of primary health care.

The first problem relates to the bureaucratic context. This was well outlined by Judith Justice in her paper: 'The bureaucratic context of international health—a sociologist's view'.¹¹ She commented that many primary health care programmes were ineffective because they reflect the perspective and needs of the health bureaucracies involved rather than those of the local villages receiving the services. Often primary health care is interpreted differently in different bureaucratic settings and adapted to bureaucratic needs, but not necessarily adapted to the village cultures and conditions.¹¹

Another issue was outlined recently in a paper in *The Lancet* by McFarlane *et al.*,¹² in which they comment that the Declaration of Alma Ata was followed by a series of northern-designed selective initiatives which are still being generated today. Selective vertical programmes enable the International Aid Agencies to measure results and protect their investments from complicated long-term multisectoral and interdepartmental implementation. Also, they comment that non-government organizations (NGOs) and religious groups

have found that holistic community-based health programmes are generally undermined by narrowly selective interventions and that the sustainability of people-owned initiatives can be put in jeopardy. So clearly this approach of selective vertical programmes often focused on particular diseases has been another problem with the implementation of primary health care.

A third problem is the tendency of primary health care programmes to dismiss curative interventions and ignore the desire people have for some help with their immediate health problems. A programme in Nepal, the Nutrition Education Intervention Programme which was evaluated some years ago, did involve some curative intervention. The evaluators found that the inclusion of curative activities in the programme seemed to be a key factor in increasing the motivation of participants and acceptance by the community, so contributing to the success of the programme.¹³

A fourth problem is the tendency to exclude practising clinicians. As the notions of primary health care were developed, the strong emphasis was on disease prevention and health promotion. Consequently, over the years, the development of the community health cum public health cum population health approach focused on healthy lifestyle and ‘wellness’ in the extreme, to the point of excluding the practitioners, the clinicians—doctors, nurses and others who are perceived to be dealing with ill health. That dichotomy and the tension itself has created difficulties.

Family practice

In most of the WHO and the other primary health care programmes around the world, there has been little medical involvement in planning other than by specialists in public health or in specific diseases. Implementation in the field has tended not to involve clinicians and particularly not to involve doctors.

Family physicians or GPs are the key providers of primary medical care and so essential to successful primary health care. The family practitioner views the practice population as a ‘population at risk’ as part of providing community-oriented patient-centred preventive care.¹⁴ The family doctor is well placed to provide the link between individual and family health care, and the community and population health focus embodied in primary health care.

This is true for developed and developing countries alike. Martha Carlough from the USA spent quite a number of years in Nepal under the Interserve USA Program. She wrote a paper describing how she sees the commonality in family practice in her experience in Nepal with the USA.¹⁵ She observes that in both countries, every encounter is influenced by family relationships, cultural tradition and socio-economic status. Clearly, a

key theme of family practice is the focus on caring for and understanding a person’s situation in the context of their home, family and community.

In 1998, the World Health Assembly could see 2000 coming and made new commitments to Health for All Policy for the 21st century. The commitment included in part: “We commit ourselves to strengthening, adapting and reforming as appropriate our health systems including essential public health functions and services in order to ensure universal access to health services that are based on scientific evidence of good quality and within affordable limits, and that are sustainable for the future. We will continue to develop health systems to respond to the current and anticipated health conditions, socio-economic circumstances and the needs of people, communities and countries concerned to appropriately manage public and private actions, and investments in health”.¹⁶

Family practice is pivotal to the development of a health system as outlined by the World Health Assembly. It is also important to have the full health team. There is a need not only for doctors but also for nurses and other health professionals, including medical assistants and village health workers who are part of the health team responding to the health care needs of the community. In fact, for the vision of primary health care to be achieved, there needs to be strong and active community involvement. Health systems work best where there is active community participation.¹⁷

In the rural context, the ideals of primary health care are best achieved through Healthy Village Projects. This community development approach supports and encourages sustainability of the small rural community, as well as facilitating improvements in health status and outcomes. The Healthy Village Project at New Hanover, only 2 h drive from Durban in rural KwaZulu-Natal, is an excellent example. Dr Neethia Naidoo, local family physician and district medical officer, has a key role in encouraging and facilitating the project. Specific activities are developed in response to demonstrated local needs. In addition, community involvement extends to an active role for the other sectors of the economy in health and development activities.

Since 1993, specific achievements include:

- A school water and sanitation project at 10 of the most needy schools in four villages.
- An AIDS preventative programme linked to the Mobile Clinic services.
- A district water reticulation scheme.
- District Social Welfare and Pension Services.
- A District Victim Support Service, an NGO linked to the University of Natal and the Criminal Justice system.
- A District (KZN 221) Creche Project. This consists of 22 creches.
- A Child and Family Welfare Society.

WONCA, The World Organization of Family Doctors

Returning to the international level, WONCA has provided leadership in rural health. It established the WONCA Working Party on Rural Practice in 1992 following the WONCA World Conference in Vancouver. At that conference, the rural delegates met to discuss matters related to rural practice. The consensus which developed formed the basis for the WONCA Policy on Training for Rural Practice which was endorsed by WONCA Council in June 1995.⁹

