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Universal Health Coverage by 2030, or the Right to Health? The continued relevance of the Alma Ata principles of voice and equity, through an intersectoral approach, to reducing global inequalities

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Regina Murphy Keith

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The COVID 19 pandemic has affected us all this year. In December 2020 my mother-in-law, Betty Keith, died, while I was finishing my thesis. I could not attend her funeral however she will be remembered.

To all of you I say: *"It mattered to me…thank you, there is still lots to be changed in this wonderful world, I look forward to working with you all, to make the world a better place, and to continue to fight for the progressive realization of the right to health for all, as set out in the 1978 Alma Ata Declaration"*

Contents

Declaration

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I hereby declare that this PhD is a result of my own original independent work except where I have indicated my credit to other sources.

I hereby declare that this PhD thesis has not been presented or accepted for any academic award or degree.

Title of Course: PhD by Publication Nutrition

Student's Name: Regina Murphy Keith

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Acronyms

BMJ	British Medical Journal
CFA	Commission for Africa
CMEH	Commission on Macroeconomics and Health
CPHC	Comprehensive Primary Health Care
CSO	Civil Society Organisation
DALY	Disability Adjusted Life Years
DFID	Department for International Development
GAVI	Global Alliance for Vaccines and Immunisations
GFATM	Global Fund to Fight AIDS TB and Malaria
GHWA	Global Health Workforce Alliance
GNT	Global Nutrition Targets
GUFP	Grow Up Free from Poverty
HSS	Health Systems Strengthening
HPN	Health Nutrition and Population (World Bank)
IHP	International Health Partnership
MDG	Millennium Development Goal
MCH	Maternal and Child Health
MMR	Maternal Mortality rate
NGO	Non-Government Organisation
PHC	Primary Health Care
PMNCH	Partnership for Maternal Neonatal and Child Health
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPPY	Per person per year
SBA	Skilled Birth Attendant
SC UK	Save the Children UK
SDG	Sustainable Development Goal
SHI	Social Health Insurance
SMI	Safe Motherhood Initiative
SOWC	State of the World's Children Report
SPHC	Selective Primary Health Care
SSA	Sub-Saharan Africa
SUN	Scaling Up Nutrition
U5MR	Under Five Mortality Rate
UCI	Universal Childhood Immunisations
UHC	Universal Health Coverage
UN	United Nations
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Education Fund
VSO	Voluntary Service Overseas
WB	World Bank
WDR	World Development Report
WHO	World Health Organization
WHR	World Health Report
WVI	World Vision International

Glossary

Advocacy: “the process of influencing those who make policy decisions, write the laws and regulation and distribute resources that affect peoples’ lives “(Save the Children 2012).

Advocacy strategy: “sets out the policies and actions that need to be changed, who has the power to make those changes. and how can you influence those decision makers” (Save the Children 2012).

Accountability a system which ensures that governments are answerable to their people for the way they run the country (and public services) (CFA 2005).

Alma Ata Declaration was signed in 1978 at the WHO and UNICEF Primary Health Care Conference in Alma Ata, with 136 countries committing to achieve the right to health for all by 2000, using Primary Health Care principles of equity, participation through an intersectoral approach (WHO 1978).

Astana Declaration: In October 2018, WHO in partnership with UNICEF and the Ministry of Health of Kazakhstan, hosted the Global Conference on Primary Health Care, 40 years after the adoption of the Declaration of Alma-Ata. Ministers, health workers, academics, partners and civil society recommitted to primary health care, as the cornerstone of Universal Health Coverage, in the new Declaration of Astana. The Declaration renewed political commitment to primary health care, focusing on achieving Universal Health Coverage by 2030 (WHO 2020)

Basic Health Care includes simple cost-effective interventions to promote health such as immunisations, care of ill children with fever, pneumonia and antenatal care (Keith 2009 b).

Cash Transfers are social protection measures to protect the most vulnerable. They can be conditional (where a mother must attend classes or education sessions) or unconditional (when the mother can decide how best to spend the extra resources). A system review carried out by Owusu Addo et al in 2018 confirmed that when utilised to support vulnerable mothers and children in sub-Saharan Africa these were effective in improving health, nutrition and food security outcomes.

Child Health Now: World Vision International’s first global campaign launched in 2009. Written by author, from evidence from six months of field research to develop the global report, encouraging country specific country advocacy (Keith 2009 b).

Community: people who live in a defined geographic area and or who share a sense of identity or common concerns (Baum 2015).

Community Health Workers “any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention; and having no formal professional or paraprofessional certificated or degreed tertiary education” (Lewin et al., 2005).

Community Health Interventions: health care interventions that are delivered by community health workers at the household or health clinic level linking homes to health system (Keith 2009 b).

Community participation: (as set out by the Alma Ata) is the bottom-up approach of communities to analyse their own health situations and be actively involved in planning solutions to addressing them through community interventions (Alma Ata WHO 1978).

Critical theory: focuses on critiquing and understanding inequities in society seeking to change them as a result (Crotty 1998).

Citizen's Voice and Action is a series of community activities that train communities groups to know their rights and how to run community programmes to feed their voices into policies and plans that affect them **(**Keith 2009 b).

Development: "is the achievement of progress in wellbeing and living standards, specifically reaching the most disadvantaged populations in a community" (Werner and Saunders 1997).

Decade of Nutrition from 2015-2025, established by the UN SG to encourage countries to focus on eradicating malnutrition globally (UN 2012).

Efficiency "measures whether healthcare resources are being used to get the best value for money. Efficiency is concerned with the relation between resource inputs (costs, in the form of labour, capital, or equipment) and either intermediate outputs or final health outcomes" (Palmer et al 1999).

Empowerment: "is the process by which disadvantaged populations work together to take control on the factors that determine their health and their lives. One cannot empower someone else, it is taken" (Scott et al 1985). Empowerment aims to reduce the number who are powerless (WHO 2008).

Equity: is a subjective concept, which has been defined in many ways. One common understanding is that everyone should have access (both financial and geographical) to health services, according to their needs rather than ability to pay (Witter and Keith 2005).

Equity orientated development places social justice principles before economic growth principles. "Health and wellbeing of a population relies on fair and equal distribution of resources and power, not only the money generated" (Werner and Saunders 1997).

Essential Health Care: usually includes all basic health services and preventative health care along with essential lifesaving treatment. Every country defines what they consider essential health care (Keith 2005).

Every Woman, Every Child: is the UN SG's Global Strategy for Woman and Children's Health launched in 2010 at the UN GA in New York USA (UN 2010).

Exclusive breastfeeding: % of infants 0-5 months given only breastmilk, with no other food or fluids (UNICEF 2013).

Fragile states: are those countries that will not or cannot provide basic services for their populations (DFID 2005).

Global Nutrition Targets: set in 2012, at the World Health Assembly, to address malnutrition in all its forms, to be achieved by 2025. There are six main targets to reduce acute and chronic malnutrition, halting the prevalence of childhood obesity, increasing the number of children exclusively breastfed, while reducing anaemia in women of childbearing age and the number of infants born with low birth weight (WHO 2012).

Global Health Governance: "a fair and equitable global governance system based on a democratic distribution of political and economic power" (Keith 2011).

Governance the ability of government and the public services to create robust economic, social and legal systems which will encourage economic growth and allow the poor to participate in it (it needs systems to collect voices, capacity to respond and accountability) (CFA 2005).

Health: "is a state of complete physical mental and social wellbeing not merely the absence of disease or infirmity**" (**WHO 1978).

Health inequalities: "The progressive realization of the right to health involves a concerted and sustained effort to improve health across all populations and reduce inequities in the enjoyment of health. Inequities are inequalities that are judged to be unfair, that is, both unacceptable and avoidable. Equity must be reached both between and within countries" (WHO 2020).

Health insurance: a form of health financing, which pools risks across patients and across time. The objective is to increase equity and protect against catastrophically expensive illnesses (WHO 2010).

Health systems: are "all organisations, people, and actions whose primary intent is to promote restore or maintain health. This includes efforts to influence determinants of health as well as more direct health improving activities" (WHO 2000).

Health workers: are all people engaged in the promotion protection or improvement of health of the population (WHO, 2006).

Intersectoral: this relates to a combination of essential sectors needed for social development such as health, education, water, sanitation, agriculture, and social welfare (Werner and Saunders 1997).

Low birthweight: is defined as a weight of less than 2.500 grams at birth (UNICEF 2013).

Making Poverty History: a global campaign to end poverty through more aid & debt cancellation (Oxfam 2013).

Malnutrition inadequate nutrition for health (underweight, micronutrient deficiency and obesity or overweight) (UNICEF 2013).

Millennium Development Goals: established at the UN General Assembly in 2000, governments committed to achieving eight goals by 2015: eradicating extreme poverty and hunger, achieving primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV and AIDS, malaria, and other disease, ensuring environmental sustainability, and developing a global partnership for development (CFA 2005).

Non-governmental organisation (NGO) An organisation that is not part of a government. NGOs are usually not-for-profit organisations. See also 'civil society' (CFA 2005)

Nutrition specific interventions have a direct impact on malnutrition such as supplementation or fortification or treatment of acute malnutrition (Keith et al 2015)

Nutrition sensitive interventions indirectly impact nutrition by targeting the underlying causes of malnutrition across a wide number of sectors such as social protection and gender (Keith et al 2015)

Positivism aims for definition of objective truth and reduces all relationships to a statistical level (Crotty 1998)

Participatory Learning in Action community activities to assess health and other sectoral situations, trends and causal factors, leading to the development of action plans for change (Keith, 2000)

Poverty the number of people living below the international poverty line of $1.25 per day as per 2005 prices (UNCEF 2013) and under $1.75 in 2015 (UNICEF 2015)

Poverty Reduction Strategy (PRS) Initiated by the boards of the World Bank and International Monetary Fund (IMF), a poverty reduction strategy should describe a country's macroeconomic, structural, and social policies and programmes to promote growth and reduce poverty, as well as associated external financing needs. PRSs are expected to be prepared by governments through a participatory process involving civil society and development partners, including the World Bank and IMF, and are required for countries seeking to obtain concessional lending and debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) initiative (CFA 2005).

Power over refers to the ability of a relatively powerful actor's action to affect the actions and thought of the relatively powerless.

Power to is about being able to act. It can begin with the awareness that it is possible to act, and can grow in the process of acting, developing skills and capacities, and realising that one can effect change.

Power with describes collective action or agency and includes both the psychological and political power that comes from being united. 'Power with' is often used to describe how

those faced with overt or covert domination can act to address their situation: from joining together with others, through building shared understandings, to planning and taking collective action.

Power within describes the sense of confidence, dignity and self-esteem that comes from gaining awareness of one's situation and realising the possibility of doing something about it. 'Power within' is a core idea in gender analysis, popular education, psychology and many approaches to empowerment.

Powerless is the inability to get what one wants or needs and the inability to influence others effectively to further your own interests (Parenti 1978)

Primary Health Care: as laid out in the Alma Ata Declaration, is a normative concept, which implies accessibility for all, community participation, and the importance of equity, the promotion of health through an intersectoral approach to the production of health (WHO 1978).

Rational Health Policy process: follows an evidence informed logical process to determine the most effective solution to a population health problem (WHO 2020).

Right to Health: "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" was incorporated in article 12 of the International Covenant on Economic social and Cultural Rights (ICESCR) agreed in 1976. (UNOHC 1976) It is a core component of the 1946 WHO constitution, the Alma Ata Declaration of 1978 and the Astana Declaration of 2018.

Scaling up Nutrition (SUN): a global movement founded on the principle that all people have the right to food and good nutrition. It brings together governments, civil society, donors, businesses, researchers, and the UN agencies in a collective effort to tackle malnutrition (Keith et al 2015)

Severe Acute Malnutrition (SAM): is defined as the % of children aged 6- 59 months whose weight for height is below minus 3 standard deviations from the median of the WHO Child Growth Standards, or by mid upper arm circumference less than 115 cms, with or without nutritional oedema (UNICEF 2013).

Skilled birth attendant (SBA): an accredited health profession such as a midwife, doctor or nurse who has been education and training to proficiency in the skills needed to manage normal (uncomplication pregnancies, childbirth and the immediate post-natal period and in the identification, management and referral of complications in women and new-borns) (WHO 2004)

Solidarity for global health infers that the countries of the world would agree on a common global health charter or framework convention for global health which sets out global priorities as well as national and international responsibilities (Keith and Ooms 2011).

Social Health Insurance: is a mandatory taxation that is specifically for health care, usually an extra tax which allows members access to an agreed set of health services, usually incurs a co-payment and often implemented with a tax funded mechanism to support the most vulnerable (Morel and Keith 2008)

Social Justice: indicates the achievement of social, economic, cultural, civil and political rights (Klugman 2011).

Social protection mechanisms: policies and practices that are intended to protect people against shocks that could push them deeper into poverty; make poor people less vulnerable to these shocks; protect people against extreme poverty and its effects on wellbeing; and protect wellbeing at vulnerable periods of the life cycle such as childhood (Witter 2005 a). Measures include cash transfers, free health and education services and subsidise social costs for housing etc.

Sustainable Development Goals (SDGs): 17 goals set in 2015 to be achieved by 2030 with SDG 3 focusing on health and universal health coverage and SDG 2 focusing on food security and nutrition (UN 2015).

Stunting: chronic malnutrition (% of children 0-59 months height for age below minus two or minus three below the standard deviation from the median of WHO Child Growth Standards) (UNICEF 2013).

Structural adjustment: "… controversial reform programmes, introduced by the World Bank and International Monetary Fund (IMF) in the late 1980s to rebalance budgets and deal with the build-up of national debt. Common guiding principles included export-led growth; privatisation and liberalisation; and the efficiency of the free market. In the health sector, they led to cuts in public expenditure and an associated rise in cost-recovery mechanisms such as user fees" (Witter and Keith 2005).

Tax Based Health Financing health services funded through mandatory taxation, the public funds are managed and allocated by the Ministry of Finance. The taxes should be progressive (taxing luxury items) rather than regressive (taxing essential goods like staple foods) (Yates 2004).

Universal Health Coverage: all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO 2020).

User fees: are fees charged to those using public services such as health, education, water and other infrastructure services (CFA 2005).

User Fees for health: "Direct payments for services at the point of use by patients, which cover some or all of the costs of the service. These payments are officially sanctioned but

may nevertheless not be fully accounted for" (Witter and Keith 2005). Co-payments, if collected at time of consultation, are still a form of user fee (Keith 2020).

Under five mortality rate: "the probability of dying between birth and 5 years of age per 1,000 live births" (UNICEF 2013).

Wasting: acute malnutrition (% of children 0-59 months whose weight for height is below minus two or minus three below the standard deviation, from the median of the WHO Child Growth Standards) (UNICEF 2013).

Vulnerability Susceptibility to poverty, hunger, and destitution because of crisis, because of inability to access services or call on informal support (CFA 2005).

World Bank (Group) "Frequently used shorthand for the International Bank for Reconstruction and Development (IBRD), one of the original Bretton Woods institutions. The World Bank group consists of the IBRD, as well as the International Development Association (IDA); the International Finance Corporation (IFC); the Multilateral Investment Guarantee Agency (MIGA); and the International Centre for the Settlement of Investment Disputes (ICSID)." (CFA 2005).

Zero Hunger Challenge: launched in 2012, by the UN SG at the Rio +20 Conference on Sustainable Development, as a call to achieve zero hunger for all. The five pillars of this challenge are to achieve 100% access to adequate food all year, abolish chronic malnutrition (stunting) in under two-year olds, sustainable food systems, increased small holder farming productivity and income and zero food waste or loss. It supports the Global Nutrition Targets set in 2012 at the World Health Assembly and the Decade of Nutrition established by the UN SG from 2015 until 2025 (UN SG, 2012)

Author's foreword and comments from health policy experts on work

The published works included in this thesis are the product of ten years of research carried out by the author. The research reports were developed and presented at strategic times to influence global decision making on health policies, strategies or resources. The published work builds upon forty years of work by the author in the health sector at all levels, from villages in Africa, to Global Health policy formation, at the World Health Assembly. Working with International Aid Agencies enabled the author to use the research and her practical and lived experiences, to feed evidenced based knowledge and marginalised voices, into global health policy discourse. The most significant impact from the work was the change to global perceptions on the role of direct payments for health care. The research led to global policy changes in the UK, Liberia, Sierra Leone, Zambia and China. The work demonstrates that progress is possible in fragile contexts when certain factors, such as equity and voice, are addressed through an intersectoral focus on nutrition, social protection and food security. The author used the research to call for more systematic engagement of communities and civil societies in health planning and policy making. Changes have occurred in this area at a global level, but there is a long way to go to offset the power, that global health stakeholders and donors have, over decisions that affect the timely access to health care for around 2 billion people around the world. To strengthen validity, I have included some comments from colleagues I have worked with to promote the progressive realisation of the right to health:

"Regina has been a powerful and effective voice in the global campaign for universal health coverage for many years. I would emphasise her role as one of the leading exponents of the removal of health care user fees from the early 2000s when many of the leading health agencies had meekly gone along with the free-market policies being enforced by the likes of the IMF and the World Bank. Regina was one of the leading academics and CSO activists who challenged this orthodoxy with research evidence and working effectively with others helped to revise global health policy to promote publicly financed UHC" Rob Yates, Director Universal Health Coverage Chatham House UK

"Regina Keith's evidence briefs for decision makers on the serious negative effects of fees for health services, and the benefits of making services free, and her passionate and articulate statements on this in fora such as the World Health Assembly contributed to drawing attention to this important area, which is now a key area of attention in the context of Universal Health Coverage." Dr. Chandra- Mouli Venkatraman, World Health Organisation, Geneva

"Speaking about voice and equity issues in health, Regina has had a prominent role in the years I have been her colleague, from the days she was with Save the Children until now, speaking up from her academic position." Claudio Schuftan, Peoples Health Movement and the World Public Health Nutrition Association, Vietnam

"Regina Keith, author of Child Health Now, was my inspiration for our maternal and child health advocacy initiative in Armenia. She has exceptional leadership and capacity building skills motivating you to seek changes in reducing inequalities" Naira Gharakhanyan MD MPH Armenia Child Health Now Campaign Leader 2009

Abstract

Introduction: In 1978, the Alma Ata Declaration pledged global solidarity towards the progressive realisation of the right to health for all by the year 2000. The strategy was to be achieved using the principles of Primary Health Care, such as the promotion of equitable access to health, through an intersectoral lens with the active engagement of communities. This target was not achieved, due to the lack of political commitment. In 2015 seventeen new Sustainable Development Goals (SDGs) were established to reduce global inequities by 2030. We need to learn lessons from the past and focus on creating a more just global health system. The COVID 19 pandemic will have long term economic and social consequences, which could reduce health system resources and capacity. However, promoting the right to health could lead to a more equitable and peaceful global society. Ensuring timely access to essential effective health care services is a key priority for the third Sustainable Development Goal, with Universal Health Coverage as a specific target.

