Primary Health Care
IN PRACTICE

Dr. Sharuna Verghis

ATHYNA.EDUCATION

LEARNING OUTCOMES

1. Explain the concept of primary health care
2. Describe the conditions recommended to enable efficient primary health care
3. Identify case examples of selective and comprehensive primary health care

This E-Book should be reviewed alongside the lecture videos and the *required reading* materials. This PDF is interactive. Please click on the links to navigate through the E-Book content.

Table of Contents

Primary care vs. primary health care 01

What is primary health care? 05

Declaration of Alma Ata 1978 06

Conditions that enable efficient primary health care 08

The Barefoot Doctors in China 10

Gonoshasthaya Kendra (Savar Project) 12

Good practice case examples of primary health care 14

Evidence of the effectiveness of primary health care 15

What does integrated primary care mean in the context of multimorbidity and chronicity? 16

Selective primary health care 17

GOBI-FFF and selective primary health care 18

Differences between comprehensive primary health care and selective primary health care 19

Must Know 21

PRIMARY CARE VS. PRIMARY HEALTH CARE?

What is the difference?

Although primary care and primary health care are frequently used interchangeably, they denote separate, yet inter-related concepts.

Primary care refers to the first point of contact with the healthcare system. It focuses on individual health and provides a patient with a diagnosis and/or treatment.

Primary health care, on the other hand, a broader concept, includes health promotion, disease prevention, public health education, community-based interventions, access to healthcare services, addressing determinants of health, and collaboration between multiple healthcare stakeholders.

The following table highlights some of the fundamental differences between primary care and primary health care.

FEATURE	PRIMARY CARE	PRIMARY HEALTH CARE
Model of health	Drawn from the biomedical model of health, focusing on individual illnesses and conditions	Drawn from the social model of health, addressing broader determinants of health including social, economic, and environmental factors.
Scope	Narrower focuses on individual health services typically provided by family doctors.	Broader, encompassing both individual health services and community-level public health initiatives.
Accessibility	Primarily concerned with providing accessible care to individuals.	Emphasizes universal accessibility and essential health services for all members of the community.
Integration in the health system	Seen as a component of the health system, often the first point of contact.	Considered the nucleus of the health system, integrating various health services and policies.
Prevention focus	Focus on early diagnosis, timely and effective treatment, often involving secondary (early treatment to minimize complications) and tertiary (rehabilitation) disease prevention.	Emphasis on primary prevention (prevent disease or injury even before it occurs), alongside secondary and tertiary prevention.
Reform drivers	Reform is driven by demographic factors such as aging populations or reduced ability of health systems to respond to health problems which often require emergency care and/or hospitalization.	Reform is driven by considerations of equity, affordability of access, sustainability of primary health care services, and people's empowerment.

FEATURE	PRIMARY CARE	PRIMARY HEALTH CARE
Health education	Health education is often driven by considerations of disease prevention rather than multidisciplinary approaches to health promotion and development.	Requires a multidisciplinary and multisectoral approach to address the determinants of health, including health promotion and disease prevention strategies.
Participation	Does not require substantive participation of those affected by the problem.	Requires the substantive participation of those most affected by the problem, fostering community engagement and empowerment.
Role in development	Focus is mainly on health outcomes for individuals.	Integral to the social and economic development of the community, addressing broader determinants of health.
Cost and resource utilization	Cost considerations are primarily at the individual or insurance level.	Emphasizes affordability and efficient use of resources at the community and country level.
Community orientation	Services are individual-centric.	Services are community-focused, aiming to bring healthcare close to where people live and work.
Service provision	Personal, patient-focused healthcare services.	Comprehensive services including health promotion, disease prevention, and addressing community health needs.

FEATURE	PRIMARY CARE	PRIMARY HEALTH CARE
Quality of services	Focus on quality within the context of individual care.	Commitment to high-quality services across a broad spectrum of healthcare.
Teamwork and collaboration	Involves collaboration but primarily within a clinical setting.	Requires teamwork and interdisciplinary collaboration across various sectors impacting health.
Decentralization	Less emphasis on decentralization.	Strong emphasis on decentralizing services to community-based organizations.
Professional skills	Provided by healthcare professionals focused on individual care needs.	Provided by professionals with skills to meet both individual and community health needs.

Keleher, H. (2001). Why primary health care offers a more comprehensive approach to tackling health inequities than primary care. Australian Journal of Primary Health, 7(2), 57-61. Although primary care and primary health care are frequently used interchangeably, they denote separate concepts yet inter-related.

