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*Does Primary Health Care still have currency in improving
sexual and reproductive health of women?**

Prepared by

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* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations

Introduction

- Socio-economic and political factors affecting poverty and inequality underlie the majority of the health problems in middle to low income countries.
- Primary resources such as land are inadequate for the population and/or unjustly distributed.
- The overall level of literacy and education is low, infrastructure is under developed.
- The health facilities and personnel are concentrated in one or two cities instead of in the rural areas where they are most needed.
- Women carry a considerable burden as bearers of children and carers of families, and continue to experience low social status and poor access to education.

These were some of the problems that culminated in the overwhelming global support for the Alma Ata Declaration on Primary Health Care (PHC) in 1978. The proposed solution, comprehensive PHC was based on a need for equity; the just distribution of resources according to need. *Comprehensive* PHC promised essential health care, universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. Health was linked to development, maternal health was a priority and the need for the empowerment of women was highlighted.

The Alma Ata Conference certainly created a momentum for social change that many signed up to. The agenda was intensely political. It was an agenda that supported further developments that were based on the identification of vulnerable groups followed by a political lobbying process to address the vulnerabilities. The International Conference on Population and Development (ICPD) extended the PHC principles, refocusing the emphasis on maternal health to also address sexual and reproductive health and other rights violations against women. There have since been many changes to national level policies and structures to encourage the empowerment of women. Gender has been mainstreamed to the extent that it is conceivable in some instances to obtain disaggregated data to describe disparities and evaluate implemented solutions.

However almost three decades since the Alma Ata Declaration, real progress in the health of the marginalised in general and of women in particular is equivocal. The potential for change promised by PHC has not been realised and certainly, the goal of “Health for All by 2000” was not achieved. Consequently, at the turn of the century, the Millennium Summit reviewed the state of the world’s population, identified the gravity of the plight of the poor, the vulnerable, women and children, and proposed another set of goals, the Millennium Development Goals (MDGs) to provide new targets towards addressing the continuing and in many cases, worsening levels of inequality.

The uncanny similarity of today’s health issues to the prevailing health problems three decades ago is incredibly frustrating. We know what the problems are; they haven’t changed much. We have a fairly good idea of the solutions but have perfected the art of avoiding changes that challenge the prevailing order. Given the overwhelming consensus reached at Alma Ata, described as a “watershed” event (Banerji 2003), it would be apposite to use the health systems proposed under the principles of PHC as a framework for pushing current boundaries towards the development of health systems that could address sexual and reproductive health for women.

The current state of sexual and reproductive health

Over recent years, gender-based inequities in general have gained some prominence on the global agenda largely because of extensive documentation of supporting evidence, concerted lobbying efforts by advocacy groups and NGOs and a clear acknowledgment in the MDGs. One would be hard pressed to find an analysis of the problems and solutions underlying the MDGs that does not present the gender implications. And justifiably so; the global burden of disease estimates place sexual and reproductive health related conditions as the highest cause of illness and death in women in their reproductive years. In addition to reproductive roles, the risk factors remain women's disproportionate poverty, low social status, and low levels of education.