Aim: The aim of this research was to present the significant contribution of original knowledge that the selected published works contributed to global health policy discourse, on the factors required for improving timely access to health services, especially in fragile contexts. There were three research questions answered: *what are the factors needed to improve timely health service utilisation in fragile contexts*? *Is Universal Health Coverage the same as the right to health, as set out in the Alma Ata? Can Social Health Insurance alone achieve Universal Health Coverage to meet Sustainable Development Goal three?*

The literature: Nine peer reviewed published papers were selected, covering publications from 2008 to 2018. All papers were reviewed by academic and professional peers, along with organisational or journal editors. Six papers resulted from primary research, published by either the contracting organisation, or a peer reviewed journal. One paper was a scholarly comment published in a peer reviewed journal and one publication was the result of a scoping review, published by Save the Children.

Methodology and theoretical framework: A mixed method participatory action approach was used for seven of the nine papers. These seven published research papers combined secondary data collection and analysis, with the collection of primary qualitative research. The former was analysed through excel files and the qualitative findings were analysed through thematic analysis and workshops with participants. One briefing report resulted from a scoping review or peer reviewed material and health financing grey papers. All research was carried out with a critical enquiry approach using evidence to reduce health inequities. An adapted theoretical framework approach was used to analyse the publications to support the overall commentary. The framework utilised merged the Primary Health Care principles of equity, voice and governance through an intersectoral lens with Gaventa's four expressions of power. This adapted framework captured the critical enquiry approach of the collective evidence, to support change in health policy and practice. Evidenced based health and nutrition advocacy can strengthen the power ***with*** and ***to*** those with unequal access to health. Each publication was published at key moments, to encourage change.

Findings: The original research demonstrated that Universal Health Coverage is not the same as the right to health, as health requires concurrent investment in multiple sectors such as water, sanitation and education. However, it could be an effective stepping stone for the progressive realisation of the right to health. The research found no evidence to support Social Health Insurance alone could achieve Universal Health Coverage. Where it was implemented successfully it used public taxation funds to cover health for the poorest. Even in these situations the co-payments led to delays in timely health seeking. Overall, four factors were identified as essential to ensure timely health service utilisation, especially in fragile contexts: (i) Health services provided free at the point of access, through publicly funded taxation, were more equitable than social health insurance or user changes. (ii) Concurrent investment in social protection, food security, sanitation and quality education, through community health services, could prevent 2.5 million under five-year-old child deaths annually. (iii) Services are more effective when there is active engagement with communities. (iv) Good governance has resulted in reductions in under five morality rates, however, the lack of financial support for the World Health Organisation has resulted in fragmented global health governance, which must be urgently addressed.

Further research is needed to support the strengthening of resilient health systems, free at point of access, through national taxation systems.

Key words: Alma Ata, Right to Health, Equity, Nutrition, Voice, Global Health Governance, Fragile contexts, Astana Declaration and Universal Health Coverage

Chapter one: Global Policies and Targets to Promote the Right to Health for All from 1978

The thesis reflects the significant contribution of original knowledge that the selected nine published works contributed to global health policy discourse, focusing on the factors required for improving timely access to health services, especially in fragile contexts. The commentary calls for renewed commitment to the Alma Ata principles of equity and voice, through an intersectoral lens, for the progressive realisation of the right to health for all. The Alma Ata quote below is particularly relevant in today's pandemic-affected world, where inequities are rising, and peace seems to be a distant dream.

What the Alma Ata promised:

> *"The promotion and protection of the health of the people, is essential to sustained economic and social development, and contributes to a better quality of life and to world peace" Alma Ata Declaration (Alma Ata Declaration, WHO 1978).*

1.1 Introduction

This thesis is being submitted in partial fulfilment of the requirements for the attainment of a PhD in Nutrition, by published work, to the School of Life Sciences, at the University of Westminster. The nine publications included in the PhD were published between 2008 and 2019. Seven papers were peer reviewed by academic and professional peers, along with organisational or journal editors, two by the journals peer reviewers. Six of the papers resulted from primary qualitative research supported by secondary data collection, published by either the contracting organisation, or a peer reviewed journal. One paper was a scholarly comment published in a peer reviewed journal and one publication was the result of a scoping review, published by Save the Children. Chapter one presents the global health policy context, from 1978 to the present, with a focus on the factors that influenced the success of the Alma Ata target of health for all, by the year 2000, and subsequent global health targets set.

1.2 Background: Global Solidarity to achieve Health for All by the Year 2000

Werner and Saunders (1997) state that "*solidarity is not an act of charity. It is an act of unity between allies fighting on different terrains towards the same objective*". As we fight against a new pandemic, perhaps it is time that we decide global solidarity for health is a worthwhile target. Just as diseases can spread across borders, so too can solutions. Over forty years ago, 134 health ministers decided that health for all was a worthy and achievable goal. Inspired by an evidenced based, rational policy process, led by WHO and UNICEF, they signed the Alma Ata Declaration (WHO 1978). This was the first ever global health policy, a commitment that acknowledged that health was a right for all, and identified Primary Health Care (PHC), as the strategy to achieve the vision, of Health for All, by the year 2000. The Alma Ata defined health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" and stated that health was an *"important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector" (WHO 1978).* The evidence presented by the World Health Organisation (WHO) and UNICEF inspired the principles of the newly agreed strategy. These were: equity of access to comprehensive primary health care services, including the prevention, promotion and treatment of illnesses. The services were to be locally determined, through active community engagement, and implemented concurrently with interventions addressing issues such as food security, nutrition, social protection, water, sanitation and quality education (WHO 1978, Werner and Saunders 1997). The design was built on the experience of good health at low cost in countries like Sri Lanka, Cuba, Guyana and places like Kerala in India (Scott et al. 1985). Good health was assessed through the achievement of universal health coverage of services, with sustained reductions in preventable maternal and child deaths (Scott et al 1985). However, the countries had

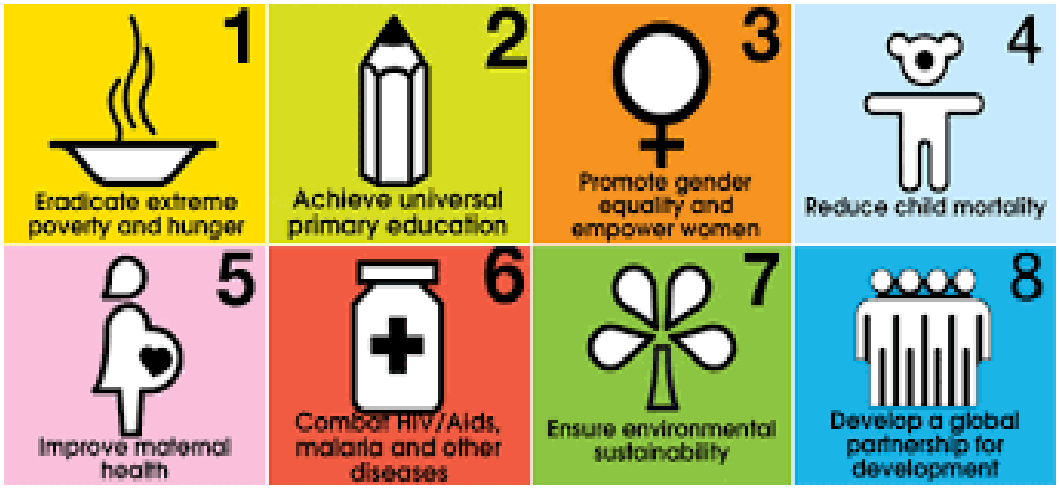
common factors such as a clear political commitment to the equitable provision of health for all, supported by active engagement from communities to identify and address local problems that affected health, such as lack of access to clean water, sanitation and food security (Scott et al 1985, Werner and Sanders 1997, Mehrota and Jolly 1998, Fustukan et al 2003, Mc Nay et al 2004, Keith et al 2009, Balabanova et al 2011). All the countries had invested in strong community health systems that linked formal health services to households, with concurrent investment in education (especially for girls), nutrition and social protection for marginalised populations (Scott et al 1985 and Mehrota and Jolly 1998, Balabanova et al 2011). Kerala, in India, invested 14% of its budget on health and Cost Rica abolished its armed forces in 1948, spending its money on social development (Scott et al 1985). The participants of the Alma Ata Conference returned home with renewed hope for a future where everyone had equitable access to health care. That hope was quickly dampened by a lack of funding to implement the ambitious policy. Funding agencies, like the World Bank and the Rockefeller Foundation, felt the policy was too expensive and suggested that the comprehensive PHC vision be reduced to a more manageable set of four interventions. This resulted in a focus on four interventions focusing on reducing childhood deaths: growth monitoring, breastfeeding promotion, oral rehydration solution and childhood immunisations. They became known as the GOBI interventions. These GOBI interventions were supported by health education messages, using top-down approaches to the selected priorities, an approach divergent from the agreed Alma Ata principles of primary health care (Werner and Saunders 1997). As countries implemented the GOBI interventions, a global recession occurred in the 1980's, which reduced the resources available to support health and other essential social spending (Werner and Saunders 1997).

Leaders in many newly independent countries had been elected on the promise of free health and education services. However, they did not have the resources to implement these promises. Many of these countries borrowed money from the International Monetary Fund (IMF), which had strict conditions, set out in structural adjustment policies. These conditions required them to reduce social sector spending and implement policy changes, such as implementing charges for accessing health care, to ensure that they could repay their loans and maintain fiscal stability (Werner and Saunders 1997). Other conditionalities were introduced, such as increasing inflation and devaluing local currencies. These measures had devastating impacts on the ability of countries to implement their new Primary Health Care (PHC) policies, based on the right to health for all (Werner and Saunders 1997, Baum 2015). Although many countries included comprehensive PHC in their health policies they only had resources, mostly from donors, to implement the selective disease specific interventions. These disease specific programmes did not adhere to the PHC principles and 'Health for All by the year 2000', was not achieved (Werner and Saunders 1997). The right to health focus was increasingly replaced by a new focus on child survival (Grant 1984), with words like community compliance, focusing on disease specific interventions and behaviour change communication, rather than the development of more robust community health services, addressing local health and social problems (Kent 1991, Schuftan 1990 and Werner and Saunders 1997). Although 12 million under-fives were dying from preventable causes each year, at this time, the focus on selective disease specific interventions led to fragmentation of the health services and lack of investment in human resources and other sectors such as water, sanitation and education (Save the Children and Medact 2001).

1.3 Millennium Development Goals and Making Poverty History

Despite the failure to achieve the Alma Ata target of health for all by the year 2000, there was increasing globally advocacy that urgent action was needed to address growing global inequalities in health and education. At the start of the new millennium global leaders agreed to work together to address some of these inequities. As over 12 million children under five were dying from preventable causes and millions of children were going to bed with little chance of formal education, they agreed on eight global goals, to be achieved by 2015 (See figure one) (UN 2000). Three of these goals were focused on health: Millennium Development Goal (MDG) four (4), focused on reducing the number of under five-year-old children dying from preventable causes and MDG five (5), focused on reducing maternal deaths, while MDG six (6), focused on halting the growing prevalence of HIV, Tb and Malaria (UN 2000). Despite setting these global commitments there was little change to how health was being implemented, with a continued focus on disease specific interventions (Save the Children 1996, Werner and Saunders 1997, Save the Children and Medact 2001). In 2003 the Grow up Free from Poverty Coalition (GUFP) carried out research which predicted that the MDGs for maternal and child health (MDG 4 and 5) would not be met for another 150 years in Sub Saharan Africa, resulting in 80 million maternal and child preventable deaths by 2015 (Fustukan, Keith and Penrose 2003). The GUFP report was launched at the UK Parliament, by the then Secretary of State, Baroness Amos. The report encouraged organisations to develop more robust evidence to support the Make Poverty History Campaign, which aimed to halve poverty by doubling aid, in 2005.

Figure one: Millennium Development Goals 2000 – 2015



Source : UN 2020 (www.un.org)

Save the Children UK (SC UK) launched their Cost of Coping with Illness in East and Central Africa series in 2005, to support the global call for more action. The research was based on a peer reviewed mixed method research programme exploring the barriers to timely access to health care, in the seven countries. This five-year longitudinal study was commissioned by Save the Children, managed by the author, to follow up the findings from the 2001 Bitterest Pill report, which highlighted the collapse of health systems in parts of Sub Saharan Africa. The longitudinal study found that in the seven countries included in the study, one third of the research population, could not afford to seek health care, while a further third of the population was pulled into poverty, due to selling capital finite assets, to pay for health care (Russell 2002, Cadge and Keith 2005 a,b,c,d,e,f,g,h, Witter 2005 a, b). This research supported the increasing global recognition regarding the negative impact that health user charges were having on health care service utilisation. Evidence had been growing since the 1990s when the World Bank and the IMF started aggressively promoting their use, as conditions linked to their of structural adjustment plans (Gilson et al 1995, Creese and

Kutzin 1996, Russell 1996, Gilson 1997, Woodward 1997, Kutzin 2001, Russell 2002, Keith and Shackleton 2006 b, James et al 2005, Witter and Keith 2005, James et al 2006, Yates 2006, Keith 2007, Keith 2009 b, Keith and Cadge 2010). Innovative research in 2005, by the author and Save the Children UK, estimated how much it would cost to abolish these user charges in 20 of the UK's priority countries in Africa. The results were published in the British Medical Journal (BMJ), estimating that abolishing health care fees in these countries could prevent the death of 233,000 children under five at a cost of £1.75 per person per year (James and Keith et al 2005). Tony Blair, the UK Prime Minister, used the research in the Labour Party Manifesto for the May 2005 General Election. He promised, if elected, to support 12 countries to move away from health user fees by 2015 (Keith and Shackleton 2005). The UK supported 10 countries, to move away from user fees for health over the next ten years, which led to increases in health spending in these countries by about 40 % (Oxfam 2013). It also galvanised a growing coalition of civil society advocates to call for their abolition, to promote more equitable access to health for the poorest. In countries like Liberia child mortality rates were halved from 235 under five-year-old deaths per 1000 live births in 1990 to 111 under five-year-old deaths per 1000 live births in 2009 (Keith, Cadge 2010). The Make Poverty History campaign succeeded in encouraging world leaders to promise to double aid to half poverty (Oxfam 2013).

In 2005, The World Health Organisation invited the author and other partners to a consultation on the development of their new World Health Report: Making every mother and child count (WHO 2005a). The WHO Director General raised concerns about the 100,000 people who were forced into poverty each year through paying for health (WHO 2005a). Her presentation was supported by the research from the author and others, such

as Gilson et al 1995, Creese and Kutzin 1996, Gilson 1997, Gilson et al 2001, Fustukian et al 2003, Keith 2005, Cadge and Keith 2005 a, b, c, d, e, f, g, h. When the 2005 World Health Report was released, it advised that countries should return to the principles of Alma Ata and move away from user fees at point of service (WHO 2005a). The importance of health systems, pro- poor health financing and trained supported health workers were also included in the report: cited as fundamental for achieving the health related MDGs, echoing findings from the Fustukian et al 2003 research (WHO 2005 a). At the May 2005 World Health Assembly 189 Ministers of Health agreed to two new resolutions (WHA 58.31 and 33), which focused on strengthening maternal and child health systems, working with communities more and moving towards pro poor health financing systems (WHA 2005 a, b). However, most low income and fragile countries did not have the resources or the capacity to move towards more equitable health financing mechanisms without external support (Keith 2005). Fragile states are those countries that will not, or cannot, provide basic services for their populations (DFID 2005). See annex 3 for a list of fragile states and those included in research publications presented. These countries are either too poor to invest in local services, or they are rebuilding their country following conflict or disaster, or they decide not to support health and social spending for political reasons. Sometimes as a tool in conflict. Although this renewed interest in global health led to new resources, much of these resources were spent through new global private public partnerships, which again were disease specific and vertical in nature. This resulted in less than 3% of the new resources strengthening national health systems (Heaton and Keith 2002, Starling et al 2002, Keith 2003, 2005, 2007, Keith and Cadge 2010). In 2010 there were 320 million children living in fragile states, but resources were not being invested in the countries with

the greatest need. In 2009, donor aid for maternal and child health, accounted for only 3%, of international aid (Keith and Cadge 2010). The impact of these globally led vertical programmes (delivered as disease specific single intervention programmes, not integrated into routine health services), along with growing national debt and recession, resulted, in the collapse of rural health systems in many low-income countries, especially those struggling with high levels of poverty, debt and conflict (Save the Children 1996, Werner and Saunders 1997, Save the Children and Medact 2001, Fustukian et al 2003, Action Aid 2005, Action for Global Health 2008). Resources were not reaching health systems and the impact of the HIV pandemic was placing more strain on health and economic systems in the poorest countries, especially in Africa (Heaton and Keith 2002, Starling et al 2002, Fustukian et al 2003, Keith 2009) and there was a global shortage of health workers, with a minimum of 4 million extra needed (WHO 2006, Blanchet et al 2006). In 2008, on the 30th anniversary of the Alma Ata Declaration, WHO released the World Health Report, focusing on the need to return to the principles of Primary Health Care (WHO 2008 b). As anticipated by Save the Children, the author and others, 2015 arrived, and the health related MDGs for maternal and child health were not achieved. Although the MDGs were not met, some progress was achieved, with 721 million fewer people living in poverty and 2.6 billion people having access to improved water and 53% fewer children dying from preventable causes (UNICEF 2015).