Muldoon, L. K., Hogg, W. E., & Levitt, M. (2006). Primary care (PC) and primary health care (PHC). What is the difference? Can J Public Health, 97(5), 409-411. https://doi.org/10.1007/bf03405354

WHAT IS PRIMARY HEALTH CARE?

Primary Health Care (PHC), also known as comprehensive primary health care, is a comprehensive and integrated approach to health care that is universally accessible to individuals and families in the community, with a focus on prevention, promotion, treatment, rehabilitation, and palliative care. It emphasizes the first level of care and often serves as the first point of contact with the health care system.

A key aspect of PHC is its role in the health system and community development. It is intended to be the center of a country's healthcare system and a crucial part of its social and economic development. PHC brings health care as close as possible to where people live and work. PHC is essential health care based on scientifically sound and socially acceptable methods, universally accessible to individuals and families with their full participation at a cost that the community and country can afford in a spirit of self-reliance and self-determination.

There are two landmark declarations related to primary health care:

- Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, 1978.
- Declaration on Primary Health Care, The Global Conference on Primary Health Care, Astana, Kazakhstan, 2018.

HEALTH AS A FUNDAMENTAL HUMAN RIGHT
DECLARATION OF ALMA-ATA, 1978

A RENAISSANCE IN PRIMARY HEALTH CARE
THE ASTANA DECLARATION, 2018

DECLARATION OF ALMA-ATA 1978

The roots of the Alma Ata Declaration can be traced back to the 1970s, a time marked by growing concerns regarding the insufficiency of healthcare systems, particularly in developing nations, to adequately address the needs of their populations.

Adopted during the International Conference on Primary Health Care (PHC) in Alma-Ata, Kazakhstan, in 1978, the declaration provided international recognition to the concept of primary health care (PHC) as a pivotal strategy aimed at achieving "Health for All" by the turn of the millennium.

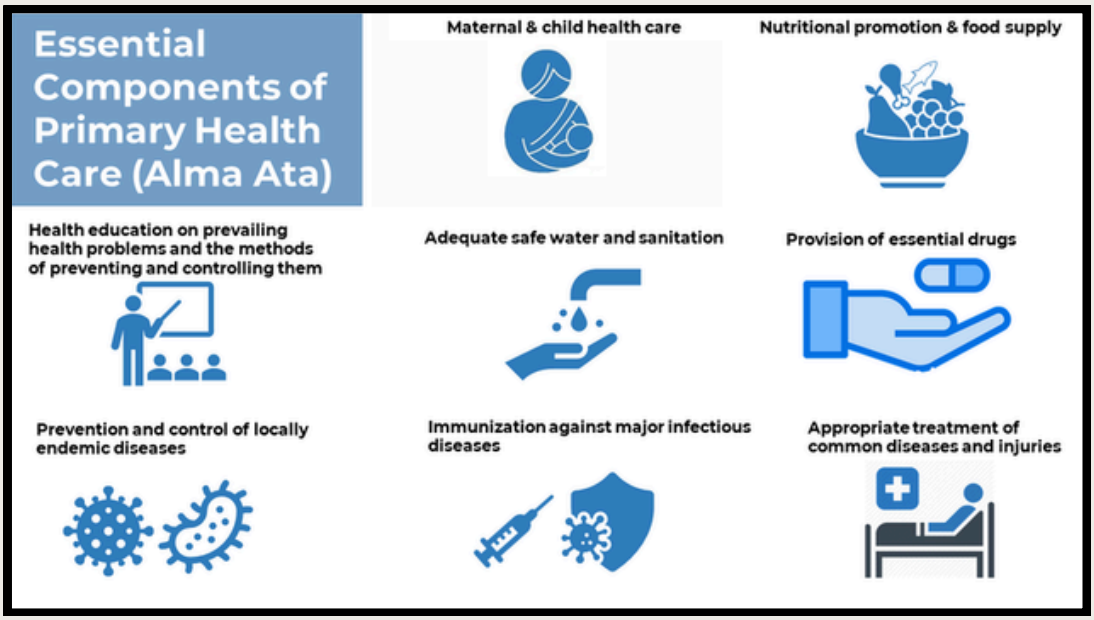
Attended by representatives from 134 countries and 67 international organizations, the conference underscored the significance of tackling social determinants of health, promoting health equity, and ensuring the provision of essential health services to individuals and families worldwide. Widely regarded as a landmark event in global health history, the Alma Ata Declaration spurred numerous member nations of the World Health Organization (WHO) to embrace primary health care as a fundamental approach to healthcare delivery.

