PRIMARY HEALTH CARE: RATIONALE, HISTORY, EVOLUTION AND REVITALISATION

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Outline

• Health trends and their context in the era of Primary Health Care - 1980 to 2004 – with special emphasis on Africa’s health situation

• Why PHC?

• What is PHC?

• What is Comprehensive Primary Health Care?

• What is Selective Primary Health Care and its evolution?

• The revitalisation of Primary Health Care

• The role of community-based care, community participation, and intersectoral and policy actions in the revitalisation of primary health care.
AFRICA and SOUTH ASIA’S CRISIS

Mortality 1 - 4 year olds

Territory size shows the proportion of all deaths of children aged over 1 year and under 5 years old, that occurred there in 2002.

AFRICA and SOUTH ASIA’S CRISIS

TB cases

Territory size shows the proportion of worldwide tuberculosis cases found there.
Despite successes, growing inequalities in global health

Figure 1: Life expectancy at birth by region, 1970–1975 and 2000–2005

Figure 1: Changes in childhood mortality 1990–2000

<table>
<thead>
<tr>
<th>Trend</th>
<th>14% reduction with 3 million fewer child deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990 USMR</td>
<td>94 per 1,000 live births</td>
</tr>
<tr>
<td>2000 USMR</td>
<td>81 per 1,000 live births</td>
</tr>
<tr>
<td>2010 goal</td>
<td>Further 33% reduction</td>
</tr>
<tr>
<td>Comments</td>
<td>63 countries achieved the goal of a 33% reduction and in over 100 countries deaths in children under 5 were cut by 20%.</td>
</tr>
</tbody>
</table>

The social gradient is not confined to poorer countries. Fig. 2.3 shows national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation. As can be seen, the mortality rate varies in a continuous way with degrees of deprivation (Romani, Baker & Griffiths, 2006). The range is large; the difference in mortality between the most and least deprived is more than 2.5-fold.

Educational attainment: o elementary (open circles), ▽ intermediate (triangles), and • university (filled circles). Reprinted, with permission of the publisher, from Murphy et al. (2008).
Unfair Trade

“...drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations”

(G8 Communiqué, Genoa, July 22, 2001)

BUT... many developing countries have destroyed domestic economic sectors, such as textiles and clothing in Zambia (Jeter 2002) and poultry in Ghana (Atarah 2005), by lowering trade barriers and accepting the resulting social dislocations as the price of global integration

Unfair Trade (2)

In addition industrialized countries apply much higher tariffs (tariff peaks)..... For example, the EU tariff on raw cocoa exported from Ghana is just 0.5 percent, but the tariff rises to 30.6 percent on chocolate imported from the same country (Elliott 2004b). Although 90% of cocoa beans are grown in developing countries, they account for just four percent of the value of global chocolate production (IMF, 2002).
“Transnational corporations have flourished as trade liberalization has broadened and deepened. The revenues of Wal-Mart, BP, Exxon Mobil, and Royal Dutch/Shell Group all rank above the GDP of countries such as Indonesia, Norway, Saudi Arabia, and South Africa (EMCONET, 2007).

The combination of binding trade agreements .. and increasing corporate power and capital mobility have arguably diminished individual countries’ capacities to ensure that economic activity contributes to health equity, or at least does not undermine it”.

Reprinted, with permission of the publisher, from Bandel, Cramer & Baking (2004).
Governance - Bribery & Corruption

- SAPs, by lowering public expenditures and workers’ salaries, abetted low level corruption as a means of survival

- Superpowers in Africa “backed venal despots who were less interested in developing their national economies than in looting the assets of their countries...”

- Amongst worst MNC bribery offenders are those located in G8 countries
  (Transparency International)

The result... unequal growth of wealth between countries

![GDP per capita in the poorest and richest countries, 1960-62 and 2000-02](chart.png)

Source: Based on a sample of 94 countries and territories with continuous time-series data from 1960 to 2002, as available from World Bank World Development Indicators 2003 (online version).
AFRICA and SOUTH ASIA’S CRISIS

GDP wealth

Territory size shows the proportion of worldwide wealth, that is Gross Domestic Product based on exchange rates with the US$, that is found there.