The Global Burden of Sexual and Reproductive Health Conditions

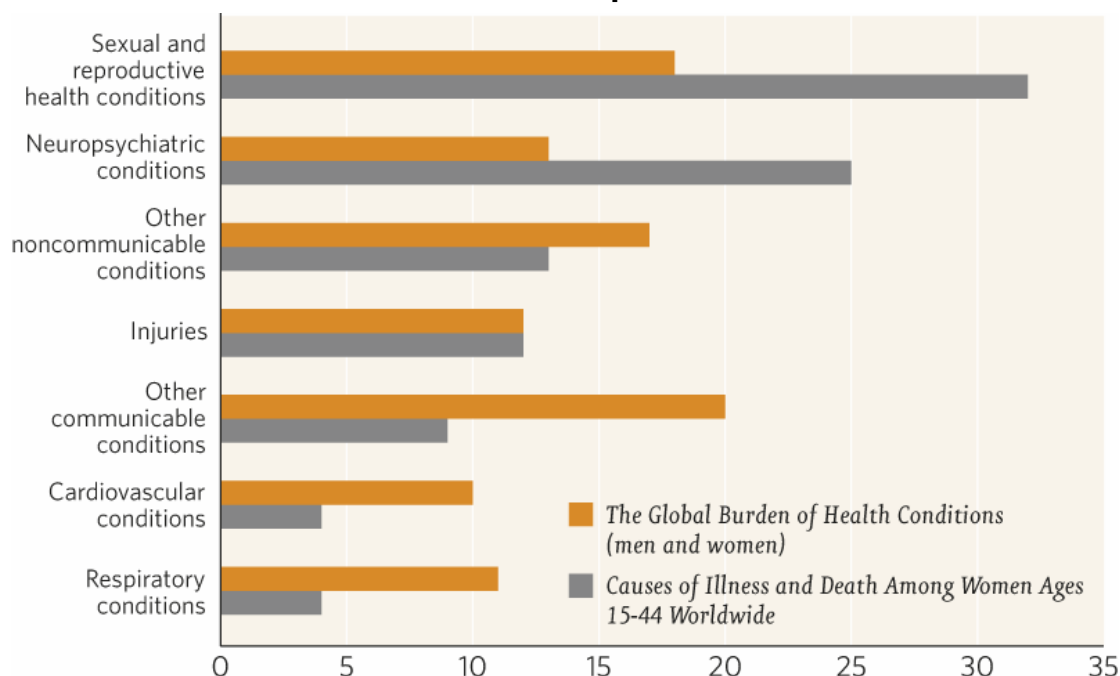


Figure 1: Source: WHO 2002

While some countries have reported reductions in maternal mortality, others report an increase in a woman's lifetime risk of pregnancy related death (Simwaka, Theobald et al. 2005). Not surprisingly, the economic status of the country is important. It is classically known that there is a strong relationship between the wealth of a country and the health of its population. Figure 2 illustrates this relationship using the maternal mortality ratio (MMR) per 100,000. GDP per capita is shown on a log-scale so that the relationship in the poorest countries can be scrutinized more readily. Seventy-five percent of the countries have a GDP per capita of less than USD\$10,000.

What is quickly apparent is the almost straight-line relationship (shown as a dotted-line) between MMR and the log of GDP per capita. The MMR declines sharply with increasing country-level wealth from around 1,100 deaths per 100,000 in the poorest of countries to around 75 per

100,000 in countries with a GDP per capita of USD\$10,000. From that point, the gains in the MMR reduce drastically, with important but relatively small reductions occurring after a GDP per capita of USD\$10,000. For the poorest 75% of countries the raw message has changed little over the decades – become wealthier.