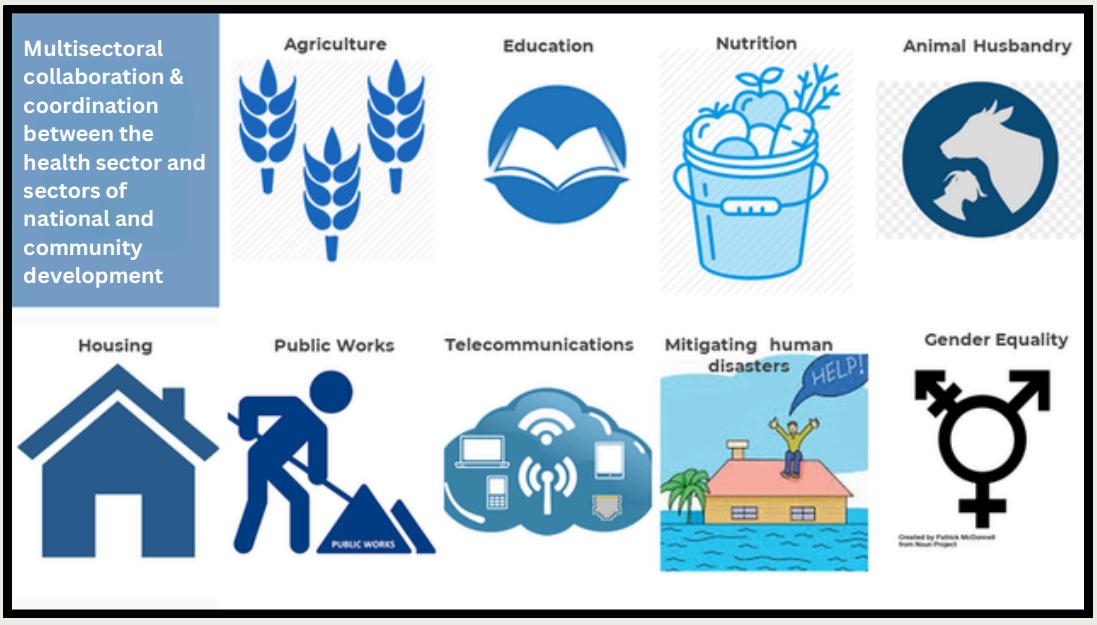
The primary objectives outlined in the Alma-Ata Declaration were:

- Establishing primary health care as the cornerstone of health systems worldwide, with a particular focus on developing nations.
- Ensuring an equitable distribution of health facilities and services within each country.
- Decreasing infant mortality rates and enhancing maternal health.
- Combating major infectious diseases through preventive measures and accessible treatments.
- Integrating traditional medicine practices into modern health systems while respecting local cultures and beliefs.
- Training and deploying more health personnel, especially in rural and remote areas.
- Promoting community involvement in health initiatives and encouraging self-care activities.
- Fostering international cooperation and solidarity to elevate global health standards.
- Striving for "Health for All" by the year 2000, recognizing health as a fundamental human right.

COMPONENTS OF THE ALMA ATA DECLARATION, 1978

According to the Alma Ata Declaration, primary health care is essential health care based on scientifically sound and socially acceptable methods, universally accessible to individuals and families with their full participation at a cost that the community and country can afford in a spirit of self-reliance and self-determination.





These objectives aimed to establish sustainable, affordable, and culturally sensitive health systems accessible to all, regardless of geographic location or socioeconomic status. However, despite initial enthusiasm, challenges in implementation and shifting priorities away from primary health care have impeded progress towards achieving these ambitious goals.

Chapman, A. (2018). ALMA-ATA at 40: Revisiting the Declaration. Health and Human Rights Journal. https://www.hhrjournal.org/2018/09/alma-ata-at-40-revisiting-the-declaration/

Rivero, D. A. T. d. (2003). Alma-Ata revisited Perspectives in Health Magazine [online], 8(2). https://www3.paho.org/english/dd/pin/Number17_article1_1.htm

CONDITIONS THAT ENABLE EFFICIENT PRIMARY HEALTH CARE

- **Accessible and equitable services**
  Services are available close to where people live, affordable, and distributed so that disadvantaged groups are not left behind.

