5. Investigating policy and system change over time

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A considerable body of HPSR work focuses on experience at one point in time (see Part 4: Cross-sectional perspectives) and studies investigating (describing and explaining) change over time are more rarely conducted.

Yet health policy change and health system development, around which many HPSR questions revolve, are processes that occur over time. Therefore the contextual influences over health policy and system experience are commonly recognized to include historical factors. Health systems never stop developing or evolving and past experience influences current development – perhaps by limiting or opening possibilities of future change. Indeed, ‘path dependency’ is a notion widely applied in institutional analysis that suggests that what happened in the past directly influences, and limits, the possibilities of institutional change today (North, 1998). Policy analysis theory, meanwhile, recognizes that policy change is a dynamic process evolving over considerable periods of time. For example, punctuated equilibrium theory seeks to explain how and why policy processes are characterized by largely incremental change for long periods of time, remaining fairly stable, but occasionally producing large-scale departures from this pattern of change (True, Jones & Baumgartner, 2007).

Longitudinal perspectives are also particularly important in understanding the complex causality embedded in processes of health policy and health systems change. At a system level, for example, a recently published volume (Balabanova, McKee and Mills, 2011) demonstrates the value of taking a long-term perspective in examining health system development. The country experiences presented (for example from Thailand, Tamil Nadu and India) clearly demonstrate how a range of different decisions and interventions, taken at different times and sometimes with unexpected consequences, accumulate over time to shape the current state and performance of health systems. At a household level, meanwhile, longitudinal work allows for the assessment of the impacts on livelihoods over time of, for example, health seeking behaviour and the associated cost burdens.

But how can change over time be tracked and investigated? The range of possible approaches include prospective tracking of events, or phenomena, over time and retrospective analysis of past events and experiences.

Historical research, for example, “is unusual in ... asking big questions and in dealing with change” (Berridge, 2001:141) and these include “Why and how do we have our current health systems? How and why do they differ from the past?” or “How and for what reasons have different health professions established their areas of competence, and how have boundaries been established?” (Berridge, 2001:141–2). Drawing on documentary, quantitative and oral sources of data, historical work involves interpretive analysis of past experiences and seeks to open up debates rather than to draw direct lessons. In contrast, fixed longitudinal study designs involve repeated measures on the same variables for the same group, or groups, on an extended series of occasions and may support prospective analysis of trends over time (Robson, 2002).

Rigour in studies of the dynamics of policy change over time

The criteria for assessing the rigour and quality of studies examining the dynamics of policy and system change over time will vary with the disciplinary perspective or research strategy adopted and must be appropriate for the particular discipline and strategy (see also Part 2, and the sections in Part 4 relating to the case-study approach and advances in impact evaluation).
References


Overview of selected papers

The papers in this section were chosen to illustrate some of the different approaches that can be used to investigate change over time in health policy and systems experience.

- Brown, Cueto & Fee (2006) address the changing role of the World Health Organization over time. Using an historical approach based on documentary review, they argue that over time and in response to larger political and historical processes, the World Health Organization has sought to reconstruct itself as the coordinator of global health initiatives, rather than being the undisputed leader in international health.

- Crichton (2008) traces the experience over time of a particular Kenyan health policy, using the theoretical lens of policy analysis and what is in essence a process tracing approach.

- Masanja et al. (2008) use statistical trends, based on epidemiological data, to support consideration of the economic burden of illness through case study household research.

- Van Ginneken, Lewin & Berridge (2010) use an historical approach to examine the evolution over time of the South African community health worker programme, drawing on data collected through oral histories and witness seminars.

See also:

Russell & Gilson (2006) in the case-study approach section which reports on prospective studies of Sri Lankan case-study households in which change over time in household livelihoods was tracked and analysed, showing how these impacts were affected by the costs associated with seeking health care.

Wang et al. (2009) in the advances in impact evaluation section which reports a before and after, with control group, evaluation of the impact on health status of a community-based insurance scheme in China.
References for selected papers

http://dx.doi.org/10.2105/AJPH.2004.050831

http://dx.doi.org/10.1093/heapol/czn020

http://dx.doi.org/10.1016/S0140-6736(08)60562-0

http://dx.doi.org/10.1016/j.socscimed.2010.06.009
The World Health Organization and the Transition From “International” to “Global” Public Health

The term “global health” is rapidly replacing the older terminology of “international health.” We describe the role of the World Health Organization (WHO) in both international and global health and in the transition from one to the other. We suggest that the term “global health” emerged as part of larger political and historical processes, in which WHO found its dominant role challenged and began to reposition itself within a shifting set of power alliances.

Between 1948 and 1998, WHO moved from being the unquestioned leader of international health to being an organization in crisis, facing budget shortfalls and diminished status, especially given the growing influence of new and powerful players. We argue that WHO began to refashion itself as an intergovernmental agency that exercises international functions and as an agent in the transition from one concept to the other.

Let us first define and differentiate some essential terms. “International health” was already a term of considerable currency in the late 19th and early 20th century, when it referred primarily to the relationships between nations (i.e., “international”). “Intergovernmental” refers to the relationships between the governments of sovereign nations—in this case, with regard to the policies and practices of public health. “Global health,” in general, implies consideration of the health needs of the people of the whole planet above the concerns of particular nations. The term “global” is also associated with the growing importance of actors beyond governmental or intergovernmental organizations and agencies—for example, the media, internationally influential foundations, nongovernmental organizations, and transnational corporations. Logically, the terms “international,” “intergovernmental,” and “global” need not be mutually exclusive and in fact can be understood as complementary. Thus, we could say that WHO is an intergovernmental agency that exercises international functions with the goal of improving global health.

Given these definitions, it should come as no surprise that global health is not entirely an invention of the past few years. The term “global” was sometimes used well before the 1990s, as in the global malaria eradication program launched by WHO in the mid-1950s; a WHO Public Affairs Committee pamphlet of 1958, The World Health Organization: Its Global Battle Against Disease; a 1971 report for the US House of Representatives entitled The Politics of Global Health; and many studies of the “global population problem” in the 1970s. But the term was generally limited and its...
use in official statements and documents sporadic at best. Now there is an increasing frequency of references to global health. Yet the questions remain: How many have participated in this shift in terminology? Do they consider it trendy, trivial, or trenchant?

Supinda Bunyavanich and Ruth B. Walkup tried to answer these questions and published, under the provocative title “US Public Health Leaders Shift Toward a New Paradigm of Global Health,” their report of conversations conducted in 1999 with 29 “international health leaders.”7 Their respondents fell into 2 groups. About half felt that there was no need for a new terminology and that the label “global health” was meaningless jargon. The other half thought that there were profound differences between international health and global health and that “global” clearly meant something transnational. Although these respondents believed that a major shift had occurred within the previous few years, they seemed unable clearly to articulate or define it.

In 1998, Derek Yach and Douglas Bettcher came closer to capturing both the essence and the origin of the new global health in a 2-part article on “The Globalization of Public Health” in the American Journal of Public Health.8 They defined the “new paradigm” of globalization as “the process of increasing economic, political, and social interdependence and integration as capital, goods, persons, concepts, images, ideas and values cross state boundaries.” The roots of globalization were long, they said, going back at least to the 19th century, but the process was assuming a new magnitude in the late 20th century. The globalization of public health, they argued, had a dual aspect, one both promising and threatening.

In one respect, there was easier diffusion of useful technologies and of ideas and values such as human rights. In another, there were such risks as diminished social safety nets; the facilitated marketing of tobacco, alcohol, and psychoactive drugs; the easier worldwide spread of infectious diseases; and the rapid degradation of the environment, with dangerous public health consequences. But Yach and Bettcher were convinced that WHO could turn these risks into opportunities. WHO, they argued, could help create more efficient information and surveillance systems by strengthening its global monitoring and alert systems, thus creating “global early warning systems.” They believed that even the most powerful nations would buy into this new globally interdependent world system once these nations realized that such involvement was in their best interest.

Despite the long list of problems and threats, Yach and Bettcher were largely uncritical as they promoted the virtues of global public health and the leaders role of WHO. In an editorial in the same issue of the Journal, George Silver noted that Yach and Bettcher worked for WHO and that their position was similar to other optimistic stances taken by WHO officials and advocates. But WHO, Silver pointed out, was actually in a bad way: “The WHO’s leadership role has passed to the far wealthier and more influential World Bank, and the WHO’s mission has been dispersed among other UN agencies.” Wealthy donor countries were billions of dollars in arrears, and this left the United Nations and its agencies in “disarray, hamstrung by financial constraints and internal incompetencies, frustrated by turf wars and cross-national policies.”9 Given these realities, Yach and Bettcher’s promotion of “global public health” while they were affiliated with WHO was, to say the least, intriguing. Why were these spokesmen for the much-criticized and apparently hobbled WHO so upbeat about “global” public health?

THE WORLD HEALTH ORGANIZATION

The Early Years
To better understand Yach and Bettcher’s role, and that of WHO...
TABLE 1—Number of Articles Retrieved by PubMed, Using “International Health” and “Global Health” as Search Terms, by Decade: 1950 Through July 2005

<table>
<thead>
<tr>
<th>Decade</th>
<th>International Health</th>
<th>Global Health</th>
</tr>
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<tbody>
<tr>
<td>1950s</td>
<td>1,007</td>
<td>54</td>
</tr>
<tr>
<td>1960s</td>
<td>3,303</td>
<td>155</td>
</tr>
<tr>
<td>1970s</td>
<td>8,369</td>
<td>1,137</td>
</tr>
<tr>
<td>1980s</td>
<td>16,924</td>
<td>7,176</td>
</tr>
<tr>
<td>1990s</td>
<td>49,158</td>
<td>27,794</td>
</tr>
<tr>
<td>2000–July 2005</td>
<td>52,169*</td>
<td>39,759*</td>
</tr>
</tbody>
</table>

*Picks up variant term endings (e.g., “international” also picks up “internationalize” and “internationalization”; “global” also picks up “globalization” and “globalization”).

more generally, it will be helpful to review the history of the organization from 1948 to 1998, as it moved from being the unquestioned leader of international health to searching for its place in the contested world of global health.

WHO formally began in 1948, when the first World Health Assembly in Geneva, Switzerland, ratified its constitution. The idea of a permanent institution for international health can be traced to the organization in 1902 of the International Sanitary Office of the American Republics, which, some decades later, became the Pan American Sanitary Bureau and eventually the Pan American Health Organization. The Rockefeller Foundation, especially its International Health Division, was also a very significant player in international health in the early 20th century.

Two European-based international health agencies were also important. One was the Office Internationale d’Hygiène Publique, which began functioning in Paris in 1907; it concentrated on several basic activities related to the administration of international sanitary agreements and the rapid exchange of epidemiological information. The second agency, the League of Nations Health Organization, began its work in 1920. This organization established its headquarters in Geneva, sponsored a series of international commissions on diseases, and published epidemiological intelligence and technical reports. The League of Nations Health Organization was poorly budgeted and faced covert opposition from other national and international organizations, including the US Public Health Service. Despite these complications, which limited the Health Organization’s effectiveness, both the Office Internationale d’Hygiène Publique and the Health Organization survived through World War II and were present at the critical postwar moment when the future of international health would be defined.

An international conference in 1943 approved the creation of the United Nations and also voted for the creation of a new specialized health agency. Participants at the meeting initially formed a commission of prominent individuals, among whom were René Cassin from Belgium, Andrija Stampar from Yugoslavia, and Thomas Parran from the United States. Sand and Stampar were widely recognized as champions of social medicine. The commission held meetings between 1946 and early 1948 to plan the new international health organization. Representatives of the Pan American Sanitary Bureau, whose leaders resisted being absorbed by the new agency, were also involved, as were leaders of new institutions such as the United Nations Relief and Rehabilitation Administration (UNRRA).

Against this background, the first World Health Assembly met in Geneva in June 1948 and formally created the World Health Organization. The Office Internationale d’Hygiène Publique, the League of Nations Health Organization, and UNRRA merged into the new agency. The Pan American Sanitary Bureau—then headed by Fred L. Soper, a former Rockefeller Foundation official—was allowed to retain autonomous status as part of a regionalization scheme. WHO formally divided the world into a series of regions—the Americas, Southeast Asia, Europe, Eastern Mediterranean, Western Pacific, and Africa—but it did not fully implement this regionalization until the 1950s. Although an “international” and “intergovernmental” mindset prevailed in the 1940s and 1950s, naming the new organization the World Health Organization also raised sights to a worldwide, “global” perspective.

The first director general of WHO, Brock Chisholm, was a Canadian psychiatrist loosely identified with the British social medicine tradition. The United States, a main contributor to the WHO budget, played a contradictory role: on the one hand, it supported the UN system with its broad worldwide goals, but on the other, it was jealous of its sovereignty and maintained the right to intervene unilaterally in the Americas in the name of national security. Another problem for WHO was that its constitution had to be ratified by nation states, a slow process: by 1949, only 14 countries had signed on.

As an intergovernmental agency, WHO had to be responsive to the larger political environment. The politics of the Cold War had a particular salience, with an unmistakable impact on WHO policies and personnel. Thus, when the Soviet Union and other communist countries walked out of the UN system and...
therefore out of WHO in 1949, the United States and its allies were easily able to exert a dominating influence. In 1953, Chisholm completed his term as director general and was replaced by the Brazilian Marcolino Candau. Candau, who had worked under Soper on malaria control in Brazil, was associated first with the “vertical” disease control programs of the Rockefeller Foundation and then with their adoption by the Pan American Sanitary Bureau when Soper moved to that agency as director. Candau would be director general of WHO for over 20 years. From 1949 until 1956, when the Soviet Union returned to the UN and WHO, WHO was closely allied with US interests.

In 1955, Candau was charged with overseeing WHO’s campaign of malaria eradication, approved that year by the World Health Assembly. The ambitious goal of malaria eradication had been conceived and promoted in the context of great enthusiasm and optimism about the ability of widespread DDT spraying to kill mosquitoes. As Randall Packard has argued, the United States and its allies believed that global malaria eradication would usher in economic growth and create overseas markets for US technology and manufactured goods. It would build support for local governments and their US supporters and help win “hearts and minds” in the battle against Communism. Mirroring then-current development theories, the campaign promoted technologies brought in from outside and made no attempt to enlist the participation of local populations in planning or implementation. This model of development assistance fit neatly into US Cold War efforts to promote modernization with limited social reform.

With the return of the Soviet Union and other communist countries in 1956, the political balance in the World Health Assembly shifted and Candau accommodated the changed balance of power. During the 1960s, malaria eradication was facing serious difficulties in the field, ultimately, it would suffer colossal and embarrassing failures. In 1969, the World Health Assembly, declaring that it was not feasible to eradicate malaria in many parts of the world, began a slow process of reversal, returning once again to an older malaria control agenda. This time, however, there was a new twist; the 1969 assembly emphasized the need to develop rural health systems and to integrate malaria control into general health services.

When the Soviet Union returned to WHO, its representative at the assembly was the national deputy minister of health. He argued that it was now scientifically feasible, socially desirable, and economically worthwhile to attempt to eradicate smallpox worldwide. The Soviet Union wanted to make its mark on global health, and Candau, recognizing the shifting balance of power, was willing to cooperate. The Soviet Union and Cuba agreed to provide 2.5 million and 2 million doses of freeze-dried vaccine, respectively; in 1959, the World Health Assembly committed itself to a global smallpox eradication program.

In the 1960s, technical improvements—jet injectors and bifurcated needles—made the process of vaccination much cheaper, easier, and more effective. The United States’ interest in smallpox eradication sharply increased; in 1965, Lyndon Johnson instructed the US delegation to the World Health Assembly to pledge American support for an international program to eradicate smallpox from the earth.
time, despite a decade of marked progress, the disease was still endemic in more than 30 countries. In 1967, now with the support of the world’s most powerful players, WHO launched the Intensified Smallpox Eradication Program. This program, an international effort led by the American Donald A. Henderson, would ultimately be stunningly successful.21

The Promise and Perils of Primary Health Care, 1973–1993

Within WHO, there have always been tensions between social and economic approaches to population health and technology- or disease-focused approaches. These approaches are not necessarily incompatible, although they have often been at odds. The emphasis on one or the other waxes and wanes over time, depending on the larger balance of power, the changing interests of international players, the intellectual and ideological commitments of key individuals, and the way that all of these factors interact with the health policymaking process.

During the 1960s and 1970s, changes in WHO were significantly influenced by a political context marked by the emergence of decolonized African nations, the spread of nationalist and socialist movements, and new theories of development that emphasized long-term socioeconomic growth rather than short-term technological intervention. Rallying within organizations such as the Non-Aligned Movement, developing countries created the UN Conference on Trade and Development (UNCTAD), where they argued vigorously for fairer terms of trade and more generous financing of development.22 In Washington, DC, more liberal politics succeeded the conservatism of the 1950s, with the civil rights movement and other social movements forcing changes in national priorities.

