

## Alma-Ata and Primary Health Care: An Evolving Story

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### Overview

The story of how Alma-Ata and Primary Health Care gained the attention of the world's health leadership must be seen as one of the most intriguing in the history of health and development. The postcolonial years in the developing world saw health care that was largely hospital-based and curative in its orientation, which meant, of course, that most people who needed health care had little or no access to it. The shift to community-oriented care with outreach beyond hospitals to health centers and even to households called for dramatic changes in all aspects of the health sector.

It was during those years that WHO was shifting its concerns from issues such as malaria eradication (which could not be accomplished) to the development of basic health services. In the cluster of years prior to Alma-Ata, 1978, WHO went through an exploratory process, partnering with interested organizations, conceptualizing various aspects of health care, culminating in the notion of primary health care, which was refined for and fully accepted at the Alma-Ata Conference.

This was the era of Halfdan Mahler, who became director general of WHO during these years and provided charismatic leadership that led to the planning for and remarkable outcomes of Alma-Ata. The WHO staff was initially mixed in its perceptions of this process, but then turned in the direction of strong support of what turned out to be one of the signal events in the history of the organization.

The Conference in Alma-Ata was a splendid event, well planned, widely attended, and focused on problems of major importance, with the policy-related product of Primary Health Care and Health for All by 2000. It was seeking ways to translate the emerging knowledge base into health care for people all over the world.

Following Alma-Ata, a major interest, reaching to present times, has been to follow implementation of the concepts, policies, and actions integral to primary health care in various parts of the world, and also to note conflicting concepts, policies, and processes. Here follows a listing of major relevant events, preceding and following Alma-Ata, up to the present, including relevant documentation (the time period that is the focus of each of the referenced materials will be noted, followed by the reference):

- The Christian Medical Commission and WHO's PHC Approach (late 1960s and 1970s), (Litsios, 2004);
- Alma-Ata Revisited (1970s to present), (Tejada, 2003);

- Alma-Ata 1978 – Primary Health Care; Declaration of Alma-Ata (Alma-Ata, 1978);
- Selective Primary Health Care, 1979 (1978 to present), (Cueto, 2004);
- The Ottawa Charter – 1st International Conference on Health Promotion (WHO/HPR/HEP, 1986);
- From Alma Ata to the Year 2000 – Reflections at the Midpoint, Riga, USSR, 1988 (World Health Organization 1988);
- Alma-Ata and After (1978 – present), (Venediktov, 1998);
- Primary Health Care – 21 Almaty, Kazakhstan, 1998 (WHO, 2000);
  1. Foreword, G. Brundtland
  2. Conclusions, D. Sanders
- Global Review of Primary Health Care, Madrid, 2003, Emerging Messages;
- Renewing PHC in the Americas, 2005 (PAHO, 2007);
- Commission on Macroeconomics and Health;
- Millennium Development Goals, and Millennium Project;
- The Commission on Social Determinants of Health;
- Primary Health Care and the new Director General of WHO, Dr. Margaret Chan;
- Addendum to Alma-Ata and Primary Health Care. An Evolving Story Buenos Aires 30/15 International Conference, August 2007 From Alma-Ata to the Millennium Declaration: *Towards Equity-Based Comprehensive Health Care*;
- Building from Common Foundations. The World Health Organization and Faith-Based Organizations in Primary Health Care (World Health Organization 2008).
- Unequivocal regional support for Margaret Chan's commitment to primary health care. (*Lancet*, Correspondence, June 19, 2008).

### Historical Reflections On Factors Leading to and Following Alma-Ata 1978

#### The Christian Medical Commission and WHO's PHC Approach (late 1960s and 1970s)

The 1968–1975 period saw dramatic changes in the priorities that governed the work program of WHO. For more than a decade, the global malaria eradication campaign had been WHO's leading program. Initiated in the mid-1950s, it was a strictly vertical program based on the insecticidal power of DDT. As it became evident that malaria eradication would not be achieved, greater

priority was given to the development of basic health services. Over the ensuing years, various steps were taken to focus attention on the importance of health services and how they might be pursued (Litsios, 2004).

The primary health care approach was introduced to the Executive Board of WHO in 1975. It is useful to review the changes that took place in the preceding years that made it possible for such a radical approach to health services to emerge when it did. Here, we will review the parallel approaches being taken by WHO and by the Christian Medical Commission (CMC) of the World Council of Churches and how they came into useful association.

Dr. Halfdan T. Mahler became assistant director general of WHO in September, 1970, and Director General in 1973. Working with Dr. Ken Newell, a new division, Strengthening of Health Services, was created in 1972 with Newell as director.

In May, 1973, the 26th World Health Assembly adopted resolution WHA26.35, titled 'Organizational Study of Methods of Promoting the Development of Basic Health Services.' Among other things, this resolution confirmed the high priority to be given to the development of health services that were both accessible and acceptable to the total population, suited to its needs, to the socioeconomic conditions of the country, and at the level of health technology considered necessary to meet the problems of that country at a given time.

The search for new approaches led to two important WHO publications in 1975:

- *Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries*, edited by V. Djukanovic and E.P. Mach, (Djukanovic and Mach, 1975)
- *Health by the People*, edited by K. Newell (Newell, 1975).

These were products of Newell's Division of Strengthening Health Services.

### **Establishment and Early Work Program of the Christian Medical Commission**

The Christian Medical Commission (CMC) was established in 1968 as a semiautonomous body to assist the World Council of Churches (WCC) in its evaluation and assistance with church-related medical programs in the developing world. Of particular concern to the WCC was the fact that many of the more than 1200 hospitals that were run by affiliated associations were rapidly becoming obsolete, with operating costs increasing dramatically. What was needed were some criteria for evaluating these programs that would help reorient the direction for their future development.

Key contributions to the formulation of the mandate of the commission came from the Rockefeller Foundation

and its extensive study of 'Health and the Developing World' (Bryant, 1969). This book was, 'one of the most definitive resources for all engaged in health care in the lesser developed countries' (McGilvray, 1981). Its author, John Bryant, became the first chairman of the Christian Medical Commission.

The CMC was composed of 25 members from diverse countries and levels of health development that met annually and was served by an executive staff of a director and three others. Its purpose was to engage in surveys, data collection, and research into the most appropriate ways of delivering health services that could be relevant to local needs and the mission and resources of the Church.

The first director of the CMC, James C. McGilvray, found the contribution of Dr. Robert A. Lambourne to be most significant, reporting a disturbing picture of the manner in which modern care was at odds with the quest for health and wholeness (McGilvray, 1981). Hospitals became a factory for repair of things rather than a hospice for the care of souls. The growth of medical specialization tended to break down the patient into pathological parts so that he is regarded or treated less and less as a whole patient.

Lambourne's concept of health and wholeness had strong implications for the congregation. It is only when the Christian community serves the sick person in its midst that it becomes itself healed and whole, suggesting a moral basis for individuals and communities to be involved in any consideration of how resources are to be used to promote their health.

The theological basis for health and healing became important points of discussion during the CMC's first meetings. These took the form of a dialogue between John Bryant, the commission's first chairman and a professor of public health, and David E. Jenkins, a commission member and a theologian. Even though there were differences of opinion between them, both were committed to a distribution of resources that improved the lots of those worst off (Bryant and Jenkins, 1971; Bryant, 1977).

CMC staff and members of the commission searched for community-based experiences around the world that would shed light on how best to develop programs that were comprehensive, part of a network of services ranging from the home to specialized institutions, and would incorporate human resources ranging from church members to specialist professionals, including auxiliary and midlevel health workers.

Three community-based experiences presented to the CMC between 1971 and 1973 proved to be critical in WHO's conceptualization of primary health care:

- Central Java, Dr. and Mrs. (Dr.) Gunawan Nugroho
- Jamkhed, India, Drs. Raj and Mabelle Arole
- Chimaltenango, Guatemala, Dr. Carroll Behrhorst.

These programs were strongly community-based, reaching out to those in greatest need, in continuous

partnership with the community, and committed to community empowerment. They reached beyond health programs to other sectors – agricultural productivity, shelters, education, water, and sanitation – that were seen as important to community well-being and often directly supportive of health.

These programs and others similar to them were given wide publicity by the CMC through its publication *Contact* (Christian Medical Commission, 1979). These discoveries were not only exciting in themselves but they were illustrative of the growing awareness that health-care systems must respond to the basic needs of people for social justice.

### **WHO and CMC Join Forces**

By the summer of 1973, the CMC had brought to the world's attention many projects that offered innovative ways to improve the health of populations in developing countries. The first official meeting of WHO and the CMC took place in 1974. A joint working group was established, with Dame Nita Barrow and Dr. Ken Newell designated as representatives from CMC and WHO respectively.

### **Primary Health Care: WHO's New Approach to Health Development**

The World Health Assembly in 1974 called on WHO to report to the 55th Executive Board in January 1975 on steps undertaken by WHO to assist governments toward their major health objectives, with priority being given to the rapid and effective development of the health delivery system. This was at the time the smallpox campaign was concluding. It provided Mahler and Newell with the opportunity to introduce primary health care in a comprehensive manner, drawing on the work of the previous 2 years.

The paper presented to the board argued that the resources available to the community needed to be brought into harmony with the resources available to the health services. For this to happen, a radical departure from the conventional health services approach is required, one that builds new services out of a series of peripheral structures that are designed for the context they are to serve, including the reorientation of existing health services so as to establish a unified approach to primary health care.