- **Adequate and sustainable funding**
  The health system has enough, reliably funded resources to provide essential PHC services over time, not just through short-term projects.

- **Skilled and supported workforce**
  Health workers are well trained, fairly distributed, and given the supervision, resources, and working conditions they need to provide quality care.

- **Multidisciplinary and team-based care**
  Different health professionals (e.g. doctors, nurses, community health workers, allied health) work together to address the complex needs of individuals and communities.

- **Integration and continuity of care**
  Care is coordinated across services and over time so that people experience smooth referral pathways, follow-up, and long-term support for chronic conditions.

- **Community engagement and participation**
  Communities are actively involved in identifying health priorities, shaping services, and taking part in health actions, rather than being passive recipients.

- **Culturally safe (socially acceptable in Alma Ata) and inclusive care**
  Services respect local cultures, languages, and beliefs, actively reduce discrimination, and make all groups feel welcome and safe using care.

- **Focus on prevention and health promotion**
  PHC emphasizes preventing illness and promoting wellbeing through immunisation, screening, health education, and action on social determinants—not only treating disease.

- **Supportive policy and governance**
  Laws, policies, leadership, and accountability structures actively prioritise PHC, equity, and intersectoral action, creating an enabling environment for frontline services.

This auntie vaccinates us (Ca. 1975)
https://chineseposters.net/themes/barefoot-doctors

THE BAREFOOT DOCTORS INITIATIVE IN CHINA

The Barefoot Doctors program was initiated after the Cultural Revolution in China in the 1970s. It had a deep influence on the Declaration of Alma-Ata of 1978. The success and principles of this program contributed significantly to the formulation of the Alma Ata Declaration, which emphasized the importance of primary healthcare.

At the heart of the Cultural Revolution was the goal of equality and the redistribution of wealth and income. Under the land reform measures that were introduced including the ownership of land by the State and the introduction of collective farming and agriculture, the barefoot doctors were members of the communes who engaged in collective farming and also the practice of medicine.

The Barefoot Doctors programs was initiated as a response to the need for rural coverage for healthcare. Following criticism from Chairman Mao Zedong about the

urban bias in medical services, doctors from urban hospitals were mandated to train paramedics in rural areas.

Most barefoot doctors had a secondary school education and practiced after an initial training of three to six months or a year. They practiced both Western and traditional Chinese medicine and continued to work as peasants.

They were called barefoot doctors because farmers in the south often worked barefoot in the paddy field.

The tasks performed by the barefoot doctors included the elimination of infectious diseases, promotion of the patriotic hygiene movement, immunization, delivery for pregnant women, improvement of sanitation, simple surgical operations, and collecting disease information.

The success of the Barefoot Doctor model demonstrated the effectiveness of providing primary healthcare at an affordable cost and highlighted the importance of preventive healthcare and community involvement in health initiatives.

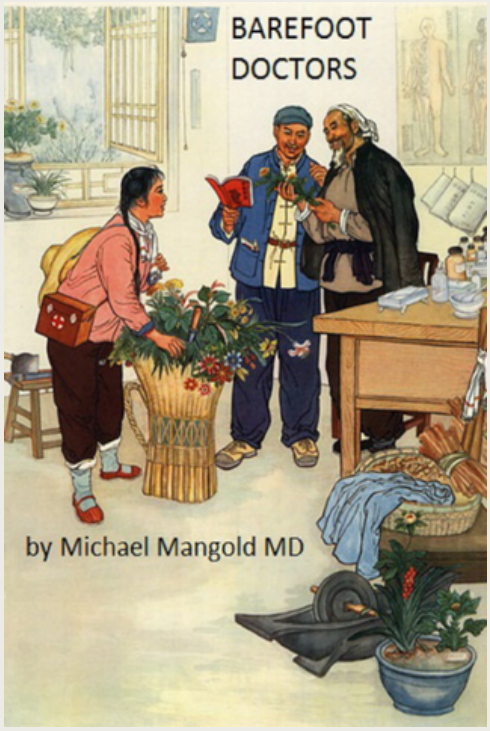
Within 10 years of the Cultural Revolution, there were one million barefoot doctors.

However, the reforms in healthcare which followed the start of market economy in China led to the collapse of this cooperative medical system, which was replaced by a payment-based system in the rural areas. Some of the barefoot doctors transitioned to become private practitioners and others joined other professions. The introduction of a payment-based system for treatment of diseases within private practice also saw the neglect of public health priorities and waning of primary health care coverage in rural areas. As China's health system becomes more hospital-centric and fragmented, there is a call to strengthen primary health care in the country.

