Learnings from multiple international case studies of people-oriented comprehensive primary health care: lessons for research, policy, and implementation

Baum, F. J., Freeman, T. J., Javanparast, S., Labonte, R., Sanders, D., Packer, C., Lawless, A., Jolley, G., Ah Chee, D., Boffa, J., Francis, T., and Bentley, M.

1. Southgate Institute for Health, Society, and Equity, Flinders University, Adelaide, SA, Australia; 2. Institute of Population Health, University of Ottawa, Ottawa, ON, Canada; 3. School of Public Health, University of the Western Cape, South Africa; 4. Central Australian Aboriginal Congress Aboriginal Corporation, Alice Springs, NT, Australia; 5. Southern Adelaide Local Health Network, Adelaide, SA, Australia; 6. General Practice Training Tasmania, TAS, Australia

Background

This poster synthesises the findings and lessons learned from two related projects investigating case studies of comprehensive primary health care: one in Australia, and one which conducted international case studies.

**“Comprehensive Primary Health Care in Local Communities” project, Australia**

- 5 year project (2009-2013), funded by the National Health and Medical Research Council
- 6 case study services: 4 South Australian state government-managed services, one South Australian non-government sexual health service (SHINE SA) and one Northern Territory Aboriginal Community Controlled Health Service (Central Australian Aboriginal Congress Aboriginal Corporation)
- Research designed as partnership between services and the researchers
- A program logic model was developed to depict good practice comprehensive primary health care in Australia. As well, a site-specific model was developed for each service
- A range of evaluation methods were conducted to evaluate the services against the logic models.

**“Revitalising Health For All” project, international**

- 5 year project (2007-2011) funded by the Teasdale-Corti Global Health Research Partnership Program, IDRC, Alliance for Health Policy and Systems Research, Lovett Institute, CORDID
- To develop/strengthen research capacity on comprehensive primary health care
- Used “triads” of new researchers, research mentors and health managers
- Research designed as partnership between services and the researchers
- A program logic model was developed to depict good practice comprehensive primary health care in Australia. As well, a site-specific model was developed for each service
- A range of evaluation methods were conducted to evaluate the services against the logic models.

**Figure 1. Selected case studies from both projects**

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Lack of explicit supportive policies for PHC leads to “disorderliness” growth of PMH. No political elements of PMH not implemented</td>
</tr>
<tr>
<td>Colombia</td>
<td>Hybrid model—community oriented, intersectoral action, but a focus on curative care. Structural constraints on PHC, neoliberal approach of health and social policy at national level</td>
</tr>
</tbody>
</table>
| South Africa | - Intersectoral action necessary for access to services for all 
- Needs coordinated government at all levels, community participation mechanisms, and local organisational and government support and leadership |
| Ethiopia | CHWs were crucial to the comprehensive PHC approach and implemented strategies that span PHC, including community participation, intersectoral action on the social determinants of health, multidisciplinary team work, treatment, prevention, and promotion, and a focus on accessibility |
| India | Women’s empowerment groups improved social support and assistance in health care and local food security. Challenges in implementing program of social health activists – understanding of their role, need right selection process, can take several years to nurture |
| Iran | - The Aboriginal community controlled service has been able to protect its comprehensive PHC approach and implemented strategies that span PHC, including community participation, intersectoral action on the social determinants of health, multidisciplinary team work, treatment, prevention, and promotion, and a focus on accessibility |
| CPHC Project: South Australia | State government and non-government services moved away from comprehensiveness to a more selective PHC model, accompanied by budget cuts and federal/state cost shifting. Unsupportive policy environment that emphasised biomedical model of health, particularly individual chronic condition self-management services. |

**Lessons for Research**

- Both projects aimed to increase the capacity of PHC partners, though in some instances this was limited by a reduction in political support for the implementation of PHC. The research triads of new researchers, research mentors and health managers in the international project provided positive feedback on the diverse expertise the method provided, as well as enhanced research relevance and the ability to develop relationships and disseminate research findings.
- Most case studies in both projects used mixed methods, including secondary data analysis, policy document reviews, key informant interviews, focus groups and surveys which allowed researchers to capture fully the development and current status of PHC from the viewpoint of various stakeholders in their case study area. Engaging managers and policy makers, through, for example:
  - critical reference groups
  - research symposia / regional workshops to disseminate and discuss emerging results
  - efforts to keep the research practice and policy relevant
  - having health managers as part of the research triads in the international project were critical in pursuing the research in times of rapidly changing political or ideological contexts and reconfigurations of health systems (e.g., Colombia, Ethiopia, India, South Africa, and South Australia). Policy changes observed following case studies included improved training for social health activists (India), adoption of the case study program as an exemplar model for national PHC reforms (El Salvador) and greater attention to community participation mechanisms (South Africa).

**Lessons for Policy and Imolementation**

- The need for supportive governance policies and financing models permeated the case studies.
- Well-trained and supported community health workers (CHWs) are able to work effectively with marginalized communities.
- Effective mechanisms for community participation, both informal (through participation in projects and programs, and meaningful consultation) and formal (though program management structures) are important for PHC to take root. In particular, community control of PHC appears to have benefits for comprehensiveness of PHC.
- Co-partnership models in program and policy development (in which financial and knowledge support from governments or institutions are provided to communities, which retain decision-making powers in program design and implementation) have been successful.
- Support for community advocacy and engagement in health and social systems decision-making helps create and sustain PHC.
- We found some strong examples of PHC acting on the social determinants of health through intersectoral action, but we also found constraints such as lack of policy support, a perception the work is “too political” and the pressure of curative work taking precedence.
- These characteristics, in turn, require a political context that supports state responsibilities for redistributive health and social protection measures.

**References**