1.4 Sustainable Development Goals and the 2018 Astana Declaration

In 2015, seventeen new global targets were agreed (the Sustainable Development Goals (SDGs). Many of the goals are linked to health and nutrition with SDG two (2) focusing on food security and nutrition while SDG three (3) focuses on improving global health. SDG 3

also includes a commitment to achieving Universal Health Coverage (UHC) by 2030. Many right to health advocates were concerned that the focus on UHC would halt the progressive realisation of the right to health for all (Peoples Health Movement 2015, Baum 2015, Keith 2018). On the 40th anniversary of the Alma Ata Declaration in 2018, a global conference on PHC was held in Astana and the Astana Declaration was signed. The author was part of a senior working group selected from the health information for all group to feed into the Astana declaration. The author also used research included in this thesis to feed into the new Declaration, publishing an article in World Nutrition in August 2018 on the importance of the Alma Ata principles (Keith 2018). The final Astana Declaration (see annex six) included many of the PHC principles, including the right to health and the importance of reducing inequities. However, Universal Coverage of Health Services does not fully address the social determinants of health or the full progressive achievement of right to health as set out in the Alma Ata Declaration (Keith 2018). See annex five, six and seven with more details of each of the declarations and the differences between them. With under ten years to go, until 2030, the world is not on track to meet the SDGs for health and nutrition. Malnutrition levels are increasing globally, with 800 million people going to be hungry and 2 billion people who do not have access to essential health services when they need them (GNR 2020). There are still 5 million under five-year-olds dying from preventable causes (WHO 2020) so there is still a long way to go to achieve Health for All. Unless we learn lessons from the past 40 years and re-orient global health systems, in line with the Alma Ata principles, we may be reflecting on another failed set of targets in 2030. The present COVID pandemic has highlighted the devastating consequences of health service inequities throughout the world. Health systems, and economies, are stretched, even in high income nations. We are

at a pivotable moment in time. This is a good time to recommit to implementing the evidenced based Alma Ata principles of equity and voice, through an intersectoral approach, to ensure the progressive realisation of the right to health for all (Keith 2018).

Figure two: Sustainable Development Goals 2015 – 2030

1.5 Aim and main findings from collection of published works

The aim of this research was to present the significant contribution of original knowledge that the selected published works contributed to global health policy discourse on the factors required for improving timely access to health services, especially in fragile contexts. There were three research questions addressed: *what are the factors needed to improve timely health service utilisation in fragile contexts*? *Is Universal Health Coverage the same as the right to health, as set out in the Alma Ata? Can Social Health Insurance alone achieve Universal Health Coverage to meet Sustainable Development Goal three?* The collective body of published works, included in this thesis, presents evidence to support the continued relevance of the Alma Ata principles of voice and equity, through an intersectoral approach,

to reducing global health inequalities especially for mothers and under five year old children. The thesis presents four key findings, set out in individual chapters 3, 4, 5 and 6. These chapters present the pledges in Alma Ata and the origional evidence the publications have added to the discourse on what are the essential factors needed to improve timely utilisation of health care services, especially in fragile contexts. The evidence uses case studies from 40 countries (see annex three). The four key findings or factors needed for improving timely access to health services are:

1. Political commitment to provide essential health care services free at the point of access, promotes equity and reduces delays in timely access of health care. (Chapter three)
2. Concurrent investment in sectors, such as food security, nutrition, social protection, water, sanitation and quality education (especially for girls), with essential community-based health services. These services could prevent 2.5 million under fiver year old deaths annually. (Chapter four)

3. Active community engagement prioritising the most vulnerable reduces inequalities and increases timely health service utilisation. (Chapter five)
4. Good governance and strong leadership can deliver positive health outcomes even in fragile contexts. However, global health solidarity and governance must be invested in to achieve the health and nutrition SDGs (Chapter six)

1.6 Thesis structure

Chapter one introduces the context of forty years of global health policies, promises and targets focusing on the progressive realisation of the right to health and the challenges

encountered by countries trying to achieve it. The aim of the commentary from the collection of published work is presented along with the four key findings. Chapter two presents a summary of the methodology used for the nine individual publications and the theoretical framework used for the reflection and thesis commentary. More details on the individual papers can be found in table one and annex one and seven. Chapter three presents the significant contribution of new evidence, around how equity can be achieved, to promote the timely utilisation of health services. Chapter four presents new evidence on how concurrent investment in sectors, such as food security, nutrition, water, sanitation and quality education, with essential health interventions, could prevent over 2.5 million child deaths each year. Chapter five demonstrates the impact of active community engagement, using experiences from the case study countries. Chapter six presents the evidence, which supports the positive impact of governance and leadership in fragile states, that has led to reductions in maternal and child deaths, between 2008 and 2018. The conclusions and further research suggestions are set out in Chapter seven. Annex one presents the impact of the collected works, while annex two sets out the critical pathway leading to the portfolio of work. Annex three presents a table of fragile states, highlighting those used in the nine publications as case studies. There is also a map of fragile states. Annex five contains the Alma Ata Declaration and Annex six presents the Astana Declaration. Annex seven presents the differences between the two declarations. Annex eight highlights the peer review and publication process for each paper. The nine publications are all uploaded as individual pdfs, in line with new graduate school instructions, due to the COVID lock down.

Chapter two: Methodology of the published works and theoretical framework

Chapter two sets out a short summary of the methodology used in each of the selected publications and table one presents the aim and impact of each of the published works. This is supported by annex one presenting the impact of the publications and annex eight sets out more details on the peer review and publication process for each paper. The chapter also presents the adapted theoretical framework, used to reflect on the collective published works, as an integrated programme of research, and a table presenting the 40 countries included as case studies in the research. A table highlighting which papers supports each finding is also included in this chapter.

2.1 Introduction to the methodology of the collected published works

A mixed method participatory action approach was used for seven of the nine papers. These seven published research papers combined secondary data collection and analysis, with the collection of primary qualitative research. The former was analysed through excel files and the qualitative findings were analysed through thematic analysis and workshops with participants. One briefing report resulted from a scoping review or peer reviewed material and health financing grey papers. All research was carried out with a critical enquiry approach using evidence to reduce health inequities. Dean et al (1993) and Crotty (1998) robustly contend that including qualitative and quantitative research is essential and any conflict between these two methodologies is '*dysfunctional.*' In health research positivist research has been favoured as more robust and effective truth to inform health policies and plans. Crotty (1998) defines positivist research as seeking an "*objective truth and reduces all relationships to a statistical level".* Statistics help us to identify what health problems exist, where and how they change over time. This can support health planning and assessment; however, as health is socially constructed and influenced by a person's or a population's

perception, it is essential for health planners and policy makers to gain a greater understanding of what influences a person or a population's health practice. Qualitative research does not present an objective truth, but it presents an in-depth subjective window in time. *Reason (1988)* presents *constructivism as "the joint creation of knowledge between the researcher and the researched…truths are socially constructed, and that reality is specific to time place and culture".* Chambers (1997) and Keith (2000) both agree on the importance of local knowledge when planning solutions and the process of working with communities to determine their needs, their influences and their perceptions, can help to create trust within a community, between health care workers and communities. Evidence is clear that when communities are involved in decisions that affect their lives adherence to changes is more robust, the communities often use reflections and discussions to inform changes in their own practices and perceptions. Crotty (1998) suggests that critical theory *"focuses on critiquing and understanding inequities in society, seeking to change them as a result"*. All the publications included in this PhD were created through a such a process of critical theory, some may consider the methodology as a participatory action research approach, as set out by Green and Thorogood (2004). As all the papers have been written by the same author, they are part of a social construct, validated through voices and data from 40 countries (see table two) to improve the reliability of the research. The research was not commissioned by the same organisation, but they do all build upon the learning from previous research carried out by the author (annex two presents a more detailed reflective journal to support this knowledge creation journey). Annex one sets out the impact of the papers included. All papers were peer reviewed and published between 2008 and 2019. Paper nine was accepted for publication by World Nutrition, in August 2018, and therefore

qualifies to be included in this decade of selected work. Annex eight presents a table, setting out the peer review and publication process, for each paper. The publications were all open access and distributed free of charge. All publications targeted specific advocacy moments, to maximise the impact of the evidence presented, such as the annual World Health Assembly. In total there are nine publications included in the PhD. The author was the lead author for seven of the research publications except for paper two on Social Health Insurance, however, the author did commission and co-authored this paper. She also co-authored paper seven (*What works for Nutrition),* having written the chapter on Kenya, as well as the introduction and conclusion of the publication. See 2.2, table one, annex one and eight for more details on individual publications. As part of the limitations of research reports being used to target policy makers, the fully methodology of the research is not always included in the advocacy papers or policy briefings. As more aid organisations and health professionals work with academic partners, the robustness of research publications is improving. Many donors are now encouraging partnerships between academics and practitioners to strengthen the collection of evidence from operational research. Each of the research collaborations in this thesis have both such partners involved.

2.2 Summary of individual published works methodologies and the chapters their evidence supports

Paper one: Keith R (2008) ***Prevention of Mother to Child Transmission (PMTCT): Global Policy Implications: reflecting on progress and challenges in three countries (Malawi, Nigeria and Zambia*)** (Chapters 3, 4, 5, 6) This was a participatory action research exploring the progress of Prevention of Mother to Child Transmission of HIV programmes in three countries with different health system capacity. Field visits were carried out involving direct observation, review of secondary data, 55 key informant interviews and 20 focus group discussions with health workers, carers and communities of mothers living with HIV (around

200 participants). The data were analysed using excel for the quantitative data analysis and a thematic analysis to pull out the themes and sub themes from participants. Themes were presented in country workshops and finalised in a UK workshop. The focus groups had common themes presented back to them for verification. The finding revealed that the PMTCT HIV /AIDS programmes, using an opt out testing approach, were more successful in getting mothers to sign up for HIV treatment. Those living with HIV were doing so positively in Zambia and Malawi where the health services were functioning, and services were free at the point of access. Participants in the Nigerian research reported more challenges around the lack of access to health care and treatment free at the point of access and high levels of stigma. The report fed into national and global policy dialogue for HIV and more equitable access to health services.

Paper two: Morel C, Keith R (2008) ***Policy Briefing: Social Health Insurance*** (Chapter 3)
A scoping review of literature was carried out using pub med to identify peer reviewed literature on the impacts of social health insurance systems, on pro poor health financing. This was supported by a grey literature review of countries utilising social health insurance, to assess the effectiveness and equity of social health insurance, to achieve universal health coverage. Out of pocket expenditure and utilisation rates were assessed for the selected countries as proxy indicators. The evidence was collated, and gaps identified as well as the urgent debates. These formed the basis for a policy briefing shared with participants of the 2008 World Health Assembly. The research found that no country had used social health insurance to provide universal coverage without adding additional tax-based funds to cover the poor. Even high-income countries required additional tax-based resources to protect the poor from catastrophic health payments. The review fed into the health financing dialogue in Ghana and globally. Co-payments required with social health insurance systems also determined timely health service utilisation.

Paper three: Keith R (2009) ***All mothers matter: Human Resources for Health (HRH) in fragile states*** **Merlin UK** (Chapters 3,4,5,6) A participatory action research using mixed methods was used to determine the barriers to improving maternal health, focusing on 15 fragile states. Secondary data collection from four MERLIN programmes in Afghanistan,

Liberia, Democratic Republic of Congo (DRC) and Nepal, combined with 45 key informant interviews. The data were analysed using excel for the quantitative data analysis and a thematic analysis to identify the themes and sub themes from participants, these were presented and agreed in a UK workshop. The paper identified that competency-based training for community midwives was essential, and the report recommended increased investment in health workers for fragile states, estimating that £2.71 per person per year was needed to increase skilled attendants in the fragile states (see Annex three) that accounted for over two thirds of maternal deaths (189,000) each year. The report called for a standardised set of competencies and definitions for community midwives and 1 skilled attendant per 175 mothers to increase the number of women delivered by a skilled attendant to reduce maternal deaths. The report also highlighted the fact that many maternal deaths occurred in countries that have been involved in conflict, with inadequate investment in health or aid from donors.

Paper four: Keith R et al (2009) *Child Health Now* World Vision International London UK (Chapters 3, 4, 5, 6) The aim of the research was to raise awareness and resources to increase attention on the 9 million annual preventable deaths of under five-year-olds in 2009. The Child Health Now report used a participatory action mixed method approach analysing secondary data from 30 countries supported by qualitative data from 62 key informant interviews, 6 focus group discussions with over 140 participants during two field visits. Secondary data were also obtained from 1600 community health programmes in 120 countries. The report focused on the countries where most under five child deaths occurred. The data were analysed using excel for the quantitative data analysis and a thematic analysis was used to identify the themes and sub themes from participants voices, these were presented in country workshops and finalised in a UK workshop. A set of critical community interventions was presented which could save 2.5 million under fiver year old lives each year. Nutrition was a key theme highlighted by the research which needed to have increased investment and support.

Paper five: Keith R, Cadge N (2010) *Unlocking Progress in Fragile States* Save the Children UK (Chapters 3, 4, 5, 6) The research aim was to identify what was working in fragile states.

A participatory mixed method approach was used analysing secondary data, 45 key informant interviews, direct observation, and four community conversations in Liberia and Sierra Leone with over 50 participants. The data were analysed using excel for the quantitative data analysis and a thematic analysis to identify the themes and sub themes from participants voices. Themes were presented in country workshops and finalised in a UK workshop. Save the Children created a position paper on fragile states using the research findings. The research fed into the UK government's prioritisation of aid resources to increase support for fragile states and WHO invited Liberia president to WHA to speak.

Paper six: Keith R and Ooms G, (2011) Improving Global Health Governance: technical briefing paper for the Child Health Now Campaign World Vision International, UK (Chapter 6) The aim of this research was to feed into the reorganisation of global health governance being discussed in 2011. A review of secondary data analysis was supported by 38 high level key informant interviews with health policy makers. The data were analysed using a thematic analysis to identify the themes and sub themes from participants. Themes were presented in a debate at the WHO Executive Board meeting in Geneva, which informed the final report recommendations. The research report was launched at the WHA with 100 delegates held at the World Health Assembly in May 2011.

Paper seven: Keith R et al (2015) ***What works for nutrition? Case studies from Vietnam, Uganda and Kenya*** **Results, Concern and University of Westminster published by Results UK** (Chapter 4, 5, and 6) The aim of this research was to determine the factors influencing progress in achieving the global nutrition targets in three countries. A critical theory enquiry carried out using mixed methods of secondary data analysis combined with data from 45 key informant interviews with nutrition and health stakeholders and Scaling Up Nutrition (SUN) members supported by 3 focus group discussions with NGOs working in the sector and three field trips. The data were analysed using a thematic analysis to identify the themes and sub themes from participants, which was agreed at a workshop between the three organisations, in UK. The report was launched at the UK Parliament, prior to the UK government's decision on the focus and scale of its nutrition aid and used to influence the Rio +20 summit on sustainable development and 2016 Nutrition for Development (N4D)

meeting. The government increased nutrition funding and its support for nutrition sensitive interventions.

Paper eight: Keith R (2018) From Alma Ata to Astana: can renewed commitment to Health for All by the 2030 be committed to in October 2018? World Nutrition Journal 10 August 2018 (C1,3,4,5,6) The aim of this article was to feed evidence into the preparation of the Astana Declaration through discussions and participation in the high-level working group. A scholarly commentary based on the author's research. Most of the author's recommendations were included however it focused on Universal Health Coverage (UHC) rather than right to health. See annex 5,6 and 7 for more details on the declarations and the differences between them.

Paper nine: Keith R et al (2019) Understanding practices and perceptions of infant and young child feeding (IYCF) in Tower Hamlets borough, London UK World Nutrition Journal (Chapter 3,4,5,6) The aim of this research was to review the early childhood services in Tower Hamlets. This is paper one based on research carried out in 2017 and accepted for publication in August 2018. This was a critical theory research using a mixed method approach of secondary data collection supported by 36 key informant interviews and 18 focus group discussions with 144 participants including mothers, parents and service providers. The data were analysed using a thematic analysis to identify the themes and sub themes from participants. The results were presented to 50 health workers in a workshop to agree priorities and recommendations, to improve health and nutrition in the borough. The report resulted in more nutrition support in the health service team, continued support for IYCF baby friendly services and more nutrition and oral health information on website, as well as an increased contact for pregnant women and mothers with health visitors.

