Annex X

Primary Health Care, Community Health, and Community Health Workers

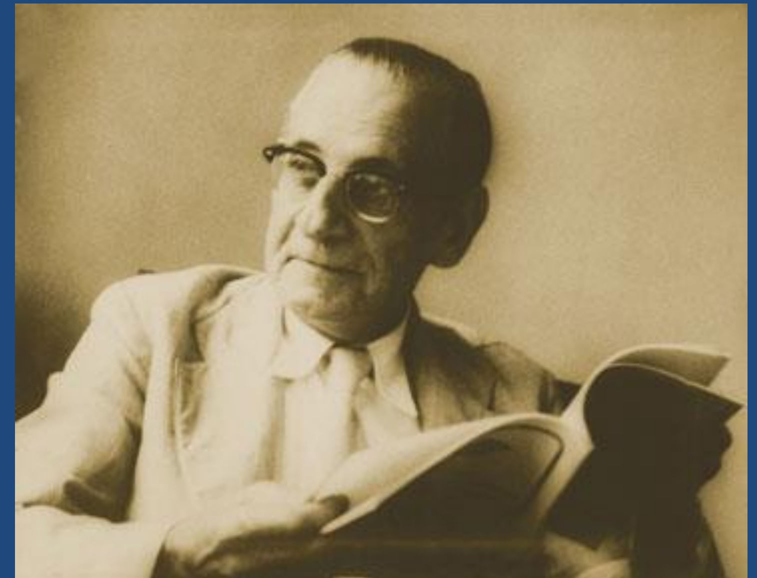
Henry Perry, MD, PhD, MPH
Health Systems Program
Department of International Health

Outline

- Historical perspectives
- Conceptual models of PHC
- The emergence of community-based PHC and the re-emergence of CHWs

John B. Grant, Father of Primary Health Care and of Jim Grant

J.B. Grant with the 2nd District, Department of Public Health of Peking, China, in 1933



The “Bible” of Primary Health Care

Links the community to health systems, to development more broadly, and to training and research

HEALTH CARE
FOR THE
COMMUNITY

SELECTED PAPERS OF
DR. JOHN B. GRANT

EDITED BY
Conrad Seipp

WITH A PREFACE BY
DR. CECIL G. SHEPS

The Johns Hopkins University Press : Baltimore & London

1963

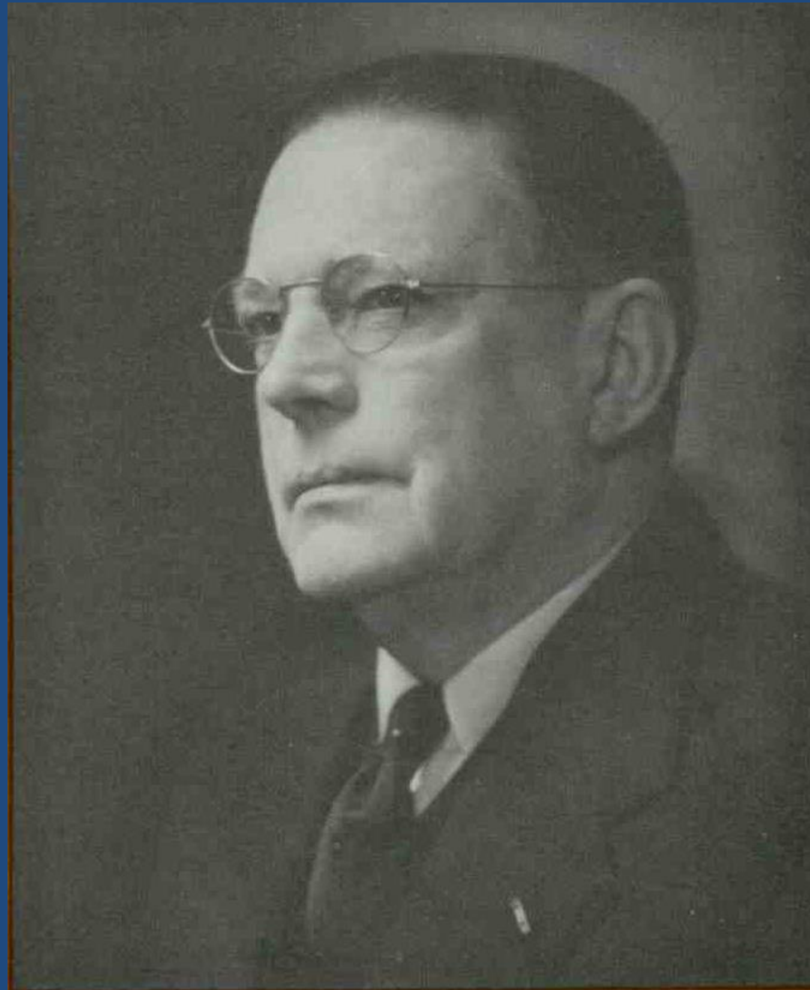
Ding Xian, 1930s
The Prototype of the Barefoot Doctor

- First example of primary health care (in the Alma Ata sense)

- Trained “farmer scholars” to record vital events, vaccinate against smallpox, administer simple treatments, give health education talks, and maintain wells

John Gordon, Professor of Epidemiology, Harvard School of Public Health, 1940s and 1950s, and Mentor of Carl Taylor and John Wyon

Worked with John Grant and the Rockefeller Foundation in China in the 1930s



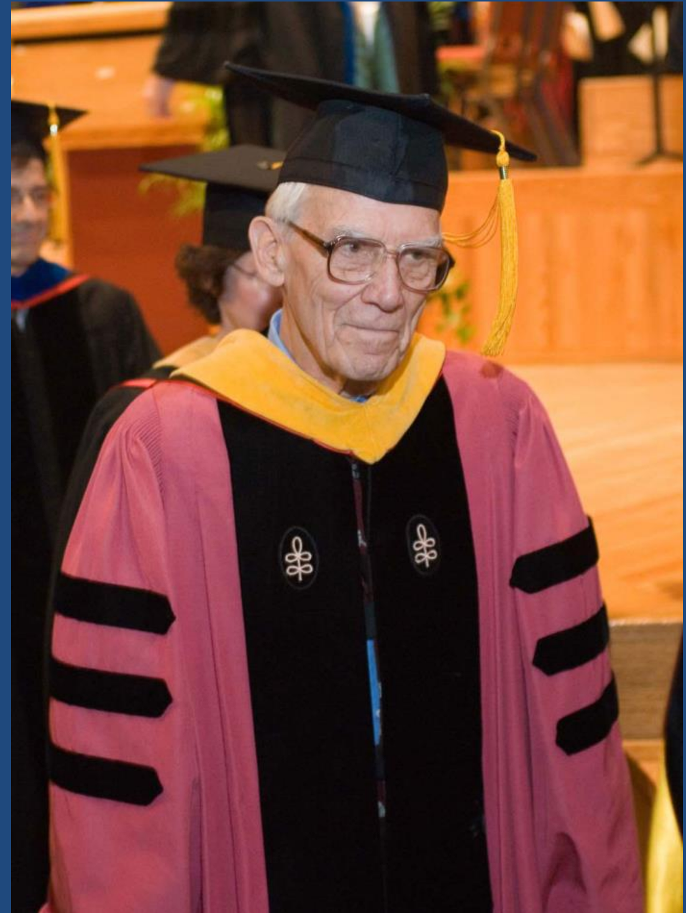
Routine systematic home visitation for surveillance

Towering Figures in the Development and Evolution of Primary Health Care

Halfdan Mahler, Director General of the World Health Organization, 1973 - 1988

James Grant, Executive Director of UNICEF, 1980-1995

Carl Taylor, 1916-2010



Carl Taylor

- "The acknowledged leader of primary care over the second half of the 20th century"
  - John Rohde, Special Assistant to James Grant, UNICEF Executive Director, 1980-1995

- "He is the greatest public health expert I have come across"
  - Halfdan Mahler, W.H.O. Director General, 1973-1988

Drs. John and Elizabeth Taylor were Medical Missionaries to India for 53 years

Camp Life during Carl Taylor’s Childhood

Carl Taylor (far left) with His Parents and Siblings

Carl Taylor (center, in shorts) with John Wyon (center to left of Carl Taylor) with Village Leaders in Khanna

The Narangwal Project, 1965-73

Narangwal Community-based Activities

Engagement of High-Level Ministry of Health Officials in Reviewing Project Progress

Child and Maternal Health Services in Rural India

The Narangwal Experiment

Volume 1
Integrated Nutrition and Health Care

Arnfried A. Kielmann and Associates

A WORLD BANK RESEARCH PUBLICATION

Prelude to 1978 Alma-Ata Conference

- Medical mission hospitals
- Christian Medical Commission
- Health by the People monograph
- Top-down, medical model of curative care not relevant for 80% of the world's population
- Carl Taylor special consultant to Halfdan Mahler in preparation for conference – played key "behind the scenes" role in writing Alma-Ata Declaration

