Bridging the Gap
White Paper

Summary

Attendees at the 1978 international conference on primary health care held in Alma-Ata (now Almaty, Kazakstan) saw the achievement of "health for all"—particularly, the delivery of basic primary health care, water and sanitation—as a possibility and indeed a right (WHO 1978) (Annex 1—Declaration of Alma-Ata). The mantle of this movement was assumed by the People's Health Movement in 2000 (People's Health Assembly 2000). (Annex 2 People's Health Charter)

The attempted destruction of the ideals of Alma-Ata was motivated by the notion of a limited set of resources and a utilitarian strategy of rationing them and rooted in the concept that governments delivering health care as a basic right was not "feasible" in poor countries. In this milieu, the concept of "selective health care" was promoted by the ideology of privatization. The Bamako Initiative (Kanji 1989) (Annex 3 Bamako Initiative) promoted user fees as "cost recovery", a concept that was bolstered by the World Bank and International Monetary Fund imposing severe restrictions on public sector spending in favor of investment in market economies. This was based on fear of inflation or "Dutch disease" if too much money went into the public sector as well as an anti-socialist ideology of the post-Cold War era. The imposition of monetarist, structural adjustment policies robbed the public sectors of the ability to meet the needs of populations with the notion that the public sector "interferes" in economic growth and rather that privatization leads to a robust market that lifts all boats (Navarro 2001).

Today, 30 years after Alma-Ata, we see that while markets have been successfully globalized, despair has not. Social inequality continues to worsen (World Bank 2008) resulting in grossly disparate social determinants that continue to drive high rates of maternal and child mortality and unacceptably low life expectancy. When AIDS was added to the already overwhelming burden of disease among the poor, the health landscape was further reshaped in devastating ways, causing immense human suffering and imposing enormous strains on already fragile health care systems throughout many parts of the developing world.

Activism by and for people living with AIDS in the developing world shone a bright light on the darkly nihilistic belief that resources for health are paltry and immutable and that only market strategies will remedy the health of the poor. Today, billions of dollars have been spent on HIV prevention, testing and treatment; the pharmaceutical industry has been cowed; user fees for HIV services and medications are thought to be unacceptable; and previously held restrictions on public sector spending, while not reversed, have been called into question. Activists, from north and south have been the leading voices in this change, with like-minded medical, political and scientific groups providing concrete examples, funding and other support.

However, with the many gains in HIV treatment accessibility, today, as in 1978, the health of the world's poor remains abysmal and should be seen as a thermometer for injustice and inequality. In this financial crisis, such inequality is worsening and renewed activism is needed to support the movement for health for all—now.

This conference is an attempt to convene people who care about the state of health among the world's poor. It aims to stop and move beyond divisive discussions that pit AIDS- or disease-

specific funding against resources allocated for primary health care and, rather, to bring together advocates for the right to health care and AIDS advocates to craft a joint strategy for activism. *Bridging the Gap* aims to renew the inherent, pragmatic synergy between AIDS and Alma-Ata activists—harnessing those linkages to bolster the movement for achieving health for all.

Alma-Ata and the Promise of Health for All

In the 1960s, the failure of vertical disease control programs, including malaria eradication, and the recognition of growing inequalities in health led to a movement to reorient the World Health Organization towards the development of health systems (Bryant 2008). Health ministers and experts from 137 countries convened the first International Conference on Primary Health Care in Alma-Ata, Kazakhstan, in 1978, and its *Declaration of Alma-Ata* (the Declaration) broke new ground in global health (WHO 1978). The Declaration advocated an approach focusing on primary care and established guiding principles for a wider social movement, rather than treating health issues in isolation. The Declaration recognized that responding to health care needs requires addressing social determinants of health through inter-sectoral collaboration (WHO 1978). It also sought to design equitable and efficient health systems on the basis of primary health care (Cueto 2004). This approach integrated health education, food and nutrition, clean water and basic sanitation, maternal and child health care (including family planning), immunization, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs (Bryant 2008).

