THE HISTORY AND EVOLUTION OF COMPREHENSIVE PRIMARY HEALTH CARE: A GLOBAL PERSPECTIVE

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Outline

• Rationale and history of the evolution of CPHC
• The emergence and nature of ‘selective’ PHC
• The rationale for and nature of health sector reform
• Health systems and their chief components: two different paradigms
• An illustrative example of a current health challenge demanding a comprehensive approach
What preceded PHC?

- Maurice King – Medical Care in Developing Countries
- Djukanovic & Mach – basic health system with focus on health centres
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.
HAS

DEATH

(IN A RAGE)

Been invited by the Commissioners of Common Sewers to take up his abode in Lambeth? or, from what other villainous cause proceeds the frightful Mortality by which we are surrounded?

In this Pest-House of the Metropolis, and disgrace to the Nation, the main thoroughfares are still without Common Sewers, although the Inhabitants have paid exorbitant Rates from time immemorial!!!

"O Heaven! that such companions they'd set unfold.
"And put in every honest hand, a whip,
"To lash the rascal naked through the world."

Unless something be speedily done to allay the growing discontent of the people, retributive justice in her salutary vengeance will commence her operations with the Lamp-Iron and the Halter.

SALUS POPULI.

Lambeth, August, 1832.

J. W. PEEL, Printer, 9, New Cut, Lambeth.

Figure 3.3 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’
What is Primary Health Care?
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
The ‘dual’ nature of PHC

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.
It can be seen that the proper application of primary health care will 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
‘Comprehensive’ PHC

Primary Health Care:
‘Addresses the main health problems in the community, providing promotive, preventative, curative, and rehabilitative services accordingly’.

Alma Ata Declaration, 1978
<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>
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.
Thus CPHC comprises both individual **clinical care** and **public health** interventions.
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</td>
</tr>
<tr>
<td>NUTRITION SUPPORT</td>
<td></td>
<td>MEASLES VACCINATION</td>
<td>SANITATION</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BREAST FEEDING</td>
<td>HOUSEHOLD FOOD SECURITY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ROTAVIRUS VACCINATION</td>
<td></td>
</tr>
</tbody>
</table>

- O.R.T.: Oral Rehydration Therapy
- NUTRITION: Nutrition Support
- EDUCATION FOR PERSONAL & FOOD HYGIENE
- MEASLES VACCINATION
- BREAST FEEDING
- ROTAVIRUS VACCINATION
- WATER
- SANITATION
- HOUSEHOLD FOOD SECURITY
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, economic efficiency and cost-effectiveness was promoted.
Selective PHC has continuities with aspects of Health Sector ‘Reform’ as promoted since the 1990s
Health sector ‘reform’:
Components and strategies

I. Actions to improve the performance of the civil service;
II. decentralisation;
III. actions to improve the functioning of national ministries of health;
IV. *universal delivery of a core set of essential (cost-effective) services*;
V. broadening health financing options;
VI. *working with the private sector* and
VII. adopting sector wide approaches to aid rational planning.

Cassells, 1996
Impact of Health Sector Reform on Health Systems

- H.S.R. impacts on public sector health systems through at least four of its key strategies:
  - the quest for efficiency through ‘rationalisation’ of staff
  - the quest for efficiency through delivery of a core set of essential services;
  - greater involvement of the private-for-profit sector; and
  - decentralisation.
Health sector ‘reform’: Quest for efficiency

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

Diagram showing increase in DALYs (log scale) vs. cost per intervention or per intervention-year (dollars, log scale). Lines represent different interventions with cost per DALY ranging from $1 to $100.
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)
Cost-effectiveness research inevitably reinforces selective PHC…

• “An important limitation on …. CE analysis …. is that …. interventions with important health consequences also affect income or welfare in other ways. Chemotherapy for T.B. has no value beyond the DALYs gained from cure ….”

• “…. improved water supply and sanitation create amenity and time-saving benefits …. (but) the cost per DALY gained may be too high to justify investment on health grounds alone, but consumer willingness to pay …. means that costs to the health system can be low”

World Bank, WDR 1993, pp 64-5
..subverting the Mission of Public Health

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

(Institute of Medicine)
Health sector ‘reform’

Quest for efficiency cont.-

The move from equity and comprehensiveness to technical 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%.
The changing donor funding architecture and the emergence of Global Health ‘Partnerships’ have reinforced ‘selective’, technocratic and vertical approaches.
What are Global Health Initiatives (GHIs)

- Entities that mount a selective response to specific aspects of the global public health agenda.
- Some focus on developing, or increasing access to specific health products such as drugs or vaccines (for example, the Global Alliance for Vaccines and Immunisation).
- Others attract, manage and allocate funding for a global response to specific diseases or health interventions (for example the Global Fund to fight AIDS, Tuberculosis and Malaria or the Roll back Malaria Global Partnership).

