

Primary health care vs. emergency medical assistance: a conceptual framework

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Primary health care (PHC) and emergency medical assistance (EMA) are discussed as two fundamentally different strategies of delivering health care. PHC is conceptualized as part of overall development, while EMA is delivered in disaster or emergency situations. The article contrasts the underlying paradigms, and the characteristics of care in PHC and EMA. It then analyzes the characteristics of PHC and EMA health services, their structure, management and support systems. In strategic aspects, it contrasts how managerial and financial sustainability are fundamentally different, and how the term accountability is used differently in development and disaster situations.

However, while PHC and EMA, development and disaster, are clear opposite poles, many field situations in the developing world are today somewhere in-between. In such non-development, non-emergency situations, the objectives and approach will have to vary and an adapted strategy combining characteristics from PHC and EMA will have to be developed.

Key words: primary health care, emergency medical assistance, health care delivery

Introduction: primary health care and emergency medical assistance

The organization of health care today invariably refers to the concept of primary health care (PHC).^{1–5} Most authors have described the principles of PHC in generic terms,^{6–8} while others have focused on practical organizational issues,⁹ and particularly district health care.^{10–14} All implicitly refer to stable situations where there is a perspective for development – not to societies struck by disaster.

Whereas PHC has a well-developed conceptual substructure, the literature on emergency medical assistance (EMA) has concentrated on technical and logistic considerations.^{15,16} The few authors who have addressed the issue highlighted the fundamental differences between PHC and EMA:¹⁷ ‘the emergency approach tends to be the antithesis of the primary health care approach’.¹⁸

The present article spells out the conceptual, practical and strategic differences between PHC and EMA. PHC aims at promoting health in a society in development, while EMA concentrates on safeguarding survival in an emergency situation. This fundamental difference in objectives and time-frame results in different characteristics of health care and of health services, with important strategic implications.

Health services organization in development and emergency

Much has been written on development, disaster and emergency,^{19–21} and on the ‘continuum’ in-between. Some authors define rehabilitation and reconstruction as distinct stages in a disaster–development continuum. Others have challenged

this.^{22–26} This debate is rich in ambiguous terms, such as chronic emergencies, protracted emergencies, developmental relief, welfare relief and humanitarian aid. One could also argue for a classification of situations in a stable–unstable continuum. However, this article uses only development, disaster and emergency, as they are most widely used, although not always unambiguously defined. The contexts are different, and, not surprisingly, the ‘paradigm’ underlying PHC is distinct from the one that underlies EMA. These paradigms determine the characteristics of health care and of health services. They also determine strategic aspects, such as sustainability, the role of different actors and accountability.

Paradigms of PHC and EMA

PHC

PHC aims at responding to people’s health needs and demands, to safeguard, promote and restore health. However, health is not an aim *per se*, but a condition for human development and wellbeing (Table 1).²⁷ Health services should thus be developed in harmony with other aspects of society – education, social and economic infrastructure – and use only a ‘reasonable’ share of the total financial and human resources available.^{28–30} Indeed, ‘... the possibility [exists] that the direct positive effects of health care on health may be outweighed by its negative effects through its competition for resources with other health-enhancing activities. A society which spends so much on health that it cannot or will not spend adequately on other health-enhancing activities may actually be reducing the health of its population through increased health spending.’³¹ To produce a maximum of health with these limited resources, health services must be rationalized to function in an effective and efficient way.²⁷

Table 1. Paradigms of primary health care (PHC) and emergency medical assistance (EMA)

	PHC	EMA
Aim	Health, as a condition for human development and well-being.	Physical survival, as a pre-condition for human development.
Relation to context	In harmony with other sectors of society.	Part of a package of 'emergency relief measures'.
Resource-use	Use a 'reasonable' share of the overall resources.	Use 'all resources that can be mobilized'.
Technical dimension (rationalization)	Optimization (effectiveness and efficiency).	Maximization (effectiveness).
Social dimension	Autonomy and participation (responsiveness).	Dignity and compliance.
Time perspective	Long term.	Short term.

