PART ONE

Primary Health Care Foundations
This page intentionally left blank
Chapter One

Primary Health Care

*History, Trends, Controversies, and Challenges*

Henry B. Perry

The people of the world—and the so-called bottom billion in particular—require and have the right to expect a strong and equitable system of primary health care. Primary health care (PHC) in the context of global health, and from the standpoint of the most disadvantaged populations around the world, represents the undisputed long-term core strategy for improving health through health programs (as opposed to overall poverty reduction and broad development). Ironically, PHC has been until recently one of the most neglected topics on the global health agenda. This chapter explores PHC in the context of global health by revisiting and updating the definition of primary care that was enunciated in the 1978 Alma-Ata Declaration and reaffirmed in the 2018 Astana Declaration. The chapter connects PHC to the context of today’s global health landscape and evidence base by reflecting on the history of the PHC movement since 1978 and by looking to the near-term future for the global health and development agenda that is geared toward achieving the UN Sustainable Development Goals, attaining universal health coverage (UHC), and ending preventable child and maternal deaths.

The waning of interest in and support for PHC that occurred over the three decades following the 1978 International Conference on Primary Health Care held in Alma-Ata, USSR (now Almaty, Kazakhstan), has recently reversed. The fortieth-anniversary celebration at Astana, Kazakhstan, in 2018 and the Declaration of Astana provided an opportunity to reaffirm support for PHC, to rethink the basic concepts of PHC, and to consider how a stronger and more equitable PHC system can help the world achieve Health for All sooner rather than later (World Health Organization, Ministry of Health of Kazakhstan, and United Nations Children’s Fund 2018).
The current renewed interest in PHC can be attributed to several converging trends, the most important of which is a growing awareness of the magnitude of remaining unmet basic health needs throughout the world. Although from a global perspective, enormous gains have been made in disease control and mortality reduction, still more than one billion people have never seen a health care provider (GHWA 2011). Of the seventy-four countries with 97% of the world’s maternal and child deaths, only four achieved the 2015 Millennium Development Goals (MDGs) for maternal and child health (Victora et al. 2016), with progress in sub-Saharan Africa for all the health-related MDGs lagging far behind the rest of the world (World Health Organization and United Nations Children’s Fund 2012; United Nations 2015). AIDS (acquired immunodeficiency syndrome), tuberculosis, and malaria—all readily preventable or treatable diseases—still claim almost three million lives a year (World Health Organization 2018a, 2018b, 2016). All of these health challenges remain despite vast improvements in the financial resources and technical knowledge with which to combat these tragedies. The number of deaths occurring each year from readily preventable or treatable conditions should be widely considered as among the greatest moral and ethical failures of our current era.

A second reason that interest and support for PHC is now waxing is the recognition that the population coverage of most basic and essential services that fall within the realm of PHC among low-income populations remains below 60% (Victora et al. 2015). (An exception is the coverage of immunizations and vitamin A supplementation, which has benefited from intense and well-coordinated donor funding, policy advocacy, and on-the-ground monitoring.) Basic health-promoting behaviors such as exclusive breastfeeding and handwashing, which we know can be effectively promoted through community-based PHC programs, are still far from the norm.

Third, the decades-long emphasis on specific disease control programs and selective top-down initiatives are increasingly recognized to have forestalled emphasis on strengthening PHC programs and community-based health service delivery.

Julia Walsh and Kenneth Warren titled their highly influential 1979 article “Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries” (emphasis added). This title shows prescience: for more and more countries, the “interim” is over and it is time to get down to the business of building the foundational structures that can help the world achieve and sustain Health for All.

Fourth, the effectiveness of community mobilization, participation, and empowerment in improving population health now has a stronger evidence
base for supporting the utilization of basic and essential services and for promoting healthy behaviors. Fifth, the emergence of adult chronic diseases as the major global disease burden of the future makes primary prevention as well as health services for screening and treatment of chronic diseases a top priority. Hence, the need for a functioning PHC system to address this coming burden is obvious since repeated contact with the health system is a prerequisite for chronic disease prevention and control.

Origin of the Term *Primary Health Care* and Organization of Primary Health Care in Developed Countries

The term *primary health care* is generally ascribed to the Dawson Report, which was presented to Parliament in Great Britain in 1920 (Dawson 1920). The report, chaired by Lord Dawson of Penn, was concerned with the “Future Provision of Medical and Allied Services.” The report arose from a recognition that the organization of medical care at that time was insufficient and that “it fails to bring the advantages of medical knowledge adequately within reach of the people.” Its general principle was that medical services should be “distributed according to the needs of the community.” The report also recognized that, while medical care had been previously provided primarily in the home, increasingly, services would need to be provided in facilities with laboratory and radiology services.* It also recognized that preventive and curative medicine “cannot be separated on any sound principle, and any scheme of medical services must be brought together in close co-ordination.” Interestingly enough, the report does not actually use the term *primary health care* but does introduce the term *primary health center.*

Early Approaches to Provision of Primary Health Care in Developing Countries

In the early part of the twentieth century, medical services for disadvantaged populations in many low-income countries that were based on modern medical science were pioneered mostly by Christian medical missionaries. These

---

*The original use of the term in 1920 was *primary health care center*, not *primary health care services*, as a way, perhaps, to stress the need for facility-based care in addition to the dominant home-based care that had been the norm up to that time. At present, we seem to need to stress the importance of outreach because the emphasis more recently has been on facility-based care.
services were provided mostly in facilities, particularly hospitals. Mission hospitals accounted for 50% to 80% of hospital beds in many developing countries at that time. Local government health services were poorly developed.

Francophone and other European colonies not under British rule gave emphasis to specific priority diseases (grandes endémies), such as sleeping sickness, elephantiasis, and leprosy. Mobile units provided preventive and curative care for these conditions. They also provided curative care to large numbers of people who came to mass gatherings rather than offering services at static facilities. Anglophone countries and colonial health services in Africa and India were beginning to be involved in disease control efforts (e.g., for hookworm, malaria, and yellow fever). In China, early hospitals were mainly established by Christian medical missions, and a national public health system began in the 1920s in response to the emergence of an epidemic of pneumonic plague (United Nations Children’s Fund 2008).

Thus, we can see that from the beginning of the twentieth century, both disease-specific (selective) approaches to improving health and more comprehensive facility-based approaches to providing health services were emerging. In developing countries in the early part of the twentieth century, more comprehensive approaches to reaching the entire population beyond facilities had not emerged until the 1930s, with the development of the Ding Xian Project one hundred miles south of Beijing.

The Ding Xian Project was developed by C. C. Chen, an experienced Yale-educated literacy expert who had developed methods for mass education among the rural poor, and Dr. John B. Grant, who was the first professor of public health at the Peking Union Medical College under an arrangement with the Rockefeller Foundation (Taylor-Ide and Taylor 2002). There, in the absence of any formally trained health workers and facilities, “farmer scholars” were trained to administer simple treatments at home using sixteen essential and safe drugs, to give talks and demonstrations on health and hygiene, to maintain clean water supplies, to vaccinate for smallpox, and to record births and deaths. These farmer scholars were the world’s first example of what we know today as community health workers (CHWs), and this program served as the prototype for China’s national “barefoot doctor” program that emerged in the 1950s. At that time, China had one of the highest death rates in the world (a crude death rate of 25 per 1,000 population and an infant mortality rate of 200 per 1,000 live births) (Sidel 1972). More than one million barefoot doctors received three months of training in traditional Chinese medicine as well as Western medicine (Sidel 1972). They
were not formally doctors, though, and their work would be described today as community-based PHC since a range of basic curative and preventive services were being provided outside of health facilities.