Unfortunately, funding was not commensurate with the ambitions of the Declaration. Rather, the health budgets of the poorest countries suffered severely under structural adjustment, resulting in severe caps on salaries of civil servants specifically and public sector spending in general. These policies curtailed governments' ability to deliver health care as a right and promoted the privatization of services. Driven by neoliberal ideology, structural adjustment programs and privatization of social services weakened social sector budgets in the 1980s, limiting funds available for delivering universal health care to the poor (Navarro 2004). Citing limited funds, donors and lead technical agencies argued that comprehensive primary health care was unrealistic and not sustainable (Warren 1988).

In the void of comprehensive primary health care, countries implemented what was euphemistically called "selective primary health care"—particularly GOBI (growth monitoring, oral rehydration, breast feeding promotion and immunization) (Cueto 2004)—which was a mere skeleton of a rights-based approach to care. Promoted on the basis of cost-effectiveness, selective primary health care promoted an isolated focus on technical health interventions (Warren 1988).

There is no doubt, that some selective interventions were effective in reaching their targets; the expansion of immunization programs and oral rehydration therapy were particularly substantial. When the Expanded Programme on Immunization (EPI) was launched in 1974, less than 5% of the world's children were immunized during their first year of life against six killer diseases—polio, diphtheria, tuberculosis, pertussis, measles and tetanus (UNICEF 2005). Immunizations have since saved over 20 million lives (UNICEF 2005). The prevalence of polio has declined dramatically since 1990 and more than 100 million infants are immunized each year, saving more than 3 million lives annually (UNICEF 2005). Significant reduction in diarrhea-related deaths has also been achieved. In 1980 and 2006, the promotion of oral rehydration therapy (ORT) decreased the number of deaths

by 2 million per year worldwide (Cesar 2000). Death from diarrhea was the leading cause of infant mortality in the developing world until ORT was scaled-up (Cesar 2000).

Yet even as selective primary health care unapologetically focuses on children under 5 without addressing the social determinants that drive poor health, 24,000 children die each day from preventable or treatable conditions like diarrhea, pneumonia and malaria (UNICEF 2008). At least 50% of these deaths are facilitated by underlying malnutrition. Additionally, reductions in child mortality have far exceeded reductions in neonatal mortality because neonates' survival is closely tied to pregnancy, labor and delivery outcomes.

Meanwhile, pregnant women and other adults with treatable acute and chronic disease are woefully underserved. Without significant investments in the reduction of maternal mortality, over half a million women die from complications of pregnancy and childbirth each year, a figure that is unchanged since the 1960s. This lack of progress is due to the neglect of health systems that lack the capacity to provide prenatal care, attended, facility-based delivery and emergency obstetric services needed to avert maternal and neonatal death (WHO 2007). At least 1.3 billion people worldwide lack access to even the most basic health care (ActionAid 2007). A profound shortage of health workers compounds the problem, limiting provision of life-saving essential interventions such as childhood immunizations and delivery services. More than 4 million additional doctors, nurses and public health workers are urgently needed to fill this gaping void (ActionAid 2007).

One year after Alma-Ata's 30th anniversary, several indicators lay bare the conference's unrealized promise. The broad social goal of health for all was effectively distorted into a narrow technical response and crippled political activism and social mobilization around a rights-based approach. Vast inequalities in health persist and have since worsened globally (CSDH 2008).

From Alma-Ata's Principles to AIDS Activism: Lessons of a Social Movement

No threat has exposed the consequences of dysfunctional health systems in poor countries as much as the AIDS epidemic. Since AIDS was first recognized in 1981, it has claimed the lives of more than 25 million people and infected more than 65 million (UNAIDS 2008). A disease that disproportionately affects the destitute, 95% of the estimated 33 million people living with HIV/AIDS reside in developing countries (UNAIDS 2008), further perpetuating the cycle of poverty in these areas. AIDS dramatically cut back gains in child survival and life expectancy. A shortage of health workers and a physical infrastructure in disrepair suffocate scale-up and rollout efforts aimed at providing universal access to all 9.7 million people needing antiretroviral treatment today (WHO/UNAIDS 2008). Indeed, even the most effective HIV/AIDS programs 'hit the ceiling of insufficient health workers and dysfunctional health systems' (Ooms 2009). Besides highlighting the weaknesses of health systems, AIDS brought into sharp focus the root causes of ill health—extreme poverty, inequality and the unjust structures promoting them.