### **Conclusion**

How dramatic a change primary health care was for WHO can be seen in the contrast between it and the ideas and approaches being promoted several years earlier concerning how best to develop national health systems. Instead of the top-down perspective of health planning

and systems analysis, priority was now being given to the bottom-up approaches of community involvement and development, but without losing sight of the importance of planning and informed decision making.

It needs to be appreciated that real courage was required for Mahler to challenge the organization to rethink its approach to health services development or for Newell to respond to that challenge in the way he did.

In January 1975, Newell formally created the Primary Health Care program area, whose members included those who had drafted the report to the executive board. While there was mixed reaction within WHO to this new priority, a wide range of nongovernmental organizations (NGOs) joined forces in what soon became the NGO Committee on Primary Health Care, which worked in close support of WHO's PHC group. This group of organizations prepared for the International Conference on Primary Health Care held at Alma-Ata in September 1978 in an independent manner, thus helping to keep WHO on track. The CMC continued its constructive relationship with WHO, learning as it was contributing (CONTACT, Christian Medical Commission, 1979).

### **Alma-Ata Revisited, Reflections of Dr. David Tejada (1970s to present)**

By the end of the 3-day event, nearly all of the world's countries had signed on to an ambitious commitment. The meeting itself, the final Declaration of Alma-Ata and its Recommendations, mobilized countries worldwide to embark on a process of slow but steady progress toward the social and political goal of Health for All. Since then, Alma-Ata and Primary Health Care have become inseparable terms (Tejada, 2003).

Looking back, the 1970s saw the cresting of the scientific and technological revolution that began with the end of World War II, a revolution that produced, among other major changes, what is today known as globalization. But there was also recognition of growing inequality among the vast sectors of the world's population. This recognition provided the impetus during the 28th and 29th World Health Assemblies in 1975–76 for the commitment to Health for All in the Year 2000.

For Mahler and others, 'Health for All' was a social and political goal, but above all a battle cry to incite people to action. Its meaning, however, has been misunderstood, and confused with a simple concept of programming that is technical rather than social and more bureaucratic than political.

When Mahler proposed Health for All in 1975, he made it clear that he was referring to the need to provide a level of health that would enable all people without exception to live socially and economically productive lives. The reference to the year 2000 meant, as of that

date, all the world's countries would have developed the appropriate political strategies and be carrying out concrete measures toward achieving this social goal, albeit within different time frames.

Perhaps because of what might be called professional deformation, it was not really understood that health is a social phenomenon whose determinants cannot be neatly separated from other social and economic determinants. Nor can it be assigned solely to one bureaucratic-administrative sector of the state. Nor was it understood sufficiently – though it was spelled out clearly – that health is, above all, a complex social and political process that requires political decision making not only at the sectorial level but also by the state, so that these decisions are binding upon all sectors without exception.

There is a fundamental difference between integral health care for everyone and by everyone – care that is multisectoral and multidisciplinary, health-promoting and preventive, participatory and decentralized – and low-cost (and lower-quality) curative treatment that is aimed at the poorest and most marginalized segments of the population and, what is worse, provided through programs that are parallel to the rest of the health-care system without the direct, effective participation of the population.

It was at the 28th World Health Assembly in 1975 that the urgent need for new approaches to health care for everyone and by everyone was finally recognized. This is how the notion of primary health care emerged, and it was a victory for the developing world. No one thought about an international conference on the subject, and during the 28th assembly, the prevailing wisdom was that new experiences were needed in this area.

### **A Soviet Proposal**

In January 1976, at the meeting of WHO's Executive Board, Dmitri Venediktov, the powerful Soviet vice-minister for international affairs in the Ministry of Health, proposed a major international conference on primary health care and offered \$2 million as an extraordinary contribution by the Soviet Union.

The idea was formally accepted 4 months later at the World Health Assembly, and the conference was scheduled for 1978, to be held in Alma-Ata, Kazakhstan, USSR. Dr. Tejada was designated by the director-general as the general coordinator in charge of the technical, logistical and political aspects. Importantly, the conference was co-hosted and jointly organized with UNICEF, as the product of several years of interaction.

### **A New Era**

The conditions that led to the social and political goal of Health for All and to the strategy of primary health care

still exist and are, indeed, even more pronounced. However, there remain gaping inequities and social injustice that leave large segments of populations without integral health care. Poverty is on the rise, and the few resources that societies have for education and health are invested and spent in misguided and unfair ways. The confusion between health and curative medical treatment that is focused on a few diseases inexplicably still prevails. Health systems have not been decentralized effectively, and both citizen participation and social control in health remain distorted concepts.

In today's globalized, unipolar world, where national sovereignty is increasingly threatened, one of the few ways in which countries can still control their own destiny is through the development of genuine decentralized and participatory democracies. Nowadays it is essential to transfer, or rather, to return political power for social decision making to its point of origin, that is, the citizenry. Integral health care for all and by all – perhaps the best way to phrase Alma-Ata's call for genuine primary health care – is a necessity not only for health but also for the future of countries that aspire to remain sovereign nations in an increasingly unjust world.

There have been major global changes and many important new experiences in the world during the 25 years since the first International Conference on Primary Health Care. Perhaps it is time to convene an Alma-Ata II, to set forth again, without distortions, the original concept that led to the conference in 1978.

## **Alma-Ata 1978 – Primary Health Care Report of the International Conference on Primary Health Care, Alma-Ata, 6–12 September 1978**

### **Declaration of Alma-Ata**

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight (World Health Organization, 1978), expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

#### **I**

The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.



## II

The existing inequality in the health status of people particularly between developed and developing countries as well as within countries is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.

## III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

## IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

## V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

## VI

Primary health care is 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 to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuing health care process.

## VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the

country and its communities and is based on the applications of the relevant results of social, biomedical, and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;
3. includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning and immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors, and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making the fullest use of local, national, and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained and integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers 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.

## VIII

All governments should formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

## IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context, the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further

development and operation of primary health care throughout the world.

### X

An acceptable level of health for all people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

### Primary Health Care

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

Primary health care addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least promotion of proper nutrition and adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and methods of preventing and controlling them; and appropriate treatment for common diseases and injuries.

In order to make primary health care universally accessible in the community as quickly as possible, maximum community and individual self-reliance for health development is essential. To attain such self-reliance requires full community participation in the planning, organization, and management of Primary Health Care. Such participation is best mobilized through appropriate education that enables communities to deal with their real health problems in the most suitable ways. They will thus be in a better position to make rational decisions concerning primary health care and to make sure that the right kind of support is provided by the other levels of the national health system. These other levels have to be organized and strengthened so as to support primary health care with technical knowledge, training, guidance

and supervision, logistic support, supplies, information, financing, and referral facilities, including institutions to which unsolved problems and individual patients can be referred.

Primary health care is likely to be most effective if it employs means that are understood and accepted by the community and applied by community health workers at a cost the community and the country can afford. These community health workers, including traditional practitioners where applicable, will function best if they reside in the community they serve and are properly trained socially and technically to respond to its expressed health needs.

Since primary health care is an integral part both of the country's health system and of overall economic and social development, without which it is bound to fail, it has to be coordinated on a national basis with other levels of the health system, as well as with the other sectors that contribute to a country's total development strategy.

### Selective Primary Health Care (1978 to Present)

The Alma-Ata Declaration was criticized for being too broad and idealistic, with an unrealistic timetable. A common criticism was that the slogan Health for All by 2000 was not feasible. Concerned about the identification of the most cost-effective strategies, in 1979 the Rockefeller Foundation sponsored a small conference entitled Health and Population in Development at its Bellagio Conference Center in Italy. The goal of the meeting was to examine the status and interrelations of health and population programs as the organizers felt there were 'disturbing signs of declining interest in population issues.'

The conference was based on a published paper by Julia Walsh and Kenneth Warren entitled: 'Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries' (Walsh and Warren, 1979). The paper sought specific causes of death, paying special attention to the most common diseases of infants in developing countries such as diarrhea and diseases produced by lack of immunizations. In the paper, and at the meeting, selective primary health care was introduced as the name of a new perspective. The term meant a package of low-cost, technical interventions to tackle the main disease problems of poor countries.

The interventions were known as GOBI, meaning growth monitoring, oral rehydration techniques, breast feeding, and immunizations. These four interventions appeared easy to monitor and evaluate. Moreover, they were measurable and had clear targets. Funding appeared easier to obtain because indicators of success and reporting could be produced more rapidly. Later, some agencies

added FFF (food supplementation, female literacy, family planning) to the acronym GOBI, creating GOBI-FFF.

One participant of the Bellagio meeting who was strongly influenced by the new proposal was James Grant of UNICEF. A Harvard-trained economist and lawyer, Grant was appointed executive director of UNICEF in January 1980 and served until January 1995. Under his dynamic leadership, UNICEF began to back away from a holistic approach to primary health care. Like Mahler, he was a charismatic leader who had an easy way with both heads of state and common people. A few years later, Grant organized a children's revolution and explained the four inexpensive interventions contained in GOBI (Cueto, 2004).

A debate between the two versions of primary health care was inevitable.

### **The Debate**

The supporters of comprehensive primary health care accused selective primary health care of being a narrow, technocentric approach that diverted attention away from basic health and socioeconomic development, did not address the social causes of disease, and resembled vertical programs. The debate between these two perspectives evolved around three questions: What was the meaning of primary health care? How was primary health care to be financed? How was it to be implemented?

