

Whatever happened to Alma Ata ?

Geneva Health Forum 2008
May 26, 2008

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Setting the stage for Primary Health Care

- 1960s:
 - Cold war
 - decolonialization, favored technology focused on imitation of tertiary care system did not reach the poor
 - International Covenant on Economic, Social and Cultural Rights
 - limited success with vertical programs (malaria eradication)
 - Experiences by missionaries and NGOs running medical grassroots projects
 - Success of small scale community based health projects in Costa Rica, Tanzania, India, Indonesia, Guatemala, Mexico, Bangladesh,
 - “PHC” movements in Cuba, China’s Barefoot Doctors
- 1969: WHA declares that malaria eradication only works within existing rural health system

Setting the stage for Primary Health Care

- 1967-72: **new divisions within WHO** under Newell and Mahler focusing on **strengthening of health services**
- 1971-73: WHO studies basic health services(WHA 26.35)
- 1973: Halfdan Mahler named WHO Director General
- 1973-74: **working group** WHO/ CMC/ NGOs to develop **plans for basic health services** in developing countries
- 1974: WHA 27.44 – assist governments in development of health delivery systems
- 1975: WHO formally creates **PHC program**
- 1975: publications
 - “Health by the People” (Newell)
 - “Alternative Approaches to meeting basic health needs of populations in developing countries” (Djukanovic & Mach)



Alma Ata conference 1978

- In Alma Ata, Soviet Republic of Kazakhstan
- Financed by USSR, prepared by WHO & NGOs, co-hosted by UNICEF
- 134 nations and 67 organizations present
- Linked health and development
- “Birthplace” of PHC as a global strategy for health care delivery



Primary Health Care

- Eight core elements of PHC
 - **Education** about health problems & solutions
 - Adequate food supply & **nutrition**
 - Safe **water** & basic **sanitation**
 - **Maternal & Child health**
 - **Immunization** against major diseases
 - **Prevention** & control of endemic diseases
 - **Treatment** of common diseases & injuries
 - Provision of **essential drugs**

AA declaration summary

“Health for All by the Year 2000”

- Health is:
 - state of complete physical, mental and social well-being.
 - Fundamental human right
 - Attainment of highest level of health is most important worldwide social goal requiring the action of many sectors.
- **Economic and social development essential** to health.
- People have **right and duty** to participate.
- **Health for all by 2000**. PHC key to attain this goal.
- **PHC evidence-based** and culturally acceptable, evolving from country's own condition (**appropriate technology**).
- Governments should formulate **national policies**, countries should cooperate.
- Attaining HFA-2000 using resources spent on military conflict

Selective PHC Counterrevolution – Back to Verticalism

- Bellagio 1979 (meeting sponsored by Rockefeller and WB)
- Walsh & Warren: “Selective PHC: An Interim Strategy for Disease Control in Developing Countries” (*NEJM*, 301, 1979, 967-974)
 - Focus on cost-effective interventions: GOBI – FFF
 - Vertical program implementation, little network
 - little community involvement,
 - little investment in development of local infrastructure
 - Donor convenient
 - Easier to train, deploy & manage staff
 - Fast, quantifiable results
 - Easier to justify & obtain donor funds, easier accountability
- SPHC vs. CPHC battle all throughout 1980s (Newell, Behrhorst, Taylor, Wisner, Banerji, Werner, Bryant)

Alma Ata Enthusiasm short-lived

- 1980s + 1990s:
 - Economic crisis and neoliberal governments
 - 1990 – Washington Consensus (goal macroeconomic stability, SAPs, trade liberalization, market oriented reforms)
 - Sizeable Opposition from medical establishment
 - Leadership changes at WHO, WB, UNICEF
 - Donors continued vertical approaches, often isolated and parallel
 - WB reports 1987 (“Financing health services in developing countries”) and 1993 (“Investing in Health”)
 - Privatization of health care, private insurance
 - User fees
- Lack of financial support and political will for PHC**
- SAPs strapped local health systems**

Why did PHC fail?

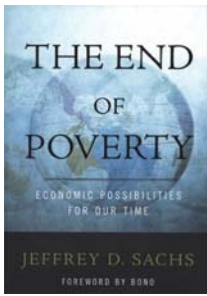
WHO Global Report 2003

“PHC: A Framework for Future Strategic Directions” :

“There is recognition that where implementation of PHC has been incomplete ..., this is due to **lack of practical guidance on implementation; poor leadership and insufficient political commitment; inadequate resources and unrealistic expectations** placed on PHC.”

