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Improving child health and nutrition through primary health care

Poor child health and nutrition impose significant economic and human development costs. The challenge in improving child health is not primarily the lack of science or knowledge, but failure to deliver known, effective public health actions such as clean water and immunisation.

In the last two decades, a decrease in the rate of improvement in child health has led to widening inequalities in survival and quality of life between richer and poorer groups. Over ten million children under five still die every year, 99 percent of them in developing countries.

A report from the Childhood Poverty Research and Policy Centre (CHIP) in the UK examines the policies and factors behind child health outcomes. The immediate causes of childhood illness and death are diarrhoea, pneumonia, malaria and HIV/AIDS, all often in association with undernutrition. However, there are underlying factors such as low incomes, poor female education, unhealthy environments (housing, water, sanitation) and inadequate access to quality health services. These demonstrate growing inequalities between and within countries, in turn influenced by macroeconomic factors such as rising external debt, structural adjustment programmes, unfair terms of trade and declining levels of overseas aid.

Despite these factors, there have been some successes in large-scale, comprehensive child health and nutrition programmes. Examples include Jamkhed and Kerala (India), Ceará and Pelotas (Brazil), and the Bangladesh Rural Advancement Committee. Such programmes have taken advantage of technical advances to deal with childhood illnesses. They have also targeted poor people, combining social policies with participatory approaches.

More specifically, these successes have been achieved through:

- applying the key primary health care concept that health improvements result from a reduction in the effects of disease (morbidity and mortality) and its incidence
- education for all, with emphasis on female education
- commitment to equitable distribution of health services
- guaranteeing adequate calorific intake (enough food) without limiting indigenous agricultural activity
- providing effective child growth monitoring and promoting breastfeeding and energy- and nutrient-rich weaning diets based on commonly available local foods
- strengthening public health systems by addressing financing gaps, preventing health worker emigration to developed countries, avoiding approaches (for example to deal with HIV/AIDS) that are not integrated with existing systems, and invigorating district and community level provision of health care.

Lessons should be learnt from public health successes. The authors recommend:

- the development of well-managed and comprehensive programmes involving the health sector, other social and economic sectors and communities, at household, community and district levels: there should be investment in health centres and their personnel, possibly through community health worker schemes
- targeted investment in infrastructure, personnel and management, and information systems, beginning with training district-level personnel
- partnerships with non-governmental organisations specialising in community development.

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'*Child health and poverty*', CHIP Working Paper No 10, by Mickey Chopra and David Sanders, 2004

Paid to be healthy in Honduras

Effective preventive health care is not reaching the mothers and children most in need. One reason for this is lack of demand for services. In parts of Latin America, families are being paid to be healthy.

Results from Mexico and Nicaragua, where direct payments are made to poor families on condition that they keep up with preventive health measures, show a significant improvement in the coverage of services. But would the improvement be similar, or greater, if the money was invested in improving basic services? In 2000 the Government of Honduras implemented a health programme that included a randomised trial to test this.

The programme included activities to increase demand for preventive health care for pregnant women, new mothers and children under three. The study measured the rates of use of health care facilities, along with the proportion of women and children covered by immunisation and growth monitoring services.

Two sets of interventions were designed: one included direct payments for regular attendance at health checks (the household level package); the other was aimed at strengthening health services (the service level package). The programme covered 70 mountainous, rural municipalities with a total population of 660,000 people.

Significant findings include:

- In 2001, 79 percent of eligible households received their payment vouchers, whereas only 17 percent of payments were made to community health teams.
- Groups receiving the payment vouchers showed an 18 to 20 percent increase in uptake of antenatal care and child check-ups. No increase occurred with the service level package.
- The household level package showed increases in coverage of some vaccines.
- Government statistics showed a marked increase in service use in municipalities with the service level package, but this was not specific to the targeted age groups. There was increased use of services for children, but not for antenatal care, in municipalities with the household level package.
- An unexpected side-effect saw the proportion of women reporting a pregnancy decrease in service level groups.

Lessons for policy are:

- Conditional direct payments to poor households in disadvantaged areas can increase the use of preventive health care services.
- The increased attendance for child check-ups allowed more regular immunisation and growth monitoring.
- Transferring resources to hard to reach primary health care services proved difficult both legally and logistically.

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'Monetary incentives in primary health care and effects on use and coverage of preventive care interventions in rural Honduras: cluster randomised trial', *The Lancet* 364: 2030-2037, by Saul S. Morris et al., 2004

Building patient–provider relations in Sri Lanka

Good relationships between users and providers are key to effective health care provision because they encourage people to use services. Research in Colombo, Sri Lanka, shows that different factors create trust in public and private providers among poor residents. .

