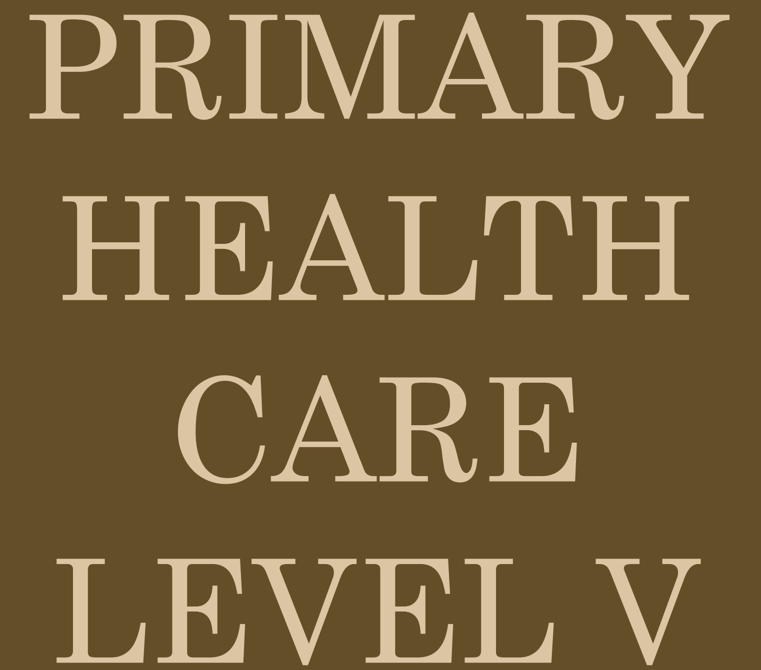


PRIMARY HEALTH CARE LEVEL V

COMPILED BY

EFFIE NAILA

INTRODUCTION TO PRIMARY HEALTH CARE

BY: DR. ATELA

DEFINITIONS

- **Health**: this is a state of complete, physical, mental & social well – being & not merely the absence of disease or infirmity.
- **Primary Health Care**: this is essential/ basic health care based on practical, scientifically sound & socially acceptable methods & technology; that is made universally accessible to individuals and families in the community through their full participation & at a cost that the community can afford to maintain at every stage of their development in the spirit of self – reliance & self – determination.

Cont.

- The PHC level is the first, nearest and local point of contact that individuals have with the health care system.
- It basically provides comprehensive community based and accessible care that responds to the needs of individuals throughout their lives.
- In other words, PHC is the 1st thing an ordinary villager does for himself right in the home to avoid getting sick. It is self – help and its emphasis is on prevention & control of diseases as well as promotion of health.

- The term PHC first gained prominence from the writings of a scholar by the name Newell titled, ‘Health By The People (1975)’.
- In his writing he describes health by people to constitute 2 main things:
  1. Several community based programs that involved community level workers.
  2. Using the examples of large scale programs and country experiences especially from China that describe how people responded to their own health needs.

Cont.

- Prior to the Alma – Ata meeting in 1978, “Primary Health care” meant first contact with a doctor.
- WHO & UNICEF in 1978 at the Alma – Ata launched a campaign to achieve “Health for All by the year 2000” through PHC.
- The Alma – Ata declaration broadened the use of the word “primary”, putting greater emphasis upon the community and its “participation, self – reliance & self – determination”.

THE ALMA ATA DECLARATION (Kazakhstan, Sept. 1978)

- This was the 1st international declaration underlining the importance of PHC.
- Newell’s thinking influenced the planning of the Alma Ata which was co – hosted by WHO and UNICEF.
- The PHC approach has since then been accepted by member countries of the WHO as key to achieving the goal of ‘Health For All” by the year of 2000.
- The Lancet in 2008 (PHC), published a series of informative journals on primary health for all and the objective was to check what milestones have been achieved since the Alma Ata declaration.

Cont.

