

Alma-Ata: Rebirth and Revision 1

Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise

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In this paper, we revisit the revolutionary principles—equity, social justice, and health for all; community participation; health promotion; appropriate use of resources; and intersectoral action—raised by the 1978 Alma-Ata Declaration, a historic event for health and primary health care. Old health challenges remain and new priorities have emerged (eg, HIV/AIDS, chronic diseases, and mental health), ensuring that the tenets of Alma-Ata remain relevant. We examine 30 years of changes in global policy to identify the lessons learned that are of relevance today, particularly for accelerated scale-up of primary health-care services necessary to achieve the Millennium Development Goals, the modern iteration of the “health for all” goals. Health has moved from under-investment, to single disease focus, and now to increased funding and multiple new initiatives. For primary health care, the debate of the past two decades focused on selective (or vertical) versus comprehensive (horizontal) delivery, but is now shifting towards combining the strengths of both approaches in health systems. Debates of community versus facility-based health care are starting to shift towards building integrated health systems. Achievement of high and equitable coverage of integrated primary health-care services requires consistent political and financial commitment, incremental implementation based on local epidemiology, use of data to direct priorities and assess progress, especially at district level, and effective linkages with communities and non-health sectors. Community participation and intersectoral engagement seem to be the weakest strands in primary health care. Burgeoning task lists for primary health-care workers require long-term human resource planning and better training and supportive supervision. Essential drugs policies have made an important contribution to primary health care, but other appropriate technology lags behind. Revitalising Alma-Ata and learning from three decades of experience is crucial to reach the ambitious goal of health for all in all countries, both rich and poor.

Alma-Ata’s 30th anniversary

This special issue of *The Lancet* marks the 30th anniversary of the Alma-Ata Declaration (panel 1).¹ 2008 has witnessed a plethora of events to mark the occasion, ranging from conferences² to reports³ to special issues of journals like this one. Is this a reflection of sentimental nostalgia for a remarkable event, and equally remarkable leadership? Or is this a relevant inquiry at a critical time in the development of equitable and affordable health systems? What can we learn from what worked and what did not work, what has been sustained and what has not? Many of the health challenges we face today, both in rich and poor countries, echo those that led to the meeting in Alma-Ata. Demographic and epidemiological transitions have strained health systems as new diseases have emerged, while the old remain. Concerns about the affordability of health care, with an ever expanding menu of newer drugs and procedures, are near universal, whether driven by the demands of an ageing population and increasing chronic diseases, by the persistence of infectious diseases and maternal, newborn, and child health conditions, or by challenges that have emerged since 1978, such as HIV/AIDS. The current crisis in health, with increasing demand, rising costs, and a return towards curative and hospital care, makes re-exploration of the Alma-Ata principles timely and relevant.

The recent interest in reinvigorating comprehensive primary health care, renewed recognition of the importance of community ownership, including expanded

use of mid-level and community health workers,⁴ and a growing recognition of the social determinants to health and the multisectoral response required, are indicative of the ongoing relevance of Alma-Ata.⁵ Shifts in global health in recent years are as revolutionary as those at the time of Alma-Ata. Today’s Millennium Development Goals (MDGs), with three explicit health-related goals—for child survival (MDG 4), maternal health (MDG 5), and HIV, tuberculosis, and malaria (MDG 6)—are garnering a more cohesive commitment than their predecessor goals: the less clearly defined Alma-Ata challenge of health for all by the year 2000, and the ambitious remit of the 26 goals of the 1990 World Summit for Children. Technical agreement has advanced around what to do to improve survival in the poorest countries, catalysed in part by a number of *Lancet* Series,^{6–9} but how to achieve these improvements remains a challenge.

Here, we review 30 years of policy shifts in primary health care in the global context, with a particular focus on maternal, newborn, and child health. Today, there is greater commitment and resources for global health. However, as evidenced over the past 30 years, global commitment does not necessarily translate into sustainable health improvements or to lives saved, especially among the poor. Were the comprehensive aspirations of Alma-Ata unrealistic, and what can we learn for the scale-up of universal care now? Are there key components of primary health care that were wrong, or did they fail from neglect? Do we have the evidence

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This is the first in a [Series](#) of eight papers about Alma-Ata: rebirth and revision

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required to guide priorities, and to measure and sustain progress to make a second primary health-care revolution work? A number of papers in this special issue tackle dimensions of progress and change in more detail. Country progress is the real test—have deaths been reduced? Has health been improved? How equitable are primary health-care services?¹⁰

Alma-Ata: revisiting the vision of health for all

The context of the Alma-Ata Declaration was remarkable, pulling together high level leaders of east, west, north, and south, and of UN agencies which traditionally worked inadequately together. The meeting of health ministers and their advisers took place in a city in what is now Kazakhstan and necessitated the building of a new

Panel 1: Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, September, 1978

- I The conference strongly reaffirms that health is a fundamental human right and that the attainment of the highest possible level of health 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 is politically, socially, and economically unacceptable.
- III Economic and social development is of basic importance to the fullest attainment of health and 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. 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: (1) 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; (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; immunisation 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, organisation, 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; (6) should be sustained by 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 launch and sustain primary health care as part of a comprehensive national health system in coordination with other sectors.
- 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.
- 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.

