PRIMARY HEALTH CARE AND THE VILLAGE HEALTH WORKER

This article was gleaned from reports by the Director General of the World Health Organization, Dr Halfdan Mahler, and other documents related to the January 1975 meeting of the Executive Board of WHO, all of which reflected its strong emphasis on the promotion of national health services and the development of primary health care as a principal means to that end. It was printed in CONTACT 25, February 1975.

THE PROMOTION OF NATIONAL HEALTH SERVICES

The Executive Board of the World Health Organization, meeting in Geneva during the last two weeks of January 1975, resolved to give top priority to the promotion of national health services. This policy decision was given a position of “crucial priority” because of its concern over the maldistribution and lack of coverage of health services – a worldwide problem. It defined the problem in the following terms:

“The Board is of the opinion that in many countries the health services are not keeping pace with the changing populations either in quantity or quality. It is likely that they are getting worse. Even if this is looked at optimistically and it is said that the health services are improving, the Board considers that we are on the edge of a major crisis which we must face at once as it could result in a reaction which could be both destructive and costly. There appears to be widespread dissatisfaction of populations about their health services for varying reasons. These dissatisfactions occur in the developed as well as the developing world. They can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness by the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own, which may be satisfying to the health professions, but which is not what is wanted by the consumer.

“The majority of the people in the disadvantaged areas of most countries of the world do not obtain sufficient care or otherwise benefit from known health technology. Health services which should provide coverage to these populations in fact provide services to only a very small proportion of the population they are supposed to serve. Furthermore, whenever health services have been provided, they have been often fragmented and isolated from other activities directly or indirectly related to health and have not corresponded with the life styles and living conditions of the population. Consequently, services have been unable to give emphasis to consumer preferences and to make medicine ‘belong’ to those whom it should serve.

“In the absence of any health services or in the presence of unsatisfactory services, the population has had to rely almost exclusively on its own indigenous resources. The care offered by traditional birth attendants, herbalists and others, and the advice and practices passed on from one generation to the next have had to serve the needs of these populations. The knowledge inherent in these community-based
health activities and the manpower required are a valuable resource for the future development of the health services. If the resources available to the community and the resources available to the health services could be brought into harmony or, in other words, could become indistinguishable, except perhaps in function, then one would no longer describe services as not belonging to the community. Degree of satisfaction would no longer be the question asked of the community by the social researcher; it would be a self-imposed criterion of a successful operation.

“A series of major national efforts to develop primary health care services at the community level is seen as the only way in which the health services can develop rapidly and effectively. The prevailing approach to the development of primary health care has been the transfer of health technology from one context to another: developed to developing as well as urban to rural. This approach has failed to meet the needs of today; a radical departure from conventional health services approaches is required. To depart radically from these approaches is to require that new services are built up out of a series of peripheral structures that are designed for the context they are to serve. Certain basic principles must be adhered to if these design efforts are to be successful. These follow directly from the above discussion and include:

i) Primary health care should be shaped around the life patterns of the population it should serve.

ii) The local population should be actively involved in the formulation of health care activities so that health care can be brought into line with local needs and priorities.

iii) Health care offered should place maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are often present.

iv) Primary health care should be an integrated approach of preventive, curative and promotive services for both the community and the individual.

v) All health interventions should be undertaken at the most peripheral practicable level of the health services by the worker most simply trained for this activity.

vi) Other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical, supply, supervisory and referral support.

vii) Primary health care services should be fully integrated with the services of the other sectors involved in community development (agriculture, education, public works, housing and communications).

“The concerns identified in the previous section can be said to be universal. There are few countries that can argue that these concerns do not apply to them. It has been stated that in the Americas as much as 37 per cent of the population are at present under-served, and in Africa, the Eastern Mediterranean, South-East Asia and in the Western Pacific (excluding China) the population of 1,660 million in 1970 may be 80 per cent rural and as many as 1,075 million may not have access to primary health care.

“It is accepted that while the need is apparent for action which is consistent with the principles identified earlier, the country response to this need may be unique for each country. These variations are not only varying responses to the different health needs within each country, but they are also national expressions of the differences in social and cultural background, political structure, economic realities and national practices and policies. It is suggested, in spite of these differences, that countries or regions within countries requiring action may yet pursue the goal of primary health care by developing a new tier
of ‘primary care’, by expanding or reorienting existing health resources in service of this aim, and by making maximum use of ongoing community activities, especially developmental ones, for the promotion of primary health care.”

One of the major factors hindering the development of health services for rural, periurban, nomadic and remote populations has been the absence of clear thinking about the kind of health personnel needed to provide the necessary services at these levels.