Successes of the Barefoot Doctors Program:

- Reduction of infant mortality
- Eradication of small pox
- Reducing sexually transmitted infections, tuberculosis and schistosomiasis* (*schistosomiasis re-emerged when China opened its economy and the three gorges dam was built on the Yangtze river)
- Increase in life expectancy from 35 years to 68 years within a 30-year period.

Xu & Hu, 2017; Weiyuan C, 2008; Zhang & Unschuld, 2008; World Bank & WHO, 2016; World Bank & WHO, 2019.



Wikimedia

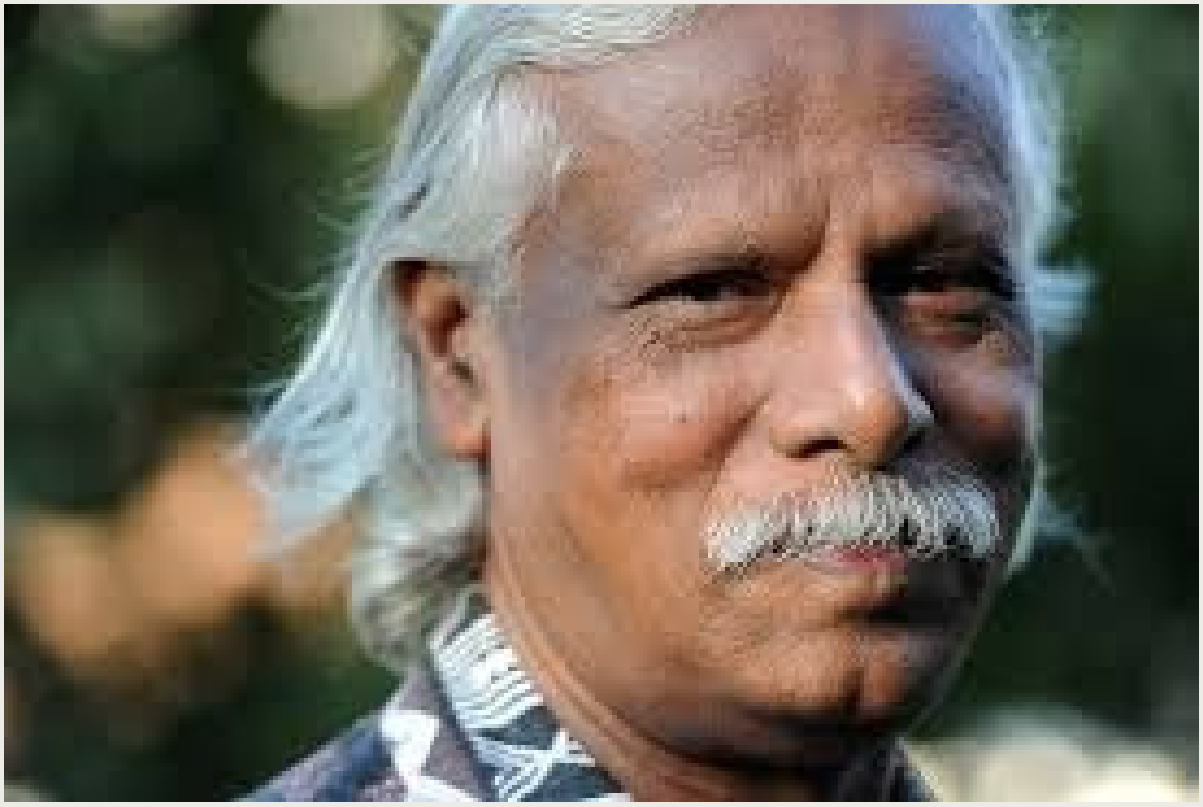
GONOSHASTHAYA KENDRA (SAVAR PROJECT)

The Savar Project in Bangladesh, now known as Gonoshasthaya Kendra (GK, "People's Health Centre"), is a pioneering example of comprehensive primary health care in practice. It began during the 1971 liberation war, when young Bangladeshi doctors, including vascular surgeon Dr Zafrullah Chowdhury, returned from overseas to set up the Bangladesh Field Hospital on the India–Bangladesh border to care for wounded freedom fighters and refugees.