Abridged from reference 1.

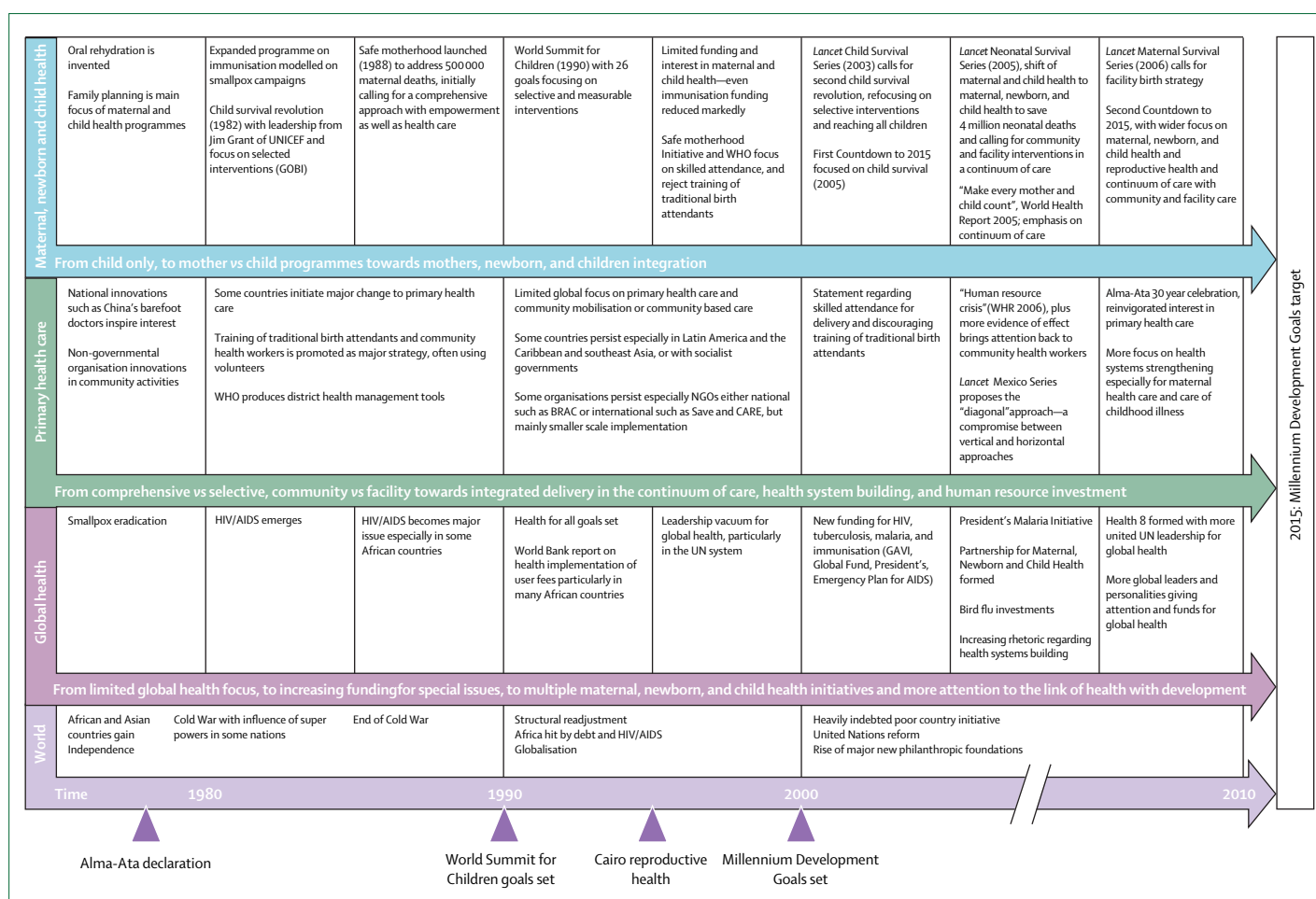


Figure 1: 30 years since Alma-Ata—the shifts towards integration for global health, primary health care, and maternal, newborn, and child health

hotel to house delegates and the chartering of planes to fly in most participants. But even more remarkable than the context was the content of the Declaration. Although billed as a primary health-care revolution, the content was much wider—a comprehensive philosophy for development (panel 1). It presented a shift in thinking that saw health not merely as a result of biomedical interventions but also an outcome of social determinants. Motivated by the call for social justice, Alma-Ata identified the key principles of equity and community participation supported by health promotion, intersectoral collaboration, and appropriate use of resources. According to Halfdan Mahler, WHO's Director at the time, Alma-Ata was "one of the rare occasions where a sublime consensus between the haves and the have-nots in local and global health emerged".¹⁴

Alma-Ata's definition of health was based on WHO's constitutional definition, where health is "a state of physical, mental and spiritual well-being, not merely an absence of disease or infirmity"¹²—a highly aspirational rather than measurable objective. Primary health care was defined as "the first level 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".¹

There was a shift in attitude from a focus on ill health and hospitals, to a focus on communities and families controlling their own health, putting the "public" into public health. The very idea of health for all energised workers and fuelled new efforts in many countries to improve service coverage, especially for previously underserved communities. The inherent focus on equity, the necessity of reaching the unreached and involving them not only in the benefits of health care, but more importantly, in the decisions and actions that collectively make health, was at once novel and revolutionary. Thus, the precepts of social justice became an integral part of health planning.