In the early 1940s in India, the foundations for PHC in India were laid by the Health Survey and Development Committee, most widely known as the Bhore Committee. The committee was established in 1943 to review the existing health conditions of India and to make recommendations for the future of health services in the country. It was chaired by Sir Joseph Bhore and included some of the international public health luminaries of the day, including Dr. Grant. After working in China in the 1930s, Grant had become the director of the All India Institute of Hygiene and Public Health in Calcutta. The committee met regularly and submitted its report in 1946. The report called for the initial development of primary health centers that would each serve forty thousand people and have for their staff two medical officers, four public health nurses, one nurse, four midwives, four trained dais (midwives), two sanitary inspectors, two health assistants, one pharmacist, and fifteen other lower-level workers. The plan called for the later development of “primary health units” with hospitals of seventy-five beds and other services for each ten thousand to twenty thousand people (Community Health 1946). The influence of the Dawson Report from England twenty years earlier is notable.

Iran was an early pioneer in the formal training of CHWs who became early prototypes of its current program of professionalized CHWs, called behvarzes. In 1942, Iran initiated the Behdar (meaning “healer”) Training Project and in 1972 the West Azerbaijan Project and the Village Behdar Training Scheme to train local people to address the health concerns of the rural poor (Assar and Jaksic 1975; Amini et al. 1983; Ronaghy et al. 1983). These early experiences formed the basis of Iran’s current rural national PHC system of thirty thousand behvarzes providing services at seventeen thousand health houses for twenty-three million Iranians (Perry, Zulliger, et al. 2017). The two-year training of the behvarzes is unique in that its focus is on group discussions, role-playing exercises, and working at a model health house set up at each training center (Shadpour 2000). More than 90% of the population has ready access to these health houses, contributing to Iran’s strong progress in improvement of its population’s health in the 1980s and 1990s (Shadpour 2000). The current program is a compelling example of comprehensive PHC because it not only provides ready access to care but also works with community members and with other sectors to address the social determinants of health (Javanparast et al. 2011).
It was, however, the Chinese barefoot doctor experience that resonated throughout the developing world in the 1960s and 1970s, and provided an inspiration and encouragement to a number of nascent community-oriented programs—particularly in Latin America, where modern health services had not yet reached populations in need. In addition, innovative approaches to addressing health needs in developing countries with few formally trained health professionals and severely constrained financial resources were beginning to accumulate. It was becoming apparent that Western approaches to medical care that had been developed in Europe and the United States were not going to be widely available in many developing countries for a long, long time, and some serious rethinking was needed regarding how to improve the health of people in developing countries.

At the same time, an influential group of international health leaders had become concerned that the work of medical missions in developing countries was also failing to reach many of the world’s most vulnerable people because of the missions’ focus on hospital care. They began discussions in 1963 and carried out fieldwork that demonstrated that the hospital-based curative services established by medical missions’ programs had a limited impact on the health of the populations served by their programs and that at least half of hospital admissions were for preventable conditions. In fact, one report found that the health of people who lived close to a mission hospital was no better than the health of people who lived far away (Arole, Kasaje, and Taylor 1995). Ethical issues were emerging about the lack of attention to people who did not have access to hospitals or who needed preventive and curative services not readily available at these facilities.

Thus, the stage was set at the Christian Medical Commission, established in 1968 in Geneva as a semiautonomous body of the World Council of Churches, to begin to explore a new concept of PHC that was adapted to the needs of developing countries. Among the distinguished people participating in these discussions were Dr. William Foege, Dr. John Bryant, and Dr. Carl Taylor.† In fact, it was in this venue that the term primary health care began to be used to refer to practical approaches for working with communities in low-income settings to address priority health problems (McGilvray 1981; Litsios 2004).

†Foege went on to lead the US Centers for Disease Control and Prevention as well as to serve as advisor to the Bill and Melinda Gates Foundation. Bryant went on to serve as dean of Columbia University’s Mailman School of Public Health and to make seminal contributions to the practice of PHC through his leadership at the Aga Khan University’s Karachi campus. Taylor’s background is discussed in more detail later in this chapter.
This led to high-level discussions between staff at the Christian Medical Commission and staff at the World Health Organization as well as to serious thinking at WHO about how to address the growing gap between the Western approach to medical care with its highly curative, facility-based orientation and the practical possibilities for addressing the health needs of poor people in developing countries. The dialogue was encouraged by Dr. Halfdan Mahler, the executive director of WHO at that time, who had spent ten years in India working with WHO on tuberculosis control and was intimately familiar with medical missions work there (Litsios 2004).

One of the outcomes of this dialogue was an influential volume edited by Kenneth Newell, then director of the Strengthening of Health Services Division at WHO, titled *Health by the People*, which highlighted case studies from around the world based on engaging the community in partnership in addressing health needs (Newell 1975). This volume includes examples from Cuba, China, Iran, and, most importantly, the Comprehensive Rural Health Project in Jamkhed, India. It provided the inspiration for the International Conference on Primary Health Care in 1978, sponsored by WHO and the United Nations Children’s Fund, where a concept of PHC that was relevant to developing countries was fully developed and embraced.

Primary Health Care as Defined in the 1978 Alma-Ata Declaration

The 1978 International Conference on Primary Health Care at Alma-Ata, USSR (now Almaty, Kazakhstan), was the largest and most representative global health conference that had been held up to that time, with representatives of 134 governments and 67 international organizations (Cueto 2004). The choice to host the conference in the USSR at the height of the Cold War is a complex and interesting story itself (Litsios 2002). Its landmark three-page declaration has turned out to be one of the pivotal documents for the development of the concepts, principles, and ideals related to PHC that are applicable to all peoples everywhere regardless of the context. The Alma-Ata Declaration expanded the narrow concept of PHC as ambulatory care provided by doctors and nurses in facilities to a much broader definition that resonated with the needs of poor counties. The declaration defined PHC as:

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 of the country’s health system, of which it is a central function and main focus, and of the overall social and economic development of the community. It is the first 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. (World Health Organization and United Nations Children’s Fund 1978)

This definition has broad legitimacy and has consistently been affirmed since as the “gold standard” for PHC, even though its lofty ideals have led some to consider it aspirational and unrealistic. The conference also called for the achievement of Health for All through PHC by the year 2000—still an unrealized goal that will remain with us for most of the twenty-first century.

Walsh and Warren and Selective Primary Health Care

Only one year following the Alma-Ata Conference, Julia Walsh and Kenneth Warren, in their seminal 1979 article “Selective Primary Health Care,” promoted selective PHC as an “interim strategy for disease control in developing countries.” Although they do not give a formal definition of PHC or of selective PHC in their article, it is apparent that they are referring to the control of priority endemic diseases using cost-effective interventions. They state that the goal of PHC as defined at Alma-Ata is “above reproach, yet its very scope makes it unattainable because of the cost and numbers of trained personnel required” (967). They state (incorrectly, in my view) that basic PHC is oriented to “provide health workers and establish clinics for treating all illnesses within a population,” and they argue that selective PHC is “potentially the most cost-effective type of medical intervention” (972). The concept of selective programmatic measures continues to guide much thinking and global action for improving health in developing countries despite having been introduced as an interim approach (Hall and Taylor 2003).

