Project title:

World Lessons in Comprehensive Primary Health Care Reform

Final Technical Report

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1. Abstract

The Revitalizing Health for All (RHFA) project was undertaken by co-principal investigators (PIs), Ronald Labonté (University of Ottawa) and David Sanders (University of Western Cape, South Africa). The project was funded by a Teasdale- Corti grant from 2007 to 2011 and had nearly 50 collaborators from countries in Africa, Asia, Latin America, North America and Europe. The overall aim of the RHFA project was to renew the evidence base for comprehensive primary health care (CPHC) and build regional and global networks of researchers and policy-makers who want to use research knowledge as a tool for advancing (and revitalizing) CPHC.

The IDRC grant at hand (107108-00020703-025) served to gather this evidence into a volume. The volume synthesized evidence from the RHFA collaboration which enabled us to extract lessons on CPHC implementation and reforms in two ways. The first method was through an extensive scan of literature which began with an initial database of some 10 000 citations for review. The second method was by selecting and funding research teams from a larger pool of applicants to investigate and report on CPHC experiences in their countries. Specifically, the project brought together 20 teams composed of 'triads' -- junior and senior primary health care researchers working alongside research users (policy makers, program managers), in a unique research/capacity-enhancing process.

Most, but not all, of the teams which were selected, funded and participated in the RHFA project contributed to this volume; in total, 17 teams from 15 countries shared their CPHC research findings.

Our work proceeded from three key propositions that informed our vision for this initiative:

1. Provision of effective, efficient, equitable and sustainable health care (including disease prevention and health promotion) depends on a broad programmatic approach which is directed to meeting the primary health care needs of communities (including vulnerable and marginalized people) while also addressing the social conditions threatening their health. CPHC provides the basis for such a programmatic approach, although the need to interrogate and expand upon the evidence base for its effectiveness remains.
2. CPHC principles have been sharply contested by other models of health care. The controversy results partly from a perception of an inadequate evidence-base and from unresolved policy debates including selective versus comprehensive programming; the roles and interrelationships of the public and private sectors; the role/importance of popular participation and mobilisation in programs of care and prevention; and engagement with other policy sectors responsible for what are now frequently referred to as 'social determinants of health' (e.g. housing, sanitation, environmental protection, social

protection, labour/employment, to name a few). There is an urgent need to synthesize and provide new evidence that addresses these areas of controversy.

3. Research to provide such evidence poses many methodological challenges, including the plurality of knowledge systems (e.g. technical, lay, culturally-embedded) and methods for gathering the required evidence; issues of voice and power in defining, generating and interpreting such evidence; the need to address the concerns of local practitioners and research users; and, above all, the need to integrate the context-specificity of CPHC implementation into general lessons about its impact and effectiveness.

The CPHC concept arose, in part, as a response to the increasing recognition of the limitations of a bio-medical and technological approach to improving health. As outlined in the Declaration of Alma-Ata (World Health Organization & UNICEF, 1978), *comprehensive* primary health care combines not only first line medical and allied health care workers offering a range of care from prevention to treatment, but also includes other elements such as equity of access, collaboration across sectors beyond health, and community empowerment and participation in the services made available. In 2008, the World Health Organization issued its annual World Health Report on the subject of primary health care addressing some of the successes and gaps.

The volume comprises 15 chapters. Chapter 1 describes the goals of the RHFA project and gives a historical recount of how the project went about achieving these goals. Specifically, we explain the rationale for the project and its distinctive features. Chapter 2 synthesizes the findings of reviews of the literature on comprehensive primary health care on a regional basis.

The remaining Chapters 3 through 15 are the contributions from the funded triad teams. Their research has been organized thematically to highlight what we considered to be the most unique or strongest "characteristic" of a PHC initiative which qualified it as a truly *comprehensive* one. In a number of cases, country studies conducted by the research teams touched upon more than one component which contributed to the "comprehensiveness" of an initiative. In these cases, we chose to place the case study under the thematic section which we felt was most strongly represented. Short snapshots of targeted CPHC initiatives in Canada, New Zealand, Australia, Ethiopia and Pakistan are also provided in the form of boxes.

