

Alma Ata and the Institutionalization of Primary Health Care

A potential breakthrough in global health rights took place at the International Conference on Primary Health Care, held in 1978 in Alma Ata, USSR (Kazakhstan). The conference, sponsored by WHO and UNICEF, was attended by ministers of health from more than 100 countries. Virtually all of the 134 nations represented subscribed to the goal of “Health for All by the Year 2000.”⁹ Furthermore, they affirmed the WHO broad definition of health as “a state of complete physical, mental, and social well-being.”¹⁰ This was articulated in the Alma Ata Declaration, the conference’s final document, which is reproduced in full on pages 21-22.

To achieve the ambitious goal of Health for All, the world’s nations—together with WHO, UNICEF, and major funding agencies—pledged to work toward meeting people’s basic needs through a comprehensive and remarkably progressive approach called *Primary Health Care* (PHC).

As we mentioned at the end of Chapter 2, many of the principles of Primary Health Care were garnered from China and from the diverse experiences of small, struggling, nongovernmental Community-Based Health Programs (CBHP) in the Philippines, Latin America, and elsewhere. The intimate connection of many of these initiatives to political reform movements explains to some extent why the concepts underlying PHC have received both criticism and praise for being revolutionary.



The Alma Ata Conference in Kazakhstan in progress

The Social and Political Implications of Primary Health Care and the Alma Ata Declaration

As proposed at Alma Ata, the concept of PHC had strong sociopolitical implications. First, it explicitly stated the need for a comprehensive health strategy that not only provided health services, but also addressed the underlying *social, economic, and political causes of poor health*. Specifically, as conceived in the Alma Ata Declaration, such a strategy must promote a more equitable distribution of resources:

Political commitment to Primary Health Care implies more than formal support from the government and community leaders.... For developing countries in particular, it implies the transfer of a greater share of health resources to the under-served majority of the population. At the same time, there is a need to increase the national health budget until the total population has access to essential health care....

Also, an explicit policy is required whereby the affluent countries commit themselves to a more equitable distribution of international health resources to enable the developing countries, and especially the least developed, to apply primary health care.¹¹

PHC also emphasized the close link between health and development of the poorer sector of the community. (Unfortunately, in order to make the declaration palatable to the politically diverse governments represented at the gathering—ranging from Mozambique to Zaire, from China to South Korea, and from the US to the USSR—a precise statement of just how development was to be achieved was left out.) Thus:

Any distinction between economic and social development is no longer tenable.... Indeed, social factors are the real driving force behind development. The purpose of development is to permit people to lead economically productive and socially satisfying lives....

Since primary health care is the key to attaining an acceptable level of health by all, it will help people to contribute to their own social and economic development. It follows that primary health care should be an integral part of the overall development of society.¹²

The Declaration of Alma Ata also maintains that in order to plan and implement PHC effectively, strong participation of the people affected would be essential. Strong consumer participation had clearly been a common feature of the successful community-based programs which had been studied in the process of formulating the Declaration. It asserts that “self-reliance and social awareness are key factors in human development,” and emphasizes the importance of “community participation in deciding on policies and in planning, implementing, and controlling development programmes.”¹³

The participants at Alma Ata also recognized that PHC itself can contribute to development and serve as an arena for awareness-raising and organized action. At the same time, they realized that the dynamic unleashed by greater awareness and mobilization was potentially revolutionary, and was therefore likely to meet with opposition from those wanting to maintain the status quo:

It can be seen that the proper application of primary health care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it will greatly influence community organization in general. Resistance to such change is only to be expected....¹⁴

Because UNICEF and WHO represent world governments, they have to be careful not to word revolutionary proposals too blatantly. As health activist Vincent Navarro has pointed out, this indeed may be the Achilles heel of the Declaration. Much of the language used leaves enough room for interpretation that oppressive governments can translate it as they see fit. This undermines the essence and muffles the power of Alma Ata’s call for “Health for All” and the sweeping changes in power structures and economic systems that it requires.

Resistance to Primary Health Care

In the wake of Alma Ata, health ministries of underdeveloped countries-prompted by international funding agencies and consultants-began to launch national pro-

grams based on Primary Health Care. It was foreseeable that in countries whose leadership was less than fully accountable to the people (that is to say, most countries), the liberating component of PHC soon resulted in resistance to its implementation.

As a result, many national programs were launched and attracted funding under the PHC banner. But in practice, they tended to treat Primary Health Care as an extension of the same old top-down, Western medical system and extend it into under-served areas. To maintain the new image, the progressive language of Alma Ata was co-opted; expressions such as “*people’s participation*,” “*decision-making by the people*,” and “*empowerment*” became part of the new, official jargon. Central control, however, remained intact. While community participation was encouraged, it was generally the participation of weak compliance, rather than the strong participation of decision-making control.