The passage of time has not resolved these differences. They have persisted, with positions reshaped by evolving local, national, and global contexts. The history of primary health care and selective primary health care analyzed in this paper illustrate two diverse assumptions in international health in the twentieth century. First, there was a recognition that diseases in less-developed countries were socially and economically sustained and needed a political response. Second, there was an assumption that the main diseases in poor countries were a natural reality that needed adequate technological solutions. These two ideas were taken – even before primary health care – as representing a dilemma, and one path or the other had to be chosen.

A lesson of this story is that the divorce between goals and techniques and the lack of articulation between different aspects of health work need to be addressed. A holistic approach, idealism, technical expertise, and finance should – must – go together. There are still problems of territoriality, lack of flexibility, and fragmentation in international agencies and in health programs in developing countries. Primary and vertical programs coexist. One way to enhance the integration of sound technical interventions, socioeconomic development programs, and the training of human resources for health is the study of history.

### **Ottawa Charter**

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

### **Health Promotion**

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, it goes beyond healthy life-styles to well-being.

### **Commitment to Health Promotion**

The participants in this Conference pledge:

- to move into the arena of health public policy and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures toward harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition, and to focus attention on public health issues such as pollution, occupational hazards, housing, and settlements;
- to respond to the health gap within and between societies and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families, and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions, and well-being;
- to reorient health services and their resources toward the promotion of health and to share power with other sectors, other disciplines, and, most importantly, with people themselves;

- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

### Call for International Action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization, and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this charter, Health For All by the year 2000 will become a reality.

### Reflections on the Ottawa Charter

It is notable that the Ottawa Charter was followed by an international insistence on the further development of health promotion as a conceptual and policy centerpiece of international health. This led, in turn, to establishing in WHO the Department of Chronic Diseases and Health Promotion. A dramatic indication of its evolving strength was the establishment in 2005 of the Bangkok Charter for Health Promotion, with strong international support (WHO/HPR/HEP, 1986).

### From Alma-Ata to the Year 2000, Reflections at the Midpoint, Riga, Latvia

The first of several meetings celebrating the anniversaries of Alma-Ata took place in Riga, Latvia Republic, USSR, 1988 (World Health Organization, 1988). The meeting reflected the intense interest of multiple parties in the consequences of the Alma-Ata conference and what had happened to the key concepts of Health for All and primary health care. Following are comments by John Bryant, who was on the U.S. Delegation to Alma-Ata, and helped to plan and organize the Riga meeting, and Halfdan Mahler, then Director General of WHO.

- Bryant. In reviewing the successes and failures since Alma-Ata, we have concluded that there is no doubt that health for all and primary health care have served the world well. At the same time, despite substantial gains in most countries, there has been a slowness and even stagnation in many countries. If you look from now, in 1988, at projections for the year 2000, you will

find a large number of African and South Asian countries where infant, young child, and maternal mortality rates will still be at levels that the world must consider completely unacceptable.

This was a turning point at Riga: The recognition that what is being done is not enough. As WHO turns the corner of the first decade after Alma-Ata, it needs to ready itself for new sets of problems. Tomorrow will not be yesterday, and yesterday's answers, though they brought glory, will not serve tomorrow. So there was a call for new forms of analysis, new partnerships, new mechanisms of action, and new resources.

Reflecting on the debate at Riga, the result was Alma-Ata reaffirmed at Riga – a statement of renewed and strengthened commitment to health for all by the year 2000 and beyond. But this was not simply a self-congratulatory exercise. There was an acknowledgment of the important shortfalls, that serious problems remained almost untouched by the Health for All effort, and new problems are emerging that are already defying solutions. An example would be the emergence of the HIV/AIDS pandemic. To address this range of persisting and emerging problems, the meeting at Riga suggested a number of actions to be taken, including empowering people, strengthening district health systems based on primary health care; overcoming problems that continue to resist solution, and finally a special priority initiative in support of the least developed countries.

The last point, about the least developed countries, is based on the fact that, while most countries have benefited from the Health for All movement, a tragic residuum remains. These nations are not the causes of the problems of severe underdevelopment, they are the victims of it. They have been marginalized by it and, to a large extent, abandoned to it. The resources and processes involved in international development have failed these people, and Health for All to date has failed them as well. And so a special initiative is proposed, which should be strongly intersectoral in nature as well as long term. Finally, we believe that WHO should monitor the rate of progress, which should serve as an indicator of the resolve of WHO and the Member States to deal with this most fundamental of challenges, namely the needs of countries which, without effective help, will likely slip further down the spiral of development failure.

The comments of Dr. Halfdan Mahler are of special interest, both because of his commitment to the underlying values and principles of Health for All and primary health care, and because this was one of the last events in his professional life as Director General of WHO.

- Mahler. There is one last point, which is very close to my heart, especially as I leave WHO. We must have an obsession, a moral obsession, about the least developed of the developing countries. They are missing out



totally, as Jack Bryant said, in the development process. It is development gone wrong. They are marginalized in the cynical economic climate of the contemporary world. With the kind of platform we are talking about, with UNICEF and WHO together with UNFPA and other multilateral agencies, we can look at how we can address the problems of their predicament at this time in history. They must be brought on board in a real and true sense before the year 2000. It is indispensable, not so that they survive in misery, but that they survive so their children can realize their physical, social and spiritual potential.

If we could make a real entry point into the development dilemma of these countries through health for all and primary health care, I think we could also challenge the other partners in development, and somehow shame them into saying that this cannot possibly go on if we have the minimum of morality on spaceship earth.

### **Alma-Ata and After – Dmitry Venediktov (1978 to present)**

Of particular interest are the reflections of Dmitry Venediktov relating to the Alma-Ata Conference (Venediktov, 1998). He played a key role in representing the Russian government in negotiating with WHO in favor of an international conference on health system development and also for having the conference in a Russian city, which turned out to be Alma-Ata. He was serving at that time on the Executive Board of WHO and was one of the most influential persons in concepts, events, and decisions leading to Alma-Ata.

We have known Venediktov for many years, beginning during the latter years of planning for Alma-Ata, and served with him on the Executive Board of WHO for a number of years. We have also seen him on occasion in more recent years. He contributed an exceedingly interesting article to the World Health Forum in 1998 in which he reflects on various issues relating to Alma-Ata (Venediktov, 1998). At the end of the article, which analyzes a variety of issues relating to the conference, he offers three lessons from Alma-Ata.

First, it marked the beginning of a new international understanding of the real dimensions of health-care needs, especially in developing countries, and of the enormous social and economic problems involved. It made it clear that meeting these needs was one of the foremost responsibilities of any government.

Second, it brought to a close the era in which technical assistance and efforts at disease eradication could be thought of as a sufficient activity for WHO. By showing that it was both necessary and possible to redesign health systems on the basis of primary health care, it pointed the way toward national self-reliance in health.

Third, it opened up new prospects for international cooperation in health. Long before the current talk of globalization, it demonstrated not only the advantages but the necessity of sharing information and strategies for promoting health and preventing and controlling disease.

The conviction that health is a human right and that governments must uphold that right for present and future generations is the most important message that comes to us from Alma-Ata as we approach the year 2000.

### **Primary Health Care – Everybody's Business, 20 Years after Alma-Ata, Meeting in Almaty, Kazakhstan 1978**

#### **Primary Health Care 21, Gro Brundtland, Director General, WHO**

The Alma-Ata Declaration of 1978 emerged from the International Conference on primary health care as a major milestone of this century in the field of Public Health. Motivated by gross inequality in health status within and between countries and arguing that health is essential to social and economic development, the declaration identifies primary health care as the key to the attainment of Health for All by the people of a level of health that will permit them to lead a socially and economically productive life. It advocates the essential elements and intersectoral nature of primary health care (World Health Organization, 2000).

As we move into the next millennium, we have new challenges, new opportunities, and unfinished agendas. Accessibility to essential care remains a challenge. Most affected is the growing number of poor and economically dependent, such as the aged who are unable to afford basic health care. Intersectoral action for health, at all levels of society, and particularly in communities where people live and work, has become a critical element of any approach to public health that aims to improve the health outcomes and help people maintain and improve their health. While the delivery of essential health care and cost-effective interventions is critical, the social relevance of health systems plays an equally if not more important role in sustaining acceptable and affordable health services. Ultimately, it is the individual, the family and the community who make the most important decisions about their health. The degree to which they are able to respond to the health challenges they encounter contributes to their ability to maintain their health and to the effectiveness of the health and social services available to them. These are key aspects of primary health care, which remain relevant and need to be an integral part of any effort to strengthen national health systems.

In today's context, I am emphasizing the need for a new universalism that includes a commitment to primary

health care to maximize the efficiency and equity gains and create a win/win situation in poorer countries with larger burden of disease. Practical steps toward universal coverage need to be taken. There is no single blueprint available for replication in all countries. We are living a world of increased democratization with expanding free market forces, which affect all sectors. Within that context, we must find ways of using these forces to incorporate the values and principles of primary health care together with partners in the private sector and civil society.

Primary health care remains a key strategy in implementing the policy of HFA. We will continue to work with our partners in UNICEF as well as new partners including the World Bank, United Nations Development Programme (UNDP) and the United Nations Population Fund (UNFPA) in ensuring that the primary health care movement continues and builds on the lessons learned and the gains achieved and the leadership and commitment of the many who have tirelessly worked to make primary health care a reality.