This changing political environment was reflected in corresponding shifts within WHO. In the 1960s, WHO acknowledged that a strengthened health infrastructure was prerequisite to the success of malaria control programs, especially in Africa. In 1968, Candau called for an organizational study of methods for promoting the development of basic health services.23 In January 1971, the Executive Board of the World Health Assembly agreed to undertake this study, and its results were presented to the assembly in 1973.24 Socrates Litsios has discussed many of the steps in the transformation of WHO’s approach from an older model of health services to what would become the “Primary Health Care” approach.25 This new model drew upon the thinking and experiences of nongovernmental organizations and medical missionaries working in Africa, Asia, and Latin America at the grassroots level. It also gained saliency from China’s reentry into the UN in 1973 and the widespread interest in Chinese “barefoot doctors,” who were reported to be transforming rural health conditions. These experiences underscored the urgency of a “Primary Health Care” perspective that included the training of community health workers and the resolution of basic economic and environmental problems.26 These new approaches were spearheaded by Halfdan T. Mahler, a Dane, who served as director general of WHO from
1973 to 1988. Under pressure from the Soviet delegate to the executive board, Mahler agreed to hold a major conference on the organization of health services in Alma-Ata, in the Soviet Union. Mahler was initially reluctant because he disagreed with the Soviet Union's highly centralized and medicalized approach to the provision of health services. The Soviet Union succeeded in hosting the September 1978 conference, but the conference itself reflected Mahler's views much more closely than it did those of the Soviets. The Declaration of Primary Health Care and the goal of “Health for All in the Year 2000” advocated an “inter-sectoral” and multidimensional approach to health and socioeconomic development, emphasized the use of “appropriate technology,” and urged active community participation in health care and health education at every level.

David Tejada de Rivero has argued that “It is regrettable that afterward the impatience of some international agencies, both UN and private, and their emphasis on achieving tangible results instead of promoting change . . . led to major distortions of the original concept of primary health care.”

A number of governments, agencies, and individuals saw WHO’s idealistic view of Primary Health Care as “unrealistic” and unattainable. The process of reducing Alma-Ata’s idealism to a practical set of technical interventions that could be implemented and measured more easily began in 1979 at a small conference—heavily influenced by US attendees and policies—held in Bellagio, Italy, and sponsored by the Rockefeller Foundation, with assistance from the World Bank. Those in attendance included the president of the World Bank, the vice president of the Ford Foundation, the administrator of USAID, and the executive secretary of UNICEF.

The Bellagio meeting focused on an alternative concept to that articulated at Alma-Ata—“Selective Primary Health Care”—which was built on the notion of pragmatic, low-cost interventions that were limited in scope and easy to monitor and evaluate. Thanks primarily to UNICEF, Selective Primary Health Care was soon operationalized under the acronym “GOBI” (Growth monitoring to fight malnutrition in children, Oral rehydration techniques to defeat diarrheal diseases, Breastfeeding to protect children, and Immunizations).

In the 1980s, WHO had to reckon with the growing influence of the World Bank. The bank had initially been formed in 1946 to assist in the reconstruction of Europe and later expanded its mandate to provide loans, grants, and technical assistance to developing countries. At first, it funded large investments in physical capital and infrastructure; in the 1970s, however, it began to invest in population control, health, and education, with an emphasis on population control. The World Bank approved its first loan for family planning in 1970. In 1979, the World Bank created a Population, Health, and Nutrition Department and adopted a policy of funding both stand-alone health programs and health components of other projects.

In its 1980 World Development Report, the Bank argued that both malnutrition and ill health could be countered by direct government action—with World Bank assistance. It also suggested that improving health and nutrition could accelerate economic growth, thus providing a good argument for social sector spending. As the Bank began to make direct loans for health services, it called for more efficient use of available resources and discussed the roles of the private and public sectors in financing health care. The Bank favored free markets and a diminished role for national governments. In the context of widespread indebtedness by developing countries and increasingly scarce resources for health expenditures, the World Bank’s promotion of “structural adjustment” measures at the very time that the HIV/AIDS epidemic erupted drew angry criticism but also underscored the Bank’s new influence.

In contrast to the World Bank’s increasing authority, in the 1980s the prestige of WHO was beginning to diminish. One sign of trouble was the 1982 vote by the World Health Assembly to freeze WHO’s budget. This was followed by the 1985 decision by the United States to pay only 20% of its assessed contribution to all UN agencies and to withhold its contribution to WHO’s regular budget, in part as a protest against WHO’s “Essential Drug Program,” which was opposed by leading US-based pharmaceutical companies.
tensions between WHO and UNICEF and other agencies and the controversy over Selective versus Comprehensive Primary Health Care. As part of a rancorous public debate conducted in the pages of Social Science and Medicine in 1988, Kenneth Newell, a highly placed WHO official and an architect of Comprehensive Primary Health Care, called Selective Primary Health Care a “threat . . . that can be thought of as a counter-revolution.”

In 1988, Mahler’s 15-year tenure as director general of WHO came to an end. Unexpectedly, Hiroshi Nakajima, a Japanese researcher who had been director of the WHO Western Pacific Regional Office in Manila, was elected new director general.


The first citizen of Japan ever elected to head a UN agency, Nakajima rapidly became the most controversial director general in WHO’s history. His nomination had not been supported by the United States or by a number of European and Latin American countries, and his performance in office did little to assuage their doubts. Nakajima did try to launch several important initiatives—on tobacco, global disease surveillance, and public–private partnerships—but fierce criticism persisted that raised questions about his autocratic style and poor management, his inability to communicate effectively, and, worst of all, cronyism and corruption.

Another symptom of WHO’s problems in the late 1980s was the growth of “extrabudgetary” funding. As Gill Walt of the London School of Hygiene and Tropical Medicine noted, there was a crucial shift from predominant reliance on WHO’s “regular budget”—drawn from member states’ contributions on the basis of population size and gross national product—to greatly increased dependence on extrabudgetary funding coming from donations by multilateral agencies or “donor” nations. By the period 1986–1987, extrabudgetary funds of $437 million had almost caught up with the regular budget of $543 million. By the beginning of the 1990s, extrabudgetary funding had overtaken the regular budget by $21 million, contributing 54% of WHO’s overall budget.

Enormous problems for the organization followed from this budgetary shift. Priorities and policies were still ostensibly set by the World Health Assembly, which was made up of all member nations. The assembly, however, now dominated numerically by poor and developing countries, had authority only over the regular budget, frozen since the early 1980s. Wealthy donor nations and multilateral agencies like the World Bank could largely call the shots on the use of the extrabudgetary funds they contributed. Thus, they created, in effect, a series of “vertical” programs more or less independent of the rest of WHO’s programs and decisionmaking structure. The dilemma for the organization was that although budgetary funds added to the overall budget, “they [increased] difficulties of coordination and continuity, [caused] unpredictability in finance, and a great deal of dependence on the satisfaction of particular donors,” as Gill Walt explained.

Fiona Godlee published a series of articles in 1994 and 1995 that built on Walt’s critique. She concluded with this dire assessment: “WHO is caught in a cycle of decline, with donors expressing their lack of faith in its central management by placing funds outside the management’s control. This has prevented WHO from [developing] . . . integrated responses to countries’ long term needs.”

In the late 1980s and early 1990s, the World Bank moved confidently into the vacuum created by an increasingly ineffective WHO. WHO officials were unable or unwilling to respond to the new international political economy structured around neoliberal approaches to economics, trade, and politics. The Bank maintained that existing health systems were often wasteful, inefficient, and ineffective, and it argued in favor of greater reliance on private-sector health care provision and the reduction of public involvement in health services delivery.

Controversies surrounded the World Bank’s policies and practices, but there was no doubt that, by the early 1990s, it had become a dominant force in international health. The Bank’s greatest “comparative advantage” lay in its ability to mobilize large financial resources. By 1990, the Bank’s loans for health surpassed WHO’s total budget, and by the end of 1996, the Bank’s cumulative lending portfolio in health, nutrition, and population had reached $13.5 billion. Yet the Bank recognized that, whereas it had great economic strengths and influence, WHO still had considerable technical expertise in matters of health and medicine. This was clearly reflected in the Bank’s widely influential World Development Report, 1993: Investing in Health, in which credit is given to WHO, “a full partner with the World Bank at every step of the
preparation of the Report. Circumstances suggested that it was to the advantage of both parties for the World Bank and WHO to work together.

WHO EMBRACES “GLOBAL HEALTH”

This is the context in which WHO began to refashion itself as a coordinator, strategic planner, and leader of “global health” initiatives. In January 1992, the 31-member Executive Board of the World Health Assembly decided to appoint a “working group” to recommend how WHO could be most effective in international health work in light of the “global change” rapidly overtaking the world. The executive board may have been responding, in part, to the Children’s Vaccine Initiative, perceived within WHO as an attempted “coup” by UNICEF, the World Bank, the UN Development Program, the Rockefeller Foundation, and several other players seeking to wrest control of vaccine development. The working group’s final report of May 1993 recommended that WHO—if it was to maintain leadership of the health sector—must overhaul its fragmented management of global, regional, and country programs, diminish the competition between regular and extrabudgetary programs, and, above all, increase the emphasis within WHO on global health issues and WHO’s coordinating role in that domain.

Until that time, the term “global health” had been used sporadically and, outside WHO, usually by people on the political left with various “world” agendas. In 1990, G. A. Gellert of International Physicians for the Prevention of Nuclear War had called for analyses of “global health interdependence.” In the same year, Milton and Ruth Roemer argued that further improvements in “global health” would be dependent on the expansion of public rather than private health services. Another strong source for the term “global health” was the environmental movement, especially debates over world environmental degradation, global warming, and their potentially devastating effects on human health.

In the mid-1990s, a considerable body of literature was produced on global health threats. In the United States, a new Centers for Disease Control and Prevention (CDC) journal, Emerging Infectious Diseases, began publication, and former CDC director William Foege started using the phrase “global infectious disease threats.” In 1998, the World Health Assembly reached outside the ranks of WHO for a new leader who could restore credibility to the organization and provide it with a new vision: Gro Harlem Brundtland, former prime minister of Norway and a physician and public health professional. Brundtland brought formidable expertise to the task. In the 1980s, she had been chair of the UN World Commission on Environment and Development and produced the “Brundtland Report,” which led to the Earth Summit of 1992. She was familiar with the global thinking of the environmental movement and had a broad and clear understanding of
the links between health, environment, and development. Brundtland was determined to position WHO as an important player on the global stage, move beyond ministries of health, and gain a seat at the table where decisions were being made. She wanted to refashion WHO as a “department of consequence” able to monitor and influence other actors on the global scene. She established a Commission on Macroeconomics and Health, chaired by economist Jeffrey Sachs of Harvard University and including former ministers of finance and officers from the World Bank, the International Monetary Fund, the World Trade Organization, and the UN Development Program, as well as public health leaders. The commission issued a report in December 2001, which argued that improving health in developing countries was essential to their economic development. The report identified a set of disease priorities that would require focused intervention.

Brundtland also began to strengthen WHO’s financial position, largely by organizing “global partnerships” and “global funds” to bring together “stakeholders”—private donors, governments, and bilateral and multilateral agencies—to concentrate on specific targets (for example, Roll Back Malaria in 1998, the Global Alliance for Vaccines and Immunization in 1999, and Stop TB in 2001). These were semi-autonomous programs bringing in substantial outside funding, often in the form of “public–private partnerships.” A very significant player in these partnerships was the Bill & Melinda Gates Foundation, which committed more than $1.7 billion between 1998 and 2000 to an international program to prevent or eliminate diseases in the world’s poorest nations, mainly through vaccines and immunization programs. Within a few years, some 70 “global health partnerships” had been created.

Brundtland’s tenure as director general was not without blemish nor free from criticism. Some of the initiatives credited to her administration had actually started under Nakajima (for example, the WHO Framework Convention on Tobacco Control), others may be looked upon today with some skepticism (the Commission on Macroeconomics and Health, Roll Back Malaria), and still others arguably did not receive enough attention from her administration (Primary Health Care, HIV/AIDS, Health and Human Rights, and Child Health). Nonetheless, few would dispute the assertion that Brundtland succeeded in achieving her principal objective, which was to reposition WHO as a credible and highly visible contributor to the rapidly changing field of global health.

CONCLUSION

We can now return briefly to the questions implied at the beginning of this article: how does a historical perspective help us understand the emergence of the terminology of “global health” and what role did WHO play as an agent in its development? The basic answers derive from the fact that WHO at various times in its history alternatively led, reflected, and tried to accommodate broader changes and challenges in the ever-shifting world of international health. In the 1950s and 1960s, when changes in biology, economics, and great power politics transformed foreign relations and public health, WHO moved from a narrow emphasis on malaria eradication to a broader interest in the development of health services and the emerging concentration on smallpox eradication. In the 1970s and 1980s, WHO developed the concept of Primary Health Care but then turned from zealous advocacy to the pragmatic promotion of Selective Primary Health Care as complex changes overtook intra- and interorganizational dynamics and altered the international economic and political order. In the 1990s, WHO attempted to use leadership of an emerging concern with “global health” as an organizational strategy that promised survival and, indeed, renewal.

But just as it did not invent the eradicationist or primary care agendas, WHO did not invent “global health”; rather, larger forces were responsible. WHO certainly did help promote interest in global health and contributed significantly to the dissemination of new concepts and a new vocabulary. In that process, it was hoping to acquire, as Yach and Bettcher suggested in 1998, a restored coordinating and leadership role. Whether WHO’s organizational repositioning will serve to reestablish it as the unquestioned steward of the health of the world’s population, and how this mission will be effected in practice, remains an open question at this time.

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References
2. For example, Yale has a Division of Global Health in its School of Public Health, Harvard has a Center for Health and the Global Environment, and the London School of Hygiene and Tropical Medicine has a Center on Global Change and Health; the National Institutes of Health has a strategic plan on Emerging Infectious Diseases and Global Health; Gro Harlem Brundtland addressed the 35th Anniversary Symposium of the John E. Fogarty International Center on “Global Health: A Challenge to Scientists” in May 2003; the Centers for Disease Control and Prevention has established an Office of Global Health and has partnered with the World Health Organization (WHO), the World Bank, UNICEF, the US Agency for International Development, and others in creating Global Health Partnerships.


5. For example, T.W. Wilson, World Population and a Global Emergency (Washington, DC: Aspen Institute for Humanistic Studies, Program in Environment and Quality of Life, 1974).


20. Ibid., 198.


27. See Litos, “The Long and Difficult Road to Alma-Ata.”


36. Ibid., 1492.


40. Ibid., 129.


43. World Bank, Financing Health Services in Developing Countries.


46. Be Stenson and Goran Sherky,
Changing fortunes: analysis of fluctuating policy space for family planning in Kenya

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Policies relating to contraceptive services (population, family planning and reproductive health policies) often receive weak or fluctuating levels of commitment from national policy elites in Southern countries, leading to slow policy evolution and undermining implementation. This is true of Kenya, despite the government’s early progress in committing to population and reproductive health policies, and its success in implementing them during the 1980s. This key informant study on family planning policy in Kenya found that policy space contracted, and then began to expand, because of shifts in contextual factors, and because of the actions of different actors. Policy space contracted during the mid-1990s in the context of weakening prioritization of reproductive health in national and international policy agendas, undermining access to contraceptive services and contributing to the stalling of the country’s fertility rates. However, during the mid-2000s, champions of family planning within the Kenyan Government bureaucracy played an important role in expanding the policy space through both public and hidden advocacy activities. The case study demonstrates that policy space analysis can provide useful insights into the dynamics of routine policy and programme evolution and the challenge of sustaining support for issues even after they have reached the policy agenda.

Keywords Policy analysis, family planning, health policy, contraception

KEY MESSAGES
- Policy space for the issue of family planning in Kenya contracted during the late 1990s, and has since begun to expand, due to changing contextual factors and the actions of different individuals.
- Proponents of family planning within two government ministries played an important role in expanding the policy space through both public and intra-government advocacy activities.
- Policy space analysis can provide useful insights into the dynamics of routine policy and programme evolution and the challenge of sustaining support for issues after they have made it onto the policy agenda.

Introduction
In many parts of the world policies relating to contraceptives tend to receive weak or fluctuating levels of commitment from national policy elites, leading to slow policy evolution and undermining implementation. This is true of Kenya, where the government made early progress in committing to population policies during the 1960s and in contraceptive service provision during the 1970s and 1980s, yet where resource allocations and implementation subsequently declined (Chimbwete and Zulu 2003). In Kenya, as elsewhere in sub-Saharan Africa, the past decade has seen a weakening prioritization of contraceptive programmes in national and international policy agendas (Cleland et al. 2006), undermining access to services and progress towards the Millennium Development Goals. This key informant study examines factors affecting the fluctuating level of prioritization of contraceptive service
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 provision among Kenyan government policy-makers since the mid-1990s. Contraceptive services are usually referred to as ‘family planning’ in national policy debates in Kenya and are framed as cutting across reproductive health and population concerns (Ministry of Health 2000, 2007; NCPD 2000, 2003, 2005, 2006a). Based on key informant interviews and a review of academic and official publications and reports, the paper focuses on the strategies and actions taken by a range of actors to ‘reposition’ family planning in government policy and to ensure the incorporation of contraceptive commodities in the national government budget of 2005, for the first time in the country’s history.

The problem of sustaining political and bureaucratic commitment for the implementation and evolution of policies affects a variety of policy issues (Grindle and Thomas 1991; Buse et al. 2005). Waning commitment can lead to stagnation in implementation, and can undermine the likelihood that political and bureaucratic actors create new policies and strategies to adapt to changing contexts, such as shifts in external funding trends. In Southern countries and elsewhere, reproductive health policies are particularly vulnerable to weak political commitment, because they do not tend to have strong national support bases and have historically been controversial and perceived as driven by external actors (Jain 1998; Chimbwete and Zulu 2003). Thomas and Grindle (1994), in their review of population reforms in 16 countries, explain that sustained commitment to the implementation of population policies tends to be constrained by two main factors: the dispersed and long-term nature of their impacts, and the lack of mobilized support from users of contraceptive services. Reproductive health and population policies have therefore been vulnerable to deprioritization and neglect in many Southern countries, especially in the context of the shift in international attention and official development assistance to HIV and AIDS programmes during the 1990s (Cleland et al. 2006).