GOBI, Selective Primary Health Care, and the First Child Survival Revolution

In the early 1980s, James P. Grant had become executive director of UNICEF. He was the son of Dr. John B. Grant and had grown up in China as well as
in India. He was not a physician but rather had graduated from Harvard Law
School and had spent his early career working in international development.
Two years after assuming his position, he heard a young pediatrician, Dr. Jon
Rohde, then working in Haiti, give a presentation titled “Why the Other Half
Dies.” Dr. Rohde highlighted the potential of selected interventions, most
notably immunizations and oral rehydration solution, to reduce child mortal-
ity in poor countries (Bornstein 2007). John Grant hired Rohde as his spe-
cial assistant and also as the UNICEF representative in India, positions he had
held for more than a decade. Under John Grant’s dynamic global leadership,
with strong technical support from Rohde and many others, UNICEF led the
way to what was then referred to as the Child Survival Revolution, saving
millions of lives through this approach (Taylor and Jolly 1988; Bornstein
2007). One of the outcomes of this emphasis was the joint WHO and UNI-
CEF Expanded Programme on Immunization, which had also been fueled by
enthusiasm surrounding the eradication of smallpox through immunization
in 1978. With the continued recognition of the importance of good nutrition
(and the demonstration of the health benefits of exclusive breastfeeding dur-
ing the first six months of life), the concept of GOBI was established during
the mid-1980s: G stood for growth monitoring, O for oral rehydration for
diarrhea, B for breastfeeding, and I for immunizations.

Selective Primary Health Care and Family Planning

In the 1970s and 1980s, there was focused attention on the perils of rapid
population growth and the need to give priority to family planning programs
over other programs for health. This led to the “verticalization” of family
planning programs. Ministries of health in many countries were forced by
external donors to divide their programs into two “wings”—a health wing
and a family planning wing—so that comingling of donor family planning
funds and their programs could not be “diluted” by funds and programs for
other health-related priorities. Part of the underlying donor philosophy was
that family planning was a higher priority than other programs since invest-
ments in health would only worsen the population explosion by creating
more mouths to feed and more population to reproduce.

‡This is often referred to now as the First Child Survival Revolution in anticipation of
another major push to improve child survival.
§Two Fs were added for food supplements and family planning, and then a later F was
added for female education.
This concept is now known to be shortsighted. Data from the fertility declines in low-income countries in the late twentieth century support a very different concept first enunciated by Taylor and referred to as the child survival hypothesis. It states that women will not have fewer children until they know that the ones they have are going to survive (Taylor, Newman, and Kelly 1976; Connelly 2008). Selective funding by external donors for family planning as well as for GOBI paved the way for addressing subsequent priorities such as HIV/AIDS, malaria, and tuberculosis with highly targeted vertical programs. To global policymakers and donors, the urgency produced by the immediate threat of these three diseases—and particularly HIV/AIDS—outweighed the benefits of long-term investments in comprehensive PHC programming.

The Effect of the Global Economic Recession and National Structural Economic Limitations on the Alma-Ata Movement

The Alma-Ata movement faced a near-fatal setback in the 1980s as a result of the major global recession of that time. Governments of poor countries were unable to meet their debt payments, and the International Monetary Fund along with the World Bank had to step in and provide short-term loans to many countries so they could meet their debt payments. These countries had to agree to structural adjustment policies in order to obtain these loans, as neoliberalism and free-market ideologies (including a reduced role for the state) drove these policies. Among the policies were those that were designed to limit government spending. The end result was reductions in spending on government-funded health care and education (Stubbs et al. 2017). Funds were not available to strengthen and expand PHC services. In this context, selective PHC became the more feasible alternative approach (Packard 2016; Rifkin 2018).

Progress with More Comprehensive Approaches to Community-Focused Primary Health Care during the Past Three Decades

Despite the flourishing of selective PHC since the 1980s and the rapid loss of enthusiasm and funding for comprehensive PHC as envisioned at Alma-Ata, important new approaches have emerged that have gradually gained traction, along with evidence of their effectiveness.
Key Individuals in the Evolution of Primary Health Care

Several important figures played a key role in developing and implementing models of primary health care (PHC). It is important to note the extraordinary influence of Dr. John B. Grant and Mr. James P. Grant, the father-son pair. Many refer to John B. Grant as the father of PHC in its more comprehensive form of preventive and curative services for impoverished populations because of his contributions to the Ding Xian Project in the 1930s, the first PHC project in a developing country using current concepts of PHC. John B. Grant was an important influence in the development of PHC in India through his leadership at the All India Institute of Public Health and his participation on the Bhore Committee.

Dr. John B. Grant’s son, Mr. James P. Grant, was a forceful champion of selective PHC for child survival (Jolly 2001; Bornstein 2007). The school of public health at BRAC University in Bangladesh (oriented to community-based PHC), established in 2004, is named after him. Dr. John B. Grant’s grandson and son of Mr. James P. Grant, also named John Grant, served as the first director of the United States Agency for International Development’s (USAID) Child Survival and Health Grants Program for US-based nongovernmental organizations (NGOs) in the mid-1980s. This program was an influential force in the development of community-based PHC.

Dr. Halfdan Mahler, the Danish physician who served an extraordinary three terms as director general of the World Health Organization (WHO) from, 1973–1988, is widely considered to have been WHO’s most effective director general. Mahler was the champion of the Alma-Ata concept of PHC, with its emphasis on the integration of services, equity, and community participation. The philosophical, as well as the practical programmatic, differences between the selective approach championed by James Grant and the more comprehensive primary approach championed by Halfdan Mahler were apparent and a source of ongoing tension.

Dr. Carl Taylor, who founded the Department of International Health at the Johns Hopkins School of Public Health in 1968, has been called the “acknowledged leader of PHC over the second half of the twentieth century” (Rohde 2002, n.p.). Taylor was a close friend of John B. Grant, Halfdan Mahler, and James P. Grant. He was also, at Mahler’s request, a leader of the 1978 Alma-Ata Conference and one of the authors of the Alma-Ata Declaration. Carl Taylor fully understood and appreciated the tension between comprehensive and selective primary care. Taylor would describe long train rides in China with James Grant where they would debate into the wee hours of the morning the pros and cons of comprehensive and selective approaches. Taylor took great pains to remind James Grant, having known James Grant’s father quite well, that his father would have come down strongly on the side favoring the comprehensive approach (Taylor 2010).

Carl Taylor was a foundational figure in PHC, having started his career as a medical missionary in north India in the late 1940s and soon thereafter teaching at the Harvard School of Public Health while developing pioneering field studies in PHC in north India in the 1950s. In the 1960s, he founded the Department of International Health at Johns Hopkins and left a lasting imprint on the academic discipline we now call international health and, increasingly, global health.
In the 1960s and 1970s, Carl Taylor led one of the first PHC operations research projects of the twentieth century: the Narangwal Project. The Narangwal Project and Taylor’s mentorship together influenced a generation of leaders of PHC—most notably Drs. Rajanikant and Mabelle Arole, Dr. Miriam Were of Kenya, and Drs. Rani and Abhay Bang. Others inspired and influenced by Taylor’s vision of PHC include Dr. Nils Daulaire (who led major global health initiatives at USAID, the Global Health Council, and the US Department of Health and Human Services), Dr. Rudolph Knippenberg (who served for many years as chief health advisor at the United Nations Children’s Fund [UNICEF]), and Dr. Mary Taylor (formerly senior program officer at the Gates Foundation and influential advisor for global health programs).

Dr. Jon Rohde, mentioned previously, is another foundational figure in the global PHC movement, positioned as he was to serve as global advisor for health and nutrition to James Grant and also as UNICEF representative of India from 1982 to 1995. It was his oral presentation and paper that inspired James Grant to pursue the selective approach to child survival, and he has championed child survival through broader approaches to PHC as well over the past half-century. He is the author of many articles and books on topics related to child survival and health for all.