### **Primary Health Care 21, Dr. David Sanders, University of Western Cape**

#### **Conclusions**

While there have been significant achievements, it is clear that progress toward Health for All has been uneven. Gains made are at risk from a complex and accelerating process of globalization and economic policies that have a negative impact on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global primary health care initiative has been successful in disseminating a number of effective technologies and programs that have substantially reduced the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilizing roles – which are the keys to its sustainability – have been neglected, both in discourse but also in implementation.

Governments enthusiastically promoting partnerships between sectors, agencies, and communities to develop intersectoral policies that address the determinants of inequities and ill health can halt, and reverse, this trend. The policy development process needs to be inclusive, transparent, and supported by legislative and financial commitment.

WHO has the opportunity to lead in the development of a strategy for primary health care by working in collaboration with Member States and national and international health agencies and professional organizations. The strategy should capture the diversity of needs and capacities and aim to establish linkages between primary care services, disease prevention, and health promotion at local levels.

A defined research agenda, and lessons about what is being learned about the impact of different primary

health care models and effective approaches to disseminating best practice, will underpin all these activities.

In promoting the above move from policy to action, WHO has to play a much bolder role in advocating for equity and legislation to facilitate its achievement; pointing out the dangers to health of globalization and liberalization; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive primary health care programs are developed; entering into partnerships with and influencing other multilateral and bilateral agencies and donors as well as nongovernmental organizations and professional bodies toward a common vision of primary health care; and arguing for major investment in health, especially in human resource development, without which Health for All will remain a mere statement of intent.

### **Global Review of Primary Health Care: Emerging Messages**

The Global Report by WHO in 2003 is based on a review of primary health care derived from the six regions of WHO (World Health Organization, 2003a).

#### **Primary Health Care in a Changing World. What's New?**

- Since Alma-Ata there have been dramatic changes in the pattern of disease, in demographic profiles, and in the socioeconomic environment, which present new challenges to primary health care.
- There have been significant changes in how governments are interpreting their roles and this has implications for both policy development and globally driven health programs.
- The policy environment now includes the widespread presence of nongovernmental organizations (NGOs) as major stakeholders in health and health care.
- The delivery of a wide range of WHO's own strategies is dependent on there being appropriate primary health care capacity at a local level.
- Both the recommendations of the Commission on Macro-economics and Health and the Millennium Development Goals (MDGs) set out a future agenda that would see major new investments in health systems. It will be vitally important for WHO to offer guidance on the most effective health solutions, including a contribution that can be expected from primary health care close-to-client services.
- It is unrealistic to expect the achievement of the MDGs without an organized primary health care.

## Primary Health Care and Evidence

Many countries have included PHC as a policy cornerstone in their health system reforms. As part of these reforms, many have carried out reviews of the available and relevant evidence. An earlier review of international literature noted that the paucity of rigorous evaluation research in such a broad policy area as primary health care delivery is striking. Whatever policies are contemplated for the reform of primary health care systems around the world, their implementation should be considered in the context of a strong policy-informing research agenda.

## Responding to the Typology for Development

There are three scenarios that could be the basis for identifying development needs and taking forward PHC policies and models in the twenty-first century.

### Scenario 1

The first scenario involves completing implementation. The challenge to key stakeholders is to understand why implementation is failing and plan remedial action to secure the benefits of primary health care for their populations. For example:

- Lack of political commitment, leadership, and insufficient policy continuity.
- Initial objectives were unrealistic.
- Local primary health care services were seen as inappropriate.
- Lack of integration between primary health care and other parts of the health system.
- Primary health care staff have the wrong skills and are not motivated.
- An effective intersectoral approach has not been developed.
- PHC policies and models are not sustainable.
- Community involvement is not working.

### Scenario 2

The second scenario involves strengthening PHC to meet new challenges.

- To be successful community participation must become part of a community's common experience and not just imposed from the outside.
- Strengthening the primary health care model at the local level.
  1. Making the primary health care model problem-oriented;
  2. Reinforcing community involvement;
  3. Reinforcing intersectoral collaboration;
  4. Strengthen integration of primary health care with other health care organizations;

5. Building leadership capacity in change management within the local primary health care team.
- Policy alignment at a national level. The impact of central policies which promote PHC will be less if:
    1. intersectoral collaboration is not reinforced at government level;
    2. tensions between vertical programs for health improvement and PHC are not addressed;
    3. the drive for integration of PHC with other parts of the health care system is undermined.

### Scenario 3

The third scenario involves locating primary health care in a new paradigm, such as integrating health goals in the larger and transcendent goals of social justice, human rights, and equity. For example:

- Promote wider social change in areas such as gender, children's rights, education, employment.
- Changes in leadership to reflect concern for social justice, human rights, and equity.
- Change education of primary health care practitioners to reinforce a values system concerned with social justice, human rights, and equity.
- Focus primary health care attention on those who suffer most from inequality and social injustice.

## Renewing Primary Health Care in the Americas

The Pan American Health Organization is in a global leadership role in reviewing problems and current inadequacies in primary health care and in proposing corrective patterns that are strongly responsive to global challenges.

### Director's Letter

Nothing great in the world has ever been accomplished without passion. Hebbel, 1818–1863

In 2003, motivated by the 25th Anniversary of Alma-Ata Conference and at the behest of its member countries, the Pan-American Health Organization decided to re-examine the values and principles that a few decades ago inspired the Alma-Ata Declaration in order to develop its future strategic and programmatic orientations in primary health care. The resulting strategy, presented in this article, provides a vision and renewed sense of purpose for health systems development: That of the Primary Health Care-Based Health System. This position paper reviews the legacy of Alma-Ata in the Americas, articulates components of a new strategy for primary health care renewal, and lays out steps that need to be taken in order to achieve this ambitious vision.

The process of developing the position paper has helped to invigorate debate about the meaning of health systems and their relationship to other determinants of population health and its equitable distribution in societies. Initial discussions about PHC renewal moved quickly from technical talk about health services to reflection about social values as fundamental determinants of health and health systems. Country consultations and meetings revealed a desire to assure that technical discussions about health policies continue to reflect the real meanings such policies have on the lives of citizens within the region.

The vision of a primary health care-based health system is well within the spirit of Alma-Ata, while acknowledging new developments such as the Ottawa Charter for health promotion, the Millennium Declaration, and the Commission on the Social Determinants of Health.

This document presents the work of numerous individuals and organizations and thus the extent and ambition of its vision reflects the diversity of its architects. The position paper focuses on the core values, principles, and elements likely to be present in a reinvigorated primary health care approach, rather than describing an all-encompassing mold into which all countries are expected to fit. Each country will need to find its own way to craft a sustainable strategy for basing their health system more firmly on the primary health care approach.

The road to achieving this vision is not expected to be a simple one, but few things of value come without dedication. Challenges include the need to invest in integrated networks of health and social services that have in many areas been inadequately staffed, equipped, or supported and inequitably distributed. This overhaul needs to take place within the context of shrinking budgets, which will require more rational and more equitable resource utilization, especially if they want to reach those with greater needs. The best available evidence supports the contention that a strong primary health care orientation is among the most equitable and efficient ways to organize a health system, although we must continue to strengthen the evidence base on innovations in primary health care and learn how to maximize and sustain their impact over time.

The position paper 'Renewing Primary Health Care in the Americas' is intended to be a reference for all countries moving forward to strengthen their health care systems, bringing health care to people living in urban and rural areas, regardless of their gender, age, ethnicity, social status, or religion. We invite you to read this document conveying the view and feelings of a great diversity of individuals living and working in the Americas as well as many experts from around the world and look forward to continuing this ongoing dialogue as we embark together on this ambitious endeavor.

Mirta Roses Periago

Director, PAHO

## Executive Summary, February 2007

For more than a quarter of a century primary health care has been recognized as one of the key components of an effective health system. Experiences in more developed and less developed countries alike have demonstrated that primary health care can be adapted and interpreted to suit a wide variety of political, social, and cultural contexts. A comprehensive review of primary health care – both in theory and practice – and a critical look at how this concept can be renewed to better reflect the current health and development needs of people around the world, is now in order. This document – written to fulfill a mandate established in 2003 by a resolution of the Pan American Health Organization (PAHO) – states the position of PAHO on the proposed renewal of PHC. The goal of this paper is to generate ideas and recommendations to enable such a renewal, and to help strengthen and reinvigorate primary health care into a concept that can lead the development of health systems for the coming quarter century and beyond.

There are several reasons for adopting a renewed approach to primary health care, including: The rise of new epidemiologic challenges that primary health care must evolve to address; the need to correct weaknesses and inconsistencies present in some of the widely divergent approaches to primary health care; the development of new tools and knowledge of best practices that primary health care can capitalize on to be more effective; and a growing recognition that primary health care is an approach to strengthen society's ability to reduce inequities in health. In addition, a renewed approach to primary health care is viewed as an essential condition for meeting the commitments of internationally agreed-upon development goals, including those contained in the United Nations Millennium Declaration, addressing the social determinants of health, and achieving the highest attainable level of health by everyone.