In this paper, I contend that policy space analysis provides a useful framework for understanding why commitment to existing policies often fluctuates over time, and for mapping the room for manoeuvre that advocates of particular policies have for addressing policies that are being neglected. Policy elites can be thought of as operating within a ‘policy space’, which influences the degree of agency they have for reforming and driving policy implementation, but which can be expanded by the exercise of that agency. These concepts are drawn from Grindle and Thomas (1991), who suggest that the scope of policy space is influenced by the way in which policy elites manage the interactions between (1) national and international contextual factors, (2) the circumstances surrounding the policy process, and (3) the acceptability of the policy’s content. Figure 1 represents policy space as a balloon, which can be expanded, constrained or contracted by shifts in these factors and by peoples’ actions.

Firstly, contextual factors are the pre-existing circumstances within which policy processes occur. They can act as opportunities and constraints for policy elites’ prioritization of a policy issue, and include historical, social, cultural, political, economic and demographic characteristics of a country and situational or focusing events, like epidemics, droughts or media coverage of issues (Kingdon 1984; Grindle and Thomas 1991). Policy-makers are confronted with a multitude of competing issues and have limited resources for dealing with them (Shiffman 2007). External actors and international structural trends have a critical influence on national health policy processes, with increasing diversity and fragmentation of international actors and sources of funding (Walt and Buse 2000; Cerny 2002). These international factors often have contradictory influences, particularly in contexts characterized by national government dependence on external funds, aid conditionalities, shifting funding priorities, and persistence in vertical programming (Walt and Buse 2000; Cerny 2002; Mayhew et al. 2005). The background characteristics of policy elites are also important pre-existing factors that shape policy space; for example the values, level of expertise, experience, degree of influence and loyalties of elites influence both their receptiveness to policy change, and their success in championing particular policies.

A second area affecting policy space is that of ‘policy circumstances’, or the ways in which policy makers’ perceptions about a policy issue shape the dynamics of decision making. The extent to which a policy issue is perceived by policy elites to be a matter of crisis or ‘politics-as-usual’ affects the level at which decisions are taken, the urgency with which decisions are made, and the extent of risk taking (Grindle and Thomas 1991; Walt and Gilson 1994). Policy crises involve strong pressure on policy makers to act, as well as high political stakes, and can lead to radical shifts in the prioritization of issues. When policies are not perceived as urgent, decision making may be dominated by concerns about micropolitical and bureaucratic costs and benefits. Policy circumstances differ from contextual factors because of their dynamic element:

How particular circumstances are perceived by policy elites [...] serves as a bridge between the “embedded orientations” of individuals and societies and the kinds of changes considered by decision makers confronted with specific policy choices. (Thomas and Grindle 1994, p.53)

Lastly, the policy’s characteristics are themselves influenced by policy elites’ decisions, but also affect the scope policy makers
have for introducing a policy and prioritizing it. The acceptability of a policy is influenced by policy characteristics such as the distribution of the costs and benefits associated with its implementation across policy actors and society, which in turn affects the level of support or opposition to the policy from various stakeholders (Kingdon 1984). Characteristics of a policy that affect its acceptability include its implications for vested interests, the level of public participation it involves, the resources required for implementation and the length of time needed for its impacts to become visible (Grindle and Thomas 1991).

In Grindle and Thomas’ model, the various factors interrelate in the following ways. Contextual factors shape the circumstances of decision making by policy elites concerning particular policies at particular times. These decisions in turn shape the characteristics of the policy, and public and bureaucratic incentives to support or oppose it. These incentives in turn shape decisions by policy makers and policy managers about resource allocation, and explain how prioritization and implementation may fluctuate over time. Though the framework was initially developed for analysing processes of agenda setting, decision-making circumstances directly affect policy makers’ and managers’ decisions about subsequent implementation, for example where shifts in perceptions of the issue among policy elites affect decisions about resource allocation. Importantly, as Figure 1 illustrates, policy makers can widen the policy space they operate within by taking actions to influence the different factors, for example by building consensus or by forming coalitions in support of an issue.

Indeed, analysis of agenda setting across different contexts shows that individual politicians and bureaucrats often play a central role in championing issues and getting them onto the policy agenda, in addition to non-government advocates (Grindle and Thomas 1991; Shiffman 2007). Such analyses also show that the level of success of advocacy initiatives depends on a combination of factors including: clear indicators to show the extent of the problem, the presence of political entrepreneurs to champion the cause, and the organization of attention-generating focusing events; as well as the political acceptability of policies (Shiffman 2007). Successful advocacy may also require the ‘framing’ of contested or neglected issues in a way that legitimizes them as an important issue for governments to address (Schon and Rein 1991; Joachim 2003), appealing to prevailing social norms (Shiffman 2007) and employing policy narratives, or stories, that simplify issues and persuade others of their importance (Roe 1991; Keeley 2001). This case study has implications for government and non-governmental advocates aiming to sustain commitment to existing policies in shifting national and international contexts, particularly policies relating to contraceptive services and other neglected sexual and reproductive health issues.

Methods
The material for this case study is based on 13 semi-structured interviews and three unstructured discussions carried out during 2006 and 2007 with high-level officials and programme staff from government ministries and agencies, international non-governmental organizations (NGOs), national NGOs, a bilateral donor and an academic with expertise in demography and reproductive health programmes. The first Population and Family Planning Policy was introduced in 1967, however government involvement in contraceptive service provision did not begin in earnest until the 1980s (Chimbwete and Zulu 2003). During the 1980s and early 1990s, the Kenyan government demonstrated considerable commitment to family planning, through the development of national policies and guidelines, involvement of high-level politicians, the establishment of the National Council for Population and Development (NCPD) in the Office of the Vice President, and support for increased distribution of contraceptives through governmental and non-governmental health facilities, and extensive information, education and communication (IEC) campaigns (Ajayi and Kekowole 1999; Blacker 2006). Service provision expanded impressively during this period, and the contraceptive prevalence rate in Kenya increased from 7 to 27% between 1980 and 1989 (Ajayi and Kekowole 1999).

International factors played a leading role in this original expansion of policy space for family planning, with external actors advocating for and supporting the implementation of the population policy. At this time, donors covered the costs of all government and non-government contraceptive and IEC campaigns. During the second half of the 1990s, however, external funding for services and IEC declined, in the context of a shift in priorities to HIV and AIDS and donor fatigue (Aloo-Obunga 2003; NCPD 2003; 15; 113). The Kenyan government was slow to respond to the shifting international aid allocations. Combined with poor management of commodity procurement between the Ministry of Health and the Kenya Medical Supplies Agency (KEMSA) (113; 14), the unreliable and dwindling international funds were a cause of a
considerable weakening of government and voluntary sector contraceptive services (12; 17; 34). In 1996, the NCPD launched a National Population Advocacy and IEC strategy for Sustainable Development 1996–2010, but this strategy floundered when funding from UNFPA was withdrawn in 2000 (15; 16; The Global Gag Rule Project 2006). Some clinics suffered from commodity stock outs and lack of method choice during the early 2000s, while others closed altogether (12; 14; 17). The Kenya Service Provision Assessment Survey of 2004 found that in the 5 years preceding the survey, the proportion of health facilities offering any method of family planning declined from 88 to 75% (NCAPD 2005). Some clinics suffered from commodity stock outs and lack of method choice during the early 2000s, while others closed altogether (12; 14; 17). The Kenya Service Provision Assessment Survey of 2004 found that in the 5 years preceding the survey, the proportion of health facilities offering any method of family planning declined from 88 to 75% (NCAPD 2005).

The 2003 Kenya Demographic and Health Survey (KDHS) results revealed a stall in fertility decline at 4.8 in 1998–2003, and the rate actually rose for women who had not completed primary education (Blacker et al. 2005; CBS et al. 2005; Westoff and Cross 2006). The 2003 KDHS revealed increases in unmet need for contraception and high contraception discontinuation rates (Blacker et al. 2005). These trends caused concern among national and international actors about the implications for the rate of population growth in Kenya. In 2004, UN predictions of Kenya’s population by mid-2050 were revised from 80 to 70 million, based on these new figures (Cleland et al. 2006).

Various societal, economic and demographic factors may have contributed to the worsening fertility and contraceptive use trends, and there are differences of opinion among analysts about the impact of declining donor resource allocations for contraceptives and weakening service delivery (Blacker et al. 2005; Bongaarts 2005; Westoff and Cross 2006). In any case, the new data provided powerful evidence for reproductive health proponents, and catalysed a series of advocacy initiatives with the aim of influencing the government to prioritize contraceptive services and allocate public funding to contraceptive commodities. The advocacy initiatives included meetings with parliamentarians and informal advocacy in government budget meetings. A line item for contraceptive commodities was eventually included in the 2005 national budget, allocating 200 million Kenyan Shillings, or US$4.17 million, in the 2006/7 budget. However, it should be noted that this is still only around one-third of the cost of Kenya’s public sector provision of family planning commodities according to 2000 projections (Ministry of Health 2003), and proponents of family planning continue to seek public funding from increased national allocations and from devolved government funds.

### Factors affecting policy space

This section examines how policy elites interacted with each of the three sets of factors in the policy space framework, to assess how each influenced the contraction and expansion of policy space over time, ultimately leading to the inclusion of contraceptive commodities in Kenya’s 2005 budget. Table 1 summarizes contextual factors, policy circumstances and policy characteristics, comparing their impact on policy space during the second half of the 1990s with the years since 2000.

#### (1) Contextual factors

Changes over time in the political, bureaucratic, national and international context had a major impact on the room for manoeuvre open to proponents of family planning within the bureaucracy. Table 1 shows how, during the mid-2000s, there were shifts in all these areas that either increased opportunities for family planning to be prioritized within government, or reduced the contextual constraints against this occurring. The role played by policy actors in working with these shifts and building on them is outlined in the text, below.

#### Influences on policy elites

Analysts of the national political environment for family planning policy in Kenya contend that commitment to the issue by policy elites tended to be ambivalent during the 1960s and 1970s,

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**Box 1 The history of family planning policy and programmes in Kenya**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1962</td>
<td>Family Planning Association of Kenya (FPAK) established</td>
</tr>
<tr>
<td>1967</td>
<td>Government of Kenya’s first population policy, but contraceptive services and Information, Education and Communication (IEC) mainly provided by the private sector</td>
</tr>
<tr>
<td>1975</td>
<td>The government launched a 5 year Family Planning Programme</td>
</tr>
<tr>
<td>1982</td>
<td>The National Council for Population and Development was established in the Office of the Vice President</td>
</tr>
<tr>
<td>1984</td>
<td>First National leader’s Population Conference in Nairobi</td>
</tr>
<tr>
<td>1994</td>
<td>United Nations International Conference on Population and Development (ICPD), Cairo</td>
</tr>
<tr>
<td>1997</td>
<td>NCPD launched National Reproductive Health Strategy published</td>
</tr>
<tr>
<td>2000</td>
<td>NCPD published the second Population Policy for Sustainable Development</td>
</tr>
<tr>
<td>2003</td>
<td>Kenya Demographic and Health Survey generates deteriorating indicators (published in 2004)</td>
</tr>
<tr>
<td>2004</td>
<td>NCPD became a semi-autonomous agency under the Ministry of Planning and Economic Development, the National Coordinating Agency for Population and Development (NCAPD)</td>
</tr>
<tr>
<td>2005</td>
<td>The budget for 2003/6 presented to parliament and passed, allocating Kenyan government funds to family planning for the first time</td>
</tr>
<tr>
<td>2007</td>
<td>National Reproductive Health Policy published</td>
</tr>
</tbody>
</table>

*Sources: Ajayi and Kekovole (1998); Blacker et al. (2005); Akso-Obunga (2000); NCPD (2000).*
and that this was strongly influenced by contextual factors such as prevailing cultural and religious attitudes. During this period, there was considerable popular opposition to contraceptives and to population control in Kenyan society, especially outside the narrow class of urban ‘modernising elites’ (Ajayi and Kekovole 1999; Chimbwete and Zulu 2003). This included opposition to the use of contraceptives from religious groups and from pro-natalist attitudes associated with tribal politics. During this period, some technocrats were convinced by arguments from the international population control lobby about the beneficial impacts of lowering fertility rates for economic development, but key policy elites expressed scepticism about family planning on cultural, religious and pro-natalist grounds (Ajayi and Kekovole 1999; Chimbwete and Zulu 2003). President Jomo Kenyatta is said to have never fully reconciled contraception with his cultural and religious attitudes, and believed that Kenyan society was too opposed to contraceptives for the government to openly promote them or directly provide services. Instead, he introduced the population policy more to impress and build links with the international community and access international population funding than out of genuine conviction (Chimbwete and Zulu 2003).

During the 1980s, President Daniel Arap Moi appears to have been less troubled than his predecessor by religious and cultural reservations about family planning, which enabled him to take important measures to ensure effective implementation of the population policy. Moi appears to have been more influenced by neo-Malthusian arguments, using them in a number of public statements in support of the issue (Ajayi and Kekovole 1999; Chimbwete and Zulu 2003; Blacker 2006). In addition, concerns about economic stagnation and heightened pressure from donors such as the World Bank also pushed Moi’s government into prioritizing family planning (Ajayi and Kekovole 1999; Chimbwete and Zulu 2003). The government-led services and IEC campaigns sparked a backlash from some religious organizations and community leaders, who made public statements of opposition to the policy. However, the government and reproductive health NGOs worked to create a supportive environment for family planning and population policies by sensitizing religious organizations, the public and the media to the issue.

### Table 1 Factors affecting policy space for family planning in Kenya

<table>
<thead>
<tr>
<th>Mid to late 1990s, Policy space contracting</th>
<th>Early 2000s, Policy space expanding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Contextual factors</strong></td>
<td></td>
</tr>
<tr>
<td>Influences on policy elites</td>
<td></td>
</tr>
<tr>
<td>↓ Lack of response to negative donor funding trends by high-level politicians</td>
<td>↑ Religious opposition becoming less vocal</td>
</tr>
<tr>
<td>↓ Religious opposition to contraceptives</td>
<td></td>
</tr>
<tr>
<td>↑ Government consensus building with religious groups</td>
<td></td>
</tr>
<tr>
<td>Change of government in 2002</td>
<td></td>
</tr>
<tr>
<td>↓ Shortage of government resources allocated to health sector</td>
<td>↑ New government increasing resources to the health sector</td>
</tr>
<tr>
<td></td>
<td>↑ Passive support from high-level politicians</td>
</tr>
<tr>
<td>Bureaucratic</td>
<td></td>
</tr>
<tr>
<td>↓ Conservative budget officials</td>
<td>↑ Mandate and influence of NCAPD</td>
</tr>
<tr>
<td>↓ Intra- and inter-sectoral competition for resources</td>
<td>↑ Concern about weak service delivery within Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>↓ Conservative budget officials</td>
</tr>
<tr>
<td></td>
<td>↓ Intra- and inter-sectoral competition for resources</td>
</tr>
<tr>
<td></td>
<td>↑ Introduction of the MTEF</td>
</tr>
<tr>
<td>International</td>
<td></td>
</tr>
<tr>
<td>↓ Vertical HIV and AIDS funding</td>
<td>↑ Financial and technical support for family planning advocacy from international NGOs and donors</td>
</tr>
<tr>
<td>↓ Prioritization of HIV and AIDS</td>
<td></td>
</tr>
<tr>
<td>↓ Reduced donor funding for contraceptive services and IEC</td>
<td></td>
</tr>
<tr>
<td>Availability of policy evidence</td>
<td>↑ Availability of new evidence of a decline in family planning</td>
</tr>
<tr>
<td><strong>2. Policy circumstances</strong></td>
<td></td>
</tr>
<tr>
<td>↓ HIV and AIDS became a policy crisis, drawing attention and funding away from family planning</td>
<td>↑ HIV and AIDS policy is making a gradual transition from ‘crisis’ policy making to ‘politics-as-usual’</td>
</tr>
<tr>
<td><strong>3. Policy characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>↓ Lack of mobilized support from users of contraceptive services</td>
<td>↓ Lack of mobilized support from users of contraceptive services</td>
</tr>
<tr>
<td>↓ Some religious sensitivity about contraceptive services</td>
<td>↑ Decreasing religious sensitivity about contraceptive services</td>
</tr>
<tr>
<td>↓ Vested interests undermining policy implementation</td>
<td>↓ Vested interests undermining policy implementation</td>
</tr>
</tbody>
</table>

↓: Factors constraining or contracting policy space.  
↑: Factors expanding policy space.
When multi-party elections were reintroduced in the early 1990s, all political parties included population issues in their manifestos (Ajayi and Kekovole 1999), demonstrating the success of these campaigns. However, Moi’s commitment had significant limits, as family planning commodities remained totally funded by donors while he was in power, and his government failed to take action in response to declining resource allocations from donors, allowing implementation and policy evolution to stagnate (NCAPD 2003). This lends weight to the assertion by some key informants from donor agencies and NGOs (I14; I16; I17) that policy elites in Kenya had never fully taken ownership of family planning policy, even during the 1980s.

By the 2000s, pro-natalist attitudes appear to have much less influence on Kenyan politicians than in the past (I2; I6; I8; I14; I15; NCAPD 2006a). The influence of organized religious opposition to contraceptives has also considerably decreased (I5; I6; I13; I14; I15). Efforts by the Kenyan government to build consensus with religious groups during the 1990s appear to have helped to reduce the opposition. The 2000 Population Policy was a milestone in this process, with religious coalitions being actively involved in the drafting of the policy before it was adopted in parliament (I5).