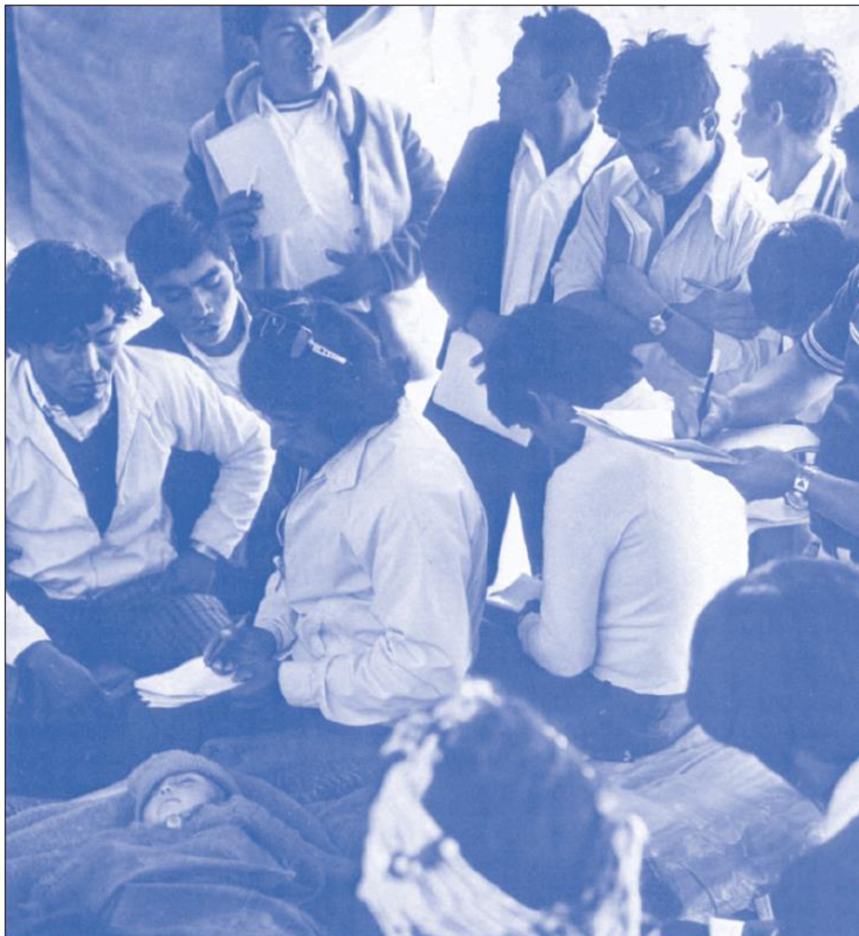
Christian Medical Commission Survey

- Health of people who lived close to a mission hospital was no better than people who lived further away
- How could this be?

The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach

| Socrates Litsios, ScD

The primary health care approach was introduced to the World Health Organization (WHO) Executive Board in January 1975. In this article, I describe the changes that occurred within WHO leading up to the executive board meeting that made it possible for such a radical approach to health services to emerge when it did. I also describe the lesser-known developments that were taking place in the Christian Medical Commission at the same time, developments that greatly enhanced the case for primary health care within WHO and its subsequent support by nongovernmental organizations concerned with community health.



Phot by Ulli Steltzer

Health promoters at the bedside of a sick child, Chimaltenango Hospital.

HEALTH BY THE PEOPLE

Edited by

KENNETH W. NEWELL

Director,
Division of Strengthening of Health Services,
World Health Organization,
Geneva, Switzerland

WORLD HEALTH ORGANIZATION

GENEVA

1975

Page

Foreword by the Director-General of WHO vii

Introduction — *Kenneth W. Newell* ix

The health care delivery system of the People's Republic of China — *Victor W. Sidel & Ruth Sidel* 1

The national health system in Cuba — *Arnaldo F. Tejeiro Fernandez* 13

The Chimaltenango development project in Guatemala — *Carroll Behrhorst* 30

The Ayurvedic system of medicine in India — *K. N. Udupa* 53

A comprehensive rural health project in Jamkhed (India) — *Mabelle Arole & Rajanikant Arole* 70

A community development approach to raising health standards in Central Java, Indonesia — *Gunawan Nugroho* 91

A health services development project in Iran — *M. Assar & Ž. Jakšić* 112

Village health teams in Niger (Maradi Department) — *G. Fournier & I. A. Djermakoye* 128

Meeting basic health needs in Tanzania — *W. K. Chagula & E. Tarimo* 145

"Simplified medicine" in the Venezuelan health services — *C. L. González* 169

Health by the people — *Kenneth W. Newell* 191

Contributors 204

International Conference on Primary Health Care, Alma Ata, Kazakhstan, 1978

Health for All by the Year 2000

Declaration of Alma-Ata

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

http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

- Why hasn't this vision of Primary Health Care become the organizing framework for health improvement in poor countries?

- How is it unrealistic and naïve?

- How is it a timeless and enduring vision for global health?

Alma-Ata Definition of Primary Health Care

- Very different from the developed country concept of primary medical care
- Based on first principles – the key components available to any society for maximizing health and the conditions for promoting good health
- It broadens the medical model to include social and economic factors
- It is integrated and comprehensive but recognizes the importance of selective approaches
- "…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

Spirit of Alma Ata in Words of Raj Arole

- "Health services, no matter how efficient, cannot change the condition of the marginalized people unless they are helped to become self-reliant and the root problems addressed…. People who are poor and illiterate are like uncut gems hidden under the dirt and stone. Given the opportunity, they can reach their full potential and live as responsible, sensitive human beings, possessing self-reliance and the liberty to shed those old customs and traditions that impede health and development."
  – Arole and Arole, 1994

(cont.)

- "Medicine needs to be demystified and knowledge shared freely with people so they can attain and maintain good health…. Hierarchical attitudes have to be replaced by a team spirit and equality. The realisation that knowledge not only gives power, but that sharing knowledge also increases self-esteem is important in the development of a team spirit."
  - Arole and Arole, 1994

Challenges That Arose to the Alma Ata Vision

- Too broad and idealistic with an unrealistic time table
- Selective approaches gained support from the donor community
- The “twin engines” of EPI and ORS
- GOBI-FFF (growth monitoring, oral rehydration, breastfeeding, immunizations, food supplementation, female literacy, family planning)
  - Easy to monitor and evaluate
  - Indicators of success and reporting

SPECIAL ARTICLE

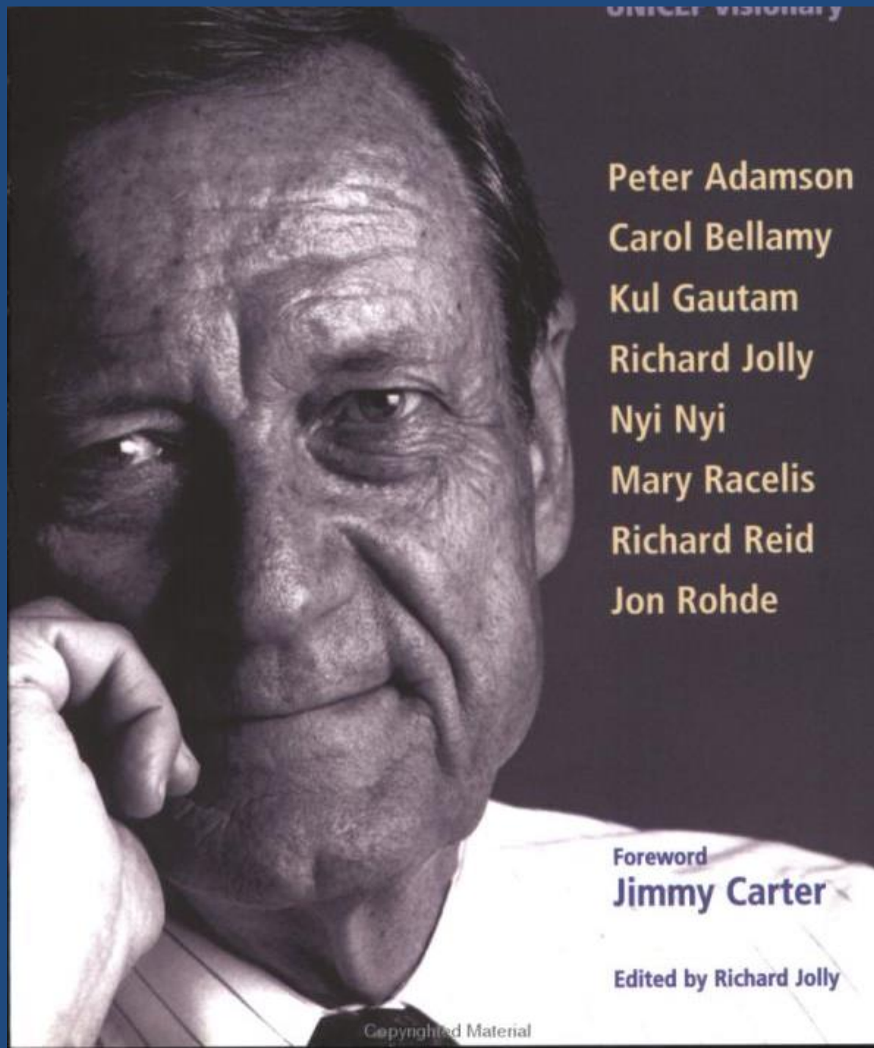
SELECTIVE PRIMARY HEALTH CARE

An Interim Strategy for Disease Control in Developing Countries

JULIA A. WALSH, M.D., AND KENNETH S. WARREN, M.D.

Abstract Priorities among the infectious diseases affecting the three billion people in the less developed world have been based on prevalence, morbidity, mortality and feasibility of control. With these priorities in mind a program of selective primary health care is compared with other approaches and suggested as the most cost-effective form of medical intervention in the least developed countries. A flexible program delivered by either fixed or mobile units might include measles and diphtheria–pertussis–tetanus vaccination, treatment for febrile malaria and oral rehydration for diarrhea in children, and tetanus toxoid and encouragement of breast feeding in mothers. Other interventions might be added on the basis of regional needs and new developments. For major diseases for which control measures are inadequate, research is an inexpensive approach on the basis of cost per infected person per year. (N Engl J Med 301:967-974, 1979)

James Grant, Executive Director of UNICEF, 1980-1995



Reasons for Rapid Loss of Momentum of Health for All Movement

- WHO leadership and country level weak (and medical orientation of the World “Disease” Organization)
- Lack of strong successes to build on (and lack of strong scientific evidence of progress)
- Cold War politics – association of Health for All with a communist/socialist agenda
- Loss of financial resources in Ministries of Health during the global financial crisis of the 1980s

Unresolved Dilemmas between Alma-Ata PHC and Selective PHC

- Diseases in less-developed countries are socially and economically sustained and need a political response to make real progress (addressing the social determinants of health)
- The major diseases in poor countries are a natural (not social) reality that require technical solutions (addressing the biomedical determinants of health)
- What should be the proper balance between selective and comprehensive approaches? Is there a “middle way”?