This new cadre of health worker is emerging in many different localities as innovative programmes take form. The workers are the product of various training programmes ranging from 2 weeks to 3 years. They are called by many names, among them being village health worker, primary health worker, health promoter, health auxiliary, dispensary attendant or assistant, paramedical worker, doctor’s assistant, first aid worker, and so on. For the rest of this paper, we will use the term “village health worker” (VHW); this is not to imply that we insist that there be uniformity or that this be the name, but simply for convenience. This, then, is the individual referred to in basic principle № v) above. And in conformity with the conviction that primary health care must of necessity be community-oriented (see principles i), ii) and iii)), the selection of such a person for training as a VHW must be made by the community. As experience with this type of worker is growing, this is emerging as a matter of essential and probably universal importance. Ideally, the VHW is recruited from among the villagers, can be trained in or near the village, and so will truly belong to the people. With training, the VHW can be used to impart health education, change the community attitude to health and give simple medical care. In its working document, presented in the form of a manual and entitled, Training & Utilization of Village Health Workers*, the WHO states:

“Admittedly, these health workers will not be able to solve all the health problems arising in a village. However, this programme is not aimed at producing ideal conditions but at tackling the most common and urgent problems encountered. It seeks to bring about a gradual improvement in the health of various population groups by strengthening the existing health services and by providing a minimum level of service as a point of departure in places where there had been nothing or practically nothing before.

“The VHW will give practical expression to the village’s own determination to take over responsibility for the health of its people, and to make up in part for the deficiencies of the existing health services. The health worker will represent the forward outpost of the health services among the population, although his functions and his range of action will be circumscribed and clearly defined. His activities must not only be desired by the village but must also be followed up, supplemented and guided by a supervisor belonging to the official health services. Such supervision is an essential and integral part of the village health worker concept. The village health worker must not be left to stand alone. He should be envisaged only in the context of a national health service, as the advance guard of the health network and as a small part of a much greater whole. The village health worker will be the link between the village and its nearest health centre or hospital. His contribution will be to the development of the outer reaches of the health services and will be given in close liaison with the other levels of the national health administration.”

In the same document, WHO offers a few standard guidelines for the selection, training and role of the VHW, which we have summarized as follows:

**ESSENTIAL CHARACTERISTICS OF THE VHW**

**Who is He/She?**

The VHW is a man or woman who, if possible, can read and write, and is selected by the village authorities or with their agreement to deal with the health problems of individual people and the community.

**Who Will He/She Report To?**

- The VHW will be responsible both to the village authorities and to a supervisor appointed by the official health services of the country.
- The VHW will be paid (in cash or in kind) by the village for his/her work, which may be full-time or part-time, depending on requirements.
- The village will provide a hut or a room to be used only for the health activities.
- The VHW will follow the instructions given by the supervisor and will work in a team with that supervisor.

**What Training Will He/She Receive?**

The VHW will receive an initial period of training of 6 to 8 weeks from the official health service of the country and will also be given a regular annual further training lasting 2 to 3 weeks. Training will be of a practical nature and will be given near the village. Preferably, the supervisor should give the instruction. The Manual/Practical Guide should be translated into the local language.

**Role and Tasks of the VHW**

The work of the VHW will cover both health care and community development, as a person’s health and that of the community in which he/she lives is so much affected by an improvement in the quality of the environment.

The health work of the VHW will be restricted to what has been taught. VHWs must realize their limitations and be aware that there is only a restricted number of things they can do. They will not be able to solve all the problems they meet, but it is hoped that they will be able to help in dealing with the most common and most urgent ones.

The community development work of the VHW should serve to encourage the village authorities and the village people to show initiative and take interest in any activity likely to improve living conditions in the village. The VHW should first consider what can be done locally with the village’s own resources at the least possible cost.

The VHW’s duties will depend on the problems met. These will vary from one country to another, and it is impossible to draw up a list of problems that will be applicable throughout the world. This is why the example list given earlier should only be taken as a specimen. However, many problems on this list will be met with by most VHWs. For that reason, it seemed possible to prepare a manual that would cover
nearly all the most common concerns of the VHW, even though it was clear that to meet the actual conditions existing in any community, some problems might have to be dropped and others added.

In view of what has been said above, the VHW should:

• care for the health of the villagers and look after community hygiene in the village;
• give care and advice, in accordance with the instructions written down in the manual or given by the supervisor, to any villager who consults him/her;
• send patients to the nearest health centre or hospital in any case in which the manual instructs such action (evacuation or referral) and in any case covered by the manual. The VHW should therefore confine care and treatment to those cases, conditions and situations described in the manual;
• with authorization from the village authorities, visit all dwellings and give those living in them advice on how to prevent disease and learn good habits of hygiene.

In addition, the VHW should:

• make regular reports to the village authorities on the health of the villagers and on conditions of hygiene in the village. Get the village authorities and the village people to provide the help and support needed for his/her work;
• keep in as close contact as possible with the superior so as to be able to give of the best in his/her work and to obtain the equipment and medical supplies needed;
• promote community development activities and play an active part in them.

This assumes that the VHW:

• is available any time of the day or night to respond to any emergency calls;
• acts in all circumstances with common sense and devotion to duty and in awareness of his/her limitation and responsibilities;
• does not leave the village without first informing the village authorities;
• takes part in the periods of training organized by the health service.

The manual itself gives a detailed description of the VHWs’ tasks and will thus enable them to deal with about 30 current and urgent problems.