The increasing visibility of HIV and AIDS-related illness and mortality over the past decade or so may also have helped to make opposition less vocal. One key informant argued that HIV and AIDS have led religious groups to reconsider their opposition to family planning, especially the use of condoms:

‘...no one has not been affected by HIV/AIDS. Religious groups have decided to lay low and remain silent’. (I5)

Although religious organizations continue to influence the government to exercise caution in their policy making in persistently controversial areas such as abortion, emergency contraception and sexuality education, key informants did not consider general family planning policy to be affected by religious opposition. In addition, high-level politicians in the 2002-07 government appear to have strong personal convictions about family planning. President Mwai Kibaki is known to be convinced by economic arguments for limiting population growth (Ajayi and Kekovole 1998; Chimbwete and Zulu 2003), and the ministers of health and finance during that period were considered to be sympathetic to reproductive health issues (I4; I6; I17).

Change of government in 2002
Moi’s government failed to address the declining implementation of family planning policy during the 1990s, and it seems that the change of administration in 2002 may have brought an impetus of change that helped to mobilize action to address this issue. The new government may have helped to expand policy space by bringing politicians who were more supportive of family planning into key positions. The arrival of the new government certainly precipitated two actions that indicate high-level sympathy for the issue. These were the creation of the National Coordinating Agency for Population and Development (NCAPD) through an act of parliament in 2004, with its new advocacy mandate, and the issuing of a Cabinet Memorandum tabled by NCAPD in the same year, which called for the government to make renewed efforts in family planning. In addition, one senior official in the Ministry of Health and one donor argued that the change of administration allowed increasing government allocations to the health sector and made it more likely that politicians would take public health issues such as reproductive health more seriously (I13; I17).

Bureaucratic culture, capacity and institutional arrangements
Conservatism, lack of transparency and concentration of decision-making power in the budget process were factors constraining the policy space throughout the period examined. These were significant in preventing the government from allocating resources to contraceptives until 2005. One key informant described budget officials and the Ministry of health as being opposed to any display of creativity or decisions that are perceived as ‘radical’ (I6). Budget officials had to be convinced of the need to innovate by introducing government funding for an item that was already funded by donors:

Health indicators such as IMR [infant mortality rates] and MMR [maternal mortality rates] are declining in Kenya. Our strategic plan 2005–2010 shows the need to reverse these trends. FP is important for reducing MMR. One third of IMR is neonatal mortality. Economists understood this. But there was a feeling that partners were already supporting adequately. So why put money to this not drugs or infrastructure? (I4)

However, other bureaucratic factors helped to facilitate the new budget line in 2005. One example is the existence of planning units in each sectoral ministry, which supported the transfer of knowledge, information and skills between the Ministry of Planning and the Ministry of Health. The head of the Planning Unit, who was seconded from the Ministry of Planning, had been involved in the production of the 2003 KDHS, and therefore had a good understanding of population and contraceptive use trends, and a personal stake in the issue (I12). This official was formally responsible for the initial drafting of the Ministry of Health budget. The introduction of the Medium Term Expenditure Framework (MTEF) in 1999 (Ministry of Health 2005) may also have been a supporting factor. Since the MTEF allows for annual increases in resources for existing budget lines, allocations for family planning were much easier to pass in 2006 than in 2005 (I1; I4; I7; I11; I13).

Since its creation as an agency in 2004, the existence of NCAPD has been an important factor expanding the policy space for family planning prioritization in Kenya. One key informant emphasized that the transformation of the National Council for Population and Development into the agency NCAPD led to a considerable improvement in its effectiveness and policy influence. NCAPD is part of the Ministry of Planning, but is semi-autonomous, so has greater operational flexibility than its predecessor (I1; I7). Unlike the Division of Reproductive Health, NCAPD has a mandate to conduct high-level advocacy (I2; I6, I14; NCAPD 2005). In 2003, shortly before NCPD made its transition to an agency, a new Director was appointed, who was charismatic and influential within government and with donors, enabling him to take advantage
of this mandate to mobilize resources for family planning advocacy, and to sell the issue in high-level meetings (19, 114). The experience of poor implementation within the Ministry of Health during the late 1990s and early 2000s was also an important factor creating concern about the issue within the ministry and triggering action to address it. In the Division of Reproductive Health and among NGO service providers, the policy problem was identified because of stock outs of family planning commodities from health facilities, leading to a concern that family planning policy implementation was ineffective and action needed to be taken to improve service delivery. One official in the ministry stated that,

**The Ministry of Health had a general feeling that FP implementation was not good enough. (I3)**

**International influences**

Population first made it onto the Kenyan government’s agenda because of the influence of external actors, and even at the height of prioritization of the issue during the 1980s and early 1990s, the government always relied on external resources to fund policy implementation (Ajayi and Kerkovole 1998; Chimbwete and Zulu 2003). As with the national government, many international donors shifted their priorities to HIV and AIDS during the 1990s, leading to declining foreign aid allocations for family planning (Aloo-Obunga 2003; NCAPD 2003). The strong external pressure that had influenced political elites to prioritize population and reproductive health issues during the 1980s and early 1990s declined. In addition, some key informants described a situation of donor fatigue brought on by frustration with poor planning and lack of ownership for family planning in the Ministry of Health.

**Donors got fed up with the lack of planning. DRH used to say, “we have a shortage of pills. UNFPA can give us an emergency drop”. UNFPA would do this, but 6 months later they’d come back and ask for another bail out. (I14)**

Some key informants stated that donor agencies consider IEC to be expensive and lack conviction in its importance and effectiveness (I6; I12). There appears to have been complacency among donors as well as national actors about fertility transition, and a belief that it would happen naturally without the need for sustained interventions.

**Implementation disappeared in the 1990s. There was an expectation that the transition would continue automatically. Resources were moved away. (I1)**

**Donors no longer wanted to support community-based distribution, questioning its impact. (I2)**

Government and donor key informants unsurprisingly differed as to where they put the blame for poor coordination and commodity stockouts, with a USAID official stating that:

*[...]* There was a major problem when the Germans picked up the bulk of procurement, but there was a 6 month gap between projects which the ministry had not picked up on, so there were almost commodity stockouts. The ministry did not understand the donor's cycle. (I14)

A senior government official on the other hand, argued,

**Donors have no idea of our procurement schedule. You would find lorries arriving at KEMSA without any storage space. (I13)**

While external assistance for service delivery and IEC has dropped, international actors have increased their support to ‘behind the scenes’ advocacy campaigns to reposition family planning. This includes the provision of financial and technical assistance for advocacy on family planning from donors such as USAID, and of technical assistance from international NGOs such as the Futures Group and the African Population and Health Research Center (12; I14). Since 2000, UNFPA has been funding improvements in the division of responsibility and coordination between the Ministry of Health and NCAPD, which may have helped them to carry out joint advocacy for family planning (I5). In the past few years, some donors have been working with the Ministry to strengthen procurement policy, though it is too early to assess the impacts of these efforts (I6; I14). A key shift in international engagement between the 1980s and recent years is, therefore, that external actors are now trying to create local ownership for family planning by supporting national advocates of the issue, particularly government officials and parliamentarians.

**Availability of policy evidence**

The availability of new data in 2003 demonstrating that a ‘policy problem’ existed was a catalyst for alerting policy entrepreneurs to the need for family planning to be reprioritized. Key informants from the NCAPD, Ministry of Health, USAID and NGOs pointed to the importance of the 2003 KDHS data in identifying and persuading others about the importance of the issue.

**The plateau [of contraceptive use and fertility rates] was a critical turning point. (I1)**

**The results showed clearly that unmet need for FP had not changed for over 10 years. Contraceptive prevalence was the same. The TFR was beginning to show an increase. These figures rang a bell. So we did further analysis. Our finding was that there was a shortage of commodities. [...] We needed a broad program of high-level advocacy to lobby government, partners and donors. (I2)**

Contrary to the previous quotation, those working on the issue in government had already expressed concern about declining prioritization of family planning and decreasing donor funding before the KDHS funding before the KDHS results were available (Ministry of Health 2000; NCAPD 2003). The publication of this data provided an opportunity and a resource for champions of family planning to use in their advocacy.

(2) **Policy circumstances**

Since the time of Kenya’s first population policy in the 1960s, family planning has consistently been regarded by policy elites as an issue of ‘business as usual’ rather than a crisis issue.
Government officials repeatedly stated that a difficulty for securing prioritization of family planning in the Ministry of Health is that it is not considered to be an emergency, unlike other health issues such as epidemics (16; 13; 14). During the 1990s, the policy space for family planning narrowed further, when HIV and AIDS was perceived as a crisis issue (Aloo-Obunga 2003; NCPD 2003).

FP has become routine. It has been overrun by other activities like HIV/AIDS. (14)

This was exacerbated by a perception that family planning and HIV and AIDS are competing issues that can be traded off against each other. This narrowed the policy space for family planning by diverting resources away and undermining acknowledgement of the interdependence between the two services and the need for integrated policies and programmes. One government official commented that:

"There was the occasional minister who would prioritize HIV over FP." (12)

During the 1990s, the deprioritization of family planning seems to have been reinforced by complacency among government officials and politicians about increasing contraceptive use rates and declining fertility. There seems to have been a perception that the fertility transition would continue without the need for continuous government intervention, further undermining the sense of importance of family planning as a policy issue.

"People did not realise what was happening when the decline in FP funding started. For a long time, FP had been doing very well. It was at the peak of its success when HIV/AIDS became a crisis issue. [The decline in government prioritization of FP] was an involuntary decrease." (15)

As demonstrated in Table 1, changing perceptions of policy makers during the first half of the 2000s helped to create a more supportive decision-making environment for family planning. This involved both an increase in concern among policy makers about the issue, and an opening up of policy space because of changing attitudes to HIV and AIDS as a policy issue. By 2003, HIV and AIDS was no longer seen as such an urgent crisis, opening the policy space for policy makers to focus more on family planning.

(3) Policy characteristics
As shown in Table 1, the policy content had an important impact on the nature of the policy space for family planning, but did not present a major change during the period examined by this case study. The decreasing religious opposition to family planning during the 1990s may have helped to increase the acceptability of family planning policy among the electorate, thus expanding policy space slightly. There appears to be insufficient knowledge about how far family planning is accepted by individual Kenyans, but generally it is unlikely to meet strong opposition, although there are high levels of myth and suspicion about particular methods in some communities (Feldblum et al. 2001; 112; 115; 16). However, a defining feature of family planning policy is the lack of a mobilized constituency of supporters for the policy among users of contraceptive services, or the Kenyan public in general (12; 16; 115; 116). The issue of family planning has therefore tended to involve low political stakes for the Kenyan Government, focusing the costs and benefits of the policy in the bureaucratic domain.

In the bureaucracy, there seem to be no significant incentives to oppose family planning programmes among government officials, with the issue being treated as relatively uncontroversial (12; 16). As with other health services, contraceptives have relatively intense administrative requirements because of the need for continuous administrative resources to be allocated to procurement, storage and distribution of contraceptive commodities, and the technical skills required for effective service delivery. The capacity of the government to distribute contraceptives beyond the district level to the facility level is weak (117). As with other areas of the health sector, entrenched vested interests associated with procurement of family planning commodities play an influential role in undermining the implementation of family planning services (114). These interests continue to frustrate efforts to address inefficiencies in procurement and distribution by improving the effectiveness of KEMSA.

Procurement is worth billions [of Kenyan shillings]. KEMSA became independent recently. But the Ministry of Health [still] wants it. How to let go of a cash cow? The previous minister selected a board chairman, but there is still no board. So there are many vested interests. It has become a donor issue. [Donors] keep saying, ‘let KEMSA go!’ (117)

The role of advocacy strategies: expanding policy space during the mid-2000s
The previous section has outlined how shifts in context, policy circumstances and policy characteristics leading up to the mid-2000s widened the policy space for family planning. This section focuses on the ways in which policy actors took advantage of these shifts and widened policy space still further through advocacy initiatives. It also examines strategies that were used effectively by these advocates in order to influence key decision-makers.

From 2003 onwards, advocacy activities led by bureaucrats, with support from political, international and civil society actors, led to increased recognition of the importance of contraceptive services among key policy-makers and ultimately resulted in the introduction of the new budget line for contraceptive commodities in 2005. Certain advocacy strategies appear to have been effective in encouraging increased prioritization of the issue, including combining public and intra-government advocacy, organizing focusing events, and using a variety of policy narratives to ‘reframe’ family planning.

The advocacy process involved a range of actors, loosely coordinated through family planning and reproductive health committees chaired by the Ministry of Health, with membership including NCAPD, NGOs and donors. The aims were multifaceted. They included ‘repositioning’ family planning by raising its profile as a government development priority, by making it genuinely multi-sectoral, and enhancing integration with HIV and AIDS and other reproductive health issues such as maternal and child health (11).
When preliminary results from the KDHS were circulated by the Central Bureau of Statistics (CBS, since renamed the Kenyan National Bureau of Statistics) in January 2004, the deteriorating trends were immediately noted, and the NCAPD carried out further analysis of the KDHS findings, with support from USAID, and held stakeholders’ meetings to discuss how to react (I12). A reproductive health working group, of government officials, NGOs and donors, chaired by the Ministry of Health, identified a specific goal to address donor dependency by ensuring the government allocated national resources to family planning for the first time.

Agenda setting to incorporate family planning in the 2005 budget process involved two advocacy processes. The first was a public process to influence parliamentarians, senior bureaucrats and the wider public, led by NCAPD. The second involved internal government networks, including budget officials in the Ministry of Finance, Planning and Health, and parliamentarians (I3; I4; I7). The public efforts centred on the budget process. In April and July 2005, two advocacy workshops were convened by NCAPD, with support from national and international NGOs and donors (NCAPD 2005, 2006b). Presentations and speeches on the importance of family planning and the deteriorating trends were delivered by NCAPD, the African Inter-Parliamentary Network on Reproductive Health and the Ministry of Health. Advocacy materials and presentations (APHRC 2005; NCAPD 2005) drew both from KDHS data and from evidence on the correlation between higher contraceptive prevalence rates, lower fertility rates, and increased maternal and infant survival published by UNFPA (2003). These workshops targeted ministers, senior administrators and budget officials from the Ministries of Finance, Planning and Health, and parliamentarians (I3; I4; I7). The workshops were reported in the press, and key informants argue that this public profile of the event helped to persuade key officials in the bureaucracy to accept and support the allocation of national resources to family planning (I1; I2; I6; I7; I14).

The exact role played by the parliamentarians is hard to pinpoint. Key informants involved in the advocacy argued that the ultimate aim of targeting MPs was to make them become active in the budget process, advocating for resources to be allocated to contraceptives (I6, I14). However, the parliamentarians’ direct impact on the budget is extremely small in Kenya, limited only to simply passing or rejecting the whole budget (Mwenda and Gachocho 2003; Gomez et al. 2004; IPAR 2004). Overall, targeting the parliamentarians may have a more long-term effect through strengthening networks of support for reproductive health among politicians and paving the way for future work with parliamentarians (NCAPD 2006b), rather than directly affecting the budget line. However, it is possible that the parliamentary workshops may have catalysed the budget line decision from the Ministry of Health, by putting senior officials in the ministry under scrutiny about their response to the deteriorating KDHS indicators. In this way, the workshops can be regarded as ‘focusing events’, which raised the profile of the issue, strengthened networks of sympathetic individuals, and mobilized action.

In the parallel, hidden advocacy process, officials within the Division of Reproductive Health (DRH) worked to influence budget officials in the Ministries of Health and Finance to support public funding of contraceptive commodities (I1). NCAPD provided data and other support to the DRH in this process. A line of advocacy was necessary through government hierarchies, where the Head of the DRH took advantage of routine meetings to persuade Ministry of Health budget officials and senior administrators such as the Director of Medical Services of the importance of adding family planning to the budget (I8; I17). In turn, these senior officials had to convey this message to the Ministry of Finance and during multi-sectoral planning meetings such as MTEF meetings.

[The Division of Reproductive Health (DRH)] needs to be able to push the DMS [Director of Medical Services] who oversees the budget under the PS [Permanent Secretary] to make these decisions. There is a line of command from DRH to DMS to PS to the Ministry of Finance. If Kibara [Head of the DRH] is not shouting enough to the DMS, the DMS will not be shouting to the PS, and so on. (I8)

The decision-making process to allocate government resources to contraceptive commodities began when bureaucrats in NCAPD, DRH and the Ministry of Health Planning Unit variously identified the need for the budget line (I4; I1; I2; I7). The process encompassed ministerial budget meetings and the Medium Term Expenditure process and culminated in the acceptance of the budget by the Minister of Finance. The Planning Unit in the Ministry of Health started the process officially, tabling arguments to the Ministerial Budget Committee charged with formulating the budget. Officials in the Planning Unit presented key budget decision-makers in the Ministry of Health, including the Director of Medical Services and the Permanent Secretary, with arguments about the need for the new budget line based on shortfalls in family planning funding from donors and the implications of declining KDHS indicators for health and development. In turn, the Ministry of Health Budget Committee inserted the budget line into the ministerial budget and defended it to the cross-sector MTEF Secretariat in the Ministry of Finance (I12; I13).

This intra-government advocacy can be seen as a strategy to create a sense of urgency about family planning as a policy problem, in order to create more favourable decision-making dynamics. The KDHS data played an important role, and government economists were said to be receptive to arguments about the importance of access to contraceptives for improving maternal health and child health indicators (I2; I4; I12; I13; I17). The Public Expenditure Review, carried out by the Planning Unit, provided evidence of the fluctuating resources for family planning, which was presented to the Minister and other senior policy-makers in the Ministry of Health to demonstrate that donor funds were unreliable and inadequate without national allocations (I13).