Drs. Rajanikant and Mabelle Arole were a husband-wife team who learned about the Narangwal Project as students at Johns Hopkins, where they were mentored by Taylor. Following their studies at Hopkins, they went off to an isolated area of central India and established a pioneering comprehensive PHC program that was featured in Kenneth Newell’s book *Health by the People* (1975) and was the most influential force for the vision of PHC embodied in the Alma-Ata Declaration. They established one of the first CHW programs in India and led the way with practical approaches to community and women’s empowerment and to addressing the social determinants of health. Their program, the Jamkhed Comprehensive Rural Health Project, was a prototype for and remains one of the best full expressions of PHC as defined at Alma-Ata. Jamkhed is a model of what PHC should be for impoverished populations in the twenty-first century, with activities that qualify for the working redefinition of PHC established for this chapter, including surgical care and inpatient beds at their health center (Arole and Arole 1994; Arole 2002; Perry and Rohde 2019). Carl Taylor continued to visit Jamkhed periodically and took great pride in the work established there and in the influence the program had nationally and internationally. Rajanikant Arole achieved national prominence in health affairs in India and served as the NGO representative of the National Rural Mission upon its establishment in 2005. The National Rural Mission set the policies for the creation of accredited social health activists, which now number one million throughout India. Mabelle Arole later became a regional advisor for UNICEF for South Asia and promoted the Jamkhed model throughout the region.

Drs. Abhay and Rani Bang are a husband-wife team who, like the Aroles, came to Johns Hopkins to study and were influenced by Carl Taylor and the Narangwal Project. They established a pioneering PHC program in
Community-Oriented Primary Health Care

Community-oriented primary health care (COPC) emerged in the 1950s in South Africa as an approach to engage PHC centers and their staffs in proactively addressing the health needs of the community rather than simply attending to patients who come to the facility for care. Through COPC, the community plays a key role in prioritizing health problems and making management decisions, and it encourages medical practitioners to engage with community health problems. It links medical practice with public health.

COPC is defined as a “continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services” (Mullan and Epstein 2002, 1750). COPC has served as the model for the community health center movement in the United States. These community health centers (now called federally qualified health centers) are governed by a local board of directors and provide health care to underserved populations. The community has control over decisions of the health policy development and in 1993 as professor and founding director of the newly established Public Health Program (which has since become the School of Public Health) at the University of Western Cape. He has had a long association with the People's Health Movement, serving as a member of its Global Steering Council. He was a frequent voice at national and international health meetings, pleading for a stronger commitment to the principles of comprehensive PHC as defined at Alma-Ata. He was also a prominent spokesperson for, as well as an activist engaged in, the wider political struggle for improving health and health care for disadvantaged populations and for addressing the broader social determinants of health and the political framework required to achieve that. He is the coauthor of one of the classic books in global health, Questioning the Solution: The Politics of Primary Health Care and Child Survival (1997).
The Jamkhed Comprehensive Rural Health Care Project was founded in 1970 by the physician team Rajanikant and Mabelle Arole. It has focused its work on a comprehensive approach to primary health care (PHC), including multisectoral actions, women’s and community empowerment, and community-based services provided by community health workers (CHWs). It has served as one of the world’s foremost training sites in PHC, with more than forty-two thousand people at all levels from throughout India and more than three thousand people from one hundred countries around the world coming to Jamkhed for short courses during which villagers do much of the teaching (Jamkhed Comprehensive Rural Health Project 2013; Perry and Rohde 2018).

The Society for Education, Action and Research in Community Health (SEARCH) was founded by physicians Abhay and Rani Bang in 1983. It is one of the world’s foremost field research sites on community-based PHC. Its rigorous small-scale studies of community-based management of childhood pneumonia and home-based neonatal care have changed the global landscape of PHC (SEARCH 2013). In addition, their program is the world’s foremost example of the census-based, impact-oriented (CBIO) approach, which is the most promising means for productively engaging the natural and potentially productive tension between vertical and comprehensive approaches to PHC (Perry et al. 1999).

BRAC (established in 1972 as the Bangladesh Rural Advancement Committee) exemplifies the principles of PHC defined at Alma-Ata (see also chapter 7). Operating almost exclusively outside of health facilities at the grassroots level through a multidisciplinary approach with women’s savings and action groups (called voluntary organizations) as the key agents of change, BRAC works in all fields of development, including health, and has become one of the world’s leaders in community-based PHC. I had the special privilege of nominating BRAC for the $1 million annual Gates Award in Global Health, which they won in 2003.

BRAC is now the largest NGO in the world, having learned how to successfully take its programs to scale while at the same time creating mechanisms by which these programs can be largely self-sustained with locally generated income. BRAC is now a global force for poverty alleviation, with programs in eleven countries in Africa and Asia. Its programs reach 130 million people: 120 million in Bangladesh and 10 million in other countries. Its CHW program in Bangladesh has 130,000 Shasthya Shebikas, making it one of the largest CHW programs in the world. BRAC has been a global leader in both selective and comprehensive approaches to PHC, making it an interesting case study from the standpoint of examining the tensions between them. Shasthya Shebikas provide comprehensive, community-based services while linking effectively to vertical disease control programs for immunizations, family planning, nutrition, tuberculosis, and many others (Chowdhury et al. 1997; Perry 2000; Standing and Chowdhury 2008). It now has an exemplary PHC program for mothers and children in the urban slums developed by way of a grant from the Gates Foundation—the Manoshi Project, which also embodies CBIO principles. Of BRAC’s $1 billion budget, 85% is generated internally through commercial
activities owned and operated by BRAC (Chowdhury and Perry 2010).

The People’s Health Movement is a global network bringing together grassroots health activists, civil society organizations, and academic institutions from around the world, particularly from low- and middle-income countries. It has a presence in seventy countries. Its framework for action is its People’s Charter for Health, which endorses the Alma-Ata Declaration and affirms health as a social, economic, and political issue but above all as a fundamental human right. In 2005, when I attended the People’s Health Assembly in Cuenca, Ecuador, Dr. Halfdan Mahler symbolically passed the “Olympic flame” of the spirit of Alma-Ata to the People’s Health Movement—in part an expression of his frustration that WHO had not done more to nurture this flame. The People’s Health Movement has provided an alternative world health report from time to time (in 2006, 2008, 2011, and 2018) called Global Health Watch, which has been influential in highlighting in particular the social and political dimensions underlying the health problems of disadvantaged people in low- and middle-income countries.

The United States Agency for International Development’s (USAID) Child Survival and Health Grants Program (CSHGP) and the CORE Group have together provided a leadership role in forging community-based programming for maternal and child health and for advancing the child survival agenda. The CSHGP, initiated in 1986 following Congress’s historic earmark for child survival funding, supported US-based nongovernmental organizations (NGOs) to implement child survival projects. As mentioned previously, it was initially headed by John B. Grant’s grandson and James Grant’s son, John Grant. Until its termination in 2018, the program provided funding and technical support to US-based NGOs (called private voluntary organizations, or PVOs, by USAID).

Although the amount of money provided annually by the CSHGP was modest and actually declined in real terms over time (it remained constant in US dollars at around $20 million per year), the nature of the program proved catalytic for virtually all of America’s leading NGOs working in global maternal and child health. The process of requiring baseline and household coverage surveys of key child survival indicators, preparation of a detailed implementation plan (based on the results of the baseline household survey), and midterm and final evaluations (based also on follow-up household surveys) led by independent consultants provided NGOs with a new approach to the professionalization of their programming. These evaluations, together with the technical support for interventions available through USAID, led to a transformation of programming for many NGOs, and this approach spread to local NGOs throughout the world who collaborated on these child survival projects.