Community health workers (CHWs) were trained, but rather than being the most important members of the health team, they were relegated to the lowest, most subservient position in the existing health hierarchy. The services that they were allowed to provide, especially the curative ones, were usually so limited that it was difficult for the CHWs to earn people’s respect. Far from being the envisaged agent of change, the community health worker’s role became that of civil servant: lackey, not liberator.¹⁵

In sum, the transformative potential of Alma Ata remained largely on the drawing board.

The use of the Alma Ata Declaration to neutralize successful community-based health work

As mentioned in the previous chapter, many of the Community-Based Health Programs which provided the inspiration for PHC were not just health initiatives. They were part of a larger struggle by marginalized people for their well-being and their rights. As such, they often ran into serious opposition. Even programs which may not have explicitly put social change on their agendas posed a threat to entrenched interests with their emphasis on addressing root causes of poor health and “putting the last first.”¹⁶ The awareness raising and community organizing they conducted to this end was often seen as stirring up trouble by local authorities.

Grassroots efforts to put health into the hands of the people posed a serious threat-not only to elites and governments-but also to the medical establishment, who for so long had maintained a powerful monopoly on the

knowledge and power of healing. Their reluctance to relinquish control, combined with government's bureaucratic procedures placed major obstacles in the path of these new programs.

Some opposition to these progressive health programs was overt; in some authoritarian countries, CHWs were harassed or arrested. More often, however, the projects were thwarted by more insidious methods. To make community-run health programs redundant, they introduced costly government-run health posts into the same communities (while often completely neglecting areas that had no health services at all).¹⁷ Staffed with uniformed, well-paid and credentialed health workers, these government posts were accountable directly to the government. They were stocked with a supply of colorfully packaged but nonessential drugs which they were encouraged to distribute liberally -in complete contrast to the PHC ethos of the community-based programs which attempted to encourage responsible and limited use of medicines. Thus, these new government-sponsored programs were instrumental in undermining the potentially progressive thrust of community-based initiatives.

Ironically then, the Alma Ata Declaration, which built its philosophy of PHC on the grassroots "struggles for health" of Community-Based Health Programs, was soon used by authoritarian governments as a pretext for getting rid of these more truly community-based programs. On the grounds that all community outreach in health should be standardized under the national PHC banner, they proceeded to assimilate, co-opt, or close down the autonomous, community-run programs.

Now, nearly two decades after the Alma Ata Declaration, many critics have concluded that PHC was an *experiment that failed*. Others argue that, in its full,

empowering sense, Primary Health Care has never been tried.¹⁸ Despite efforts aligned against them, however, there are

some success stories-or stories of at least temporary success. During the 1980s, the governments of both Mozambique and Nicaragua carried out comprehensive PHC initiatives very much in line with the Alma Ata protocol. Both countries were lauded by WHO for expanding their PHC coverage and greatly improving their health statistics. The keys to these accomplishments appeared to be: (1) the presence of the political will to meet all citizens' basic health needs; (2) active popular participation in the effort to realize this goal; and (3) increased social and economic equity.

Unfortunately, the early successes in both Mozambique and Nicaragua were short-lived. The governments of South Africa and the United States, respectively- concerned about the alternative model these countries might be setting for their neighbors-launched destabilization campaigns designed to halt their progress. Health workers in both countries were singled out for elimination by proxy terrorist forces sponsored by the regional and global superpowers.¹⁹ When the two countries were unable to sustain their early progress, opponents of PHC (and of equity-oriented development) used this to argue that the successes of these people-supportive alternatives were transitory and unsustainable.

The biggest assault on PHC, however, came from within the international public health establishment itself. The powerful global health institutions launched an international effort to strip PHC of its comprehensive and potentially revolutionary components, and reduce it to a narrow approach with which the national and global power structures could feel more comfortable. This disembowelment of PHC will be the subject of the next chapter.

THE DECLARATION OF ALMA ATA

- 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 world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.
- II. The existing gross inequality in the health status of the people-particularly between the developed and developing countries as well as within them-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 people live and work, and constitutes the first element of a continuing health care process.
- VII. Primary health care:
 - A. Reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
 - B. Addresses the main health problems in the community, providing promotive, preventative, curative, and rehabilitative services accordingly;
 - C. 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; 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;

THE DECLARATION OF ALMA ATA, CONTINUED...

- D. 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;
 - E. Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
 - F. Should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health for all, and giving priority to those most in need;
 - G. 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 the 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 well 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.



The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.