Source: www.who.int/healthsystems/GHIsynergies/en/index.html
GHPs, established 1974-2003, (overall) <www.ippph.org>
Total annual resources available for AIDS 1986–2005

Notes: [1] 1986-2000 figures are for international funds only
[2] Domestic funds are included from 2001 onwards

Donor practices

5 highest burdens for LMICs *

1. donor driven priorities and systems
2. difficulties with donor procedures
3. uncoordinated donor practices
4. excessive demands on government time
5. delays in disbursements

* survey of 11 recipient countries cited in:

Guidelines for harmonising donor practices for effective aid delivery
OECD Development Assistance Committee, 2003

Brugha 2007
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
In summary: health status is stagnant or improving very gradually and public health systems in Africa (and many Southern countries) are weak, poorly staffed and fragmented.

... reversing previous gains in PHC implementation.
Stagnation in coverage of key interventions due to weak health systems
Use of basic maternal and child health services by lowest and highest economic quintiles, 50+ countries.

Reprinted, with permission of the publisher, from Gwatkin, Wagstaff & Yazbeck (2005).
Worrying Trends:
“Health systems that focus disproportionately on narrow specialized curative care…”

“Health systems where a command and control to disease control focused on short-term results fragments service delivery…”

“Health systems where *laissez-faire* approach has allowed unregulated commercialization of health to flourish…”
A Definition of Health Systems

The WHO definition of health systems includes “all the activities whose primary purpose is to promote, restore, or maintain health”:  
- Interventions in the household and community and the outreach (health information and education, etc.) that supports them;  
- Facility-based system and broader public health interventions, such as food fortification or anti-smoking campaigns.  
- All categories of providers: public and private, formal and informal, for-profit and not-for-profit, allopathic and indigenous  
- Mechanisms, such as insurance, by which the system is financed  
- Regulatory authorities and professional bodies who are meant to be the “stewards” of the system.  

Figure 1: Conceptual framework of the interaction between global health initiatives and country health systems
CHWs’ roles in facilitating ‘demand’ and catalysing social action
Task-shifting as an alternative approach

– Task shifting is the name now given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers.
WHO recommendations

Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting
Factors influencing success of CHW programmes

**Political and Community factors**

Large trials in Nepal have demonstrated a **30% reduction in newborn mortality** simply by facilitation of women’s groups involving pregnant women.

‘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.’

‘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.’

Rosato et al, Lancet 2008; 372: 962-71
“Liberator or lackey” (David Werner, 1981)

- The early literature emphasises the role of the CHWs as not only (and possibly not even primarily) a health care provider, but also as an advocate for the community and an agent of social change:
  - functioning as a community mouthpiece to fight against inequities and advocate community rights and needs to government structures.

- This view is also reflected in the Alma Ata Declaration which identified CHWs as one of the cornerstones of comprehensive primary health care.
Implications of shift to ‘task-shifting’

• Does the current term (and operationalisation) reflect a restriction of the role of CHWs?
• Is this reflective of a change in paradigm for Primary Health Care?
Obesity and related NCDs: is the currently dominant approach sufficient?
The example of South Africa
The shape of things to come
Overweight and chronic disease in rural S Africa

In a 2005 study of a rural black population from Limpopo Province, South Africa:

51% of women were overweight or obese

Diabetes diagnosed in 8.8% of women and 8.5% of men

Hypertension was found in 25.5% of women and 21.6% of men

Figure 2. Diabetes prevalence based on 1985 WHO criteria presented by age categories for men and women in 1990 and 2008/09.

http://www.plosone.org/article/info:doi/10.1371/journal.pone.0043336
Risk Factors/Determinants

DOWNSTREAM

Biological

Behavioural

Societal

Structural

UPSTREAM

Burden of Disease study, PGWC
Dietary changes

- **Dietary intakes of 1751 apparently healthy adults**, stratified according to gender and stratum of urbanization were assessed using a validated quantitative food frequency questionnaire (QFFQ).

