

## Editorial

### Reimagining primary health care: more of the same is not enough

Assaye Kassie Nigussie<sup>1</sup>

<sup>1</sup>Adjunct Professor of Pediatrics and Child Health, College of Health Sciences, Bahirdar University, Bahirdar, Ethiopia

\*Corresponding author: [assayek@gmail.com](mailto:assayek@gmail.com)

One of the major achievements in global development, especially in global health, is the incredible progress in child survival. Since the launch of the Millennium Development Goals in 2000, the number of young child deaths has dropped significantly to unprecedented levels.

According to the 2023 estimates from the United Nations Inter-Agency Group for Child Mortality Estimation (IGME), there was an accelerated decline in under-five deaths between 1990 and 2022. The global under-five mortality rate dropped from 12 million annually in 1990 to 5.5 million in 2022. This represents a significant milestone, as humanity has not seen such notable progress recently (1,2).

At this pivotal moment, it is essential to ask what factors contributed to these significant changes and how we can fully understand the elements that drove this remarkable achievement. While multiple factors have played critical roles in improving child survival and reducing young child mortality, the most significant contributors can be summarized as follows (3,4):

**Improvements and increased investment in the health sector:** The health sector has accounted for approximately 50% of the reduction in young child mortality. Within this sector, advances in strengthening primary health care by enhancing access to routine immunizations and community health programs have been instrumental in improving child survival outcomes.

**Socio-economic development improvements:** The other 50% of the reduction is attributed to enhancements in various socio-economic development sectors, including household food and nutrition security, access to safe and adequate water, and improvements in personal and environmental hygiene and sanitation. Furthermore, expanded access to quality education, particularly for girls and women, as well as early childhood development initiatives, has significantly contributed to better child survival outcomes.

In addition, the commitment from key global health and child survival actors has been vital for documenting this accelerated progress.

**Citation :** Nigussie A. K., Reimagining primary health care: more of the same is not enough, *Ethiop J Pediatr Child Health*. 2025;20 (2): 107-113 **Submission date:** 20 August 2025 **Accepted:** 25 August 2025 **Published:** 1 September 2025

These commitments are encapsulated in the “five Cs” of the global primary health care (PHC) optimization guideline, representing the chain of commitment among key PHC actors:

**1. Commitment from the Community:**

Community support for PHC programs, including advocacy for increased health budgets and both financial and non-financial contributions, is crucial. Community ownership and oversight of PHC program implementation have proven pivotal.

**2. Commitment from Health Professionals:**

Health workers must be dedicated to providing quality health care to all sectors of society with respect and compassion. Retaining and motivating the health workforce is essential to ensuring the PHC system functions effectively.

**3. Commitment from Health Program Managers:**

Health management teams at all levels must be committed to effective planning, implementation, and management of health programs to achieve better outcomes.

**4. Commitment from Policymakers:**

Members of parliament and officials from the Ministry of Health should engage in policy dialogue, remain open to policy changes, and commit to allocating the necessary human and financial resources to improve overall health and social well-being.

**5. Commitment from Development Partners:**

Development partners must remain committed to playing a catalytic role, align-

ing their priorities with national goals, and providing predictable and sustainable development assistance.

A systematic review conducted to identify successful factors in maternal and child survival in countries like Vietnam, Sri Lanka, and Kerala (India) has revealed several common elements that have significantly contributed to the reduction of maternal and child mortality (6):

- Relatively low-income inequality
- High levels of female education
- Improved access to healthcare
- Household food and nutrition security
- Political commitment and
- Enhanced communication and transport facilities

Despite notable progress in child survival during the Millennium Development Goals (MDG) era, stagnation has occurred since 2015. In some low- and middle-income countries, there has even been a regression in overall health and social well-being milestones. This decline is primarily attributed to the impacts of the COVID-19 pandemic and a global stagnation in household food and nutrition security observed since 2021.

While we continue to strengthen community health programs, it is crucial to reimagine the entire Primary Healthcare (PHC) system and develop innovative initiatives to boost PHC outcomes. To achieve this, reframing the PHC system is essential. The latest Global PHC Optimization Guideline introduces a

new approach aimed at improving the efficiency and effectiveness of the PHC system through vertical integration and program convergence.

### **Optimizing PHC through Vertical Integration and Program Convergence:**

The new guideline presents two interconnected concepts. The first focuses on optimizing the PHC system by acknowledging the need to move away from the notion of an "ideal system," which is rarely achievable in real-world settings. Instead, it aims to establish an optimal PHC system where the three "Vital Organs"—Human Resources for Health, Health Commodities, and Health Financing—are developed and maintained to ensure the PHC system is functional and effective (12). It is important to note that while these foundational elements are prioritized, other health system pillars, such as governance and Health Management Information Systems (HMIS), will also be addressed once the foundational issues are resolved.

The second concept emphasized in the new PHC guideline is that optimization will occur solely through “Vertical Integration and Program Convergence.” This means that current vertical programs, which operate in silos, will begin to integrate their initiatives under one comprehensive plan, implementation strategy, and system of support. Specifically, all vertical Maternal, Neonatal, and Child Health (MNCH) programs will adopt an integrated planning and implementation approach. Furthermore, the

objective is to integrate various social sector programs at the district level through a multi-sectoral programming approach. This collaborative effort includes sectors such as Health, Nutrition, Water, Sanitation and Hygiene (WASH), Education, and social policy and child protection, which is known to reduce transaction costs, enhance efficiency, effectiveness, and ultimately improve overall health and social well-being outcomes.