PHC, however, also has important social dimensions: autonomy and participation, also referred to as responsiveness.^{1,3,32,33} Where possible, health professionals should avoid making the users dependent on the health services. Instead, they have to promote autonomy, and deliver services that are complementary to self-care and family care.³⁴ This requires a partnership between health professionals and the population, based on a continuous dialogue.^{32,35,36} The need for participation has several foundations: 'Increasingly, the demand is being made that both consumers and providers participate . . . this stems, in part, from general social values that indicate a preference for egalitarian and participatory forms of governance. Partly, it stems from more pragmatic arguments. One of these is that consumers and providers have somewhat different perspectives on "health" and on its management, and that both viewpoints need to be taken into account and synthesized or reconciled if the agency is to be maximally effective. Another argument is that participation in decision making creates a sense of belonging and commitment and encourages behavior that is in line with agency objectives.'⁸

The technical content of health care in a PHC perspective can be defined in fairly straightforward and objective terms. Rationalizing its implementation and balancing technical content with autonomy and participation are essentially local issues. Developing autonomy and participation are more difficult and take more time than rationalizing the technical aspects. Fast success in developing participation is less frequent than in rationalization. A 'technocratic imbalance' is often unavoidable, at least in the short term. Developing PHC is necessarily slow and requires a long-term perspective.

EMA

EMA, or medical relief, on the other hand, concentrates on protecting physical survival (Table 1).³⁷ WHO defines relief as 'assistance and/or intervention during or after a disaster to meet the life preservation and basic subsistence need'.³⁸ Physically surviving the emergency is an aim *per se*; it is the pre-condition for human development, once the emergency is over. EMA should be part of a package of emergency relief measures, including provision of water, shelter and food.^{16,39-41} These emergency relief measures may use 'all resources that can be mobilised'. In EMA, rationalization aims at producing a maximum output in terms of lives saved with the resources available. Effectiveness is thus the main consideration, even if this means jeopardizing autonomy and creating dependence. Participation is often reduced to compliance. Health professionals work with 'beneficiaries', often in a paternalistic way. Safeguarding human dignity is an ethical imperative, even in EMA. As the technical dimension is dominant, and short-term effectiveness paramount, there is a tendency to rely on standard strategies.

Characteristics of care

From the differing paradigms of PHC and EMA result differing characteristics of care (Table 2). The objectives of PHC include the maintenance and restoration of health (providing 'cures'); preventing further deterioration; relieving symptoms, particularly pain; offering assistance in coping with the inevitable; and providing reassurance through authoritative interpretation, while still exercising control over one's own health.³¹ To reach the triple objective of cure, care and autonomy, health care should find an optimal balance between

Table 2. Characteristics of care in primary health care (PHC) and emergency medical assistance (EMA)

PHC	EMA
Triple objective: cure, care and autonomy.	Cure is dominant over care and autonomy.
Search for optimal balance between being effective, integrated, continuous and holistic.	Effectiveness takes precedence over other characteristics.
Care provided is a compromise between need and demand.	Need gets precedence over demand.

Table 3. Characteristics of health services in primary health care (PHC) and emergency medical assistance (EMA)

	PHC	EMA
Temporal accessibility	Permanent facilities are mandatory for curative activities and for emergencies; preventive activities can be intermittent.	
Geographical accessibility	Decentralization, balanced with quality of care.	Decentralized services are paramount, including home visitors.
Financial accessibility and financial participation	A balance should be struck between financial participation and financial accessibility.	Services should be free of charge.
Polyvalent or specialized?	Polyvalence is necessary for integrated and holistic care.	Specialized services are often needed.
Relationship between client and health care provider	Whole range of valued aspects should be aimed at.	The quality of the relationship is subordinate to other characteristics.

being effective, integrated, continuous and holistic.^{27,42–44} Effectiveness of care should be balanced with its cost and with the importance of holistic care. Integration of curative and preventive care with health promotion is desirable, as it yields the best results in the long term. Continuous health care means care till the end of the episode of disease or risk. Holistic health care takes into account the physical, psychological and social dimensions of health and wellbeing. Each of these four characteristics is thus important, but none is absolute or takes precedence over the others. In PHC, the health care offered is variable according to circumstances and resources. It has to balance, both collectively and individually, the professionally defined need with the demand as expressed by the patient. As an interim strategy, responding to ‘irrational demand’ may be considered, or the relative importance of ‘non-felt need’ decreased.