By examining concepts and components of primary health care and the evidence of its impact, this document builds upon the legacy of Alma-Ata and the primary health care movement, distills lessons learned from primary health care and health reform experiences, and proposes a set of key values, principles, and elements essential for building health systems based on primary health care. It postulates that such systems will be necessary to tackle the unfinished health agenda in the Americas, as well as to consolidate and maintain progress made and rise to the new health and development challenges and commitments of the twenty-first century.

The ultimate goal of the renewal of primary health care is to obtain sustainable health gains for all. The proposal presented here is meant to be visionary; the realization of this document's recommendations, and the realization of primary health care's potential, will be limited only by our commitment and imagination.



The main messages include:

- Throughout the extensive consultation process that formed the basis for this paper, it was found that primary health care represents, even today, a source of inspiration and hope, not only for most health personnel, but for the community at large.
- Due to new challenges, knowledge, and contexts, there is a need to renew and reinvigorate primary health care in the region so that it can realize its potential to meet today's health challenges and those of the next quarter-century.
- Renewal of primary health care entails recognizing and facilitating the role of primary health care as an approach to promote more equitable health and human development.
- Primary health care renewal will need to pay increased attention to structural and operational needs such as access, financial fairness, adequacy and sustainability of resources, political commitment, and the development of systems that assure high-quality care.
- Successful primary health care experiences have demonstrated that system-wide approaches are needed, so a renewed approach to primary health care must make a stronger case for a reasoned and evidence-based approach to achieving universal, integrated, and comprehensive care.
- The proposed mechanism for primary health care renewal is the transformation of health systems so that they incorporate primary health care as their basis.
- A primary health care-based health system entails an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Such a system is guided by the primary health care principles of responsiveness to people's health needs, quality orientation, government accountability, social justice, sustainability, participation, and intersectoriality.
- A primary health care-based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first-contact care. Families and communities are its basis for planning and action.
- A primary health care-based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial, and technological resources. It employs optimal organization and management practices at all levels to achieve quality, efficiency, and effectiveness and develops active mechanisms to maximize individual and collective participation in health. A primary health care-based

health system develops intersectorial actions to address other determinants of health and equity.

- International evidence suggests that health systems based on a strong primary health care orientation have better and more equitable health outcomes, are more efficient, have lower health care costs, and can achieve higher user satisfaction than those whose health systems have only a weak primary health care orientation.
- The reorientation of health systems toward primary health care requires a greater emphasis on health promotion and prevention. This is achieved by assigning appropriate functions to each level of government, integrating public and personal health services, focusing on families and communities, using accurate data in planning and decision making, and creating an institutional framework with incentives to improve the quality of services.
- Full realization of primary health care requires additional focus on the role of human resources, development of strategies for managing change, and aligning international cooperation with the primary health care approach.
- The next step to renewing primary health care is to constitute an international coalition of interested parties. The tasks of this coalition will be to frame primary health care renewal as a priority, develop the concept of primary health care-based health systems so that it represents a feasible and politically appealing policy option, and finds ways to capitalize on the current window of opportunity provided by the recent 25th anniversary of Alma-Ata, the international consensus on the importance of attaining the Millennium Development Goals (MDGs), and the current international focus on the need for strengthening health systems.

### **Building Primary Health Care-Based Health Systems**

The conceptual framework presented here is meant to serve as a foundation for organizing and understanding components of a primary health care-based health system; it is not meant to define, exhaustively, all of the necessary elements that constitute or define a health system. Due to the great variation in national economic resources, political circumstances, administrative capacities, and historical development of the health sector, each country will need to design their own strategy for primary health care renewal. It is hoped that the values, principles, and elements described below will aid in that process.

#### **A. Values**

- Right to the highest attainable level of health
- Equity
- Solidarity.

- B. Principles
- Responsiveness to people's health needs
  - Quality-oriented
  - Government accountability
  - Social justice
  - Sustainability
  - Participation
  - Intersectoriality.
- C. Elements
- Universal coverage and access
  - First contact
  - Comprehensive, integrated, and continuing care
  - Family- and community-based
  - Emphasis on promotion and prevention
  - Appropriate care
  - Active participation mechanisms
  - Sound policy, legal, and institutional framework
  - Pro-equity policies and programs
  - Optimal organization and management
  - Appropriate human resources
  - Adequate and sustainable resources
  - Intersectorial actions.

### **The Commission on Macroeconomics and Health**

The Commission was launched by Gro Brundtland, Director General of WHO, in the year 2000, with Jeffrey Sachs as its director, with the mandate of examining the interactions of health and economic development. The Commission argued that by taking essential interventions to scale and making them available worldwide, eight million lives could be saved each year by 2010. To achieve these huge gains in health and economic development, the Commission called for a major increase in the resources allocated to the health sector of the next few years. Then, on a very practical note, the Commission recommends that the most effective interventions can be delivered through health centers and similar facilities and through outreach, which they collectively describe as close-to-the-client (CTC) systems. This can be seen as an important endorsement of PHC principles and practice (CMH, 2000).

### **The Millennium Development Goals Coupled with the Millennium Project**

The MDGs were the product, in the year 2000, of 189 countries signing the UN Millennium Declaration. This historic call to action – at the dawn of the new century – set forth an ambitious agenda for improving the lives of the world's poorest citizens by 2015, through a joint effort of both developed and developing countries. The key goals were then expanded, refined and operationalized

as the MDGs, including concrete targets and a specific timetable, with accountability at all levels: international, regional and country, as well as municipal and community (Sachs, 2005).

Given the ambitious range and the global complexities of the MDGs, it became apparent that further refinement of strategies would be required, thus the establishment of the UN Millennium Project in 2002 under the leadership of Jeffrey Sachs. Thirteen task forces were formed to address the goals and targets, and their work culminated in a final report in 2005: *Investing in Development – A Practical Plan to Achieve the MDGs*.

This must be seen as a remarkable process encompassing threats to the health and well-being of humanity, and the need to extend responsive actions not only to diverse national settings, but onward to community levels. This is well stated by Jeff Sachs.

Our Project has been a microcosm of a larger truth: achieving the MDG will require a global partnership suitable for an interconnected world. Another special aspect of the Project is the rare and powerful opportunity to help give voice to the hopes, aspirations, and vital needs of the world's poor and most voiceless people. We have met countless heroes and heroines of development in the three years of our work – in the villages and slums of Africa, Asia, Latin America and other parts of the developing world (Sachs, 2005).

Not surprisingly, multiple flaws in the nature of responses and coverage relating to populations in need have been identified in the MDGs, and the insights of the Millennium Project have covered many of them. Indeed, it is impressive to see the realities specified by the task forces of the project.

Overall, there is no doubting the implications of these global developments for PHC. They provide a new platform for PHC policy and program development, with profound potential for constructive change.

### **The Commission on Social Determinants of Health**

Established by the Director General of WHO in 2005, the Commission on Social Determinants of Health (CSDH) is a strategic mechanism to promote a global health agenda to improve equity in health and health through action on the social determinants of health at global, regional, and country levels.

The CSDH states that today, an unprecedented opportunity exists to improve health in some of the world's poorest and most vulnerable communities by tackling the root causes of disease and health inequalities. The most powerful of these causes are the social conditions in which people live and work.

In assessing the general field of health and development, the founders of the Commission have reflected on the policies and processes that have been supportive of social factors in health and those that have been conflictual. It is interesting to include PHC in those considerations as it is closely related to social determinants of health.

One factor of importance has been intersectoral action, which was central to the model of comprehensive primary health care proposed to drive the Health for All agenda following the 1978 conference at Alma-Ata, USSR.

One of the conflictual approaches was that of selective primary health care, introduced in 1979, which focused on a small number of cost-effective interventions and downplayed the social dimensions of health.

Like other aspects of comprehensive primary health care, action on social determinants was weakened by the neoliberal economic and political consensus that was dominant in the 1980s and beyond, with its focus on privatization, deregulation, shrinking states, and freeing markets. A key postulate of the neoliberal economic orthodoxy of the 1980s and 1990s was that, since economic growth was the key to rapid development and ultimately to a better life for all, countries should rapidly and rigorously implement policies to stimulate growth, with little concern for the social consequences in the near term.

Another major factor related to neoliberal doctrines was the structural adjustment programs (SAPs) imposed on a large number of countries as a condition for debt restructuring, access to new development loans and other forms of international support. The SAPs were implemented in many countries of Africa, Asia, and Latin America under the guidance of the International Financial Institutions (IFIs). A central principle of SAPs was sharp reduction in government expenditures, in many cases meaning drastic cuts in social sector budgets. These cuts affect areas of key importance as determinants of health, including education, nutrition programs, water and sanitation, transport, housing, and various forms of social protection and safety nets, in addition to direct spending in the health sector. In addition, many SAPs demanded large and abrupt cuts in public sector payrolls. The negative impacts on primary health care as well as social determinants of health were striking (World Health Organization, 2005).

In contrast, the Millennium Development Goals (MDGs) shape the current global development agenda in strongly positive ways. The MDGs recognize the interdependence of health and social conditions and present an opportunity to promote health policies that tackle the social roots of unfair and avoidable human suffering.

It is interesting, indeed, to see that although several global processes or policies, like neoliberal perspectives and structural adjustment programs, have had distinctly negative impacts on the social side of health development where primary health care resides in the development

process, other actions, such as the Commission on Macroeconomics and Health, the MDGs, and the Commission on Social Determinants of Health, are being envisaged and implemented that are strongly supportive of the social and economic base for health development for poor populations. How timely it is to recall Mahler's comments in his address to the 1978 World Health Assembly: 'Health and economic development are indivisible; cutting back on health programs retards economic development.'