Activism by and for people living with AIDS in the developing world effectively challenged, for the first time, the destructive political forces strangling Alma-Ata's primary health care strategy. Neoliberalism, privatization and disbelief in public goods were held suspect as AIDS activism successfully mobilized collective resources for health, leading to improvement in the lives of the people living with HIV. Today, billions of dollars have been spent on HIV services, the pharmaceutical industry has been cowed, user fees for HIV services and medications are thought to

be unacceptable and previously held restrictions on public sector spending have been called into question.

How did AIDS activists generate the political will to mobilize immense resources? What strategies did they use to dismantle powerful forces, like neoliberalism, confining spending on health? And, what, if any, lessons might be learned and leveraged for current activism to achieve health for all?

Activists built the backbone of the AIDS response based on principles espoused at Alma-Ata. These principles were perhaps AIDS activism's greatest strengths: that health and health care, including HIV prevention and treatment services, were universal rights to be enjoyed by all (Mann 1992); that unequal social status meant HIV disproportionately affected the poor and marginalized (Farmer 2002); and that conquering AIDS must therefore involve action to achieve broader social equity, led by many sectors and foremost by communities affected by the disease (Senterfitt 1998).

Evidence

AIDS activists wielded the power of a social movement to frame AIDS as a moral crisis. Epidemiological studies demonstrated a highly unequal social distribution of AIDS. The disease disproportionately afflicted the most vulnerable people in society – women, the poor and the marginalized (Farmer 2002). When life-saving antiretroviral medicines were introduced, their high costs meant the populations most affected were least likely to receive them. Crafting rights-based policy imperatives, such as "universal access" to antiretroviral treatment, AIDS activists effectively argued that this schism was intolerable and unjust (Mann 1992).

If social forces shaped the distribution of AIDS and who received treatment for it, then activism around AIDS had to work towards broader social equity. Activists urged that AIDS was a major threat not only in health, but also across multiple sectors. The consequences for society cut broad and deep. As HIV/AIDS claimed the lives of society's most productive members, predictions emerged that economic growth would slow, especially in the hardest hit countries. Some predicted economic growth rates to slow by up to 1.47% (Over 1992). Increased mortality from HIV/AIDS shrunk the skilled labor force and compressed the tax base, foreshadowing economic collapse in the most-affected nations in Africa (Over 1992).

Political will

Activists combined their knowledge base with political might to ramp up pressure for an emergency response to AIDS. From San Francisco's city halls to South Africa's rural townships, a broad and diverse coalition of constituents aligned to press governments for greater resource allocation towards fighting AIDS. Groups as seemingly disparate as rich, white, gay men and poor, rural African women rallied together like never before in protests and marches towards a common goal. Enlisting more than 16,000 members, the South Africa-based Treatment Action Campaign deployed strategies of "treatment literacy" and "community health advocacy", incorporating high quality and grassroots community-level education on the science of HIV treatment to patients and allies, and was emblematic of the burgeoning grassroots movement against AIDS (Mbali 2005). Their efforts were bolstered in no small way by like-minded activist organizations in rich countries. Health GAP, for instance, brought together civil rights activists, economists, clinicians and direct-action oriented AIDS activists to lobby rich-country governments for increased access to antiretroviral medicines

(ART), and against structural adjustment policies as well as pharmaceutical companies pricing ART out of the hands of the poor. This kind of multi-national, multi-faceted grassroots movement building—with Alma-Ata-like vision—led to dramatic reductions in the price of ART, revolutionizing access to these life-saving drugs for millions in poor countries.

It is important not to discount the absolutely vital contribution of people living with AIDS in generating this social movement. Its essence, in fact, depended on the power of life-stories such as those like Ryan White from America and Zachie Achmat from South Africa to inspire focus on what was at stake, and help foster hope and optimism (Power 2003). Narratives of AIDS affected peoples like Joseph Jeune, whose life was transformed when he was one of the first people to receive ARVs in rural Haiti, proved that all was not doomed, but rather, with collective action focused on pragmatic goals, things could and would change (Farmer 2005).