Table one: Published work with aim, methods and impacts related to main four findings

P	Title	Study type and methods	Research Aim	Significance of the publication's outcomes	Findings
1	Prevention of Mother to Child Transmission (PMTCT): Global Policy Implication: reflecting on progress and challenges in three countries (Malawi, Nigeria and Zambia)	Mixed method with 3 country visits, 20 FGDs, qualitative 55 key informant interviews and secondary data collection. Data analysed using excel and thematic analysis	Explore the progress and challenges to increasing roll out of HIV PMTCT services	Fed into global PMTCT programming on opt out testing and positive impact of free treatment on uptake of testing in Sub Saharan Africa (SSA).	1,2,3,4
2	Policy Briefing: Social Health Insurance	Scholarly scoping review	Role of SHI in UHC for poor	Fed into Global Policy Dialogue	1
3	All mothers matter: HRH in fragile states	Mixed method participatory research including quantitative and 45 KII qualitative voices. Data analysed using excel and thematic analysis	Identifying successful health worker strategies to improve coverage of maternal health care in fragile states	ICM and ICN developed new competency-based training for Community Midwives	2
4	Child Health Now	Mixed method participatory research including quantitative and 62 KIIs 6 FGDs with 140 participants collecting qualitative voices. Data analysed using excel and thematic analysis	Aim was to increase global attention on preventable deaths and call for interventions in nutrition and health	$1.5 billion invested into MNCH by WVI and Global evidence used for UN SG EWEC and country advocacy on importance of PHC approach and free health care.	1,2,3,4
5	Unlocking Progress in Fragile States	Mixed method participatory research including quantitative and 45KIIs, FGDs 50 people. Data analysed using excel and thematic analysis	Identifying effective interventions to MNCH outcomes in fragile states	Liberia invited to the WHA and increased funding from fragile states from UK government.	1,2,3
6	Improving Global Health Governance: technical briefing paper for the Child Health Now Campaign	Critical theory with 38 key informant interviews (KIIs) Data analysed using thematic analysis.	Feeding into the WHO discussion on priorities and global health governance role in 2012	WHO added governance to its official agenda and is presently implementing the changes	2
7	What works for nutrition? Case studies from Vietnam, Uganda and Kenya	Mixed method participatory research including 45 KIIs & 3 FGDs with 120 people and four workshops. Data analysed using thematic analysis	Exploring the factors resulting in progress in nutrition outcomes in high performing countries	Resulted in UK continuing to invest in nutrition and increasing investment in NS interventions	2, 4
8	The importance of the Alma Ata principles of equity and voice through intersectoral investment	Scholarly Commentary in World Nutrition	Exploring the role of PHC in achieving UHC by 2030	Fed into Astana Declaration (Alma Ata 2)	1,2,3,4,

9	Understanding perceptions and practices on infant and young child feeding and oral health in Tower Hamlets Borough	Mixed method participatory research including 36 KIIs and 18 FGDs with 144 people. 1 workshop. Data analysed using thematic analysis	Exploring the perceptions and practices of IYCF oral health	Resulted in 14 recommendations being approved and implemented by Tower Hamlets (TH) Public Health team	2, 3,4

2.3 Theoretical framework

An adapted theoretical framework was created from the Alma Ata Primary Health Care framework (Werner and Saunders 1997, WHO 1978) and Gaventa's expressions of power (Gaventa, 2006) (see figure three). The components of the Alma Ata framework included the principles of equity (of access to health care services) and voice (active engagement of communities in health programme and policy development and implementation) and governance, through an intersectoral approach (addressing the social determinants of health). However, as all the publications were created to bring about change in inequalities, it was necessary to recognise the importance of power in the construction and the use of the papers in global and national policy discourse. Each of the research reports attempted to bring the voices of the marginalised into the health policy arena. To do this, campaigns were established, and evidence collected to strengthen the validity of the voices presented. Robust research informed by *lived experience* can strengthen the power of those whose voices are usually overlooked (Chambers 1997). The inclusion of Gaventa's (2006), expressions of power, into the adapted framework, recognises the intention of the author and the organisations commissioning the research, to strengthen the ***power with*** and the ***power to*** the marginalised, over those who normally have ***power over*** *them.* Gaventa's (2006) four expressions of power are:

> *"Power 'over' refers to the ability of the powerful to affect the actions and thought of the powerless. The power 'to' is important for the capacity to act; to exercise agency and to realise the potential of rights, citizenship or voice. Power 'within' often refers to gaining the sense of self-identity, confidence and awareness that is a precondition*

for action. Power 'with' refers to the synergy which can emerge through partnerships and collaboration with others, or through processes of collective action and alliance building".

The agencies who commissioned the research intended for the research to strengthen the power of citizens 'to' and 'with' others by creating enabling environments and partnerships. Creating safe spaces for communities to feed into decisions that affect them can help to bring change and reduce the power over populations by their governments or others. By engaging in the campaigns, the communities strengthened the power within.

Figure three: Theoretical framework used to reflect on collected publications (Keith 2021). Adapted from WHO (1978) Primary Health Care Framework and Gaventa's (2006) expressions of power.

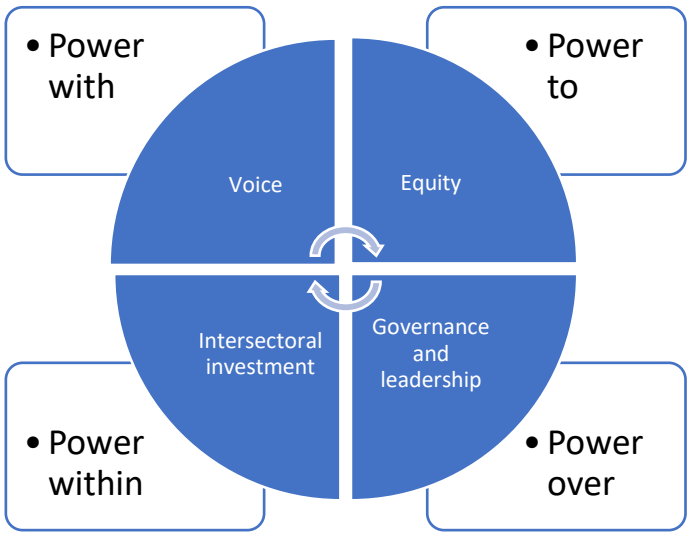


Table two presents the 40 countries that were involved in the collective research

Afghanistan	**Gambia**	**Myanmar**	**Togo**
Angola	**Guinea**	**Nepal**	**Uganda**
Burundi	**Guinea Bissau**	**Nigeria**	**UK**
Cambodia	**Haiti**	**Niger**	**Vietnam**
Cameroon	**India**	**Pakistan**	**Yemen**
Chad	**Indonesia**	**Rwanda**	**Zambia**
CAR	**Kenya**	**Sierra Leone**	**Zimbabwe**
Cote d' Ivoire	**Lao**	**Somalia**	
DR Congo	**Liberia**	**South Africa**	
Ethiopia	**Malawi**	**South Sudan**	
Eritrea	**Mali**	**Sudan**	

Chapter three: Key finding one: Health policies and services promote equity through proving essential health care services free at the point of access

Chapter three supports key finding one, which demonstrates that equity of access was achieved through health services provided free at the point of access, through tax based or aid supported financing. It also provides evidence that co-payments and social health insurance systems, unless concurrently supported by tax-based funding for the poor, do not provide pro-poor health financing or equitable access to health. These findings support the Alma Ata principle below.

What the Alma Ata promised:

> "*Inequality in health status of the people…is politically socially and economically unacceptable and is therefore a common concern to all countries" (Alma Ata, WHO 1978)*

Earlier research evidence by the author:

> *"Abolishing fees at point of access, in just 20 SSA countries, could prevent the death of 233,000 under five-year-olds every year, costing only £1*.75 per person per year" (Keith 2005, James et al 2005)
>
> On average, around a third of families in Ethiopia, Tanzania, Sudan, DRC, Burundi and Rwanda, in 2005, did not seek care due to cost of health care, while another third was pulled into poverty paying for health care. A 12-year-old Ethiopian girl said: *"It's simple. If you have money, you will be cured, if you do not have money you will die. If my mother is alive, I will be alive. If my mother dies, what will become of me*? (Cadge and Keith 2005 a, b, c, d, e, f, g, h)
>
> The countries with the highest levels of inequity also had the highest levels of mortality (Fustukan, Keith and Penrose 2003)

Promises made:

> *"..countries need to move away from user fees for health care" WHO 2005 Resolution 58.31 and 33 WHA*
>
> *" ..we promise to support 12 countries to move away from user fees by 2015"* Blair 2005

New evidence from Papers one, three, four and five on what promotes equity of access

> Services provided universally, free at the point of access, funded by public progressive taxation, reach the poor (Keith 2008 b, 2008c, 2009 a,20009 b, 2010). There was no evidence that countries using social health insurance systems were

able to protect the poor without adding extra taxed based resources. As Ghana now does. (Keith 2008).

Thousands of lives were saved by making health care, free at the point of access. Countries like Uganda, Nepal, Malawi, Zambia, Ghana, South Africa, and Burundi have all increased health service utilisation, by making services free at the point of access, DFID invested resources as promised to support countries to move away from user fees (Keith and Cadge 2010).

"Thank you…. yesterday I was ill with malaria…I went to the clinic and got medicine, without needing money and now I am back at school" Liberian schoolgirl (Keith 2010)

3.1 What is equity and how can it be achieved in low-income and fragile contexts?

WHO (2020) defines equity as a "fair opportunity for everyone to attain their full health potential, regardless of demographic, social, economic or geographical strata." The papers covered in this thesis focus on two specific areas of equity: equity due to the cost of services, and their availability due to the strength of health systems and human resources. Scott et al (1985) contends that *"equity requires strong organised demand for accountability of government by the people".* In many fragile contexts holding governments to account may place populations at risk, hence the use of ***power with*** other organisations can protect marginalised groups, while still sharing their voices (Keith 2010).

"Many of the things we need can wait. The child cannot. Right now, is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer Tomorrow. His name is Today" Gabriela Mistral in Saunders and Carver 1985

Gabriela Mistral used her voice to call for greater attention to be focused on children. They may be our future, but if we do not invest in them today then we are reducing their chance to achieve their potential. Latin and Central America counties have a long history of using their voices to call for change. Paulo Freire (Werner and Saunders 1997) called the rising of people against those with ***power over*** them as conscientizing, there are numerous examples of populations using their voices to fight against inequity. In 1983 UNICEF moved away from

using the word equity, replacing it with universal coverage, and replacing active community engagement with social mobilisation and compliance (Werner and Saunders 1997).Increasing attention was given in health information messages and child health days attempting to get children immunised in large scale coverage programmes, rather than working with communities to ensure routine health services were used in a timely way for prevention (though immunisations) and care of illness such as malaria. In 1984 James Grant presented a paper on the need to use more social marketing strategies in child survival (Grant 1984). The world was changing from a bottom-up focus on the right to health, using comprehensive PHC, to more selective vertical interventions focusing on individual responsibility for health. These approaches were neo-liberal in ideology, vastly different to the principles that led to the creation of the Alma Ata Declaration (Werner and Sanders 1997). This led to increased global investment in interventions such as immunisations and food aid instead of working with governments to strengthen health systems and human resources for health (Werner and Saunders 1997). In 1993, the World Bank introduced their DALY (Disability Adjusted Life Years) analysis which helped countries decide which cost effective interventions to prioritise (WB 1993). This DALY analysis tool helped countries decided what health interventions to focus on and the economic analysis prioritised keeping the most economically productive population, the twenty-year-old men, active and working. This led to the prioritisation of HIV TB and Malaria interventions over health system strengthening for child or maternal health services. Although pneumonia, diarrhoea, malaria and malnutrition were the major killers of under five-year-old children (Werner and Saunders 1997, Keith 2008 d, 2009 b). The research which fed into the 2009 Child Health Now research publication clearly demonstrated the negative impact of decades of

underinvestment in health systems. The report highlighted the silent emergency of preventable child deaths which a daily death toll of 24,000 children each day. The report was launched by the author at the United Nations General Assembly in New York with the Assistant UN Director General to call for urgent action and investment in maternal and child health. The UN Secretary General subsequently launched the Global Strategy on Women and Children's Health in 2010, which had new pledges of $40 billion for maternal and child health from countries, donors and other stakeholders. The CHN report (paper four) illustrated that those countries with the highest inequalities, like India and Nigeria, also had the highest death rates. While countries where health services were free at the point of access had halved their child death rates, even in fragile states. Liberia reduced their under-five death rates from 235/1000 live births to 111/1000 live births between 1990 and 2007, despite a ten-year civil conflict (Keith 2009 b and Keith 2010). In paper one, the PMTCT research publication (Keith 2008 d) illustrated that dramatic progress had been made in the coverage of services for HIV positive mothers, since treatment was made free at the point of access. Keith (2008 d) presented evidence that people living with HIV increased their health seeking behaviour, adherence to treatment, and had enhanced health outcomes, despite their HIV positive diagnosis, due to the provision of free treatment (Keith 2008 d). *"…Free health care has been great for increasing the numbers coming to the clinics" Health worker, Malawi (Keith 2008 d)*

In paper five, Keith (2010) demonstrated that Liberia had halved its child death rates by increasing government expenditure on health to 20% and keeping services free at the point of access. However, in paper nine Keith (2019) notes that even when services are free at the point of access, as they are in the UK, other barriers, such as language, can reduce service

utilisation. In five of the papers, Keith (2008 b, 2009 b, 2010, 2015 and 2019) demonstrates the importance of health systems being close to the community to link households to the health centre. Populations needed to trust the services, staff need to be skilled and have the resources they need to deliver quality services (Keith 2001, Keith 2003, Keith 2005, Keith 2009 b, Keith 2010, Keith 2019). The Alma Ata and Astana declarations both capture the need for stronger health systems and investment in health workers (WHO 1978 and 2018). See annex five and six.

The author demonstrated in papers one, three, four, five, and nine (Keith 2008 a, 2009 b, 2010 and 2019) that when there are not enough health workers, deadly delays can occur in service utilisation. WHO in 2006 estimated that to provide 80% of the population with essential health care you needed 2.3 health workers per 1,000 people (WHO 2006). In this research papers (Keith 2008 b, 2009a, 2009 b, 2010, 2015 and 2019) it was clearly demonstrated that when countries fall below this level, services do not reach the poorest. In paper three (Keith 2009 b) the link between maternal deaths and conflict was presented with 13 of the 15 countries accounting for two thirds of maternal deaths recovering from or presently engaged in conflict. All these countries had fewer than 2.3 health workers per 1000 populations and 13 countries having fewer than 1, health worker per 1,000 population. The report estimated that investing an extra £2.71 per person per year could double equitable access to skilled attendants, for pregnant mothers, in these fragile countries. The report also included solutions to increasing capacity in fragile contexts through the creation of a new cadre of community midwives (Keith 2009 a).

There is now global agreement that user fees at the point of access are regressive and result in deadly delays to timely health seeking care (WHO 2005b, WHO 2010, WB 2013, Keith

2018). However, there is increasing pressure on low- and middle-income nations to move towards social health insurance systems, rather than tax funded services, free at the point of access (Keith 2018). Actors such as the world bank and ministers of health see the value in double taxation systems which ensure a sustained income for health.

3.2 Moving away from user charges of any kind at point of access promotes equity and more timely use of services in fragile contexts

Research led by the author over five years (from 2000 until 2005) in seven countries (Tanzania, Ethiopia, Uganda, DRC, Rwanda, Burundi and Sudan) indicated that the introduction of user fees reduced timely utilisation of services, while raising less than 5% of service costs (Cadge and Keith 2005 a, b, c, d, e, f, g, h). When Uganda abolished user fees in 2001, this resulted in an increased utilisation of services by 25% in 2001 and a 55% increase by 2002. Madagascar also showed a 25% increase in service utilisation following fee abolition. These positive impacts were balanced by the evidence of the negative impact of user fee introduction such as a 52% reduction of service utilisation in Vietnam when fees were introduced in 1989, and a 35% reduction in service use in Zambia in 1982 when they introduced fees. In Niger, the introduction of fees resulted in 41% reduction of utilisation and in Kenya by 52% (SC 2008). This evidence was fed into global health policy fora and into the development of the UN SG's action plan for improving maternal and child health. In 2013, the Director General, of the World Bank, Jim Kim, speaking at the World Health Assembly, advised countries to move away from regressive user fees for health, despite countries being forced by the WB to implement these (Kim 2013, Keith 2013).

3.3 Social Health Insurance (SHI) does not protect the vulnerable, without extra tax funded resources

While evidence against the use of user fees increased, more countries were encouraged to move towards pooled funding, through either taxes or insurance. Most countries had

limited tax-based funds and were encouraged to develop social health insurance (SHI) options as a way of sustainably funding health (Keith 2011, Oxfam 2013). However, there was no evidence that SHI would protect the poorest. The author commissioned a scoping review to explore the evidence supporting the use of social health insurance to protect the poorest to achieve universal health coverage. Paper two (Morell and Keith 2008) was shared with ministers of health at the World Health Assembly to share this evidence with them. However, as the World Bank provides significant technical and financial support for health financing most countries have agreed to set up social health insurance systems. Ministers of Health are enticed by the ability to have more control over their resources. However, as SHI systems generally only cover those in formal employment, not the poorest, they often result in more people being pulled into poverty when paying for health, unless the country chooses to fund free care for the poorest (often through tax-based funding). When the government of Ghana decided to pursue SHI, Oxfam (2011) carried out an analysis which illustrated that the poorest majority were not covered, Ghana then changed its policy and decided to support the rural poor through tax funds. If more countries were supported to strengthen their tax-based systems, to progressively cover a comprehensive essential health package, long-term gains could be made in maternal and child health outcomes (Morel and Keith 2008). Social Health Insurance may provide coverage of health care, but it does not protect the poorest from impoverishment without concurrent tax-based financing, which will reduce the efficiency of the SHI programme. No country has succeeded in using a SHI approach for UHC without adding tax-based funds to cover the poor. Fees at the point of service leads to deadly delays in seeking care and they can also pull families into further poverty (Morel and Keith 2008, Keith and Cadge 2005).