2. Keywords

Comprehensive primary health care (CPHC), community engagement, community health workers, health governance, health equity, intersectoral action.

3. The Research Problem

Primary health care reform has a prominent position in national and global policy discourse. Building on health system reforms in line with health promotion, population health and recent emphases on social determinants of health, "comprehensive" primary health care is defined as attempting to achieve the following broadly stated outcomes, which are in turn associated with improved health:

- increased equity in access to health care and other services;
- reduced vulnerabilities through increases in community empowerment (capacities);
- reduced exposures to risk through changes in social and environmental determinants of health;
- improved participatory mechanisms for marginalized population groups; and
- increased intersectoral policy actions on the social and economic determinants of health that involve the health sector.

While comprehensive primary health care (CPHC) can lead to extensive health benefits, as listed above, our global literature review revealed that there are very few documented stories of truly extensive CPHC initiatives. Indeed, upon review of the literature, we often found that initiatives claiming to be "comprehensive" reforms of PHC were not. The "comprehensiveness" of these reforms was generally described as combinations of rehabilitative, curative, preventive and promotive services, as well as continuity in care from primary through secondary and tertiary levels. While these conceptualizations remain important, they relate more to individual patients than to broader communities or community-level (i.e., population) health.

As such, the evidence base of CPHC was found to be generally weak. Yet grey literature (largely in reports by non-profit organisations) and presentations at world health fora, revealed that efforts were being made to implement "comprehensive" PHC reforms that capture and extend this comprehensive vision of PHC first articulated in the 1978 Alma Ata Declaration. Research into these CPHC initiatives, would provide extensive health benefits, renew the evidence base and guide future reform initiatives in their goal to be "comprehensive".

4. Objectives

The overall aim of the RHFA project was to renew the evidence base for CPHC and build regional and global networks of researchers and policy-makers who want to use research knowledge as one tool for advancing (and revitalizing) CPHC. In addition to building the

evidence base for CPHC, the stories collected provided lessons to be shared and applied to future health reforms with the goal of implementing truly “comprehensive” primary health care.

The purpose of this writing project has been to document these experiences of CPHC reform and extrapolate the lessons learned from each one. These were compiled and drafted in a volume which is under peer review by commerical publisher at time of writing this report.

Following our global review of literature on CPHC under the RHFA project we also uncovered initiatives attempting to reform primary health care systems to the extent that they could be qualified as “comprehensive”. Lessons were extrapolated from this literature review and also included in the volume.

17 of the RHFA teams committed to this book project. While they drafted reports at the end of the RHFA project to summarize their CPHC research findings, reports were not consistent in nature, were sometimes repetitive, lacked some information or offered too much detail. Neither were they drafted in the format of a book chapter. The teams were asked to revise their findings following a format set by the PIs on this application and these chapters were edited. The volume’s editors contributed front end, linking and back end chapters to the book. The editors also contributed a chapter synthesizing CPHC findings from a structured literature review carreid out by the RHFA project. Annex 1 contains a description of the literature review exericse.

Together with IDRC, we are attempting to have the book published by an academic publisher. Should we be successful in securing an academic publisher to print the book, copyright issues will be resolved with the publisher. If a publisher for a printed version is not secured, we will seek to have the book e-published and uploaded on the website of IDRC and the websites of both PIs.

5. Methodology and Project Activities

The 20 teams that originally participated in the RFHA project were contacted prior to this application to determine their interest in re-drafting their findings according to a proscribed format set by the Co-PIs. This format was already drafted and circulated. 17 of these teams confirmed their participation in the book.

Amongst the CPHC themes addressed in the chapters are:

- Lay (or community) health workers:

What is their role in the health system? How well do they work on local social determinants of health? What should be their level of formal training? Should their roles be primarily voluntary or paid? What are the gender issues of having voluntary lay health workers, who are more often women than men? How embedded in their local communities should they be? How should their activities be governed by, or accountable to, health authorities or community groups?