A major policy achievement of the AIDS movement was to dismantle structural barriers stifling AIDS program expansion. "Fiscal constraints" imposed by the IMF under its structural adjustment scheme restrained the amount of international aid poor countries could spend on public health (Ooms 2009). A recent IMF report revealed only 27% of the additional international aid to sub-Saharan Africa from 1999 to 2006 was actually programmed to be spent—the other 73% was put into savings (IMF 2007). This practice allows the IMF to impose compliance with fiscal space constraints; whenever a country is at risk of exceeding fiscal space, the IMF can program international aid to be saved by the recipient nation instead of being spent, for example, to expand health services to vulnerable populations.

Global AIDS activists found a path out of this economic impasse. Arguing that the most affected countries would not be able to become "self-sufficient" in financing costly HIV/AIDS treatment, activists called for a mandate demanding an international emergency response (Piot 2003). As a result, a general exemption for AIDS expenditure was secured from fiscal space constraints (Piot 2003). This policy change effectively liberated AIDS from the prevailing restrictive utilitarian paradigms of cost-effectiveness and sustainability.

Social Strategy

Breaking structural barriers on AIDS financing opened the door for the growing AIDS social movement to develop a social strategy to deliver on universal access. They put forth a demand for a global mechanism to finance comprehensive HIV services, including treatment. Based on notions of solidarity, activists lobbied rich governments to share responsibility for the health of all people living with HIV/AIDS. Under tremendous pressure, the governments pledged unprecedented support to the global AIDS fight, culminating in the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Abuja Declaration 2001). The multi-year financing arm sought to provide an independent, transparent, accountable, participatory and rigorously evaluated source of funding for poor countries seeking to address AIDS, representing a paradigm shift in international health aid.

The Global Fund and other financing mechanisms like PEPFAR have had a dramatic impact on AIDS. According to UNAIDS, global funding to combat HIV/AIDS has more than quadrupled from $2.1 billion in 2001 to $8.9 billion in 2006 (UNAIDS 2008).

With the advent of the Global Fund, countries and the movement turned attention towards developing ambitious, discrete targets. Initiatives like the World Health Organization's "3 by 5" initiative embarked on robust partnerships with governments to cost-out and develop strategies for the delivery of ART to millions of HIV-infected people (WHO 2004). Most importantly, as predicted at Alma-Ata, evidence has found that community-driven programs are the most effective at delivering HIV care, while also improving primary health care for the poor (Walton 2004).

The impact of AIDS activism has been tremendous. Over 3 million HIV-infected people are now receiving life-saving antiretroviral treatment. Renewed commitments to the Global Fund and PEPFAR have recently been pledged, including health systems strengthening components. The AIDS response put global health firmly on the geopolitical agenda.

Conclusion

The 1978 *Declaration of Alma-Ata* signaled a primary health care strategy aimed at fostering a revolutionary social movement to achieve health for all by the year 2000. Millions of lives were saved through a selective primary health care approach in areas such as immunization coverage. We have yet to fulfill the commitment of health for all, but we must not forget or abandon it. The lessons of AIDS activism, born on the back of Alma-Ata, offer reason for optimism. Combining technocratic power with social activism can transform political will and reshape the way the world responds to the crisis of inequity in health.

POLICY RECOMMENDATIONS FOR ACHIEVING HEALTH FOR ALL

Below, we propose recommendations that, if followed, could dramatically impact primary health care in poor countries.

End the false debates pitting disease-specific programs against primary health care

Recent years have seen a rapid increase in funds and programs to expand access to HIV treatment in resource-poor settings, the scale up of HIV/AIDS treatment has exposed in the underlying weaknesses of health systems in poor countries. Weak health systems stifle HIV/AIDS treatment scale-up and its impact. Likewise, strong health systems must be able to deliver complex health interventions, such as HIV treatment, if they are to provide comprehensive primary health care for all.