All nine research papers presented evidence that pro-poor health financing and community health workers, like community midwives, are important factors in improving equity in the countries reviewed. Case studies presented also illustrated those low incomes countries can reduce inequities by making health care free at the point of access, to achieve good health at low cost as has been found in Cuba, Costa Rica, Sri Lanka and Uganda (Keith 2009 b, 2010). In paper three (All-mothers matter), 100% of respondents in the DRC cited cost as a barrier, and 81% of the population were unable to pay for health services (Keith 2009). The indirect costs of seeking health care, such as the lack of time, transport, cultural or gender related concerns, were also barriers to timely utilisation (Keith 2009, 2019). Other social safety nets, such as cash transfers, were found to be the most empowering for health and nutrition when targeting the poorest mothers (Keith 2009, Owusu Adde et al 2018). Cash transfer programmes give mothers money to help offset the impact of poverty. They can be conditional (like the Progressa programme in Mexico requiring mothers to attend schools and clinics) or they can be unconditional such as the Brazil programme. Evidence indicates these programmes improve health nutrition and food security outcomes for the poorest (Owsu Adde et al 2018). This is in line with research from Garret et al (2009) and WHO (2010). Equity does not just mean providing services free at the point of access it also means that all people should have access to the health care they need. However, 1 billion people in the world will never see a health worker, and 2 billion do not have access to essential health care (Keith 2018). People living in low-income countries or contexts, where health care is not available or is too expensive, are not able to seek the care they need. This results in unnecessary or preventable suffering and deaths, the avoidance of which often means people must sell finite assets to fund the cost of care and treatment, pulling them, and their

families, (further) into poverty (Keith 2010). In 2009 fragile states were spending on average around $9 per person per year for health care despite WHO estimating that $40 per person per year was needed by 2015 to meet the health related MDGs (Keith 2009 b). In 2020, WHO estimates that $60 per person per year is now necessary to ensure essential health for all. Many countries still invest less than £25 per person per year (WHO 2020). Thirteen of the fifteen countries with the highest rates of maternal death have also endured violent conflict as shown in paper three (Keith 2009 b). Despite hosting only 8% of the global population these countries account for 35% of maternal deaths (Keith 2008 d). Many of these countries had fewer than 1 health worker per 1,000 population to reach at least 80% of the population with essential health care. Inadequate funding, lack of health workers and insecurity, can all reduce timely health-seeking behaviour (Keith 2009 b). Fragility does not simply exist in post-conflict countries; populations living in areas of high deprivation can also be deterred from seeking care as presented in paper nine (Keith et al 2019). Following a decade of austerity in the UK, Keith (2019) highlighted the negative impact of reducing public health budgets, with some London boroughs suffering funding cuts of over £2 million, translating directly into reductions in maternal and child services. Boroughs cut their health and nutrition staff, resulting in reduced access for vulnerable groups, such as those for whom English is not a second language, and young inexperienced mothers (Keith et al 2019). Ensuring that data is collected, and inequities are recognised and addressed, is one of the most important functions of a robust health system. Most health systems do not collect this information effectively, which results in many vulnerable groups being missed (Keith 2019). In fragile contexts, resources, services and trust are often stretched, resulting in deadly delays in populations seeking care (Keith 2009b, 2010, 2019).

Chapter four: Finding two: Concurrent investment in sectors such as nutrition, water, sanitation and quality education, with essential community-based health services could prevent 2.5 million under five-year-old deaths annually.

Chapter four addresses key finding two, that concurrent investment in sectors such as food security, nutrition, water, sanitation, social protection and quality education can lead to reductions in maternal and child deaths and illnesses, even in fragile contexts. Although set out as a clear principle in the Alma Ata, the concurrent investment in these sectors has not occurred universally, especially in fragile contexts.

What the Alma Ata promised:

> *"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible" (Alma Ata WHO 1978)*
>
> *"Primary Health Care (PHC) includes preventing illness, promoting food supply and nutrition, safe water and sanitation, immunisation, disease prevention and management…" (WHO 1978)*

New evidence from selected works:

4.1 Investment in skilled health workers especially in fragile contexts reaching hard to reach saves lives

Paper three demonstrated that fragile countries can strengthen health services through the investment in a cadre of competent community midwives. Including the community in the selection criteria and planning of programmes, can increase the trust between the health system and the community. Midwives must be equitably distributed, and international aid must reach the most marginalised health systems and populations. The paper called for global health funds and partnerships to invest 50% of their available funding into health systems strengthening (HSS) to offset the impact of vertical programmes. Rapid scaling up of skilled attendants (doubling the number of health workers) would cost £2.71 per person per year in fragile states. This would include one skilled birth attendant (SBA) for every 175 pregnant women, providing free maternal health care, in accessible health facilities.

Paper four demonstrated that 2.5 million under five-year-old lives could be saved annually, through 18 interventions delivered at community level. Services must be delivered free at the point of access and there must be well-resourced and supported community health workers, linked to the health system. These community health workers need standardised training and should have a minimum of nine years of primary education, without which, they will not effectively retain complex health messages and will usually require extra training and support on site. The report highlighted the importance of improving infant nutrition to reduce child death rates in the first two years.

Paper nine demonstrated the negative impact of ten years of austerity on local UK government funding, which had led to reduced services for the most marginalised in London, resulting in only 1% of mothers still breastfeeding at six months, from the over 80% of mothers, who start breastfeeding at birth. Mothers needed more support in the first six weeks. Health workers suggested that societal change was needed to promote breastfeeding. Urgent changes were also needed in NHS units, to ensure policies are implemented such as not giving bottles breastfed babies. Training is taking place but is not being effectively implemented, coordination between providers was weak and mixed messages were common, leading to confusion and misperceptions (Keith et al 2019). Paper nine also demonstrates that the provision of additional support does work, the Tower Hamlets borough has 13% higher levels of breastfeeding after six weeks than the rest of London, due to its support of mothers through peer counsellors (Keith et al 2019).

4.2 Community level intersectoral interventions can prevent 2.5 million under five deaths

The Alma Ata Declaration was developed through an evidenced based policy process from countries that had implemented universal health care by addressing the social determinants of health (Werner and Saunders 1997, Baum 2105, Keith 2018). Research conducted by the author in 2003 estimated that MDG 4 and 5 would not be achieved by 2015, without more investment in health systems and health workers. The author then commissioned and co-authored a paper that explored how Sri Lanka achieved good health at low cost. The paper determined that services were delivered close to populations, communities had a voice in its focus, and staff were given incentives to work in rural areas. Services were free at the point of access (Mc Kay, Keith and Penrose 2004). The report also demonstrated that the government had invested in education and water and sanitation at the same time as strengthening health services. When the author wrote paper four (Child Health Now) (Keith 2009 b), previous research was considered as well as field evidence from 1,600 community health programmes in 120 countries across the world. The evidence supported previous research, that access to health, free at the point of access, along with social protection measures, nutritious and balanced diets, quality education, water, sanitation and economic empowerment opportunities for women, were all key factors for improving health outcomes for mothers and their children under five. The author calculated that 2.5 million children's' lives could be saved through 18 low-cost interventions (Keith 2009b): such as sleeping under a bed net to prevent malaria, protecting children with immunisations, supporting safe delivery of infants with skilled birth attendants and ensuring all children with diarrhoea are given oral rehydration solution (fortified with zinc). These interventions were all reflected in the Lancet Nutrition series in 2008 and 2013, and in the 2008 World

Bank report on scaling up nutrition in 2009 (Black et al 2013 and WB 2009). The report was launched, simultaneously, in Kenya, India, Indonesia and Geneva. World Vision International was invited to be part of the UN SG's Commission on Information and Accountability for Woman and Children's Health, ensuring that marginalised voices would be involved in the monitoring of the UN SG's Every Woman and Every Child campaign. Since 2009, the number of children dying from preventable causes has reduced by around 4 million (WHO 2020). Paper four was supported by a global campaign which helped to bring ***power with*** other maternal and child health stakeholders while also bringing ***power to*** the country programmes who needed simple data that could be used for local level advocacy (WV 2016). In 2010, WHO focused the World Health Report on health financing, reminding the countries of their 2005 pledge to move away from user fees for health care, and increased levels of civil society engagement in health service planning cycles. Publication four (Keith 2009 b) also called for a redefinition of health systems, to incorporate family and community-level care, supported by increased public investment in social sectors such as water and sanitation and nutrition in line with evidence and the principles of PHC. Countries that paid for these services through public taxation were more pro-poor, reducing national inequities (Keith 2009). The report identified nutrition as a key sector that required more investment especially investment into supporting exclusive infant and young child feeding practices and the integration of malnutrition programmes into national health systems.

> *"Babies who are not breastfed are 6 times more likely to die before the age of two months than children who are not" (Keith 2009 b).*

The report gave essential evidence to countries (strengthening *power within and to*) to hold governments to account for more investment and attention on nutrition and food security.

The Scaling up Nutrition (SUN) global campaign was launched in 2010. In 2012 the UK hosted the Nutrition for Development conference resulting in $4 billion worth of pledges for nutrition interventions globally. Tracking the impact of these extra investments, in paper seven, Keith et al (2015) demonstrated that when countries invest in nutrition, gains were made in improving nutrition and health outcomes. Sadly, many countries remain focused on behaviour change messages without strengthening community health systems (Keith et al 2015). Integrated programming was also presented in paper five (Keith 2010) demonstrating that community health services delivered free at the point of access, by community health workers, can achieve enhanced health outcomes, even in fragile states. The author was invited to a high-level planning meeting, in Sierra Leone, in 2010 at the President's office, which resulted in free services being implemented for under five-year-olds and health worker strengthening programmes being supported by the UK government. This investment and change in policy approach resulted in halving the child mortality rate, before the devastating impact of the Ebola, led to reversal in health outcomes. In paper three (Keith 2009 b) an ambitious call for increased investment into doubling health care workers in fragile states was ignored which would have only cost £2.71 per person per year. This amount would include the cost of training community midwives, paying them and facilitating the provision of essential maternal health care services free at the point of access. The calculation called for 1 skilled attendant per 175 pregnant women, 4 health facilities per 500,000 people providing basic emergency obstetric health care and 1 facility that could provide comprehensive emergency obstetric ealth care. Paper three (Keith 2009 b) presented Afghanistan's maternal health programme as an example, where the number of women delivered by skilled attendants had increased from six per cent in 2002 to 19.9

per cent in 2006, despite ongoing conflict and instability. This has been achieved by investing in a new cadre of health worker, called community midwives. The midwives all had nine years primary schooling and then 18 months training. The programme was supported by a Provincial Health Officer from the Ministry of Health demonstrating the importance of leadership. The community were integrally involved in the criteria for selection of the midwives. This increased the trust and resulted in increased utilisation.

> "*more women are choosing to deliver in the health centre as they know they will have a trained midwife looking after them" Afghanistan community midwife. (Keith 2009 a)*

4.4 Intersectoral investment in social determinants of health: focusing on nutrition, food security, social protection, water, sanitation, and quality education improves health

Seven of the nine reports (papers one, three, four, five, seven, eight and nine) demonstrate evidence of the positive impact of addressing other sectors concurrently, specifically female education, social protection, nutrition, water and sanitation and food security. Keith (2008 d, 2009 a, 2009 b, 2010, 2015 and 2018) presented evidence that although there is recognition of the importance of the social determinants, there is a significant lack of concurrent investment and although policies were developed and staff were being trained, they were not being implemented. A second common challenge was the lack of coordinated intersectoral programming, specifically the collection of disaggregated data reporting the impact on health of other sectors. More investment is required to address this gap. However, paper nine (Keith 2019) demonstrated that even with these challenges, progress can happen when leadership prioritises health and nutrition.

Chapter five: Finding three: Active community engagement, prioritising the most vulnerable, reduces inequalities

Chapter five supports key finding three that active community engagement promotes more effective health services and outcomes. It presents evidence from seven of the nine papers (1,3,4,5,7,8,9) on the positive impact of active engagement in health planning and policy determination by communities and health workers. The work also demonstrates the negative impact of forty years of top-down social mobilisation programmes that do not create safe spaces for communities to share their voice and feed into the development of sustainable solutions for their contexts. This has also broken the trust between communities and health services (Keith 2018, Gilson and Adyepong 2018).

What the Alma Ata promised:

> *"people have the right and duty to participate individually and collectively in the planning and implementation of their health care" PHC "relies, at local and referral levels, on health workers….to work as a health team and to respond to the expressed health needs of the community" (Alma Ata, WHO 1978)*

New evidence from published works:

> *Papers one, three, four, five, seven eight and nine demonstrate that investing in active community engagement, even in fragile contexts, increases trust and increases the timely use of preventive and curative care (Keith 2008a, 2009 a, 2009b, 2010, 2015, 2018, 2019). As these papers all led to change, they also demonstrate that collecting voices, stories and evidence, and feeding it into political planning processes, can also lead to change. Strengthening the power with and to. Examples included maternal health programmes in Afghanistan with husband-and-wife teams increasing safe maternal health in deliveries (Keith 2009), and in Zambia the community support for HIV and nutrition programmes to support HIV positive mothers (Keith 2008).*
>
> Paper four presented examples on the impact of Citizens Voice and Accountability interventions from thirty countries demonstrating that the active engagement with communities can increase health service utilisation and community ownership of community health programmes in countries like Armenia, India, Indonesia, Kenya, Peru, Brazil Uganda and Ethiopia (Keith 2009 b).

When inequalities become too oppressive, populations or citizen groups use their agency to call for change. Joining together creates increased ***power with*** and ***power to*** so that populations can reduce the ***power over*** them. Political action for change is not new. In the UK in 1819 there was a massacre in Lancaster due to increasing poverty and poor living

conditions, these riots led to the first Public Health Act in 1848 revised in 1875 to include investment in water supply, sanitation, housing and education (Saunders and Carver 1985). Riots in rural China on the cost of health care led to policy change in 2008 while the Make Poverty History campaign raised millions for development in Africa, as civil societies joined together to call for a change resulting in G8 pledges to double aid to halve poverty (Oxfam 2013). Paper three, four and five all demonstrated that creating mechanisms for communities to have a voice in health planning and policy determination can also lead to increased trust and more timely access of health services (Keith 2009a, 2009 b and 2010).

5.1 Community Participation and Social Mobilisation

Kent (1991) asserted that the UNICEF watered down approach to community participation, which was replaced by compliance and mobilisation, was used as a recruiting strategy to get communities or other actors to support a top-down neoliberal-based agenda. Social marketing communication strategies replaced active engagement of communities in their own community analysis and planning for change. This has reduced trust between communities and health systems (Gilson 2005, Keith 2009 b, Keith 2018, Gilson and Adyepong 2018). Community Health Workers were treated as the lowest level of the health system, given simple tasks rather than seen as agents of change (Kent 1991, Werner and Saunders 1997). PHC was implemented as a top-down approach rather than supporting empowerment, where communities encouraged to diagnose their own problems and plan their own solutions and priorities (Werner and Saunders 1997). In paper one (Keith 2008 d) enhanced health outcomes was combined by increased social cohesion when communities were involved and supported, as occurred with HIV programmes in Malawi and Zambia. In papers one, three, four and five Keith (2008 d, 2009 a, 2009 b, 2010) demonstrated

examples of positive impacts of active engagement which echoed evidence previously presented by Chambers (1983), Werner and Saunders (1997), Gilson (2005).

> *"Timothy was a taxi driver who used to wait outside when his wife was pregnant, she was found to be HIV positive. Timothy and his two other children all had HIV as well. "… I learn that I am HIV positive, my two children were HIV positive. In addition, even my unborn child may be positive. I knew my life had come to an end…" but I was wrong… today my youngest child does not have HIV and the rest of the family are living positively with HIV on ARVs. The children are being supported to go to school and I take computer classes while my wife takes the sewing classes, and we are saving up to buy a small shop for her to sell her clothes….[1] PLWA Jos Nigeria (Keith 2008 d)*

5.2 Community Voice and Accountability

Although the Alma Ata used the term community participation, the author has used voice and accountability in this paper, due to the impact of forty years of top-down replacement of active engagement of communities in their own solutions to an increased focus on compliance with behaviour change programmes focusing on knowledge rather than creating enabling environments for change. Paper four presented numerous examples of how active Community voice and accountability seeks to ensure that safe spaces are created for communities to feed actively into health plans and policies. However, even this term has now become a checklist to be completed by many organisations, rather than an active collaboration between communities and health systems (Keith 2009 b). In my MSc thesis in Nigeria my research demonstrated how communities increase ownership of community health programmes when they are involved with the determination of the problems and planning solutions (Keith 2000). This was also demonstrated in papers one and five (Keith 2008 d and Keith 2010). Between 2001 and 2008 the author actively advocated for the creation of civil society platforms for the Global Alliance for Vaccines and Immunisations

(GAVI), The Global Fund to Fight AIDs Tb and Malaria (GFATM), and the World Bank Health Nutrition and Population (HPN) Unit. These platforms were established. The author sat on many of the steering committees but, after eight years, the voices on these platforms had ceased to be authentic. Many of the participants were directly supported by the hosts of the platforms, reducing the ability of those participants to reflect accurate lived experience due to **power over** them. New mechanisms must be explored where the voices of all people can feed into the policies created at local and national level, perhaps harnessing the power of technical innovations as mentioned in the Astana Declaration can lead to new ways to bring marginalised voices into the health policy and planning arena. The HIV community conversations have been highly successful in creating safe spaces (as presented in paper one and four) however even within this group of stakeholders a few voices became the voice of all communities. The present pandemic is demonstrating that social media may be one way of sharing voices, however, it can also be used to spread inaccurate messages, so more work is needed to implement accountability measure seven from the UN SG's Women and Children Global Health Strategy (PMNCH 2012). It states that all countries need to create a functioning mechanism to collect voices of all, listen to them and act upon them. So far, no country has succeeded in achieving this target (Keith 2020) due to lack of political commitment, however there are several positive pilots presented in the CHN report (Keith et al 2009) illustrating what can work and how impactful they can be. Such as child parliaments in India and community score cards in India and Armenia. The WHO WCGH group are also tracking progress on this indicator, but more urgency is required. Also, it helps when a donor or an influential advocate supports the target. At present non-

governmental organisations and community organisations are helping to create safe spaces for community voices to be harnessed.

