Editorial
A Rejuvenation of Primary Health Care

GuptaSN*, Gupta Naveen, Gupta Shivani*****

Abstract

Primary health care refers to the essential health care provided as the basic level of effective contact between the individual and the health care system. Globally, we have built a strong health care system, and have achieved a level of health of which we are all proud. A majority of prevailing health problems can be satisfactorily prevented and managed, with approaches to a spectrum of services beyond the traditional health care system that play a part in health, including income, housing, education, and environment. This approach represents a philosophy of health care and a model for providing health services.

Keywords: Primary health care; Infant mortality rate; Holistic approach; Alma Ata.

At Alma Ata in Kazakhstan in 1978, experts from 180 countries participated in international conference on **Health for all through primary health care (HFA through PHC).** At this conference medical, public health and global policy experts proclaimed: *that health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity*.[1]" In its boldness, the Declaration, asserts the **Director-General of the WHO Dr. Margaret Chan,** "articulated primary health care as a set of guiding values for health development, a set of principles for the organization of health services and a range of approaches for a addressing priority needs and the fundamental determinants of health.[2]" It also means that the whole person is treated, *not just the disease-a holistic approach.* Among the contributors to this groundbreaking document was **Dr. Carl Taylor[3,4]**. Now I will discuss about the **three specific actions/challenges** as examples that need to be to undertaken that I am going to undertake while working for accomplishment of HFA through PHC.

(A) Action One: Presently, I am working as a medical faculty in government medical training and research institute in Himachal Pradesh. National Rural Health Mission (NRHM) was launched in India in 2005 and it covers the entire country with special focus on 18 States including Himachal Pradesh. Despite best health indicators, Himachal Pradesh has been included in NRHM because of High Infant Mortality Rate (IMR) (51/1000 Live births) and High Maternal Mortality Rate (MMR) (200/100, 000 Live births) while as per NRHM goal, IMR needs to be 30/1000 live births and MMR as 100/100,000 live births. In order to slash down IMR and Neonatal Mortality Rate (NMR) in the state, we studied the **SEARCH MODEL-Neonates in Gadchiroli-Field Trial in Home based New Born Care (HBNC) by Bhang et al published in Lancet.** In Himachal Pradesh, out of 45 deaths 36 are neonates; hence if we want to bring down IMR we will have to bring down NMR. A neonate is 59 times at higher risk of death compared to a child (under five). The main causes of the neonatal

Author's Affilation: *Epidemiologist in Charge, District Chamba cum Faculty, Regional Health and Family Welfare Training Centre, (RHFWTC), Chheb, Kangra, Himachal Pradesh, India, **Freelance researcher in Epidemiology, Kangra, Himachal Pradesh, India, ***Free lance researcher in infectious diseases and food technology, SU, Solan, Himachal Pradeash,

Reprint's request: Dr SN Gupta, *Epidemiologist in Charge, District Chamba cum Faculty, Regional Health and Family Welfare Training Centre, (RHFWTC), Chheb, Kangra, Himachal Pradesh, India.

E-mail: drsurendernikhil@yahoo.com

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mortality are pre-term babies, birth asphyxia, sepsis and hypothermia. 35% deliveries are home based and women are discharged within 48 hours. Not only there is scarcity of pediatricians but also non availability of neonatal services at village level also exists. Therefore, we, 45 national trainees got ourselves along with our two streams of senior health educators and supervisors trained at SEARCH-Gadchiroli in the marginalized communities. One stream of trainees was from health department and second one from Integrated Child Development System (ICDS) for two months in two different spells in a year. So in HBNC, 4 persons are most important from Community and our health system: *Mother, TBA, Link worker and Supervisor.* The link workers would be trained for examination of new born, high risk assessment, wrapping, weighing the neonate in blanket and correct method of breast feeding. Besides these, she would also manage pre-term baby, low birth weight baby, hand washing, handling of baby, counseling of mother for breast feeding, nutrition and family planning. (Bangladesh Rehabilitation Assistance Committee) **BRAC-Manoshi Project_CBIO** (Census-Based, Impact Oriented Methodology) **in Bangladesh** is also successful example. We will train 12 batches of twelve officers of all the 12 districts of the state including chief medical officer (one from each district), district health officers (one from each district and block medical officers (6) and senior medical officers (7) on fortnightly basis. In return, they train medical officers / paramedics at block level and downwards with **film shows on pediatric care for the community**. His concept-**"Think locally and act globally"** will generate results.

(B) **Challenges/Obstacles:** Since the workers have been taken from the two different departments, problems of **unity of commands** from the higher officers and submission of compliance report are getting worsened. Monitoring and supportive supervision is becoming causality in the whole exercise. To settle it out, joint nodal officers are being suggested in the areas after multiple rounds of secretarial level meeting of the two departments.

