Malaria: rocking or rolling back?

Professor William Brieger examines the Progress of malaria control in the forty years since the Alma Ata Declaration

The Concept of Primary Health Care (PHC) was formalised in 1978 when the World Health Organization and Unicef convened a major conference in the city of Alma Ata (now Almaty) in Kazakhstan.[1] The resulting Alma Ata Declaration resulted in advocacy for Health for All, which has evolved into Universal Health Coverage. The Declaration outlined important principles such as community participation in health care planning and delivery, promotion of scientifically sound and acceptable health interventions, the use of community-based health workers (CHWs), and addressing the common endemic health problems in each community. One of those endemic problems common to a majority of communities in Africa is malaria. Now, 40 years after the Alma Ata Declaration, we explore how malaria has progressed within the context of PHC.

Roll Back Malaria also has an anniversary

The Roll Back Malaria Partnership (RBM) began in 1998, 20 years after Alma Ata. When RBM convened a meeting of African Heads of State in 2000, the resulting Abuja Declaration set targets for major malaria interventions of 80% coverage by 2010.[2] The Abuja Declaration reflected the principles of Alma Ata when it called on all member states to undertake health systems reforms to:

1. Promote community participation in joint ownership and control of Roll Back Malaria actions to enhance their sustainability.
2. Make diagnosis and treatment of malaria available as far peripherally as possible including home treatment.
3. Make appropriate treatment available and accessible to the poorest groups in the community.

By 2011, reality had intervened. WHO reported[3] that 'In the 10 years that has passed since the Abuja Declaration, there has been progress towards increasing the availability of financial resources for health at least in terms of dollar values. However, there has not been appreciable progress in terms of the commitments the Africa Union governments make to health, or in terms of the proportion of GNI the rich countries devote to Overseas Development Assistance.' Since that time, funding from international and bilateral donors has levelled, such that there is even greater need for malaria-endemic countries to step forward and guarantee access to malaria prevention and treatment services are available through PHC at the grassroots. Such access needs to move beyond removing barriers to making malaria interventions attractive to the community.[4]

The actualisation of the Alma Ata approach to PHC requires investment. Atkinson et al. reviewed a variety of malaria interventions to learn whether efforts at global malaria elimination could benefit from PHC.[5] First they note that an elimination 'campaign calls for a health systems strengthening approach to provide an enabling environment for programmes in developing countries'. A traditional infrastructure and management approach will not realise the benefits of this (PHC) approach 'unless there is adequate investment in the 'people' component of health systems and understand

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the multi-level factors that influence their participation'. They observed that a people-centered focus in needed in order that 'current global malaria elimination efforts do not derail renewed momentum towards the comprehensive primary health care approach.'

The challenge of taking interventions to scale

Around this same time, James Christopher and colleagues examined how response to malaria and other childhood illnesses were faring 30 years since Alma Ata.[6] After reviewing seven studies of CHWs they concluded that 'CHWs in national programmes achieved large mortality reductions of 63% and 36% respectively when insecticide-treated nets and anti-malarial chemoprophylaxis were delivered, in addition to curative interventions.' They found little evidence of the effectiveness of these community interventions on pneumonia and diarrhoea. The challenge they saw was countries moving beyond successful studies to scale up and sustain community malaria control interventions to the national level and thereby reap the full promises and benefits of PHC.

More recently, Malaria Consortium has looked at the position of malaria control within the context of Community Based PHC (CBPHC) and the use of CHWs as a means for revisiting Health for All.[7] They define key community-based malaria activities including supporting mass drug administrations, mosquito net distribution, seasonal malaria chemoprevention, improving community knowledge of hygiene, sanitation and good health-seeking behaviour, and encouraging uptake of maternal services, such as antenatal care and intermittent preventive treatment of malaria in pregnancy (IPTp). Their report documents that community interventions avert many more child deaths than health facility based services. While noting that CBPHC has great potential, the authors also explain that this will not be attained unless, 'National governments…invest in national CBPHC programmes, but also have an important role in coordinating the various actors delivering CBPHC to ensure synergy rather than fragmentation.'

Ghana's community-based health planning and services (CHPS) programme aims to make primary care accessible at the grass roots. CHPS compounds are small clinics in space usually donated by the community, staffed by community health officers who oversee community-based agents (CBAs) and other community volunteers. Ferrer and co-researchers studied the effectiveness of this system in reaching children in the community who had malaria, pneumonia and/or diarrhoea.[8] Generally the community was satisfied with enhanced access to health services, and home-based care through CBAs increased prompt access to care. Unfortunately there were medicine shortages and inappropriate treatment problems. Better monitoring, supervision and logistical support is needed for such community systems fulfil the ideals of Alma Ata.

Community based, not community owned

Questions have been raised as to whether the seeming strengths of CBPHA and CHW interventions for malaria and other endemic diseases are actually in keeping

with the philosophy and goals of Alma Ata. Druetz at al.[9] look at the upsurge of interest in CHWs in low- and middle-income countries and the World Health Organization's global call to re-establish PHC policy as a 're-framing of this approach rather than its renewal'. Rather than promoting social change and community empowerment, these commentators wonder whether, 'Community case management of malaria perfectly illustrates this shift towards a pragmatic, medically centered, use of CHWs.' In short, 'By conceptualizing CHWs as front-line clinicians rather than as agents of social change, the case management of malaria becomes flawed.'