In addition to the use of statistics, a wide range of policy narratives were employed by different actors in their bid to reframe family planning as an important issue for economic growth, development and health, which should be prioritized in public policy-making. Arguments were made to counter a general perception among policy-makers that sustained fertility transitions occur automatically due to socio-economic change,
without requiring government intervention (12; 16). One key informant stated that ‘without continual family planning IEC, acceptance will decline’ (16). Another key informant argued that argued that there is a tendency for poor communities to continually reduce their acceptance of FP [...] FP is not readily accepted by the poor except if they receive information and community-based distribution. Hence the need for continuous IEC provision. (12)

Particular individuals used various policy narratives, targeting arguments to particular audiences. Key informants explained how the Head of the Division of Reproductive Health used ‘government language’ and internal advocacy within the Ministry of Health to make sure the issue did not seem radical or part of an external agenda (17, 16). Advocates appealed to nationalism (12; 13):

NCAPD’s argument to the government is: “don’t allow the life of your citizens to hang on the whims of donors”. We must have a Plan B – of government money for family planning. (12)

The slogan ‘Planning our families is Planning for our Nation’s Development’ was used in advocacy materials distributed at the advocacy workshops (NCAPD 2005). In advocacy initiatives to influence government officials and parliamentarians, proponents of family planning focused on the importance of family planning for economic and social development and poverty reduction, and specifically for achievement of the Millennium Development Goals (APHERC 2005; NCAPD 2005, 2006a,b).

There were also attempts to transform attitudes among policy elites about the beneficiaries of contraception, highlighting the benefits for men, children, low-income families, and the nation at large, countering popular assumptions that contraception is a ‘women’s issue’ (APHERC 2005). Some key informants for this study described the importance of presenting family planning as uncontroversial and in line with national Kenyan aspirations and prevailing gender norms.

With a couple of notable exceptions, reproductive health rights were very rarely used in advocacy materials distributed at the advocacy workshops (NCAPD 2005; NCAPD 2005), and remain controversial even among some senior government officials (117). However, population and sexual and reproductive health narratives were adeptly combined by some key informants, without explicitly referring to rights. One example was the argument that high quality contraceptive services based on a choice of methods are essential for acceptance of contraception by the Kenyan public and for lowering total fertility rates. Shortages of family planning commodities in clinics and poor quality of service delivery were blamed for causing discontinuation of contraceptive use and decreasing acceptance of contraceptive methods (11, 12, 18).

In the 1990s, there was unmet need for FP. Many women had unintended children. When they went to a facility, they did not find the contraceptive of their choice. They went away, meaning to come back another time, but did not [...]. When there are shortfalls in FP commodities, fertility goes up automatically. (11)

Discussion and conclusion

This paper examines the challenge of sustaining commitment to existing policies in politics-as-usual circumstances, rather than focusing on the agenda-setting phase of policy reform, as is more common in the field of policy analysis. Policy space for the issue of family planning in Kenya contracted during the late 1990s, and subsequently began to expand, due both to changing contextual factors and the ways in which advocates within and outside government worked with these factors.

The case study approach brings certain limitations to this paper. In particular, it limits the potential for developing concrete assertions about causality in the policy process or for generalizing about results. However, the paper does support lessons on policy processes from other contexts, and also provides suggestions for how policy space analysis could be utilized more widely in health policy analysis.

Firstly, the paper demonstrates the potential for the use of policy space analysis to identify the challenges and opportunities for sustaining or increasing commitment to existing policies in politics-as-usual circumstances. This is particularly useful for cases involving ‘unplanned drift’ of policies in response to trends such as political pressures or opportunities or shifts in funds provided by global initiatives (Buse et al. 2005).

Policy space analysis can be used both as an analytical framework and as a tool that proponents of a policy issue can use to map the boundaries of policy space and identify the actions that could be undertaken to expand it. Key advantages of the policy space analysis framework include its explicit focus on the dynamics of decision-making circumstances, the influence of vested interests in shaping policy outcomes, and the agency of policy elites (Walt and Gilson 1994). In this way, policy space is a powerful and under-utilized tool for analysis of the political economy of public health policies.

The case study reveals the important role government officials can play in sensitizing colleagues within and between ministries to neglected SRH issues. In Kenya this was dependent on the existence of highly motivated individuals in both the Ministry of Planning and the Ministry of Health, and the existence of the NCAPD, which had the independence and mandate to carry out advocacy on population-related issues.

This case study provides support for Thomas and Grindle’s observation that the ‘policy content’ of population policies, involving sustained bureaucratic demands, dispersed benefits and low political stakes, is a likely reason why policies relating to contraceptive services tend to evolve slowly and are often poorly implemented (Thomas and Grindle 1994). In Kenya, the advocacy around family planning and the 2005 budget involved attempts to counter this tendency by securing political commitment and government resources for the issue and addressing complacency by feeding new evidence from the 2003 KDHS into policy.

The public advocacy events involving parliamentarians and the media organized by NCAPD and other partners could be seen as an attempt to move the issue from the purely bureaucratic arena into the public domain. The case study demonstrates that research examining policy processes would benefit from investigating budget processes in more detail, because of their role in intra-government negotiation and advocacy for planning and prioritizing policy issues.
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The case study supports Shiffman’s assertion of the importance of both the availability of reliable indicators to demonstrate the policy problem and the organization of focusing events (Shiffman 2007). As predicted by Thomas and Grindle (1994), technical analyses of population problems played a central role in persuading policy elites of the need for reform. The government officials and politicians who support family planning appear to have been skilled at selecting from the range of policy narratives and tailoring their arguments for different audiences. Advocates’ use of arguments to frame contraceptive services as non-radical and in tune with national development goals and prevailing gender norms can be seen as a useful strategy for increasing recognition of the importance of these services and tackling sources of scepticism about them (Scho¨ n and Rein 1991; Joachim 2003). Grindle and Thomas (1991) focus on the implications of policy characteristics for the distribution of costs and benefits to key stakeholders. However, where policy issues that are highly influenced by social and cultural values are concerned, including sexual and reproductive health policies, the ways in which policies are framed to stakeholders may be equally important.

Despite the significant expansion of policy space identified in this case study, very few of the key informants interviewed were of the opinion that contraceptive service delivery and information campaigns have returned to the levels of success experienced during the 1980s. Proponents of family planning in Kenya continue with their efforts to promote family planning as a priority in Kenya and to secure further resources for implementation. However, they may not be able to achieve major improvements in service delivery without successfully tackling the weaknesses in government procurement and distribution of contraceptive commodities.

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References


Endnotes

1 The key informants were from the Ministry of Health [one official in the ministry’s Planning Unit and two officials in the Division of Reproductive Health (15; 14; 113)], the National Coordinating Agency for Population and Development (NCPAD) (11; 12; 17), the Kenyan National Bureau of Statistics (112), the donors USAID and UNFPA (114; 117), and the NGOs Planned Parenthood Federation of America, Futures Group, Kenyan Association for the Promotion of Adolescent Health (KAPAH), and Marie Stopes International (15; 16; 18; 115; 116). Additional unstructured discussions were carried out with an international adviser to the Ministry of Health (110), an NGO representative (111), and a demographer with expertise on family planning in Kenya (19).

2 The public sector Medical Supplies Coordinating Unit (MSCU) was transformed into a parastatal and renamed KEMSA in 2000.

3 The KDHS 2003 results were published in 2004 but were discussed in meetings during late 2003 within the Ministry of Planning and with other stakeholders.

4 This figure is based on the conversion rate between Kenyan Shillings and US Dollars in June 2005.

5 Although the specific agenda to use advocacy to ‘reposition family planning’ began to appear in government documents during 2003, the agenda appears to have its roots among actors in the then NCPD and supporting US agencies from before the KDHS figures emerged. A 2003 document that does not feature KDHS results cites the need for ‘renewed high-profile public commitment by high-level leaders to reinvigorate FP in Kenya’ (NCPD 2003).


NCAPD. 2006a. Proposed Workshop of Parliamentary Network on Population and Development to be held on 5–6 May 2006: A summary of initiatives to work with MPs to lobby for support to population and development issues. Nairobi: NCAPD.


Child survival gains in Tanzania: analysis of data from demographic and health surveys

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Summary

Background A recent national survey in Tanzania reported that mortality in children younger than 5 years dropped by 24% over the 5 years between 2000 and 2004. We aimed to investigate yearly changes to identify what might have contributed to this reduction and to investigate the prospects for meeting the Millennium Development Goal for child survival (MDG 4).

Methods We analysed data from the four demographic and health surveys done in Tanzania since 1990 to generate estimates of mortality in children younger than 5 years for every 1-year period before each survey back to 1990. We estimated trends in mortality between 1990 and 2004 by fitting Lowess regression, and forecasted trends in mortality in 2005 to 2015. We aimed to investigate contextual factors, whether part of Tanzania’s health system or not, that could have affected child mortality.

Findings Disaggregated estimates of mortality showed a sharp acceleration in the reduction in mortality in children younger than 5 years in Tanzania between 2000 and 2004. In 1990, the point estimate of mortality was 141·5 (95% CI 141·5–141·5) deaths per 1000 livebirths. This was reduced by 40%, to a peak estimate of 83·2 (95% CI 70·1–96·3) deaths per 1000 livebirths in 2004. The change in absolute risk was 58·4 (95% CI 32·7–83·8; p<0·0001). Between 1999 and 2004 we noted important improvements in Tanzania’s health system, including doubled public expenditure on health; decentralisation and sector-wide basket funding; and increased coverage of key child-survival interventions, such as integrated management of childhood illness, insecticide-treated nets, vitamin A supplementation, immunisation, and exclusive breastfeeding. Other determinants of child survival that are not related to the health system did not change between 1999 and 2004, except for a slow increase in the HIV/AIDS burden.

Interpretation Tanzania could attain MDG 4 if this trend of improved child survival were to be sustained. Investment in health systems and scaling up interventions can produce rapid gains in child survival.

Funding Government of Norway.

Introduction

The Millennium Development Goal (MDG 4) to reduce mortality in children younger than 5 years by two-thirds between 1990 and 2015 has come into focus in recent years as a galvanising force to align global and national efforts towards poverty reduction and better health.1,2 Much of the current burden of mortality in children younger than 5 years in low-income countries is preventable if effective coverage of available cost-effective interventions can be achieved.3 However, global assessments of the 60 priority countries where most children younger than 5 years die show that very few are on track to reach MDG 4.4,5 Many of these countries are in sub-Saharan Africa, where little or no reduction in mortality in children younger than 5 years was evident throughout the 1990s. Since 2000, global health initiatives and resources for health have increased sharply,6 which has increased coverage of life-saving child health interventions in several countries.7-10 We would therefore expect to see more evidence of progress towards MDG 4 in such settings in the mid-decade assessments.

Since registration systems in sub-Saharan Africa have low coverage, most countries rely on periodic national birth-history surveys to obtain direct retrospective estimates of child mortality.11 Such national surveys are done every 4–5 years and generally include measures of coverage for priority child-health interventions.12 The surveys are standardised by national bureaus of statistics such as demographic and health surveys (DHS), which are sponsored by USAID, and multiple indicator cluster surveys, which are sponsored by UNICEF. More than 40 national mortality surveys from the 60 priority countries will be available in 2005–07,12 one of the first of which is from Tanzania.

In 1990, mortality in children younger than 5 years in Tanzania was 141 per 1000 livebirths; thus, Tanzania’s MDG 4 is to reduce this to 47 per 1000 by 2015. In Tanzania, demographic and health surveys were done in 1992, 1996, 1999, and 2005.13-16 The first three surveys showed that the rate of child mortality throughout the 1990s was high but static, oscillating between 141 and 147 deaths per 1000 children (table 1). The most recent survey, from late 2004 and early 2005, showed that the probability that a child would die before they reached their fifth birthday fell by 24%, from 146·6 (95% CI 128·4–164·8) deaths per 1000 in 1999 to 112·0 (95% CI 108·4–115·0) deaths per 1000 in 2005.17 We aimed to investigate yearly changes to identify what might have contributed to this reduction and to investigate the prospects for meeting the Millennium Development Goal for child survival (MDG 4).
102·6–121·5) deaths per 1000 in 2004 (p=0·02). Similarly, the probability of dying before the first birthday (data not shown) fell by 31% from 99 to 68 deaths per 1000 over the same period. Reductions in mortality were concentrated in postneonatal infants (ie, those older than 28 days and younger than 12 months) and were greater in rural areas. Neither neonatal nor maternal survival increased during this period. The 24% drop in mortality in children younger than 5 years, to 112 deaths per 1000, was calculated from the average mortality across the 5 years before the survey.

Such a decline is unlikely to be due to one factor. But what can account for it? What are the prospects now for Tanzania to reach MDG 4 over the ensuing 10 years? And what can we learn that would help other countries to accelerate progress towards MDG 4? We aimed to calculate the annual rates to examine the pattern of the reduction in mortality and to see if the point estimate for the year 2004 differed from historical values or from the period average. We also investigated Tanzania’s health-system investments, including coverage of child-survival interventions between the late 1990s and 2000–04, and examined other factors, not related to the health system, such as national economic growth, poverty reduction, food security, climate shock, fertility, maternal education, and HIV/AIDS, that could plausibly have exerted large, rapid effects on child survival.

**Methods**

**Data sources**

To assess trends in mortality since 1990 we used all four Tanzanian demographic and health surveys, from 1992, 1996, 1999, and 2004–05. These were nationally representative cluster sample surveys that covered 8327, 7969, 3615, and 9735 households in 1992, 1996, 1999, and 2005, respectively. The surveys provided direct estimates of child mortality through complete fertility (birth) histories of 32 877 women aged between 15 and 49 years. The surveys also provided detailed information about household demographics; asset ownership; dwelling conditions; health and nutritional status of women and children; coverage of health-care services such as immunisation, insecticide-treated nets, and maternal and child health; and current knowledge and practices related to health. Survey data were obtained by trained personnel, with the verbal informed consent of participants. To assess coverage of child-health interventions, we also used a 2003 survey on service provision in Tanzania, which was a nationally representative facility-based survey of maternal and child health and HIV/AIDS services. All the surveys provided cross-sectional data on intervention coverage in their respective years.

We obtained data for poverty from Tanzanian household budget surveys in 1992 and 2002, which tracked the progress of the government’s poverty-monitoring strategy. These surveys sampled 4000 households in 1991–92, and 22,000 in 2001–02. The sampling of the survey was designed to allow estimates of household variables for the 21 administrative regions of mainland Tanzania. Household and individual indicators included measures of income poverty and performance of priority sectors as defined in a paper on the government’s poverty-reduction strategy. Data for trends in gross domestic product (GDP) per person were obtained from the Bank of Tanzania’s annual reports, the Penn World Tables, and the Tanzania public expenditure review.

**Statistical analysis**

We analysed the raw data from all four Tanzania DHS surveys (1992, 1996, 1999, and 2004) to generate several estimates of mortality in children younger than 5 years for every 1-year period before the respective survey back to 1990, by use of direct methods based on complete birth histories. For every child recorded in these birth histories, we computed survival for every month from birth until either their fifth birthday or the date of the survey. We grouped periods at risk and deaths for each calendar year, and constructed a separate life table for each year in the birth histories for which sufficient data were available to show, for a person at each age, the probability that they would die before their next birthday. This generated 35 estimates of mortality over the 15-year period from 1990 to 2004. We estimated trends in mortality from 1990 to 2004 by fitting Lowess regression of the natural log of mortality in children younger than 5 years in[5q0] to time with bandwidths ranging from 0·2 (representing high sensitivity to recent data) to 2·0 (low sensitivity) and forecasted this trend for mortality from 2005 to 2015 with the same range of bandwidths. We calculated confidence intervals for probabilities with Greenwood’s formula.

We obtained fiscal-year data on total health spending, both on-budget and off-budget, from the public-expenditure reviews of the Tanzanian Ministry of Finance and Ministry of Health and Social Welfare. Spending data included all domestic government health spending (including the government’s contribution to the national health insurance fund) and all aid spending on health from official documents. We did not include private out-of-pocket expenditure. We adjusted total government health expenditure for each year with consumer price-index deflators on the 1998/99 base year to provide the total government health expenditures per person per year. Thus,
Figure 1: Annual mortality in children younger than 5 years from 1990 to 2005
Data are from an analysis of the 2004–05 national demographic and health surveys in Tanzania.14 Dotted line shows Tanzania’s MDG-4 target of 47 deaths per 1000 livebirths by 2015. Vertical lines show 95% CIs for survival probabilities.

Figure 2: Estimates of annual mortality in children younger than 5 years
Data are from reanalysis of four national demographic and health surveys in Tanzania, which included the birth histories of 32,877 women aged 15–49 years in 1992, 1996, 1999, and 2004–05.15 The MDG-4 target in 2015 is shown by the horizontal line. The dotted line shows the rate of reduction needed to reach this target. Lowess regression forecasts of possible future trends are shown by coloured lines, with red giving most weight and yellow giving least weight to recent data trends.

Factors not related to health systems included fertility, GDP per person, and rates of poverty. We also examined any major shocks, such as measles or meningitis epidemics, famine, or increased food insecurity, that might have affected mortality differently in the 1990s and after 2000.

Role of the funding source
The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results
Our results for disaggregated annual mortality (figure 1) show that the rate of reduction accelerated between 2000 and 2004. In 2004–05, the reduction in mortality between 1990 and 1999 was 1.4% per year whereas for 2000 to 2005, this trend accelerated to 10.8% per year (from regression trend analysis). The point estimate of mortality in children younger than 5 years in 2004 was 83.2 (95% CI 70.1–96.3) per 1000, which was 40% lower than typical values seen in the 1990s corresponding to a change of 58.3 per 1000 in absolute risk (95% CI 32.7–83.9). This raises the question: is MDG 4 more achievable than was previously appreciated? Figure 2 shows the family of smoothed regressions of the combined disaggregated mortality data from all four demographic and health surveys with extrapolation to 2015 under different weightings for the recent past. All these weighting projections suggest that MDG 4 is within reach in Tanzania by 2015.