(C) Action Two: Again to reduce the IMR, MMR and Total Fertility Rate (TFR) in a highly populous country like India. It is exceedingly important to tap energy of the vibrant adolescents-**demographic bonus-**30% of the total 1.21 billion populations. That is why; we need to invest heavily (i) to reduce morbidity and mortality in adolescents; (ii) to impact National indicators like high TFR (19%), MMR (13%) IMR and arrest HIV epidemic (50%) (iii) A healthy adolescent grows into a healthy adult, physically, emotionally and mentally-maximize potential and productivity (iv) Economic benefits: Increased productivity, averting future health costs of treating AIDS, tobacco related illness, life-style related illness. Adolescent Friendly Reproductive and Sexual Health Services (ARSH) is the right adolescent specific option for **empathizing** the community as well as the serving personnel to deal with their teenager patients. The *principle objectives* of this training would be to **(a)** equip the health providers with knowledge and problems of adolescence like growth spurt, menstruation, night emissions, masturbation etc; and **(b)** to sensitize as well as empower the health providers to impart the adolescent friendly health services and teen clinics. We would arrange 60 trainings for this year; 30 batches of teachers and senior class students and NGOs; 20 batches of paramedics and 10 batches of medical officers (20 participants each batch). There would be five sets of evaluation team in the last quarter of the year to actually observe the changes in the community through **teen clinics**.

(D) Challenges/Obstacles: Our experiences highlight that reproductive and sexual health concerns in the adolescents are still very sensitive issues in the community. Even educated people like teachers still shy away discussing the details with their students despite being trained. Rural elders in the community feel offended on this subject. The issues need to be addressed **emphatically** and most of the times, in **privacy and confidentiality**.

(E) Action Three: Routine Immunization is one of the most cost effective public health interventions and was first introduced in India in 1978 at Alma Ata Conference as Expanded Program of Immunization after successful eradication of smallpox. Initially, BCG, DPT, OPV, Typhoid were introduced and limited to mainly urban areas. In 1985, Universal Immunization Program was introduced and subsequently, expanded to entire country. Measles was added. There was close monitoring of <1 yr age group. The National Family Health Survey (2005- 06) reported that only 43.5% of children in India are fully immunized. While Routine Immunization has played a significant role in preventing childhood deaths and disability, thousands of children in India continue to die from vaccine-preventable diseases each year. Three days refresher courses in immunization for health care workers (50 batches with 20 participants in each course) were planned every week for six months with film shows for community.

(F) Challenges/Obstacles: Improper cold chain maintenance at the peripheral levels, especially in remote mountainous areas. Many outbreaks of VPDs like measles / mumps measles have been observed in many districts. Safe injection practices coupled with inadequate disposal of biomedical waste products are challenging fields. Refresher trainings will address the issues.

These above noted examples have only highlighted as to how we can plan and implement HFA_PHC in our places and communities slowly and gradually. Rome was not built in a day. It was a gradual process. Similarly, in line to what action plans have displayed and in Watershed conference, It was conclusively deduced that the "top-down, medical model of **curative care** was not relevant for **80% of the world's population**" and therefore, the healthcare net ought to be widened to incorporate preventive, promotive and rehabilitative services. Alma Ata label for PHC meant comprehensive (Horizontal) care but it became selective (Vertical) in 1984 due to the changing perception of donors, for example, the Bill Gates Foundation opted to focus on one global health issue at one time- eradication of Polio. Second well-known example of the selective PHC approach is the child survival revolution, championed by Jim Grant. But now PHC is shifting towards combining the strengths of both approaches in health systems.

In terms of the history of PHC, Ding Xian project in China that later formed the basis of Chairman Mao's **"Barefoot doctors"** concept. The foundational projects like **Kark et al in Pholela, South Africa** and the Narangwal project in India aimed at improving the health of the communities and populations using approaches that sort to "engage communities as *partners and promotes community empowerment* by linking a 'top-down' with a 'buttom-up' approach. These were followed up with insights on modern PHC practices and principles shared by Dr. Henry Perry. Besides, there were proofs of several success stories of PHC projects embarked on in different parts of the world as demonstrated by *Tiyatien Health in Liberia by Raja Panjabi; SEARCH_CBIO by Bhang; Jamkhed_Arole-CRHP in India; Gambia Case Study in West Africa; BRAC-CHW self financed model by Bangladesh Vs Brazil government model for South Africa. John B. Grant, father of PHC*, summarized selected papers in the 1963

book *"Health Care for the Community,"* called *"Bible" of Primary Health Care. Feeling extremely concerned* for qualified doctors to actually visit the villages in the developing countries, Carl has rightly said**," There is no universal solution, but there is a universal process to find an appropriate local solution"?[5]**

Conclusion

In brief, to achieve the goal we need to revitalize the original revolutionary tenets of the Alma-Ata Declaration, sticking consistently to the core values of universal access for care, equity, community participation, intersectoral collaboration and blended use of both approaches. The success stories of various PHC models used as illustrations should give very good hopes for several developing countries and hence should be replicated in several of these countries. Like the first primary health-care revolution, this will take champions—as **Mahler** said at the 2008 World Health Assembly *"unless we all become partisans in renewed local and global battles for...equity...we shall indeed betray the future of our children and grandchildren."* Similarly, **Mary Chan** in her editorial in the Lancet of 2008 corroborates *"a renaissance in primary health care".*

Dr SN Gupta,
Epidemiologist in Charge,
District Chamba cum Faculty,
Regional Health and Family Welfare Training Centre, (RHFWTC),
Chheb, Kangra,
Himachal Pradesh, India.
E-mail: drsurendernikhil@yahoo.com

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