### **Demystifying PHC Policy Translation**

The new PHC guideline clarifies the misconception that translating PHC policy into practice is challenging and complex. The key takeaway from countries that have successfully reframed and redesigned their PHC systems is that optimizing PHC is achievable, provided the reframing process begins with robust diagnostics. Based on these diagnostics, the health system's maturity level can then be classified at both national and subnational levels. Here are simplified and practical steps to follow when reframing and redesigning the PHC system in low- and middle-income countries (12):

1. **Conduct Robust Diagnostics:** Generally, the health systems in most low- and middle-income countries are either weak or fragile and struggle to meet the growing health demands of their communities. Therefore, it is crucial to adopt a method similar to clinical assessment, where clinicians conduct thorough evaluations before

treating patients or prescribing medication. In the same vein, understanding that health systems in low-income countries grapple with various chronic health system issues is vital; these issues must be identified early and addressed promptly. Thus, a comprehensive investigation of the health system is essential to uncover major policy gaps and implementation challenges before attempting to reframe the PHC system.

## 2. Classify Health System Maturity Levels:

Based on diagnostic findings, it is crucial to classify the current level of health system maturity, as well as the Obstetric and Neonatal Transition Levels. This classification can effectively be done at both national and subnational levels. For practical purposes, health systems in low- and middle-income countries can be categorized into three maturity levels (8):

- **Health System Maturity Level One:** This classification refers to a country, province, or district where the Maternal Mortality Ratio (MMR) exceeds 400 per 100,000 live births, or the Neonatal Mortality Rate (NMR) is over 30 per 1,000 live births, along with a breakdown of one of the “Vital Organs” of the PHC system indicated by recurrent outbreaks of common communicable diseases (e.g., Malaria, Measles, Cholera). Such circumstances necessitate a radical overhaul of the PHC system, with a strong focus on repairing broken “Vital Organ components.

- **Health System Maturity Level Two:**

This level applies to a country, province, or district with an MMR between 140-400 per 100,000 live births or an NMR between 12-30 per 1,000 live births. In these cases, no recurrent disease outbreaks are documented, but serious quality challenges exist. The focus should be on quality planning and improvement, as well as strengthening quality assurance and quality control mechanisms to deliver quality, respectful, and compassionate healthcare.

- **Health System Maturity Level Three:**

This category pertains to a country, province, or district where the MMR is less than 140 per 100,000 live births, and the NMR is below 12 per 1,000 live births, where quality healthcare is provided with respect and compassion. These countries should aim to advance their tertiary and quaternary health systems to achieve health outcomes comparable to those of high-income countries.

## 3. Narrowing Disparities in Healthcare

After assessing the maturity level of the health system, the next step is to create a strategic and operational plan with clear overarching goals and milestones to address healthcare disparities. It is essential to identify and engage the most vulnerable segments of society, as a significant number of maternal and child deaths occur within these communities. Vulnerability can arise from biological factors (e.g.,

pregnant women), socioeconomic issues (e.g., individuals living in poverty), or geographic challenges (e.g., rural and remote areas or urban slums).

#### 4. **Increase Total Health Expenditure: Target the Nadir Point for Health Financing**

The Nadir Point for health financing is the minimum Total Health Expenditure (THE) per capita per year that is necessary to ensure that the primary healthcare (PHC) system is fully functional. The global PHC guidelines present the minimum calculated THE for low- and middle-income countries (LMICs) as USD 240 per capita per year. Most countries that have successfully reformed their PHC systems and documented better health outcomes have invested a minimum total health expenditure of over USD 400 per capita per year. In contrast, countries that have invested less than 100 USD per capita per year are struggling with dysfunctional health systems and fail to cope with recurrent communicable disease outbreaks (9,12).

The Nadir Point for health financing should not rely solely on national treasury funds. Communities must contribute through risk pooling (such as health insurance) and other innovative health financing mechanisms. Additionally, development partners should continue providing catalytic funding to initiate change. Importantly, they should align their support with national health priorities

and offer predictable and flexible financing.

#### **Conclusion**

In conclusion, we strongly suggest that low- and middle-income countries take the lead in reimagining and redesigning their own PHC systems. They should conduct a detailed situational analysis of the health sector to identify major policy gaps and implementation challenges, particularly focusing on fixing the broken "vital organs" of the PHC system. It is equally important to identify and address the demand-side difficulties that hinder the utilization of health services. Priority should be given to improving access and expanding services for the most vulnerable groups in society. Most maternal and child deaths are concentrated among socially disadvantaged and marginalized populations, especially those living in remote areas, rural communities, and urban slums.

It is imperative to acknowledge that the highest quality health services are not free. If LMICs are committed to optimizing their PHC systems and transforming their health sectors to be more efficient and effective, they must be prepared to cover incremental costs through improved health budgeting and innovative health financing mechanisms. This includes actively engaging communities to support the PHC system both financially and in-kind.

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