- Mean energy and protein intakes for all strata were adequate. Mean intakes of micronutrients were low in comparison to reference standards.

- 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
Societal Factors in Obesity

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

- ‘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.

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

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

Value of imports from world in Rand


<table>
<thead>
<tr>
<th>Category of Packaged Foods</th>
<th>Subcategory</th>
<th>Sales Volume*</th>
<th>Rate of Change of Sales Volume (%), 2005–10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bakery</td>
<td></td>
<td>2009.3</td>
<td>16.2</td>
</tr>
<tr>
<td>Meal solutions</td>
<td></td>
<td>547.2</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Canned/preserved food</td>
<td>241.8</td>
<td>16.2</td>
</tr>
<tr>
<td></td>
<td>Frozen processed food</td>
<td>102.1</td>
<td>18.2</td>
</tr>
<tr>
<td></td>
<td>Chilled processed food</td>
<td>95.9</td>
<td>−2.8</td>
</tr>
<tr>
<td></td>
<td>Sauces dressings and condiments</td>
<td>88.1</td>
<td>27.0</td>
</tr>
<tr>
<td></td>
<td>Ready meals</td>
<td>70.1</td>
<td>43.3</td>
</tr>
<tr>
<td></td>
<td>Soup</td>
<td>11.1</td>
<td>32.6</td>
</tr>
<tr>
<td>Impulse and indulgence products</td>
<td>Confectionery</td>
<td>119.4</td>
<td>16.3</td>
</tr>
<tr>
<td></td>
<td>Sweet and savoury snacks</td>
<td>87.9</td>
<td>27.5</td>
</tr>
<tr>
<td></td>
<td>Snack bars</td>
<td>1.9</td>
<td>42.6</td>
</tr>
<tr>
<td></td>
<td>Ice cream</td>
<td>76.0</td>
<td>14.7</td>
</tr>
<tr>
<td>Dried processed food</td>
<td></td>
<td>345.4</td>
<td>−2.8</td>
</tr>
<tr>
<td>Pasta</td>
<td></td>
<td>62.9</td>
<td>35.0</td>
</tr>
<tr>
<td>Noodles</td>
<td></td>
<td>7.4</td>
<td>44.5</td>
</tr>
<tr>
<td>Oils and fats</td>
<td></td>
<td>343.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Meal replacement</td>
<td></td>
<td>0.6</td>
<td>9.6</td>
</tr>
<tr>
<td>Spreads</td>
<td></td>
<td>28.8</td>
<td>23.9</td>
</tr>
</tbody>
</table>

Source: Euromonitor 2011 [17].

*In thousand tonnes, except for ice cream, which is million litres.

doi:10.1371/journal.pmed.1001253.t001
<table>
<thead>
<tr>
<th>Rank</th>
<th>Company</th>
<th>Location of Company Headquarters</th>
<th>Contribution to Total Packaged Food sales (%)</th>
<th>Examples of Product Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tiger Brands Ltd</td>
<td>South Africa</td>
<td>17.2</td>
<td>Milling and baking, groceries, confectionery, beverages, value added meat products, fruit and vegetables, products for the food services sector</td>
</tr>
<tr>
<td>2</td>
<td>Unilever Group</td>
<td>UK/Netherlands</td>
<td>4.9</td>
<td>Spices, sauces, dressings, margarine, teas, syrup and food solutions</td>
</tr>
<tr>
<td>3</td>
<td>Parmalat Group</td>
<td>Italy</td>
<td>4.8</td>
<td>Dairy products including milk, yoghurt, ice cream and cheese, fruit juices</td>
</tr>
<tr>
<td>4</td>
<td>Nestle SA</td>
<td>Switzerland</td>
<td>4.6</td>
<td>Baby foods, drinks, breakfast cereals, chocolate, confectionery, coffee, dairy products, ice cream</td>
</tr>
<tr>
<td>5</td>
<td>Clover Ltd</td>
<td>South Africa</td>
<td>4.6</td>
<td>Dairy products, desserts, beverages such as fruit juices, nectars and ice teas</td>
</tr>
<tr>
<td>6</td>
<td>Dairybelle (Pty) Ltd</td>
<td>South Africa</td>
<td>4</td>
<td>Dairy products, fruit juices</td>
</tr>
<tr>
<td>7</td>
<td>Pioneer Food Group Ltd</td>
<td>South Africa</td>
<td>3.7</td>
<td>Baking aids, tea/coffee, breakfast cereals, biscuits, condiments, juices and acidic drinks, dried fruits, eggs</td>
</tr>
<tr>
<td>8</td>
<td>Cadbury Plc (bought by Kraft in 2011)</td>
<td>UK/US</td>
<td>2.8</td>
<td>Chocolate, candy, gum, biscuits, coffee, other grocery</td>
</tr>
<tr>
<td>9</td>
<td>AVI Ltd</td>
<td>South Africa</td>
<td>2.8</td>
<td>Coffee, tea, biscuits, potato chips, frozen fish and seafood products</td>
</tr>
<tr>
<td>10</td>
<td>PepsiCo Inc</td>
<td>US</td>
<td>2.4</td>
<td>Drinks, savoury snacks</td>
</tr>
</tbody>
</table>