In EMA ‘cure’ is dominant over care and autonomy, which are of secondary importance. The effectiveness of care takes absolute precedence over the other characteristics. Integration is less important; it may even hamper immediate effectiveness (e.g. when it is imperative to reach a high measles vaccination coverage in the very short term). Continuity of care and holistic care are less important.^{17,45} There

are no top-priority activities that require continuous care. In EMA, the focus is on life-saving interventions. The professionally defined needs take precedence over demand.

From these differing objectives and characteristics of health care in PHC and EMA result differing characteristics of the health services.

Characteristics of PHC and EMA health services

In PHC, temporal, geographical and financial accessibility are all important features of a health service that facilitate the delivery of effective, integrated, continuous and holistic care.^{12,46} Permanent facilities, with opening hours in accordance with people’s activities, are mandatory for curative care (Table 3). There is also a need for immediate access in case of emergency, even outside opening hours. Indeed, ‘... access when need arises may be the most salient feature of care for consumers ... the stand-by function must be an integral part of the responsibility and of the work ... to do otherwise would be, paradoxically, to be least effective when the client is most vulnerable’.⁸ Preventive activities, however, can be intermittent. Health services should be decentralized, to the extent that this is compatible with human and material

Table 4. The decentralized health system in primary health care (PHC) and emergency medical assistance (EMA)

	PHC	EMA
First line	Polyvalent health centres responsible for a defined population (one for 5000 to 15 000 people).	Curative health posts (one for 3000 to 5000 people).
Second line Exceptions to two-tier system	District hospital. Peripheral extensions and intermediate facilities are sometimes justified. Community health workers are seldom adequate.	Referral hospital. Home visitors and intermediate structures are often needed.
Vertical services	Mobile team sometimes justified.	Mobile team and feeding centres often needed.
Articulation of services	A two-tier integrated district health system, avoiding gaps and overlap. A rational referral system should be encouraged.	Often a parallel health system; marginally linked to pre-existing health system. A strict referral system has often to be imposed.

resources needed for quality care.^{47,48} Financial accessibility is important, but should be balanced with the need for financial participation of the clients. Financial participation can be a lever for community participation in decision-making and for accountability, especially at first line health services.^{49–55} Polyvalence is necessary to enable integrated and holistic care. Acceptability, conditioned by cultural and financial accessibility, requires that all valued aspects of the relationship between client and health care provider should be aimed at: such as stability, maintenance of client autonomy and family ties, active client participation – sharing knowledge, shared decision making, and participation in carrying out therapy – empathy, supportive relationship, maintenance of dignity, privacy and confidentiality.⁸ A health information system with patient records, family files and operational cards facilitates integrated and continuous care.

EMA entails mainly the *ad hoc* delivery of life-saving interventions.^{56,57} Temporal, geographical and financial accessibility are paramount and take precedence over other characteristics.¹⁷ Maximizing access requires permanent facilities for curative activities (Table 3). Preventive activities can be intermittent. Decentralized services are paramount, especially when there is social breakdown.⁵⁸ Home visitors are often necessary as outreach contacts, and to guide patients to the health services.⁵⁹ Services should be free of charge. Specialized services are often needed to reach high coverage in the short term, and to reach immediately high technical quality.^{60,61} The quality of the relationship between the patient and the health care provider is subordinate to other characteristics.

These characteristics of the health services and the scope of activities offered determine the structure of the health system (Table 4). Together with the time perspective, they also determine how the health system is managed (Table 5) and supported.