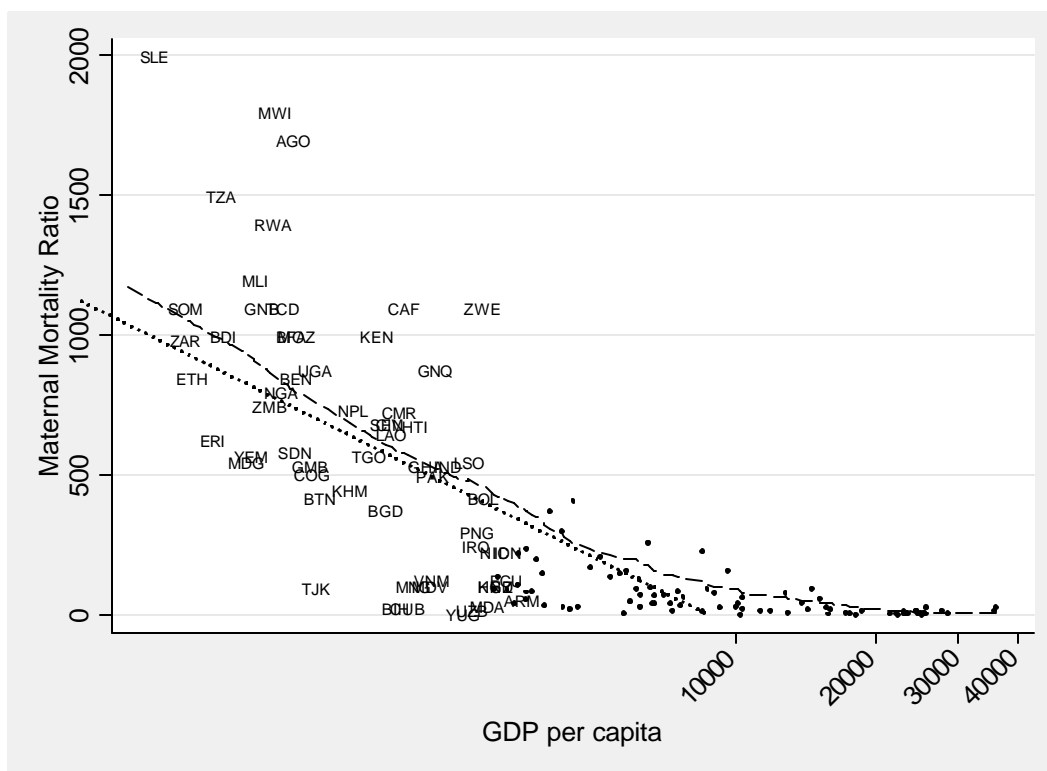


Figure 2

The relationship between the Maternal Mortality Ratio and Countries' GDP per capita.

Macro-economic growth on its own however, would not be sufficient in the absence of policies that ensure equitable distribution of wealth within the country, a dilemma that has resulted in the gender inequalities in the first place. The importance of policies within countries that promote equity are therefore paramount.

The promise of equity under PHC

PHC was based on the principle that health and development were inextricably linked. Ensuring health, therefore, had to be multi-sectoral, involving agriculture, food and sanitation as much as it did health care delivery, health promotion and family planning support (Hall and Taylor 2003). It involved the participation of communities and civil society in the prioritization of their health needs and in the development of the solutions.

In acknowledgement of the serious lack of technical capacity, a range of primary level practitioners or health workers and nurses were trained to undertake procedures that had traditionally been performed by physicians (Editorial 1977; Pierce and Hirschhorn 1977; Werner 1977). Prior to Alma Ata, this system had been used with some success in countries like China with the barefoot doctors, Tanzania, Venezuela and Sudan (Bennett 1977; Benyoussef and Christian 1977).

In spite of the laudable intentions of comprehensive PHC, its implementation raised considerable controversy. The objections were on the basis that it was too ideologically driven, overtly political and therefore impractical. The shift of power to communities was considered unworkable and funding bodies were reluctant to commit to projects over which they had no control and for which accountability remained unclear (Rifkin and Walt 1986). An alternative *selective* approach was conceptualized that allowed a focus on single interventions and targets such as immunization and the reduction of child mortality (Warren 1988).

With the lack of commitment to the comprehensive PHC agenda, very little effort went into the necessary reforms required across sectors in general and within health systems in particular. Some politicians saw PHC as a mechanism to devolve responsibility for health and social welfare expenditure onto communities. Limited health sector funding continued to flow to tertiary institutions in urban centres. Programs to develop the roles and build capacity of the PHC workforce were poorly resourced and intensely criticised by professional associations of health practitioners. Under comprehensive PHC programs, for instance traditional birth attendants were supposed to be up-skilled to increase the numbers of quality care attended births. The successes of that particular strategy have been variable. In some settings, objections from influential professional nursing and medical lobby groups heavily restricted both the training and the practice of traditional birth attendants (Dovlo 2004). In others the implementation of training programs did not take account of local contexts (Allotey 1999). There were major concerns both from the community and from the TBAs about their role, quality of care and continuing development and career within the health sector. There were also problems with adequate supervision. These were not insurmountable concerns. They required a creation of a formal role within the health sector and the establishment of a state recognised accreditation system that gave the role legitimacy. It also required a stated commitment to ongoing development to ensure continuing high quality care and staff retention. The current estimate however, is that less than 60% of births in developing countries take place in the presence of skilled attendants (UNFPA 2005).