### **Primary Health Care and the New Director General of WHO, Dr. Margaret Chan**

It has been dramatic, indeed, to hear the remarks of the new Director General of WHO, Dr. Margaret Chan, regarding her perspectives on health and health care. Here are excerpts of her presentation to the World Health Assembly, November, 2006. (The sequence of these remarks has been modified from the presentation)

So let me be clear about the results that matter most. Reducing burden of disease is important. Improving the strength of health systems is important. Reducing the threat of risk factors for disease is important.

These are all vital. But what matters to me is people. And two specific groups of people in particular. I want us to be judged by the impact we have on the health of the people of Africa, and the health of women.

Health systems are the tap root for better health. When we talk about capacity, we absolutely must talk about the importance of primary health care. It is the cornerstone of building the capacity of health systems. I plan to promote primary health care as a strategy for strengthening health systems. The reason is simple: It works. This is the only way to ensure fair, affordable, and sustainable access to essential care across a population. We have the evidence. I have experienced this personally. During my tenure in Hong Kong, I introduced primary health care from the diaper to the grave.

There have been numerous enthusiastic responses to her call for special attention to primary health care. She has sought advice from Halfdan Mahler and others with close familiarity with the Alma-Ata story and its contemporary challenges. There will be a Conference on Primary Health Care in Buenos Aires, Argentina, August 13–18, 2007, sponsored by PAHO, with the title 'Rights, Facts, and Realities, strengthening PHC and health systems to achieve the MDGs'. This conference is seen as setting the stage for another conference to be held in 2008 to celebrate the 30th Anniversary of Alma Ata and the 60<sup>th</sup> Anniversary of the founding of WHO, including the possibility of organizing an Alma-Ata II!

## **Addendum to Alma-Ata and Primary Health Care: An Evolving Story. Buenos Aires 30/15 International Conference, August 2007 From Alma-Ata to the Millennium Declaration: Towards Equity-Based Comprehensive Health Care**

### **Background**

The interest in and commitment to primary health care, which found its origin at the WHO/UNICEF International Conference on Primary Health Care at Alma-Ata in 1978, has been increasing globally. Important support has come from Dr. Margaret Chan, the new Director General of WHO, who has called for a global rejuvenation of primary health care. Virtually all of the six regions of WHO have been taking supportive steps. The support of the Pan American Health Organization has been particularly strong, as illustrated by the publication in 2005 of its position paper on *Renewing Primary Health Care in the Americas*.

These factors coalesced into the convening of the International Conference – From Alma Ata to the Millennium Declaration, Buenos Aires 30/15. The title of the conference is revealing – 30 years since Alma Ata, and now near the mid-point in the countdown to 2015, the year given so much significance and promise by the Millennium Declaration and its goals.

The conference brought together a wide range of persons who have had major impacts on global health policies with special interest in Primary Health Care. The following presentations are illustrative of the broad international support given to the Buenos Aires Conference:

- Gines Gonzalez Garcia, Minister of Health of Argentina: *Prologue*;
- Halfdan T. Mahler, Director General, WHO, at the time of the International Conference, Alma Ata in 1978: *Leadership and Equity in Health*;
- Michael Marmot, Chairman, Commission on Social Determinants of Health, WHO: *Social Determinants of Health. Global Context and Challenges*;
- Ravi Narayan, Coordinator of the Peoples Health Movement: *Health for All – A Supreme Challenge*;
- Margaret Chan, Director General, WHO: *Contribution of Primary Health Care to the Millennium Development Goals*;
- Mirta Roses Periago, Director, PAHO: *Closing Statement*.

The Conference Report concludes with the Buenos Aires Declaration: *Towards a Health Strategy for Equity-Based Primary Health Care*, which deserves special attention, as it expresses the concern of the participants for equity-based comprehensive care, accessible to all including those who are most disadvantaged.

### **Prologue**

#### **Gines Gonzalez Garcia, Minister of Health of Argentina**

The main challenges for world health systems are the access to quality services for all, a more humanized care at health centers, and an equity-based distribution of resources and sanitary results.

These were the conclusions of the Buenos Aires 30/15 International Conference, held in August, 2007, which gathered specialists and representatives from over 60 countries and was attended by more than 3000 people.

The two major breakthroughs in the interests of the right to health for our people have been the Universal Declaration of Human Rights (1948) and the Alma-Ata Conference (1978). The 30-year period between both milestones outlined the most important paradigm in public health policies: primary health care.

In a few months, another 30 years will have passed. The objective of the Conference held in Buenos Aires was to relaunch primary health care as essential approach to tackle new and old health problems.

During Buenos Aires 30/15, we all realized that the primary health care strategy is still producing very good results in the countries of the region. But there is still a lot to be done. This is why we must deepen the reforms, turning this strategy into the core of the whole system. Our main struggle is not against biological agents, but against society and behavior models that bring disease and death to millions of people.

Recent experience in the region has shown that the sanitary reforms that focused on primary health care produced excellent results, and Argentina is a good example. This forces us to deepen the ongoing transformations. If we can adequately implement the ideas set out in Buenos Aires 30/15, we will be closer to the scenario where everyone has the opportunity to live a long and healthy life.

### **Leadership and Equity in Health**

#### **Halfdan Mahler, Former Director General of WHO**

I am morally and intellectually convinced that the Health for All approach and the primary health care strategy provide significant initial strengths and have added impetus to health development in the whole world.

I see amazing inequity patterns in health indicators throughout our whole miserable world. I am not talking about the first, second, or third world. I am talking about one single world, the only one that we have to share and take care of. Therefore, I will continue supporting everything that contributes to providing health levels to allow all the people in this one world to have a productive and both socially and economically satisfactory life.



What hundreds of millions of people around the underprivileged world need and want is the same as everyone in any part of the world needs and wants: The well-being of their loved ones and a better future for their children, the eradication of the increasing injustice, and the beginning of hope.

Equity, understood as assurance of satisfaction of basic needs in terms of health as well as social and economic needs, especially in connection with vulnerable groups, such as the poor, children, women, the elderly, and the handicapped, is for me the fundamental objective of every development.

Actually, I consider equity as a moral imperative that involves all social and economic activities.

This morally binding commitment of Health for All was the basis of the primary health care strategy, which implied a commitment not only to the reorientation of traditional health care systems – which should be called medical palliative systems – but also to a change where people have their own control over their health and well-being, up to the point when they actually lead to deep social reforms in the health care field. This implies a process of permanent empowering, by means of which people acquire a skill and the desire to become a social agent of their own health and well-being.

This is why I actually believe that the fundamental values of social justice and equity are the essence of the Health for All approach and the primary health care strategy. And this approach and strategy can actually become true and constitute a powerful force and conduction line to achieve equity and social justice. Health might not be all, but without health there will be very little well-being.

## **Social Determinants of Health Global Context and Challenges**

### **Michael Marmot, Chairman, Commission on Social Determinants of Health, WHO**

It's a pleasure to be here in this most important conference.

I have one clear point: When we rediscover the importance of primary health care, we should also rediscover the importance of the social determinants of health. They are not the same. I think that saying that social determinants of health are simply a part of primary health care is liable to cause confusion. They need each other. There should be a partnership between social determinants of health and the redevelopment of primary health care.

A central task of the Commission on Social Determinants of Health is to gather and synthesize evidence in such a way that it can lay the basis for action. The problem with which the Commission is concerned is health inequalities between and within countries.

There are substantial health differences within countries. For example, in the 25-year follow-up of the first Whitehall Studies of British Civil Servants, we showed that for men classified according to grade of employment in the civil service, the higher the position in the hierarchy, the lower the mortality. The importance of this Whitehall study is that it shows that we are not dealing only with absolute deprivation. Even people at the bottom of the British Civil Service are not poor. Twenty percent of the national population of Argentina lives on \$2 a day or less. No one in the British Civil Service lives on \$2 a day or less – they are not poor in the sense of absolute deprivation. Yet there is a remarkable social gradient in health, running from the top to the bottom of the society. In the United States, we see a 17-year gap in life expectancy between poor Blacks in downtown, Washington, DC, and richer Whites of nearby Montgomery County, Maryland.

The Commission is action-oriented. High-quality academic work is an important foundation of our deliberations but we want to see academic work translated into action. We want to create a global movement that places fair health, health equity, at the head and heart of social policy. Coming to Argentina, I felt the need to read your most famous author, Jorge Luis Borges, who said “My humanity is in feeling we are all voices of the same poverty.” That, colleagues, is what the Commission is trying to deal with.

## **The People's Health for All Movement**

### **Ravi Narayan, Coordinator, People's Health Movement Global Secretariat**

How can we go beyond the market forces that operate all over the world and prevent health from being only for those who can afford it? I represent the people who are being left out of our current health programs. On their behalf, I would like to say that the first step any of you as decision makers and political scientists must take is to listen to the people. What are people saying?

Today, I would like to show you the evidence, the proof people gave us and the way we interpreted it. People come to see us with a cough and we give them cough syrup. But if we sit down and listen to their life stories, they tell us stories of poverty, injustice, discomfort, exploitation. Is the cough syrup enough?

In the lives of ordinary people, then, to summarize what people are saying, there are social, political, economic factors that impact our lives, our access to health care, our access to all types of public policies, and unless we address these determinants health for all cannot be a reality.