Structure

In PHC, the health district catering for 100 000 to 300 000 people is the basic organizational unit of the decentralized

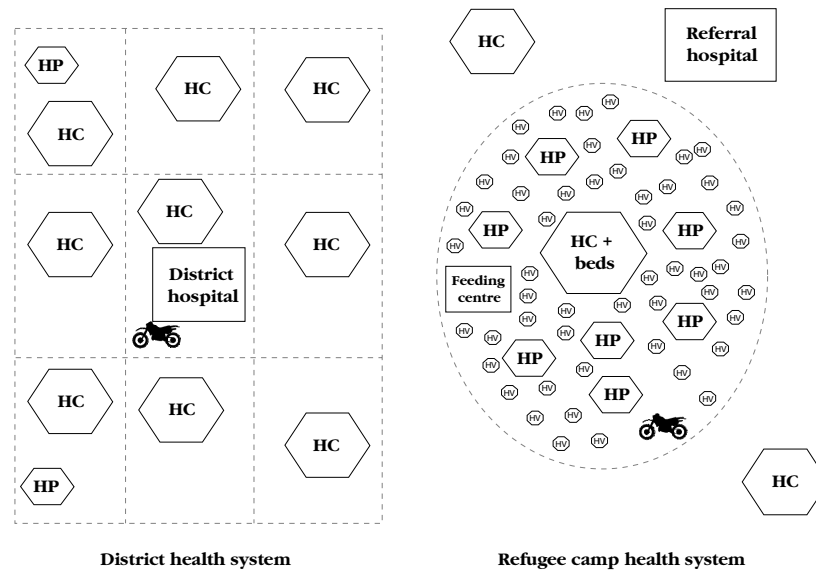
health system.^{10,12,62} In a health district, a network of polyvalent health centres and a district hospital are linked in a two-tier system (Figure 1). A small team, headed by a nurse practitioner or medical doctor, staffs each health centre.⁶³ The team delivers all curative and preventive first line activities, and is responsible for a population of 5000 to 15 000 people (Table 4).⁶⁴ This population is defined, geographically or by registration. Health centres can refer patients to the district hospital, which delivers both outpatient and inpatient care and has surgical, laboratory and imaging facilities.^{65–68} There may be exceptions to this two-tier system. Peripheral extensions (e.g. curative outposts with one staff) or intermediate facilities (e.g. health centres with beds for non-surgical hospitalization) may sometimes be justified, depending on local circumstances and constraints. But community health workers can at most be a complement to a health system run by professionals, and not its cornerstone.^{30,69–71} In a health district, a mobile team may be useful; not to deliver routine services, but to reinforce services in case of epidemics, or to reduce a temporary gap in health services coverage.^{72,73}

A district health system should avoid gaps and overlap in functions; all resources, including public and private, should have a well-defined and rational role.⁷⁴ This implies that a rational referral system between first and second level should be encouraged (e.g. by granting preferential tariffs to those respecting it), but stringent measures to enforce the referral system are rarely justified. When peripheral extensions or intermediate structures are part of the system, they should not constitute a systematic stage in the referral process.

For EMA it is often necessary to set up a separate health system. This rarely results in a district health system, but a basic two- or three-tier system is invariably present. A typical refugee camp health system can illustrate this (Figure 1).⁵⁹ A network of curative health posts constitutes the first line. A small team, often headed by an auxiliary nurse, staffs such health posts. There is usually one health post per 3000 to 5000 population (Table 4), located in a makeshift building close to the affected population. Peripheral extensions with ancillary services such as home visitors are often necessary to

Table 5. Management of the decentralized health system in primary health care (PHC) and emergency medical assistance (EMA)

	PHC	EMA
Management structure	Team of professionals with authority over the different health facilities in a health district.	Team of professional people with full operational and administrative authority, high degree of autonomy.
Types of logic in management	Balancing the medico-technical, administrative and sociological types of logic.	Medico-technical logic is paramount.
Responsiveness to epidemic alerts	Important.	Paramount.
Pre-established objectives	May be counterproductive.	May be necessary.
Methods to improve utilization, coverage and adherence	Good quality of care, empathic relationship, dialogue during care, structured dialogue with the community, education, etc.	Relatively coercive methods may be justified.



(🏍️ = mobile team, HC = health centre, HP = health post, HV = home visitor)

Figure 1. District health system in PHC vs. refugee camp health system in EMA

establish a link between the beneficiaries and the health services. Also intermediate structures (e.g. health centres with referral level outpatient consultation and observation beds) are often established close to the beneficiaries. Vertical and specialized services (e.g. mobile teams or feeding centres) are often needed. All these services usually result in a parallel health system that is only marginally linked to pre-existing health systems, for instance, only to refer patients needing surgery or blood transfusion.⁵⁶ In EMA, a strict referral system has often to be imposed (e.g. the health post as mandatory entry point in the health system, except for emergencies, to avoid overburdening of referral outpatient consultation).