*Euromonitor does not collect data on the informal sector (defined as sales that are not taxed).

doi:10.1371/journal.pmed.1001253.t002
Rapid growth of supermarkets in South Africa

- Supermarkets now share at least 50-60% of food sales in South Africa, with most growth occurring after 1994.
- Nearly two-thirds of households in a rural area in South Africa are now buying their food at supermarkets.
- Healthier foods typically cost between 10% and 60% more when compared on a weight basis (R per 100g) and between 30% and 110% more when compared based on the cost of food energy (R per 100 kJ).

Number of households in two rural areas in Transkei, Eastern Cape going to supermarkets

<table>
<thead>
<tr>
<th>Percent of total</th>
<th>Xume</th>
<th>Luzie</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>78.4%</td>
<td>50.0%</td>
<td>64.8%</td>
<td></td>
</tr>
</tbody>
</table>

Growth in Supermarket Food Sales


Structural Determinants of ‘Overnutrition’ Globally
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)
- **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 and supermarkets

• **From 1990 FDI penetrated supermarkets**: FDI from US-based supermarkets increased from $4bn to $13bn between 1990 and 1999.

• **In LA supermarkets increased share of retail market** from 10-20% in 1990 to 50-60% in 2000.

• **Between 1990 and 2001 foreign sales of world’s largest 100 TNCs increased** from $88.8bn to $257.7 bn.
Food firms: Size and orientation

Number of countries

Number of food categories

Fonterra/New Zealand  ($2.3bn)
Wrigley Jr. Co./U.S.  ($2.4bn)
PepsiCo/U.S.  ($17bn)
Unilever Dutch/UK  ($23bn)
Nestlé/Switz.  ($27bn)
Ferrero/Italy  ($3.9bn)
Parmalat/Italian  ($5.2bn)
Heinz/U.S.  ($5.5bn)
Danone/France  ($9.6bn)
Dean Foods/U.S.  ($6.2bn)
Meiji Dairies/Japan  ($5.5bn)
Arla Foods Amba/ Denmark  ($4.3bn)
ConAgra/U.S.  ($12.4bn)

Note: Dollar amounts are values of packaged food sales only, in billions.
Source: Euromonitor 2003
From a Nestlé press release:
Vevey, February 21, 2008

“Popularly positioned products (PPPs). Products aimed at lower income consumers in the developing world, will continue to grow strongly in 2008 and beyond. Nestlé PPPs, which mostly consist of dairy products, Nescafé and Maggi culinary products, grew by over 25% to reach around CHF 6 billion in sales in 2007. The overall market for such products in Asia, Africa and Latin America is estimated at over CHF 80 billion.”
Olivier de Schutter
UN Special Rapporteur on the Right to Food
March 2012

Felicity Lawrence, The Guardian, 9 March 2012
What can be done?
Obesity management

- Promote weight loss
- Long-term weight maintenance
- Long-term prevention of weight gain
- Encourage active lifestyle
- Improve quality of life
Role of family in prevention and management of childhood obesity

- Encourage children to play
  - Limit time spent watching TV
- Avoid using food as reward
- Avoid comments about body size
Promote community agriculture and combat climate change

- Encourage self-sufficiency and reduce waste in wealthier and poorer nations eg through promotion of community-based initiatives in urban farming, school gardening programs, and indigenous live-stock preservation.