Finally, I would like to emphasize, together with all of you and all of the people of the world, that health for all needs a new paradigm. We have to confront WHO and the

World Bank and other international health players to ensure that their policies have the needs of the people at the center, and not the market economy: that the Millennium Development Goals (MDGs) become more sustainable. We have to make sure that the MDGs are not only eight stand-alone vertical programs, but that there must be a more integrated and holistic approach. We cannot have MDG 3, empowering women, and MDG 5, that of children, being tackled separately. We have to move from top-down, vertical globalization to a people-led globalization involving everybody from the bottom up.

We are glad that PAHO has quoted our people's health charter and emphasized that for a good PHC service in the new millennium we should "encourage community participation, prepare accountable health programs, provide appropriate services for all, and we have to make sure that services become accessible regardless of people's ability to pay."

## Contribution of Primary Health Care to the Millennium Development Goals

### Margaret Chan, Director General of WHO

The topics explored in this conference embrace some of the most pressing issues in public health today. Obviously, if we want better health to work as a poverty reduction strategy, we must reach the poor. And we must do so with appropriate high-quality care.

What role can primary health care play in this quest?

What are our prospects of reaching the health-related MDGs?

More specifically, how can we overcome major barriers, such as weak health systems, inadequate numbers of health-care staff, and the challenge of financing care for impoverished people?

When I took office at the start of this year, I called for a renewed emphasis on primary health care as an approach to strengthening health systems.

The experiences and recommendations coming from this conference are extremely relevant to public health today, both within countries and for the work of WHO.

1. Millennium development goals. We are near the mid-point in the countdown to 2015, the year given so much significance and promise by the Millennium Declaration and its Goals. These goals represent the most ambitious commitment ever made by the international community. Their achievement would make the biggest difference in the lives and future prospects of impoverished populations in the history of humanity.
2. Health for all. Looking back, we are approaching the 30th anniversary of another historical set of commitments: the Declaration of Alma-Ata. That document promoted primary health care as the key to attaining an

acceptable level of health for all people in this world. This was the heart of the Health for All movement.

Apart from its passionate call for equity and social justice, Health for All also launched a political struggle on at least three fronts.

- First, it sought to make health part of the political agenda for development, to upgrade the profile of health and increase its prestige.
- Second, it sought to broaden the approach to health, to move away from the narrow medical model of curative care. It acknowledged the power of prevention. And it recognized that health has multiple determinants, including some in sectors other than health.
- Third, the Declaration of Alma-Ata argued that better health for populations should go hand in hand in a mutually supportive way, with better economic and social productivity.

These, then, were some of the political struggles surrounding a movement launched in the name of social justice and for the good of our common humanity. But the Health for All movement paved the way for even more ambitious goals agreed on at the start of this century.

- First, the goals place health firmly at the center of the development agenda.
  - Second, the goals make intersectoral collaboration a prerequisite for success. They attack the root causes of poverty and acknowledge that these causes interact.
  - Third, by making better health a poverty reduction strategy, the goals move the health sector from a mere consumer of resources to a producer of economic gains.
3. Present situation. It is by no means certain that we will reach the health-related Millennium Development Goals. We are still not reaching underserved populations with sustainable, equitable, and comprehensive care on an adequate scale. In 2005, the Millennium Project Task Force issued its assessment of the prospects for achieving the goals for child and maternal health. "The health system that should make interventions available, accessible, and utilized is in a crisis. Only a profound shift in how the global health and development community thinks about and addresses health systems can have the impact necessary to meet the Goals." When I think about this dilemma, I reach two conclusions.
    - First, in matters of health, I believe our world is out of balance, possibly as never before in history. We have never had such a sophisticated arsenal of technologies for treating disease and prolonging life. Yet, the gaps in health outcomes keep getting wider. Life expectancy can vary by as much as 40 years between rich and poor countries. This is unacceptable.
    - My second conclusion relates directly to the topic of this conference. I do not believe we will be able to

reach the Millennium Development Goals unless we return to the values, principles, and approaches of primary health care. Decades of experience tell us that primary health care is the best route to universal access, and the best way to ensure sustainable improvements in health outcomes.

Having said this, I want to commend PAHO and its member states for their enduring commitment to primary health care.

I would now like to suggest four principles that can guide us as we explore ways to achieve equity-based comprehensive health care and look at the contribution of primary health care.

- First, we must maintain our commitment, determination, and above all, our sense of urgency. As Dr. Mahler stated almost 30 years ago, our determination must be absolute. We must refuse to retreat.
- Second, we must hold our politicians accountable for the promises they make, whether to their voting constituency or at international summits.
- Third, if we want politicians to make the right priorities and keep them, we must provide solid evidence. Evidence gives health arguments persuasive power at the policy level. As I have said, what gets measured gets done.
- Finally, we must never underestimate the power of human ingenuity. This power goes hand in hand with resolute determination to reach a goal.

As my last remark, I believe that, when we talk about primary health care, we must also acknowledge the great ingenuity of communities. Human nature has certain commonalities that transcend differences of place, race, religion, and culture. Time and time again we see how, when communities are given opportunities they want and programs they can own, they are empowered to achieve the lives they desire. Given a hand up, they can indeed lift themselves out of poverty and improve their health.

This, then, is part of our common humanity, as expressed in the Millennium Declaration. These are our shared traits of compassion, inspiration, aspiration, and great ingenuity. Our common humanity gives us reason to care. It is why we must act with urgency in the face of an emergency. It is also why we have so much to gain, in the name of social justice.

## **Toward an Equity-Based Comprehensive Health Care**

**Mirta Roses Periago, Director, Pan American Health Organization**

We have arrived at the final moment of this Buenos Aires 30/15 International Conference. It has been a very intense

week for the delegations that are present, with many months of preparation and fruitful participation from across the world.

At first glance, Buenos Aires 30/15, and the Declaration that it has produced, are very important symbolically because they come 30 years after the International Conference in Alma-Ata, and at the halfway point of the period set for the fulfillment of the Millennium Development Goals (MDGs).

There is historical continuity between the most important political and doctrinal definition of public health in the world, which established a noble and ambitious goal (Health for All) and put us on the road to achieve it (Primary Health Care), and the most ambitious commitment to combat poverty ever undertaken by the international community, the Millennium Development Goals.

What is the Legacy of Alma-Ata? The social and health policy itinerary from 1978 to 2007 shows us that PHC has had an enormous influence on public policies, on the configuration of health systems, and on the thinking and actions of health workers.

Developments derived from Alma-Ata are consolidated and enriched by contributions from political and moral philosophy and the economy of development (as pointed out in the work of Amartya Sen), which have produced a reconfiguration of frameworks for social policy and governmental action. Along the way there has arisen a new vision of sustainable human development and the relationship between economic development, democracy, and social protection that has led to a new view of social and health policies and the contribution of health systems.

The view from this perspective of the fundamental social determinants of health and human development has assigned health a more important place on the global development agenda and has strengthened the role of health in public policies. Health is not only an input for economic growth, but rather, and principally, an essential component of human development.

Following Sen, this new approach regards health as a basic human capacity, as a fundamental requirement for human beings to be able to carry out their life projects and achieve their maximum life potential, and as an essential human right and a dimension of freedom.

We can say that as long as social and health inequities persist and social exclusion in health continues, the ideal, as well as the principles and values of Alma-Ata will remain in force.

It is on that axiological and ethical legacy, and on the enormous experience of public health workers accumulated over 30 years, that we can and should build a new vision of the role of PHC in health systems in order to make them capable of achieving health for all. This is to say health systems based on PHC.

## Reflections and Looking Ahead

At least three generations have met here, inspired by Alma-Ata and under the wise and firm guidance of the founders, and they are now carrying the torch forward as in the Olympics.

From these days of work, three points remain clear for all of us.

- We do not need weak, selective, or incomplete PHC that, as we say, is like a poor man's blanket that when stretched to one side leaves the other side uncovered. We want something that covers us all, not a PHC with basic packages only for the poor, or for rural areas, or for marginal areas.
- We need and we want PHC that has equity, universality, solidarity, and social participation, that reflects a rich encounter of knowledge, that is intersectoral, that makes it possible for us to successfully address the social determinants of health, and that affirms and ensures the right to health care.
- We need and we want the PHC of Alma-Ata firmly rooted in the passion and commitment of 1978 and with the projection and capacity to transform current health systems, because we need them urgently, and because they are indispensable to the viability and sustainability of human society in the twenty-first century, when we will all have to share the same and only planet.

### **Buenos Aires 30/15 Declaration Towards a Health Strategy for Equity, Based on Primary Health Care August 17th 2007**

We, the Ministers of Health and representatives of the Ministries of Health attending the International Conference of Health for Development: Rights, Facts and Realities, have gathered in the City of Buenos Aires on August 16th and 17th, 2007, to analyze the achievements and difficulties in the implementation of the Primary Health Care Strategy and with the object to foster the strengthening of already established consensus and generate new proposals, tending toward the establishment of a strategy of an equity-based comprehensive health care.

