

Marching Ahead with Powerful Contingent of Adolescents -*the Demographic Dividends-* towards Renaissance of Primary Health Care

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An overarching theme to be observed in several of the primary health approaches that we have studied is the emphasis on comprehensive care. That is to say that in caring for people in all communities, social, economic, and historical factors should be considered together with health studies. It also means that the whole person is treated, not just the disease. At the Alma Ata Conference in 1978, among the contributors to this groundbreaking document was Dr. Carl Taylor. 30% of adolescents of our total 1.2 billion population eye eagerly towards Primary Health Care.

In one of the lectures delivered in Johns Hopkins University in 1987, Carl Taylor explained the roots of the Primary Health Care (PHC) and discussed the drafts by WHO and UNICEF leading to international conference on Health for all through PHC at Alma Ata in 1978. At this conference, medical, public health and global policy experts proclaimed: "The Conference strongly reaffirms 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.

If we peep through the historical overview of the PHC by Carl, we observed that US clinicians first called PHC as the individual focus while community oriented primary care started with Kark in South Africa, then it went to US and Israel. 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-diseases specific and target to make maximum impact the eradication of Polio. In other words, health has moved from under-investment, to single disease focus, and now to increased funding and multiple new initiatives. Second well-known example of the selective primary health-care approach is the child survival revolution, championed by Jim Grant. This debate—between comprehensive and selective, horizontal and vertical, top-down and bottom-up—was the major topic of discussion in global health for the 1980s and 1990s, with few programs or agencies bridging the gap. Debates of community versus facility-based health care are starting to shift towards building integrated health systems. But now it is shifting towards combining the strengths of both approaches in health systems.

Carl also mentioned about Community based PHC (CBPHC) and integrating CBPHC with Seed Scales. Highlighting the broad sweep of history of PHC, he underlined the amazing similarities of ancient system of India, China and Greece practicing as natural medicines, role of religions, shamans and Babylon public square concept and further added about hot and cold forms, spirits possession for ill health, humors, miasmas and

heating practices[3]. He enlightened that earlier PHC was preventive and integrated but Hippocrates differentiated medicine and public health streams. Indian systems like Charak, Susuruta, Vagbhata were based upon Ayurveda and Chopra commission legalized it but western doctors defeated it. Successful research on Indian herbs like Rauwolfia for hypertension gave the idea of earning of money to the commercial companies and similarly, yellow emperor's classic system in China.

Let us note down that it was Virchow, the German pathologist who originated modern PHC as social medicine. Later on, post world war-1, Dawson report, Peckham health centers social work centres in US strengthened it. Ding Xian from Beijing introduced the Mao's concept of Bare food doctors for a quarter of world population but later on, it was collapsed by Deng Xiao Ping's economic reforms in 1980. Second and third generation projects emerged in late 1930s to 1950s, e.g., Hydrick from Indonesia; Stamper from Croatia; major historical contribution by Rockefeller foundation, developing centers from Sri Lanka, Kerala in India. In 1950s, Kark et al; Pholela-South Africa[4] developed the health system. In contrast an example of a partly successful run public health program was in South Africa. The Community Oriented Primary Care (COPC) founded by Sidney and Emily Kark in the rural area of South Africa. The organization's philosophy was comprehensive healthcare for all, which focused primarily on the health needs and using preventative care. The Kark's used a team of doctors, nurses and trained healthcare workers for community programs for mothers, children and to strictly promote infant and childhood development and growth. Another of their goal was to train community members to track diseases which were data oriented and its goal was to keep records of births, deaths, and illnesses in the area. This model has been proven to be partly successful in South Africa due to the lack of help from the government. This lack of help was political in nature and was strongly tied to Apartheid, hence resulting in the Kark's leaving South Africa. Though partly

successful, this was the model that the USA emulated for their Primary Health Care guidelines. From 1960 to 1970, other health systems also came into the existence like Narangwal Punjab, Fendall from Kenya, Geiger from US and Aroles-Jamkhed and finally, in 1978 at Alma Ata. The Jamkhed model has achieved results far in excess of the Millennium Development Goals (MDG) in about 40 years. It transformed the community so much that it is not just healthier; it is also self-sufficient and economically respectable.

Let us re-assert that there are three vital pillars of PHC; Equity, intersectoral coordination and community participation. Empowering Community in Nagpur, Gadchiroli model in Home Based New Born Care (HBNC) Dr. Abhay Bhang resulted in lowering the Infant Mortality Rate and then Neonatal Mortality Rate to 25/1000 Live Births from 125/1000 live births. The driving force was-Think locally but act globally. The model was replicated in Pakistan, Africa and Bangladesh with equal success by the people power-so called Demographic Dividends. Certainly, achievement of high and equitable coverage of integrated primary health-care services requires consistent political and financial commitment, incremental implementation based on local epidemiology, use of data to direct priorities and assesses progress, especially at district level, and effective linkages with communities and non-health sectors. In order to demonstrate the Demographic Dividends, we are quoting another example to highlight as to how post-war Liberia was built up by Community Health Workers was vividly brought out by Dr. Panjabi. This resolved multiple problems such as providing employment, boosting the economy along with the purpose of spreading knowledge to the people.

Carl also emphasized the role of traditional practitioners and their competitions with the modern practitioners in PHC. Their roles are still ambiguous in CBPHC especially in the poorest and the remotest areas. In order to make the public health routine work interesting, he briefed out for some natural

experiment and importance of people and not their numbers. Pat Rubinstein and Massachusetts, the great old epidemiologists used to understand the shoe leather epidemiology of diseases, their causation, diagnosis, control and shared with people and work intelligently with the community. Lastly and quite importantly, he concluded the discussion with a trawling question about ways and means for qualified doctors to actually visit the villages for PHC in the developing countries.

Now we still have old health challenges and certainly, new priorities have emerged (eg, HIV/AIDS, chronic diseases, and mental health), ensuring that the tenets of Alma-Ata remain relevant. We examine 30 years of changes in global policy to identify the lessons learned that are of relevance today, particularly for accelerated scale-up of primary health-care services necessary to achieve the Millennium Development Goals, the modern iteration of the “health for all” goals. Revitalizing Alma-Ata and learning from three decades of experience is crucial to reach the ambitious goal of health for all in all countries, both rich and poor; also for today and tomorrow. Carl has rightly said, “There is no universal solution, but there is a universal process to find an appropriate local solution”?

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In 20 years from now, at the half century of Alma-Ata, we could see a different world, with basic health care reaching many of the poorest families. Wonderfully, we have a bubbling contingent of adolescents which is one third of the total population in India, anxiously looking forward to PHC. However,

to achieve this goal we need to revitalize the original revolutionary principles of Alma-Ata, sticking consistently to the core values of universal access for care, equity, community participation, intersectoral collaboration, and appropriate use of resources. We believe that revitalization of the tenets of the Alma-Ata Declaration is necessary to meet the MDGs in 2015 and beyond. 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.”

References

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