Management and support

In PHC, a district health management team, composed of professionals with operational and administrative authority over the different health facilities, manages a health district.^{12,74,75} The district health management team should have a certain degree of autonomy to manage human and financial resources, and to establish priorities (Table 5). Coordination with private not-for-profit facilities, and regulation of private for-profit practices are needed.⁷⁶⁻⁸¹ District management requires balancing medico-technical logic (such as quality of care, rationalization of health services, etc.); sociological logic (such as participation of the population, motivation of staff, etc.); and administrative logic (health services as part of Ministry of Health and wider society, civil servants, law, etc.).⁸² Health services should be responsive to epidemic alerts, and tackle them adequately. Control measures for most epidemic diseases are very effective, and adequate interventions may considerably improve the credibility of routine services. Trying to reach pre-established objectives of

coverage or utilization may be counterproductive.⁴⁴ They may jeopardize the development of participation, and lead to 'technocratic imbalance'. The short-term results obtained may then not be sustainable. Good quality of care, empathic relationships, dialogue during care, structured dialogue with the community, education, etc. are the methods most indicated to improve utilization, coverage and adherence to therapy.

In EMA, the health system has to be managed by a team of professional people with full operational and administrative authority, and a high degree of autonomy to manage human and financial resources, and to establish priorities (Table 5). In EMA, the medico-technical logic is paramount, even if the importance of a sociological logic is not to be underestimated.⁸³⁻⁸⁷ The administrative logic is often replaced by adherence to the institutional policy of relief agencies.^{19,88} As epidemics are frequent and severe, responsiveness to epidemic alerts is foremost in the managers' minds.^{15,61} Very high coverage of preventive activities may be necessary (e.g. achieving a near-total measles vaccination coverage is often an imperative). Relatively coercive methods may then sometimes be justified (e.g. restriction of movement during vaccination campaign).

In both PHC and EMA the management needs two major supports: supplies and information. In PHC it is the sustainability of the supply system that is crucial;⁸⁹⁻⁹¹ in EMA it is speed and reliability of the supplies. Supply of standard kits, such as the standard drug kit for 10 000 people for 3 months, is often preferable.⁹² In PHC the design of the information system should support district organization and self-regulation. Its focus is on supporting quality of care, monitoring achievements and managing resources. In EMA

Table 6. Sustainability in primary health care (PHC) and emergency medical assistance (EMA)

	PHC	EMA
Project vs. programme approach	Programme format is usually preferable.	The project format is usually preferable.
Institutional strengthening	Important to obtain managerial sustainability.	Of low priority.
Importance of cost constraints	Often paramount; to be sustainable health services should be organized at 'affordable' cost.	Limited, funding from international donors. Sustainability is not an aim.
Sources of funding	Cost-sharing between government, international donors and users.	Often exclusively funded by international donors.

the key issue is early detection of epidemics, using a disease surveillance system.^{93–95} Relief officials often rely on surveys to assess measles vaccination coverage and prevalence of malnutrition.⁹⁶

Strategic aspects

All these differences between PHC and EMA have important strategic implications for sustainability (Table 6), the role of different actors (Table 7) and accountability.

Managerial and financial sustainability

In PHC sustainability is paramount.^{97–99} Different components of PHC should be developed harmoniously, and the health sector should be in harmony with other sectors of society. A programme format, becoming an integral part of health and social policy, is thus preferable over a project format (Table 6).^{97,100–102} The 'programme – project' typology is a simplification similar to the 'development – disaster/emergency' typology. Both typologies can be largely superimposed, and thus also many of their characteristics (such as time perspective, role of different actors, funding, etc.). The project format can, however, be justified to innovate, or to facilitate management of a particular part of a programme. Most often, however, foreign donors impose a project format to facilitate financial accountability. Institution building and institutional strengthening are

important to obtain managerial sustainability (see also manpower policy, Table 7). In PHC, there is often cost sharing between government, international donors and users.^{30,103–105} Cost constraints are often overriding,¹⁷ and even if this is not the case in the short term (e.g. when a foreign donor funds a PHC programme), efficiency and sustainability are important considerations. To be sustainable, health services should be organized at 'affordable' cost.