The creation and acceptance of the Alma-Ata Declaration was influenced by a range of successful health projects run by non-governmental organisations, embedded in the community and responding to expressed and objective health needs and overall development,

especially of the poor.¹³ By definition, it relied on innovative approaches to health-care delivery, with care provided by community workers, and with an emphasis on prevention and the underlying determinants of health such as the environment, agriculture, education, and

livelihoods. Up to that point only China, with its barefoot doctors supported by communes and work brigades, public housing, education, and other social benefits had demonstrated success on a national scale. For a major international declaration to be based on such limited experience was revolutionary.

Panel 2: The child survival revolution: selective primary health care with wide political ownership, but variable sustainability

James Grant took over the leadership of UNICEF in 1980 and sought a limited set of interventions with quantified predictable outcome that could reach all children. Universal coverage was the key concept, based on Alma-Ata. At a meeting in 1982, malnutrition, diarrhoea, and immunisable diseases were identified as major killers of children for which affordable and effective interventions were available but at low coverage. GOBI—growth monitoring, oral rehydration, breastfeeding, and immunisation—was born, initiating the child survival revolution, analogous to the green revolution that had increased food production in south Asia. Grant envisaged adding other interventions once success was achieved with these selected high impact programmes, reaching comprehensive primary health care through incremental expansion of the range of interventions. Although this progression did not work in all countries, some did succeed, most notably in Latin America. Indeed, even within GOBI, most of the focus was on oral rehydration and immunisation, since these were affordable, had predictable outcome and were trackable.

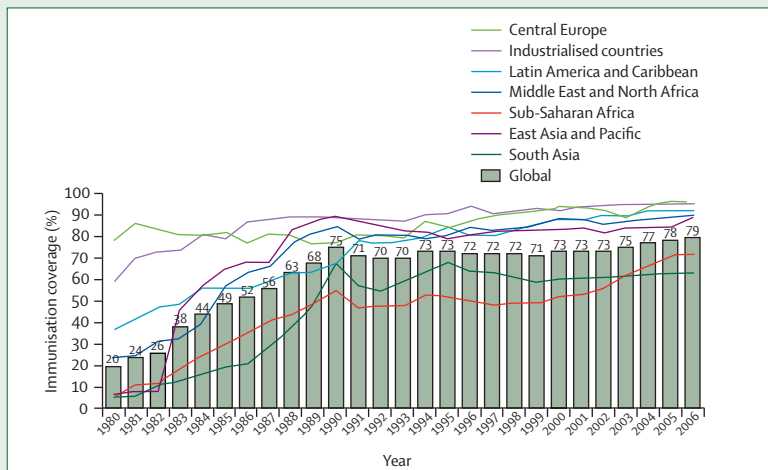


Figure 2: Global average trends for immunisation coverage with three injections of diphtheria, pertussis, and tetanus, 1980-2006

Data from UNICEF (<http://www.childinfo.org>).

By the late 1980s, the push for universal immunisation became the major focus of child survival, and global coverage of three immunisations with diphtheria, pertussis, and tetanus (DPT3) rose from 20% to 75% in just 10 years (figure 2). The World Summit for Children in September, 1990, was the first ever gathering of world leaders for a common cause. This summit was encapsulated in 26 one-line goals designed to fall within the political lifetime of the heads of state who were signing the declaration. National plans of action were to establish mid-decade goals, 5 years on, by which leaders could be judged. Eventually this extended to annual or biannual reports on progress to regional heads of state meetings. For most regions, the state of children became a standing agenda item on their Summit, and for many, a source of pride. "Keeping the promises to children" was the accountability message led by Grant and others and enhanced by UNICEF's annual State of the World's Children Report and later, by country ranking in the annual Progress of Nations assessment.

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30 years of changes in policy affecting primary health care

The Declaration was a turning point, but what progress has been made since? To understand the successes and failures for primary health care since Alma-Ata requires an appreciation of the broader changes in global health, which in turn often reflected global politics. From the comprehensive approach set out in 1978, the challenges of such a wide and truly community-based agenda quickly led to a series of dichotomies, with parallel tracks, or at times competing agendas and major shifts between priorities and proposed approaches to scaling up. An understanding of some of these major global shifts in development and health policy is essential to understand progress within countries. Figure 1 summarises the past 30 years of transitions at three levels: (1) global politics and international health; (2) primary health care; and (3) maternal, newborn, and child health, showing the transition from dichotomies back towards a more comprehensive approach at all three levels.