- Health care governance and intersectoral actions on the social determinants of health:

What governance structures are most effective in enabling local health centres and community health workers to engage in actions on social determinants of health? How can intersectoral action on determinants be strengthened at government (local, provincial/state, national) levels? How can local health concerns be communicated effectively to, and acted upon by, formal health systems and, through health systems, to other policy and program decision-making sectors of government?

- Equity in access:

What strategies have been used to improve equity in access to primary health care services? How have these strategies also improved access to resources that improve equity in social determinants of health (e.g. housing, physical environment, income/employment)? What techniques work most effectively to engage communities in decisions to improve equitable access to services, and to resources for social determinants of health?

Two assistant editors were selected for the book. Unfortunately, one was unable to contribute as fully as foreseen due to serious illness. The second editor, along with the co-PIs, contacted each team to provide guidance on the content of each of the teams' chapters. They provided each team with a drafting schedule, feedback and editing throughout the process.

Each team was offered an honorarium of CAD 500 in recognition of the time and effort put in by each team; one decided to forego the honorarium and a few others requested the editors draft their chapters on their behalf owing largely to linguistic challenges. All teams consisted of a minimum of three members - a junior researcher, academic mentor and knowledge/research user (some teams have more than one researcher, mentor or research user). Genreally, the junior researchers took the lead in drafting contributions and were the contact points for the chapters. As such, the honoraria were paid out to them. The research users in each team will have validated the usefulness and applicability of the research and lessons learned throughout all the research steps, from helping identify the research question, helping decide the most appropriate methodology, connecting the researcher to key literature and informants and, at the end, disseminating the research findings to stakeholders who would benefit from the

findings. For most teams, the research users were civil servants involved in health care policy making and delivery at the city, provincial or federal level.

Three chapters/boxes were contributed in Spanish. A professional translator was engaged to translate these into English.

The PIs on this grant will seek venues to launch the book. The events will be chosen according to the greatest likelihood that participants will be interested in CPHC reform initiatives. Co-PI Sanders will also launch the book through the People's Health Movement (PHM); PHM having been one of the conceptual founders of the RHFA project and holder of a significant members' mailing list with members typically interested in CPHC.

Attention to gender equity was paramount throughout this book project. It is already known that improved access to primary health care (regardless of its comprehensiveness) disproportionately benefits women, especially women with families, through improved maternal/child health care. Its comprehensiveness in disease prevention and health promotion, and in the actions on broader social determinants of health it supports such as gender empowerment and employment initiatives, also positively affect women's health outcomes. CPHC health reforms should also improve referral to secondary or tertiary care, an issue with respect to emergency obstetric services. To the degree that CPHC extends its work locally and nationally across sectors responsible for other major causes of ill-health (e.g., environment, workplace, social protection), it can ensure that these policies are gender-equitable and are designed to meet the health needs and health risks that may be differentiated by sex. Improved program and political forms of participation, partly through giving 'voice' to historically excluded groups, is an element in reforms in both sites. These are examples only of the types of gender issues that were monitored as part of the CPHC roll-out in all three sites, including a baseline situational analysis.

6. Project Outputs

The volume, comprising findings from our teams and literature review, will offer some novel insights into CPHC practice. Despite the contextual differences amongst the different country studies, the similarity in many of their findings attests to certain generalizable characteristics of the abilities of health systems to create and sustain CPHC practices that embody actions on key public health and social determinants of health issues. In summary, some of these are:

- well-trained and supported community health workers are able to work effectively with marginalized communities;

- health system managers and policies that support the importance of work on social determinants of health, community accountability and resource transfers make for strengthened CPHC;

- effective mechanisms for community participation, both informal (through participation in projects and programs, and meaningful consultation) and formal (though program management structures) are paramount in rolling out CPHC ;

- co-partnership models in program and policy development prove helpful; and

- the importance of support for community advocacy and engagement in health and social systems decision-making.

