Primary health care must go beyond WHO

We were pleased to hear Margaret Chan's strong commitment to primary health care 30 years after the Alma-Ata Declaration. In your Editorial on her statement (May 31, p 1811),[1] you mention that the challenge in revitalising primary health care lies in tying together the ever-increasing number of global initiatives.

However, there is more to it than this. To reappraise primary health care, we should go back to the basics, or the three pillars of primary health care: participation, intersectoral collaboration, and equity.[2] We have seen great progress in participation and equity. Participation has been strengthened in many communities and countries, as exemplified by the growth of the civil society movement. In terms of equity, "health for all" used to be the slogan for primary health care, and access has been the key to achieving it. The Global Fund and other initiatives have indeed improved access to bednets, antiretrovirals, and tuberculosis treatment, which has resulted in visible outcomes.

By contrast, we have seen little progress in intersectoral collaboration. When the UN set up the Millennium Development Goals, each goal was expected to have synergistic effects. However, in trying to achieve each goal more rapidly and more effectively, the leading health initiatives have instead taken selective approaches. Now the Global Fund and GAVI Alliance are trying to spend more funding on health systems. A diagonal approach is also recommended.[3]

However, intersectoral collaboration must go beyond health, it must go beyond WHO. To make a breakthrough in primary health care, we need more progress in intersectoral collaboration and in synchronising all three pillars of primary health care at a global level.

We declare that we have no conflict of interest.

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1 The Lancet. Margaret Chan puts primary health care centre stage at WHO. *Lancet* 2008; **371:** 1811.
2 Macdonald JJ. Primary health care. London: Earthscan Publications, 2004.
3 Ooms G, Van Damme W, Baker BK, Zeitz P, Schrecker T. The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems? *Global Health* 2008; **4:** 6.

Iodine nutritional status in Tibet

The Comment by Sumei Li and colleagues (June 14, p 1980)[1] on iodine status in Tibet is alarming. More than 30 years after the Tibet Autonomous Region launched an ambitious programme to prevent iodine deficiency, the situation seems to have hardly changed, since today two-thirds of the Tibetan population reportedly have no access to iodised salt. Li and colleagues correctly describe Tibet as having "among the most severe iodine deficiency in the world", so one might wonder why so little has been achieved so far. The data presented by Li do not even mention the existence of endemic cretinism in Tibet, which, unlike goitre, is the hallmark of severe iodine deficiency. 10 years ago, we reported neurological cretinism in Tibet.[2]

Apparently, some Tibetan schoolchildren are fortunate enough to receive iodised salt while at school. However, we do not know what happens with children who do not attend school or with children born of severely iodine-deficient pregnant women. In fact, few data on iodine deficiency in Tibet have been published in peer-reviewed publications, and none of the studies published on iodine intake in China was done in Tibet.[3]

Elimination of severe iodine deficiency has been achieved in most developing countries because strong and long-term political commitment has prevailed over economic difficulties. Consequently, there seems no reason why an emergent economy like China cannot take the appropriate steps to eliminate severe iodine deficiency in Tibet.

We declare that we have no conflict of interest.

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1 Li S, Wei H, Zheng Q. Elimination of iodine-deficiency disorders in Tibet. *Lancet* 2008; **371:** 1980–81.
2 Moreno-Reyes R, Suetens C, Mathieu F, et al. Kashin-Beck osteoarthropathy in rural Tibet in relation to selenium and iodine status. *N Engl J Med* 1998; **339:** 1112–20.
3 Teng W, Shan Z, Teng X, et al. Effect of iodine intake on thyroid diseases in China. *N Engl J Med* 2006; **354:** 2783–93.

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Sumei Li and colleagues[1] provide an informative insight into the enormous challenge of eliminating iodine deficiency disorders in Tibet. Although their comments on the poor coverage with iodised salt in remote communities are accurate, we believe they portray a rather pessimistic view of the successful iodised oil supplementation programme.

From 2000 to 2004, working collaboratively with the Tibet Department of Health at the operational level, and with financial support from AusAID and WHO, we developed a Tibet region-wide supplementation programme aimed at providing sufficient iodine by administering one capsule of iodised oil annually to all women of child-bearing age and children younger than 2 years. Implemented as an interim strategy, in the absence of an effective programme of iodised salt production and distribution, the iodised oil reached about 95% of the target population.[2] Urinary iodine excretion in these women increased on average from 39 μg/L to 96 μg/L.

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