- Based on the phraseology of the declaration, PHC stands for essential care that is:
  - Accessible
  - Affordable
  - Acceptable
  - All – inclusive (integral)
  - Altogether (participatory)
  - At the center (it is the nucleus)
  - Amenable to self – reliant initiative

Cont.

– Furthermore in the Alma – Ata terms of reference, PHC renders the following services:
  – Promotive
  – Preventive
  – Curative
  – Rehabilitative

ELEMENTS OF PHC [Mnemonic: '*ELEMENTS*']

– These are the 8 projects/ programs that promote PHC & they include:

1. Health ***E***ducation
2. Prevention & control of ***L***ocal/ indigenous endemic disease
3. Supply of ***E***ssential drugs
4. ***M***aternal child health & Family planning
5. ***E***xpanded program of immunization against major infectious diseases
6. Promotion of ***N***utrition & food security
7. ***T***reatment of common diseases and injuries
8. Adequate supply of safe water & basic ***S***anitation

Health Education

- This involves teaching the community about basic health care needs & what is expected out of them. The community is enlightened on prevailing health problems as well as methods of preventing & controlling them.
- This is done in a language that the people understand.

Cont.

Expanded program of immunization against major infectious diseases

- Many children die or become mentally or physically disabled because of 6 diseases which can be prevented by immunization:
  1. TB
  2. Poliomyelitis
  3. Diphtheria
  4. Whooping cough
  5. Tetanus
  6. Measles
- Children are therefore immunized against these major infectious diseases.

Cont.

Maternal child health & Family planning

- Healthy mothers are more likely to have healthy children.
- Antenatal & under – 5 services are therefore provided.

Supply of Essential drugs

- The most needed drugs should be available & affordable.
- Essential drug programs to treat majority of the illnesses of the people are necessary.

Cont.

Adequate supply of safe water & basic sanitation

– This is done, for example, by identifying water sources, constructing boreholes & maintaining them.

– Clean waste disposal is vital.

PRINCIPLES OF PHC

- Universal accessibility and coverage based on need
- Comprehensive care
- Community & individual involvement and self – reliance
- Inter – sectoral action for health
- Appropriate technology & cost – effectiveness in relation to limited resources

Universal accessibility and coverage based on need

- This is in reference to the principle of equity in health care which is derived from the norms of social justice
- The idea behind this is 'from each according to their ability, to each according to their need'
- When one allocates resources for health e.g. workforce, medical equipment etc., they need to consider the needs of individuals. In other words, to those who need more, more should be given.

Assignment: look at the MOH website and check the distribution of health workers across the country according to counties and evaluate whether the distribution is in tandem with the principles of equity.

Cont.

- The principle of **comprehensive care** emphasizes not on the curative but on disease prevention & health promotion.
- Regarding the principle of **community & individual involvement and self – reliance**:
  - Communities should be involved in decisions that affect themselves
  - They should be empowered to contribute in health planning.

Inter – sectoral action for health

- PHC is dependent on inter – sectoral synergy.
- The MOH & the MOE can, for instance, combine efforts to deal a blow to the disease burden in the country.
  - Teachers should be trained on how to handle basic illnesses amongst children.
- The economic sector could invest in parameters that promote health.
- The ministry of labor could invest in policies that protect workers at the workplace.

Cont.

- The government could provide clean water and sewerage services to stall diseases such as cholera
- Girls could be provided with sanitary towels so that they can stay in school. This delays child birth and prevents unwanted pregnancies.
  - Concerted efforts to ensure that early pregnancies are prevented goes a long way in the health of women. Give them equal opportunities to acquire education.
  - A woman that has gone to school will know how to take care of their children. This reduces the infant mortality rate.
- Health is not the sole responsibility of nurses and doctors.

