The Global Health Situation: Key Challenges to Civil Society Action

David Sanders

Member of Global Steering Council
Peoples Health Movement

Emeritus Professor: School of Public Health
University of the Western Cape
South Africa

A WHO Collaborating Centre for Research and Training in Human Resources for Health
AFRICA and SOUTH ASIA’S CRISIS

Mortality 1 - 4 year olds

Territory size shows the proportion of all deaths of children aged over 1 year and under 5 years old, that occurred there in 2002.
Trends in Maternal Mortality Ratio (per 100,000 live births) by UN MDG Regions

WHO 2010
Progress in MDGs

- Twenty-three (31%) of 75 countries are on track to achieve the MDG 4 target for child survival, whereas only
- nine (12%) are projected to reach the MDG 5 target for maternal mortality.

Rapidly growing inequalities

A child born in Sub-Saharan Africa

- In 1970 faced a risk of dying before his or her fifth birthday that was 9 times greater than a child born in an industrialized country.
- In 1990, the base year of the Millennium Development Goals (MDGs), the same risk was 19 times greater.
- In 2006, it was 27 times greater.
The social gradient is not confined to poorer countries. Fig. 2.3 shows national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation. As can be seen, the mortality rate varies in a continuous way with degrees of deprivation (Romeri, Baker & Griffiths, 2006). The range is large: the difference in mortality between the most and least deprived is more than 2.5-fold.
Despite successes, growing inequalities in global health

Figure 1: Life expectancy at birth by region, 1970–1975 and 2000–2005

AFRICA and SOUTH ASIA’S CRISIS

GDP wealth

Territory size shows the proportion of worldwide wealth, that is Gross Domestic Product based on exchange rates with the US$, that is found there.
### Table 3.1

Increasing income inequality among countries

<table>
<thead>
<tr>
<th>Year</th>
<th>Richest countries*</th>
<th>Poorest countries*</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>US$ 11 840</td>
<td>US$ 196</td>
<td>60</td>
</tr>
<tr>
<td>2000</td>
<td>US$ 31 522</td>
<td>US$ 274</td>
<td>115</td>
</tr>
<tr>
<td>2005</td>
<td>US$ 40 730</td>
<td>US$ 334</td>
<td>122</td>
</tr>
</tbody>
</table>

*Containing 10% of the world’s population. Data derived from Table 1 in the World Bank’s World Development Reports for 1982, 2002, and 2007, respectively, and market exchange rates in the relevant years. The ratios among these nominal US$ figures are comparable across years.

Reprinted, with permission of the publisher, from Pogge (2008).
Inequalities on the Rise

• High net worth individuals, the 24 million of us with liquid assets of between $1 and $50 million.

• ‘Ultra’ high net worth individuals, the 80,000 whose liquid assets exceed $50 million.

• And then there are the 1,200 global billionaires.

• 8.5 million people (1/10th of 1%) own 84% of total global personal wealth.

Sources: Credit Suisse, 2010, 2011
In 2002, there was USD 24 trillion in untaxed, private wealth.

By 2010, this had swollen to USD 44 trillion.
Main pathways of influence of neoliberal globalisation on health

Via:

• Economic, social and environmental factors (determinants) eg employment levels and conditions, food/diets, living environments, climate change

• Health system factors eg funding architecture and financing mechanisms, global policy influences, medicines, services availability

• Population movements eg cross-border movement of people, workers and diseases

• Communications and ideology eg dominant ‘explanations’ of underdevelopment and health situation
Leading global risk factors and contributions to global burden of disease: % DALYs, World

- Infant and maternal underweight: 9.5%
- Unsafe sex: 6.3%
- High blood pressure: 4.4%
- Tobacco: 4.1%
- Alcohol: 4%
- Unsafe water, sanitation, and hygiene: 3.7%
- High cholesterol: 2.8%
- Indoor smoke from solid fuels: 2.7%
- Iron deficiency: 2.4%
- High BMI: 2.3%
- Zinc deficiency: 1.9%
- Low fruit and veg intake: 1.8%
- Vitamin A deficiency: 1.8%