- Secure real commitments to reducing GHG emissions to slow climate change
Policy Interventions to Combat ‘Overnutrition’

- Review local government policies and regulations around vending eg in and around schools and advertising, especially to kids
- Invest in school and community infrastructure for sport and recreation and improved personal safety (eg more street lights, bicycling lanes, policing)
- Analyse pricing incentives/disincentives to healthy diets and consider consumer subsidies
- Review trade policy, especially wrt food trade
- Challenge unfair global macroeconomic regime through evidence-based advocacy and social mobilisation
“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)
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
Challenges: Effects on Non-Focal Health Care Services eg Ethiopia

“Health providers are shifted from the medical and surgical departments to the ART clinic. This is creating work burden on health providers, for they have to cover services that used to be offered by the shifted staff”.

Regional hospital, head of the ART clinic.

Banteyerga, 2007
Priority Actions Needed by the Health sector

• Catalysing social action to address environmental and social determinants
Interventions Required at the Policy Level

• Review local government policies and regulations wrt to vending eg in and around schools and advertising, especially to kids
• Invest in school and community infrastructure for sport and recreation and improved personal safety (eg more street lights, bicycling lanes, policing)
• Analyse pricing incentives/disincentives to healthy diets and consider consumer subsidies
• Review trade policy, especially wrt food trade
• EDUCATE AND MOBILISE COMMUNITIES AND CIVIL SOCIETY
Health systems & human resources

- Health personnel vital, consume between 60 – 80% of recurrent public health expenditure (WB, 1994).
- Health personnel development is primary step in health systems development
Health Workers Save Lives!

Anand & Barnighausen, 2004
Health professional migration from Africa

- Between 1985 and 1995, 60% of Ghana’s medical graduates left.
- During the 1990s Zimbabwe lost 840 of 1,200 medical graduates.
- In 1999, 78% of doctors in South Africa’s rural areas were non-South Africans.
Unfair trade

International migration- Winners

- The United Nations Conference on Trade and Development (UNCTAD) estimates that for each professional aged between 25 and 35 years, US$ 184,000 is saved in training costs by developed countries (UNECA, 2000)

- The 27 OECD countries have a workforce of approx. 3 million professionals educated in developing countries. The OECD savings are a staggering US$552 billion if UNCTAD figure of US$184,000 is used.
Key strategies and actions to revitalise CPHC and strengthen health systems
Strategies for health development

- **Equitable development** is the key
  Eg ‘Good Health and Low Cost’ countries

- Value of **investment in health and social sectors** must be emphasized

- ‘Strong’ community participation is key to achieving political commitment to health

- **Complementary strategies** needed:
  - Bottom-up community-based programme development
  - Top-down policy development and planning
Common Features of GHALC Countries

- Political and social commitment to equity
- Education for all with emphasis on primary level
- Equitable distribution of public health measures and PHC and increased community level coverage
- Assurance of adequate diets without inhibiting indigenous agriculture

Mosley, ‘Good Health at Low Cost’ 1985
Strategies for health development

- promoting healthy policies and plans
- implementing comprehensive and decentralised health systems
- Success of these strategies depends upon the creation of a facilitatory environment through such actions as **advocacy**, **community mobilisation**, **capacity-building**, **organisational change**, **financing** and **legislation**
Governance = voice, accountability, political stability, effectiveness, regulation, rule of law

Van Lerberghe et al, 2005
Achievements of CPHC.

• In countries where CPHC has been implemented, dramatic improvements occurred eg greatly improved coverage, especially of MCH care and particularly EPI, and steep declines in child mortality

  eg Brazil, Thailand, Iran, Costa Rica, Cuba, Nepal and Rwanda when political commitment sustained.
• Advocate for improved access and coverage, especially at primary and community levels and strengthen community participation to address environmental and social determinants
How many child deaths could be prevented per year with proven efficacious 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
Task-shifting as an alternative approach

– Task shifting is the name now given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers.
Evidence for impact and cost-effectiveness of community health workers

- 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.
- 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.
- At present, 29 countries in Africa allow CHWs to administer antibiotics for pneumonia.
RWANDA
Total health personnel in publicly funded facilities has almost doubled in 3 years...