5.3 Evidence of the impact of community voice and accountability

Five of the nine reports included in the thesis present strong case studies of how voice was used to hold governments to account. The Bjorkman et al (2009) Power to the People paper, implemented a randomised control trial to demonstrate the impact that the voice of the communities can have to increase service utilisation and reduce morbidity rates. Chamber (1983), Werner and Saunders (1997), Rosato et al (2008) and Keith (2008, 2009, 2010, 2015, 2018, 2019) all demonstrate increased trust in health services when populations are included in planning and implementation of services.

> *"Trust was earned through community dialogues and involving the community in development and implementation of the community midwife programme" Keith 2009 b*

Chapter six: Finding six: good governance and leadership support positive health outcomes, even in fragile contexts.

Chapter six supports key finding four and presents evidence from papers one, three, four, five, six, seven and nine on the important role that governance and leadership plays at local, national and global levels. It presents evidence to demonstrate that when a country commits to health and equity then progress can occur even in the poorest contexts. The chapter also demonstrates that global health governance is essential to achieve the right to health for all and the SDGS.

What the Alma Ata promised:

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures... Primary health care is the key to attaining this target as part of development in the spirit of social justice." (Alma Ata WHO 1978)

PHC requires that "*all aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors"* (Alma Ata WHO 1978)

"All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people, since the attainment of health by people in any one country directly concerns and benefits every other country". (Alma Ata, WHO 1978).

New evidence from published works:

The new global partnerships are raising resources, but they are not reaching health systems and the most vulnerable populations are missing out from effective investment (Keith 2009, 2010, 2018)

In paper three the fifteen countries with the highest maternal mortality rate (Sierra Leone, Afghanistan, Niger, Chad, Angola, Somalia, Rwanda, Liberia, Burundi, DRC, Guinea Bissau, Malawi, Nigeria, Cameroon and Central African Republic) account for 184,290 maternal deaths (in 2008) received only $81 million dollars in aid for maternal health (Keith 2009).

Paper three demonstrated that Global Health Partnerships do not always strengthen health systems and often place extra work on stressed staff through parallel vertical programmes and structures. They should invest 50% of their resources to strengthen health systems.

Papers three four and five demonstrate that concurrently investment in food security, nutrition, sanitation, clean water, universal education (especially of girls), women's empowerment, and social protection measures (like cash transfers for the poorest) has achieved and maintained good health at low cost, in low income and fragile contexts (Keith 2009, 2010)

Liberia struggled with ten years of conflict which resulted in high levels of maternal and child deaths. However, the implementation of pro-poor policies (such as a focus on district health systems and staffing, joint assessments of services and services free at the point of access) along with concurrent investment in water and sanitation resulted in the country halving its under-five mortality rate by 2010 (Keith 2010).

Paper six demonstrated that the lack of coordination of global health is resulting in lost lives. WHO has the mandate but not yet the resources or authority to coordinate and lead global health actions. To meet the MDGs for global health $42 billion was needed but not provided. Little of what was provided was invested in fragile states or health systems. Global health investment needs to prioritise health systems (Keith 2011).

6.1 Global Health Governance

"*Global governance for health is achieved when we obtain a fair and equitable global governance system based on a more democratic distribution of political and economic power that is socially and environmentally sustainable*" (Otterson et al 2014 in Baum 2015).

Today there are more than 100 organisations working in global health. Over 90 global health partnerships, 20 global and regional health funds, 26 UN agencies as well as more than 40 bilateral donor agencies (Keith 2011). There is no effective mechanism to coordinate these actors, and accountability differs according to each global health stakeholder. The 2005 Paris Agreement on Aid Effectiveness, and the Accra Agenda for Change, both attempted to increase national ownership, and harmonisation with national plans and priorities, through mutual accountability, but progress has been slow in moving these principles into action (DFID 2007). The International Health Partnership, established by Gordon Brown, to bring all country level actors together has had some impact in countries such as Ethiopia, Nepal and Mozambique, but is it not consistently being implemented (Keith et al 2011). The complexity of harmonising this group while maintaining the voice of people is a challenge, and one that

World Vision and other civil society actors were increasingly concerned with, as more private public partnerships answered to their donors rather than to the countries where they worked (Keith et al 2011). In 1946 the World Health Organisation was given the mandate to *"act as the directing and coordinating authority in international health work",* however, for the last thirty years WHO has only received 20% of the planned funding for its normative work. This has resulted in its inability to complete all its roles effectively. To be given responsibility without power, resources, or authority, was a challenge that the WHO DG asked the member states to consider in 2011. The DG stated that WHO could no longer attempt to complete all the roles given to it without significant changes to their resources and clarification of their role. Ministers of health from the 193 countries assembled, agreed they wanted the WHO to continue to coordinate and lead global health governance. For this paper *"Global Health Governance is about the action and means adopted by global society to improve health and to achieve equity in health worldwide" (Keith et all 2011)*

For WHO to be able to effectively take up this renewed authority, changes are needed. As part of the Child Health Now Campaign, WVI sought to ensure that the voices of civil society and the poorest communities were represented in any new processes established to strengthen global health governance. Keith et al (2011) carried out a critical theory approach, including debates and 38 key informant interviews, to respond to the points presented to the assembly by the WHO DG. Paper six supported the role given to WHO but called for more robust systems to ensure that voices from civil society and the poorest populations could be gathered effectively to feed into local national and global health planning and policy determination (Keith et al 2011). This is in line with the principles of the right to health in the WHO constitution and included in the Alma Ata Declaration. The paper

suggested that a normative framework was required that would use the right to health as the underlying principles, recognising that most countries would achieve this through progressive realisation. To be able to lead global health effectively, WHO would need to be given the authority from all global health actors, not just member states. This would require the setting up a global health framework convention, or charter, where all actors would agree their roles and responsibilities and resources galvanised with at least $42 billion dollars by 2015. The spending on global health would also need to be better allocated towards those in most need such as in fragile states, and further strengthening health systems and human resources (Keith et al 2011). The debate continues, but as COVID has clearly shown, not enough investment has been placed into WHO to ensure it can do its job and until there is global solidarity on what its role is governance will be difficult. Equally challenging is the underinvestment in health systems, we expect to have access to health when we need it but fail to invest in the health workers or the systems, we need to provide it.

6.2 Leadership can reduce inequities and promote progress even in fragile contexts

If Global Health Governance is complicated, so too is leading a country. Many leaders have failed to prioritise health until there is a significant problem. The lives lost through the delayed acknowledgment of the problem of HIV in Southern Africa or Cholera in Zimbabwe are poignant examples. When leaders do engage and use their voice, they can bring about significant impact in the health of the people. Again, we can see clearly from the impact of leadership in the present pandemic. The Prime Minister of New Zealand acted quicky and effectively contained the virus, while other leaders failed to implement the public health measures required to save lives (WHO WP 2021).

The last global pandemic the world had to deal with was HIV/ AIDS. Although it affected many countries it devasted five countries in Southern Africa. Malawi is a small country which was already struggling with issues around poverty and human resources to deliver essential care to its population. When HIV began to take hold, the President spoke out, sharing his grief at the loss of his own brother. He established a multi sectoral AIDS unit in the office of the president and included a unit for nutrition, recognising how important nutrition is to health and fighting the HIV pandemic.

> ***"****…I have no apologies for making this known to Malawians. We should be open and break the silence about HIV/AIDS. The fight against the killer disease can only succeed if we break the barriers of silence, stigma and discrimination…"* 2004 President Bakili Mulizi to Malawians re: brother's death from AIDS (Keith 2008 d)

He approved an HIV/AIDS budget and strategy and set up a national HIV /AIDS partnership for voices of people living with HIV to be listened to (Keith, 2008 d).

> "Before ARVs became free the government offered an incentive of 5,000 Kwachas (£5) to all HIV+ civil servants to disclose their status to offset the cost of treatment" (Keith 2008)

In paper seven Keith et al (2015) several factors were presented as essential for progress in achieving nutrition outcomes such as national leadership, prioritisation of nutrition and an active Scaling Up Nutrition partnership that was linked to the Ministry of Health. However, one voice from a young girl in Liberia remains with me until today

> *"…thank you for making our treatment free…" (Keith 2010*).

Chapter seven: Conclusion and recommendations

Overall, the integrated programme of research presented demonstrates a significant contribution of original knowledge by answering the three research questions, using evidence from the published papers. *Universal Health Coverage is not the same as the right to health, as health requires concurrent investment in other social sectors. There was no evidence supporting the role of Social Health Insurance alone to ensure Universal Health Coverage, many countries using this system need to provide tax-based resources to protect the protect the poorest. The four key findings required to achieve more timely use of health systems (especially in fragile contexts) were presented in* chapters 3,4,5 and 6 demonstrated that:

1. Equity is supported through essential services provided free at the point of access, not through insurance or direct payment systems. Equity of access is one of the most essential factors to timely utilisation. Countries permitting user charges and using health insurance systems, are not reaching the most vulnerable citizens unless they implement tax-based funding for the poorest.
2. Progress will only be possible if concurrent investment in food security, nutrition, social protection, water, sanitation and quality education (especially of girls) occurs.
3. Active community engagement is essential to rebuilding trust for sustainable solutions at community level. Top-down social mobilisation approaches should be avoided.

4. Good governance and leadership can support progress in fragile contexts, but global solidarity needs to be prioritised, and invested in, to support a robust and resilient global health governance system.

These key findings were augmented by specific original knowledge to support global change: Paper three calculated that the 15 fragile states used as case studies in the report, could double their health worker capacity through spending an extra £2.71 per person per year to ensure all women were delivered by a competent skilled community midwife. Paper four, that presented eighteen community interventions to prevent 2.5 million deaths each year. Paper four also highlighted that an increased focus on nutrition was essential for progress. Specific interventions that delivered the highest impact, were those addressing malnutrition, especially regarding poverty reduction and increasing the number of exclusively breastfed children, while ensuring the early identification and treatment of severe acute malnutrition through government services.

The work provides evidence about how essential it is for communities to have a voice and to be supported to build on their **power with** to balance the overt **power over** national and global health decisions, that governments and global health partnerships currently enjoy. More investment is required to strengthen community voices, creating enabling environments for them to use their **power with** to reduce inequalities.

7.1 What still needs to be done?

We need more investment in strengthening equitable resilient health systems, supported by active community engagement systems. More research needs to be done to link the health delivery mechanisms with other sectors such as nutrition, food security, water, sanitation and social protection. More research would also help regarding infant and young child

feeding in relation to the formation of a healthy microbiome and how this links to ill health and increased morality and malnutrition through the life cycle. Progress is possible in fragile states or contexts with high level political commitment to deliver essential health services free at the point of access through community health workers supported by robust and resilient health systems.

Papers 1, 3, 4, 5 and 7 demonstrate that we can achieve health for all, but that it will require more intersectoral resources, which reduce inequity, and more health workers, reaching communities with essential services, free at the point of care. WHO (2020) estimate that essential health services can reach 80% of the population through a minimum investment of $60 per person per year. However, some countries spend a lot more on health care without reaching the poorest. A greater focus on social development and social justice is required (Keith 2018). We need to create enabling environments for communities and health workers to have their voices heard determining their health and nutrition priorities.

This decade 2008- 2018 has been a highly active period for global health and nutrition. The previous decade from 1990 until 2000 focused on more selective primary health care interventions such as immunizations and polio. While the recession of the 80s dramatically reduced social sector spending for health and education. The recent health campaigns have given some communities a voice, especially around disease specific issues like HIV, increased resources for community engagement led to greater impact of programmes. When power is harnessed with communities and the organisations supporting them it can have positive impact on health and nutrition outcomes, but also on community resilience and peace. These concepts were also captured in the Alma Ata and when fragmented support occurs is undermines community development and resilience. This can result in the loss of power

especially for marginalised groups. There has been enhanced community and organisation collaboration in global health and nutrition in the last decade which has strengthened some communities **power to**, their **power with** and even their **power within**. However, global health is still a positivist top-down, club with increasing corporate influence, that wants a stronger voice over agenda setting in global health. The COVID pandemic offers us a chance to reflect on our future and implement the evidenced based Alma Ata principles, focusing on equity and voice through intersectoral investment. These principles are still relevant in the 21st century, even in fragile contexts. The 2018 Astana Declaration, while keeping many aspects of the Alma Ata, made Universal Health Coverage the goal, rather than the right to health. There is also no specific target for achieving health for all. This is a paradigm shift, from addressing health in its fullness, which is determined socially, to the focus on health intervention services and their financing, rather than robust, resilient, people centred, health and nutrition. The Astana Declaration includes lots of excellent promises for the next decade, however, we need to encourage government leaders and donors to increase political commitment to implementing promises such as equity and voice through an intersectoral lens, as there is evidence that this can work. There are fewer than ten years left until the SDGs must be achieved. Although we are off track, the impact of the COVID pandemic may create a window of opportunity for global change and a recommitment to the Right to Health.

Annex one: Environment impact of publications

Paper one: Keith R (2008) ***Prevention of Mother to Child Transmission (PMTCT): Global Policy Implication: reflecting on progress and challenges in three countries (Malawi, Nigeria and Zambia*)** Tearfund UK Report was commissioned by Tearfund and required three field visits to each of the country's meetings with Tearfund partner organisations, health workers and mothers living with HIV in the three countries. The report fed into policy dialogue on changing the Voluntary Counselling and Testing approach to an opt out approach as that which was being used in Malawi and Zambia. This is now the recommended approach for PMTCT programmes. Also, the voice of the participants regarding the value and importance of free health care on their quality of life and adherence to timely health service utilisation strengthened the global call for more attention to be given to making health carefree at the point of access for all essential health interventions.

Paper two: Morel C, Keith R (2008) ***Policy Briefing: Social Health Insurance*** Save the Children UK Following the adoption, 2005, at the World Health Assembly, resolutions 58.31 and 58.33, it had become clear that there was a misperception that the WHO was supporting social health insurance, as the mechanism to achieve pro-poor health financing. A scoping review of evidence on the role of social health insurance in protecting the poorest was considered essential to feed into World Health Assembly discussions taking place in 2009, and to feed into the 2010 World Health Report on Universal Health Coverage. At the time the WHO had considered closing their health financing department due to the lack of normative funding. The policy briefing report was used to stimulate dialogue which resulted in the UK government agreeing to support the WHO financing department for two years. However, the World Bank were pushing social health insurance very strongly at country level, where the WHO did not have the capacity or the research to support evidenced based policy dialogue. More research on how to support low-income countries to strengthen tax-based finances to support health services.

Paper three: Keith R (2009) *All mothers' matter: HRH in fragile states* Merlin UK
This research used field experience to develop strong messages on human resources and community health workers in fragile contexts. The publication was launched as part of the Hands up for Health Workers Campaign and used to promote increased investment in health workers. The Global Health Workforce Alliance convened a meeting to discuss the role of CHWs and establish a standardised set of competencies and definitions for community health workers. The GHWA held a meeting in Indonesia and developed a standardised definition for CHWs and called for all CHWs to be integrated into health systems and paid.

Paper four: Keith R et al (2009) *Child Health Now* World Vision International London UK
The report was launched at a side event in New York at United Nations, in September 2009, with Jon Sopel, the Assistant UN SG and the CEO of World Vision. At the launch World Vision pledged $1.5 billion dollars to support maternal and child health which stimulated global support into MNCH funding pledges for the UN SG's Women and Child Global Health Strategy (Every woman, every child). As the Scaling up Nutrition was also launched at this

UN GA increased commitment to Nutrition was also pledged. The report was also launched in India and Kenya and Geneva. In Geneva, the Director General of the WHO, Dr. Margaret Chan, stated the publication was excellent and would support the achievement of the MDGs in the poorest countries. World Vision was elected to be on the Interagency Monitoring committee for the UNSG's WCSH implementation. The report was also presented at the World Health Assembly in May 2010 and at the Women Deliver Conference in 2010 held in Washington, when regional advisers from WVI took part in advocacy training and presentations.

Paper five: Keith R, Cadge N (2010) ***Unlocking Progress in Fragile States*** **Save the Children UK** Report released to target UK decisions on prioritising support for fragile states, which the UK government did prioritise. The report also led to the WHO inviting the Liberian president to attend the World Health Assembly, to discuss how Liberia had achieved a 50% reduction in under five child mortality rates.

Paper six: Keith R, Ooms G, (2011) Improving Global Health Governance: technical briefing paper for the Child Health Now Campaign World Vision International, UK
The research publication was launched at the World Health Organisation's executive board, in 2011, to call for Global Health Governance to be added to the 2012 WHA agenda. A debate was held as a side session with Ministers of Health and other key informants which had over 100 delegates attending. The Armenian chair of the WHO Executive Board did add governance to the WHA agenda and in the May 2012 World Health Assembly all 193 countries called for WHO to continue to lead in Global Health Governance and tracking health trends across the world. However, there was a call for WHO to make efficiency changes to support countries better, to diversity staff competencies and to take the lead on health emergencies.

Paper seven: Keith R et al (2015) ***What works for nutrition? Case studies from Vietnam, Uganda and Kenya*** **Results, Concern and University of Westminster published by Results UK Launched** at the UK Parliament in a debate led by MPs, prior to the government decision on national support for nutrition aid. The main call from the report, for sustained investment in nutrition and increases for nutrition sensitive spending were both implemented by the UK government.

Paper eight: Keith R (2018) From Alma Ata to Astana: can renewed commitment to Health for All by the 2030 be committed to in October 2018? World Nutrition Journal 10 August 2018 A commentary based on PhD publications, written to feed into the Astana declaration planning process, the author was part of a global task force feeding into the draft of the Astana declaration. The Astana declaration maintained the focus on PHC and right to health but placed UHC as the overall goal rather than the right to health for all.

Paper nine: Keith R et al (2019) Understanding practices and perceptions of infant and young child feeding in Tower Hamlets borough, London UK World Nutrition
Article one from the 2017 research Keith R et al (2017) Understanding perceptions and practices of infant and young child feeding and oral health in Tower Hamlets Borough,

London University of Westminster**.** This research was completed in time to feed into the development of the five-year strategy and spending review for Tower Hamlets Public Health Team. A workshop was held with all senior health and nutrition staff where results were shared, this fed into the report and a separate paper on recommendations for the council. All recommendations (except one) were implemented. The infant and young child feeding programme was continued as a priority, a new nutrition role was created, and the capacity of health visiting team was increased for nutrition.