Selective Disease-Specific Approaches Are the Dominant Form of Global Funding Today

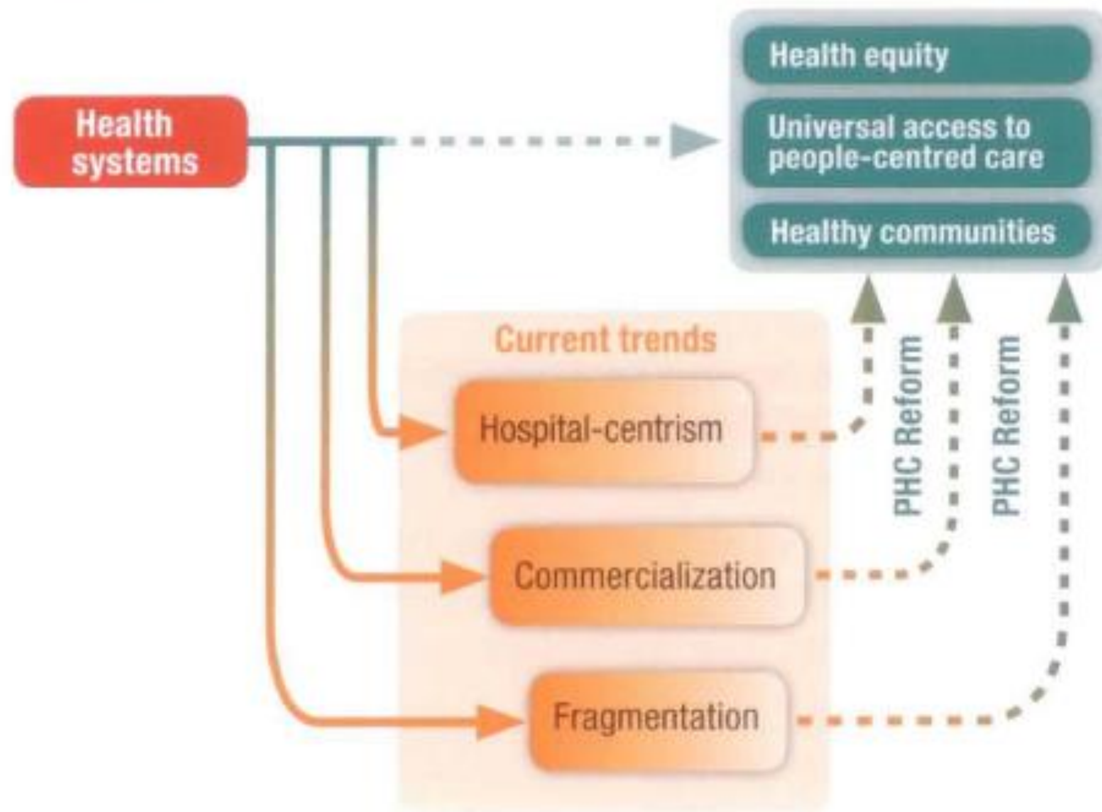
- PEPFAR
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- President's Malaria Initiative
- GAVI and Global Polio Eradication Initiative

- But widespread agreement that more emphasis on horizontal/integrated/systems strengthening approaches also needed

Are We All "Diagonalists" Now?

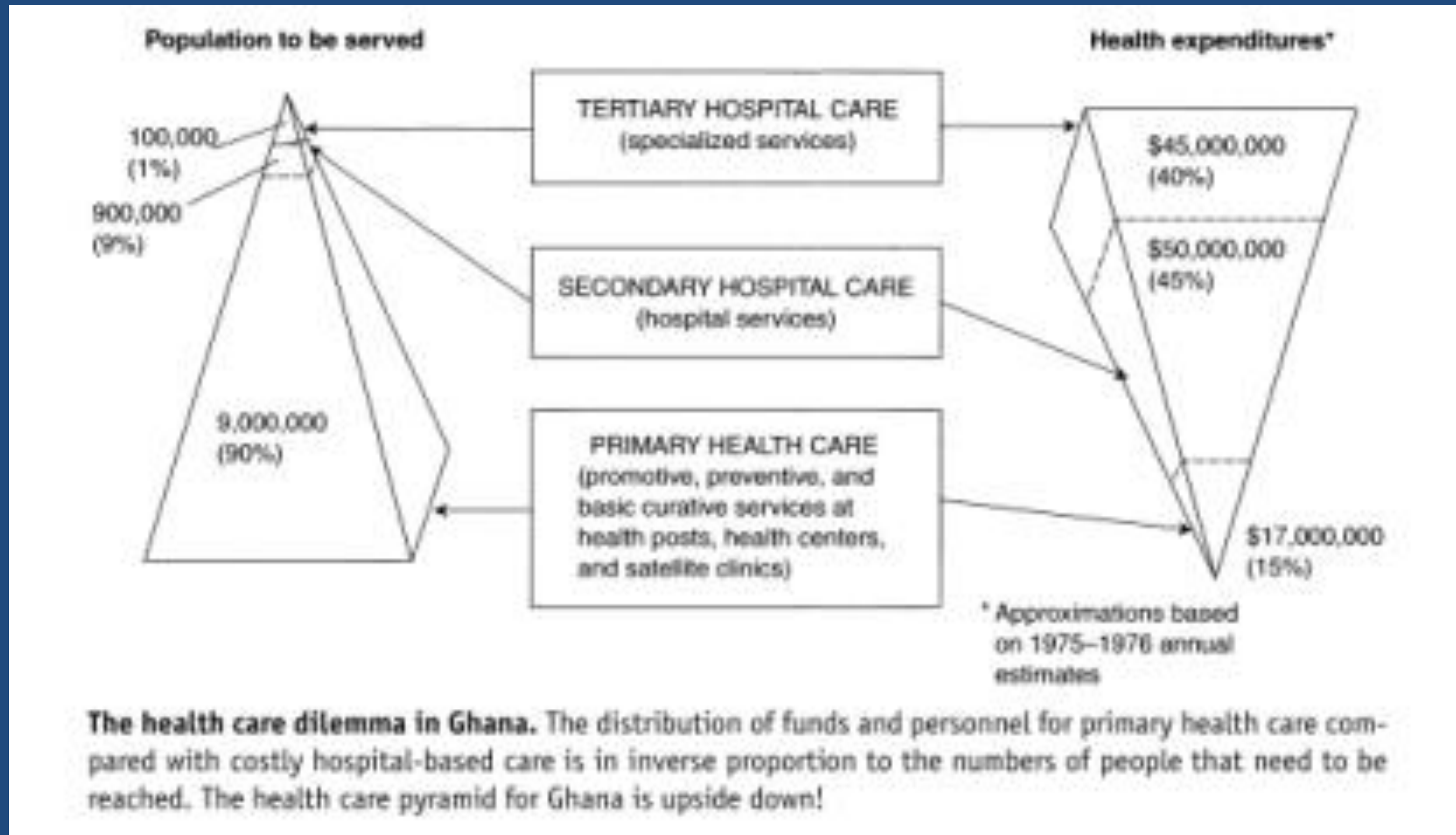
- Both vertical and horizontal programs need to co-exist
- Horizontal: integrated, demand-driven, resource-sharing health services
- Vertical: focuses, proactive, disease-specific interventions
  - Sepulvida et al., 2006

Other Detractors to Strong Primary Health Care Programs



WHO, 2008 (Primary Health Care: Now More Than Ever)

Hospital-Centrism: Health Systems Built around Hospitals and Specialists



The health care dilemma in Ghana. The distribution of funds and personnel for primary health care compared with costly hospital-based care is in inverse proportion to the numbers of people that need to be reached. The health care pyramid for Ghana is upside down!

Source: MOH, Republic of Ghana, *A Primary Health Care Strategy for Ghana*, 1978

Public Health and Primary Health Care

“Public health is the science and art of social utilization of scientific knowledge for medical protection by maintaining health, preventing disease, and curing disease through organized community efforts.”

-- John Grant, 1940

There are three kinds of public health: disease-oriented, service-oriented, and community-oriented. Each complements the other like the legs of a three-legged stool.

-- John Wyon, 1990

Primary Health Care: What Do the Words Mean?

- Primary
  - First contact
  - Basic (some would say "inadequate quality")
  - Essential (is emergency simple inexpensive life-saving surgery or life-promoting surgery such as C-section and cataract surgery primary health care?)
  - Addressing "first causes" (multi-sectoral, including education, nutrition and water and sanitation)

- Health or Health Care
  - Preventive and curative medical services
  - Biomedical disease orientation (and passive recipient of medical services) versus creating conditions/ environments that are healthy or health-promoting
  - Health as a “social phenomenon whose determinants cannot be neatly separated from other social and economic determinants”
  - Social/community/household/behavioral determinants of health

Primary Health Care: An Ambiguous Mental Model?