The project evaluations accumulated by USAID through this program over the past three decades constitute the most extensive library of child survival programming in the world. After decades of experience with these programs, NGOs learned the value of sharing experiences, knowledge, and ideas about how to best improve child survival programming. This was possible in part by attending annual conferences for grant recipients. One individual described the program this way: “What began in this simple spirit of openness quickly gained momentum as participants realized significant savings in time, thought and
resources—all made possible by collaborating.” The group realized that this “community of practice” model was also fertile ground for the creation of new knowledge and ideas as well (CORE Group 2013). This association of NGOs became a formal legal entity in 2000 and called itself the CORE Group (from Collaboration and Resources for Community Health). It committed itself to “technical excellence in integrated, community-based global health programming” (CORE Group 2019, n.p.). The CORE Group is now a global force for community-based PHC through its technical resources that are used widely around the world by programs implementing community-based interventions for maternal and child health. It has created opportunities for networking among program managers and continues the facilitation of sharing relevant programming experiences in community-based PHC. The CORE Group Polio Project, in operation since 1999, has played an instrument role in stopping poliovirus transmission in hard-to-reach and resistant populations such as Uttar Pradesh, India; Angola; Ethiopia; and now South Sudan and Nigeria by pioneering community-based PHC programs that reach every household (Losey et al. 2019). The lessons learned from this experience hold great promise for strengthening health programs in underserved areas around the world (Perry et al. 2019).

National Actors That Have Influenced Primary Health Care

Other chapters in this book cover national case studies of countries that pursued PHC strategies to great results since 1978. Nepal (chapter 9) has been a global leader in the development of community-based PHC services through its cadres of CHWs, most notably female community health volunteers. Progress despite Nepal’s difficult terrain and political instability is noteworthy (BASICS II, the MOST Project, and USAID 2004; Gottlieb 2007; Henry B. Perry 2016; Perry, Zulliger, et al. 2017).

Bangladesh (chapter 7) also developed strong community-based PHC programs that have made possible high population coverage of immunizations, oral rehydration therapy for treatment of diarrhea, and family planning services, among other interventions (Perry 2000; El Arifeen et al. 2013). Bangladesh has also been a global leader in addressing the social determinants of health—most notably by improving the educational status of women.

Rwanda, Eritrea, and Ethiopia are beginning to stand out. Ethiopia’s progress is particularly notable (chapter 8) for its massive expansion of PHC services beginning in 2003 with the training of one full-time, government paid health extension worker for every twenty-five hundred people and one voluntary CHW for every five households. Ethiopia has seen rapid progress in reducing child and maternal mortality as well as controlling HIV/AIDS, tuberculosis, and malaria, and in reducing undernutrition in children, making it one of the few countries in the world to achieve the Millennium Development Goals for Health by the year 2015 (Admasu, Balcha, and Getahun 2016; Admasu, Balcha, and Ghebreyesus 2016; Assefa et al. 2018; Assefa et al. 2019). The Federal Ministry of Health of Ethiopia is now hosting the newly emerging International Institute for Primary Health Care for training delegations from throughout Africa and beyond in strengthening of PHC.
Although they are not covered extensively in this book, Brazil and Thailand are also notable. Brazil is emerging as a global model for PHC for low-income countries. As a low-income country itself fifty years ago, Brazil gradually built a PHC program that has been effective in making services available to its population and in achieving equity and proactive preventive services through home visits to every household by CHWs who work as members of family health teams based at health centers (Rice-Marquez, Baker, and Fischer 1998; Jurberg and Humphreys 2010; Kleinert and Horton 2011). Brazil has had one of the most rapid declines in under-5 child mortality in the world and has achieved one of the most equitable distributions of health service coverage and health status among low- and middle-income countries. Its CHW program is now the model for South Africa’s new CHW program, and this influence will likely spread throughout southern Africa. As an example of its commitment to equity and PHC, Brazil’s government was one of the first to ensure free universal access to treatment for HIV/AIDS with antiretroviral medication.

Thailand ranks first among low-income countries (those with a gross national income of less than US$5,000 per person) in terms of progress in reducing its mortality among children younger than 5 years of age (Rohde et al. 2008). It achieved all of the Millennium Development Goals in the early 2000s. This extraordinary success was achieved during a time of rapid economic development, so expanded funding for health services was available. All interventions were fully integrated into a PHC network and were implemented through district health systems, with ten to twelve health centers in a health district each serving five thousand people. Nurses and public health workers are the backbone of the rural health system and provide community-based services, including home visits, with a strong emphasis on health promotion and prevention (Patcharanarumol et al. 2011).

Beginning with the previously mentioned case studies in the WHO book *Health by the People*, there has been a gradually accelerating accumulation of evidence and experience demonstrating that services provided in the community outside of health facilities, either alone or in coordination with facility-based care, can be effective in improving health. Perhaps the most...
important pioneering field research study of this type was the Narangwal Project (1967–1973) in rural north India. The Narangwal Project was a four-cell experimental design that tested various combinations of program interventions for improving maternal and child health using community-based workers and engaging in a collaborative partnership with the community (Kielmann et al. 1983; Taylor et al. 1983). This was one of the first (in a group of only ten) projects constituting the world’s evidence at that time, reported by Davidson Gwatkin, Janet Wilcox, and Joe Wray in 1980, showing that child mortality and nutrition can be improved through PHC interventions if they have a strong outreach component that reaches a high proportion of the target population.

The Narangwal Project either directly or indirectly spawned other seminal field projects and research activities that have demonstrated the power of community-based PHC. Notable scions include the Jamkhed Comprehensive Rural Health Project, established in 1970, and the SEARCH Project in Gadchiroli, established in 1985. The Jamkhed Project was one of the archetypes for the Alma-Ata Conference described in WHO’s Health by the People, published in 1975. Jamkhed used community participatory approaches, including illiterate village health workers, to make dramatic health gains in a short period of time, including a decline in the infant mortality rate from 176 deaths per 1,000 live births to 20 deaths per 1,000 live births (Arole and Arole 1994; Perry and Rohde 2019). SEARCH carried out some of the first studies demonstrating the effectiveness of using illiterate CHWs to diagnose and treat childhood pneumonia and provide home-based neonatal care (Bang et al. 1990; Bang et al. 1999; Bang, Bang, and Reddy 2005).

Community-based work in Haiti at the Hospital Albert Schweitzer (Berggren, Ewbank, and Berggren 1981) and in Bolivia through the Andean Rural Health Project, now Curamericas Global (Perry et al. 1998; H. B. Perry, Shanklin, and Schroeder 2003), in the 1970s and 1980s led to the emergence of the census-based, impact-oriented approach to PHC (Perry et al. 1999), which attempts to find a “middle way” to respond to both the broad health needs within a population and the epidemiological priorities in a way that can achieve measurable results (Mosley 1988). The CBIO approach gave prominence to the process of mapping and identifying homes and inhabitants in a defined program area, home visitation, surveillance and registration of vital events, and provision of health education and health services in the home or nearby—approaches that are now widespread, including application on a national level in Ethiopia, a country of one hundred million people.
CBIO provided a foundation for the emergence of the Care Group model, an approach to community-based PHC in which a low-level health promoter meets every two to four weeks with groups of women volunteers who then share an educational message with ten or so households for which they are responsible. This approach, utilized in more than thirty child survival projects around the world, has shown marked expansion of coverage of key child survival interventions, reductions in under-5 mortality, and improvements in child undernutrition (Edward et al. 2007; Perry et al. 2010; Davis et al. 2013).