Ezzati et al. 2002
Malnutrition – the global situation

• Undernutrition is the underlying cause of the death of 2.6 million children each year – one-third of the global total of children’s deaths

• One in four of the world’s children are stunted

• In 2005 22mn children were overweight

• By 2015 some 2.3bn adults will be overweight 700mn will be obese

Overweight and obesity predispose to several non-communicable diseases (NCDs)
Risk Factors/Social Determinants

DOWNSTREAM

Biological

Behavioural

Societal

Structural

UPSTREAM

Burden of Disease study, PGWC
In Nigeria and India, the highest populated countries in Africa and South Asia respectively, parents appear to be struggling the most to feed their children. Specifically, about a quarter of parents in Nigeria (27%) and in India (24%) report that their children go without food for an entire day—not surprisingly, in both countries, those who have more than one child, are less educated or have low income are more likely to report this.

Although both nations have fast emerging economies, this finding underlines the fact that many people are yet to experience the economic benefits.

In the slides that follow, results reveal that the struggle to provide sustenance for children is greater in Nigeria.

Q2 How frequently would you say the following things happen – never, sometimes or often?
   a. My children go without food for a whole day
The majority of people in Peru and Nigeria report that they have reduced the quantity of food they buy for their family. About half indicate the same in Bangladesh.

Those in India are least likely to have reduced the food they buy – but it should also be noted that compared to the other countries, more people in India say they are never able to afford to buy nutritious food such as meat, milk or vegetables.

Q4 And since the rise in food prices over the last year, please tell me whether you have…?

a. Reduced the amount of food you buy for your family
Structural Determinants of Undernutrition Globally
Trade agreements and agricultural trade

- **Agreement on Agriculture 1994** – opening of markets by reducing tariffs, non-tariff barriers, export subsidies and domestic agricultural support

- **Agreement on Application of Sanitary and Phytosanitary Measures**

- **Technical Barriers to Trade Agreement** –

- **TRIPs** - expanded scope of private property rights on food products, including patents on seeds
Northern agricultural subsidies: Japan, the EU and the US

Source: UNDP HDR 2005
World Agricultural Trade

- In developing countries on average food import bills as share of GDP more than doubled 1974 - 2004 (FAO 2004)
- Food imports - into developed countries increased by 45% (1970-2001) - into developing countries increased by 115%
- Large increase in exports of high-value foods eg fruit, veggies etc.
Speculation in Commodities: the ‘Food Casino’

This deregulation of commodities derivatives markets in 2000 allowed large institutional investors to enter commodities derivatives markets.

Morgan Stanley estimates that the number of outstanding contracts in maize futures increased from 500,000 in 2003 to almost 2.5 million in 2008.

Already in 2006, Merrill Lynch estimated that speculation was causing commodity prices to trade at 50 per cent higher than if they were based on fundamental supply and demand.

‘Land Grabs’: the new colonialism
More than 200m hectares claimed between 2000 and 2010, the majority in sub-Saharan Africa

Ethiopia has sold leases to 3.6 million hectares of its best farmland to foreign companies yet relies on 700,000 tonnes of emergency food aid each year

Karmjeet Sekhon, project manager for Indian food company Karuturi Global, with crops in Ethiopia’s Gambella province.

Photograph: John Vidal for the Guardian
Growing national food insecurity is demonstrated by the rise in the number of developing countries that are now food importers - from 74 in 1995-1999 to 89 in 2005-2009
I'M HUNGRY!