These lessons were brought to the forefront in the book and provide a rich evidence base from which future CPHC reform initiatives can draw, no matter their country setting.

The book provides an evidence-based summary of promising practices which can be scaled-up and implemented. We anticipate the audiences most likely to be interested in the book will be:

- ministries of health and any other ministries from related sectors whose policies influence health in some way (e.g. transport, education, social welfare);

- local and national organisations, associations or licencing institutions relevant to health (e.g. nurses' associations);

- networks of non-governmental organisations (particularly in developing countries whereh such organisations frequently organize and provide health care to communties). An example would be Medicus Mundi;

- individuals who are skilled professionals or are in policy-making positions in governments; and

- the academic community.

7. Project Outcomes

A compilation volume, approximately 220 pages in length, was completed. It consists of 15 full chapters, five boxes offering a highly synthesized snapshot of CPHC initiatives, figures and tables. A copy of the table of contents of this volume is provided in Annex 2. Should the book currently under review be accepted by the academic publisher, we will be able to track sales. In order to boost potential sales, we will send a flyer of the book throughout our networks.

Should we e-publish the book, we will track the number of unique visitors to the web pages of the e-book. While this may not be indicative of its application, it will demonstrate the degree of interest in the subject of CPHC. Google analytics will enable us to track the countries from which views were made. RHFA teams will be informed if there is a particularly high number of views emanating from their countries, which will suggest that they should take up opportunities to raise awareness among knowledge users within their countries of their CPHC findings and attempt to increase traction for CPHC reform. Google analytics will also demonstrate which chapters are most popular among visitors to the e-book. We will monitor this and determine whether there are patterns in the popularity of chapters. For instance, if there are consistently more visitors to chapters addressing community health workers or community engagement in CPHC efforts this will suggest interest in certain CPHC themes or components. The co-PIs will inform the authors of these chapters as it would suggest more knowledge sharing activities should be undertaken.

8. Overall Assessment and Recommendations

In terms of "assessment" we encountered a number of challenges in compiling this volume from which we can derive recommendations for future similar projects.

As we have alluded above, some teams had difficulties writing chapter length texts, of high enough quality for inclusion in the book. The editors resolved this by drafting summaries of approximately one page in length of the lessons learned by these teams. These summaries were presented in the volume in the format of boxes rather than chapters.

Recommendation: Expect variations in the ability of non-English mother tongue contributors and plan for how their contributions can still be included in the publication. Arrange and budget for professional translation of contributions where possible.

Some teams (particularly our indigenous collaborators) required permission from their communities to include their findings in this publication. This was more time-consuming and burdensome than expected.

Recommendation: Schedule enough time for contributors to seek and obtain permission from their communities where necessary.

Finally, we learned that we had to provide sufficient time for the teams to work as a team together to consult and comment on drafts. Many team members worked in different locations and cities and therefore had little or no time to work together on drafts.

Annex 1

Literature Search Parameters - Analytical Framework and Literature Review Guidelines

Based upon the research questions that drive this initiative, there are a number of outcomes or pathways for which search terms should be created.

The 'highest' order research question concerns:

1. What is the effectiveness of comprehensive primary health care on:

- increased equity in access to health care and other services/resources essential to health
- reduced vulnerabilities through changes in community empowerment (capacities)
- reduced exposures to risk through changes in social and environmental determinants of health
- improved participatory mechanisms and opportunities and political capabilities of marginalized population groups reached by comprehensive primary health care initiatives
- increased community resilience to enable effective responses to promote and protect health
- equitable increase in population health outcomes

The potential pathways by which these outcomes might be affected by CPHC strategies are represented in the preliminary Conceptual Model in our proposal (see next page).

Several issues need to be considered when searching for literature related to these outcomes.