- Medical care system delivery concept vs. multi-sectoral Alma Ata concept
- Health system model vs. production of health model (World Health Organization vs. World "Disease" Organization) – household production of health model
- Facility-based care versus community-based primary health care

The World Health Report 2008

Primary Health Care

Now More Than Ever

World Health Organization

THE LANCET

Volume 372 · Number 9642 · Pages 863-1008 · September 13-19, 2008 www.thelancet.com

Alma-Ata 30 years on: "Health for all need not be a dream buried in the past."

See Editorial page 863

Five PHC Frameworks

- Alma Ata
- Community-Oriented Primary Health Care
- CBPHC: Community-based primary health care
- CBIO: Census-based, impact-oriented approach
- Care Groups/Participatory Women's Groups

Alma Ata Concept of PHC

- "… 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 …"
- It addresses the main health problems in the community
- Includes promotive, preventive, curative, and rehabilitative services

(cont.)

- Includes:
  - Promotion of food supply and proper nutrition
  - Adequate supply of safe water and basic sanitation
  - Maternal and child health care, including family planning and immunizations
  - Prevention and control of locally endemic diseases
  - Appropriate treatment of common diseases and injuries
  - Provision of essential drugs

(cont.)

- Includes as well:
  - Agriculture
  - Animal husbandry
  - Food
  - Education
  - Housing
- Requires and promotes:
  - Maximum community and individual self-reliance and participation in planning, organization, operation and control of PHC

(cont.)

- Should be sustained and integrated into functional and mutually supportive referral systems leading to comprehensive health care for all and giving priority to those most in need
- Relies on physicians, nurses, midwives, auxiliaries and communities workers as applicable – as well as traditional practitioners as needed – to work as a health team and to respond to the health needs of the community

Key Alma-Ata Concepts

The three “pillars” of Alma-Ata

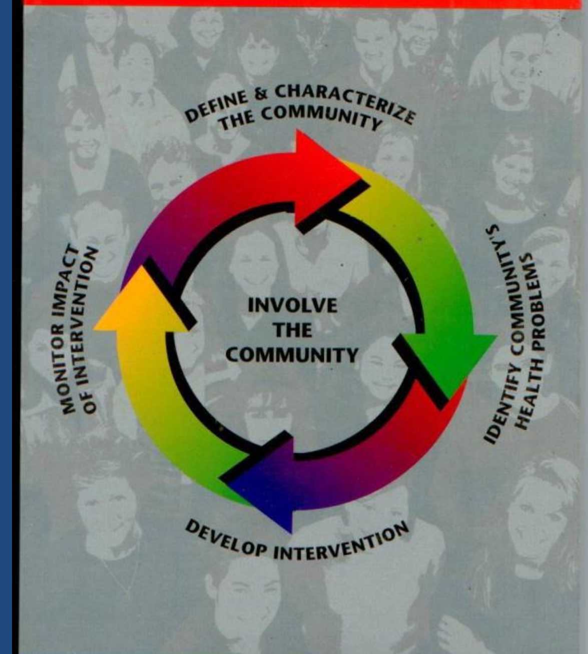
- Equity
- Community participation
- Inter-sectoral development

COPC

South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town — Posbus 643, Kaapstad
Vol. 26, No. 6 — Cape Town, 9 February 1952 — Weekly 2s 6d

THE PHOLELA HEALTH CENTRE
A PROGRESS REPORT *

SIDNEY L. KARK, M.B., B.CH.
Institute of Family and Community Health, Durban
and
JOHN CASSEL, B.SC., M.B., B.CH.
Pholela Health Centre, Bulwer, Natal



Community-based Primary Health Care

- Services provided outside of health facilities
- Usually provided by some type of community-based worker

Examples of Community-Based Primary Health Care

- BRAC Health Program
- Community-based family planning
- Community IMCI (Integrated Management of Childhood Illness)

Integrated Management of Childhood Illness (IMCI)

- Facility-based IMCI
- Community-based IMCI

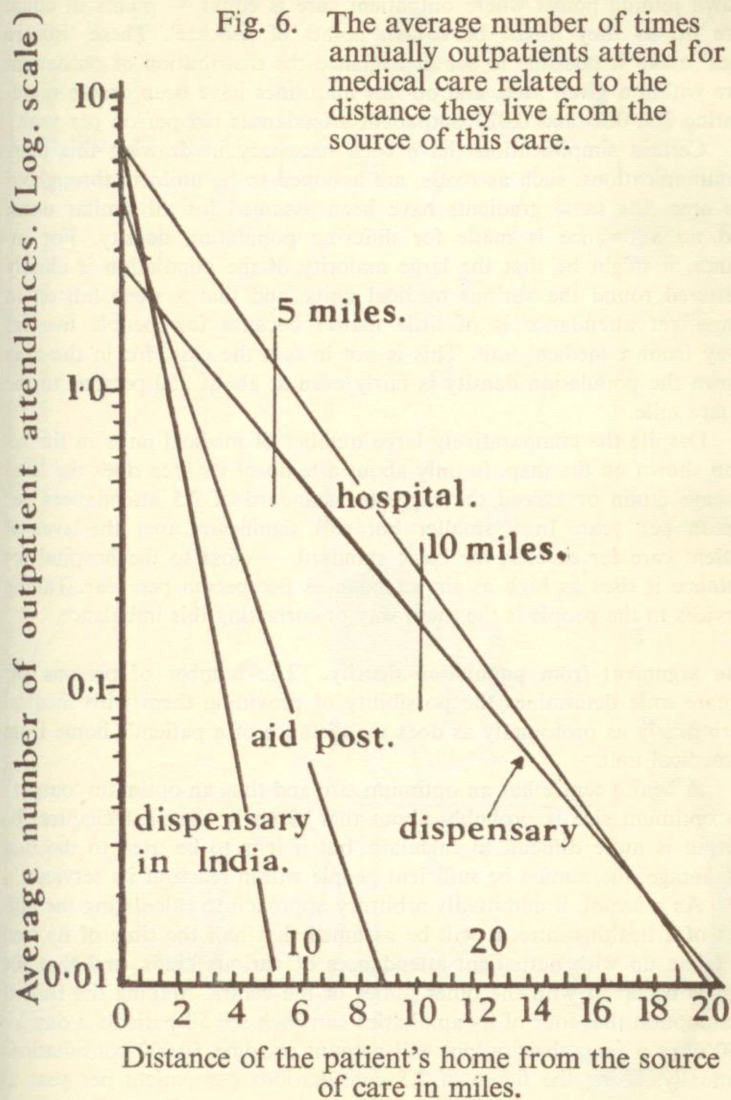


Fig. 6. The average number of times annually outpatients attend for medical care related to the distance they live from the source of this care.

King, 1966

HOUSEHOLD & COMMUNITY IMCI
AN IMPLEMENTATION FRAMEWORK
ELEMENT 1
Improving partnerships between health facilities and the communities they serve
ELEMENT 2
Increasing appropriate and accessible health care and information from community-based providers
CLINIC
VILLAGE SHOP
ELEMENT 3
Integrating promotion of key family practices critical for child health & nutrition
MULTI-SECTORAL PLATFORM
Optimizing a multi-sectoral platform to support sustainable child health & nutrition

COMMUNITY CASE MANAGEMENT (CCM)
of Sick Children
Children Who Benefit
pneumonia
newborn infection
malaria
diarrhea
malnutrition
Basic Medicine & Supplies
job aids
medicines
stopwatch
soap
patient register
oral rehydration solution
ready-to-use therapeutic food
Community Health Care
community health worker selected by community
family with sick child
health hut/clinic
referral hospital
local shop
Family Support
bednet
breastfeeding
swaddling newborn
handwashing / hygiene
nutrition / care treatment compliance
Community Support
village health committee
money
safe water
communication
transportation

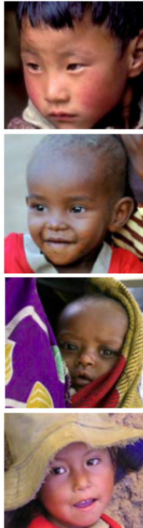
Family and community practices that promote child survival, growth and development

A REVIEW OF THE EVIDENCE

WORLD HEALTH ORGANIZATION
GENEVA

http://whqlibdoc.who.int/publications/2004/9241591501.pdf

A Review of the Evidence



How Effective Is Community-Based Primary Health Care in Improving the Health of Children?

Summary Findings
Report to the Expert Review Panel

Henry Perry[1] and Paul Freeman[2], Study Directors

Sundeep Gupta[3] and Bahie Mary Rassekh[4],
Study Coordinators

Community-Based Primary Health Care
Working Group, International Health Section
American Public Health Association