STOP TALKING POLITICS!
Undernutrition: what is currently being done?
The medicalisation and commodification of undernutrition: the promotion of ‘ready-to-use-foods’
RUTFs

- Energy dense food with added minerals and vitamins
- Required for short term management of SAM (about 5% children, about 6-8 weeks)
- No doubt that much more needs to be done for treatment of SAM (severe acute malnutrition)
- No doubt that calorie dense food (RUTF) is effective, necessary and desirable
- No doubt that it saves women time and energy
The 3 major users in the world are:

UNICEF
Medecins sans Frontieres
The Clinton Foundation
Possible harmful implications of the use of RUFs for prevention of malnutrition:

• to breastfeeding;
• to indigenous foods and cultural practices;
• to local agriculture
• diverting scarce family, national and agency funds away from more beneficial uses
• diverting attention and activity away from economic and political causes of undernutrition

RUTFs should "do no harm".
Double Burden
Determinants of ‘Overnutrition’ in South Africa
Risk Factors/Determinants

DOWNSTREAM

Biological

Behavioural

Societal

Structural

UPSTREAM

Burden of Disease study, PGWC
Overweight and chronic disease in rural S Africa

In a 2005 study of a rural black population from Limpopo Province, South Africa:

51% of women were overweight or obese

Diabetes diagnosed in 8.8% of women and 8.5% of men

Hypertension was found in 25.5% of women and 21.6% of men

Figure 2. Diabetes prevalence based on 1985 WHO criteria presented by age categories for men and women in 1990 and 2008/09.

http://www.plosone.org/article/info:doi/10.1371/journal.pone.0043336
Prevalence of dietary risk factors for NCDs (high fat and sugar intake) by locality, SA 2012

(n=15 332)

Percentage

Urban formal: 23.1 (High fat score), 23.1 (High sugar score)
Urban informal: 15.1 (High fat score), 18.2 (High sugar score)
Rural informal: 11.3 (High fat score), 14.7 (High sugar score)
Rural formal: 9.8 (High fat score), 11.7 (High sugar score)
Total: 18.3 (High fat score), 19.7 (High sugar score)

SANHANES

HSRC
Consumption of sweet beverages and confectionery

- Compared with a **worldwide average of 89** in 2010, South Africans consumed **254 Coca-Cola products per person per year**, an increase from around **130 in 1992** and **175 in 1997**.

- Carbonated drinks are now the third most commonly consumed food/drink item among very young urban South African children (aged 12–24 months)—less than maize meal and brewed tea, but more than milk.

Societal Factors in Obesity

• There is a shortage of healthy low-fat food and little fresh fruit and vegetables in the townships.

• ‘Low-fat milk is not available in our shops’, stated one of the CHWs after she had tried to cut down on the fat in her diet.

• ‘I am scared of exercising because I will lose weight and people may think that I have HIV/AIDS.’

Bread, Pastry, Cakes, Biscuits and Other Baker's Wares

Value of imports from world in Rand

Value of imports from world in Rand

<table>
<thead>
<tr>
<th>Category of Packaged Foods</th>
<th>Subcategory</th>
<th>Sales Volume*</th>
<th>Rate of Change of Sales Volume (%) 2005–10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bakery</td>
<td></td>
<td>2009.3</td>
<td>16.2</td>
</tr>
<tr>
<td>Meal solutions</td>
<td></td>
<td>547.2</td>
<td>18.5</td>
</tr>
<tr>
<td>Canned/preserved food</td>
<td></td>
<td>241.8</td>
<td>16.2</td>
</tr>
<tr>
<td>Frozen processed food</td>
<td></td>
<td>102.1</td>
<td>18.2</td>
</tr>
<tr>
<td>Chilled processed food</td>
<td></td>
<td>95.9</td>
<td>-2.8</td>
</tr>
<tr>
<td>Sauces dressings and condiments</td>
<td></td>
<td>88.1</td>
<td>27.0</td>
</tr>
<tr>
<td>Ready meals</td>
<td></td>
<td>70.1</td>
<td>43.1</td>
</tr>
<tr>
<td>Soup</td>
<td></td>
<td>11.1</td>
<td>32.6</td>
</tr>
<tr>
<td>Impulse and indulgence products</td>
<td>Confectionery</td>
<td>119.4</td>
<td>16.3</td>
</tr>
<tr>
<td></td>
<td>Sweet and savoury snacks</td>
<td>87.9</td>
<td>27.5</td>
</tr>
<tr>
<td></td>
<td>Snack bars</td>
<td>1.9</td>
<td>42.6</td>
</tr>
<tr>
<td></td>
<td>Ice cream</td>
<td>76.0</td>
<td>14.7</td>
</tr>
<tr>
<td>Dried processed food</td>
<td></td>
<td>345.4</td>
<td>-2.8</td>
</tr>
<tr>
<td>Pasta</td>
<td></td>
<td>62.9</td>
<td>35.0</td>
</tr>
<tr>
<td>Noodles</td>
<td></td>
<td>7.4</td>
<td>44.5</td>
</tr>
<tr>
<td>Oils and fats</td>
<td></td>
<td>343.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Meal replacement</td>
<td></td>
<td>0.6</td>
<td>9.6</td>
</tr>
<tr>
<td>Spreads</td>
<td></td>
<td>28.8</td>
<td>23.9</td>
</tr>
</tbody>
</table>