Global health priorities: the challenges of linking health and development

In the two decades after Alma-Ata, the global political climate cooled (figure 1). Indeed, the Cold War has been linked to stifling momentum for Alma-Ata. At the same time global development policy was dominated by neoliberal macroeconomic and social policies. For many of the poorest countries, especially in Africa, these policies manifested as structural adjustment programmes that sought to reduce budget deficits through devaluations of the local currency and cuts to public spending in all sectors, including health, education, and transport. Structural adjustment resulted in phased removal of subsidies, enforcement of cost recovery in the health sector, and rationalisation of public sector employment, with caps on the numbers of nurses and doctors that could be hired. There is evidence that these policies adversely affected the performance of health systems in terms of supply, with chronic underfunding of infrastructure and public health, reductions in the number and quality of health personnel, and worsening access to health care for the poor.^{14,15} Even China retreated from its socialist policies, with privatisation of the communes and factories and barefoot doctors funded through private fee-paying clients, often leaving the poor to fend for themselves.

The World Development Report 1993¹⁶ was influential in shifting focus back to the link between health and development, promoting the rational selection of

cost-effective sets of interventions, encouraging increased government spending in health and greater private sector involvement. However, the report focused on a narrow aspect of health service delivery that omitted the use of the term primary health care and neglected the role of other sectors and communities. These wider themes were included and further developed by the Commission for Macroeconomics and Health in 2001,¹⁷ helping to generate major investments in HIV/AIDS, tuberculosis, and malaria which were recognised as threats to not only health, but also development and security.

Primary health care: tensions between comprehensive and selective primary health care

Alma-Ata stated that a comprehensive primary health-care system “addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly”. The term primary care was used to describe first-line health services, while the term primary health care was used to describe a wider construct of social justice based on the Alma-Ata philosophy.¹⁸ This vision catalysed a swing from emphasis on large teaching hospitals being built in many newly independent countries, towards more emphasis on preventive health, training of multipurpose paramedical workers, and training of community-based workers.⁴

The essence of Alma-Ata was a vision for preventive and curative interventions as well as increased social wellbeing, the comprehensive process of local community involvement, and improving health and the social environment through effective intersectoral action. The process, however, was challenging and variably implemented.^{19,20} Guidance was provided regarding the principles of bringing care closer to homes, ensuring referral links were functional between communities and facilities, and the provision of essential drugs, but the priority setting and implementation processes were left to the local level. Some manuals were produced, particularly around community diagnosis, district health management, and training of community health workers and traditional birth attendants, but in most cases the scaling-up process was left to each country or, in more decentralised countries, to each region or district.^{18,19} In countries undergoing socialist restructuring—eg, Tanzania, Nicaragua, Eritrea, and Cuba—the community process and social reform was often more extensive and sustained.

However, within a year of the Declaration, an influential paper proposed that a simpler approach was required, involving the selection of the few interventions most justified by epidemiological importance and technological affordability, and a more top-down management approach.²¹ Given the daunting array of health demands and the limitations of both workers and finances, this more selective approach was considered to be more feasible, measurable, rapid, and less risky than really empowering communities to make choices. Funding

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However, during the 1990s, the child survival revolution faltered and not only did commitment wane but focus on results was lost, as evidenced by sliding coverage for immunisation, with the global average for DPT3 falling back to 71% by 1999. There were many reasons for this including: loss of leadership at the global level, with Jim Grant no longer leading UNICEF; lack of data tracking and less public use of data for management; limited civil society ownership; and the leaving of the poor behind.

However, despite these losses, the child survival revolution set a strong foundation that is still the cornerstone for current global and national immunisation programmes, and for the success of GAVI Alliance in re-invigorating investment and seeing a second wave of increasing immunisation coverage. Some of the national programmes started in the 1980s with a focus on GOBI have progressed to a comprehensive health system (eg, Thailand, Malaysia, Mexico), although in other countries (eg, Bangladesh) the intervention range has remained limited or in some cases not been sustained at all, and even immunisation coverage remains low (eg, Nigeria).¹⁰

agencies found this focus particularly attractive, since it enabled training, logistics support, management, and supervisory systems to achieve results that could be measured. Preventive activities that focused on the delivery of discrete items were the most likely to be selected, particularly family planning, immunisation, endemic disease control, and nutrition. These interventions were often delivered through “vertical” programmes, taking the decisions out of the hands of communities, but rapidly reaching high coverage, at least for some selected priorities, most notably family planning and immunisation. One well-known example of the selective primary health-care approach is the child survival revolution, championed by Jim Grant,²² who became director of UNICEF soon after Alma-Ata (panel 2). This provided many lessons to be learned for today’s global initiatives, notably the power of consistent leadership both globally and from national governments, and the need for data and results to drive action.

This debate—between comprehensive and selective, horizontal and vertical, top-down and bottom-up—was the major topic of discussion in global health for the 1980s and 1990s, with few programmes or agencies bridging the gap. Most policy analysts and funding agencies saw this as an either/or choice. Indeed, some analysts suggest the debate between comprehensive and selective was a WHO and UNICEF dispute.²³ A notable feature of the debate was the almost complete lack of evidence from evaluations of the different approaches. Table 1 summarises these inherent tensions.