..and growth of poverty

- In spite of decades of global economic growth, the numbers of people living in poverty have grown

<table>
<thead>
<tr>
<th>Income Poverty line</th>
<th>1981</th>
<th>2004</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1 (excl China)</td>
<td>836</td>
<td>841</td>
<td>+ 5</td>
</tr>
<tr>
<td>$1</td>
<td>1,470</td>
<td>970</td>
<td>-500</td>
</tr>
<tr>
<td>$2 (excl China)</td>
<td>1,576</td>
<td>2,096</td>
<td>+ 520</td>
</tr>
<tr>
<td>$2</td>
<td>2,450</td>
<td>2,550</td>
<td>+ 100</td>
</tr>
</tbody>
</table>
..and growth of poverty in Africa

- According to the World Bank’s most recent figures, in sub-Saharan Africa 313 million people, or almost half the population, live below a standardized poverty line of $1/day or less (Chen and Ravallion 2004).

- Sub-Saharan Africa is the only region of the world in which the number of people living in extreme poverty has increased – indeed, almost doubling between 1981 and 2001.

Why should a Japanese cow enjoy a higher income than an African citizen?

- Japan annual dairy subsidy, per cow
- EU annual dairy subsidy, per cow
- Per capita annual income, sub-Saharan Africa
- Per capita cost of package of essential health interventions
- Per capita annual health expenditure, 63 low income countries
Primary Health Care: a response to growing health inequities

Evidence base for PHC

Pre Alma Ata:
- Work of McKeown and McKinley demonstrated importance of socioeconomic and environmental factors
Figure 2. Age-adjusted death rates for respiratory tuberculosis: England and Wales. Reprinted from McKeown (1979) with permission from Princeton University Press.

Figure 3. An 1832 broadside on sanitary conditions. (By courtesy of the Wellcome Trustees.)
Evidence base for PHC

- Newell – “Health by People” (1975) described:
  - several community-based projects and the role of community level workers
  - large-scale programmes and country experiences of CPHC, especially China
  Influenced thinking and planning for Alma Ata Conference (1978)

WHO/UNICEF Alma Ata Conference (1978)

Alma Ata, the capital of Kazakhstan, now called Almaty
Site of the 1978 WHO/UNICEF conference
‘Health for All by the Year 2000’
Principles of the Primary Health Care Approach

- **Universal accessibility** and coverage on the basis of need (**equity**)
- **Comprehensive care** with emphasis on disease prevention and health promotion
- **Community and individual involvement** and self-reliance
- **Intersectoral action** for health
- **Appropriate technology** and cost-effectiveness in relation to available resources

Elements / Programmes of PHC

- Promotion of proper nutrition and adequate supply of safe water, basic sanitation
- Maternal and childcare, incl. family planning
- Immunisation against major infectious diseases
- Prevention and control of locally endemic disease
- Health education concerning prevailing health problems, and methods of prevention/control
- Treatment for common diseases and injuries
Comment

The concept of PHC had strong sociopolitical implications. It explicitly outlined a strategy which would respond more equitably, appropriately and effectively to basic health care needs and ALSO address the underlying social, economic and political causes (determinants) of poor health.
<table>
<thead>
<tr>
<th>Primarily Individually Focussed</th>
<th>Primarily Population Focussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitative approach</td>
<td>Preventive approach</td>
</tr>
<tr>
<td>Curative approach</td>
<td>Promotive approach</td>
</tr>
</tbody>
</table>

### Preventive approach

Emphasises preventing or avoiding sickness in populations and individuals

For example, through anti-malarial tablets, use of bed nets to protect against mosquitoes, health education and immunisation programmes
### Promotive approach

Addresses basic social, economic and political causes of ill-health through advocacy and lobbying government and policymakers, for example, to ban smoking in public places, as well as intersectoral interventions directed at households or communities to improve water supply, sanitation, housing etc.