![Graph showing the increase in total staff from 6961 in 2005 to 13133 in 2008.](image)
Nearly 60% of the existing health personnel are either nurses or paramedical workers while doctors contributed to less than 7%
Trends in ANC & Delivery

Figure 9.1 Trends in Antenatal Care and Delivery, Rwanda 2005, 2007-08, and 2010

- Antenatal care: 94%, 96%, 98%
- Delivery assisted by trained personnel: 39%, 52%, 69%
- Delivery at a health facility: 28%, 45%, 69%

Legend:
- RDHS-III 2005
- RIDHS 2007-08
- RDHS-IV 2010
Trends in Vaccination Coverage

Percentage of children 12-23 months fully vaccinated
Possession of Mosquito Net

Percent of households

<table>
<thead>
<tr>
<th>Any mosquito net</th>
<th>ITN</th>
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<tr>
<td>RDHS 2005</td>
<td>RDHS 2010</td>
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<tr>
<td>18</td>
<td>82</td>
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<td>59</td>
<td>83</td>
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Trend in Early Childhood Mortality

Deaths per 1,000 live births

Infant mortality
- RDHS 2005: 86
- RIDHS 2007-08: 62
- RDHS 2010: 50

Under-five mortality
- RDHS 2005: 152
- RIDHS 2007-08: 103
- RDHS 2010: 76

MDG
- Infant mortality: 28?
- Under-five mortality: 50?
Reduction of MMR

Maternal mortality rate (/100,000 livebirth)

Source: DHS Rwanda
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

Lehmann and Sanders, WHO, 2007,
http://www.who.int/hrh/documents/community_health_workers.pdf
“Liberator or lackey” (David Werner, 1981)

- The early literature emphasises the role of the CHWs as not only (and possibly not even primarily) a health care provider, but also as an advocate for the community and an agent of social change:
  - functioning as a community mouthpiece to fight against inequities and advocate community rights and needs to government structures.

- This view is also reflected in the Alma Ata Declaration which identified CHWs as one of the cornerstones of comprehensive primary health care.
Implications of shift to ‘task-shifting’

- Does the current term (and operationalisation) reflect a restriction of the role of CHWs?
- Is this reflective of a change in paradigm for Primary Health Care?
Factors influencing success of CHW programmes

Political and Community factors

Large trials in Nepal have demonstrated a 30% reduction in newborn mortality simply by facilitation of women’s groups involving pregnant women. ‘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.’

Priority Actions Needed (2)

- Develop comprehensive approaches that address social determinants of (ill) health through healthy public policies and intersectoral action
Interventions Required to Address Obesity at the Policy Level

• Review local government policies and regulations wrt to vending eg in and around schools and advertising, especially to kids
• Invest in school and community infrastructure for sport and recreation and improved personal safety (eg more street lights, bicycling lanes, policing)
• Advocate for pricing incentives to healthy foods and taxes on unhealthy foods
• Review trade policy, especially wrt food trade
• EDUCATE AND MOBILISE COMMUNIES AND CIVIL SOCIETY
“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)
Priority Actions Needed (3)

• Improve integration of health and non-health sector (social) determinants at different levels of care and especially community level. Successful **intersectoral collaboration** usually entails social mobilisation
Undernutrition and overweight: what is being done and what can be done?
The medicalisation and commodification of undernutrition: the promotion of ‘ready-to-use-foods’
What We Are Told About RUTF

• Energy dense food with added minerals and vitamins
• Required for short term management of SAM (about 5% children, about 6-8 weeks)
• Community use
• Safe
• Ad lib administration
• Sterile
• Waterless
• Rigorous quality control (WHO standards) for vitamin and minerals
• Cannot be manufactured in a decentralized way if it is to meet standards of sterility and waterlessness. Thus need for packaging.
The good things about RUTFs

• No doubt that much more needs to be done for treatment of SAM (severe acute malnutrition)
• No doubt that calorie dense food (RUTF) is effective, necessary and desirable
• No doubt that it saves women time and energy
The 3 major users in the world are:

UNICEF
Medecins sans Frontieres
The Clinton Foundation
UNICEF and MSF are using various RUTFs already in Africa; not only to treat, but to prevent

- **UNICEF** is introducing an innovative food supplement — “Plumpy’Doz” — to very young children in Somalia.