PHC & THE SOCIAL DETERMINANTS OF HEALTH

- The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
- PHC has a dual role. It also affects the social sectors.
  - 'it can be seen that proper application of PHC will have far reaching consequences, not only throughout the health sector, but also other social and economic sectors. Moreover it will greatly influence communities. Resistance to such change is, therefore, to be expected' *Alma Ata declaration of 1972*

Cont.

- Restoration of health begins at the household level; communities should therefore be empowered to take charge of their own health.
- The Alma Ata declaration talks about comprehensive PHC.
- By comprehensive PHC, the Alma Ata declaration refers to care that addresses the main health problems in the community by providing promotive, preventive, curative & rehabilitative services accordingly.
  - At individual level, the focus is on rehabilitative & curative services whereas at population level, it is on preventive and promotive services.

Cont.

- Promotive PHC addresses basic socioeconomic and political causes of ill health.
- It does this through advocacy & lobbying the government and policy makers.
  - This has been instrumental, for instance, in policies regarding tobacco smoking & provision of safe water.

THE CHILD SURVIVAL & DEVELOPMENT REVOLUTION

– After the Alma – Ata declaration was established in 1978 promoting health as a human right as well as PHC, **Walsh & Warren** proposed selective PHC as a subset of PHC that is intended to be more attainable. Selective PHC is the basis of GOBI – FFF & the child survival revolution.

– The revolution was an effort started by UNICEF (but joined by others) to reduce child mortality in the developing world. The effort lasted from 1982 to the 1990s.

– It included various programs and conferences, including the World Summit for Children in 1990. Rather than treating child mortality as a measurement of development, the effort sought to directly reduce child mortality as a way toward development.

The GOBI – FFF strategy

– For much of the revolution, UNICEF adopted a strategy known as the **GOBI – FFF**, a form of selective primary health care.

1. **G**rowth monitoring to detect under – nutrition in small children
2. **O**ral Rehydration Therapy to treat childhood diarrhea
3. **B**reastfeeding (this had declined precipitously due to working mothers & **t**he marketing of infant formula)
4. **I**mmunization against the 6 basic childhood diseases
5. **F**amily planning
6. **F**ood supplements
7. **F**emale education

Cont.

- Of the above, immunization & ORT were seen as the twin – engines of the child survival revolution.
- After 1986, vitamin A administration also became a focus.

Challenges of PHC

- At the point when the declaration was made the world was just coming out of economic crisis (1978 – 1980s).
  - Oil crisis of the 70s
- PHC did not, therefore, enjoy the economic support that was expected as spending was limited by many countries
- Structural adjustment programs/ policies (SAPs)

Cont.

- Health systems that focus disproportionately on narrow specialized curative care
- Health systems where command and control focused on short term results and fragments service delivery (vertical approach to care delivery)
- Health systems where laissez faire approach has enlarged.

Structural Adjustment Programs/ Policies (SAPs)

– These were economic programs imposed on developing countries. They required that countries had to cut down on spending so as to gain economic support from the developed countries & the IMF.

– **DISCUSS: In relation to the above, what was referred to as 'economic prostitution' in developing countries?**

Health sector reforms: Components include -

- Actions that improve the performance & delivery of services
- Decentralization of health: spreading control of health to the periphery
- Broadening the health financing options
- Working with the private sector (Public – Private Partnerships, PPPs)
- Adopting sector – wide approaches to planning
- Improving the functions of the national MOH
- Universal delivery of a core set of essential services

The objective of health sector reforms is to achieve efficiency through -

- – Rationalization of staff
- – Delivery of core essential services
- – Greater involvement of private non – profit centers
- – Achieving decentralizations

– **DISCUSS: What are the challenges of a health system that is not people – focused?**
  - Profit – driven
  - Uncoordinated and places unnecessary demand on government resources

Task shifting

- This refers to a process of delegation whereby tasks are moved where appropriate to less specialized health workers.
- This draws from a WHO recommendation, 'optimizing health worker roles to improve access to key maternal and newborn health interventions through task – shifting’
- **DISCUSS: How has task – shifting been aimed at in PHC**
  - **Community Health Workers**

Documents & facts to look up:

- KEPH (Kenya Essential Package for Health)
- ‘Primary health care now more than ever’ WHO report 2018 – worrying trends
- The Alma Ata Declaration
- Medical elitism:
  - medicine tends to be over – specialized and has a vey top – down approach in contrast to community participation.
- Universal Health Coverage
  - This provides, accessible; equitable; quality health as well as financial risk protection.