Annex two: Pathway of learning from earlier research & publications

It mattered to me….

> *"One day a man walked along a beach and saw a boy throwing star fish into the sea. He asked what he was doing and the responded that the starfish would die if they could not get back into the water. The old man saw that there were thousands of star fish on the beach and remarked that the boy could not make a difference to them all. The boy threw another star fish into the sea and stated: it mattered to that one Eisley L (1969)."*

This PhD by Publications is a subjective view of a window in time, my constructed view of over 39 years of engagement in health system strengthening and research. I was brought up in a single parent household, in New York and Ireland. My lived experience planted seeds of the importance of using a collective voice to speak against inequalities and to fight for justice. I trained as Registered General Nurse in Cork 1982, in Ireland, I wanted to work in public health with communities, so I moved to England in 1985 to train as a midwife in Essex. I learned early in my career the power of research. Using research, I was able to assess certain admission practices, such midwives wearing hats and giving all mothers an enema on admission. I was able to use the evidence from the research to bring about changes to admission practices, improving the mothers experience in delivery. Health in the UK was changing, and the world was changing with a famine in Ethiopia, this awakened in me an urgent need to use my skills in Africa. I accepted a PHC management role to work in West Africa.

Health Practitioner days as a nurse midwife in Europe and Africa (1982 – 1999)

In 1988 I joined VSO (Voluntary Services Overseas) and worked a Primary Health Care Nurse Manager, in the Gambia, for three years, from 1988 until 1991. One research I took part in was an MRC intervention RCT study on the effectiveness of using insecticide treated bed nets to reduce the burden of malaria (Alonso et al 1991). The research indicated dramatic reduction in malaria when women and children slept under nets before ten pm at night. In my intervention sites the mothers were happy to use the nets as when they placed the wet nets on their beds, the insecticide killed the scabies mites, which led to severe irritation in their children. Understanding why populations change their practices and perceptions is essential for health care practitioners and researchers. Twenty years after this successful research, I would reflect, with concern, that so few (less than 2%) under-fives year olds slept under a bed net in 2009, despite malaria causing over 800,000 under five deaths (Keith 2009

b). The translation of knowledge into action has always fascinated me. My lived experience has repeatedly demonstrated that knowledge alone was not enough to bring about change in practices and perceptions regarding timely use of health services, there were many barriers that needed to be identified and addressed. Working in the Gambia I was able to see how Primary Health Care could be effective, bringing essential health care closer to populations, working with communities, their leaders, teachers and health workers. This PHC programme resulted in over 90% coverage of immunisations and skilled birth attendant deliveries, despite most of the population living on less than $1 a day (Murphy 1989). The effective detection and treatment of malnutrition was also integrated into the programme combined with community programmes to improve water and sanitation and food security (Murphy 1990). The programme was a clear and functioning health programme using the Alma Ata principles to ensure the right to health (Murphy 1989). One of the biggest bottle necks was the lack of resources such as trained skilled health workers and commodities such as medicines and dressings. There was less than 1 health worker per 1,000 population. In 2006 WHO estimated that 2.5 health workers were required to deliver basic health care to 80% of the population. In 2020 they estimate that 4.5 health workers are required (including community health workers (WHO 2020). The 12 general nurses trained in the three years I worked there all secured work in Europe and migrated with weeks of graduating with their registered nursing degree. A clear health system barrier, resulting in community health workers having their roles expanded, often without resources or supervision.

My time in Gambia finished, I returned home to work as a Practice Nurse team leader in 1991, in a busy GP clinic in Edinburgh, Scotland. To improve the care of the large population I developed the Practice Nurse role, creating expanded protocols to carry out health promotion clinics for those with asthma and chronic illnesses like heart disease and diabetes, as well as family planning and reproductive health clinics and smoking cessation programmes (Murphy 1992). These expanded roles improved patient care and trust within the community. These roles are now part of the NMC register and practice nurse training is formalised in the UK. The practice had the highest number of HIV positive cases in Europe, we carried out research on drug adherence and care of HIV AIDs patients in the community. This experience was to be help me in my future roles in Africa. We also piloted research into the use of inhaled pentamidine as a way of slowing the progression from HIV to full blown AIDS, but adherence was a challenge. A second important lived experience at the surgery, was the role out of the new measles mumps and rubella vaccine. The community were very unsure about the need and safety of the new vaccine. We addressed these fears through clear messages and community meetings and clinics with health visitors. The importance of trust in community health care is essential. Identifying these barriers to timely health service utilisation here supported me throughout my research in future years. The importance of voice and working with communities to determining and overcome barriers to health care utilisation, is essential, as set out in the Alma Ata.

In 1994 I moved to work in Botswana, as a midwife, and a newly appointed baby friendly hospital adviser, for infant and young child feeding. It was a tumultuous time in southern

Africa with political change and the increasing impact of HIV and AIDS in Botswana. As a new mother, delivering my first child in Botswana, without effective health care was a challenge. Breastfeeding without support and the lack of post-natal care moved theoretical knowledge, from my Maggie Myles textbook, into lived experienced. Using my experiences and my training I worked as a midwife and then a health practitioner in Gaborone. Working for the USA Embassy health unit, I won a grant to carry out health promotion work on HIV and nutrition with young mothers in Gaborone. Many young mothers were being encouraged not to breastfeed their infants due to the risk of transmitting HIV through the breastmilk, however there was not a clean supply of water and infant formula was expensive. Mothers watered down the feeds, resulting in under nourished infants and a rise in infections. Their children all died by the age of one and all twenty mothers died within three years. There was no treatment yet for HIV and although Botswana did provide free health care, being diagnosed with HIV led to pensions and insurances being halted which led many people to refuse to be tested. A few years later UNAIDS (1995) published research findings on the negative impact of mixed feeding on children born to HIV positive mothers. Today this research informs the global Infant and Young Child Feeding guidelines globally to exclusively breastfeed all infants until six months (including HIV positive infants). However, the earlier communications about the risk of breastfeeding your infants have been hard to change, with only 12% of infants exclusively breastfed in South Africa in 2009. Trust once lost is hard to reclaim. I left Africa in 1996 and returned to Scotland to have my second child, another valuable lived experience followed by a sister's role in a cottage hospital emergency room. Working nights, with two young children, helped enrich my lived experience again, regarding the importance that time and childcare had on timely health service utilisation. Especially when the mothers are sleep and nutrient deprived.

My experience in the emergency room was to be well used in my next posting in Northern Nigeria, from 1997 until 1999 when I worked in a state, with a population of 10 million people, where 90% of the population were living in poverty. Health systems were under funded and although there were skilled health workers available, insecurity and weak local level management of services, like the cold chain disruptive effective service provision, which reduced trust and timely utilisation of services. Supply side failures were addressed through rapid health facility assessments and the determination of demand side barriers was carried out using participatory learning in action sessions. In community meetings where the health team worked closely with communities to determine priorities, barriers and develop community action plans. A six-month qualitative research programme, using a naturalist enquiry approach, focused on exploring the communities' perceptions of quality, in relation to community health workers (Keith 2000). Despite the health workers being trained to value local knowledge, they often believed they had more knowledge than the rest of the community and at times looked down at the community. Despite being trained to work in the community, many wanted to work at the health centre. It was interesting to learn that despite participatory training they valued working at the clinic more that in the communities (Keith 2000). It was time to add more theory to my experience and I enrolled for an MSc programme.

Save the Children Head of Health: Health systems and human resources 2000- 2008

I decided to do my MSc in International Health at the Centre for International Health in 1999 in Edinburgh. The core reader, *The Politics of Primary Health Care*, was eye opening to me like the missing piece in my twenty years of experience (Saunders D & Werner D 1997). It introduced me to the importance of politics and power in relation to health. After graduating with my MSc in 2000, I was appointed as the first female and non-medical, Head of Health for Save the Children UK. Bringing my 18 years of experience to my role I used my new voice to ensure other voices were heard and led the investment of over £100,000 into innovative research into demand side barriers to health care access in Africa (Keith, 2001, 2003 a, b, Save the Children 2001). I was able to invest in both global and field research to inform our policy positions and advocacy positions. Within a year we released a research report with MEDACT on negative impact of structure adjustment policies and under investment in Africa's health systems: The Bitterest Pill of All: the collapse of Africa's health systems was launched in 2001 (Save the Children and MEDACT 2001). The new millennium introduced new global public private partnerships, many health experts were concerned about their impact on the ground and so I commissioned the London School of Hygiene and Tropic Medicine to carry out a four-country study, on the impact of the new Global Alliance for Vaccines and Immunisations. I was concerned that the programme did not include much money for health systems, focusing only on new vaccines, not essential vaccines such as measles which killed around 900,000 children in 2001. The research report, New Products into Old Systems, was launched at the WHA Executive Board in Jan 2002, calling again for more investment in immunisation cold chain and health systems like managing waste. (Starling et al 2002 and Heaton and Keith 2002). The head of UNICEF attended the launch, NORAD established set up a health system working group and GAVI agreed to a more inclusive civil society group to feed into the implementation of their strategic plan. GAVI also added a data quality audit to their M and E systems to enhance the robustness of their DPT 3 indicator. However, they also held a high-level meeting in New York and used their power to get the Minster of Health Ghana to refute the messages in the report, I learned a valuable lesson on power and voice when working with vastly different groups, power always matters. In 2002 when we launched the GAVI report a new partnership was established, the Global Fund to Fight AIDs TB and Malaria. Kofi Annan (the UN SG addressed the World Health Assembly in May 2002 and announced the fund for HIV, he had just returned from South Africa where HIV and AIDs was devastating communities. A lot of the barriers picked up in our GAVI report were fed into the setting up of the GFATM board and Save the Children were appointed as the Northern NGO alternate voice. We held meetings regularly with 45 organisations, to feed in their voices into the GFATM planning cycle, however the politics were at play again and much of the first ten years resources failed to reach the health systems. It was not until the US pledged $15 billion dollars to HIV and this supported the GFATM funds that HIV programmes were able to make HIV treatment free at the point of access. The 3 by 5 Campaign, set up in 2003, to get 3 million HIV people one treatment by 2005 was ambitious. Only 600,000 people were on treatment in 2003. Until then much of the HIV treatment was reaching only men who could afford to pay for the

treatment. When the treatment was made free at the point of access, communities began to seek testing and treatment. In 2005 The President of Nigeria called for the prevention of mother to child transmission to be given increased support and within three years antenatal programmes began to integrate opt out programmes to test pregnant women placing them on treatment and adding nutrition to strengthen their health outcomes (Keith 2009 d).

In 2000 Gordon Brown set up the Grow up free from Poverty Coalition to bring together NGOs and faith-based groups to tackle child poverty. In 2003 I led the coalition to complete field informed research into the progress of world in achieving the MDGs 4 and 5 for maternal and child health. The report (80 million lives) called for more investment into health systems, especially health workers and recurrent costs. It also called for health workers and communities to feed into health programme and policy decisions. The report was launched by Baroness Amos the Secretary of State in the Parliament. Voices from staff in the field were included in the launch to bring the reality of the field into the policy fora. (Fustukian, Keith and Penrose 2003) The next research commissioned needed to present a solution and in 2004 I commissioned another research report with Queen Margaret's University to identify how Sri Lanka was able to achieve good health at low cost. The research demonstrated that when the Alma Ata principles are adhered to good health outcomes can be achieved at low cost. The key reasons for this were equity of health care (with all essential services free at the point of access) combined with a concurrent investment in water sanitation education and food security and an investment in human resources. [Mc Nay, Keith and Penrose 2004]. The presentation of a possible solution was welcome in the health policy fora and I was asked to present our research in Mexico at *the Global Health Research Conference Mexico* in 2003 and then at the World Bank's reaching the poor conference in Washington DC in 2004 (Keith 2003, 2004). These networking opportunities led to collaborations with WHO and other organisations such as the Peoples' Health Movement.

While these global research projects were underway, I supported longitudinal field research over 5 years, from 2000 until 2005, in seven of our country programmes, in Africa (Uganda, Tanzania, Sudan, Rwanda, Burundi, DRC and Ethiopia). Liberia was also included in the research, but due to the war the research had to be halted. The volcanic eruption in DRC also resulted in the loss of essential data. The research series was entitled: *The cost of coping with illness* and we ensured that each country had a steering group of health professionals supported by academic leads. Each country carried out a household survey to determine the health seeking practices and this was supported by a Household Economic Analysis to determine the impact of health care costs on household budgets. These tools were supported by seasonal calendars and interviews and focus group discussions with health workers and communities. The research demonstrated that the biggest barrier to timely use of health care was the direct and indirect cost of health care, this resulted in over a third not seeking care, the research also demonstrated that the cost of health care also pulled around a third of families into poverty as they sold finite resources to pay for health care. Summary papers were developed from each country and a synthesis paper created to

feed into the Making Poverty History campaign and field advocacy programmes (Cadge, Keith 2005 a, b, c, d, e, f, g, h, Save the Children 2005 and Witter 2005 a, b). I commissioned a review on user fees Witter S, Keith R (2005) which I then developed into a new Save the Children user fee position paper (Keith 2005b) and Save the Children (2005) used the results to feed into the global advocacy to halve poverty through doubling aid. The Making Poverty History campaign succeeded in gaining more money for developing countries. A new ask was needed. I collaborated with James, Morris and Taylor to work out how much abolishing user fees in 20 SSA countries would cost, and how many lives could be saved. Our research was published in the British Medical Journal in 2005 (James et al 2005) and was used by Tony Blair in his election manifesto, stating that if elected the Labour government would support 12 countries to move away from user fees to support the saving of 285,000 under five lives. The UK also agreed to change its policy on user fees. In May 2005, at the World Health Assembly, two resolutions were passed (58.31 and 33) which called for countries to move away from user fees (WHA 2005 a, b).

Many organisations joined the global call to move away from user charges, but Save the Children, Oxfam and MSF were the most supportive. The World Health Report in 2005 focused on achieving the MDGs for maternal and child health and I was invited to participate in a meeting on whether to separate the mother and the child, the consultation resulted in keeping both together. We developed a new report which looked at the negative human impact of paying for health care in Sierra Leone (Keith 2006 b). Neonates were largely ignored the Lancet included my letter calling for free maternal health (Keith 2006 a). Also, in 2005 to strengthen maternal and child health advocacy a new group was established (the Countdown to 2015 core group included WHO, UNICEF, Save the Children, LSHTM and the Bellagio group. The first meeting held in the UK was a success in 2005 and the reports all contained two-page country profiles for the countries where the most children and mothers were dying. Richard Horton, from the Lancet, became a key partner with the maternal new born and child health advocacy group to ensure that research was published in the Lancet to correspond with key moments. Another partnership was formed (The Partnership for Maternal New-born and Child Health) which brought together key child and maternal health stakeholders to establish a global united voice to achieve the MDGS for maternal and child health. The following year the WHO focused their World Health Report on health workers, and we also commissioned research to explore why so many health workers were leaving Africa [Blanchet K, Keith R and Shackleton P (2006). I coordinated a two-day conference with THET and had Minsters of Health from Malawi and Ghana attend to discuss the challenges they faced in raising human resources for health (Keith R 2006 c) these reports were presented at the World Health Assembly. The Global Health Workforce Alliance explored how the world would find 4 million health workers before 2015. In May of 2007, I attended the Meeting of the Commonwealth Health Minsters to advocate for them to move away from user fees, writing an article in the annual report (Keith 2007 a).

In 2007 my earlier work in Nigeria came into good use when we applied for, and won, a £40 million pound programme to strengthen immunisations in Northern Nigeria (PRINN). Many

of the states had a 0% coverage rate. In 2008, before leaving Save the Children, to set up my own consultancy company, I travelled to China to take part in a high-level conference on improving equity of access to health care. The presentation generated a lot of interest and DFID supported a pilot to explore the impact of free rural health care in two districts. China revised their health financing policy for rural areas since then.

World Vision, Merlin, IRC, Tearfund, VSO, Cara International Consulting Ltd 2008- 2012

In 2007 I was appointed as a special adviser for maternal health to the UK Parliament International Development Committee for their maternal health enquiry. WHO contracted me to carry out a stakeholder consultation to feed into the UK IDC maternal health enquiry and one to feed into the Women Deliver meeting (Keith 2007 b and c). In 2008 I left Save the Children to set up my own company (Cara International Consulting Ltd.). I was contracted by IRC to assess an EU programme on health system strengthening in Sierra Leone (Keith 2008 b) and an evaluation of the Myanmar Thai border IDP programme (2008 c). Both evaluations were carried out using mixed methods resulting from field trips which again highlighted the importance of voice in health systems planning especially from community elders. The global health policy world was crowded with many stakeholders that hold little experience in the field as new resources became available more actors crowded the arena. In 2008 I was contracted by VSO to collaborate on their new Health strategy, it was an honour to be feeding into future volunteer roles (Keith 2008 a) and then I was requested to carry out a three-country research field trip to Nigeria, Malawi and Zambia to assess the impact of the Prevention of Mother to Child Transmission programme for HIV (Keith 2008 b). The main finding from this research was the importance of opt out strategy for mothers attending antenatal clinics, with all mothers tested for HIV and they could opt out from getting the results. It was great seeing the positive impact of HIV treatment and resources, in the three countries and although more women were getting tested and put onto free treatment, there was now a problem getting men to get tested. Zambia's innovative couples testing programme was innovative and delivering social and health impacts. My next research programme was developing a critical enquiry into maternal health in fragile contexts. For Merlin to feed into their hands up for health workers campaign (Keith 2009 a). This research showed the importance of investing in a standardised 18 months of training of community midwives who have a least nine years of formal education and the importance of including communities in setting the criteria for the selection of the community midwives.