We compared the status of selected health-system factors across the major functions of governance, financing, resource allocation, and service delivery for 1999 and 2005. Health systems improved substantially on the basis of most of the indicators that we investigated. With respect to governance, financing, and resources, Tanzania adopted a sector-wide approach (SWAp) for medium-term and long-term planning, in which a coherent policy and expenditure programme, under government leadership, was jointly funded by pooled government and donor partners. A so-called basket fund, jointly funded by partners, was created to provide an additional US$50–50 per person to districts as recurrent financing support. This approach was implemented in 2000–01 and constituted a major change in the health system that decentralised substantial financial resources for the first time. Moreover, between 1999 and 2004, we noted a 2.3-fold increase in total government health expenditure, from US$4.70 to $11.70 per person. Total health expenditure, including private expenditure, increased from US$23 to $29 per person, indicating that most of the growth in health spending was due to increases in government expenditure.

On the policy front, many health reforms planned during the 1990s started to be implemented during
the 2000s, including the sector-wide approach basket funding; new guidelines, methods, and informatics for district planning and management; and new policies (eg, substitution of more effective first-line anti-malarial drugs). Under its poverty-reduction strategy, Tanzania’s Ministry of Health and Social Welfare increased the priority of cost-effective interventions which supported national decisions and commitments to scale up and strengthen several key child-survival interventions such as Integrated Management of Childhood Illness (IMCI), vitamin A supplementation, immunisation, and insecticide-treated nets. We did not record major gains in numbers of health professionals or physical infrastructure for health during this period.

For service delivery, the coverage of interventions relevant to child survival improved between the 1999 and 2004–05 surveys (figure 3). The most noticeable changes were vitamin A supplementation (up from 14% in 1999 to 85% in 2005), IMCI (up from 19% to 73% of districts), households with mosquito nets (up from 21% to 46%), children sleeping under insecticide-treated nets (up from 10% to 29%), iron supplementation in pregnancy (up from 44% to 61%), oral rehydration therapy for children (up from 57% to 70%), and exclusive breastfeeding for those younger than 2 months of age (up from 38% to 70%) and younger than 6 months (up from 32% to 41%). Coverage of other interventions did not change significantly, since it was already high in 1999 (figure 3). Coverage of prevention of mother-to-child transmission of HIV (PMTCT) and antiretroviral therapy as of 2005 remained very low, and national decisions and commitments to scale up and strengthen several key child-survival interventions such as Integrated Management of Childhood Illness (IMCI), vitamin A supplementation, immunisation, and insecticide-treated nets. We did not record major gains in numbers of health professionals or physical infrastructure for health during this period.

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Discussion

In Tanzania, the most recent demographic and health survey in 2005 showed a 24% improvement in child survival, with mortality rates in children younger than 5 years down from 147 deaths per 1000 for 1994–99 to 112 deaths per 1000 for 2000–04 (p<0·02). In national birth-history surveys, these 5-year averages conceal the pattern and degree of change in yearly rates. Since this 5-year change substantially exceeded 15%, the minimum regarded by Korenromp and colleagues as indicative of a true reduction, we decided to calculate the yearly rates to examine the pattern of the reduction and to see if the point estimate for the year 2004 differed from historical values or from period average.

Our analysis of the annual rates shows a pattern of continuous reduction in mortality reaching 83·2 (95% CI 70·1–96·3) deaths per 1000 in 2004. Within the 2004–05 survey data, five of the six lowest values over the 15 years were recorded in the last 5 years, indicating that mortality in this group fell by 40% between 1990 and 2004. Based on Tanzania’s 2002 population of 34·4 million, this finding suggests that 280 000 children’s lives were saved between 1999 and 2005 that would otherwise have been lost had the prevailing rate of the 1990s continued.

Our analyses of data from all four demographic and health surveys, analysed by year of reference, thus suggest that Tanzania is on the trajectory necessary to achieve MDG 4 by 2015, for a range of different weightings of past performance in the distant or near past, back to 1990. Our results differ from those of an analysis of all available data from direct and indirect estimates of mortality disaggregated into 2-year intervals, including data before 1990, which concluded that Tanzania would not be able to achieve this goal. However, the data from before 1990 can have little bearing on the ability to achieve a goal for which the starting point is 1990, especially since the purpose of the MDG was to elicit changes in trends. To assume that the trend before 1990 continued would imply that setting the goal was futile. In this specific instance, performance was poor before 1990, and inclusion of earlier data biases the conclusion towards a slower improvement. Furthermore, all extrapolations must, of necessity, assume a degree of continuity in the underlying processes, and so tend to over-smooth if a trend accelerates, as it seems to have done in Tanzania in about 2000. Since aggregation of the data into longer time-units tends to increase the degree of this smoothing, we disaggregated the data into shorter time units.

The large reduction in mortality evident since 2000 immediately raises questions about the quality of surveys and data and about comparability over time. Additional quality control was provided for the 2004–05 demographic and health survey and its data precisely because fewer information about children whose mothers died. However, the demographic surveillance systems in Tanzania, which track entire populations longitudinally, also reported reductions in mortality in children younger than 5 years, which substantiates the data from the demographic and health survey and its data precisely because fewer child deaths were recorded than were expected. Under-reporting bias could also have occurred, for example if maternal mortality increased because of HIV/AIDS or other factors. The cross-sectional demographic and health surveys did not gather information about children whose mothers died. However, the demographic surveillance systems in Tanzania, which track entire populations longitudinally, also reported reductions in mortality in children younger than 5 years, which substantiates the data from the demographic and health surveys. Furthermore, demographic and health surveys in 1999 and 2005 did not detect any major increases in maternal mortality between these two periods, although such changes would be difficult to detect in sample sizes used in the demographic and health surveys. With respect to deaths of mothers due to HIV/AIDS, reduced mortality in children younger than 5 years is probably not an artifact caused by the under-reported deaths, since the estimated magnitude of this effect in a rural Tanzanian population with an HIV prevalence of 4·3% would underestimate deaths in children younger than 5 years by only 2·3%.

If we assume that our finding of a reduction in mortality for children younger than 5 years is real, what can explain this apparent acceleration of survival in Tanzania after a decade of high but static mortality rates in the 1990s? And can this improvement be sustained? We examined differences in the health system in Tanzania between 1999 and 2004 and in external factors that could reasonably be expected to have contributed to large survival gains over

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Table 2: Comparison of non-health system changes between 1999 and 2005 that might be expected to affect child survival

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2004–05</th>
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<tr>
<td>Completed primary education</td>
<td></td>
<td></td>
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<tr>
<td>Completed secondary education</td>
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<tr>
<td>Years of schooling</td>
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Table 3: Educational attainment of men and women aged 15–49 years

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2004–05</th>
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<tbody>
<tr>
<td>Gross domestic product per person</td>
<td>05·276</td>
<td>05·303</td>
</tr>
<tr>
<td>Number living in poverty (food)</td>
<td>21·6%</td>
<td>18·7%</td>
</tr>
<tr>
<td>Number living in poverty (basic needs)</td>
<td>38·6%</td>
<td>35·7%</td>
</tr>
<tr>
<td>Food security</td>
<td>No change</td>
<td></td>
</tr>
<tr>
<td>Climate shock</td>
<td>No change</td>
<td></td>
</tr>
<tr>
<td>Total fertility rate (children for every mother)</td>
<td>5·6 (5·0–6·1)</td>
<td>5·7 (5·4–5·9)</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>2·5 (20·5–3·3)</td>
<td>2·4 (2·3–2·6)</td>
</tr>
<tr>
<td>Age at first birth (years)</td>
<td>19·2 (17·4–21·6)</td>
<td>19·4 (17·7–21·8)</td>
</tr>
<tr>
<td>Birth spacing (months)</td>
<td>33·3 (28·0–41·0)</td>
<td>34·4 (28·0–42·4)</td>
</tr>
<tr>
<td>Malaria epidemics</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Measles epidemics</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>HIV/AIDS epidemics</td>
<td>Increasing mortality</td>
<td></td>
</tr>
<tr>
<td>Data are from demographic and health surveys in Tanzania in 1999 and 2005.</td>
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Women 46% 49% 5% 9% 6·1 6·2
Men 51% 52% 7% 11% 6·2 6·3

Data are from demographic and health surveys in Tanzania in 1999 and 2005.
this short period. Between 1999 and 2004, Tanzania more than doubled its public expenditure on health; such increased expenditure has been strongly correlated with increased survival in children younger than 5 years in developing countries, especially in poor people. Increased public expenditure on health could also be especially powerful in decentralised health systems when such resources are targeted towards essential cost-effective interventions. Tanzania implemented such governance shifts towards greater decentralisation in 2000, by introducing sector-wide capitation grants that gave districts substantial financial resources. This was perhaps one of the most important distinctions in Tanzania’s health system between the 1990s and the 2000s, since it opened opportunities for local problem solving and provided resources for districts to selectively increase resources for key interventions, as has been shown in pilot studies since 1996.

Decentralisation allowed the introduction and scale-up of new interventions such as the integrated management of childhood illness, which facilitated adoption of new treatment policies for malaria that replaced failing first-line treatments with more effective case management for the largest single cause of death for children. The IMCI programme also assisted promotion of the use of insecticide-treated nets for malaria prevention. Sentinel districts had piloted the introduction of IMCI from 1997, with full provision, increased use, and effective coverage by 1999–2000. Impact studies showed that, after a 2-year follow-up, IMCI was associated with 13% lower child mortality in pilot districts that had health-system strengthening than in other districts. Other pilot studies in Tanzania showed the high local effectiveness of insecticide-treated nets for reduction of mortality in children of this age.

Tanzania started nationwide scale-up of insecticide-treated nets in 1999 and of IMCI in 2000, and changed its drug policy for malaria in 2001. Since malaria mortality in Tanzania is concentrated in postneonatal infants younger than 5 years, the survival gains recorded in the 2004–05 demographic and health survey were highest for postneonatal infants, suggesting that malaria-specific mortality reduction has made progress. Moreover, several sentinel sites in Tanzania, which monitor cause-specific mortality by use of continuous longitudinal demographic surveillance systems, also reported reductions in mortality in children younger than 5 years before the findings of the 2004–05 demographic and health surveys, and detected declines in malaria and acute febrile illness deaths in children younger than 5 years. These findings add plausibility to the hypothesis that the collective effect of a multifaceted approach to malaria contributed to child-survival gains during this period. Coverage of other child-survival interventions, such as antenatal care an immunisation, exclusive breastfeeding, oral rehydration therapy and iron supplementation for children, increased. For other interventions, such as antenatal care an immunisation, coverage was already high, and did not change.

Modelling showed that a 33% reduction of mortality in children younger than 5 years could be expected between 1999 and 2004, from 129 to 86 deaths per 1000 livebirths. These effects would mainly be in reduction of postneonatal mortality in children younger than 5 years. The predicted failure to affect neonatal (and maternal) mortality draws attention to problems with the continuum of care necessary to achieve MDGs. The general scarcity of data and analyses continues to limit programme efforts and monitoring of progress.

Among factors not related to the health system, gains in wealth would be expected to exert a major effect on survival in children younger than 5 years. Tanzania has enjoyed many decades of political stability and, in recent years, steady economic growth. Nevertheless, GDP per person has increased by only 93 international dollars (US$47) over the 5 years between 1999 and 2004. An increase of this size corresponds to an expected decrease in mortality in children younger than 5 years of 2·2%, on the basis of a regression of GDP (in international dollars) per person and mortality in children younger than 5 years for 45 sub-Saharan countries (data reanalysed from WHO statistics). Although important, this growth in national wealth would be unlikely to account for much of our finding of a 40% reduction in mortality, especially since the proportion of the population living below the absolute poverty line and food poverty line in the 1990s had improved only slightly in 2002. Although gains have been made in the education of Tanzania’s current cohort of schoolchildren, child-health outcomes are affected by the educational status of parents, which had improved only marginally by 2004. Early child-bearing and short birth-spacing both raise the risk of child mortality, and the total fertility rate, average age at first birth, adolescent childbearing, and median birth intervals remained similar in the two periods. Hence changes in fertility probably did not contribute to our findings of a large improvement in child survival.

We did not find evidence of any major epidemics (for example, of measles or meningitis) that might have occurred in the late 1990s but not in the early 2000s. Conversely, adult and child mortality due to HIV/AIDS continued to increase slowly, and therefore differentials in HIV/AIDS interventions might have affected overall mortality, since 25% of children who are born to HIV-positive mothers are infected. The PMTCT programme is a proven cost-effective combination of strategies and interventions that can be tailored to specific local conditions. These interventions and strategies, including voluntary and confidential counselling and testing, provision of antiretroviral drugs to HIV-positive pregnant women, planning of safe delivery procedures, and counselling about appropriate infant-feeding options, can reduce mother-to-child transmission by 50%. However, in Tanzania access to HIV/AIDS interventions...
such as voluntary counselling and testing, PMTCT, and antiretrovirals was not yet sufficient as of 2004 to have affected child survival on a national scale. Epidemic patterns, including HIV/AIDS and its response, can therefore be excluded as an explanation for the reduction in child mortality, and could even have worked against this trend.

Nutrition can be determined by health systems (eg, micronutrient supplementation and other health sector interventions) and by other factors (eg, food insecurity, poverty, climate shocks, and natural disasters). We did not identify evidence of major events outside the health system that could have contributed to changes in nutritional status in Tanzania during the study period. However, the nutritional status of children did improve slightly, possibly because of better access to various general health interventions (eg, IMCI, insecticide-treated nets, and vitamin A supplementation), and slight gains in wealth. Improved nutritional status is likely to have contributed to the reduced risk of mortality in children younger than 5 years.

If we assume that the trend is real, and is due to a strengthening health system and increased access to key child-survival interventions, can this trend be continued? It should be noted that the most recent demographic and health survey, in 2004–05, preceded the potential effect of increased funding to Tanzania from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Although the first grants were announced in late 2002, the actual programmes that they supported did not begin until late 2004, and the benefits would not have been detectable in the last demographic and health survey but can be expected to assist the downward trend into the future. For children, these funds will boost access to insecticide-treated nets through a national voucher scheme, which is designed to provide the nets to all pregnant women and their newborn babies, which started in late 2004. Scaling up the PMTCT programme and antiretroviral therapy started in 2005; programmes for zinc supplementation and oral rehydration therapy started in 2007; and access to improved antimalarial treatment through artemisinin combination therapy in 2007.

Since neonatal mortality remains constant and forms an increasing share of the mortality in children younger than 5 years, it could emerge as a barrier to continued reductions in mortality and attainment of MDG 4. Renewed efforts are being planned to address neonatal and maternal mortality in Tanzania. These efforts will coincide with a doubling in the sector-wide district basket fund for the Tanzanian health system to US$1·00 per person per year. Such continued efforts at scaling up will need concomitant investments in strengthening of health systems, including management of human resources, procurement and supply chain management, health information management, and constant attention to enhancing quality of care.

We were unable to estimate the relative contributions of different factors in the health system to reduction of child mortality since 2000. However, the collective weight of so many positive changes in the health system, in the absence of other explanations, is compelling. Rather, we could ask why we would not expect to see gains in survival. Broad, multifaceted progress in stewardship, public expenditure on health, decentralised financing, resource allocation, and better coverage of essential child-survival services can work synergistically to effect important progress towards MDG 4 in low-income countries such as Tanzania. Increased health resources combined with strengthening of decentralised health systems to ensure that life-saving interventions reach those in need is a key child-survival strategy.

References
1 Horton R. A new global commitment to child survival. Lancet 2006; 368: 1041–42.
The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis

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c Norwegian Knowledge Centre for the Health Services
d Centre for History in Public Health, London School of Hygiene and Tropical Medicine, United Kingdom

A B S T R A C T

There is re-emerging interest in community health workers (CHWs) as part of wider policies regarding task-shifting within human resources for health. This paper examines the history of CHW programmes established in South Africa in the later apartheid years (1970s–1994) — a time of innovative initiatives. After 1994, the new democratic government embraced primary healthcare (PHC), however CHW initiatives were not included in their health plan and most of these programmes subsequently collapsed. Since then a wide array of disease-focused CHW projects have emerged, particularly within HIV care.

Thirteen oral history interviews and eight witness seminars were conducted in South Africa in April 2008 with founders and CHWs from these earlier programmes. These data were triangulated with written primary sources and analysed using thematic content analysis. The study suggests that 1970s–1990s CHW programmes were seen as innovative, responsive, comprehensive and empowering for staff and communities, a focus which respondents felt was lost within current programmes. The growth of these earlier projects was underpinned by the struggle against apartheid. Respondents felt that the more technical focus of current CHW programmes under-utilise a valuable human resource which previously had a much wider social and health impact. These prior experiences and lessons learned could usefully inform policy-making frameworks for CHWs in South Africa today.

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Introduction

Community health workers (CHWs) are increasingly advocated as a potential solution to overcoming current shortfalls in human resources for health in different settings (Chopra, Munro, Lavis, Vist, & Bennett, 2008; Lewin et al., 2010; WHO, 2008). CHW is an umbrella term used for a heterogenous group of lay health workers. Their remit can range from implementing biomedical interventions to acting as community agents of social change (Lewin et al., 2010; WHO, 2008). This paper defines CHWs as people chosen within a community to perform functions related to healthcare delivery, who have no formal professional training or degree. CHWs initially gained global support at the 1978 Alma Ata conference on primary healthcare. They were seen as a key element of the strategy to achieve WHO’s goal, set in 1975, of ‘Health for All by the year 2000’. Many CHW programmes were established in the 1970s in low- and middle-income countries (Walt & Gilson, 1990). However, interest waned in the late 1980s and 1990s for several reasons: structural adjustment programmes; government failure in countries where large programmes were operational; and changes in ideology (Frankel, 1992; Walt & Gilson, 1990; WHO, 1986).