Since the 1995 WONCA World Conference, the Working Party on Rural Practice has been involved in the organization of a series of International Rural Health Conferences. Each of these conferences has involved >300 delegates from up to 30 different countries around the world. These conferences have provided a forum for exchange of ideas between rural family practitioners, and have developed recommendations which form the basis for WONCA Policies on Using Information Technology to Improve Rural Health Care (1998)¹⁸ and on Rural Practice and Rural Health (1999).¹⁹ The Second World Rural Health Congress was held at Durban South Africa in 1997. It had a particular focus on rural health in the developing world. The Congress adopted: 'Health for All Rural People: The Durban Declaration'.²⁰ This Declaration outlines a series of principles which are followed by a Call for Action renewing the 'Health for All' initiatives and calling on WHO, UNICEF, Development Banks such as the World Bank and other Regional Development Banks, and National Governments to work with local communities, doctors, nurses and other health workers actually working in poorer areas of the world to make a success of the 'Health for All' initiative at this time. The Declaration calls for a combined effort to address the historical inequities facing rural and disadvantaged communities. It recommends that targets be set in stages until the year 2020 to reduce substantially all aspects of global poverty, social, cultural, economic, education, nutritional and health. The Declaration concludes that, "Since the great majority of poor people of the world live in rural areas, we pledge ourselves to this global initiative to achieve health for all rural people by the year 2020".²⁰

The WONCA Policy on Rural Practice and Rural Health outlines a framework for rural health care, noting that there are special problems in rural health care that are not seen in urban health care. The document calls for affirmative action policies by Government structures at national and regional levels which address the needs of underserved rural areas. It calls for research to inform rural health initiatives and to monitor progress in rural health care. The WONCA Policy goes on to outline a series of strategies: to establish rural health administrative structures; for the allocation of financial resources; to increase rural health research; and to

enhance the development and representation of rural doctor issues.¹⁹

One of the remarkable features of World Rural Health Conferences has been the high level of common interest and strong sense of fellowship coupled with a willingness to discuss even the most difficult issues. Each conference has been much more than just an International Conference. Each conference has contributed to the growing world rural health movement.

The World Health Organization

During the last decade, there has also been a developing relationship at the international level between the WHO and WONCA. The WHO appears to have recognized the need for doctors in the field as part of the primary health care team. In 1994, WHO and WONCA held a landmark Invitational Conference at London, Ontario on 'Making Medical Practice and Education More Relevant to People's Needs: The Contribution of the Family Doctor'.²¹ The conference and its report have led to major changes in medical education around the world, shaping the development of new medical schools as well as curriculum reform in established ones. In 1998, WONCA and WHO developed a Memorandum of Agreement which includes the Rural Health Initiative.

Rural health around the world: challenges and solutions

Recently, the WHO has initiated the 'Towards Unity for Health' (TUFH) project. The project intends to study and promote efforts worldwide to create unity in health service organizations—particularly through a sustainable integration of medicine and public health, or, in other words, of individual health and community health-related activities—and consider the implication for important reforms within the health professions, practice and education. It is in rural practice that integration of health care is well exemplified. As well as knowing the health care needs of individual patients, the rural doctor must understand the needs of the community and its resources for health.

Following a WHO International Conference, 'Towards Unity for Health: Challenges and Opportunities for Partnership in Health Development' in Thailand, August 1999, the WHO has produced a working paper intended to further the TUFH Project.²² This working paper explores innovative patterns of services for integrating medicine and public health, focusing particularly on reference population and geography. A district has been described as an ideal geographic area at the level at which health services could be usefully decentralized for planning and organization, and health status monitored

with the understanding that it should be large enough to justify its own health surveillance system, but small enough to allow an efficient co-ordination and management of health interventions. Many of the issues raised in this working paper are particularly pertinent in rural and remote areas. Innovative models of health service delivery have been developed by rural practitioners. There is particular potential for the use of communication information technology and telehealth in serving the needs of rural people and their carers.

WHO–WONCA Rural Health Initiative

In the context of the WONCA–WHO Memorandum of Agreement (1998), commitment to the Rural Health Initiative, as well as the WONCA Durban Declaration, ‘Health for All Rural People’ (1997) and the WHO TUFH project (1999), WHO and WONCA have agreed to collaborate in addressing the immense challenges for improving the health of people in rural and remote areas around the world. It was agreed in 2001 to undertake a WHO–WONCA co-sponsored consultation: ‘Health for All Rural People’.

A focal point of the consultation process was a co-sponsored WHO–WONCA Invitational Conference on Rural Health held in April 2002. The conference explored the major issues and challenges of health and health services in rural and remote areas around the world. The conference was planned and organized in a similar way to the successful joint WHO–WONCA conference in London, Ontario in 1994. Invited participants to the conference represented WHO regions, NGOs, Medical and Health Science Schools around the world, health professional organizations, governments and health authorities, and WONCA.

The conference drew on the programmes and activities of WONCA and WHO, as well as specific case examples of successful rural health initiatives around the world. Guiding principles of the conference discussions were equity and integration in the development of innovative strategies to break the poverty–ill health–low productivity downward spiral for people in rural and remote areas.

The conference considered both developed and developing world perspectives, and focused on deliverable outcomes. It established a consensus as the basis for an Action Plan on Rural Health which integrates the individual and population health approaches towards improving the health and well-being of people in rural and remote areas around the world. The Action Plan proposes a range of global, regional and country-specific activities. Principles and guidelines were developed to assist educational institutions, health professional organizations, health services agencies and communities on implementing the proposed activities.

Conclusion

This article has outlined the major challenges facing rural health around the world, reviewed the problems experienced with primary health care and Health for All programmes, highlighted the pivotal role of family practice, described the leadership provided by WONCA in addressing rural health issues at the international level, and presented the growing collaborative WONCA–WHO Rural Health Initiative.

The WHO–WONCA co-sponsored Invitational Conference ‘Health for All Rural People’ focused world attention on rural health and marked the beginning of a new era for improving the health and well-being of people in rural and remote areas of the world.

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