Similar to the Care Group model are widespread women’s groups practicing participatory learning and action (PLA). PLA groups have now been tested in a series of randomized-controlled trials. A meta-analysis of these studies demonstrates substantial reductions in maternal and neonatal mortality (Prost et al. 2013). Community-based approaches have a firm evidence base as part of effective health programming in resource-constrained settings (Rohde and Wyon 2002; Rosato et al. 2008; Black et al. 2017). Community-based approaches also have the added benefit of strengthening community accountability and making programs more responsive to community needs.

Over the past three decades, there has been extensive experience in implementing community-based child survival projects led by nongovernmental organizations (NGOs) working in collaboration with ministries of health but working alongside them rather than through them. This has produced a rich experience of community-based approaches that have produced dramatic improvements in coverage of key child survival interventions. Unfortunately, even though these projects often undergo rigorous evaluations, only a few of these have been published in the peer-reviewed literature (Perry et al. 1998; Perry, Shanklin, and Schroeder 2003; Edward et al. 2007; Davis et al. 2013; Ricca et al. 2013).


The Alma-Ata Declaration called for services to be provided “as close as possible to where people live and work,” and for services to be provided by health teams composed of “physicians, nurses, midwives, auxiliaries and
community workers as applicable, as well as traditional practitioners as needed.” This gave impetus for the development of national-level CHW programs in a number of countries across Africa and South Asia. Unfortunately, for multiple reasons including poor selection of CHW candidates, inadequate training and supervision, and a decline in public sector funding during the 1980s, many of these programs failed, leading to a loss of enthusiasm thereafter.

However, with the growing scientific evidence of the capacity of CHWs to reduce under-5 mortality through interventions such as home-based neonatal care (Lassi, Haider, and Bhutta 2010) and community case management of pneumonia, diarrhea, and malaria (Young et al. 2012), and with the growing realization that countries such as Brazil, Bangladesh, Nepal, and Ethiopia are making strong progress in reducing child mortality through the development of strong CHW programs, there has been justifiably renewed interest in CHWs and in scaling up national CHW programs. A high-level push is now underway for deploying one million CHWs in rural Africa, one for every 650 rural inhabitants (Singh and Sachs 2013).

The Growing Recognition That Facility-Based Care Alone Will Not Accelerate Progress in Achieving Health Gains

One important theme to emerge during the first decade of the twenty-first century has been the limitation of health facilities by themselves to improve the health of impoverished populations where resources are scarce. The Integrated Management of Childhood Illness was a major effort of WHO and UNICEF in the late 1990s and early 2000s to develop a scientific basis for health workers at peripheral facilities to diagnose and treat childhood illness (World Health Organization 2013). This was an attempt to integrate several vertical child health programs sponsored by external donors, most notably the control of acute childhood respiratory diseases and diarrheal diseases. IMCI attempted to bring in nutritional counseling as well as recognition and treatment of childhood undernutrition, although it was obvious to those who worked in field settings that facility-based programs were not going to be effective without a strong community-based component since in the great majority of settings the utilization of services at facilities would never achieve high levels of population coverage of key child survival interventions. It has been widely known and demonstrated since the 1960s that the rate of utilization of health facilities decreases exponentially with one’s distance from the facility (King 1966). Nevertheless, the underlying philosophy at WHO seemed
to be that if the quality of facility-based services for treatment of childhood illness could be improved, then families would seek out care for their sick children at these facilities, thereby reducing under-5 mortality rates.

This hypothesis was put to a rigorous test in a twelve-country study of IMCI led and funded by WHO and UNICEF in the late 1990s and early 2000s. As this effort was moving forward, the NGO child survival community (and in particular NGOs supported by the United States Agency for International Development’s Child Survival and Health Grants Program) had experienced success with community-based approaches in child survival programming, resulting in what today is referred to as C-IMCI, or community-based IMCI (Winch et al. 2002).

The findings from a $10 million evaluation of the IMCI Program in twenty-one countries were finally published in 2005 and demonstrated no impact on under-5 mortality, though the quality of care provided at facilities did improve, and the cost per illness treated was lowered (Bryce and Victora 2005; Bryce et al. 2005). The community-based component of IMCI was never well implemented during the twelve-country study, and enormous obstacles were encountered in the training of health care providers and supplying them with the needed medicines.

This and the broader lack of evidence for the effectiveness of strengthening facility-based care in improving population health further reinforced the importance of community-based approaches in improving population health. As further research on these issues has progressed, the unwillingness of parents to take sick children to health facilities has become increasingly apparent. One recent randomized trial has demonstrated that outcomes are better when sick children meeting the criteria for referral are treated by CHWs in the community (Bari et al. 2011). The explanation for this is twofold: (1) the additional time lost in obtaining care at a facility leads to a lower chance of success if the child’s condition is worsening rapidly, even with high-quality care, and (2) the (presumed) improved quality of care obtained at a facility does not provide that much additional benefit over the quality of care provided by a properly trained and supported CHW. The most current available evidence now indicates that the expansion of community-based platforms for delivery of interventions that have been demonstrated to be effective outside of health facilities provided by community-level workers would save 2.3 million lives of mothers and their offspring per year globally compared to 0.8 million lives by expanding the coverage of services that can be provided in health centers and 0.9 million lives by expanding the coverage of services in hospitals (Black et al. 2016; Black et al. 2017).
The Selective versus Comprehensive Primary Health Care Debate

The debates of the past three decades between those who favor selective vertical approaches to PHC and those who favor comprehensive horizontal approaches have been bitter, with those who give priority to impact and cost-effectiveness favoring the former and those who give priority to community participation and responding to the interests and needs of communities favoring the latter (Hall and Taylor 2003; Cueto 2004; Magnussen, Ehiri, and Jolly 2004). But, of course, both approaches are essential, though unfortunately most donor and high-level technical support has gone to selective vertical approaches.

In an address in 2009, Dr. Margaret Chan, director general of WHO, stated: “I think we can now let a long-standing and divisive debate die down. This is the debate that pits single-disease initiatives against the agenda for strengthening health systems. . . . As I have stated since taking office, the two approaches are not mutually exclusive. They are not in conflict. They do not represent a set of either-or options. It is the opposite. They can and should be mutually reinforcing. We need both” (Chan 2009).

Trying to find ways of building on the best of both approaches (e.g., through “diagonal” approaches) has been an important theme in the literature over this time (Mosley 1988; Taylor and Jolly 1988; Sepulveda et al. 2006; Taylor 2010). As discussed in detail in chapter 4, which looks at the particular case of polio control, there is deep complementarity between vertical and horizontal approaches, and both have to be pursued. The donor-led interim emphasis on selective interventions instead of comprehensive PHC (Walsh and Warren 1979) is increasingly giving way to the compelling logic for simultaneously pursuing both vertical and horizontal programs to achieve the synergy.

The Movement for Universal Health Coverage: Implications for Primary Health Care

UHC is a growing global movement called for initially by the World Health Assembly in 2005. As defined by World Health Assembly Resolution 58.33 (2005): “Universal coverage is defined as access to key promotive, preven-

tive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of health for all and primary health care” (World Health Assembly 2005). The connection of the concept of UHC to PHC with the Alma-Ata Declaration and the goal of Health for All is obvious from the aforementioned quotation, which comprises the first words of the World Health Assembly resolution. The previous full definition expresses a concept of comprehensive coverage because the interventions are “promotive” and “preventive” as well as curative.