The Sri Lankan Government has invested heavily in public health care, producing well trained health professionals and an extensive network of free to access services. But are these services trusted over private sector alternatives? How does trust and utilisation of public versus private sector providers affect household spending on health care?

Research by the University of East Anglia, UK looked at treatment seeking behaviour in two poor urban communities through interviews and focus groups, a survey of 423 households and 2,197 individuals, and in-depth case studies of 16 households over eight months.

The study found that:

- 98 percent of hospital admissions are in the public sector. People from a range of backgrounds use public providers for serious illnesses because services are free and they trust their technical competence at both personal and institutional level.
- For chronic illnesses requiring regular outpatient visits, public providers are used more frequently than private ones, except among the 'better-off' group.
- Unsatisfactory interpersonal care in the public sector means many residents, including some of the poorest, prefer private providers for moderate acute illnesses.
- People are willing to pay for private services because they save time, doctors listen and they can build better relationships with private doctors.
- People have confidence in the competence of their private family doctor, most of whom have trained and also work in the public sector.

Monthly household spending on treatment is considerably higher for outpatients with acute illness than for hospital admission or regular treatment of chronic illness. In low income households, treatment costs often go beyond household budgets, forcing borrowing, or pawning or sales of assets. So policymakers need to work to sustain trust in public hospitals and rebuild trusting relationships in the public health system if they wish to meet targets for coverage and financial protection.

The public health system has strengths that include good medical training and professional standards and has achieved high levels of service coverage, equitable access and benefits for poor people, including remarkable health outcomes. This has generated widespread trust in public health services. However, this trust in technical quality of care is undermined by poor interpersonal quality. Recommendations for building trust and ensuring equitable access include:

- shifting public spending from tertiary hospitals to public family doctors
- providing financial incentives for public sector doctors to work in user-friendly environments
- developing regulations to ensure private sector quality and affordability, possibly through a national accreditation scheme.

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'Treatment-seeking behaviour in urban Sri Lanka: trusting the state, trusting private providers', *Social Science and Medicine* 61: 1396-1407, by Steven Russell, 2005

Bringing gender to bureaucracies Experiences from African ministries of health

The integration of a gender focus into sector-wide approaches for development (SWAps) presents a number of challenges and opportunities. Case studies of health SWAps in four sub-Saharan African countries suggest that the approach has raised the profile of gender in ministries, but has not yet received the support or capacity to fully integrate gender equity into policy.

Sector-wide approaches (SWAps) involve governments taking a leading role and ownership of development and expenditure programmes for entire sectors such as health. SWAps feature partnerships working between governments, civil society and donors.

The concept of gender mainstreaming as a strategy to promote gender equity is complex. It implies that gender should be included at every stage of the planning and implementation of policies. Different languages used by the various actors that come together as part of SWAps can complicate policy processes.

Researchers from the Liverpool School of Tropical Medicine, Southampton University and the Institute of Development Studies, UK, outlined the achievements and challenges of introducing gender mainstreaming in SWAps. They drew on the experiences of ministries of health in Uganda, Ghana, Malawi and Mozambique. They found that:

- A number of SWAps have made great progress in integrating gender into key policy documents and plans. This creates the legitimacy necessary for the implementation of practical policies towards achieving gender equity.
- The increase in specialist staff working on gender mainstreaming has often resulted in the creation of special advisors in this area. However, they do not always have the resources to carry out their brief and have limited influence over decision makers.
- Health ministries often show a narrow understanding of what gender mainstreaming means. It is necessary to develop training and capacity building to identify gender issues that fits with the needs of each SWAp.
- Although some improvements have been made in the availability and adequacy of health indicators that are gender sensitive, these are neither exhaustive nor consistent.
- There were few cases of funds being used to finance gender training and gender sensitive research. This might be due to misunderstanding and hostility towards gender mainstreaming.

In sum, the study found that SWAps have brought about a renewed impetus for gender mainstreaming. However, the challenges that remain are related to actors' different understandings of gender mainstreaming. The article argues for an awareness of the ways in which institutional, personal and political experiences shape understanding of gender mainstreaming. The specific policy implications include the need for:

- supporting gender mainstreaming advisors as part of a wholesale human resources structure that supports gender mainstreaming
- increasing capacity building for gender sensitive practices within each SWAp
- increasing and improving health indicators that are disaggregated by gender
- sustainable financing of gender mainstreaming activities.

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'Engendering the bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches' *Health Policy and Planning* 20(3): 141-149, by Sally Theobald, Rachel Tolhurst, Helen Elsey and Hilary Standing, 2005

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