- **Three teaspoons of Plumpy’Doz three times a day provides each young child with additional energy, including fats, high-quality protein and all the essential minerals and vitamins required to ensure growth and a healthy immune system.**

- Other partners, such as the World Food Programme and Doctors Without Borders, have already been using the supplement

- “By adopting this new approach, we aim to reach children before they become malnourished.” (UNICEF Somalia Representative)
Possible harmful implications of the use of RUFs for prevention of malnutrition:

- to breastfeeding;
- to indigenous foods and cultural practices;
- to local agriculture
- diverting scarce family, national and agency funds away from more beneficial uses
- diverting attention and activity away from economic and political causes of undernutrition

RUTFs should "do no harm".
More appropriate and sustainable approaches

- Community-based Nutrition Programmes
- Intersectoral action
- Regulation
- Promote community agriculture and combat climate change
Intersectoral Action in Brazil

School attendance has increased since 1990, and illiteracy rates have decreased from 33.7% in 1970 to 10.0% in 2008.

Between 1991 and 2008, Brazil’s gross domestic product doubled and its Gini coefficient, although among the highest in the world, decreased by 15% from 0.637 to 0.547. The poverty index decreased from 68% in 1970 to 31% in 2008.

This improvement can be attributed to a combination of social policies, including the social security system, the Bolsa Família conditional cash transfer programme (which, in 2008, distributed R$13 billion [about US$7.2 billion] among 10.5 million families), and increases in the legal minimum wage. Living conditions have also changed substantially.

In 1970, only 33% of households had indoor water, 17% had access to sewerage, and less than half had electricity. By 2007, 93% of households had indoor water, 60% had access to sewerage, and most had access to electricity.
Time trends in the prevalence of stunting according to family income in four Brazilian surveys, 1974/5 to 2006/7. Source: Monteiro et al, Bull WHO (in press)
Conclusions

Main actions required from Public Health Community:

- Challenge ill-considered health sector reforms through research and advocacy
- Develop well-managed comprehensive programmes
- Develop capacity and improve quality through health systems and equity-oriented research, practice-based and problem-oriented training.
- Rapidly (re)train CHWs and equip them with community development skills
- Involve other sectors and communities through focussed intersectoral efforts
- Challenge unfair global macroeconomic regime through social mobilisation
- Strengthen progressive civil society
Priority Actions Needed (4)

- CHWs catalysing social action
Mitanin Programme:
About 60000 Women as Community level Health Volunteers
To Support the Public Health System & Public Health Initiatives in Chhattisgarh

State Health Resource Centre, Chhattisgarh, India
Key Activities of Mitanins

- Facilitate **proper Antenatal care**; Prompt referral for complications and institutional delivery
- Day 1 visit at childbirth, delivering **essential neonatal care** messages
- Regular **Health Education, awareness** and initiatives for health entitlements through **women's groups**
- Identification of **malnourished children** - refer the severe cases and counseling for moderate cases
- **Mobilize community** for public health services
- Early detection, first contact care and referral - focus on common but **critical childhood illnesses**
- To act as **community interfaces for health & related interventions**- national health programmes, epidemic control, education, food security, water & sanitation etc.
- To lead the hamlet level initiatives for **health related development**.
IMR 2000-2006: A comparison with Madhya Pradesh, the mother state, and India

Total IMR

Rural IMR
Anti-Deforestation Agitation by CHWs Chhattisgarh-India

In Chhattisgarh:

• Mitanins led opposition to state government plan of felling and selling 40,000 hectares of dense natural forests involving felling of 20 million trees for timber

• Mitanins mobilised women to oppose deforestation policies of state as deforestation threatens livelihoods and nutrition security of tribal (indigenous) communities especially the women
They organised anti-felling demonstrations

They mobilised Village Assemblies and Forest Protection Committees (Formal mechanisms of local self governance) to pass resolutions demanding a stop to the felling
When resolutions and demonstrations did not seem to put an immediate stop to felling, they snatched the axes and saws.

They chased the timber contractors away.
They did not allow the contractors to take away the wood.

They fought against pressure from police and administration.
They forced Central Government to institute an Enquiry
Mitanin – CHWs fight against deforestation

• Filed a Public Interest Litigation in State High Court

• Mitanins won the litigation, thus forcing the Government to withdraw its deforestation programmes in three districts of Chhattisgarh

• Followed it up with national litigation in the Supreme Court, which is now demanding an end to all state sponsored deforestation programmes
Healthy life expectancy (HALE) and government expenditure on health as per cent of GDP 2000

Mackintosh and Koivusalo 2005
Log of probability of dying before five years and private expenditure on health as per cent of GDP, 2000

Mackintosh and Koivusalo 2005