Source: Euromonitor 2011 [17].

*In thousand tonnes, except for ice cream, which is million litres.

doi:10.1371/journal.pmed.1001253.t001
Table 2. Packaged Food Company Shares in South Africa, 2009.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Company</th>
<th>Location of Company Headquarters</th>
<th>Contribution to Total Packaged Food sales (%)</th>
<th>Examples of Product Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tiger Brands Ltd</td>
<td>South Africa</td>
<td>17.2</td>
<td>Milling and baking, groceries, confectionery, beverages, value added meat products, fruit and vegetables, products for the food services sector</td>
</tr>
<tr>
<td>2</td>
<td>Unilever Group</td>
<td>UK/Netherlands</td>
<td>4.9</td>
<td>Spices, sauces, dressings, margarine, teas, syrup and food solutions</td>
</tr>
<tr>
<td>3</td>
<td>Parmalat Group</td>
<td>Italy</td>
<td>4.8</td>
<td>Dairy products including milk, yoghurt, ice cream and cheese, fruit juices</td>
</tr>
<tr>
<td>4</td>
<td>Nestle SA</td>
<td>Switzerland</td>
<td>4.6</td>
<td>Baby foods, drinks, breakfast cereals, chocolate, confectionery, coffee, dairy products, ice cream</td>
</tr>
<tr>
<td>5</td>
<td>Clover Ltd</td>
<td>South Africa</td>
<td>4.6</td>
<td>Dairy products, desserts, beverages such as fruit juices, nectars and ice teas</td>
</tr>
<tr>
<td>6</td>
<td>Dairybelle (Pty) Ltd</td>
<td>South Africa</td>
<td>4</td>
<td>Dairy products, fruit juices</td>
</tr>
<tr>
<td>7</td>
<td>Pioneer Food Group Ltd</td>
<td>South Africa</td>
<td>3.7</td>
<td>Baking aids, tea/coffee, breakfast cereals, biscuits, condiments, juices and acidic drinks, dried fruits, eggs</td>
</tr>
<tr>
<td>8</td>
<td>Cadbury Plc (bought by Kraft in 2011)</td>
<td>UK/US</td>
<td>2.8</td>
<td>Chocolate, candy, gum, biscuits, coffee, other grocery</td>
</tr>
<tr>
<td>9</td>
<td>AVI Ltd</td>
<td>South Africa</td>
<td>2.8</td>
<td>Coffee, tea, biscuits, potato chips, frozen fish and seafood products</td>
</tr>
<tr>
<td>10</td>
<td>PepsiCo Inc</td>
<td>US</td>
<td>2.4</td>
<td>Drinks, savoury snacks</td>
</tr>
</tbody>
</table>


*Euromonitor does not collect data on the informal sector (defined as sales that are not taxed).

doi:10.1371/journal.pmed.1001253.t002
Rapid growth of supermarkets in South Africa

- Supermarkets now share at least 50-60% of food sales in South Africa, with most growth occurring after 1994.
- Nearly two-thirds of households in a rural area in South Africa are now buying their food at supermarkets.
- Healthier foods typically cost between 10% and 60% more when compared on a weight basis (R per 100g) and between 30% and 110% more when compared based on the cost of food energy (R per 100 kJ).