### Achievements of CPHC.

- In countries where CPHC was implemented, dramatic improvements occurred eg greatly improved coverage, especially of MCH care and particularly EPI, and steep declines in child mortality
  - Short-lived in some countries eg Mozambique, Zimbabwe, Nicaragua when political context changed.
  - Continued in some countries eg Kerala, Costa Rica, Thailand, Brazil when political commitment sustained.
US compared to Costa Rica

<table>
<thead>
<tr>
<th>Indicator (2005)</th>
<th>US</th>
<th>Costa Rica</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>77</td>
<td>79</td>
</tr>
<tr>
<td>IMR</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Gross National Income per capita (US$)</td>
<td>41,440</td>
<td>4,470</td>
</tr>
<tr>
<td>Health expenditure per capita (US$)</td>
<td>5,711</td>
<td>350</td>
</tr>
</tbody>
</table>


An excerpt from the Alma Ata Declaration

‘It can be seen that the proper application of primary health care with have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at community level. Moreover, it will greatly influence community organisation in general. Resistance to such change is only to be expected’

Alma Ata Declaration, 1978
A Split in the PHC Movement

In 1980s, a focus on cost-effective technologies and a neglect of social and environmental determinants and processes led to substitution of “selective” for “comprehensive” primary health care (PHC) – e.g. UNICEF “Child Survival and Development Revolution”

Selective Primary Health Care

“Child Survival and Development Revolution”
(Dominant approach 1980s to early 1990s)

Growth Monitoring
Oral Rehydration Therapy
Breast Feeding
Immunisation

Family Planning
Food Supplements
Female Education
EXAMPLE: Comprehensive management of diarrhoea

<table>
<thead>
<tr>
<th>REHABILITATIVE</th>
<th>CURATIVE</th>
<th>PREVENTIVE</th>
<th>PROMOTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUTRITION REHABILITATION</td>
<td>O.R.T.</td>
<td>EDUCATION FOR PERSONAL &amp; FOOD HYGIENE</td>
<td>WATER SANITATION</td>
</tr>
<tr>
<td>NUTRITION SUPPORT</td>
<td></td>
<td>MEASLES VACCINATION</td>
<td>HOUSEHOLD FOOD SECURITY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BREAST FEEDING</td>
<td></td>
</tr>
</tbody>
</table>

The Demise of PHC

- Rise of PHC coincided with global debt crisis and conservative macroeconomic policies
- Imposition of Structural Adjustment policies in 80s and 90s undermined many countries’ capacity to support health systems development as fiscal stringency, user charges etc were introduced
- In late 1980s ‘health sector reform’, based on market principles,
Global Immunization 1980-2002, DTP3 coverage

Global coverage at 75% in 2002


Figure 14.3 Full immunization rates among the poorest and richest population quintiles (regional averages).

Reprinted, with permission of the publisher, from Gwatkin & Deveashware-Bahl (2001).
Primary Health Care includes addressing social determinants

Selective PHC has continuities with aspects of Health Sector ‘Reform’ as promoted in the 1990s
Health sector ‘reform’: Quest for efficiency

Cost-effectiveness analysis has focused only on certain easily measurable interventions and proposed limited ‘packages’ of care – reminiscent of selective PHC..

Health sector ‘reform’

(Dominant approach since early 1990s)

Includes the following components:

- decentralisation;
- actions to improve the efficiency of national ministries of health;
- universal delivery of a core set of essential services;
- broadening health financing options;
- working with the private sector, including GPPIs and
- adopting sector wide approaches to aid rational planning.

Adapted from Cassels 1995
CEA does not evaluate the effectiveness of ‘broader’ interventions that may result in health improvement through numerous direct and indirect mechanisms.

"[C]ost-effectiveness analyses have shown **improved water supply and sanitation to be costly** ways of improving people’s health. .... encouraging people **to wash their hands and making soap available** have reduced the incidence of diarrhoeal disease by 32% to 43%... (Commission on Macroeconomics and Health, 2001/02)

**Health sector ‘reform’**

**Quest for efficiency** cont.-

The move from equity and comprehensiveness to efficiency and selectiveness leads to:

- A return to vertical programmes;
- Fragmentation of health services
- Neglect of SDH, erosion of intersectoral work and community health infrastructures
Access to water and hygienic sanitation

- Only 44 percent of rural SSA ie 60 percent of SSA population, has access to adequate water supplies and good sanitation in 2004.
- Over the period 1990 – 2004, the number of people without access to drinking water increased by 23% and those without sanitation increased by over 30%.