7 July 2009

Community-Based Primary Health Care

Planning, Implementation and Evaluation Framework

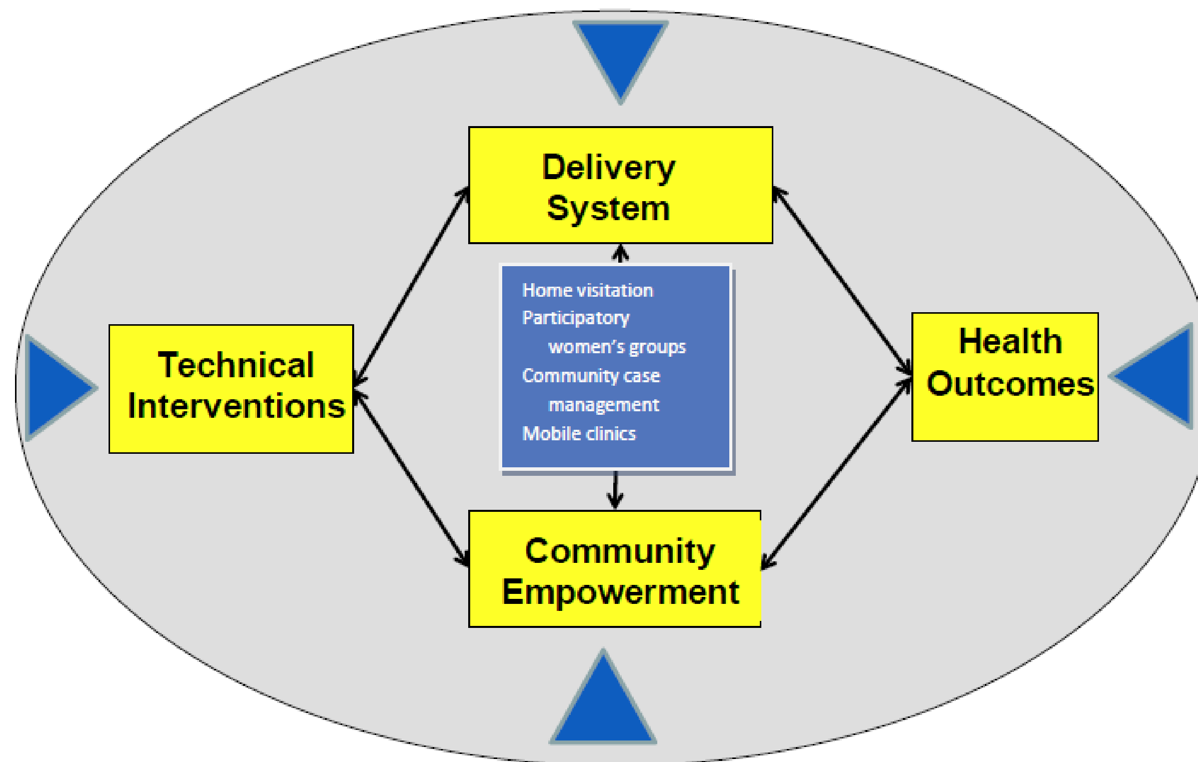


Figure 2. A conceptual framework for planning, implementing and evaluating the effectiveness of proven technical interventions in routine field situations at scale

Note: Blue triangles represent contextual factors.

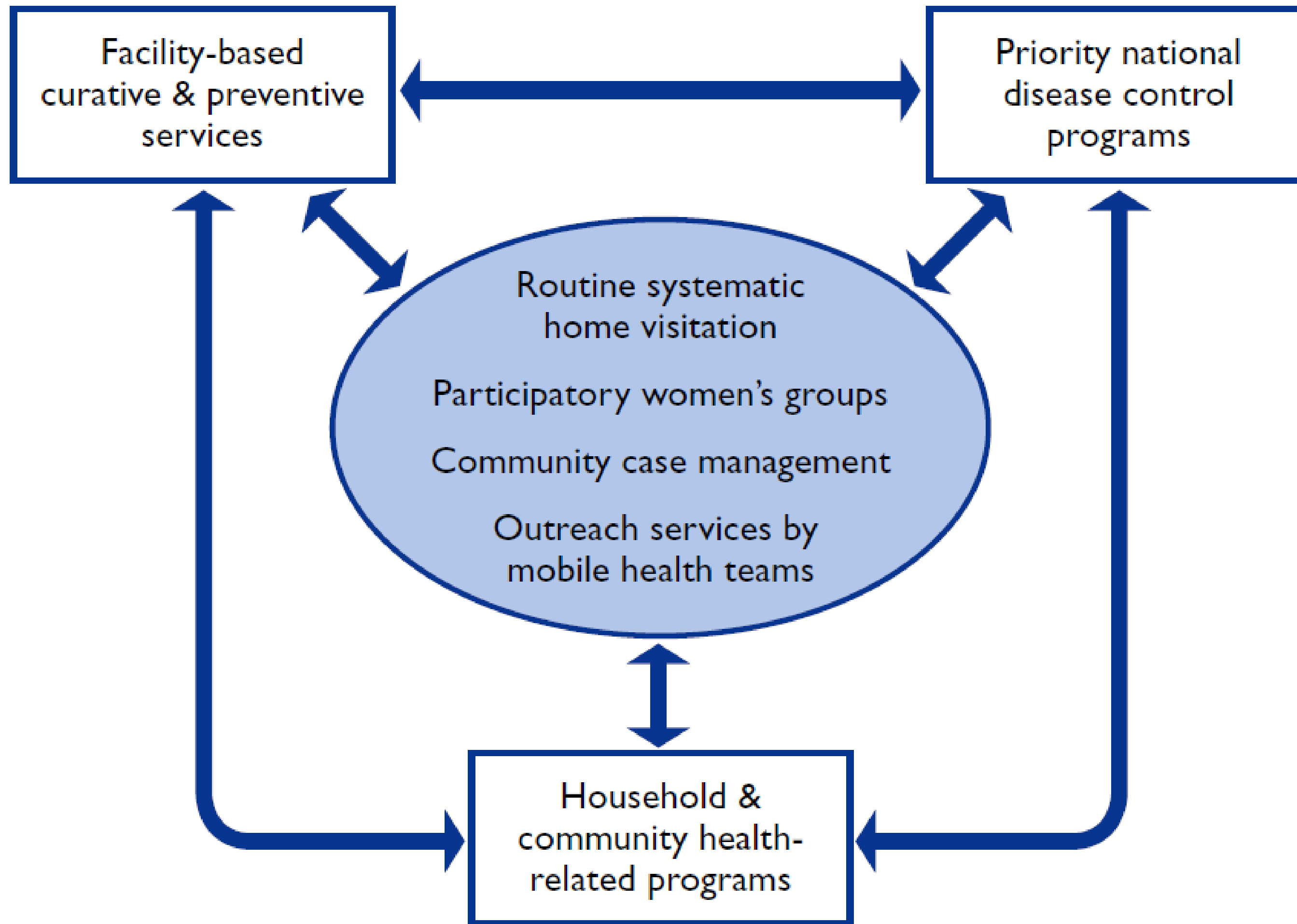
Framework of Public Health (the Health of the Public)

- Disease-oriented public health
  - Control specific diseases or conditions
- Services-oriented public health
  - Ensure that those who need services get them
- Community-oriented public health
  - Work with communities to help them improve their health

- All three are equally important and are like the legs of a three-legged stool

  – John Wyon

FIGURE 1: FRAMEWORK FOR MAXIMUM IMPROVEMENT IN COMMUNITY HEALTH



COMMUNITY SYSTEMS STRENGTHENING FRAMEWORK
JANUARY 2010

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

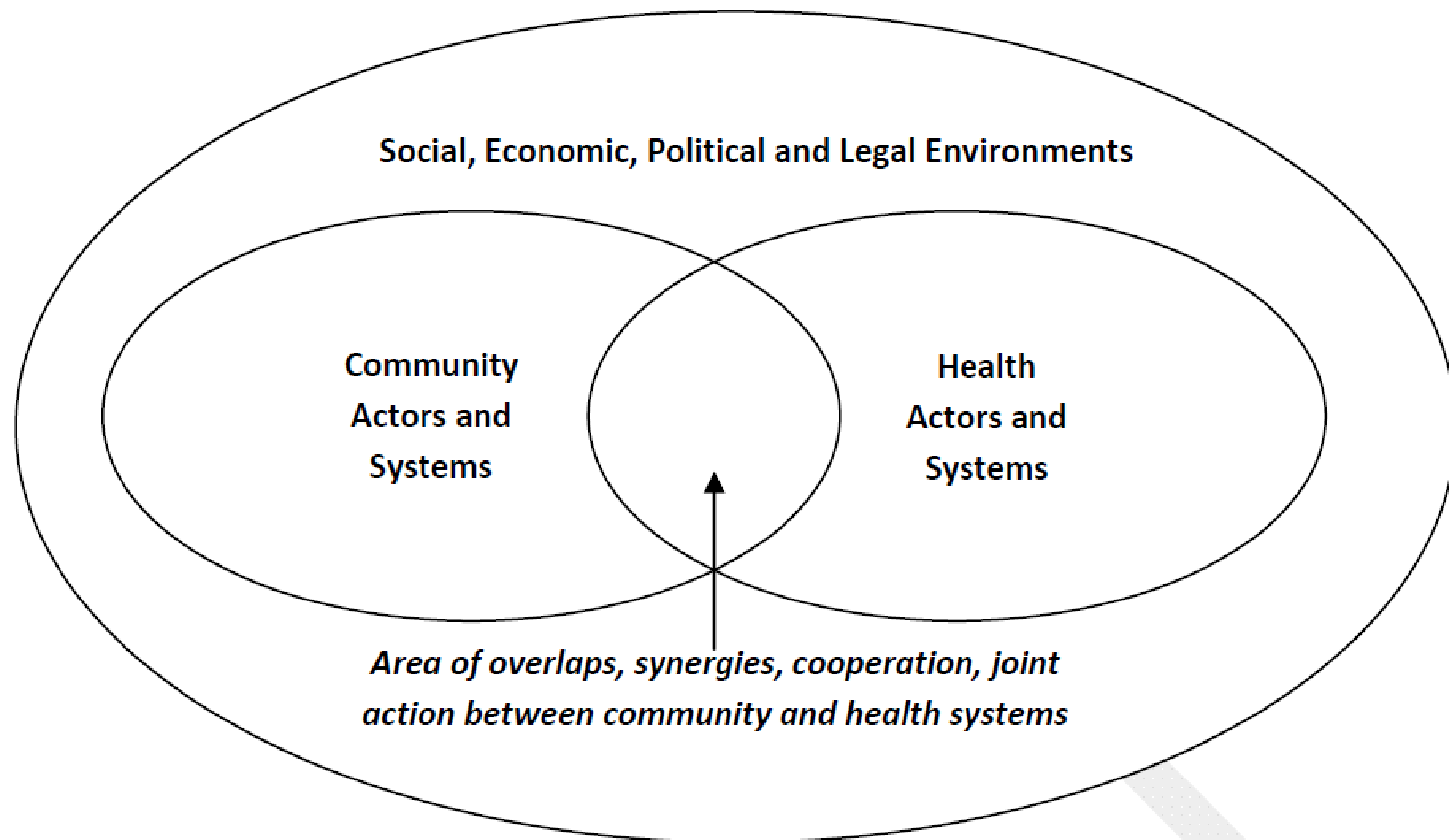


Figure 1: Community and health actors & systems – complementary and connected

Examples of Types of Community Involvement/Participation

At community leadership level

- Village health committees
- Associations of village health committees
- Village development committees
- Health action committees
- Community leadership committees
- Meetings with chiefs/mayors/elders/imams
- Imams as community mobilizers
- Community meetings/assemblies
- Community pharmacies
- Self-sufficient maternity homes