Health sector reforms

Health systems in most countries consequently remained moribund. Following the economic crises of the 1980s, structural adjust programmes were introduced in many middle and low income countries with health sector reform policies aimed at revitalising the health systems (Berer, 2002 #1). In very broad terms the reforms were based on a market-driven, economic philosophy and targeted health financing, priority setting and accountability; the structure of national health systems; and the role of the state in health service provision (World Bank 1993). Health sector reforms became the updated and practical solution to the persistent health problems

identified under the PHC agenda (Sundari Ravindran 2002). The policies met the needs of funding agencies if not those of the population.

In general the effect of the reforms for many countries was a change from state, highly subsidised health systems to private sector based systems. Users had to pay for services but the blow was cushioned with the introduction of, in some cases innovative, community based health insurance schemes. While the operationalisation of reforms was by no means universal across countries, commonalities derived from similar conditions tied to bilateral and multilateral funding agencies (Standing, 2002 #4).

To examine the importance of health financing by governments, we analysed it against maternal mortality. A measure of health sector financing is the proportion of GDP spent on health. A related alternative is the proportion of GDP spent on health by the government. The ratio of these two figures might be characterized as a measure of the government's commitment to the health of the population.

The MMR was regressed against GDP per capita (log transformed), governance (as operationalised by the World Bank), and the spending ratio on health. Countries included in the analysis were those with GDP per capita above USD\$10,000 because of the quality of the available data. The spend ratio was a significant predictor of MMR. Those countries in which governments spend the majority of the money within the health system tended to have lower MMRs ($r=-.39$). The relationship is illustrated in Figure 3.

Countries like Cyprus and Singapore, which have per capita GDPs above USD\$10,000 rely on the majority of health care spending coming out of the private sector. In contrast, countries like Sweden, Slovakia, Japan, and Denmark, tend to rely on government spending on health care. It is also those latter countries that have lower MMRs. Importantly, the relationship holds, even when one controls for the actual per capita expenditure on health care. It is not surprising therefore that some of the best examples of success are from countries that have taken control of the funding of their health sector in defiance of agendas of funding agencies (Suleiman 2000).

A just and effective health system

A major difference in the political processes that drove the PHC and health sector reform agendas was that while PHC was extensively debated and unanimously agreed to by developed and developing countries, health sectors reforms in developing countries were perceived as an imposition from economists in the US and the UK (Hall and Taylor 2003). It was also not clear how the health sector reform agenda could be implemented to address the underlying inequalities and inequities.