..subverting the Mission of Public Health:

- “Ensuring the conditions in which people can be healthy”

(Institute of Medicine)
The changing donor funding architecture and the emergence of Global Health ‘Partnerships’ have reinforced ‘selective’, technocratic and vertical approaches
AIDS and Aid may both disrupt health systems...

In 2000, Tanzania was preparing 2,400 quarterly reports on separate aid-funded projects and hosted 1,000 donor visit meetings a year.

Labonte, 2005, presentation to Nuffield Trust
Challenges: Sustainability eg Ethiopia

HIV/AIDS especially ART is donor dependent—HIV Spending (in Birr) by Source of Funds: Donor Vs Government (source HAPCO documents till 2005)

Banteyerga, 2007
### Table 1 How experience has shifted the focus of the PHC movement

<table>
<thead>
<tr>
<th>Early Attempts at Implementing PHC</th>
<th>Current Concerns of PHC Reforms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended access to a basic package of health interventions and essential drugs for the rural poor</td>
<td>Transformation and regulation of existing health systems, aiming for universal access and social health protection</td>
</tr>
<tr>
<td>Concentration on mother and child health</td>
<td>Dealing with the health of everyone in the community</td>
</tr>
<tr>
<td>Focus on a small number of selected diseases, primarily infectious and acute</td>
<td>A comprehensive response to people’s aspirations and needs, assessing the range of risks and lifelines</td>
</tr>
<tr>
<td>Improvement of hygiene, water, sanitation and health education at village level</td>
<td>Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards</td>
</tr>
<tr>
<td>Simple technology for volunteer, non-professional community health workers</td>
<td>Teams of health workers facilitating access to and appropriate use of technology and medicines</td>
</tr>
<tr>
<td>Participation as the mobilization of local resources and health centre management through local health committee</td>
<td>Institutionalized participation of civil society in policy dialogue and accountability mechanisms</td>
</tr>
<tr>
<td>Government-funded and delivered services with a centralized top-down management</td>
<td>Pragmatic health systems operating in a globalized context</td>
</tr>
<tr>
<td>Management of growing scarcity and downsizing</td>
<td>Guiding the growth of resources for health towards universal coverage</td>
</tr>
<tr>
<td>Bilateral aid and technical assistance</td>
<td>Global solidarity and joint learning</td>
</tr>
<tr>
<td>Primary care as the antithesis of the hospital</td>
<td>Primary care as coordinator of a comprehensive response at all levels</td>
</tr>
<tr>
<td>PHC is cheap and requires only a modest investment</td>
<td>PHC is not cheap, it requires considerable investment, but it provides better value for money than its alternatives</td>
</tr>
</tbody>
</table>


### Figure 1 The PHC reforms necessary to refocus health systems towards health for all

**Universal Coverage Reforms**
- **Service Delivery Reforms**
- **Leadership Reforms**
- **Public Policy Reforms**

Key actions to revitalise CPHC

Table 3.1 Aspects of care that distinguish conventional health care from people-centred primary care

<table>
<thead>
<tr>
<th>Conventional ambulatory medical care in clinics or outpatient departments</th>
<th>Disease control programmes</th>
<th>People-centred primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on illness and care</td>
<td>Focus on priority diseases</td>
<td>Focus on health needs</td>
</tr>
<tr>
<td>Relationship limited to the moment of consultation</td>
<td>Relationship limited to programme implementation</td>
<td>Ensuring personal relationship</td>
</tr>
<tr>
<td>Episodic curative care</td>
<td>Programme-defined disease control interventions</td>
<td>Comprehensive, continuous and person-centred care</td>
</tr>
<tr>
<td>Responsibility limited to effective and safe advice to the patient at the moment of consultation</td>
<td>Responsibility for disease-control targets among the target population</td>
<td>Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health</td>
</tr>
<tr>
<td>Users are consumers of the care they purchase</td>
<td>Population groups are targets of disease-control interventions</td>
<td>People are partners in managing their own health and that of their community</td>
</tr>
</tbody>
</table>

Priority Actions Needed (1)

• Improve access and coverage, especially at primary and community levels

How many child deaths could be prevented per year with proven interventions?