Along the way another disease control program, the African Program for Onchocerciasis Control (APOC) raised similar concerns. After multi-country community research, APOC arrived at an approach and policy known as Community-Directed Treatment with Ivermectin (CDTI).[10] CDTI was a community decision-making process that selected and oversaw local volunteers, conducted a village census and planned annual ivermectin distributions. Subsequently, another multi-country intervention study found that the CDTI approach could also successfully handle malaria community case management, community-led distribution of insecticide treated bednets and vitamin A provision, and in a couple settings directly observed treatment of tuberculosis. Through this approach, which became more broadly known as Community Directed Intervention (CDI), the community achieved success not by relying on one volunteer CHW, but by actively planning and distributing the tasks among its members.[11] Ironically, a single disease control programme led the way back to a more comprehensive delivery of essential health services through the community's own efforts.[12]

USAID's Maternal and Child Survival Program frames the context for malaria and other interventions clearly in the light of a re-envisioned PHC effort 40 years on:[13]

> *2018 will see the 40 anniversary of the Alma Ata Conference. Though important successes have been achieved in increasing access to health, there is much work to be done. Years of vertical, horizontal, diagonal approaches to primary health care have not yet been successful in providing a fair chance for all women and children to thrive and transform their communities and societies. Are we ready to lead a paradigm shift in health systems thinking? Has*

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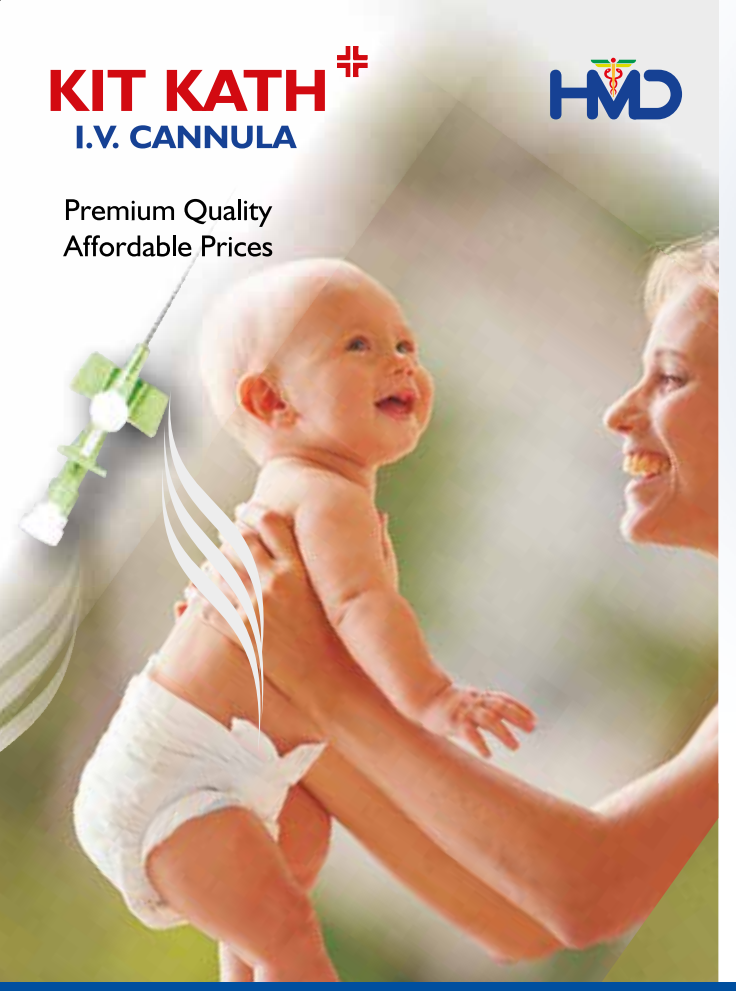

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the time finally come for building robust community health systems– supported by empowered and engaged communities – as a foundation of effective health systems?

Re-invigorating the PHC Approach

For now international donors will play an important role in ensuring malaria interventions reach the grassroots through community PHC efforts. The Global Fund to Fight AIDS, TB and Malaria (GFATM) has fostered the concept of community systems strengthening (CSS) as a supportive component to its basic disease control grants. CSS for Malaria[14] is 'A community-owned response is built on the principle of putting people first and on the belief that people have the capacity to respond, to take charge, to learn from each other, and to change.' CSS stresses community capacity building and a deep understanding of community structures, perceptions, gender and power dynamics, and the ways by which the community mobilises itself, among other components of a 'community system.' For malaria, CSS leads to …

Community-owned responses can potentially establish effective, sustainable links between available commodities, information about these commodities, and community members. Community-owned response can result in improved management of the local environment and efforts to promote appropriate health-seeking behavior, such as organizing transportation for complicated cases. Communities can also take a more active role in demand creation, influencing service provision (by monitoring local need), and regulating the activities of service providers, whether community-based volunteers, traditional healers, private sector vendors or health workers. Community-owned response approaches should, therefore, be used to complement conventional methods of communication and behavior change programming and service delivery.

Controlling and eventually eliminating malaria will certainly go a long way toward helping achieve Health for All. On this 40th Anniversary year of Alma Ata, it is time to ensure that all malaria-endemic countries and malaria donors revisit the basic philosophy of community action and participation and ensure that these principals guide us to accessible and sustainable malaria programming by the community 'through their full participation'.

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