In EMA, the project format is often preferable. Developing EMA as a programme, with its corollary of institution building, may hinder timely abolition or integration in the PHC programme. Institutional strengthening is thus of low priority. In EMA, efficiency is less important than in PHC.¹⁷ To be effective in the very short term, important resources are needed, and these originate often exclusively from international donors. Funding is thus usually not the main constraint. Sustainability is not a major concern.

Actors

PHC is a local and public responsibility.¹⁰⁶ A collaboration with the local administrative and political authorities is necessary to imbed health services in overall society (Table 7). The central Ministry of Health (MOH) has an important role in resource allocation among areas and programmes; it must set norms and regulate (stewardship).^{33,107,108} The MOH should develop policies on manpower and training, on health care

Table 7. Actors in primary health care (PHC) and emergency medical assistance (EMA)

	PHC	EMA
Identity of decision-makers	Local.	Often outsiders.
Relation with local authorities	Collaboration is necessary.	Links are necessary.
Role of central MOH	To allocate resources, to set norms, and to regulate (stewardship).	Often very limited.
Role of foreign assistance	Mainly as technical assistance.	Substitution is often needed.
Manpower policy	Staff is mainly constituted of health professionals on long-term contracts. Training is important.	Staff often recruited among beneficiaries, with short-term contracts. Training geared to execution of standardized tasks.
Public/private	Increasingly, PHC managers will have to come to terms with private health care, both non-profit and for-profit.	Dominated by private non-profit actors.

financing, on pharmaceutical supply and quality control, etc. Outside assistance may be necessary, but there is then also a higher risk of non-appropriate solutions, with a dominance of the technical dimension over the social one. The role of foreign support should be mainly a technical assistance; otherwise, the feeling of 'ownership' may be absent.^{100,109} Temporary substitution can only be justified as an interim measure in situations where local capacity is inadequate, and on the condition that there is a perspective for local take-over, otherwise sustainability could be jeopardized.¹¹⁰

The long-term perspective and the necessary capacity building require long-term involvement of the same staff. Staff will thus often be health professionals on long-term contracts, with attention for career structure and promotion possibilities. Work with on-the-spot trained auxiliaries may yield some short-term results, but often leads to a dead-end in the medium term. This is well illustrated by the failure of most so-called primary health care programmes based on the wide-scale training of village health workers. Although they may have generated some short-term results (e.g. when measured in terms of number of consultations or turnover of village pharmacies), they quickly lead to a dead-end.¹¹¹ However, training at all levels is an important component of PHC.¹¹²⁻¹¹⁵

Increasingly, PHC managers will have to come to terms with private health care. This does not seem to raise unconquerable obstacles for the private non-profit sector (NGOs, churches, etc.).^{78,79} However, the growth of private for-profit medicine in developing countries confronts public health professionals with serious challenges. Increasingly, they will have to find ways to have an impact on the quality of care it delivers, and on the inequalities it often reinforces.⁷⁷

In EMA, decision-makers will often be outsiders (UN agencies and other representatives of the international community), and foreign substitution the rule rather than the exception.¹⁷ Substitution is often needed. Paramount is the technical expertise and the ability to mobilize and manage the necessary resources. Links with local health authorities are useful, but lines of authority should be simple and straight. Links with administrative and political authorities are necessary. However, this is more to pay respect and to avoid obstruction than to involve them in decision making. The role of the central MOH is often limited. Staff will often be recruited among beneficiaries and work with short-term contracts. There may be a need to work with on-the-spot trained auxiliaries.^{116,117} Training is often geared to obtaining execution of standardized key tasks from auxiliaries. Private non-profit actors, especially international NGOs, presently dominate EMA.⁸⁸

Accountability

Accountability is a complex and value-loaded subject. Others have tried to get a grip on accountability of health services in PHC,⁸ and on accountability of emergency relief.^{19,88,118} In PHC and EMA in developing countries, the funding agency (frequently a foreign aid donor) and the clients (the recipients or beneficiaries of the aid) more often than not have different

agendas and preferences. It seems thus appropriate to distinguish accountability to the donor from accountability to the beneficiaries. In relief and aid, this distinction roughly coincides with the distinction between financial accountability and social accountability.