At household level

- Health days (for community clean up)
- Model mothers
- Competitions among mothers for healthiest babies
- Breastfeeding support groups
- Husbands and mothers-in-law as targets for messages
- Pregnant women's groups
- Mothers' clubs
- Child clubs

CBIO Framework

PERGAMON

Social Science & Medicine 48 (1999) 1053–1067

SOCIAL SCIENCE & MEDICINE

Attaining health for all through community partnerships: principles of the census-based, impact-oriented (CBIO) approach to primary health care developed in Bolivia, South America

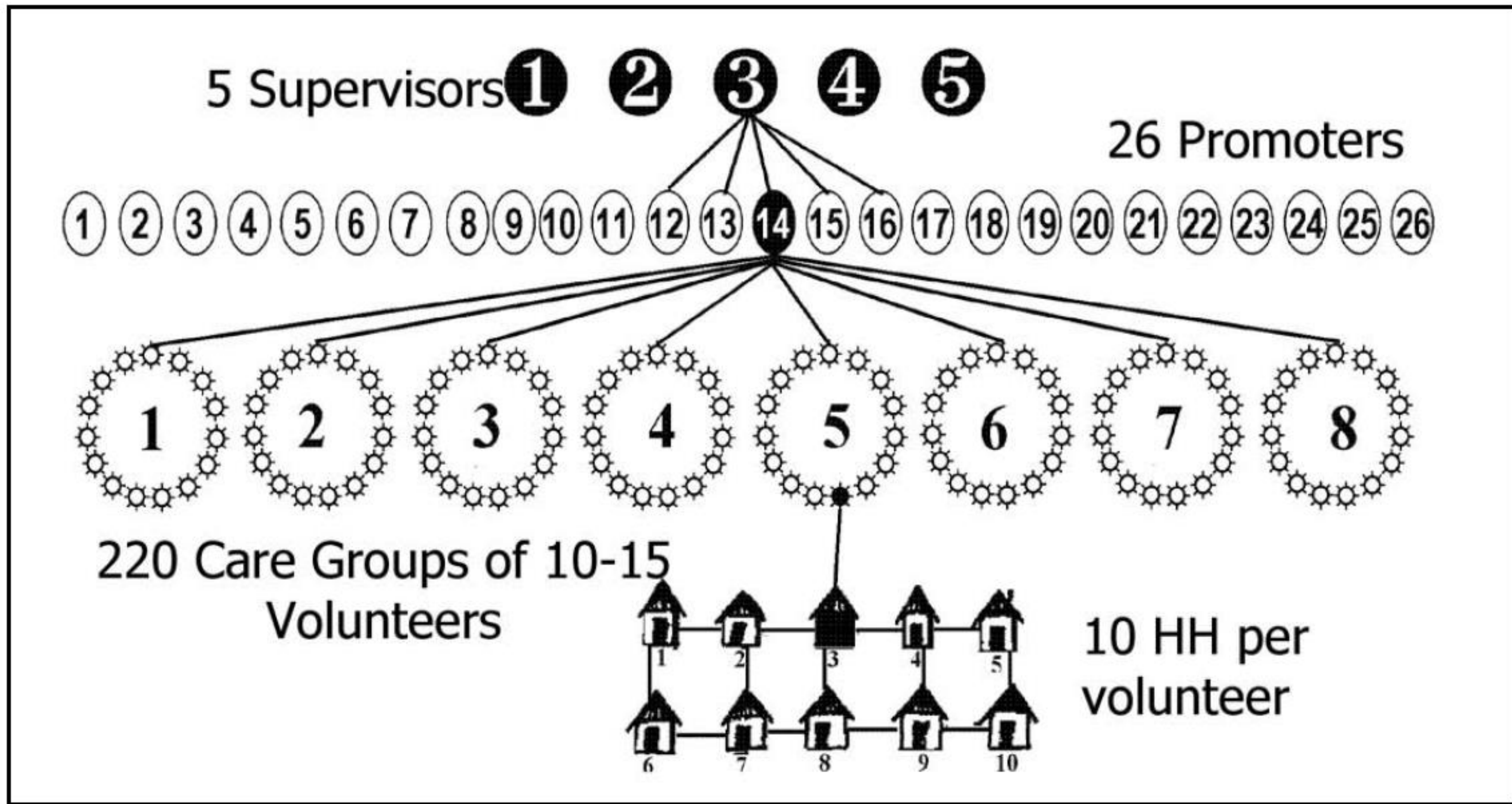
Henry Perry[a,*], Nathan Robison[b], Dardo Chavez[c], Orlando Taja[d], Carolina Hilari[b], David Shanklin[e], John Wyon[f]

Participatory Women's Groups/ Care Groups

- Care Group model
- Facilitated women's groups
- BRAC Village Organizations

Pieter Ernst, Pioneer Developer of the Care Group Model

The World Relief Original Care Group Program in Gaza Province, Mozambique



Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique

Anbrasi Edward[a], Pieter Ernst[b], Carl Taylor[a,*], Stan Becker[c], Elisio Mazive[d], Henry Perry[e]

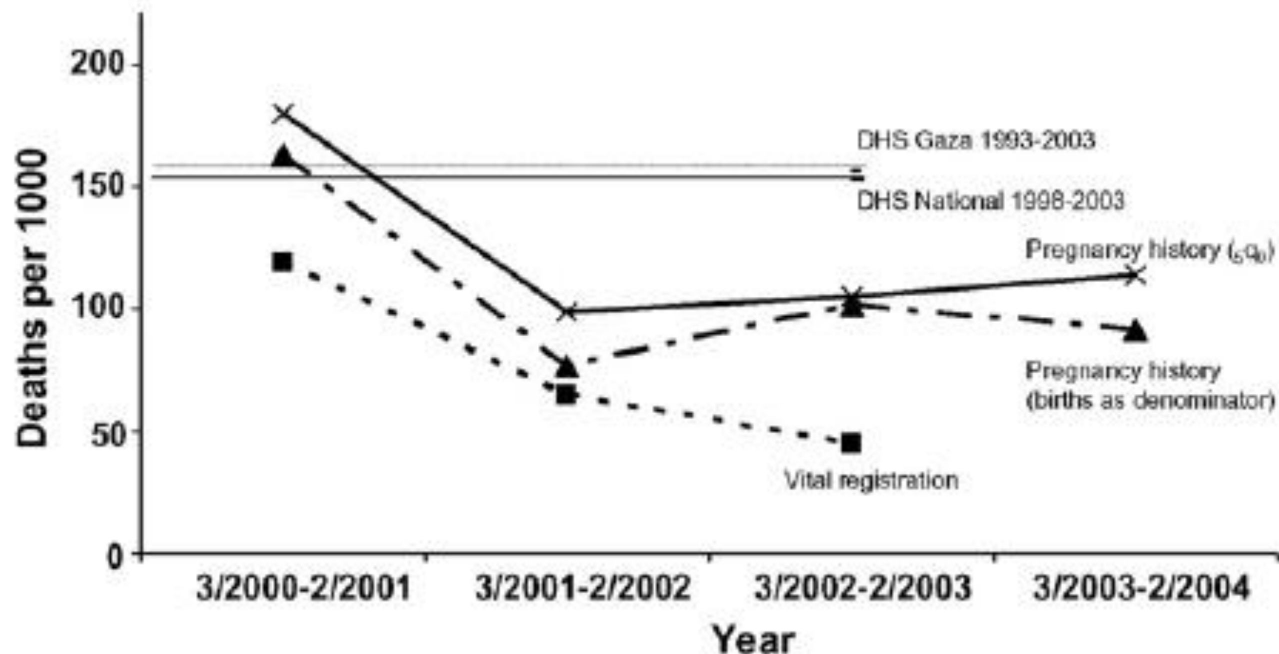


Figure 3 Under-five mortality in Chokwe district, 2000—2004. DHS: Demographic and Health Survey.