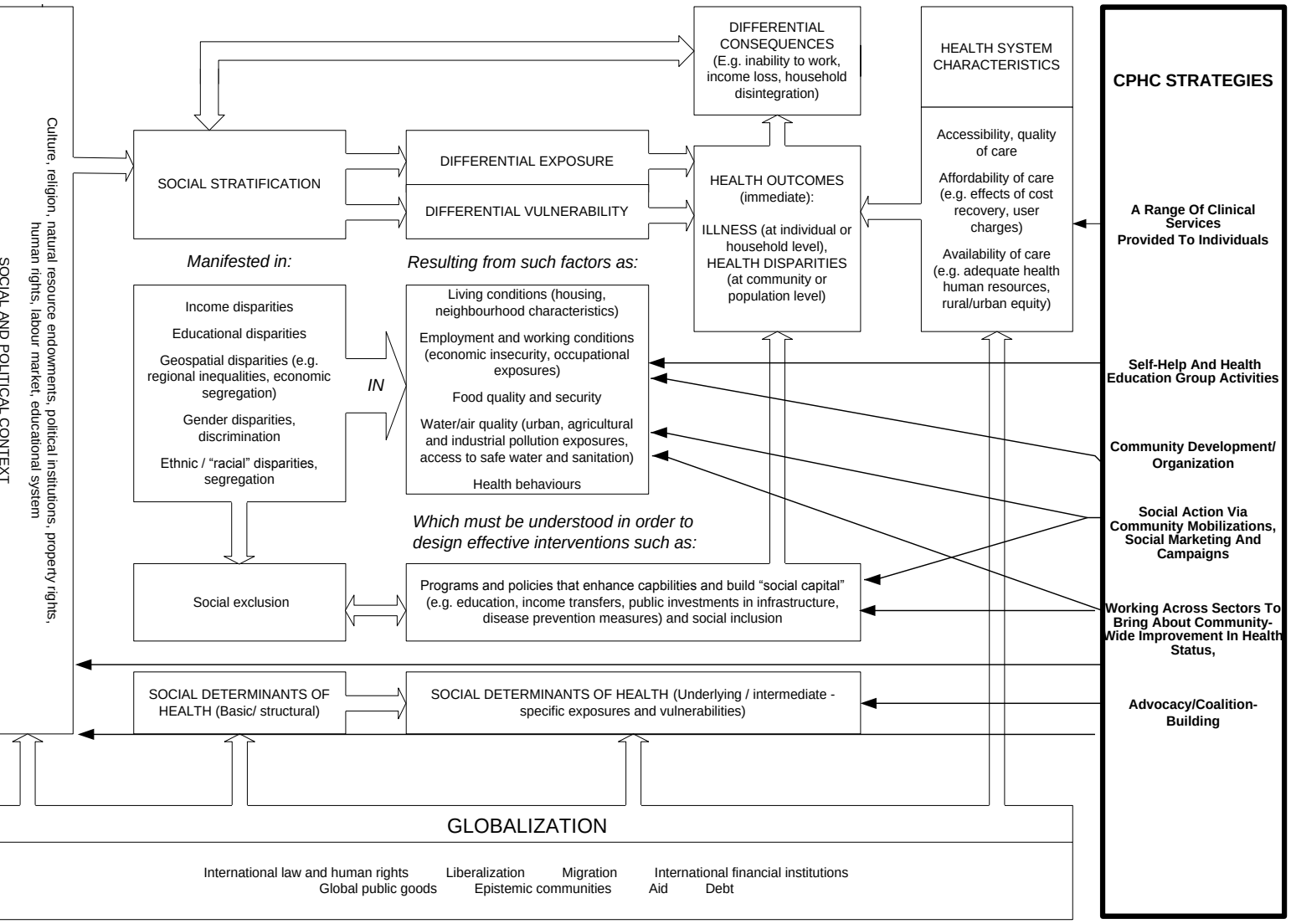
First, it is unlikely that most of the documented efforts have embodied 'comprehensive' primary health care.