In PHC, it is now widely accepted that health services have a responsibility to the population, and not only to the users who present to the health service. A step further is being accountable towards that population.¹¹⁹ The style of governance and the degree of participation in the wider society will determine how financial and social accountability are valued and practised in the health services. When clients participate financially in the health services, this can be used as a lever to increase both financial and social accountability.^{49,120-122}

In EMA, discussions on accountability have usually focused more on financial accountability than on social accountability. Financial accountability of implementing agencies to donors, with its corollaries – bureaucratic regulations and financial audits – have steeply increased over the last decade. But social accountability remains largely on the level of good intentions. In disasters, decision-makers often feel accountable to their employers – international agencies and NGOs – who claim to be themselves accountable to the beneficiaries, the 'victims'.¹⁹ However, agencies' own agendas, bureaucratic logic and the short timeframe may hamper understanding of the beneficiaries' perspective.¹⁰²

Discussion: between primary health care and emergency medical assistance

If PHC is the appropriate strategy in a society in development, and EMA in the case of an emergency, many real-life situations are somewhere in-between. Figure 2 shows a range of non-development non-emergency situations, characterized by different degrees of political stability. Stable situations with economic growth and functioning public services are probably optimal for development. Other situations, while definitely not emergencies, do not offer the same potential for development. This is the case when the government is unstable or lacks a constituency, when there is economic degradation and a weak public service.

An acute exacerbation of a chronic conflict – with total breakdown of government and public services resulting in mass displacement, epidemics and high excess mortality – can easily be qualified as an emergency. But a conflict between two well-organized parties with relative preservation of law and order and of public services may have less disastrous consequences for the population. The same may be the case when a conflict results in a stalemate, and becomes chronic and blocked: in such situations active fighting is often more limited. Such situations often change over time. A real emergency that is managed timely and adequately can at times be 'under control' after weeks rather than months. ('Under control' means that there is no excess mortality any more, and that physical survival is thus no longer threatened: the situation moves away from the disaster pole.) On the other hand, a situation of chronic conflict