THE KENYA HEALTH CARE SYSTEM

BY DR. ATELA

History:
After independence, we had a 3 tier health care system -

National level: Provincial → local level

Religious - based/ missionary level: Operated at the district & sub-district level

Local government

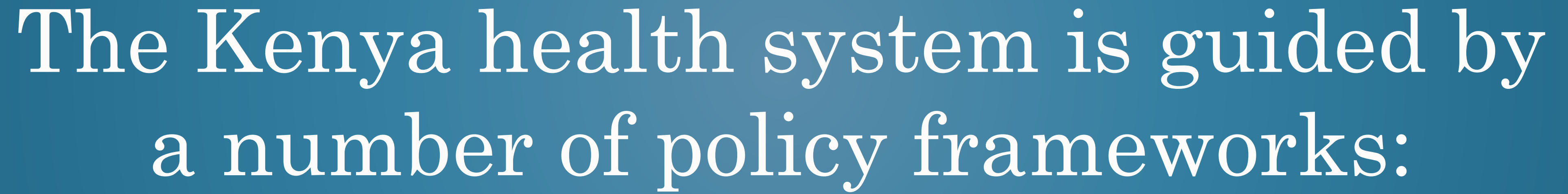
Cont.

- In 1965, NHIF was introduced
- In 1970, the government established a comprehensive rural health service system characterized by the health center being the crucial point for preventive, promotive and some limited curative services.

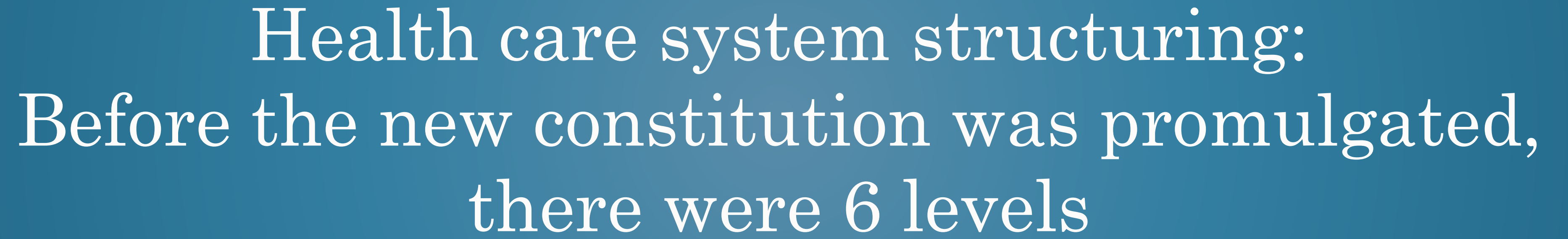
Cont.

- In 1989, the government introduced user fees. i.e., cost – sharing/ out of pocket expenditure.
  - At the time the concept was called 'the 10 – 20 rule' i.e. one pays 10 Kshs. at the dispensary (where more basic services are offered) & 20 Kshs. at the health center.
  - This rule was introduced as a way of dealing with the SAPs.

- To provide quality, efficient & accessible services.
- To ensure equity, social and financial risk protection for the community.
- Ultimately, the goal of any health sector system is to improve the health status of the population by reducing mortality and morbidity.