### Number of households in two rural areas in Transkei, Eastern Cape going to supermarkets

<table>
<thead>
<tr>
<th></th>
<th>Xume</th>
<th>Luzie</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of total</td>
<td>78.4%</td>
<td>50.0%</td>
<td>64.8%</td>
</tr>
</tbody>
</table>


### Growth in Supermarket Food Sales

Expansion of Supermarkets in Cape Town

Battersby, AFSUN
Structural Determinants of ‘Overnutrition’ Globally
Liberalisation and growth of TNCs

• **Growth of FDI in food industry** – bilateral investment treaties increased from 181 to 2495 between 1980 and 2005 (UNCTAD 2000, 2006)

• **TNCs now control** seeds, fertilisers, pesticides, production, processing, manufacturing and selling of foods

• In 1980s TNCs expanded into manufacture of **processed foods** eg snacks, soft drinks, dairy
Regional trade and investment policies in SADC since 1990

- early 1990s: ongoing liberalization associated with multilateral trade negotiations
- 1996: SADC trade agreement signed
- 1997-2003: South Africa strengthens investment policy and signs 22 Bilateral Investment Agreements
- 1999: South Africa signs bilateral agreement with European Union (EU)
- 2000: SADC trade protocol comes into effect; Government of South Africa strengthens support for regional export and investment
- 2002: new Southern Africa Customs Union Agreement completed
- 2007: Interim Economic Partnership Agreement concluded between EU and Botswana, Lesotho, Namibia, Swaziland and Mozambique
- 2008: SADC Free Trade Area completed (except for Angola, Democratic Republic of the Congo, Seychelles)
Total imports of soft drinks and processed snack foods into South Africa and other SADC countries

Source: FAOSTAT detailed trade data
“Transnational corporations have flourished as trade liberalization has broadened and deepened. The revenues of Wal-Mart, BP, Exxon Mobil, and Royal Dutch/Shell Group all rank above the GDP of countries such as Indonesia, Norway, Saudi Arabia, and South Africa (EMCONET, 2007).

The combination of binding trade agreements and increasing corporate power and capital mobility have arguably diminished individual countries’ capacities to ensure that economic activity contributes to health equity, or at least does not undermine it.”
Leading Food and Beverage Companies Worldwide, 2001

- Nestle
- Unilever
- Cargill
- Kraft
- Conagra
- PepsiCo
- Tyson Foods
- Coca-Cola
- Diageo PLC
- Mars, Inc.
- Danone Group

Sources: *Global Supermarket*, Department of Foreign Affairs and Trade, Austrade, Australia; selected company income statements.

Economic Research Service, USDA
“Popularly positioned products (PPPs). Products aimed at lower income consumers in the developing world, will continue to grow strongly in 2008 and beyond. Nestlé PPPs, which mostly consist of dairy products, Nescafé and Maggi culinary products, grew by over 25% to reach around CHF 6 billion in sales in 2007. The overall market for such products in Asia, Africa and Latin America is estimated at over CHF 80 billion.”
“... trade policy that actively encourages the unfettered production, trade, and consumption of foods high in fats and sugars to the detriment of fruit and vegetable production is contradictory to health policy ...” (p 10)
'The global food system is causing a public health disaster'

The UN rapporteur on the right to food says governments in rich and poor countries must bring in tough measures to combat the unhealthy products being marketed.