However, since 2000 there has been a shift to combine the strengths of both approaches, and indeed, to use selective programmes to gradually strengthen health systems to be able to deliver more comprehensive care. So, for example, child health days, which began as an important campaign outreach approach to reach rural or other marginalised families with polio immunisation, have now expanded in many countries to include other immunisations, nutritional interventions such as

	Comprehensive primary health care	Selective, focused primary health care (categorical programmes)
Philosophy	Societal change and community ownership, differs everywhere; surveillance as an intervention; full intersectoral model; provide comprehensive, locally relevant primary health care	Selected interventions which are the same everywhere that problems are same; specific targets and use of data for management; focus primarily on supply of services
Measurement	Focus on outputs (eg, the number of community health workers trained)	Impact and outcome assessment intrinsic to success, particularly focused on immunisation coverage
Champions	Halfdan Mahler (WHO), Ransom Kuti (Nigerian ministry of health), Debabar Banerji (Jawaharlal Nehru University, India)	Jim Grant (UNICEF); Bill Foege (Task Force for Child Survival)
Examples 30 years ago	China's barefoot doctors; Latin American countries many linked to communist philosophy (eg, Cuba, Nicaragua, Honduras, Guatemala); India's rural health centres (Bhopi) and health guides (500 000 community health workers)	Growth monitoring, oral rehydration, breastfeeding, immunisation (GOBI) then shifting to GOBI plus family planning, food supplements, female education (GOBI-FFF); smallpox eradication; guinea worm eradication; tetanus elimination goals; vitamin A distribution; salt iodation
Examples now that have been sustained	Nepal's community health worker system; Malawi's health surveillance assistants; Nigeria's community health extension workers	Expanded programme of immunisation; tuberculosis direct observed therapy; Bangladesh nationwide oral rehydration therapy programme (mainly through the non-governmental organisation BRAC)
New initiatives	Indian National Rural Health Mission, and 600 000 village-based workers being trained; Ethiopia's health extension worker package with 32 000 workers being trained; Ghana's community health prevention service being scaled up	GAVI Alliance; Global Fund to Fight AIDS, Tuberculosis and Malaria; President's Malaria Initiative; PEPFAR

Table 1: Comparison of comprehensive and selective primary health care over the past 30 years

vitamin A and deworming, and even maternal interventions such as family planning, plus a wider scope of health messages. Likewise, countries have used a selective set of programmes, initially more focused on child health, to build a pathway to a more comprehensive health system.^{10,24}

Programmatic shifts: from competition to integration within the continuum of care

There are a number of examples within primary health care of programmes related to a high burden of disease, but with inadequate attention. Here, we examine some

key shifts within maternal, newborn, and child health with shifts in emphasis and at times competing agendas. Other examples that are relatively neglected include chronic diseases²⁵ and mental health.²⁶

For much of the 1980s the focus of maternal, newborn, and child health was on selective interventions for the child. In 1988, following an influential call for action,²⁷ the Safe Motherhood movement was launched in Nairobi, Kenya. Given the lack of attention to the mother, the advocates for safe motherhood had a justifiable cause to fight for, but unfortunately in the ensuing conflict with child health advocates, newborn survival was neglected. More than 15 years passed before the world's 4 million newborn deaths a year came to global attention,⁷ and some of the delay—despite the huge numbers of deaths—was due to competition between maternal and child health.^{28,29} However, there has been a recent shift towards a lifecycle approach (figure 1) with the integration of maternal, newborn, and child health.²⁹⁻³¹ Adolescent health, which links child to maternal health, has also been neglected and is brought into the package through a lifecycle approach to planning.

Another dichotomy in maternal, newborn, and child health is the apparent conflict between community and facility level strategies, especially for care around childbirth. Alma-Ata emphasised the delegation of tasks and use of existing community cadres and, during the 1980s, WHO promoted the training of traditional birth attendants. In some countries, such as Malaysia, this formed a stepping stone to increase the number of births in facilities. However, in other countries, supervision and systematic linkages with the health system were missing and there was no measurable progress in reducing maternal mortality.³² During the 1990s, there was a major

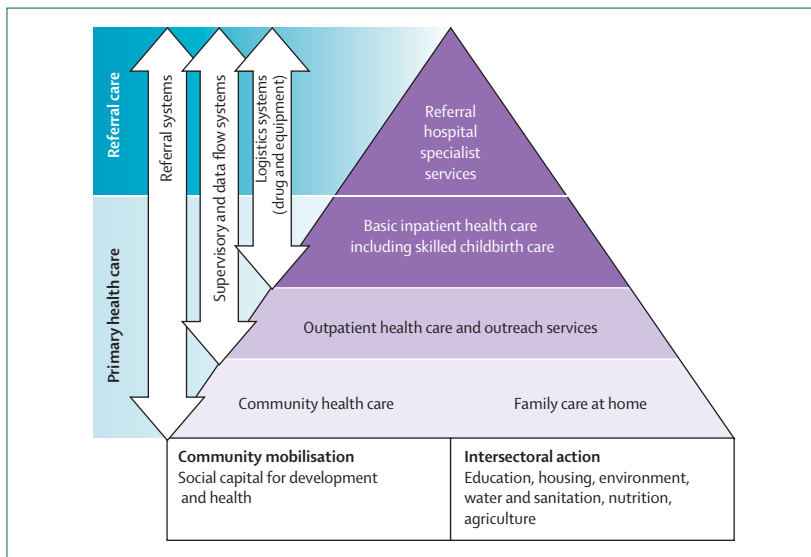


Figure 3: Primary health care and the context of the wider health system, community mobilisation, and intersectoral action