1. The constitution promulgated in 2010 which states that health is a right for everyone.
2. Vision 2030 which is the guiding development blueprint in Kenya.
3. Kenya Health Policy (2014 – 2030)
4. Health sector strategic and investment plan (2012 – 2017)



I. Community
II. Dispensaries
III. Health centers
IV. District referral hospitals
V. Provincial referral hospitals
VI. National referral hospitals:
   - Kenyatta National Hospital
   - Mathare Teaching & Referral Hospital
   - Moi Teaching & Referral Hospital

I. Community
II. Primary care level: Previously, this was KEPH level II & III.
III. County level: Previously, this was KEPH level IV
IV. National level: Previously, this was KEPH level V & VI

Cont.

- If the above categories were to be broken down in terms of the elements of PHC:
  - Curative services, which were offered by national to district referral hospitals under the previous system, are now expected from level III → level V hospitals.
  - Preventive & promotive services are expected from level I & II hospitals.
    - Note that health promotion & prevention does not necessarily mean the absence of the use of any drugs.
    - Consider vaccines which serve a preventive role.

- Alma Ata (1978)
- UN declaration
- Bamako initiative
- Maputo declaration
- International conference & Population Development, Cairo
- Ottawa declaration of health promotion, 1986
- Jakarta declaration, 1987 (Indonesia)
- Nairobi ‘call to action’ , 2009

Why should Kenya adopt PHC?

- What is the level of poverty in Kenya?
  - The proportion of Kenyans living in poverty has fallen by 10.5% in a decade to **36.1%** (Kenya National Bureau of Statistics)
- 70% of the poor live in rural & peri - urban communities in Kenya.

Cont.

– Majority of the population have limited social infrastructure, experience deteriorating health services & a high burden of CD & NCDs.

– Kenya still has a fairly high population growth rate of **2.65%**, which results in high young dependent & urbanized population.

– Gender and regional disparities still plague the country.

Cont.

- There is insufficient involvement of communities in particular decisions of health and a generally weak health care delivery system esp. at the lower levels.
- There's also insufficient availability of motivated & highly skilled human resources, limited leadership for health & a weak interface between communities and the formal health care delivery system.

Community Health Strategy (2006)

- The Kenya Community Health Strategy is the key document that supports the country in implementing/ delivering PHC.
- It is based on the key principles of PHC, primarily that the individual and collective involvement and participation of people is at the center of health development.
- It is also based on the fact that investments at household level and community levels have enormous impact on reducing morbidity & mortality.

History of the Kenya Community Health Strategy

- It was developed in 2006 to support the achievement of NHSSP II (National Health Sector Strategic Plan II, 2005 – 2010).
- NHSSP I was launched in 2000 – 2004. Its focus was on curative services.
- After implementation of this plan, there were particular indicators that deteriorated. The second plan, i.e., NHSSP II was launched in 2005 to reverse that decline in particular health indicators.
- NHSSP II focused on the following:
  - Preventive & promotive health care
  - Introduction of KEPH
  - Strengthening community participation

How the KEPH is structured

– 1st cohort: pregnancy & newborns up to 28 days → Find out what the package provides

– 2nd cohort: childhood which is 29 days to 59 months → IMCI package kicks in here

– 3rd cohort: children & youth up to 19 years old → Nutrition & mental health

Cont.

- 4th cohort: adulthood 20 – 59 years → This is the time of highest economic productivity
- 5th cohort: 60 years and above → this age is not economic productive but they are enjoying pension.
- The extremes of ages consume more from the economy than they give. These include the 1st 3 cohorts and the last

Cont.

- As a way of strengthening community participation (this was a focus of NHSSP II), the community health strategy (2006) was developed.
- Both NHSSP I & II were blamed for a mainly facility – based intervention focus. At the time, there was a ready & committed pool of workers that were providing health care but there was a lack of structures to link them to higher levels of health care providers.
- The idea of PHC was actually a cost – cutting measure as local human resource & skill would be used. This informs the shift from facility – based care to primary care.

Cont.