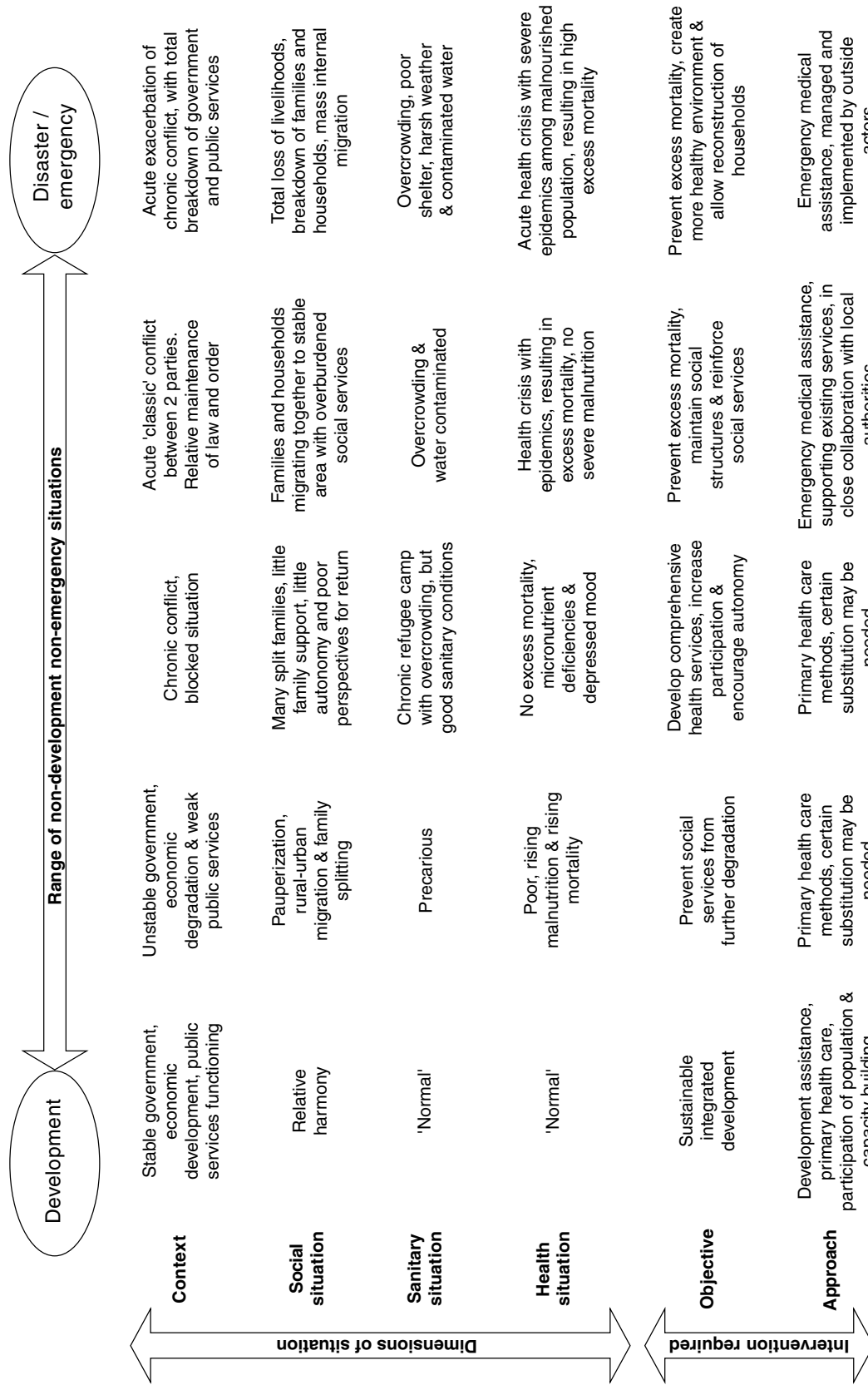


Figure 2. Examples of situations in-between development and disaster

where public services initially had continued to function can deteriorate, both in severity and degree of emergency.

An example of a situation in-between occurred in Guinea, where between 1990 and 1996 some 500 000 refugees self-settled among the host population. There was no dramatic emergency phase. A refugee-assistance programme gave refugees free access to the pre-existing Guinean health facilities wherever possible, and reinforced the health centres and district hospitals to enable them to cope with the additional workload. But the refugee-assistance programme also created many new health services. Links between the pre-existing health services and the newly created health services were intense and complex.^{123–125} Such an approach to the health problems of refugees is not new. It was common before refugee camps became the dominant approach,^{126,127} but it has not been well documented in the scientific literature, nor was it clearly conceptualized. In the absence of documented precedents, the implementation of the refugee-assistance programme in Guinea was far from straightforward, and more a matter of ‘muddling through’ than of planned rational intervention. Ad hoc decisions progressively shaped the health services for refugees in Guinea. From its onset the refugee-assistance programme was a compromise between PHC and EMA, and had to reconcile their conflicting types of logic.

In other non-development non-emergency situations, the objectives and the approach will also have to be adapted to the context. Creative compromise strategies will have to be worked out, adapted to the local situation, and have to be adjusted over time, with changes in the situation. ‘Pure EMA’ nor ‘pure PHC’ are indicated for these ‘in-between’ situations.^{128,129} Health managers will need creativity as no blanket recommendations can be formulated, adapted to all situations. They will have to balance the different objectives, and find the right equilibrium in changing environments to match the response to the context.^{128,129} Their preparation will have to stress this capacity to adapt and balance strategies.⁸⁴

To enhance lessons learning from past experience in these in-between situations, the conceptual framework described here could be used to document a series of case studies, documenting both the context and the strategies used. Such case studies should not be limited to narratives or documentation of results and impact, but evaluate the relation between the strategy and context. Where possible, such studies should be longitudinal and dynamic, stretching beyond the initial emergency situation.

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