• 63% of child deaths
• More than 6 million deaths
Why should interventions be delivered in community settings?

- Many deaths occur outside health facilities
- Currently the coverage of many effective interventions is low — well under 50% in many cases — and the quality of care is deficient in many communities
- Poor families are less likely to access government health facilities than wealthier families

Community Health Workers
Why the renewed interest?

- Brain drain and continued maldistribution
- Increased requirements imposed by HIV/AIDS, particularly chronic care needs
- A renewed interest in/focus on PHC and roles of communities and “community empowerment”.

Lehmannn and Sanders, WHO, 2007
http://www.who.int/hrh/documents/community_health_workers.pdf
Evidence for impact and cost-effectiveness of community health workers

• A meta-analysis of community-based trials of pneumonia case management on mortality suggested an overall reduction of 24% in neonates, infants, and preschool children.

  Sazawal and Black, Lancet Infectious Diseases 2003; 3: 547-556.

• A trial in Tigray, Ethiopia, of training local coordinators to teach mothers to give prompt home antimalarials showed a 40% reduction in under-5 mortality.


Comparing the performance of doctors and nurses with other health workers in child care

• In Bangladesh lower level workers (family welfare visitors and nursing aides) performed much better than higher level workers (paramedics, physicians, and nurses) in rational prescription of antibiotics and provision of appropriate advice to caregivers.


• In Benin much higher percentages of children with diarrhoea received ORS and were appropriately treated with an antimalarial by nursing aides compared with nurses (intermediate) and physicians (worst performance).

Factors influencing success of CHW programmes

- Selection
- Training
- **Health system factors – esp support & supervision**
- Community factors
- Political, macroeconomic and international factors
- Financial and non-financial incentives

Lehmannn and Sanders, WHO, 2007,
http://www.who.int/hrh/documents/community_health_workers.pdf

*Figure 1: From passive to active community participation*


In Makwanpur district, Nepal, women’s groups, led by a locally recruited woman facilitator, were supported through a community mobilisation action cycle where they discussed maternal and newborn health problems, developed strategies to address them, and then implemented and assessed the strategies in co-operation with local leaders, men, and health workers. The mobilisation intervention had been developed in Bolivia under the Warmi programme (figure 2). The Warmi programme had seen a large reduction in perinatal mortality rate using before and after analysis of a small population, and the larger Makwanpur cRCT showed a 30% reduction in neonatal mortality rate, as well as significantly fewer maternal deaths (although the numbers of maternal deaths were few and maternal mortality ratio had not been a primary outcome for the trial). Rosato et al, Lancet 2008; 372: 962–71

‘Women’s groups in Malawi and Nepal are increasing the important capacities within communities, such as the ability to identify maternal and neonatal health problems and their root causes; the ability to mobilise resources necessary for improving the health of mothers and newborn infants; the internal and external social networks they can draw on when needed; and the development of strong local leaders who have the motivation and drive to improve maternal and neonatal health in the community.’

‘The women’s groups are also drawing on these social capacities to make fundamental choices to improve their health, such as about the equitable sharing of resources needed for Better maternal and neonatal health; about planning feasible strategies to address maternal and neonatal health problems; about planning, implementation, evaluation, finances and reporting of programmes; and about which people and organisations to approach to address problems.’


‘What are the mechanisms through which community mobilisation brings about improved health outcomes? Some observers feel that community mobilisation works simply by bringing about changes in behavioural risk factors such as home care practices and decisions about care seeking. Although undoubtedly one important mechanism through which community mobilisation works, studies of health education suggest that simply providing key messages to improve maternal and newborn care cannot possibly account for all the effect these approaches have on morbidity and mortality.’

‘A large proportion of this effect is thought to be due to community mobilisation bringing about changes in socioenvironmental risk factors by developing the capacities of communities, the choices they make, and their ultimate empowerment.’