Later in 2009, I was asked to write a report for World Vision International to inform their first global health campaign. The report, Child Health Now, forms part of this PhD (Keith 2009 b). The research utilised information from 120 countries and 1600 community programmes as well as key informant interviews and field trips to ensure the results were from the community. The report was launched in New York at the UN GA in September 2009 and fed into the implementation of the UN SG's Every woman and every child strategy. World Vision International invested $1.5 billion into MNCH at launch of the report and was given a role on the global tracking secretariat for Every Woman Every Child. Regional

briefings were developed to support regional launches of the campaign and many countries developed CHN strategies and reports (Keith 2009 c, d, e, f). While completing this research I was also contracted by Save the Children UK to develop a report on what was working to improve health in fragile states (Keith and Cadge 2010). World Vision then hired me to work with them from 2010 until 2012 to strengthen health system and advocacy capacity across their programmes. In 2012 I commissioned and co-authored research into Global Health Governance, as the WHO had been under funded for over two decades resulting in many normative roles being side lined for more global partnership roles which were funded (Keith and Ooms 2012). We held a debate in Geneva and worked with strategic partners to get WHO to place governance on the agenda for the WHA in 2012.

University of Westminster and a focus on Global Public Health Nutrition (2012 until 2022)

I joined the University of Westminster in 2012 as a visiting lecturer as I continued to complete research for Cara International Consulting. I also continued to mentor civil society actors on how to engage with WHA and WHO and the UK government. In 2013 I developed a one-week short course on strengthening health systems, which many NGO staff attended, although the cost and five days was hard for many to commit to. To use the birth of a new Prince in the UK I wrote an article for BMJ on Breastfeeding to coincide with world breastfeeding week (Keith 2013). In 2015 I collaborated with Results and Concern on a three-country research programme exploring what works for Nutrition. The report was completed in 2015 launched at the UK Parliament (Keith et al 2015). The report fed into the policy decisions on nutrition aid. In 2017 I was contracted by Tower Hamlets Public Health team to carry out an evaluation of their infant and young child feeding programmes in the borough to feed into a strategic policy analysis. Five students collected their MSc thesis data along with two graduates hired as researchers to collect the data from the 119 participants (Keith et al 2017, 2019). The report fed into Tower Hamlets budget and priority decisions in 2017 with all, but one recommendation implemented. In 2018 it was 40 years since the Alma Ata was agreed and I was invited to take part in a working group to feed into the development of the new Astana declaration (Keith 2018). Many of the research recommendations were implemented but the right to health was weakened by aligning it to Universal Health Coverage.

In 2017 I was elected to the World Public Health Nutrition Association's executive committee, covering a global remit of strengthening public health nutrition services and capacity globally through research and conferences. We held a regional conference in India in 2018 on the double burden of malnutrition, where I was asked to lead a panel on hidden hunger, due to micronutrient deficiencies. The conference was attended by around 500 participants from India and Asia mostly and led to further research and collaborations with academics and practitioners.

As part of my role on the WPHNA EC I lead a UK hub on public health nutrition competencies to assess the global standards set for training and accreditation of nutritionists.

Over the last 10 years I have co created with student's research on infant and child feeding (IYCF) in six boroughs of London as well as IYCF practices in Ghana, Nigeria and Nepal. This research has been used to feed into book chapters and articles published in World Nutrition.

In 2018 and 2019 I took a group of ten MSc students to Ethiopia to explore high rates of severe acute malnutrition, to determine exploratory causal links and possible solutions. In 2019, following collaboration with the Minster of Health in Zanzibar a group of five MSc GPHN carried out research on barriers to healthy eating and timely use of health services in Zanzibar, this research is planned for 2022 in Nigeria, Ghana and Mozambique as well as India and China. Results from this research will feed into national and global policy and practice.

I was contracted in 2018 to also evaluate a school holiday food and activity programme to assess the impact on reducing the loss of learning in Tower Hamlets London. The research indicated that children who attended the programme had increased confidence, willingness to learn and personal aspirations. I developed a policy brief using the findings and shared it with the public health team. I was also asked to present the report findings to city hall in 2019 to other borough public health teams. To harness this learning into action I wrote an article on the history of UK school meals for the Conversation (Keith 2020 a) and another article in June 2020 on the impact of poor nutrition on long term health and education outcomes (Keith 2020 b). These were to support the UK advocacy to continue free school meals, which was achieved more through Marcus Rusford than my article which did have over 14,000 reads.

In 2020 I worked with a group of nutrition focused academics from London, Chester and Plymouth to carry out an exploratory analysis of the impact of COVID on England's public health nutrition services. The collaboration was called the Future of Public Health Nutrition and the results were published in World Nutrition and a UK journal for dieticians (Noonan-Gunning et al 2021 a and b). The results indicated that the third sector (charities) were the groups reaching most of the people struggling for access to food for their families. These services were not consistently available across the country and there was a lack of national leadership and support for public health nutrition. The group is now running an advocacy campaign for England to follow Scotland's Dignity programme, where they promise to support it citizens right to health and food, especially for the most vulnerable such as children and the elderly.

Just before COVID began in March 2020, I had been selected to lead a global panel on exploring the effectiveness of health systems in enabling the achievement of the Global Nutrition Targets which as due to be achieved by 2025 (we are presently in the Decade of Nutrition, which was established by the UN SG to encourage countries to urgently address malnutrition and hunger in all its forms). This panel bought together academics and practitioners from all over the world to share experiences, and the conference was due to be held in Australia in March 2020. The pandemic led to the conference being moved online however thousands of participants attended the sessions and discussions on possible

solutions to addressing global health and nutrition systems and governance. Eight of my UoW MSc GPHN graduates also had their research accepted for presentation through posters or presentations, increasing the dissemination of their research to support policy change around malnutrition, food security and infant and young child feeding.

We are presently designing a new UG degree on Global Public Health and exploring the need for more community focused health and nutrition public health teams in the UK and globally to help create enabling environments for enhance health and nutrition outcomes.

It has been an amazing forty years and there is still so much to learn I feel so privileged to have played a small role in improving the access to health services for some of the most marginalised populations, but there is still lots of work to do.

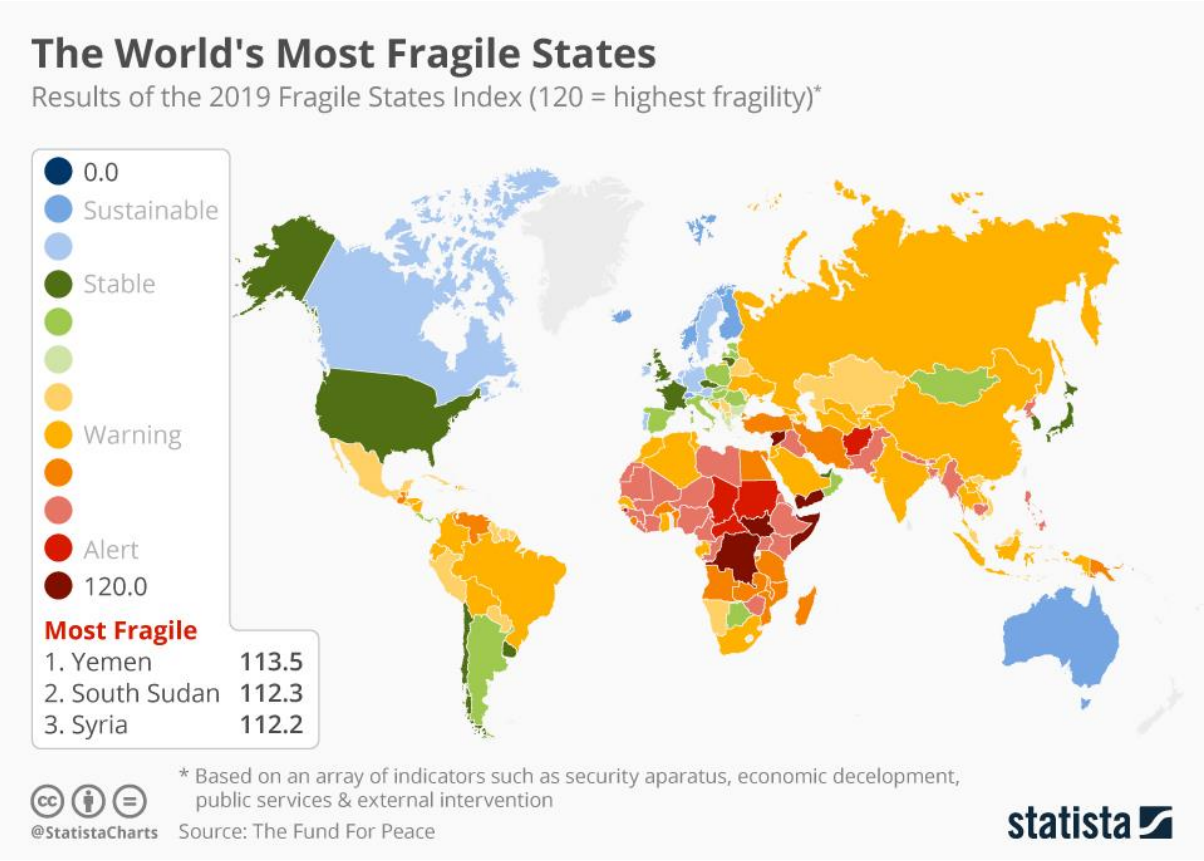
Annex three: Fragile states

Table three: Fragile states in 2016 (Source: Foreign Policy (2016) Fragile States Index 2016)

1	Somalia *	11	Iraq	21	Cote D' Ivoire*
2	South Sudan*	12	Guinea *	22	Cameroon *
3	CAR *	13	Nigeria *	23	Uganda *
4	Sudan *	14	Pakistan *	24	Ethiopia *
4	Yemen *	15	Burundi *	25	Libya
6	Syria	16	Zimbabwe *	26	Myanmar *
7	Chad *	17	Guinea Bissau*	27	Liberia *
8	DR Congo*	18	Eritrea*	28	Mauritania
9	Afghanistan *	19	Niger *	29	Mali*
10	Haiti	20	Kenya *	30	North Korea

*** Fragile states research included in the publications**

Figure four: The world's most fragile states in 2019 (2019 Fragile States Index)



(Source: https://www.statista.com/chart/19070/results-of-the-fragile-states-index/)

Annex four: Alma Ata Declaration

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. **IV** The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both country's health system, of which it is the central function and focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as

close as possible to where people live and work and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience.

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination

with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Annex five: Astana Declaration

Global Conference on Primary Health Care: From Alma-Ata towards universal health coverage and the Sustainable Development Goals. **Astana, Kazakhstan, 25 and 26 October 2018**

We, Heads of State and Government, ministers and representatives of States and Governments[1], participating in the Global Conference on Primary Health Care: From Alma-Ata towards universal health coverage and the Sustainable Development Goals, meeting in Astana on 25 and 26 October 2018, reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All, hereby make the following Declaration.

We envision

Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems.

Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed.

Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being.

Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

I

We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.

II

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-

related Sustainable Development Goals. We welcome the convening in 2019 of the United Nations General Assembly high-level meeting on UHC, to which this Declaration will contribute. We will each pursue our paths to achieving UHC so that all people have equitable access to the quality and effective health care they need, ensuring that the use of these services does not expose them to financial hardship.

III

We acknowledge that despite remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs. Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

We will continue to address the growing burden of noncommunicable diseases, which lead to poor health and premature deaths due to tobacco use, the harmful use of alcohol, unhealthy lifestyles and behaviours, and insufficient physical activity and unhealthy diets. Unless we act immediately, we will continue to lose lives prematurely because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors. We must not lose opportunities to halt disease outbreaks and global health threats such as antimicrobial resistance that spread beyond countries' boundaries.

Promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. We must save millions of people from poverty, particularly extreme poverty, caused by disproportionate out-of-pocket spending on health. We can no longer underemphasize the crucial importance of health promotion and disease prevention, nor tolerate fragmented, unsafe or poor-quality care. We must address the shortage and uneven distribution of health workers. We must act on the growing costs of health care and medicines and vaccines. We cannot afford waste in health care spending due to inefficiency.

We commit to:

IV

Make bold political choices for health across all sectors

We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. We will promote multisectoral action and UHC, engaging relevant stakeholders and empowering local communities to strengthen PHC. We will address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All, leaving no one behind,

while addressing and managing conflicts of interest, promoting transparency and implementing participatory governance. We will strive to avoid or mitigate conflicts that undermine health systems and roll back health gains. We must use coherent and inclusive approaches to expand PHC as a pillar of UHC in emergencies, ensuring the continuum of care and the provision of essential health services in line with humanitarian principles. We will appropriately provide and allocate human and other resources to strengthen PHC. We applaud the leadership and example of Governments who have demonstrated strong support for PHC.

V

Build sustainable primary health care

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health2. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks.

The success of primary health care will be driven by:

Knowledge and capacity-building. We will apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy. We will continue to research and share knowledge and experience, build capacity and improve the delivery of health services and care.

Human resources for health. We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of

the PHC workforce, with an appropriate skill mix. We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas. We assert that the international migration of health personnel should not undermine countries', particularly developing countries', ability to meet the health needs of their populations.

Technology. We support broadening and extending access to a range of health care services using high- quality, safe, effective and affordable medicines, including, as appropriate, traditional medicines, vaccines, diagnostics and other technologies. We will promote their accessibility and their rational and safe use and the protection of personal data. Through advances in information systems, we will be better able to collect appropriately disaggregated, high-quality data and to improve information continuity, disease surveillance, transparency, accountability and monitoring of health system performance. We will use a variety of technologies to improve access to health care, enrich health service delivery, improve the quality of service and patient safety, and increase the efficiency and coordination of care. Through digital and other technologies, we will enable individuals and communities to identify their health needs, participate in the planning and delivery of services and play an active role in maintaining their own health and well-being.

Financing. We call on all countries to continue to invest in PHC to improve health outcomes. We will address the inefficiencies and inequities that expose people to financial hardship resulting from their use of health services by ensuring better allocation of resources for health, adequate financing of primary health care and appropriate reimbursement systems to improve access and achieve better health outcomes. We will work towards the financial sustainability, efficiency and resilience of national health systems, appropriately allocating resources to PHC based on national context. We will leave no one behind, including those in fragile situations and conflict- affected areas, by providing access to quality PHC services across the continuum of care.

VI

Empower individuals and communities.

We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. We will promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals. We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.

VII

Align stakeholder support to national policies, strategies and plans.

We call on all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations and others – to align with national policies, strategies and plans across all sectors, including through people-centred, gender-sensitive approaches, and to take joint actions to build stronger and sustainable PHC towards achieving UHC. Stakeholder support can assist countries to direct sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights.

We will act on this Declaration in solidarity and coordination between Governments, the World Health Organization, the United Nations Children's Fund and all other stakeholders.

All people, countries and organizations are encouraged to support this movement.

Countries will periodically review the implementation of this Declaration, in cooperation with stakeholders.

Together we can and will achieve health and well-being for all, leaving no one behind.

Annex seven: Comparative table between Alma Ata and Astana Declarations

Table four: Comparing the Alma Ata and Astana Declarations

Focus	Alma Ata	Astana
Right to Health	Health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right	Commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health
Voice	Communities will be involved in active planning	We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.
Community engagement	Active engagement in health	We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. We will promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals.
Target	An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources,	We will address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All
Health systems	PHC focus	We will strengthen health systems by investing in PHC.
Human resources	Strengthen health workers and referral systems	We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix
Harmonisation	Support national plans and priorities	Align stakeholder support to national policies, strategies and plans.
Inequality	The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace	We will address economic, social and environmental determinants of health and aim to reduce risk factors
Multisectoral approach	Education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.	Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All

Annex eight: Peer review and publication details for publications

Table five: Published work with peer review and publication details

P	Title	Peer review process	Publication details
1	Prevention of Mother to Child Transmission (PMTCT): Global Policy Implication: reflecting on progress and challenges in three countries (Malawi, Nigeria and Zambia)	UK Academic and professional reviewers, as well as country steering committees and organisational editors	Published by Tearfund and distributed at the GFATM HIV partners meeting 2009
2	Policy Briefing: Social Health Insurance	Academic and professional reviewers, as well as editors	Published by Save the Children UK and distributed at the World Health Assembly 2008
3	All mothers' matter: HRH in fragile states	UK Academic and professional reviewers, as well as country steering committees and organisational editors	Published by Merlin Hands Up for Health workers campaign
4	Child Health Now	UK Australia Canada Kenya and USA Academic and professional reviewers, as well as country steering committees and organisational editors. Child Health Now academic review board.	Published by WVI CHN team and launched at the UN General Assembly in 2009 and at the 2010 World Health Assembly
5	Unlocking Progress in Fragile States	UK Academic and professional reviewers, as well as country steering committees and organisational editors	Published by Save the Children and distributed at the World Health Assembly 2011
6	Improving Global Health Governance: technical briefing paper for the Child Health Now Campaign	UK Australia Canada Kenya and USA Academic and professional reviewers, as well as country steering committees' organisational editors. Child Health Now academic review board.	Published by WVI CHN team at the World Health Assembly 2011
7	What works for nutrition? Case studies from Vietnam, Uganda and Kenya	UK Uganda Cambodia and Kenyan academic and professional reviewers, as well as country steering committees and organisational editors. .	Published by Results and launched at a Parliament debate with all three organisations and with MP. Also launched at University of Westminster.
8	The importance of the Alma Ata principles of equity and voice through intersectoral investment	World Nutrition peer review process	Published in World Nutrition in August 2018
9	Understanding perceptions and practices on infant and young child feeding and oral health in Tower Hamlets Borough	Workshop with health professions on LBTH, Tower Hamlets council workshop with 50 health care workers. World Nutrition peer review process	Published by World Nutrition team at the World Health Assembly 2011

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