After independence, the field hospital was moved to Savar, a poor agrarian region with high levels of poverty, recurrent floods, and very high maternal and infant mortality. The founders adopted the motto "Gram e cholo, Gram goro" ("Let us go to the villages and build the villages"), signalling a commitment to village development rather than a narrow, hospital-centred model of care. They and their colleagues lived in tents alongside a 480-bed makeshift hospital serving about 50 villages (around 50,000 people), deliberately locating care close to where people lived and worked.

A core innovation was "demystifying medicine" by training mostly young rural women as paramedics. Initially recruited to staff the wartime field hospital, these women received robust hands-on training as surgical assistants, medicine dispensers, nurses, and nursing aides, and later as village-based health workers. Paramedics and trained traditional birth attendants provided antenatal care, safe delivery, basic emergency care, health education, and referrals in women's homes, addressing both geographic and gender barriers to access. As maternal health improved, research from Savar documented dramatic reductions in maternal mortality compared with hospitals in Dhaka, despite GK working in a far poorer rural context.

From the outset, GK framed health as inseparable from wider social needs in



Dr. Zafrullah Chowdhury was awarded the Right Livelihood Award in 1992, often known as the "alternative Nobel Prize," for his outstanding work in promoting health and human development. He also earned the inaugural Independence Day Award, the highest civilian award in Bangladesh, in 1977.

Savar: nutrition, clean water, sanitation, family planning, education, income, and gender equality. Health services were integrated with schools for farmers' children, vocational training and income-generation projects for women (e.g. sewing, carpentry), agricultural extension, micro-insurance, and later a wide range of facilities including pathology and vaccine laboratories, herbal medicine research, pharmaceutical production, and dialysis services.

GK's work also extended "upstream" to national policy. Drawing on the WHO Essential Medicines concept, Dr Zafrullah and colleagues advocated successfully for Bangladesh's 1982 National Drug Policy, which limited irrational and harmful pharmaceuticals and prioritised an affordable list of essential medicines for the whole population. This was internationally recognised as a landmark in essential drugs policy and made basic medicines more available and affordable, particularly for the rural poor.

Over time, Gonoshasthaya Kendra evolved into one of Bangladesh's largest non-government, not-for-profit health and development organizations, serving more than a million people across hundreds of villages through a network of rural clinics and hospitals, and earning national and international awards for its contribution to health and human development. The Savar/GK model illustrates comprehensive primary health care as envisioned in Alma-Ata: community-based, person-centred, strongly participatory, intersectoral, and explicitly focused on equity and social justice rather than on hospital-centred, doctor-dominated care.

CASE EXAMPLES OF GOOD PRACTICE OF PHC

What Do They Have In Common?

In 1985, a study funded by the Rockefeller Foundation identified five key factors contributing to successful case examples of achieving good health at low cost in China, Kerala, Sri Lanka, and Costa Rica:

- Historical and political commitment to health as a social goal
- High-level investment in primary health care and other community-based services
- Strong societal values of equity, political participation and community involvement in health
- Widespread education, especially of women
- Intersectoral linkages for health.

Approximately 25 years later, a subsequent study revisiting the concept of good health at low cost, which built upon the findings of the 1985 study across the same four countries while also exploring additional locations such as Tamil Nadu, Ethiopia, Kyrgyzstan, Bangladesh, and Thailand, revealed the following associated factors:

- High coverage of interventions to improve maternal and neonatal and child health such as skilled birth attendance (regarded as a proxy for primary health care) and immunization.
- Higher government spending on health care although the proportion of health spending as a proportion of GDP might not be high.
- High density of physicians was associated with lower under-five mortality
- Higher female literacy was associated with lower under-five mortality
- Sanitation was a predictor of good health
- Increased public spending on primary care is largely pro-poor.

Balabanova, D., et al (2013). Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. Lancet, 381(9883), 2118-2133. https://doi.org/10.1016/s0140-6736(12)62000-5

Halstead SB, Walsh JA and Warren KS (eds). 1985. Good health at low cost. New York: Rockefeller Foundations Conference Report.

EVIDENCE OF THE EFFECTIVENESS OF PRIMARY HEALTH CARE

Low-and-Middle Income Countries (Kruk et al., 2010)

Integrated primary care programs implemented in Latin America, Thailand, Kerala, and Iran have provided coverage and good health outcomes for an estimated 240 million people for:

- **Childhood illnesses**
- **Infectious diseases**
- **Access to essential medicine**

Sri Lanka has healthcare utilization levels comparable to industrialized countries.