More than 1.3 billion people around the world are overweight or obese.
Photograph: Finbarr O'Reilly/Reuters

Olivier de Schutter
UN Special Rapporteur on the Right to Food
March 2012

Felicity Lawrence, The Guardian, 9 March 2012
The shape of things to come
WHO/UNICEF Alma Ata Conference (1978)

Alma Ata, the capital of Kazakhstan, now called Almaty
Site of the 1978 WHO/UNICEF conference
‘Health for All by the Year 2000’
‘Comprehensive’ PHC

Primary Health Care:
‘Addresses the main health problems in the community, providing promotive, preventative, curative, and rehabilitative services accordingly’.

Alma Ata Declaration, 1978
A Split in the PHC Movement

In 1980s, a focus on cost-effective technologies and a neglect of social and environmental determinants and processes led to substitution of “selective” for “comprehensive” primary health care (PHC) – e.g. UNICEF “Child Survival and Development Revolution”
Selective Primary Health Care

“Child Survival and Development Revolution”
(Dominant approach 1980s to early 1990s)

Growth Monitoring
Oral Rehydration Therapy
Breast Feeding
Immunisation

Family Planning
Food Supplements
Female Education
The Demise of PHC

• Rise of PHC coincided with global debt crisis and conservative macroeconomic policies

• Imposition of Structural Adjustment policies in 80s and 90s undermined many countries’ capacity to support health systems development as fiscal stringency, user charges etc were introduced

• In late 1980s ‘health sector reform’, based on market principles, economic efficiency and cost-effectiveness was promoted.
Selective PHC has continuities with aspects of Health Sector ‘Reform’ as promoted since the 1990s
Health sector ‘reform’

Quest for efficiency cont.-

The move from equity and comprehensiveness to technical efficiency and selectiveness leads to:

• A return to vertical programmes;
• Fragmentation of health services
• **Neglect of SDH**, erosion of intersectoral work and community health infrastructures
Access to water and hygienic sanitation

• Only 44 percent of rural SSA ie 60 percent of SSA population, has access to adequate water supplies and good sanitation in 2004.

• Over the period 1990 – 2004, the number of people without access to drinking water increased by 23% and those without sanitation increased by over 30%.
Sanitation Situation in West Africa

Source: WSMP,
The changing donor funding architecture and the emergence of Global Health ‘Partnerships’ have reinforced ‘selective’, technocratic and vertical approaches
What are Global Health Initiatives (GHI’s)

- Entities that mount a selective response to specific aspects of the global public health agenda.
- Some focus on developing, or increasing access to specific health products such as drugs or vaccines (for example, the Global Alliance for Vaccines and Immunisation).
- Others attract, manage and allocate funding for a global response to specific diseases or health interventions (for example the Global Fund to fight AIDS, Tuberculosis and Malaria or the Roll back Malaria Global Partnership).

Total annual resources available for AIDS 1986–2005

Notes:  [1] 1986-2000 figures are for international funds only
       [2] Domestic funds are included from 2001 onwards

Burden of disease

Share of population

Share of health workers

Our Common Interest 2005: 184
Doctor emigration from sub-Saharan Africa: winners and losers

• Nine sub-Saharan African countries with an HIV prevalence of 5% or greater or with more than one million people with HIV/AIDS and with at least one medical school: Ethiopia, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

• In the nine source countries the estimated government subsidised cost of a doctor’s education ranged from $21 000 (£13 000; €15 000) in Uganda to $58 700 in South Africa. The overall estimated loss of returns from investment for all doctors currently working in the destination countries was $2.17bn, ranging from $2.16m (1.55m to 2.78m) for Malawi to $1.41bn (1.38bn to 1.44bn) for South Africa.

• The benefit to destination countries of recruiting trained doctors was largest for the United Kingdom ($2.7bn) and United States ($846m).