- The Kenya Community Health Strategy addresses priority challenges for improving access, utilization & quality of integrated package of health services at tier 1.
- It recognizes that 70% of common conditions are manageable at household & community levels.
- The strategy recognizes the cost – saving potential associated with utilizing local knowledge system, community level volunteers and mobilizing local financing options as well as using local governance structures to deliver care.

What does the community health strategy cover?

- It establishes a service delivery unit called the community health unit.
- It sets quantitative targets for the number of community health workers per population and geographical coverage, i.e., how many CHWs should serve a given number of people within a given geographical distance.
- Puts in place a governance structure community health committees (CHCs).

Cont.

- Provides for community based Health Information System that is linked to the National Health Information System.
- There is a commodity supply system in place to support CHWs.
- Community Health Extension Workers (CHEWs) are deployed with a mandate to supervise CHWs.

Structures to deliver the community health strategy

- The Community Unit (CU)
- Community Health Workers (CHWs)
- Community Health Committees (CHCs)
- Community Health Extension Workers (CHEWs)

The CU

– This is equivalent to a sub – location with a population of about **5,000 persons**.

- These are volunteers elected by community members,
- Their objective is to provide services to households ranging from **10 to 100**.

– These are community members from different interest groups elected by communities to oversee the activities of CHWs.

- These are professionally trained health workers drawn from various cadres in charge of community units.
- They supervise the CHWs.

Documents & facts to look up:

- Integrated Management of Childhood Illnesses (IMCI)
- The Kenyan population pyramid is wide – based. What are the disadvantages of this structure and how can the problems be solved?
- The Kenya Community Heath Strategy (2006)
- Universal Health Coverage
  - The idea behind this is everyone have an access to a minimum package

HEALTH FINANCING FOR PRIMARY CARE

BY: DR. ATELA

Financing options can be divided into 2:

Public sources

- Taxes: Direct & indirect
  - Indirect taxes are like fines, VAT
  - Direct taxes are like PAYE
- Grants & donations
- Deficit financing: government funding by spending by borrowing
- Social insurance

Private sources

- User fees/ OOP expenditure
- Employer financing
- Private insurance
- Voluntary organizations

User Fees

- This concept is about how people finance their own health care.
- These can take different forms:
  - Registration fees
  - Fees for consultation
  - Charges for drugs
  - Payment in kind
- They can also be called fee per episode of illness

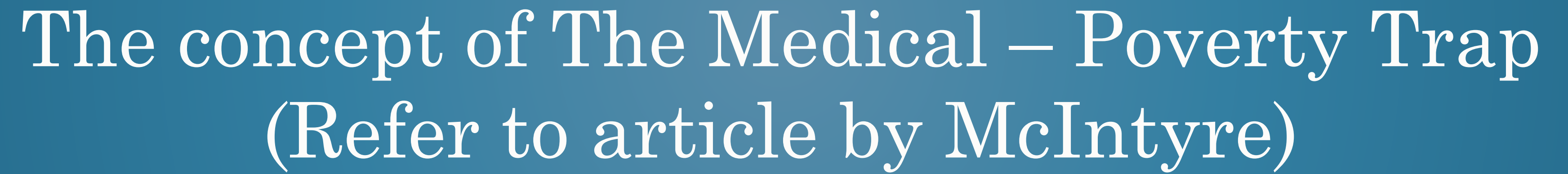
Cont.

- User fees can be supported by pre – payment schemes
  - Communities & individuals come together and pool savings that are used only when one is unwell, e.g. M – wallet
- Various forms of insurance schemes can also support user fees.
- Whenever there are user fees, we have exemption schemes. This is a way of exempting people who are not able to pay the user fees. An exemption criteria can be:
  - A particular disease of public health significance (e.g. TB, HIV in Kenya)
  - High priority services e.g. maternal health care
  - Exemption schemes for the poor

Look up:

- Benefits of user fees
- Goals of user fees

- By Diane McIntyre et. al. in the journal of social science & medicine
  - *"What are the economic consequences for households of illness & of paying for health care in low & middle income country contexts?"*, 2006
  - Social science & medicine issue number 62 of 2006, pages 858 – 865
  - Informal payments for health care in transitioning economies
- User fees at a public health hospital in Cambodia & the effect on health performance By Akasha et. al.
- Health financing to promote access in lower income settings By Natasha Palmer, Lucy Gillson & Mills; published in the LANCET of 2004, issue number 364, pages 1365 - 1370



The concept of The Medical – Poverty Trap (Refer to article by McIntyre)

– The medical – poverty trap is a situation where a health care system/ strategy places considerable emphasis on OOP payments which can have serious economic consequences for low income households especially when the direct costs of medical expenses is combined with a loss of income due to ill – health.

The Medical – Poverty Trap

Perceived illness

If one seeks care they incur:
1. Direct costs like service, medication, transport & nutrition fees
2. Indirect costs

These impact the economics of the household negatively.

Coping strategy:
1. Labor substitution
2. Use of savings to pay for medical needs. This results in a change in the consumption patterns since money for a particular previous pattern is diverted to health care
3. Selling assets
4. Borrowing money

Ultimate consequence: Trapped in poverty due to illness

If one doesn't seek care, there are indirect costs incurred. These include:
1. Time cost
2. Cost for informal health care

Coping strategy:
Most families resort to labor substitution where someone else within the household (or from elsewhere) takes up the responsibility that has been left by the sick person.