Despite this clear interdependence between delivering HIV/AIDS treatment and strengthening health systems, a debate has emerged pitting disease-specific funding against money allocated for health care systems. The vertical program model, treating single diseases such as HIV or tuberculosis, is often viewed as being at odds with a horizontal model of providing comprehensive primary care. This is a false and dangerous dichotomy. The WHO Maximizing Positive Synergies project demonstrates that HIV-specific funds have been utilized to improve staffing and investment in public health infrastructure, to provide essential drugs, to strengthen women's and child health, and to address social and economic conditions, such as food insecurity, that contribute to disease and poor health.

- End the vertical versus horizontal funding debate and commit to a diagonal or comprehensive health care approach.
- Increase funding for both primary health care and disease-specific funding programs.

Build a broad coalition for "health for all"

- Campaign to engage politicians and luminaries in the call for action on primary health care; link to MDG policy of Obama administration; link to exacerbation of global economic downturn; consider links to universal health care reform in rich countries.
- Incorporate poor communities and people affected by lack of access to health care (e.g. treatment literacy, People's Health Movement); highlight narratives of those affected.
- Set clear and ambitious targets

Lift structural barriers on primary healthcare

- Abolish IMF fiscal constraints on health sector spending, allowing increased investment in public health systems by low-income countries.
- Transform the paradigm of the "sustainability" argument by building a long-term, reliable global financing mechanism for primary health care (e.g. Global Health Fund).
- Build on initiatives like the International Health Partnership but ensure that funds are not being cut from vertical programs and commitments to the GFATM to support these wider initiatives.

Fully fund primary healthcare through long-term, reliable direct budgetary support

- Monitor government spending to meet *at least* US$40 per person per year on basic health, according to the findings of the Commission on Macroeconomics and Health (CMH). (In 37 of the world's low-income countries, public health expenditure was less than US$10 per person per year in 2004).
- Promote examples, like the Rwandan government robustly increasing spending to $27 per capita to achieve universal healthcare, and encourage other governments to follow suit.
- Increase direct budgetary support to fund national health plans in low-income countries.
- Develop sustained financing to effectively and efficiently disburse funds to health programs with multi-year funding cycles rather than annual appropriations.
- Direct more U.S. aid to recipient country public sectors to develop health systems, and encourage other donor countries to follow suit. Such funds should be allocated to refurbish facilities, to hire and train new clinical and administrative staffs, to compensate existing Ministry of Health staff, and to waive patient user fees.
- Increase the total number of health workers in resource-poor areas to, at a minimum, 2.3 doctors, nurses, and trained midwives and 1.8 health auxiliaries (including community health workers) per 1,000 residents.

- Revise U.S. policy regarding compensation of community health workers for their services, moving beyond an unsustainable model that relies on local residents to volunteer their time for health and development projects that benefit the community.
- Increase Official Development Assistance to 0.7% of GNI and proportionately increase funding for all global health programs, with a focus on maximizing outcomes.

Drive value into programs by benchmarking them against outcomes

- Increase focus on measurement and evaluation in performance of health programs.
- Place the focus of evaluation on the quality of programs measured against specific patient outcomes, rather than process indicators (e.g. immunization figures, enrollment numbers and other targets).
- Establish benchmarks to measure effectiveness and create a normative framework for identifying model programs (e.g. SEARCH) and systems (e.g. benchmark what proportion goes to indirect costs such as. consultants and administrative fees) and what proportion goes directly into services for the poor.

Improve the social determinants of health

- Improve the social and economic conditions that promote health (a fundamental tenet of the Alma-Ata vision for health for all).
- Promote social protection programs that demonstrate mechanisms to increase basic goods for the poor (e.g. oportunidades, food security programs, education).
- Support mechanisms of global health financing architecture for countries to build a social protection floor.

Ensure community leadership in primary healthcare

- Increase direct funding to build organizational, technical and management capacity through local NGOs, grassroots and community-based organizations, and health ministries. Establish a benchmark to monitor this direct funding
- Empower communities to engage in and drive the movement for health for all (a central aim of Alma-Ata.

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