Transactions of the Royal Society of Tropical Medicine and Hygiene (2007) 101, 814—822

Table 2 Estimates (and 95% CI) of care-seeking and behavioural change practices of caretakers

Process indicator	Baseline (Oct. 1999)		Final (July 2003)	
	N	% (95% CI)	*N*	% (95% CI)
Mothers reporting initiation on BF within 1 h of delivery	–	–	299	71
Children with diarrhoea treated with ORT	115	53 (43.9–62.1)	110	94 (89.6–98.4)
Children with diarrhoea given extra food for 2 weeks following diarrhoea episode	115	4 (4.2–7.6)	110	87 (80.7–93.3)
Households with latrines	300	28 (10.4–45.6)	300	75 (70.1–79.9)
Children who slept under ITN the previous night	0	–	240	85 (80.5–89.5)
Children with fever treated at health centre/post within <24 h	25	28 (10.4–45.6)	20	90 (76.9–103..2)
Children with fast or difficult breathing treated at health centre/post within <24 h	50	2 (1.9–5.9)	15	60 (35.2–84.8)
Children with severe malnutrition (−3 Z-scores)	–	–	265	14 (9.82–18.2)
Mothers reporting increased food intake (past pregnancy)	300	44 (38.4–49.6)	300	82 (77.7–86.4)
Mothers reporting delivery by trained provider (last pregnancy)	300	65 (59.6–70.4)	300	87 (83.2–90.8)
Children fully immunised	128	74 (66.4–81.6)	123	89 (83.5–94.5)
Caretakers who knew three ways to prevent STIs/AIDS	300	0.3 (0.3–0.9)	300	56 (50.4–61.6)

BF: breastfeeding; ORT: oral rehydration therapy; ITN: insecticide-treated bed net; STI: sexually transmitted infection.

Reducing child global undernutrition at scale in Sofala Province, Mozambique, using Care Group Volunteers to communicate health messages to mothers

Thomas P Davis, Jr,[a] Carolyn Wetzel,[a] Emma Hernandez Avilan,[b] Cecilia de Mendoza Lopes,[c] Rachel P Chase,[d] Peter J Winch,[d] Henry B Perry[d]

Findings: More than 90% of beneficiary mothers reported that they had been contacted by CGVs during the previous 2 weeks. In the early implementation project area, the percentage of children 0–23 months old with global undernutrition (weight-for-age with z-score of less than 2 standard deviations below the international standard mean) declined by 8.1 percentage points ($P<0.001$), from 25.9% (95% confidence interval [CI]=22.2%–29.6%) at baseline to 17.8% at endline (95% CI=14.6%–20.9%). In the delayed implementation area, global undernutrition declined by 11.5 percentage points ($P<0.001$), from 27.1% (95% CI=23.6%–30.6%) to 15.6% (95% CI=12.6%–18.6%). Total project costs were US$3.0 million, representing an average cost of US$0.55 per capita per year (among the entire population of 1.1 million people) and US$2.78 per beneficiary (mothers with young children) per year.

Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial

Lancet 2004; 364: 970–79

See Comment page 914

Mother and Infant Research Activities (MIRA), PO Box 921,

Dharma S Manandhar, David Osrin, Bhim Prasad Shrestha, Natasha Mesko, Joanna Morrison, Kirti Man Tumbahangphe, Suresh Tamang, Sushma Thapa, Dej Shrestha, Bidur Thapa, Jyoti Raj Shrestha, Angie Wade, Josephine Borghi, Hilary Standing, Madan Manandhar, Anthony M de L Costello, and members of the MIRA Makwanpur trial team

Figure 2: **Typical women's group meeting**
Picture courtesy of Thomas Kelly and Save the Children, USA.

Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis

- 7 randomized controlled trials
- 37% reduction in maternal mortality
- 23% reduction in neonatal mortality

Prost et al., Lancet, 2013

Engaging the Community as a Partner

Alma-Ata: Rebirth and Revision 5

Community participation: lessons for maternal, newborn, and child health

Mikey Rosato, Glenn Laverack, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Kishwar Azad, Joanna Morrison, Zulfiqar Bhutta, Henry Perry, Susan Rifkin, Anthony Costello

Primary health care was ratified as the health policy of WHO member states in 1978.[1] Participation in health care was a key principle in the Alma-Ata Declaration. In developing countries, antenatal, delivery, and postnatal experiences for women usually take place in communities rather than health facilities. Strategies to improve maternal and child health should therefore involve the community as a complement to any facility-based component. The fourth article of the Declaration stated that, "people have the right and duty to participate individually and collectively in the planning and implementation of their health care", and the seventh article stated that 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". But is community participation an essential prerequisite for better health outcomes or simply a useful but non-essential companion to the delivery of treatments and preventive health education? Might it be essential only as a transitional strategy: crucial for the poorest and most deprived populations but largely irrelevant once health care systems are established? Or is the failure to incorporate community participation into large-scale primary health care programmes a major reason for why we are failing to achieve Millennium Development Goals (MDGs) 4 and 5 for reduction of maternal and child mortality?

Lancet, 2008

The Process of Community Empowerment

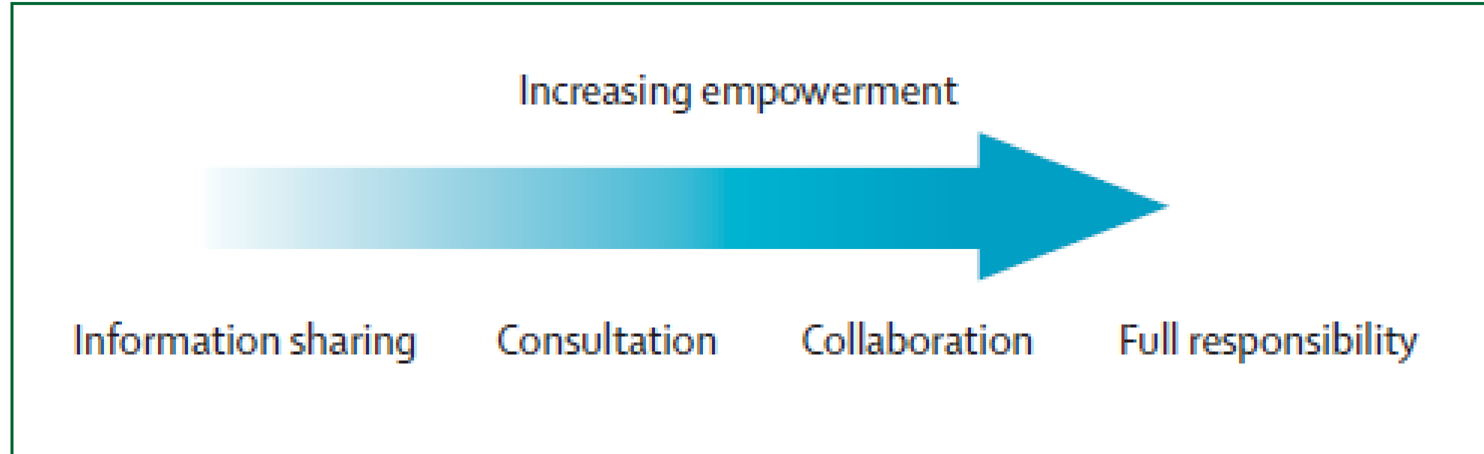


Figure 1: From passive to active community participation

Rosato et al., 2008

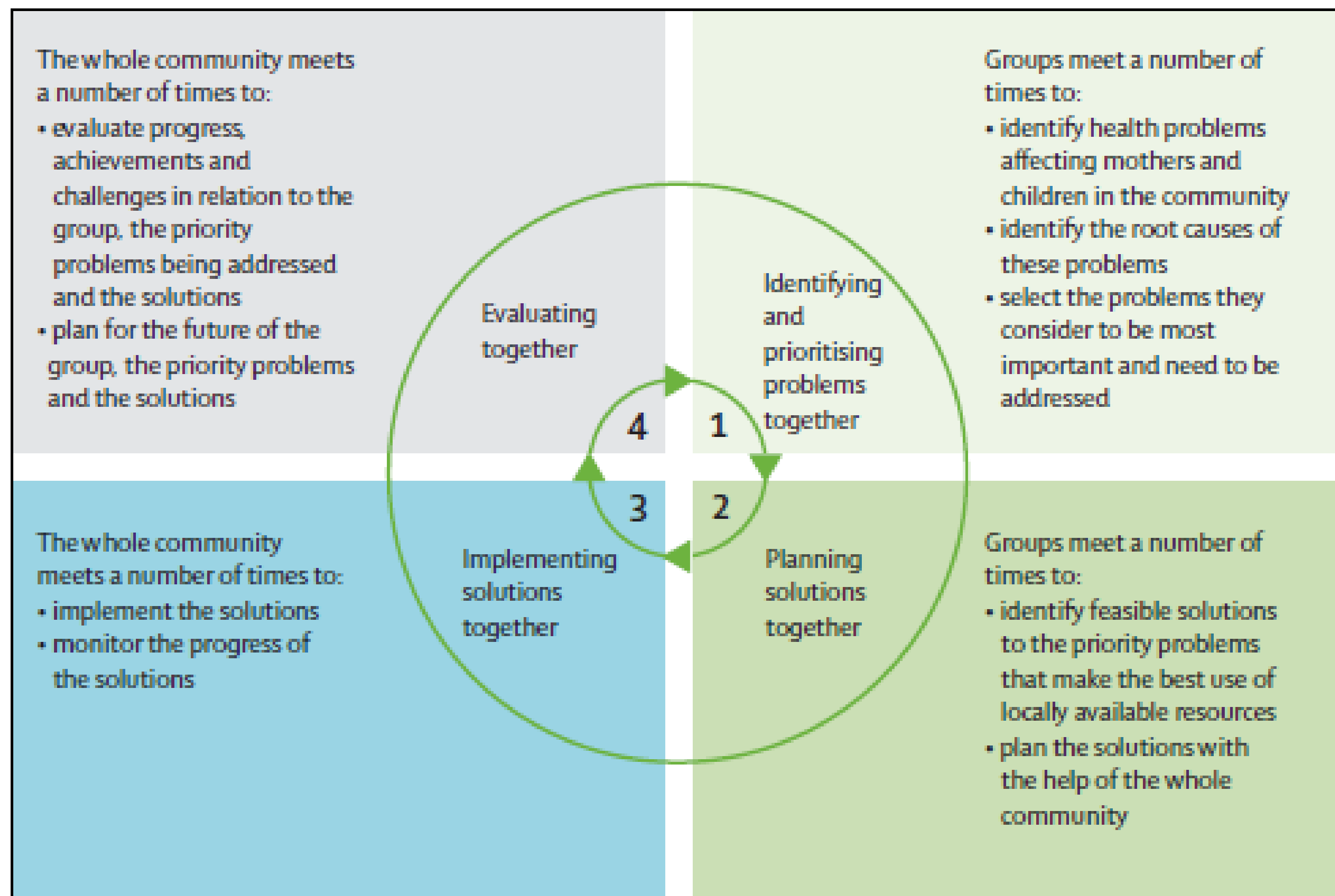


Figure 2: Women's groups community mobilisation action cycle

The Warmi project in Bolivia developed a model for community mobilisation using this community action cycle.[40] Women's groups discuss and prioritise their problems, develop strategies to solve them, and, after engaging with other community members, implement and evaluate these solutions. The completed Makwanpur (Nepal) trial and ongoing trials in Mumbai (India), Jharkhand and Orissa (India), Mchinji (Malawi), Dhanusha (Nepal), and Bangladesh are assessing the effect of different women's group models, developed from this model, on mother and child health (table).