Priority Actions Needed (2)

- Address social determinants of (ill) health
Nutritional problems in South Africa and globally

Nutrition – the global situation

- In 2001-2003 854 mn people undernourished
- Since 1990-92 the undernourished population has fallen by only 3mn (compared with 100 mn in 1980s)

- In 2005 22mn children were overweight
- By 2015 some 2.3bn adults will be overweight
  700mn will be obese
Children under 5: Nutritional Status

- Overall, 12 percent of children are underweight, 27 percent are stunted and 5 percent are wasted (DHS 2003).
- NFCS (2005) showed 18% stunting.

- There are no indications that the nutritional status of children has changed substantially over the past 10 years.
The prevalence of overweight and obesity in children (n=2 200) in South Africa in 1999

Source: NFCS; Reference: Steyn et al. 2005

Key Determinants of Nutritional Status, Disease and Death
Risk Factors/Determinants

DOWNSTREAM

Biological

Behavioural

Societal

Structural

UPSTREAM

Burden of Disease study, PGWC

Biological and behavioural factors in underweight and overweight
Dietary changes

- Dietary intakes of 1751 apparently healthy adults were assessed using a validated quantitative food frequency questionnaire (QFFQ).

- Intakes of the staple, maize meal, decreased between the urban middle and upper class strata. Fruit and vegetable consumption was low throughout the sample. Food intakes showed a shift from the traditional high carbohydrate, low fat diet to a diet associated with non-communicable diseases.

MacIntyre et al, Nutrition Research 22 (2002) 239–256

Figure 12.1 Fast food consumption (1995 and 1999) in selected countries.

Reprinted, with permission of the publisher, from Hawkes (2002).
Societal Factors in Obesity

• There is a shortage of healthy low-fat food and little fresh fruit and vegetables in the townships.

• The majority of local shops sell cheap fatty foods. Street vendors’ stalls sell fatty meat and sausages.’

• ‘Low-fat milk is not available in our shops’, stated one of the CHWs after she had tried to cut down on the fat in her diet.

Chopra M, Puoane T. Diabetes Voice 2003; 48: 24

Societal Factors in Obesity

‘I am scared of exercising because I will lose weight and people may think that I have HIV/AIDS.’

‘People who boil food are not civilised. Fried food is attractive and tasty such as “Kentucky Fried Chicken”. If your neighbour boils food people say she is still backward because the food does not taste nor look attractive’

Chopra M, Puoane T. Diabetes Voice 2003; 48: 24
Structural Factors in Obesity

Declining per capita food production

# Market Sizes - Historic - Retail Value

## RSP - R mn - Current Prices

<table>
<thead>
<tr>
<th>Category</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Packaged food</td>
<td>69475</td>
<td>74462</td>
<td>78929</td>
<td>84062</td>
<td>92671</td>
<td>101192</td>
</tr>
</tbody>
</table>

Source: Packaged Food: Euromonitor from trade sources/national statistics

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**Bread, Pastry, Cakes, Biscuits and Other Baker's Wares**

**Value of imports from world in Rand**

Company Shares (by Global Brand Owner) Retail Value % breakdown

<table>
<thead>
<tr>
<th>Geography</th>
<th>Category</th>
<th>Company Name</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Tiger Brands Ltd</td>
<td>17.8</td>
<td>18.0</td>
<td>20.3</td>
<td>20.0</td>
<td>19.5</td>
<td>19.1</td>
<td>16.2</td>
<td>16.8</td>
</tr>
<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Parmalat Group</td>
<td>4.9</td>
<td>4.9</td>
<td>4.7</td>
<td>4.7</td>
<td>5.2</td>
<td>5.3</td>
<td>5.4</td>
<td>5.3</td>
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<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Unilever Group</td>
<td>5.3</td>
<td>5.7</td>
<td>5.7</td>
<td>5.6</td>
<td>5.4</td>
<td>5.2</td>
<td>5.2</td>
<td>5.2</td>
</tr>
<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Nestlé SA</td>
<td>5.2</td>
<td>5.2</td>
<td>5.2</td>
<td>5.0</td>
<td>5.0</td>
<td>4.9</td>
<td>4.8</td>
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<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Clover Ltd</td>
<td>4.1</td>
<td>4.2</td>
<td>4.1</td>
<td>3.9</td>
<td>3.8</td>
<td>3.9</td>
<td>3.7</td>
<td></td>
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<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Dairybelle (Pty) Ltd</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3.2</td>
<td>3.2</td>
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<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>AVI Ltd</td>
<td>2.6</td>
<td>2.4</td>
<td>2.4</td>
<td>2.5</td>
<td>2.5</td>
<td>2.6</td>
<td>2.8</td>
<td>2.9</td>
</tr>
<tr>
<td>South Africa</td>
<td>Packaged food</td>
<td>Cadbury Pic</td>
<td>-</td>
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<td>Packaged food</td>
<td>PepsiCo Inc</td>
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<td>Willowton Oil &amp; Cake Mills</td>
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<td>Packaged food</td>
<td>Danone, Groupe</td>
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<td>1.1</td>
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Source: Packaged Food: Euromonitor from trade sources/national statistics