Global Health 2008

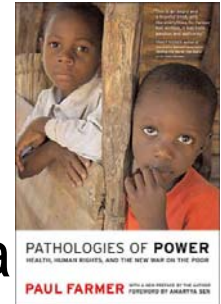
- Millennium Development Goals for 2015 increasingly unattainable with current strategies
- Health results since 1978:
 - Child mortality (decrease, but behind targets)
 - Maternal mortality (stagnant)
 - New diseases (HIV/AIDS), prevailing old diseases (TB, Malaria), neglected tropical diseases
- Shortage and Drain of health skills (internal and international poaching)
 - 3-4 million health workers needed
- Verticalism again in dead end street:
 - Parallel vertical programs inefficient and not scalable without existing local health infrastructure



New enthusiasm for community based projects



- HIV epidemic and Cairo goals brought renaissance of “Health as a Human Right” school-of-thought
 - Jonathan Mann, RIP
- Paul Farmer “Partners in Health” projects
- Community observed treatment for HIV, TB, Malaria
- Ethiopia – National Health Extension Worker Program
- Jeffrey Sachs “UN Millennium Villages Project”
- Globalization is REAL



- Cold War is over, ideological agendas discredited
- Local crisis live into global living room
- Internet (making a glocal network reality) as the great communicator, equalizer and platform of the “unheard”
- “appropriate technology” for community health care can become reality
- Pop culture influences public opinion, creates critical mass

Global policy revisits Alma Ata



Margaret Chan, DG of WHO:

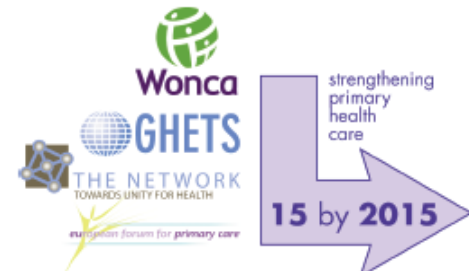
“...The **Millennium Development Goals** can be viewed as yet another **legacy of the Health for All movement** and the declaration that launched it. ...

I do not believe we will be able to **reach the MDGs** unless we **return to** the values, principles, and approaches of **Primary Health Care.**”

Opening Address at the International Conference on Health For Development,
Buenos Aires, 16 August 2007

Global policy revisits Alma Ata

- PAHO 2003:
 - regional consensus about renewal of PHC
 - commitment to include strategy in development of national healthcare systems
- Discussion about training of mid-level cadres for health service delivery
- 15 BY 2015 INITIATIVE
 - dedicate 15% of vertical disease-oriented budgets towards strengthening of local PHC systems
 - World Organization of Family Doctors
 - Global health through Education, Training and Service
 - The network: Towards Unity for Health
 - European Forum for Primary Care



Global policy revisits Alma Ata

- World Bank states in WDR 2004 “Making Services Work for Poor People”
 - that broad improvements in human welfare would only occur if **wider access to affordable and improved services in health, education, water, sanitation** was achieved.
 - that aid should be given to **improve service delivery** (budget-support aid).

Global policy revisits Alma Ata

- **WDR 2004 “Making Services Work for Poor People”:**

“...It is tempting to recommend a technical solution ..., why not develop a **“minimum package” of health interventions** for everybody?

Although each intervention is valuable, recommending them alone **will not address the fundamental institutional problems** that precluded their adoption in the first place.”

What can Alma Ata offer to the Global Health Discourse of the 21st century?

- Rights based perspective on health
- Multisectoral approach as basis for health improvements
- Horizontal health networks, rooted in existing health infrastructure
- Community participation, people as partners in health, not consumers of care
- Engagement of community health workers as mid-level cadres for health system
- Develop and use appropriate technology for local resources

Revitalizing Alma-Ata Goals

- Concrete implementation strategies & processes
 - more equitable allocation of resources, balance between horizontal and vertical programs
- Social policies
 - Labor policies, education (especially of girls)
- Intersectoral forums
 - different sectors develop common goals, strategies, program
- Funding commitments
 - Sustained funds; private sector involvement; community participation in funding
- Trained health personnel
 - better PHC training, supervision & management
- Long-term social intervention
 - Shift from vertical short-term measures to revitalization of PHC goals of poverty alleviation and community participation

Avoiding the post-Alma Ata pitfalls this time around:

- Discourse within policy groups and civil society about PHC goals AND roadmap
- Integrate health goals in larger goals of social justice, human rights and equity
- PHC of the 21st century must come with
 - community ownership, referral system, ongoing training and supervision, infrastructure (facilities, equipment, drugs, staff)
- expand concept of appropriate technology
 - 21st century communication opportunities meets simple local techniques for prevention and treatment)

Avoiding the post-Alma Ata pitfalls this time around:

- Clear targets for commitment, PHC roadmap without reduction to vertical interventions
- Political will
- Long-term donor commitment, rethink accountability of donors
- “bottom-up” approach may threaten status-quo of governments, the medical and pharmaceutical establishment – be prepared
- extend inclusion of Social Sciences in PHC operations research, planning, monitoring and evaluation

PHC implementation

- Thousands of village health workers trained in
 - basic sanitation,
 - diagnosis of common communicable diseases,
 - distribution of essential medicines,
 - breast feeding, family planning
- Training of traditional birth attendants
- Surgical officers (Mozambique, Tanzania, Ethiopia) for obstetric & abdominal procedures