South Africa has a rich history of CHW projects that burgeoned during the repressive regime of apartheid (Table 1 juxtaposes key historical and project events). Under this racially and politically divided regime, healthcare was intentionally inequitably distributed (WHO, 1983). Among the first CHWs were malaria assistants trained in the late 1920s by G.A. Park Ross, a senior health officer in Natal and Zululand (MacKinnon, 2001). In the 1940s, despite an early Smuts government advocating racial segregation, supporters of social medicine initiated the ‘health centre’ movement. Chief among the politicians involved was Henry Gluckman, the then Minister of Health, who had been influenced by the United Kingdom’s Beveridge Report (1942). The ambitious 1942 National Health Service Commission and 1945 Gluckman Report set out to provide “unified healthcare to all sections of the people of South Africa”. They addressed both the social and biomedical causes of disease, responding in part to concerns regarding the effects of poor health on black migrant labourers’ and miners’ productivity.

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(Phillips, 1993). However, the government only adopted the recommendation to establish health centres (Jeeves, 2000, 2005; Marks, 1997). Modelled on the rural health centre in Pholela (near Durban) initiated by Sidney and Emily Kark — a progressive and politically well connected medical couple — these centres were staffed by community nurses and assistants who treated and surveyed health problems (Kark, 1951; Tollman, 1994). Only 40 of these centres were eventually built to serve black communities. This service became racialised and gained a reputation for being a “second class service” (Marks, 1997).

As the Africaner National Party strengthened from 1948, the government withdrew its support from these centres. Many centres closed and a number of their founders, including the Karks, went into exile (Marks, 1997). From the 1960s to 1980s, when the bantustans (‘homelands’) became ‘independent’, the responsibility for the forcibly relocated black population’s health care was given to the ‘homeland’ governments (van Rensburg & Harrison, 1995).

Most of these governments were under-resourced and corrupt and thus neglected health service funding.

Another phase of CHW projects began in the 1970s and continued into the 1990s, established mostly by individuals or small civic or religious organisations (Tollman & Pick, 2002). There was a growing conviction from the late 1980s that apartheid would soon end, particularly after African nationalist organisations were unbanned and their leaders released (Baldwin-Ragavan, Gruchy, & London, 1999). This encouraged progressive thinkers and academics to develop community initiatives and formulate advice which they hoped would inform a new government’s health policies (Price, 1993).

In 1994, South Africa welcomed its first democratic government. Though the government adopted the district health system (DHS) as the cornerstone of their national health plan, CHWs were not included. Subsequently, many CHW projects collapsed as international donors withdrew their earlier support, or redirected their funds through government departments. In recent years, an uncoordinated array of CHW programmes has re-emerged, mainly within healthcare for people living with HIV/AIDS (Friedman, 2005).

The early history of the 1930s and 1940s CHW projects has been analysed elsewhere (Jeeves, 2000, 2005; Marks, 1997; Tollman, 1994). However the late apartheid period (post-1970s) lacks historical analysis. This study aims to explore the factors affecting these late apartheid projects’ evolution. This historical analysis intends to contribute to current debates on the appropriateness, effectiveness and sustainability of CHW initiatives within South Africa and to similar global debates.

**Methods**

Our approach used oral history interviews (in-depth, open-ended interviews seeking people’s reconstruction and interpretation of events) with founders, coordinators and health workers of CHW initiatives active during the study period. This approach was chosen as people working within CHW projects at this time were busy ‘doing’ rather than ‘documenting’. This technique recognises individual experience, often missing from standard social histories, and gathers unrecorded information (Perks, 1992).

To select interviewees, four contacts known to one of the authors (SL) helped identify further participants through snowballing. Participants were chosen from urban and rural projects where documentation was available. Of 54 potential interviewees, 39 were selected on the basis of representativeness of professional background, involvement in CHW programmes, and availability. Tragically, one key participant, Ivan Toms, died unexpectedly before his interview. A total of 38 participants were therefore interviewed from 10 projects (Table 2). One author (NVG) visited five provinces (Western Cape, Eastern Cape, KwaZulu-Natal, Mpumalanga and Limpopo) in South Africa in April 2008 to conduct 10 oral history interviews. An additional two interviews were conducted by phone, and one in London. Eight witness seminars (focus groups) were conducted at the same time.

**Table 1**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1913</td>
<td>Native Land Act (7.3% of South African land dedicated for Africans’ habitation)</td>
</tr>
<tr>
<td>1930s</td>
<td>Park Ross: Malaria assistants</td>
</tr>
<tr>
<td>1940s</td>
<td>Revival of African nationalism. National Congress (ANC) rebuit</td>
</tr>
<tr>
<td>1940</td>
<td>Phoella Health Unit founded by the Karks (KwaZulu)</td>
</tr>
<tr>
<td>1942–1944</td>
<td>National Health Services Commission</td>
</tr>
<tr>
<td>1945</td>
<td>Gluckman Report: intersectoral recommendations for comprehensive health service: Only health centres and IFCH established.</td>
</tr>
<tr>
<td>1948</td>
<td>Nationalist Party comes to power</td>
</tr>
<tr>
<td>1951</td>
<td>Banu Authorities Act: forcible relocation of blacks to homelands</td>
</tr>
<tr>
<td>1951</td>
<td>Valley Trust established</td>
</tr>
<tr>
<td>1958</td>
<td>Karks’ exodus</td>
</tr>
<tr>
<td>1960</td>
<td>Sharpville massacre; ANC and Pan African Congress (PAC) banned.</td>
</tr>
<tr>
<td>1970</td>
<td>Chalumna/Newlands project started</td>
</tr>
<tr>
<td>1976</td>
<td>Soweto uprising: sparks nationwide uprisings</td>
</tr>
<tr>
<td>1976</td>
<td>Elim Care Groups started</td>
</tr>
<tr>
<td>1977</td>
<td>Steve Biko (leader of Black Consciousness Movement) tortured/dies in detention</td>
</tr>
<tr>
<td>1977</td>
<td>Public Health Act: dual/segregated healthcare</td>
</tr>
<tr>
<td>1979</td>
<td>Health Care Trust–VHW project started</td>
</tr>
<tr>
<td>1980</td>
<td>Valley Trust establishes CHW programmes</td>
</tr>
<tr>
<td>1981</td>
<td>SACLA clinic</td>
</tr>
<tr>
<td>1982</td>
<td>National Medical and Dental Association founded to address human rights</td>
</tr>
<tr>
<td>1986</td>
<td>SACLA clinic taken over by army</td>
</tr>
<tr>
<td>1986</td>
<td>Mamre Community Health Project and Rural Foundations Health Project started</td>
</tr>
<tr>
<td>1987</td>
<td>National Progressive Primary Health Care Network founded</td>
</tr>
<tr>
<td>1989</td>
<td>Relaxing of emergency laws</td>
</tr>
<tr>
<td>1990</td>
<td>ANC/PAC unbanned; progressive release of imprisoned leaders (including Mandela)</td>
</tr>
<tr>
<td>1991</td>
<td>Mamre/Zibonele projects start CHW programmes</td>
</tr>
<tr>
<td>1992–1994</td>
<td>Preliminary ANC health plan; national CHW workshops/conferences</td>
</tr>
<tr>
<td>1992</td>
<td>HCT– Brown’s Farm and Agincourt started (CHWs until mid-1990s)</td>
</tr>
<tr>
<td>1994</td>
<td>First democratic elections (Mandela elected); final health plan</td>
</tr>
<tr>
<td>1994–2003</td>
<td>Social/health policies promoting development and intersectoral collaboration (e.g. 1994: Reconstruction and Development Programme); Many late-apartheid CHW programmes close</td>
</tr>
<tr>
<td>2004</td>
<td>Community Health Policy Framework</td>
</tr>
</tbody>
</table>

*Note: The table continues with additional information.*

**Timeline of CHW projects and historical landmarks in South Africa.**

<table>
<thead>
<tr>
<th>Project</th>
<th>Comments</th>
<th>CHW characteristics</th>
<th>Current Status</th>
<th>Interviewees</th>
<th>CHW</th>
<th>C</th>
<th>D/N</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERI-Urban Initiatives</strong></td>
<td>CHW programme in several peri-urban townships in Cape Town</td>
<td>Paid; generic and specialist (rehabilitation)</td>
<td>Running</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>South African Christian Leadership Assembly Health Project</td>
<td>Coloured community. 3 components: research, CHW project, student teaching (academic)</td>
<td>Paid; specialist (youth, chronic illnesses, hypertension)</td>
<td>Closed</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mamre Community Health Project</td>
<td>Peri-urban township in Cape Town</td>
<td>Paid; generic</td>
<td>Closed</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Health Care Trust — Brown’s Farm Project</td>
<td>Peri-urban township in Cape Town</td>
<td>Paid; specialist (women, children)</td>
<td>Closed</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Health Care Trust</td>
<td>Coloured community. 3 components: research, CHW project, student teaching (academic)</td>
<td>Paid; generic</td>
<td>Closed</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Rural Initiatives</strong></td>
<td>CHW project: part of Valley Trust — a large influential organisation, KwaZulu-Natal.</td>
<td>Volunteers then paid; generic</td>
<td>Running</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The Elim Care Group Project</td>
<td>Focus on nutrition, immunisation, TB</td>
<td>Stipend; generic</td>
<td>Closed</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chalumna and Newlands Village Health Worker Project</td>
<td>Focus on nutrition, immunisation, TB</td>
<td>Volunteers; generic</td>
<td>Closed</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Trust — Village Health Worker Project</td>
<td>CHW project: part of Valley Trust — a large influential organisation, KwaZulu-Natal.</td>
<td>Volunteers then paid; generic</td>
<td>Running</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The Valley Trust Community Care Project</td>
<td>Focus on health and ecology.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Rural Foundation Health Programme</td>
<td>Nationwide CHW programme for farm workers (started in Transvaal)</td>
<td>Paid by farmers; generic</td>
<td>CHW programme closed</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>National Progressive Primary Health Care Network</td>
<td>Nationwide CHW programme for farm workers (started in Transvaal)</td>
<td>Paid by farmers; generic</td>
<td>CHW programme closed</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Agincourt</td>
<td>National Training Centre. Community health project with a focus on surveillance in Gazankulu (academic)</td>
<td>Paid research assistants</td>
<td>Running</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C, coordinator; CHW, community health worker; D, doctor; N, nurse; F, founder.
programmes’ development. The interview guide was adapted to incorporate emerging themes.

Primary and secondary historical sources were obtained from libraries (UK and South Africa), government databases, the South African National Archives in Cape Town and from bibliographies. Grey literature held by interviewees (conference papers, reports, minutes, theses, photographs) was reviewed. The interviews were manually transcribed, coded and analysed by one author (NVG) using thematic content analysis. The other authors read selected transcripts and commented on emerging themes.

The analysis involved an inductive process to identify emerging themes. Constant comparison ensured that the themes reflected the original data. Oral sources were cross-examined with written material. This methodological triangulation allowed the identification of critical perspectives and emerging themes (Green & Thorogood, 2004).

Because some respondents requested anonymity, participants have been kept anonymous. Their quotes are coded according to participants’ professional background (C: coordinator; CHW: community health worker; D: doctor; N: nurse; F: founder). This research was approved by the ethics committees of the London School of Hygiene and Tropical Medicine and the University of Cape Town.

Results

How CHW programmes started

The driving force for non-governmental organisations’ (NGO) or rural health initiatives was often the desire of individuals to address the health of the under-served black majority. Most leaders of these initiatives were white doctors or nurses as oppression and poverty made it difficult for blacks to establish such infrastructures. Many health centre project set up by Mamphela Ramphele was one exception to this (Ramapele, 1992). Involvement was sometimes fuelled by religious conviction (CHW12, C3) or by guilt about their privileged position compared to racially-oppressed black counterparts (C9).

Founders of many programmes explained that these projects arose during a time of growing discontent with apartheid, expressed through uprisings and demonstrations. The promise that the 1977 Public Health Act would expand healthcare for the black population remained unfulfilled (De Beer, 1984; Digby, 2006). The health and social problems experienced by the black majority worsened, as documented in the Second Carnegie Inquiry into health and social problems experienced by the black majority (C9).

During this period, CHW projects often started as single interventions to address what was seen as the greatest need (Table 2). The Elim Care Groups, spear-headed by the Swiss ophthalmologist Erika Sutter, responded to trachoma (an eye infection causing blindness). The Newlands and Chalumna projects, led by Trudy Thomas, a paediatrician, set up a nutrition scheme to respond to kwashiorkor (protein-energy malnutrition). The success of these single interventions led them later to address wider health issues in their communities.

Health projects, such as the Empilisweni SACLA (South African Christian Leadership Association) in an informal settlement outside Cape Town, and Health Care Trust’s (HCT) rural health initiative in Cala in the Transkei (now Eastern Cape) were motivated partly by community requests:

“We weren’t looking for long term projects. We were approached to do these so I think it was something that we had as part of our values. We weren’t just ‘go and plonk ourselves’ in communities. It had to be something that we were approached by.” (F7)

The motive for helping the black population was not always altruistic. There was also fear of a spill-over of ‘black diseases’ to the white community. This provided an incentive for a study on health and urbanisation to assess the impact of black urban migration on white city dwellers. Prevention strategies to ‘sanitise’ the most disadvantaged are globally recognised in history across public health reform (Pelling, Berridge, Harrison, & Weindling, 2001). This study ultimately led to the creation of the Centre for Epidemiological Research in Southern Africa (CERSA), which included progressive thinkers concerned with documenting and addressing the ill health of the underprivileged (F5).

The Karks’ Community Oriented Primary Care (COPC) model, developed in South Africa, contributed to shaping the 1977 Alma-Ata declaration and subsequent global community health movements. It also influenced later projects in South Africa. The Karks’ visits to Johannesburg and Durban in the 1980s and 1990s contributed to academics reviving surveillance/research-based projects based on the COPC approach. Mamre (in the Western Cape) and the Agincourt site (in Gazankulu, now Limpopo Province) of the University of Witwatersrand Health Systems Development Unit, developed and utilised participatory research approaches to create an important body of evidence on community health needs (Katzenellenbogen, Hoffman, & Miller, 1990; Tollman, 1999).

Leaders of non-academic civic projects drew less influence from the Karks’ model. Though South Africa did not attend the Alma Ata conference due to international sanctions, project founders embraced these principles as they reflected and justified their efforts. One founder explained why:

“Immediately...I was taken up with the idea. In fact Alma-Ata was in 1978, so ideas about primary healthcare were floating around at that time and were starting to get formalised. What was clear to me was that our project had been practising PHC for nearly two decades before that. Because if you looked at what the principles of Alma-Ata were, things like community involvement, community development, appropriate health technologies, using a basic approach, even... basic equity. I mean there were things of course that weren’t being done, but some of those principles were being implemented and I felt very much at home. And for the next decade we really tried to make it a living example of primary healthcare in action.” (F2)

Some respondents, particularly from repressive regime areas like the Ciskei, felt that their projects started in isolation and had few external influences as political sanctions hindered communication and access to information from outside of South Africa:

“I was the only one. Mine was the only community health department. There weren’t any others in this province. There was no such thing as community health work...you know, I was just the clinic doctor and then the sense of a community health service grew.” (F8)

In the late 1980s, conditions became more favourable to information exchange. Health activism grew alongside anti-apartheid activism. A network of local community health organisations formed the Progressive Primary Health Care Network (PPHCN). Supported by the National Medical and Dental Association and the (Kaiser-Foundation, 1988), it strengthened project cross-fertilisation and collaboration to formulate a future primary healthcare strategy (NPPHCN, 1986).

The political nature of CHW projects

Most respondents felt that healthcare provision was inseparable from democracy, reflecting De Beer’s (1984) description of apartheid as the most important ‘disease’ affecting South Africa. Some
respondents’ conviction that politics and health are connected explained their involvement in political activism. This put them at significant risk of detention without trial (D1, F3, F6), receiving threats (C11) or being harassed (CHW1), but did not hinder their commitment to work.

Other respondents were not politically active or found it too dangerous. They masked their desire for political change under the banner of healthcare provision while simultaneously challenging the status quo by empowering CHWs to become agents of social change. The Valley Trust, HCT and SACLA, for example, successfully introduced democratic community structures and elections within their projects. As one of the founders said:

“I felt we needed to bring in the social aspects, where we needed to bring in elements of community involvement. Dangerous stuff at that time, because working with black communities was on the fringe of social revolution, but luckily primary healthcare permitted that ideology.” (F2)

Most of the respondents who were active politically worked in areas where major political and social injustices had been carried out. The government’s systematic attempt in the 1980s to crack down on ‘illegal’ squatter areas through encouraging community riots led to a local SACLA clinic closing in 1986. Individuals working within projects that had some approval from their ‘homeland’ governments, such as Agincourt/Manguzi in Gazankulu and Valley Trust in former Kwazulu, were less likely to be heavily involved in political activism. A project coordinator felt that their work was part of the struggle for democracy.

“During apartheid our main struggle was for freedom. Once that was achieved our remit was over.” (C10)

This statement, which was reflected by many respondents, raises the question whether the same level of commitment of health workers to communities can be reproduced in a more democratic political climate in which human rights are less threatened.

Innovative and experimental leadership, supervision and training

Respondents saw the presence of a charismatic idealistic leader, who had a firm development approach, as key to six projects’ success (Valley Trust, SACLA, HCT, Elim, Chalumna/Newlands and Rural Foundation). Ivan Toms, who helped establish the Empilisweni SACLA clinic, was seen as an example of such a leader and as crucial to the project’s success. In addition to actively defending the clinic and community during the mid 1980s’ riots, respondents described how he enlisted and trained lay people to work as CHWs or management staff, and empowered community members and staff to later adopt full managerial and clinical responsibility (C2, CHW1).