Second, much of the literature which refers to 'primary health care'is really about primary medical care rather than 'comprehensive primary health care;' and may also use terms such as health promotion, public health, community health, community-based health and so on. The discriminating feature to look for is that (a) the services include primary care and (b) the services are not restricted to primary care but include a variety of educational, organizational,

intersectoral or policy/advocacy initiatives aimed at the determinants of disease, and to the social and environmental determinants of health more broadly.

Third, there are likely to be a number of lists or identifications of these determinants. Noting the determinants being addressed by the service/program will be important data to capture in the review.

Fourth, our initial list of CPHC strategies is non-exhaustive; there may be other strategies considered to be part of CPHC (or primary health care, or whatever terms are used to describe the services/programs). Noting what strategies are being used will be important data to capture in the review.



Fifth, it is unlikely that there will be much *direct* evidence related to the outcomes above; rather, judgements (inferences) will need to be made on what types of outcomes were targeted by the services/programs and how or where in the larger set of pathways in the draft Conceptual Model these outcomes 'fit'.

Sixth, details on the relationships with community members (how participatory, which groups) and which institutional (governmental or formal civil society) sectors are important to capture. A simple ranking scheme for citizen participation (low, medium, high) will be developed for this purpose.

2. To what extent will an international capacity building program on research skills for CPHC, facilitated by the People's Health Movement (PHM) and involving practitioners, managers and policy makers, contribute to strengthening the evidence base for the effectiveness of CPHC?

In answering the above two questions, we will attend to, and develop new knowledge on:

- What strategies or mechanisms used by CPHC in different contexts work best to achieve the outcomes specified above.
- How the development level and political and policy context of countries, or within-country inequities in wealth and/or regional differences in policy, affect these impacts.
- What combinations of resources, policy and state/civil society/university relationships facilitate and sustain appropriate and effective comprehensive primary health care.
- What types of strategies or forms of mobilisation have secured the above resource and organisational arrangements.
- What are the enabling and constraining international conditions for establishing sustainable comprehensive primary health care systems, including a consideration of how the macro-economic and health sector reform (HSR) policies, concepts and methods of the industrialized countries and international financial institutions have influenced these international conditions.
- What research skills and methodological approaches are necessary to underpin the effective operation of CPHC and the production of a convincing evidence base.
- What is the role of locally conducted research projects in contributing to development of local CPHC systems and to the international evidence base on CPHC.

3. What approaches to research, and what research/evaluation tools and methods, are most useful in advancing understanding of, and action on, CPHC implementation?
Under this broad third question, we anticipate a number of important questions to arise from new local projects developed by research teams participating in our training courses. An indicative set of questions, based on discussion with our strategic research users, include:

- What program evaluation methods are most suited for use in a CPHC setting?
- How can the effectiveness of community empowerment in CPHC be measured?

- What research and implementation knowledge, skills and values may be required for the advocacy component of CPHC in particular contexts?
- To what extent do existing methods of quality assurance designed for community health settings capture the effectiveness of CPHC?
- How can health information systems be modified to take greater account of local and culturally-specific health frameworks and indicators, particularly for Indigenous groups?
- What is the cost-effectiveness of CPHC in particular settings?
- To what extent do the health care reform processes being implemented in particular settings support the implementation of CPHC?
- What indicators can be used to measure the extent to which a health system has re-orientated towards CPHC?

Literature Review Guidelines

Emphasize grey literature; source out (strategic search, contacts) programs that appeared comprehensive but only a 'slice' reported in scientific literature; use key informants, including contact with persons from extremely good cases that might be highlighted in the regional synthesis reports; examine some previously 'discarded' policy analysis reports on PHC to guide the contextualization of the synthesis report; contact those who signed to the original proposal; review of previous reviews, notably the infant/child health review.

Draft Final Regional Synthesis Report due end of April (or earlier), for comment from others; circulate to all regional groups and to David, Ron, Corinne, Nikki

All to review all reports with some comments; skype or elluminate call late May for feedback

Final by end of May (must be at least two weeks before start of first training)

Global overview paper by end of June or July, depending on release of WHR 2008

Annex 2

World Lessons in Comprehensive Primary Health Care Reform

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