reversal in policy, with WHO and other UN agencies strongly discouraging the use of traditional birth attendants and exclusively promoting facility births with skilled attendants.³³ Although this is undoubtedly the solution of choice, this shift has left a vacuum for countries that are still reliant on traditional birth attendants that required urgent investment in generating more midwives, adapting training to shorter courses, and deploying and retaining midwives in hard to serve areas. There is also evidence to suggest that traditional birth attendants can fulfil other roles and help facilitate a transition to increased facility care.³⁴ Linking communities and facilities in a continuum of care is more effective in reducing maternal and newborn deaths than is focusing on either community or facility alone.^{29,31}

The reality of comprehensive primary health-care services

The Alma-Ata Declaration was not a “how to” manual, but rather a philosophy of holistic health. Progress in countries and even within countries for this comprehensive approach has been variable, ranging from major reductions in mortality and fairly equitable service provision, to lost ground in some countries with natural or man-made disasters or massive AIDS epidemics.³⁰ Integration of common management functions for all programmes—eg, essential drugs, transport, supervision, and information—is a crucial first step to providing comprehensive care. Many countries now have fairly high coverage of schedulable interventions such as immunisation, providing a platform for the addition of more comprehensive interventions at the same visit such as nutrition, integrated management of childhood illnesses, and family planning services.

However, integration and coordination within health systems remains an important challenge with very limited empirical evidence of what works.^{35,36} If quality is low or competent providers, drugs, or life-saving interventions are missing at the lowest level, then users will go straight to district or referral centres, to the private sector, or not seek services at all.^{36,37}

The formation of links between community and primary health care is essential and requires clearly understood protocols that indicate when the services of one or other is required, and when patients should be referred for higher level care, as well as functional communication, referral, and supervisory systems.³⁸ Figure 3 provides a framework for a tiered health system, which builds on both community mobilisation and intersectoral action. The foundation and emphasis for promotion and provision of health is the family and community, and cannot be divorced from the social and intersectoral context. Massive inequities in health tend to reflect massive inequities in education, housing, and other sectors.

The content of primary health care—which interventions are included and which are priorities for universal access—has shifted over time. Bhutta and

Panel 3: Summary of the main programmes and tasks within the remit of primary health-care workers and community health-care workers

Health promotion and community mobilisation for health

- Water, sanitation, and hygiene
- Infant and young child feeding, including growth monitoring
- School health
- Food and other public-health control measures
- Dental health
- Special programme areas—HIV and tuberculosis, malaria, guinea worm, trachoma, river blindness, bilharzia

Outpatient or outreach services (often commodity dependent)

- Family planning, antenatal care, postnatal care
- Extended programmes of immunisation and polio eradication
- Specific nutritional interventions (eg, vitamin A, iron, iodine, zinc, deworming)
- HIV services (prevention activities, voluntary counselling and testing, prevention of mother-to-child transmission, provision of antiretrovirals)
- Malaria prevention (eg, bednets) and outpatient care

Case management and care (skill and some infrastructure/clinic required, with referral system)

- Childbirth care
- Essential newborn care and basic care of preterm babies
- Case management of childhood illness (diarrhoea, pneumonia, malaria, neonatal sepsis)
- Protein energy malnutrition: care and rehabilitation
- HIV/AIDS and tuberculosis
- Malaria
- Syndromic management of sexually transmitted infections
- Integrated management of adolescent and adult illness
- Chronic diseases (eg, hypertension, diabetes)
- Mental health
- Eye care (eg, cataract and others)

Health systems tasks

- Management and microplanning
- Essential drugs supply and logistics
- Data monitoring, birth registration, audits
- Transport and referral
- Financing: conditional cash transfers, issuing vouchers for health care, and revolving drug funds

colleagues³⁶ examine in detail the evidence for interventions particularly for maternal, newborn, and child health. As the emphasis shifts back to comprehensive, integrated services, the complexity of tasks, associated logistics, and managerial support required is ever increasing, whether for a general practitioner in England or a health surveillance assistant in Malawi. Panel 3 summarises the main components

now regarded as being essential primary health-care services. The challenge is especially high in African settings with AIDS,³⁹ tuberculosis, and malaria adding to the complexity, but often also contributing to the fragmentation of programmes.

Alma-Ata: lessons and future directions

Comprehensive primary health care was proposed as the vehicle for achieving progress, and despite 30 years of a largely dichotomised approach, there are encouraging signs at all levels of a shift towards embracing a more comprehensive menu of health intervention content and more comprehensive health system building, if not yet a major shift towards a fully participatory, comprehensive process. Table 2 summarises some lessons learned about what worked and also what did not work so well. A key success is the now foundational principle of universal access to essential health care, and at least lip service to the need for equity. The health-related MDGs have garnered wider political attention from governments and agencies, link health with development, and include some of the broader agenda for maternal and now reproductive health, for example, although no real place has yet been found for chronic diseases.²⁵ However, the major funding for MDGs remains focused on selective, commodity-driven components,⁴⁰ despite encouraging signs of a shift towards health system strengthening.