Mills et al, BMJ 2011;343
Worrying Trends:

“Health systems that focus disproportionately on narrow specialized curative care…”

“Health systems where a command and control approach to disease control focused on short-term results fragments service delivery…”

“Health systems where *laissez-faire* approach has allowed unregulated commercialization of health to flourish…”
In summary: health status is stagnant or improving very gradually and public health systems in Africa (and many Southern countries) are weak, poorly staffed, fragmented and inequitable

... slowing progress in PHC implementation
## Deficits in universal health protection: Global, regional and country estimates by rural/urban areas (ILO)

<table>
<thead>
<tr>
<th>Region or country</th>
<th>Legal health coverage deficit, % of population without legal coverage&lt;sup&gt;1, 3, 4, 9, 12, 13&lt;/sup&gt;</th>
<th>Out-of-pocket expenditure, % of total health expenditure&lt;sup&gt;1, 3, 5, 6, 12, 15&lt;/sup&gt;</th>
<th>Financial deficit, % of population not covered due to financial resource deficit (threshold: US$239)&lt;sup&gt;1, 2, 3, 7, 8, 11, 12, 14&lt;/sup&gt;</th>
<th>Staff access deficit, % of population not covered due to health professional staff deficit (threshold: 41.1)&lt;sup&gt;1, 2, 3, 8, 10, 12, 14&lt;/sup&gt;</th>
<th>Maternal mortality ratio, deaths per 10,000 live births&lt;sup&gt;1, 3, 4, 8, 11, 14&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Urban Rural Year&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Total Urban Rural Year&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Total Urban Rural Year&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Total Urban Rural Year&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Total Urban Rural Year&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
<tr>
<td>Africa</td>
<td>74.6 60.8 83.5 ...</td>
<td>46.0 53.0 42.2 ...</td>
<td>80.3 69.6 86.8 ...</td>
<td>65.9 50.0 77.1 ...</td>
<td>47.7 28.9 54.9 ...</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>14.5 9.8 32.6 ...</td>
<td>34.4 33.6 9.5 ...</td>
<td>7.4 4.4 19.5 ...</td>
<td>14.2 11.3 23.9 ...</td>
<td>11.2 8.0 16.0 ...</td>
</tr>
<tr>
<td>North America</td>
<td>14.4 13.5 18.4 ...</td>
<td>12.0 12.0 12.0 ...</td>
<td>0.0 0.0 0.0 ...</td>
<td>0.0 0.0 0.0 ...</td>
<td>2.0 2.0 2.0 ...</td>
</tr>
<tr>
<td>Western Europe</td>
<td>0.4 0.4 0.4 ...</td>
<td>13.7 13.1 15.4 ...</td>
<td>0.0 0.0 0.0 ...</td>
<td>0.0 0.0 0.0 ...</td>
<td>0.7 0.7 0.7 ...</td>
</tr>
<tr>
<td>Central and Eastern Europe</td>
<td>5.6 1.7 13.6 ...</td>
<td>32.4 40.6 15.5 ...</td>
<td>7.3 6.8 8.5 ...</td>
<td>0.0 0.0 0.0 ...</td>
<td>2.3 2.3 2.3 ...</td>
</tr>
<tr>
<td>Asia and the Pacific</td>
<td>42.2 24.5 55.8 ...</td>
<td>46.4 46.9 45.9 ...</td>
<td>57.3 46.7 65.6 ...</td>
<td>44.2 33.3 52.5 ...</td>
<td>14.5 8.4 18.0 ...</td>
</tr>
<tr>
<td>Middle East</td>
<td>26.2 18.3 41.2 ...</td>
<td>57.8 56.7 62.1 ...</td>
<td>36.1 22.9 56.7 ...</td>
<td>38.8 28.0 56.2 ...</td>
<td>6.3 3.9 10.1 ...</td>
</tr>
<tr>
<td>World</td>
<td>38.1 21.5 55.8 ...</td>
<td>41.2 40.6 41.9 ...</td>
<td>48.0 33.2 63.2 ...</td>
<td>37.7 24.2 51.5 ...</td>
<td>21.9 10.8 28.9 ...</td>
</tr>
</tbody>
</table>
Only a third of children with diarrhoea in developing countries receive ORS and this trend remains stagnant.