Under-five mortality and life-expectancy in Cuba, Sri Lanka, and Iran rival those of wealthier countries.

Thailand reduced its under-five mortality rate by 32 percent.

In Afghanistan, Rwanda, the Democratic Republic of Congo and Liberia, basic packages of health services reduced under-five mortality.

Reduction in gap in access to services and increase in equity

- **Costa Rica & Brazil focused on socio-economically disadvantaged areas to implement primary health care.**
- **Sri Lanka and Thailand expanded rural primary care to reduce geographical imbalances in health service availability.**

High Income Countries

Study on primary health care in 31 European countries:

- **Lower hospital admission rates for asthma and diabetes**
- **Fewer potential deaths due to ischemic heart disease, chronic asthma, bronchitis, and emphysema.**
- **Countries with better continuity of primary care were associated with a significantly lower socioeconomic inequality in self-rated**

(Kringos et al., 2013)

Low utilization of primary care by the poor was associated with high hospitalization rates (United States & Spain).
(Starfield et al., 2005)

Lower utilization of primary health care by the poor compared to rich co-existed with hospitalization concentrated among the poor but with a clear time trend toward equality (Sweden).
(San Sebastian et al., 2017)

Kringos, D. S., Boerma, W. G. W., van der Zee, J., & Groenewegen, P. P. (2013). Political, cultural and economic foundations of primary care in Europe. Social Science & Medicine, 99, 9-17. https://doi.org/https://doi.org/10.1016/j.socscimed.2013.09.017.

Kruk, M. E., Porignon, D., Rockers, P. C., & Van Lerberghe, W. (2010). The contribution of primary care to health and health systems in low- and middle-income countries: A critical review of major primary care initiatives. Social Science & Medicine, 70(6), 904-911. https://doi.org/https://doi.org/10.1016/j.socscimed.2009.11.025.

San Sebastian, M., Mosquera, P. A., Ng, N., & Gustafsson, P. E. (2017). Health care on equal terms? Assessing horizontal equity in health care use in Northern Sweden. Eur J Public Health, 27(4), 637-643. https://doi.org/10.1093/eurpub/ckx031.

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. The Milbank quarterly, 83(3), 457-502. https://doi.org/10.1111/j.1468-0009.2005.00409.x.

WHAT DOES INTEGRATED PRIMARY CARE MEAN IN THE CONTEXT OF MULTIMORBIDITY & CHRONICITY ?

Check out this case example of Eksote, South Karelia, Finland

https://www.youtube.com/watch?v=w4aasiZLY9Q

SELECTIVE PRIMARY HEALTH CARE

Selective primary health care emerged as an alternative to the comprehensive primary health care approach in the late 1970s and early 1980s owing to the various obstacles encountered by the latter. These challenges included high costs, complex logistics, and significant demands for prolonged investments in both physical infrastructure and skilled workforce. These challenges stemmed from the ambitious scope of this model, aiming to address diverse aspects of community well-being while promoting equitable access to healthcare, particularly within underprivileged regions.

Selective primary health care was a more practical approach, focused on cost-effective interventions targeting specific health problems. It was popularized by Julia Walsh and Kenneth S. Warren in their influential 1979 article "Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries." Selective primary health care aimed to prioritize certain health interventions that could yield the most significant immediate health improvements, such as immunization, oral rehydration therapy, and family planning services. The rationale behind selective primary health care was to achieve significant health improvements within the constraints of limited resources, often focusing on children's health and infectious diseases, which were major mortality drivers in low-income countries. However, selective primary health care also sparked debate about compromising equity, community participation, and the comprehensive integration of health services. The global health community has endeavored to integrate the strengths of both strategies cohesively, to create robust yet accessible health systems.

Cueto, M. (2004). The origins of primary health care and selective primary health care. Am J Public Health, 94(11), 1864-1874. https://doi.org/10.2105/ajph.94.11.1864

GOBI-FFF AND SELECTIVE PRIMARY HEALTH CARE

The acronym GOBI-FFF represents a focused approach within the selective primary health care strategy, aiming to improve child survival and health outcomes in resource-limited settings. Developed in the 1980s, this initiative prioritizes cost-effective and high-impact interventions that can be rapidly deployed to reduce child mortality and enhance child health.