If one key principle of Alma-Ata has been lost more than any other, it is that of community participation. If

communities rise to set priorities and act accordingly, progress may be slower but will be more sustained than that achieved with commodity-driven approaches alone. Community participation was a central principle of Alma-Ata, with health prioritisation and action to be owned and driven by communities and linked with other sectors beyond health, notably education, agriculture, and food security, as well as the environment, particularly water and sanitation. Community participation for health was a central tenet of the comprehensive primary health-care approach, although perhaps more difficult to implement than the technical elements that went more readily to scale.⁴¹ Costello and colleagues⁴² explore the role of communities and the reality of community empowerment in more detail.

Intersectoral collaboration has also been a weak strand of primary health care, largely because other sectors have their own priorities and responsibilities, and felt that health concerns were not theirs. Likewise, health personnel may forget the potential public-health gains that are possible from non-health interventions. The improved health status of countries like Sri Lanka, Cuba, Costa Rica, and Bangladesh is attributable at least as much to public works, education, agriculture, microcredit, and job creation as to health advances. National policies can facilitate such collaboration, but only local action can make these synergies happen.

Another pitfall was the concept of primary health care being scientifically sound and socially acceptable, promoting a dichotomy between science and social or

	What worked?	What did not work?
Common global vision of health for all: universality and equity	Promoted wide involvement of stakeholders in health; problem: focused on the needs of many, reaching scale; pro-poor: overcoming the inverse care law; primary care solutions: health service provision and health promotion (supply and demand); the MDGs have revitalised this common vision with intersectoral development linkages	Health for all and Summit for Children goals not country specific so some countries could achieve easily and others could never achieve; some goals were unreachable as no effective, feasible intervention (eg low birthweight reduction) so pushed the action focus to more specific, achievable interventions; very low investment except for a few specific issues (eg, some vaccine preventable conditions and even for immunisation funding fell during the 1990s); challenge of competing priorities but perhaps case not communicated clearly to the key audiences
Comprehensive action	Conceptual framework of an integrated health system with intersectoral linkages and appropriate technology and essential drugs; successes in some countries persisted with incremental implementation	Conceptual framework of comprehensive health care considered too complex—broken into dichotomies: health or development (intersectoral), vertical or horizontal delivery, coverage or quality, facility vs community, mother vs child, central vs decentralised; management and programme tools lacking
Community participation and ownership	Community diagnosis process, now embedded in some societies and programmes, and revitalised as community action cycle, participatory learning and action leading toward empowerment	Community ownership perceived as slower and less controllable, less measurable; very bottom up, so variable and harder to track and risk that communities may select a priority judged to be inappropriate leading to conflict with professionals rather than partnership
Community workers	Promotion of innovative delivery strategies not just the status quo (eg, delegation of tasks)	Patchy: lack of consistent supervision and linkages to existing health system, reliance on volunteerism, local cost recovery erratic and mostly for the lowest levels
Collection of data for action	Use of coverage data to drive action, especially for immunisation, leading to the development of coverage data surveys, the precursor of UNICEF's Multiple Indicator Surveys (MICS)	Focus on outputs instead of impact (eg, number of trained community health workers or trained doctors who may not be retained or may not be effective especially without supervision and functional system support)
Innovation for supplies and technology	Developed innovations: cold chain, oral rehydration solution, partogram, vitamin A capsules, salt iodation; essential drug list used in almost every low-income and middle-income country	Technology, even appropriate technology, considered a waste of money compared with other priorities, very low investment in innovative technologies for health in low-resource settings
Environment	Recognition of importance of water and sanitation to health. Some countries placed major emphasis, especially on water.	Sanitation and garbage disposal more complex than clean water and has progressed slowly, especially for the poorest countries and rural areas, so inequity has increased
Intersectoral action	Some countries convinced agriculture to take on a role in food security, occasionally even household nutrition, but this was rare	Education, agriculture, housing, public works often ignored their role in health and were ignored by health planners. The intersectoral concept is good in theory, but in practice each sector has its own agenda and major change is required for effective intersectoral collaboration

Table 2: 30 years after Alma-Ata, what worked and what did not?

traditional norms. The paradigm has now shifted to take into account the context of each situation and traditional systems to avoid this unnecessary conflict. Indeed, the socially acceptable tenet also risked entrenching negative social dynamics that promote gender disparities. The focus should be on applying science and being socially transformative in the direction of improved quality of life, not just preserving the social norms at all costs.⁴³

The success of primary health care depends on the interactions of families and communities with primary health-care workers. Human resources are key, not just in skill and distribution but in their relationships with communities. Throughout many countries of low or middle income, extension workers and community health workers are experiencing a renaissance, with training schemes proliferating at a rate similar to the early 1980s. Generally there is more willingness to revisit the idea of delegation of tasks using mid-level cadres and community health workers that was prevalent in Alma-Ata, and attention is being given to training and supervising human resources.⁴ India has once again embarked on efforts to develop and deploy a vast cadre of village-based workers. Learning from the failures of the Health Guide Scheme of 25 years ago, this new effort emphasises linking families to the lowest levels of the formal health-care system. Throughout Africa, the power of communities has been demonstrated in programmes to combat HIV and AIDS, with volunteers forming the backbone of HIV counselling and testing; home care has also helped reduce the burden on hospitals, and overwhelmed social services are supplemented by community action for children and others devastated by the epidemic. With the ever increasing array of health service programmes, each a priority in the minds of the designers, there is a danger of overwhelming primary health-care workers with a massive menu, sometimes placed all on one cadre (panel 3). Features of effective primary care services include a mix of delegation and skills, adoption of standard management protocols, integrated information systems, and essential drug supplies.