Too few children with pneumonia are receiving appropriate care, especially in Sub-Saharan Africa

Proportion of children under five with suspected pneumonia taken to an appropriate health-care provider, 2007–2012
Gaps in appropriate careseeking for suspected childhood pneumonia exist across household wealth quintiles

Share of children under age 5 with suspected pneumonia taken to an appropriate healthcare provider or facility, by household wealth quintile and region, 2006–2011 (per cent)
PHM Position Paper

Ebola epidemic exposes the pathology of the global economic and political system

- Liberia, Guinea and Sierra Leone number 175, 179 and 183, respectively, out of 187 countries on the UN Human Development Index
- Companies (Sime Darby, Malaysia) and (Golden Veroleum USA) land-grabbing in Liberia in logging industry and palm oil
- Sierra Leone's economic growth as slowed to 15 percent this year from 21 percent in 2013 with expansion of foreign investment in the mining and farming industries.
- Prolonged dry spells in the region, through deforestation and penetration of new roads into previously remote forest areas primarily for extractive operations, have led to easier inter-mixing between the animals and humans driven deeper into the forest areas for survival and sustenance.
- Weak health systems ('brain drain'), poor investment, corruption, poor preparedness and equipment lack; globally little research and development
- Double standards of treatment for expats and nationals
- WHO’s poor role

www.phmovement.org
Priority Actions Needed (1)

- Develop comprehensive approaches that address social determinants of (ill) health through healthy public policies and intersectoral action. This will inevitably entail confronting corporate interests.
Priority Actions Needed (2)

• Promote increased public expenditure on health services and reduce role of private sector
Universal health coverage (UHC) has the potential to transform the lives of millions of people by bringing life-saving health care to those who need it most. UHC means that all people get the treatment they need without fear of falling into poverty. Unfortunately, in the name of UHC, some donors and developing country governments are promoting health insurance schemes that exclude the majority of people and leave the poor behind.
<table>
<thead>
<tr>
<th>Indicator (2005)</th>
<th>US</th>
<th>Costa Rica</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>77</td>
<td>79</td>
</tr>
<tr>
<td>IMR</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Gross National Income per capita (US$)</td>
<td>41,440</td>
<td>4,470</td>
</tr>
<tr>
<td>Health expenditure per capita (US$)</td>
<td>5,711</td>
<td>350</td>
</tr>
</tbody>
</table>

Priority Actions Needed (3)

• Advocate for improved access and coverage, especially at primary and community levels and strengthen community participation to address environmental and social determinants
Evidence for impact and cost-effectiveness of community health workers: example of Rwanda
Trend in Early Childhood Mortality

Deaths per 1,000 live births

Infant mortality

- RDHS 2005: 86
- RIDHS 2007-08: 62
- RDHS 2010: 50

Under-five mortality

- RDHS 2005: 152
- RIDHS 2007-08: 103
- RDHS 2010: 76

MDG

28?
50?
U-5 MR: Rwanda & SA

U-5 deaths / 1000 live births

Evidence for impact and cost-effectiveness of community health workers: enhancing ‘demand’

- CHW-led women’s groups in Nepal provided education to reduce neonatal and maternal mortality. The programme achieved substantial reduction in both neonatal and maternal mortality rate and was very cost-effective.


Implications of shift to ‘task-shifting’

• Does the current term (and operationalisation) reflect a restriction of the role of CHWs?
• Is this reflective of a change in paradigm for Primary Health Care?
Priority Actions Needed (4)

Build a broad-based social movement for health: the example of the Peoples Health Movement
Conclusions

- Challenge ill-considered health sector reforms through research and advocacy
- Develop well-managed comprehensive programmes
- Develop capacity and improve quality through health systems and equity-oriented research, practice-based and problem-oriented training.
- Rapidly (re)train CHWs and equip them with community development skills
- Involve other sectors and communities through focussed intersectoral efforts
- Challenge unfair global macroeconomic regime through social mobilisation
- Strengthen progressive civil society