GOBI-FFF stands for:
G - Growth monitoring
O - Oral rehydration therapy
B - Breastfeeding
I - Immunization
F - Family planning
F - Female education
F - Food supplementation

GOBI-FFF emphasizes the importance of early detection of malnutrition through growth monitoring, life-saving treatment for diarrheal diseases through oral rehydration therapy, essential nutrients and immunity provided by breastfeeding, and prevention of major childhood diseases through immunization. The addition of family planning, female education, and food supplementation acknowledges the broader determinants of child health, emphasizing the importance of healthy family practices, women's empowerment, and nutritional support in improving child health outcomes.

UNICEF played a pivotal role in endorsing and disseminating the GOBI-FFF strategy, facilitating the mobilization of resources and fostering international collaboration to implement the GOBI-FFF interventions across many countries.

Cueto, M. (2004). The origins of primary health care and selective primary health care. Am J Public Health, 94(11), 1864-1874. https://doi.org/10.2105/ajph.94.11.1864

DIFFERENCES BETWEEN COMPREHENSIVE PRIMARY HEALTH CARE AND SELECTIVE PRIMARY HEALTH CARE

The table below explains the key distinctions between comprehensive primary health care and selective primary health care. These paradigms differ fundamentally in their approach to health, with comprehensive primary health care focusing on holistic well-being and equity, involving multiple sectors and community empowerment, while selective primary health care concentrates on disease-specific interventions and cost-effectiveness. The comparison provides an understanding of their unique attributes and operational methodologies.

FEATURE	COMPREHENSIVE PRIMARY CARE	SELECTIVE PRIMARY HEALTH CARE
Concept of health	Emphasizes physical, mental, and social wellbeing.	Focuses on the absence of disease. Focuses on reducing specific diseases that are most harmful and feasible to control.
Approach	Encourages a multidisciplinary team approach involving nurses, physicians, and other health professionals working together to meet the complex needs of patients and communities.	Tends to use a more fragmented approach to health care, potentially leading to gaps in care for certain populations.
Equity vs efficiency	Equity is a core principle, addressing the root causes of poverty and resource distribution required to guarantee equitable access to healthcare services.	Prioritizes cost-effective interventions for specific diseases. It does not specifically target the poor or needy.

FEATURE	COMPREHENSIVE PRIMARY CARE	SELECTIVE PRIMARY HEALTH CARE
Health as a development issue	It emphasizes economic, environmental, and social factors of health. Actions implemented beyond the confines of the healthcare sector can yield health impacts far surpassing those achieved within it. It emphasizes healthy public policies.	Focuses on medical interventions and cost-effectiveness without multi-sectoral engagement.
Community participation	Community participation is core to eventual community self-reliance and empowerment.	Community involvement is limited to accepting medical interventions chosen by professionals.

In summary, selective primary health care has some advantages over comprehensive primary health care, including being cost effective and more easily and rapidly implementable, with the focused approach and more targeted response providing a more immediate and visible impact on specific health issues. However, thinking about long term sustainability and broader health needs of the population. comprehensive primary health care, despite being more expensive and complex to implement, addresses a wider range of health issues, promotes holistic well-being, and emphasizes community participation and empowerment. Unlike, selective primary health care, it does not lead to a more fragmented approach to healthcare.

Fran, B., Toby, F., Angela, L., Ronald, L., & David, S. (2017). What is the difference between comprehensive and selective primary health care? Evidence from a five-year longitudinal realist case study in South Australia. BMJ Open, 7(4), e015271. https://doi.org/10.1136/bmjopen-2016-015271.

Obimbo, E. M. (2003). Primary health care, selective or comprehensive, which way to go? East Afr Med J, 80(1), 7-10. https://doi.org/10.4314/eamj.v80i1.8659.

Rifkin, S. B., & Walt, G. (1986). Why health improves: defining the issues concerning 'comprehensive primary health care' and 'selective primary health care'. Soc Sci Med, 23(6), 559-566.

MUST KNOW

1. **What is primary health care or comprehensive primary health care?**
2. **What is the Alma Ata Declaration and what are the essential components of the Alma Ata Declaration?**
3. **Key conditions that enable efficient PHC.**
4. **What is selective primary health care and GOBI-FFF?**
5. **What is the difference between comprehensive primary health care and selective primary health care?**

Alma-Ata, 1978 (Source: PAHO)

Primary Health Care
IN PRACTICE

Dr. Sharuna Verghis

THEME II:POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1

MONASH University MALAYSIA | JEFFREY CHEAH SCHOOL OF MEDICINE & HEALTH SCIENCES