This movement is, in principle, “a fairer, more efficient financing that pools risk and encourages prepayment to share health-care costs equitably across the population” (Latko et al. 2011, 2162). As Frenk and de Ferranti (2012) observe: “Universal health coverage sits at the intersection of social and economic policy. Introduction of reforms that promote universal coverage is not only the right thing to do on ethical grounds; it is also the smart thing to do to achieve economic prosperity. The paradox of health care is that it is one of the most powerful ways of fighting poverty, yet can itself become an impoverishing factor for families when societies do not ensure effective coverage with financial protection for all” (863–864).

UHC has been called the “third global health transition,” following the demographic transition (when low mortality and fertility rates replace high mortality and fertility rates) and the epidemiologic transition (when the burden of noncommunicable diseases and conditions grows as the burdens of infectious diseases and maternal/neonatal conditions diminish) (Rodin and de Ferranti 2012).

The movement for UHC is deeply embedded in Article 25 of the Universal Declaration of Human Rights, which proclaims that everyone has the right to a standard of living adequate for health, including medical care, and the right to security in the event of sickness or disability (United Nations General Assembly 1948). It is also deeply embedded in WHO’s constitution, which states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (World Health Organization 1948).

The movement for UHC has the potential to provide more funds for PHC services; improve the fairness of funding a collective public good; reduce the
potential for unjust economic setbacks as a result of expenditures for health care, particularly among the very poor; and, most importantly, expand access to primary health care. For the foreseeable future, it is impossible to envision how UHC can, in fact, be meaningfully achieved without a full-fledged expansion of CHW programs in low-income settings, where it will take more than a generation (if not two or three) to overcome the existing shortages of health care professionals, their concentration in more urban settings, and the great distances that people living in rural areas often have to traverse to reach a health facility.

In practice, many of the subsequent speeches, symposia, and studies on UHC have subtly altered the emphasis of the movement, reducing the definition to coverage with financing for curative and individually delivered services of health care. The original and full definition of coverage, which includes population-level, multisectoral, community-based health promotion and prevention, is very much aligned with the comprehensive PHC approaches described throughout this book.

Current Controversies and Challenges Facing Primary Health Care

As is readily apparent from the history presented previously, the quest to achieve Health for All through PHC has faced an abundance of controversies and challenges. Many of these persist presently, and new ones are emerging. What follows is a selective set of the most pressing questions.

To What Extent Can a Core Package of Primary Health Care Functions and Activities Be Identified?

The concept of UHC implies a need to define the package of promotive, preventive, curative, palliative, and rehabilitative services to include. How might one go about defining such a core package? The most logical ways to approach a problem like this were pioneered by Dr. John Wyon in north India in the 1960s (Wyon and Gordon 1971), Carl Taylor in north India in the 1970s (Kielmann et al. 1983; Taylor et al. 1983), Rajanikant and Mabelle Arole in central India in the 1970s (Arole and Arole 1994), Drs. Warren and Gretchen Berggren in Haiti in the 1970s (Berggren, Ewbank, and Berggren 1981), Abhay and Rani Bang in central India in the 1980s (Bang et al. 1990), and Dr. Henry Perry in Bolivia in the 1980s (Perry et al. 1999). This approach is now called the CBIO approach (Perry and Davis 2015). It involves the de-
Development of a partnership between a health program and a population, using local surveillance carried out by routine home visits to define epidemiological priorities (the most frequent, serious, readily preventable or treatable conditions in the population) and to help the communities in the population identify what their health priorities are. Unsurprisingly, almost always in low-income settings, the community’s health priorities revolve around improving curative care services. Then, with the available resources (financial, infrastructure, and human), a plan is developed with the community that addresses program priorities, which are a combination of epidemiological and community-defined priorities. Thus, the actual content of the services would vary from place to place and over time, depending on the local situation.

But even within this framework, is there still an essential set of services that should comprise the core of PHC. Table 1.1 is an attempt to define this core starting point of a community’s deliberation on priorities. Strategies for working with communities to define local priorities based on locally available resources and local health needs, and strategies for working in partnership with communities to make these services universally accessible (through shared financing, community mobilization, and utilization of CHWs and participatory women’s groups) are still poorly developed in most low-income settings. Further development of these strategies and assessing their effectiveness in typical field settings represents one of the great frontiers in PHC for the twenty-first century.

The Neglected Demand-Side Solutions to Strengthening Primary Health Care

The lack of a consumer orientation to the provision of health services in low-income countries, especially those services provided by ministries of health, has often led to a lack of compassionate care and, not surprisingly, marked dissatisfaction in and distrust of health systems, particularly among the poorest inhabitants of low-income countries. In large health care organizations, and particularly those operated by ministries of health, there has been too often a lack of local accountability, leading to absent staff, frequent staff turnovers, lack of supplies and equipment, and so on.

The concept of community participation in PHC is strongly emphasized in the Alma-Ata Declaration, with its call for the following:

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.
Table 1.1. A proposed set of core primary health care services for disadvantaged communities in low-income countries

Core Preventive Primary Health Care Services
- Immunizations promoted by WHO
- Micronutrient supplementation
- Antenatal care
- Detection of hypertension in adults
- Screening for HIV, tuberculosis, and syphilis
- Distribution of insecticide-treated bed nets in malaria-endemic areas and intermittent preventive treatment of malaria in pregnant women and children
- Promotion of good dental health

Core Promotive Primary Health Care Services
- Promotion of good nutrition (exclusive breastfeeding during the first six months of life, appropriate complementary feeding after six months of age, and so forth)
- Promotion of handwashing, access to clean water and sanitation
- Promotion of healthy household behaviors for good maternal and child health, in addition to promotion of good nutrition (promotion of importance of birth spacing, household cleanliness, and warning signs of pregnancy and serious childhood illness, for which care should be sought)
- Promotion of smoking cessation, weight reduction for those who are obese, and physical activity for those who are sedentary

Core “Curative”* Primary Health Care Services
- Diagnosis and treatment of common ailments and conditions (e.g., eye and skin infections, acute respiratory infection, and diarrhea) and pain management
- Management of serious childhood illness
- Management of serious mental illness
- Initial management of obstetrical complications (removal of retained placenta, management of preeclampsia, and initial management of eclampsia, obstructed labor, postpartum hemorrhage, and puerperal sepsis)
- Provision of first-line family planning services (oral birth control pills, condoms, injectable contraceptives, contraceptive implants)
- Recognition of and referral of life-threatening conditions to a higher-level facility
- Continued treatment and management of conditions of patients referred down from a higher-level facility for ongoing follow-up care

Core Rehabilitative Services
- Physical therapy for those recovering from injury
- Assistance to those in the community with long-term disabilities (e.g., blindness, deafness, limb loss, mental retardation, and congenital deformities) and to their families

*Putting curative in quotation marks serves to highlight the fact that not all conditions will be curable—whether it is HIV infection, hypertension, some forms of mental illness, and so forth.
Primary health care is essential health care . . . made universally accessible to individuals and families in the community through their full participation 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.

Primary health care . . . requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care . . . and to this end develops through appropriate education the ability of communities to participate.

Primary health care . . . relies . . . on health workers . . . suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community. (World Health Organization and United Nations Children’s Fund 1978)

Community-oriented PHC is a pillar of PHC, and this involves working in partnership with communities to help them improve their health.