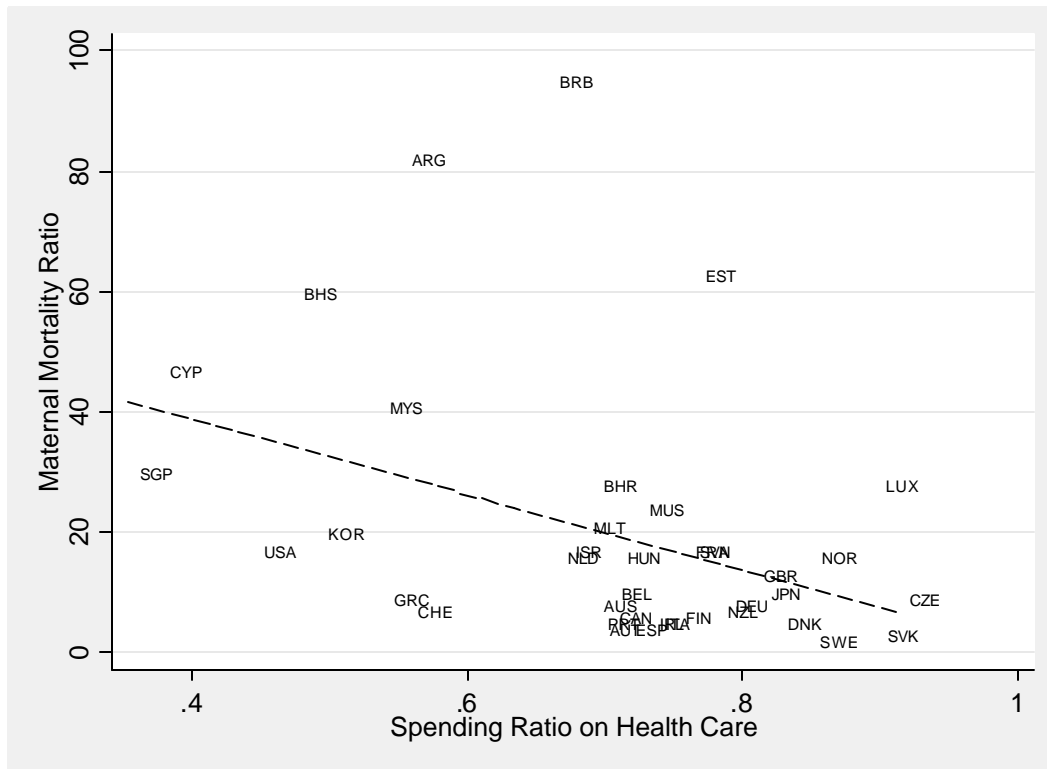


Figure 3

The relationship between the Maternal Mortality Ratio and the Spending Ratio on Health Care

Health systems need to embody the PHC principles of accessibility, affordability and acceptability, and this requires scaling up the quality of health care available at the primary level, in the villages and districts in the rural areas. This is indisputable, and it will require resources (WHO 2005). No more, however, than has been spent on defence budgets (UN Millennium Project 2005) or other investments of limited social value. Indeed it is interesting that the “defence of the realm,” although occasionally questioned, never comes under the same degree of scrutiny as spending on health. Governments may squander any sum on the military because it is a national good – but the healthy nation needs to be funded by the individual consumer? More importantly, we know that effective interventions exist that are simple, low cost and low-tech, and cost-effective (UN Millennium Project 2005).

Thinking creatively in PHC, an example

The details of strategies to improve health systems at the primary care level need to be open to some innovation and be permitted to break down existing structures created more to maintain the power base of a minority than to address inequalities. The concept of the community health worker and traditional birth attendant under PHC was well intentioned but the effectiveness was lost in the execution of the idea. Notwithstanding, the human resources within a health system are critical and one of its principle inputs. Health systems today face a number of challenges with regards to the human resources. Tensions exist in funding for training between ministries of education and health (WHO, 2000). But more importantly, the brain drain of highly qualified

health workers from developing to developed countries takes the returns on the training investment away from where it is most needed. The brain drain again highlights an inequality between resource poor and wealthier nations. However it is also a predictable result of globalization, the operation of free market principles for services as well as goods (Allotey and Zwi In Press). It is proving a major obstacle to the improvement of health systems in low and middle-income countries.

Responses to the global movement of health staff have included negotiations between sending and receiving countries towards regulation and for countries such as the Philippines, some contributions from receiving countries towards continuing education of health staff. The reality however is that without major changes within health systems of sending countries, there is little incentive for qualified staff to remain or return. While solutions are being explored to address the wider international migration issues, there is a need for more immediate solutions within sending countries.

There are some lessons to be learnt from countries that have achieved some successes in creating and maintaining a skilled workforce of community health workers and birth attendants under the PHC model. In Indonesia and other parts of South East Asia, for instance, the strategy to improve the numbers of births with skilled attendants was to put resources into the training of midwives. In addition to the commitment to training there was a formalised recognition of the importance of their contribution to the national health system through the creation of career structures (Geefhuysen 1999; Sherratt 1999).

African countries such as Tanzania, Malawi, Mozambique, Zambia, and Ghana have introduced a mid level cadre within the health system. The skill base of the cadres is specialized and training is therefore not as resource intensive as is required for the more traditional nursing and medical training. A recent review found little difference between the quality of their practice and that of clinicians both from the patients' feedback and the quality of the procedures they performed (Dovlo 2004). The medic corps of the Special Air Services (SAS) in Australia undertakes a similar intensive training program. There are several community health worker programs in Central and South America that appear to have met with considerable success under models of training developed by Werner et al.

There were challenges faced by this model when first introduced under PHC. However there is a desperate need for the political will to break down many of these barriers. There is a slow trickle of change. The WHO has recently recommended the use of antibiotics by community level health workers. Some national policies appear to providing the space to allow for innovative thinking. Under controlled conditions and with systematic evaluation of both processes and outcomes, it may be possible to develop best practice models of the sort of workforce that was envisioned under the principles of PHC, developed with the focussed goal of providing health for all.

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