The Re-Emergence of Community Health Workers

Early Experience with CHWs – 1960s to 1980s

- China (Barefoot Doctors)
- Indonesia (based at Pos Yandus)
- India (Jamkhed)
- Nepal (VHWs)
- Tanzania
- Zimbabwe (VHWs)
- Nicaragua (Brigidistas)
- Honduras
- Brazil

HEALTH BY THE PEOPLE

WORLD HEALTH ORGANIZATION

CONTENTS

	Page
Foreword by the Director-General of WHO	vii
Introduction — *Kenneth W. Newell*	ix
The health care delivery system of the People's Republic of China — *Victor W. Sidel & Ruth Sidel*	1
The national health system in Cuba — *Arnaldo F. Tejeiro Fernandez*	13
The Chimaltenango development project in Guatemala — *Carroll Behrhorst*	30
The Ayurvedic system of medicine in India — *K. N. Udupa*	53
A comprehensive rural health project in Jamkhed (India) — *Mabelle Arole & Rajanikant Arole*	70
A community development approach to raising health standards in Central Java, Indonesia — *Gunawan Nugroho*	91
A health services development project in Iran — *M. Assar & Ž. Jakšić*	112
Village health teams in Niger (Maradi Department) — *G. Fournier & I. A. Djermakoye*	128
Meeting basic health needs in Tanzania — *W. K. Chagula & E. Tarimo*	145
"Simplified medicine" in the Venezuelan health services — *C. L. González*	169
Health by the people — *Kenneth W. Newell*	191
Contributors	204

1975

Declaration of Alma Ata – 1978

Called for basic health services – promotive, preventive, curative and rehabilitative – to be provided by "health workers, including physicians, nurses, midwives, auxiliaries and *community workers* [italics added] as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

The Declaration also recognized the importance of providing health services "as close as possible to where people live and work."

Failure of Large-scale CHW Programs in the 1980s

- Local selection of CHWs often politically motivated
- Lack of supervision and support (including necessary supplies and medicines) and integration into the primary health care system
- Lack of funding (global recession in the 1980s and structural adjustment/neo-liberal economics/the Washington consensus)
- Lack of strong evidence of effectiveness of the approach
- The power of selective approaches (EPI, ORS, FP)

Reasons for Renewed Interest in CHWs

- Growing evidence of effectiveness of CBPHC in reducing maternal and child health
- Lack of progress in reaching MDGs and continued low coverage of key interventions
- Seen as critical for increasing access to and coverage of key interventions
- Critical for effective and sustainable TB and HIV programs
- Potential to reach most remote and poorly-served populations, thereby improving equity
- Some interventions more effectively delivered by CHWs rather than by facility-based health workers
- Recognition in India and South Africa that CHWs will be needed after the epidemiologic transition has been achieved (for chronic disease care and care of the elderly)

Examples of Types of Community Outreach Workers

- CHWs/VHWs
- Health agents
- Promoters
- Family health workers
- Peer educators
- Family planning agents
- Malaria/nutrition agents
- Community case management workers
- Lead mothers
- Community health extension workers
- Animators
- Community health officers
- Mobile clinic team
- Care groups
- “Socoristas”
- “Accompagnateurs”
- Health surveillance assistants
- Community surveillance volunteers
- Auxiliary nurses
- Bridge to health teams
- Nutrition counselor mothers

Activities that CHWs Can Carry Out

- Routine systematic home visitation – identify those in need and build relationship of trust
- Community mobilization
- Water and sanitation interventions
- Nutrition
- Vector control
- Treatment of large numbers of patients with common conditions
- HIV/AIDS and tuberculosis
- Community case management of childhood illness

Community Case Management by CHWs (iCCM)

- Diagnosis of pneumonia and treatment with antibiotics
- Diagnosis of diarrhea and treatment with ORS and zinc
- Diagnosis of malaria by Rapid Diagnostic Test and treatment with Artemisinin combination therapy

BRAC CHWs – A "Maximalist" Approach

- Routine systematic home visitation
- Promote of health, nutrition and hygiene
- Treat 10 common diseases and sell essential drugs
- Implement DOTS
- Sell iodized salt, delivery kits, condoms, pills, soap, etc.
- Social mobilization for NID and Vitamin A campaigns
- Collect health information and ensure timely referrals

Shasthya Shebika providing DOTS

Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals:

A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems

Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals:

A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems

Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo* and Luis Huicho**

Division of Women & Child Health, The Aga Khan University, Karachi, Pakistan

*Makerere University School of Public Health, Kampala, Uganda

**Universidad Peruana Cayetano Heredia, Universidad Nacional Mayor de San Marcos and Instituto de Salud del Niño, Lima, Peru

Available at:

http://www.who.int/workforcealliance/knowledge/publications/alliance/Global_CHW_web.pdf

2010

Report can be downloaded at:

http://millenniumvillages.org/files/2011/06/1mCHW_TechnicalTaskForceReport.pdf

2011

- Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guidance for Program Managers and Policy Makers, Henry Perry and Lauren Crigler, Editors (available on-line later this fall)

How Effective Are Community Health Workers?

An Overview of Current Evidence with Recommendations for Strengthening Community Health Worker Programs to Accelerate Progress in Achieving the Health-related Millennium Development Goals

September 2012

Henry Perry and Rose Zulliger

Departments of International Health and Health, Behavior and Society

Johns Hopkins Bloomberg School of Public Health

http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/review%20of%20chw%20effectiveness%20for%20mdgs-sept2012.pdf.

Also, forthcoming in Annual Reviews of Public Health

Examples of National-Scale CHW Programs

- India:
  - ASHA (Accredited Social Health Activists): 800,000
  - Anganwadi workers: 2 million
- Brazil:
  - Community Health Agents: 233,000
- Ethiopia (dual cadre):
  - Community Health Extension Worker: 38,000
  - Health Development Army/Community Health Promoters: 3 millilon
- Bangladesh:
  - BRAC *Shashtya Shebikas:* 80,000
- Nepal:
  - FCHVs (Female Community Health Volunteers): 50,000

Summing Up

Carl Taylor's Last Publication

What would Jim Grant say now?

Our greatest mistake has been to oversimplify the Alma-Ata vision of primary health care. Real social change occurs when officials and people with relevant knowledge and resources come together with communities in joint action around mutual priorities. The interplay between comprehensive (horizontal) and selective (vertical) approaches requires careful blending.[12] It is my conviction that, if Jim were here now, he would champion this blending, adapted to the local context with a focus on communities, to ignite the next child survival and development revolution.

www.thelancet.com Vol 375 April 10, 2010

More Information about Carl Taylor and His Legacy

http://www.jhsph.edu/dept/ih/carltaylor

Emergence of PHC Systems

“The emphasis has to shift from showing immediate results from single interventions to creating integrated, long-term, sustainable health systems, which can be built from a more selective primary health-care start.”

Walley et al., Lancet 2008

“There is no universal solution, but there is a universal process to find appropriate local solutions”

Carl Taylor

Conclusion

- Primary health care is a deceptively simple concept
- It is a fundamental strategy for improving the health of populations
- Finding a locally appropriate way to link vertical and horizontal approaches in a way that is equitable, engages communities as partners, promotes community empowerment by linking the “top-down” with the “bottom-up” is the challenge for today and tomorrow

Primary Health Care:

A Redefinition, History, Trends, Controversies and Challenges

Henry B. Perry, MD, PhD, MPH

Senior Associate
Department of International Health
Johns Hopkins Bloomberg School of Public Health

3 September 2013

•221.635.01/.81 CASE STUDIES IN PRIMARY HEALTH CARE (4 credits)

Courses

SECOND TERM

224.689.01 HEALTH BEHAVIOR CHANGE AT THE INDIVIDUAL, HOUSEHOLD AND COMMUNITY LEVELS

(Peter Winch, on-site)

THIRD TERM

221.635.01/.81 ADVANCES IN COMMUNITY-ORIENTED PRIMARY HEALTH CARE

(Henry Perry and Henry Taylor, on-line and on-site)

221.688.81 SOCIAL AND BEHAVIORAL FOUNDATIONS OF PRIMARY HEALTH CARE

(Bill Brieger, on-line)

FOURTH TERM

221.661.01 PROJECT DEVELOPMENT FOR PRIMARY HEALTH CARE IN DEVELOPING COUNTRIES

(Gilbert Burnham and Anbrasi Edward, on-site)

SPECIAL STUDIES IN PRIMARY HEALTH CARE

(Henry Perry, on-site)