Although the strength of community action and low level trained workers is well proven, they must not be exploited, as all too often occurred in the past.⁴ Another pitfall is a lack of systematic planning and investment in supervision and on the job training. Many of these principles are lessons learned by trial and error in the decades since Alma-Ata, often despite limited attention to systematic evaluation, particularly at scale. One key lesson is the need for more careful assessment of retention, effectiveness, and costs for all cadres of health worker, including community health workers.

The district health system gained recognition as the most appropriate unit to implement primary health care in terms of management, implementation, and community dialogue, as well as integration with other sectors. Furthermore, the district with a first level hospital

provided the logical interface with higher levels of the national health system, and could provide hands-on support to the constituent lower levels of care. The integrated health system vision and management are detailed in Ekman and colleagues' paper,³⁷ mapping a way forward for action to reinvigorate primary health care within the district health system. Successes in effective district health management have occurred, notably in Thailand and Tanzania.¹⁰

Health information, especially on coverage of primary health-care interventions, is improving and serves as an objective local measure of progress and as a tool for decentralised management to take appropriate and timely action to increase coverage to those most in need.⁴⁴ National and regional averages obscure the important local disparities that should lead to concerted action with communities to redress inequity in service provision. There are many lessons learned from immunisation programmes for data-driven programming (panel 2). The goal of health equity can only be addressed when timely information is available and acted upon locally.⁴⁵

Another key tenet of Alma-Ata was appropriate drugs and technology for health. The essential drugs policy, now well established in almost every member state of WHO, has been a success story in increasing the availability of key drugs and also limiting the power of the pharmaceutical industry. Although few new drugs have been developed for high burden illnesses in poorer countries, there are some successes, notably new malaria drugs and new vaccines. The advent of communication technologies (eg, mobile phones, palm and laptop computers, internet, television) also provides many opportunities for primary health care. However, innovation for health technologies has again been left to profitability alone, rather than objectively determined health needs (table 2). There is a need for strategic prioritisation of which devices would make the most difference in resource-poor settings and for investment and innovation to make devices that are robust and easily usable.

There is still much that we do not understand about what makes for success and more detailed analysis of health system progress and associated changes in countries is an evolving science beyond the epidemiology of randomised controlled trials.^{10,46} Rigorous trials are required of combinations of these interventions in various settings to measure real costs and effects on populations. Attention needs to be paid to developing and codifying change and providing indicators for process as well as outcome.

Alma-Ata: can it be revitalised?

Health for all is more possible now than 30 years ago—shifts from dichotomies towards integration for primary health care provide opportunities not envisaged before. Many of the ingredients are in place. Today, unlike after Alma-Ata, governments, donors, and even private

foundations are at least talking about working together and respecting national leadership.⁴⁷ The major health agencies, who have often acted in competition, have now formed the so-called Health 8; cooperation and coordination seems to be increasing, as evidenced by the coordinated messages for the recent G8 meeting in Japan. The overseas development funding available for maternal, newborn, and child health has gone up by two-thirds between 2003 and 2006 to a total of \$3·5 billion per year,⁴⁰ in stark contrast with the lack of funding for the goals of Alma-Ata or the World Summit for Children. Funding is increasing and is also shifting from selective global funds, towards health system strengthening, in some countries through sector-wide approaches.⁴⁸ There are a plethora of management and programme guides for both community and facility rollout. More commitment and resources produce a greater potential for change but also an increased demand for accountability and measurable results. As evidenced over the past 30 years, global commitment does not equate to sustainable changes in health in individual countries, or to lives saved, especially among the poor and especially when competing agendas produce dichotomies.

In 20 years from now, at the half century of Alma-Ata, we could see a different world, with basic health care reaching many of the poorest families. However, to achieve this goal we need to revitalise the original revolutionary principles of Alma-Ata, sticking consistently to the core values of universal access for care, equity, community participation, intersectoral collaboration, and appropriate use of resources. This special issue demonstrates that health for all and primary health care are as relevant and more possible today than 30 years ago.⁴⁹ What is needed is consistent commitment to the principle of health for all, and consistent policy and action that is not fragmented. This is especially important for those underserved communities, present in every country, that have seen the least progress in the last 30 years. We believe that revitalisation of the tenets of the Alma-Ata Declaration is necessary to meet the MDGs in 2015 and beyond. Like the first primary health-care revolution, this will take champions—as Mahler said at the 2008 World Health Assembly “unless we all become partisans in renewed local and global battles for...equity...we shall indeed betray the future of our children and grandchildren.”¹¹

Conflict of interest statement

We declare that we have no conflict of interest.

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