Whereas, and taking into account that:

1. We reaffirm that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction as to race, religion, political belief or economic or social condition. This is a key responsibility of the State, together with the participation of the citizens.
2. We acknowledge that the efforts of the public policies and societies must be oriented towards human development. This implies that said efforts require an orientation towards the improvement of quality of life for the people, against poverty and exclusion, ensuring equal opportunities and the development of the capacities of the persons and their communities.
3. Health is an outcome of different and dynamic social, economic, cultural, and environmental determinants. Responsibility for it belongs to everyone. Although it goes far beyond the curative, disease-oriented medical care, health services systems have a key role in bringing sectors together including the community. This implies a need for policies by the State and the collaboration and commitment from all the sectors: public organizations, private sector, community organizations, international organizations, and each citizen.
4. We acknowledge that health is fundamental to secure the objectives of development agreed to internationally, including those stated in the Millennium Declaration, and that these objectives create an opportunity to integrate health as an essential part of development and therefore, to increase the political commitment and the resources destined to the sector.
5. We affirm that equity, solidarity, and universality should govern health and development systems and policies.
6. The Primary Health Care (PHC) Strategy is based on values and principles that remain relevant and which must guide the structure and operation of the health systems at all levels and for all.
7. Health problems do not respect boundaries between states and jurisdictions. Furthermore, old problems of poverty and exclusion still exist today, and new challenges exist related to the environment, demographic changes, unhealthy lifestyles, and emerging and re-emerging diseases.
8. The Primary Health Care (PHC) Strategy must be capable of dealing with both old health problems as well as the new and emerging ones.
9. Nearly 30 years after the Alma-Ata Declaration the health situation of a great part of humanity is deplorable and large parts of humanity do not enjoy equitable, comprehensive, or even basic health care.
10. Health human resources are generally not trained to respond to socially complex health problems involving prevention, promotion, intersectoral cooperation, client-provider relations, and community participation.
11. We are very far from reaching the goals related to health contained in the Millennium Declaration. We acknowledge that international and national policies, including social and economic policies, have affected our ability to meet the MDGs and develop equitable health systems.
12. It is imperative that we solve these difficulties and develop a new implementation plan for the strategy that brings us nearer not only to reaching the



objectives of the Millennium Declaration, but to the full implementation of the values and principles of Primary Health Care.

We accept the following principles:

13. Health is a cause and generating factor of development and growth of a nation. For this reason, we consider health as an investment and not as an expenditure, and also a responsibility of the State and society as a whole.
14. Equitable health care is a key factor for development and can stimulate equitable approaches in other fields. This requires priority and strong public policies which involve all stakeholders.
15. In order to achieve equity-based health care, it is imperative to strive towards universal and comprehensive coverage. In doing so, policies and programs need to be gender-responsive, inclusive, nondiscriminatory, and prioritize vulnerable groups.

Therefore we commit to develop processes that:

16. Take into account the values and principles of primary health care, to guide the policies, structure, and functions of the health systems at all levels for all.
17. Support the leadership and stewardship role of the State and the participation of families, communities and all other stakeholders in guiding planning and where appropriate, in the implementation and support of health programs and services in a comprehensive and intersectoral manner.
18. Determine the set of programs and services necessary to achieve equity-based health care, that the countries can implement according to their national contexts.
19. Assure adequate financing of the programs and services that are considered necessary for each country, ensuring sustainability and working towards universal coverage.
20. Incorporate into the design and implementation of health and development policies, factors such as socioeconomic status, culture, ethnicity, gender, age, and disability.
21. Strive to eliminate inequities in the quality of health services within the countries.
22. Ensure that health systems do not reproduce inequities found in other sectors and engage in intersectoral collaboration to promote social inclusion and poverty reduction public policies.
23. Strengthen relationships between the health authorities and educational institutions to meet the needs of the population by training health workers to use interdisciplinary approaches for new social, environmental and health problems.
24. To involve the health authorities in intersectoral collaboration to help develop public policies of other sectors when they affect health, such as those aimed

at improving access to drinking water, safe food, decent work, a healthy environment, and adequate shelter.

25. Include in official publications indicators to measure equity.
26. Strengthen joint cooperation between countries and institutions in managing health issues of local, national, and international concern.
27. Support rapid implementation of the above-mentioned actions, in a framework of equity and social justice, to achieve the enjoyment of the highest attainable standard of health, which is one of the fundamental rights of every human being without distinction as to race, religion, political belief or economical or social condition.

### **Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Health Care. WHO 2008**

The World Health Organization worked closely with faith-based organizations (FBOs) in preparing for the Alma-Ata Declaration of 1978. The role of the Christian Medical Commission was particularly notable in that process. Together they gained a clearer picture of health-care in the developing world, and then established the concept of primary health care. This report of WHO focused on FBOs is intended to assist in the process of rejuvenating dialogue and partnership with FBOs in the face of widespread health challenges in communities around the world, not least of which is HIV/AIDS. The revival of the primary health care model within WHO underscores that if this framework is to be promoted as a more sustainable system of health servicing and delivery, then the inclusion of FBOs will add greater potential for breadth and effectiveness.

In 2006, WHO commissioned South Africa-based African Religious Health Assets Programme (ARHAP) to conduct an extensive survey of FBO healthcare delivery in two South African countries. The study concluded that the proportion of faith-based health service provision averages about 40 percent in many sub-Saharan African nations.

Thus, the current scale of FBOs' involvement in health care in sub-Saharan Africa makes a compelling case that religious entities (not only Christian) could become significant players in the new primary health care approach to strengthening health systems globally, especially related to achieving the goal of universal access.

Conclusion: Much can be achieved in renewed interaction and cooperation between WHO and FBOs. This requires a clear long-term commitment to dialogue and mutual learning. The next step should involve forming a

road map that interested parties can commit to so they can embark on the next stage of the journey together.

### **Unequivocal Regional Support for Margaret Chan's Commitment to Primary Health Care. (*Lancet*, Correspondence, June 19, 2008.)**

An exceedingly interesting dialogue was prompted by an editorial written by Richard Horton, Editor of *Lancet*, published May 31, 2008, highlighting that Dr. Chan had placed PHC at the center stage at the WHO. Mr. Horton had attended a Technical Briefing on PHC during the May World Health Assembly, which was very well-attended and well-received. While applauding the DG's PHC prioritization, *Mr. Horton questioned whether the WHO's six Regional Directors (RDs), who as he stressed, have influence at country level, would support the DG's PHC agenda.* This sentence caused an immediate reaction among the six RDs. Drafts were exchanged back and forth among the RDs and Dr. Chan. It seems unlikely that *The Lancet* ever anticipated this reaction!

*The Lancet* issued a press release, June 19, stating *WHO DG's quest to revitalize Alma-Ata gets unqualified and unprecedented support from her lieutenants.* In that press release, Mr. Horton said

"...the alignment and combined advocacy of WHO's global leadership is an unprecedented moment in WHO's history. Revitalizing PHC is the single most important action that countries and donors can do to save lives and avoid disability. WHO is now perfectly poised to lead this new movement for PHC..."

The RDs issued a statement in *The Lancet*, Correspondence, June 19:

"Dr. Chan's commitment to primary health care is in itself an expression of the unequivocal support from the six regional directors and of the unanimity of views among the senior management of the organization with regard to primary health care. Despite the wide variation across and within regions with respect to health challenges and the responses required to address these, there is mutual agreement that primary health care will continue to be central to WHO's strategy to strengthen health system towards the vision of 'Health for All'".

### **Concluding Comments**

The Alma-Ata story is truly inspirational with reference to several issues.

First, to have been at Alma Ata, as the authors of this article were (as members of the U.S. Delegation), to have

played a small part in the formulation of the Declaration, was truly one of the great honors of our professional lives.

Second, to have absorbed the major features of Alma-Ata as it happened, and to now be tracking the diverse events and processes that have followed, many of them unpredictable, some with negative impacts, others positive, but still building on the solid base that Alma-Ata provided, is exhilarating.

Third, to have experienced the Buenos Aires Conference, August 2007, entitled: From Alma-Ata to the Millennium Declaration: Towards Equity-Based Comprehensive Health Care, in the presence of Margaret Chan, Mirta Roses Periago (Director, PAHO) and Halfdan Mahler (Director General, WHO, at the time of Alma-Ata), was so uplifting. It was filled with clear expressions of local, regional, global commitment to primary health care. Of special interest was that such commitment was often expressed in new terms, new values, new concepts, reaching beyond the solid foundation of Alma-Ata. This is not to diminish the importance of the original perspectives, but to show that there is room for expanding the conceptualization and actions of Alma-Ata.

Fourth, at this very moment we are seeing the new initiative of WHO as it seeks constructive interaction with faith-based organizations in global pursuit of primary health care. And to have the new Director General of WHO, Dr. Margaret Chan, herself championing primary health care in this way is an extremely important positive factor.

Fifth, is an intriguing example of the support Margaret Chan is gaining in her call for the revitalization of primary health care. Richard Horton, Editor of *Lancet*, was congratulating WHO on its support for primary health care, but in the process asked if the regional directors of WHO were in full support of that process. Surprised by that question, Dr. Chan and the Regional Directors came forward with strong support, which led Horton to add an editorial in *The Lancet*, in which he stated: *WHO DG's quest to revitalize Alma-Ata gets unqualified and unprecedented support from her lieutenants!* Further, the alignment and combined advocacy of WHO's global leadership is an unprecedented moment in WHO history.

Sixth, and finally, to look around the world and sense the myriad people who have benefited from the Alma-Ata story, and to know that there will be many more in the future, gives one a sense of encouragement that our world will allow and support such processes. And, we who are involved in those processes are indeed honored.

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