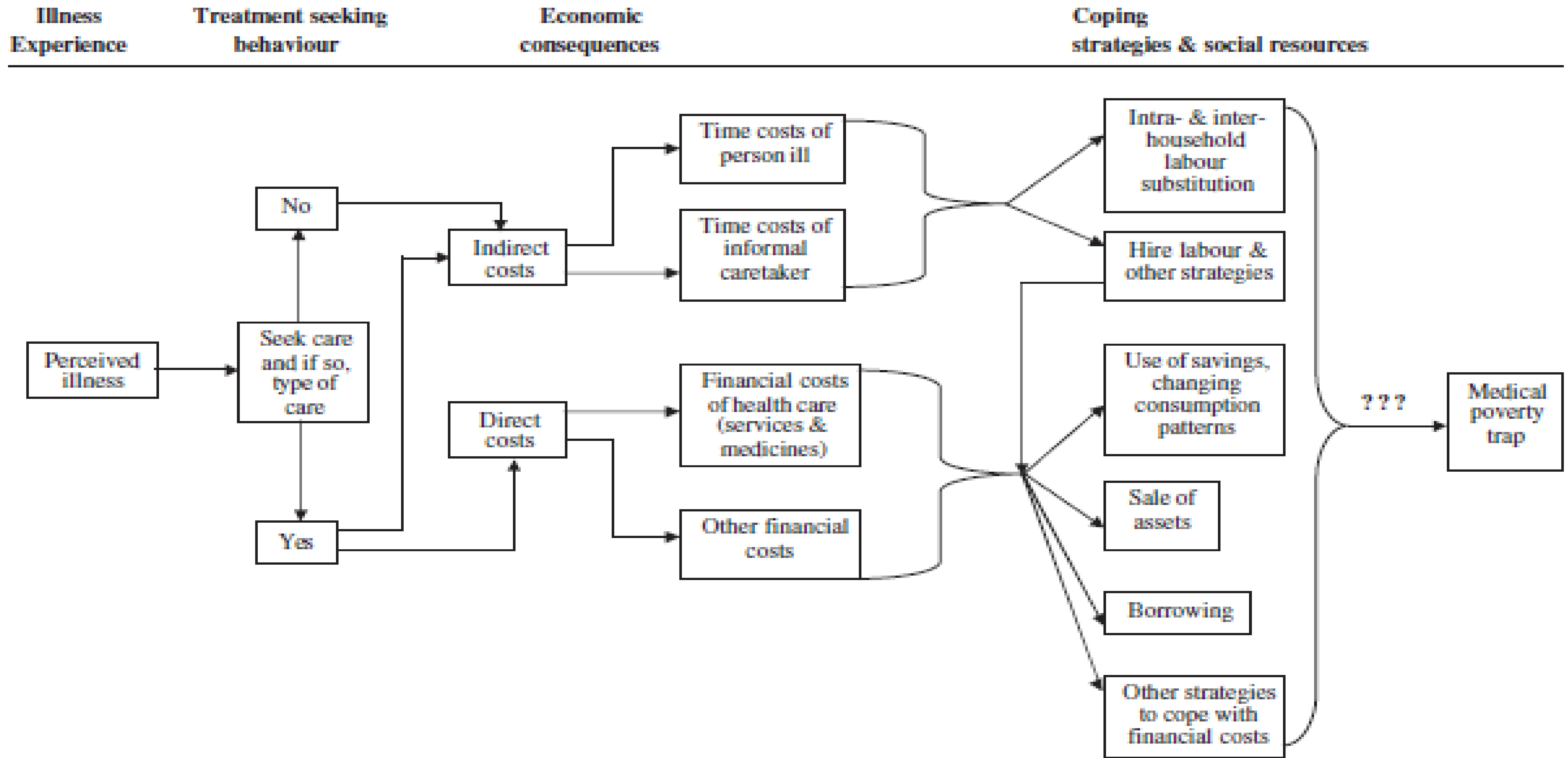


Fig. 1. Simplified flow-chart of key issues relating to the economic consequences of illness.

Medical Insurance: Types include -

- State/ government funded systems e.g. National Health Service in the UK
- Social health insurance
- Community – based health insurance
- Voluntary/ private health insurance

- Financing is from general revenue, i.e., tax that the government raises
- Universal health coverage
  - Everyone has access to a certain minimum health package
- Public health delivery system

Strengths of NHS

- Provides comprehensive coverage
- Provides opportunity for a large scope for raising resources
- There is **potential** (it is not a guarantee) for administrative efficiency & cost control

Weaknesses of NHS

- Unstable funding
- Disproportionate benefits for the rich
  - Taxes are blind, i.e., they don't take into consideration one's wealth status. The rich pay a much lower percentage of their earnings to tax as compared to the poor, yet poor people are more likely to get unwell due to their living conditions.
  - Health should therefore be viewed as a social service & a human right rather than a market economy.
  - Rather than provide a blanket free health care for all, use the resources to enhance the package for the poor.
- Traditional inefficiency
  - This has been the bane of NHS in the UK. It has been accused of bureaucracy

ii. Social Health Insurance e.g. NHIF

- It is an insurance program which meets **at least 1** of the following 3 conditions:
  - Participation in the program is compulsory either by law or by conditions of employment.
  - The program is operated on behalf of a group and access to benefits is restricted to group members.
  - An employer makes the contribution to the program on behalf of the employee.

Characteristics of social health insurance

- Membership is publicly mandated for a designated population
- Financing is mainly through payroll contributions
- Management by non – profit insurance fund with some degree of autonomy from the government
- Existence of a benefits package
- Concept of social solidarity is essential
  - This is referred to as cross – subsidizing in health economics

Strengths of social health insurance

- More resources for the health care systems
- Less dependent on budget negotiations
- High redistributive dimension
- Strong support by the population

Weaknesses of social health insurance

- Possible exclusion of the poor
- Negative economic impact of payroll contributions
- Complex & expensive to manage
- Escalating costs
- Poor coverage for chronic illnesses & preventive care

YOU WILL ONLY BECOME WHAT YOU ARE BECOMING NOW

THOUGH YOU CANNOT GO BACK AND MAKE A BRAND NEW START, MY FRIEND ☺,

ANYONE CAN START FROM NOW, AND MAKE A BRAND NEW END

#JESUSISLORD