Roles of More- and Less-Qualified Personnel

The 1978 Alma-Ata Declaration calls for the inclusion of the full spectrum of PHC providers, from mothers in the home to CHWs, auxiliary workers, nurses, and physicians. In resource-constrained settings, and even in resource-rich settings such as the United States, the team approach to provision of health services leads to the best-quality services and to the most cost-efficient use of available resources. (Even in the United States, inequities in health status and in the utilization of health services has led to a recent and rapid growth in the use of CHWs [Perry, Zulliger, and Rogers 2014]). The global experience now is vast in the suitability and advisability of delegating to lesser-trained staff many tasks and responsibilities that were once the sole purview of physicians or graduate nurses. WHO recently convened a task force to recommend which tasks for maternal, neonatal, and child health could be safely and appropriately delegated to lower-level staff, including CHWs (Dawson et al. 2014). Although not without controversy still, the weight of the evidence continues to strongly support the full engagement of carefully selected lower-level workers to carry out many well-defined tasks and responsibilities as long as these persons are carefully trained and well supervised.
Remuneration and Other Incentives for Frontline Workers

The remuneration of frontline health workers is a current source of controversy, particularly with respect to whether it is appropriate for health programs to engage CHWs on a voluntary, nonsalaried basis. Although the amounts of money paid to frontline workers are modest, the vast numbers of these workers mean that the implications of these policies are substantial, especially when the funding comes from a central government source. On the one hand, there is the charge that engaging CHWs without remuneration is unjust exploitation, while, on the other hand, there is the reality that communities have people who are eager to serve their neighbors on a voluntary basis. If funding scarcity were not a problem, then payment would, of course, be desirable. However, there are examples of CHW programs that made initial commitments to pay their workers but then could not maintain that commitment, leading to a crumbling of the program. This happened in Nepal in the early 1980s, and later these workers, who had become inactive, were recruited back as female community health volunteers. If the creation of an expectation for a salary is established and then the program cannot sustain that expectation over time, the program is worse off than if it had originally started with volunteer CHWs who had no expectation of a salary.

In NGO child survival programs, there are many examples of volunteer CHWs who receive no formal salary but who receive some kind of “incentives”—special recognition from the community, release from certain community responsibilities, special privileges in accessing health services, and so forth. The most balanced approach to this issue is to not expect from volunteers more than a modest amount of work (e.g., no more than four to five hours per week) and, if ongoing financial remuneration is to be provided, to be confident that this support can be maintained on a sustainable basis.

In 2019, WHO released guidelines to countries for CHW programs that include, among other things, recommendations regarding remuneration of CHWs. WHO has proposed that CHWs be remunerated “with a financial package commensurate to the job demands, complexity, number of hours, training, and roles that they undertake” (Cometto et al. 2018; World Health Organization 2018c). Another important recommendation related to remuneration is that CHWs should not be paid exclusively or predominantly according to performance-based incentives because current evidence indicates that such a policy leads CHWs to focus on those aspects of the work related to remuneration and to neglect other important activities that are not tied to remuneration.
Impact of Global Trends on the Evolution of Primary Health Care for the Disadvantaged in Low-Income Countries

Anticipating the specific influences of global forces and trends on PHC is, of course, impossible, but we can be sure of a few things. For example, more and more of the disadvantaged in low-income countries will be living in urban slums, and technological advances will bring new diagnostic and laboratory tests within the reach of low-cost PHC programs. Innovations like mHealth will make it easier for people to receive useful health-related messages, for people to communicate with their health care provider, and for different members of the health team to communicate among themselves, with great potential for improving the quality of care. As the population ages, chronic, noncommunicable diseases will increasingly dominate the burden of disease. AIDS will have become a chronic disease, and PHC will be increasingly focused on care of the elderly. Socioeconomic development will lead to higher living standards and higher educational levels, and this will increase the demand for and consumption of PHC services. Continuing improvements in the educational level of women and their level of empowerment will also produce an increase in the demand for and the consumption of PHC services.

Toward a Rebirth and Revisioning of Primary Health Care

In recent scholarship related to PHC, there is a persistent theme: The concept of PHC as articulated at Alma-Ata is valid and needs to be maintained. But at the same time, there is a broadly held view that we are now at a time for a renewal and revitalization of PHC and perhaps even a redefinition of PHC for the twenty-first century, leading to a full-fledged fulfilment of the ideas that emerged at Alma-Ata.

In recognition of the twenty-fifth anniversary of the Alma-Ata conference, which took place in 2003, the Pan American Health Organization convened a series of events and dialogues culminating in a 2007 position paper on renewing PHC in the Americas. Their report states that there is “a growing recognition that PHC is an approach to strengthen society’s ability to reduce inequities in health; and a growing consensus that PHC represents a powerful approach to addressing the causes of poor health and inequality” (Pan American Health Organization 2007, 2). In celebration of the thirtieth anniversary of the Alma-Ata Declaration, The Lancet published a series of papers titled “Alma-Ata: Rebirth and Revision.” The lead editorial by The Lancet team stated that “the Alma-Ata Declaration revolutionized the world’s
interpretation of health. Its message was that inadequate and unequal health care was unacceptable: economically, socially, and politically” (“A Renaissance in Primary Health Care,” 2008, 33).

Dr. Margaret Chan, then director general of WHO, in her lead editorial to the series, remarked: “With an emphasis on local ownership, primary health care honoured the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them” (Chan 2008). One of the articles in the series expressed the same idea this way: “The very idea of health for all energised workers and fueled new efforts in many countries to improve service coverage, especially for previously underserved communities. The inherent focus on equity, the necessity of reaching the unreached and involving them not only in the benefits of health care, but more importantly, in the decisions and actions that collectively make health, was at once novel and revolutionary. Thus, the precepts of social justice became an integral part of health planning” (Lawn et al. 2008, 919).

The 2018 Astana Conference marked the latest rededication to the principles of PHC. During Astana’s closing plenary, Dr. Carissa Etienne, director of PAHO and regional director for the Americas of WHO, drew a standing ovation with her resounding injunction: “Ladies and gentlemen, primary health care must form a central part of the strategy for transforming health systems to achieve universal access to health and universal health coverage” (Pan American Health Organization 2018). In his address to the World Health Assembly in 2019, Dr. Tedros Adhanom Gebreyesus, director general of WHO, affirmed the centrality of PHC for achieving Health for All (Tedros 2019):

The Declaration of Astana, endorsed by all 194 Member States last year, was a vital affirmation that there will be no UHC without PHC. Primary health care is where the battle for human health is won and lost. Strong primary health care is the front line in defending the right to health, including sexual and reproductive rights. It’s through strong primary health care that countries can prevent, detect and treat noncommunicable diseases. It’s through strong primary health care that outbreaks can be detected and stopped before they become epidemics. And it’s through strong primary health care that we can protect children and fight the global surge in vaccine-preventable diseases like measles. . . . Of course, strong primary health care depends on having a strong workforce, working in teams. Doctors, nurses, midwives, lab technicians, community health workers—they all have a role to play.”
At that same meeting, the World Health Assembly passed a historic, first-ever resolution on CHWs (World Health Assembly 2019). This resolution recognizes the essential role the CHWs play in delivering PHC and calls for further development of CHW programs, better integration of these programs into health systems, and stronger support for CHW programs from health systems. Of particular note is that this resolution also calls for strong efforts at monitoring and evaluating CHW programs “in order to ensure a strong evidence base for their promotion” (World Health Assembly 2019).

Now is the time to convert this rhetoric into a genuine renaissance in PHC to better serve the disadvantaged in low-income settings. PHC is the means for achieving the highest attainable standard of Health for All people, and now, as the world celebrates the fortieth anniversary of the Alma-Ata Declaration, is the time for a renewed focus on the principles outlined at Alma-Ata. Health for all—the elimination of disparities in access to health services and in health status—was not achieved by the year 2000 and may not be achieved by the year 2100, but it will eventually be achieved. This a common quest that all humanity shares.

REFERENCES (SEE PAGE 341 FOR FULL CITATIONS FOR BOXED TEXT)


Primary Health Care 55