Respondents from all projects admitted to being experimental. Supervision, training and management of staff and CHWs were often done on an ad-hoc basis, as outlined by a SACLA doctor:

“Those first CHWs were a huge experiment. We were just flying by the seat of our pants, we didn’t know what we were doing. We equipped them with basic medications and dressings and so on. And they were fantastic, so they were with the project for many, many years.” (C3)

Project leaders were health professionals or academics with little experience in management — they were “trying things and seeing if they worked” (C10). Management difficulties sometimes developed, such as when SACLA and Rural Foundation became larger and more complex (C3, F10). One Elim report (Annual report, 1980) outlined difficulties of project expansion such as staff shortages and inadequate delegation. These caused management overload and demotivation of staff. Some projects, however, successfully involved communities. Brown’s Farm health–clinic lay managerial committees, and Elim and Rural Foundation coordinators were good mediators for enhancing community participation and dissipating personal and political disputes. However, community participation was never comprehensive — rather, it was restricted to certain tasks within projects. With the exceptions of SACLA and Elim, projects were established and run exclusively by people from outside the communities served.

Experienced programme clinicians and leaders developed and undertook hands-on supervision and ongoing training of CHWs and coordinators. Most CHWs described their supervision as informative and non-threatening:

“One of the foundation was to walk me and the house-visit. And she look at us. And when something not right she don’t say: ‘He he he, no’. She go with us in the clinic. In the container, we sit down, and she say: ‘Do you remember, what did you learn?’” (CHW3)

Appropriateness and adaptability

Adapting the project’s goals to community needs was important. Selina Maphorogo, the first CHW motivator (and later director) of the Elim Care Groups, re-shaped the project by adopting culturally-sensitive methods for delivering community health messages. These methods were reported as effective and sustained through the project’s history (Maphorogo, Sutter, & Jenkins, 2003).

Projects in their early stages, or which were geographically and ideologically isolated, were innovative in their use of appropriate technology and training approaches. Many succeeded despite sanctions in accessing international literature and low technology resources. They adapted key CHW training guides including the Chinese Barefoot doctors manual (Hunan-Zhong, 1977), Werner’s books Where there is no doctor (1977) and Helping health workers learn (1982) as well as WHO guidelines (1992). The Rural Foundation and Elim also used UNICEF tools such as Road-to-Health charts. In the late 1980s, networks wanted to create a feasible training model for the post-apartheid era. Emerging training centres (such as the PPHCN learning centre) were modelled, in part, on the Institute of Family and Community Health (IFCH) (1945–1961) which trained the 1940s’ health centres.

In the late 1980s, these projects also adapted to a changing disease burden in South Africa, moving away from child survival towards chronic diseases and HIV (Bradshaw et al., 1999). SACLA, Mamre and HSDU trained CHWs who specialised in rehabilitation, chronic disease and HIV. This also coincided with the move to a more selective PHC approach, influenced by international critiques that the comprehensive PHC approach provided few concrete recommendations (Cueto, 2004).

There was an interesting paradox, which several key informants recognised. These CHW projects, they suggested, experienced a ‘golden’ era under the constraints of apartheid and lack of political freedoms. Projects were free to respond innovatively to needs. Funders — whether international donors (for most projects) or ‘homeland’ governments (as for Valley Trust) — had minimal requirements. Project leaders felt their impact was greatest on community health and development during apartheid. In contrast, they criticised current funding for being constrictive and conditional, and thus hindering creativity and local adaptation. However these divergent views may result from a tendency to romanticise the achievements possible in times of struggle and to resist, as many did globally, the emerging funding bureaucracy of the 1990s.
Links with communities

In the late apartheid era, some local authorities felt threatened by the growing influence of projects (Toms, 1987). Also communities sometimes found it difficult to accept CHW programmes. With individuals expressing jealousy regarding CHWs’ status (C6, F10, CHW-workshop, 1982). In addition, local expectations were hard to meet. For example, within the HCT-Cala project, villagers “did not get involved unless remuneration for services or products was guaranteed” (Alperstein & Bunyonyo, 1998). Participation fluctuated and depended on social and power relationships, and satisfactory incentivising, as described in the wider literature (Frankel, 1992).

Despite these challenges, rural and peri-urban projects reported some success in retaining CHWs in voluntary or partially paid work and in community ownership of projects:

“So we started January 1987... and we had patients that followed us from Old Crossroads. Because we moved to New Crossroads, that community welcomed us. So we had patients who followed us, the chronic patients saying that ‘we can’t do without you.’” (C2)

With the shift to employment within the public health system following the democratic elections, many CHWs felt that their accountability to the community had changed. They were no longer flexible community-based workers, but located in health clinics full-time. A few missed community work intensely (CHW3, CHW6). However, many CHWs now resented unpaid requests from fellow villagers:

“They used to come to my house asking for help after even after working hours. I used to help them but now I am unable, I tell that I am tired as I have started working at 06h00 in the morning until 16h00 in the afternoon.” (CHW7)

Coordinators (C11, C6) and founders (F2, F8) also commented on changes in CHWs’ attitudes since 1994:

“There’s a very serious materialist dependency. I hate it but I have to face up that it has happened... it’s not that I am saying it was idealistic, the community health workers were at least as enthusiastic as I. I can’t talk about the CHWs now in those glowing terms. The government now has this huge thing, they’ve got this small business programme – the pay roll. And the village health worker... if the pay doesn’t come out, they ‘toy-toy’, they don’t go to work.” (F8)

There is likely to be an element of romanticising the past in describing volunteers as only committed during the apartheid era. However, introducing a stipend would expectedly reduce a volunteer’s willingness to work unpaid. The CHWs interviewed, who had worked in both the old and new systems, rejected volunteering. This is supported by contemporary literature (Binedell, 1990; HCT, 1982, pp. 45–50) and by recent findings in the Free State province (Schneider, Hlopha, & van Rensburg, 2008).

CHWs within the health system

Whether CHWs can adequately bridge the gap between the formal health service and the community has long been debated internationally (Walt & Gilson, 1990). CHWs in Mamre and Elim reported that knowledge of their communities allowed them to successfully bridge the gap between researchers and communities. For example, they explained the purpose of community surveys in culturally-sensitive ways. But because some CHWs, for example in Elim, officially reported to the nurse-in-charge at the hospital, they did not bridge the gap with health services but were instead viewed as the lowest level of the health service hierarchy.

Many dedicated nurses (including five coordinators and three founders interviewed) played a significant role in supporting and training CHWs within NGO projects (Clarke, 1991; Mamre, 1992). Some CHW literature advocates nurses as ideally placed to support CHWs (Buch, Evian, Maswanganji, Maluleke, & Waugh, 1984; Roscher, 1990). However, some CHW respondents were disparaging of clinical supervision by hospital nurses, one commenting that it was only by “the will of God” that nothing disastrous happened during childbirth (CHW7). One founder suggested why nurses’ supervision was poor:

“[The nurse facilitators] wouldn’t have that kind of vision or experience of working with communities in a democratic way, so they would tend to be bureaucratic and play things by the book. They could supervise but it was much more mechanical. And that if I found that was not helpful in developing the analytic skills of the CHWs.” (F2)

CHWs were not necessarily welcomed by formal health system staff. Although the South African Nursing Council — the main regulatory body for the profession supported CHWs in principle (Marks, 1994), in practice nurses on the ground were reportedly intimidating and rude to them (C8). One doctor interviewed explains:

“The attitude of the nurses is very, very problematic, they’re also so hierarchical now. My thesis is that nurses are fighting a feminist battle in their work place, black nurses in particular, because they have been so oppressed and the present health system oppresses them too, but there’s a bit of a perverse feminism acting there.” (F8)

This quote illustrates that nurses have, in both the late apartheid and post-apartheid eras, enforced hierarchies within healthcare with CHWs in health centres often becoming nursing subordinates (Schneider et al., 2008). These limitations of nursing care in South Africa have been discussed extensively elsewhere (Marks, 1994; Stein, Lewin, & Fairall, 2007; Wood & Jewkes, 2006), with Marks (1994) noting that nurses may feel their role is threatened within primary healthcare, particularly in light of potentially professionalising CHWs.

The end of an era: the closure of CHW programmes in the 1990s

Respondents noted that the early 1990s were a time of transition out of the bleak system of apartheid (F9) towards a more idealistic vision of the future (F8). Progressive community health leaders were active in formulating health policy which informed the ANC’s forthcoming national health plan (NPHCN, 1992a, 1992b). Sidney Kark also held many meetings with health officials and academics to promote the Community Oriented Primary Care decentralised approach with strong community involvement (Kark, 1981).

Respondents were surprised that the new 1994 government had dropped support for CHW projects (A national health plan for South Africa, 1994), as the 1992 draft of the ANC health plan had favoured CHW coverage (Slabber, 1992). Despite decentralisation being a key element of the new health plan (van Rensburg, 2004) the incoming minister of health, Nkosasana Zuma, believed that CHWs would provide second rate care (F2). Rather, a professionalised team of doctors and nurses was visualised. In addition, health service leadership was preoccupied with structural transformation of the health sector (Tollman & Pick, 2002). Respondents felt the 1994 health plan was poorly informed with regards to CHWs:

“It was] highly ambitious, had little connection to and had not consulted contemporary projects on what they were actually doing and achieving.” (F9)
Interviewees understood why international funders had redirected their support to the new democratic government. However, they were frustrated that established community-based initiatives folded because of the government’s idealistic vision of a professional-driven DHS, which, in their view, failed to incorporate adequately existing South African experiences. Some projects survived with meagre charitable contributions (Elime, SACLAC). A few, such as the Valley Trust, continued to receive government support and helped to develop a provincial health plan.

The government’s decision in the mid-1990s to provide free primary healthcare was a further blow to organisations such as the Rural Foundation which had relied partly on community contributions. This decision changed community expectations of projects.

The HIV epidemic also negatively impacted several small vertical projects. Respondents suggested providing care to people living with AIDS in the pre-antiretroviral drugs era had diverted funds away from CHW projects. In the late 1990s, when PPHCN struggled for funds, a budget ten times its global budget was allocated to it to run the national AIDS programme (F2). The AIDS epidemic also shifted CHWs towards being single-purpose workers – a phenomenon also noted in Britain (Berridge, 1996).

A comparison of past and present CHW programmes is shown in Table 3. Respondents saw these changes as having shattered the ideal of community-oriented and comprehensive primary care (Oppenheimer & Bayer, 2007).

Has more recent community health policy been informed by the past?

The Community Oriented Primary Care approach informed the development of the DHS in the late 1990s. However, it has been noted that its community focus and epidemiological surveillance have not been implemented widely, mainly because of a poor management capacity and accountability to communities (Moosa, 2006; Tollman & Pick, 2002).

More recently, South Africa established a CHW Framework (2004) to guide the development of a national CHW programme. This aimed to establish cohesion between old and new CHW community-based organisations and to address the growing crisis of health worker shortage. Interviewees felt “this policy [had] come too late” (C10, F3) as this Framework had only drawn upon the newer single-purpose fragmented projects and not upon apartheid era comprehensive community health initiatives. One interviewee, one of the few to be consulted prior to the finalisation of this policy, was disappointed:

“The policy had ignored the recommendations we had made based on the spirit and the experience of the CHW projects [in the 1970–1990s]” (C10)

This statement equates to what Lund (1993) called a policy paradox in describing the 1992 national CHW policy draft. The policy, she argues, attempts “to give the category of CHW a place, but whilst so doing, has failed to recognise diversity, needs and flexibility, thus invalidating its initial aim.”

Others suggested that implementation of the CHW Framework remains rigid and gives insufficient focus to rural areas (Friedman, 2005). The Framework has also been criticised for its vague and conflicting statements about remuneration and responsibility for CHWs (Schneider et al., 2008). Respondents felt that community health leaders’ recommendations for appropriate incentives (C10) were distorted into meagre stipends. Keeping CHWs as volunteers may have serious implications for their motivation, retention and the quality of care they provide (F2).

The 2004 CHW framework suggests that the “government would provide grants to NGOs who would employ CHWs” (DoH, 2004). Three respondents identified partnership with civic organisations as positive but that the framework abridges government financial responsibility and diminishes NGOs to stipend distributors (Schneider et al., 2008). In addition, the policy was seen to put insufficient emphasis on supervision, with directors deploving the fact that so few current budgets included adequate funds for supervision (F2). Quality of supervision, they suggested, is poor and is performed by inexperienced and overburdened staff.

Discussion

This research contributes to filling a gap in the history of South African CHW programmes in the late apartheid period. These projects had similarities to the earlier community health initiatives of the 1940s. For example, as a consequence of the socio-political context, primarily outsiders, many of whom were white, middle-class professionals, started these projects. However, early and late apartheid projects evolved in different contexts. Due to a more liberal political leadership, the 1940s projects received government support as potential models for universal health care. In contrast, the late-apartheid projects studied were initiated within an era of heightened repression and segregation; were intertwined with the contemporaneous wider social aims of democracy and social justice, and did not generally receive backing from the state. Unfortunately, many late-apartheid programmes were poor at documenting the process and impact of their work, in part because of the repressive conditions. Projects of both apartheid periods, which were influenced by Community Oriented Primary Care, were much better at this, given the epidemiological focus of this model.

Our respondents argued that the strong socio-political motivations of the late apartheid period projects were mostly not carried through into the post-apartheid period. The current struggle to redress the economic, health and racial inequalities is not, it could

Table 3
Comparison of past and current CHW programmes in South Africa.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>1970–1990s programmesa</th>
<th>Current programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision and training</td>
<td>Experimental but applied; done by experienced and inspiring people</td>
<td>Supervisors are of lower grades and less motivated/committed.</td>
</tr>
<tr>
<td>Funding</td>
<td>International donors. More flexibility of allocation given to project by funders</td>
<td>Variable training qualitya</td>
</tr>
<tr>
<td>Remuneration</td>
<td>Variable, some CHWs well paid, many volunteers</td>
<td>Government-channelled funding, or charitable fundsa</td>
</tr>
<tr>
<td>Scope</td>
<td>Started with a vertical issue, then extended to integrate larger health issues. PPHCN network established to coordinate projects.</td>
<td>Rigid spending allowance, often determined by fundersb</td>
</tr>
<tr>
<td>Relationship with community</td>
<td>Project more dependent on community and linked to activism, Community more participatory.</td>
<td>Discontent with voluntary contributionsb, low government stipendc</td>
</tr>
<tr>
<td>Relationship with health sector</td>
<td>Filling a large gap that health service was not providing. Mixed acceptance by health sector.</td>
<td>Most are single-disease focused (e.g. HIV, TB) community-based organisationsd</td>
</tr>
</tbody>
</table>

a Based on (Friedman, 2005).
b Based on interviewees responses/contemporaneous literature.
be argued, fuelled by the same fervour for action, partly because the country is now a stable democracy (Friedman, 2002). In addition, the changing burden of disease (HIV, TB, chronic diseases) means that a national CHW programme would now have to incorporate significantly different needs (Oppenheimer & Bayer, 2007).

However, a number of contemporary social movements, such as that to improve access to treatment for people living with HIV/AIDS, may have benefited from the leadership and experience of activists from the earlier projects (Ballard, Habib, Valodia, & Zuern, 2005).

Though these small-scale programmes were a product of their times, they have important lessons for current CHW programmes and policy within South Africa and potentially globally. It is suggested that the now predominant, single-purpose CHWs’ focus on clinical conditions fails to address the social determinants of health (Friedman, 2005). Reinvigorating the political nature of community healthcare by addressing social, economic and environmental issues, may have a greater impact in tackling ill health of the most disadvantaged.

Although interviewees claimed that dissatisfaction among CHWs with volunteering was minimal during apartheid, this may, in part, be a romanticisation of the past. In reality, many late apartheid programmes had very limited funding and repressive conditions often allowed few opportunities for local people other than voluntary involvement. Within their current work, CHW respondents indicated dissatisfaction with volunteering. Social changes in South Africa have created better local opportunities for people to contribute to health and seeking employment. Poorly- or un-remunerated involvement is perhaps no longer possible, and might be seen as exploitative (Lehmann, Friedman, & Sanders, 2004).

The current debate about the potential professionalisation of CHWs makes the ideal of ‘bridging a gap’ between the community and the health system more remote. For many younger workers, a CHW position is a stepping stone to a nursing career, not a long-term commitment to this cadre (Schneider et al., 2008). CHWs interviewed reported the community contact and trust experienced during the 1970s and 1980s as crucial to their work, although the degree of community participation was perhaps not as extensive and empowering as respondents claimed. Within the current model, CHWs risk becoming over-medicalised and no longer embedded in communities. Professionalisation may also blur the differences between nurses and CHWs, thereby contributing to power struggles between these two cadres. Furthermore, funding bodies’ centralised control on the remit and extent of these projects may curtail projects’ adequate community responsiveness.

Un-surprisingly, interviewees highlighted that good leadership and supervision, even though not always achieved, were essential to the success of programmes. Furthermore, community involvement and adequate financial capacity were seen as crucial for sustainability. Indeed, the ethos and funding flexibility of earlier programmes were seen to have led to community acceptance, CHW job satisfaction and health gain. Many problematic managerial issues then are also now further complicated by changes in the burden of disease and in user and provider expectations of health services. Many ongoing CHW programmes would probably benefit from stronger professional management and better integration within the district primary health system.

The issues identified in this historical analysis of CHW programmes are still recognised as important today but often remain poorly addressed, particularly in larger scale initiatives (Lehmann et al., 2004; Walt & Gilson, 1990). Given the renewed growth of CHW programmes within South Africa and globally, lessons learned from past programmes should play a stronger role in informing current policies.

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References