Trade agreements and agricultural trade

- Agreement on Agriculture 1994 – pledged countries to open markets by reducing tariffs, non-tariff barriers, export subsidies and domestic agricultural support
- Agreement on Application of Sanitary and Phytosanitary Measures – further reduced trade barriers by adoption of of equivalent food safety standards
- Technical Barriers to Trade Agreement – ensured national regulations, voluntary standards etc would not impede trade
- TRIPs - expanded scope of private property rightson food products, including patents on seeds
World Agricultural Trade
- In developing countries on average food import bills as share of GDP more than doubled 1974 - 2004 (FAO 2004)
- Food imports-into developed countries increased by 45% (1970-2001) -into developing countries increased by 115%
- Large increase in exports of high-value foods eg fruit, veggies etc
- Trade in cereals declined relative to higher-value products

Liberalisation and growth of TNCs
- Growth of FDI in food industry –bilateral investment treaties increased from 181 to 2495 between 1980 and 2005 (UNCTAD 2000, 2006)
- FDI in food processing and retailing has influenced growth of TNC food corporations
- TNCs now control seeds, fertilisers, pesticides, production, processing, manufacturing and selling of foods
- In 1980s TNCs expanded into manufacture of processed foods eg snacks, soft drinks, dairy
- FDI from USA spawned increased sales from foreign affiliates – US$39.2bn in 1980 to US$150bn in 2000
FDI and supermarkets

- From 1990 FDI penetrated supermarkets: FDI from US-based supermarkets increased from $4bn to $13bn between 1990 and 1999
- Between 1990 and 2001 foreign sales of world’s largest 100 TNCs increased from $88.8bn to $257.7 bn
- The degree of transnationalisation of food-related TNCs is high relative to other TNCs

Effects of globalisation on food security

- Trade liberalisation has increased and decreased food availability: in China per capita food supplies increased while in Malawi they decreased (FAO 2006)
- Despite trade reform food prices have increased, as a result of rising demand from India and China, climate change and diversion of food for biofuels
- Liberalisation has led to increased imports of high energy foods eg oil and processed foods (soft drinks sales increased in US by 1.4% pa and China 8.8%)
CSDH notes that the dominant model of ‘development’ has resulted in health-harming effects and is threatening the environment.

“Growing car dependence, land-use change to facilitate car use... have knock-on effects on local air quality, greenhouse gas emission, and physical inactivity” (p. 4)

“… trade policy that actively encourages the unfettered production, trade, and consumption of foods high in fats and sugars to the detriment of fruit and vegetable production is contradictory to health policy …” (p 10)
“The health sector is a defender of health, advocate of health equity, and negotiator for broader societal objectives. It is important therefore that ministers of health, supported by the ministry, are strongly equipped to play such a stewardship role within government” (p 111)

CONCLUSION

- A CPHC approach can be applied to a single health problem or intervention
- A CPHC approach addresses the ‘multilevel’ causes of the problem by
  - Combining (at least some of) promotive, preventive, curative and rehabilitative components
  - ‘Promotive’ interventions involve other sectors and communities and often advocacy and legislation
- A CPHC approach informs and is reinforced at all levels of the health system