International Perspective on Primary Health Care Over the Past 30 Years

Authors:
Nikki Schaay
David Sanders

Abstract
This chapter provides a brief overview of the concept of Primary Health Care and how the Primary Health Care approach has been implemented in different international contexts. In this process, the key successes and failures of its implementation over the past 30 years, and specifically the emergence of large global health initiatives and their influence on Primary Health Care will be reflected upon. Finally, the current interest in revitalising Primary Health Care and what implications this has for South Africa will be considered.
The concept of Primary Health Care (PHC) emerged during the 1970s when ideas about health care began to change generally and specifically in relation to the so-called third or developing world. Walt and Vaughan suggest that these new ideas about health care emerged from many sources. Examples of these sources include: changing theories about the relationship between health and development; concerns about population growth; questions about the relevance of implementing a western-type medical service in a developing country; the remarkable progress that was being made in improving health in countries like China; and the achievements of many small, mostly community-based health care initiatives in developing countries. Another source was the work of the Christian Medical Commission of the World Council of Churches, whose church-related medical programmes in the developing world emphasised, amongst other things, the importance of community engagement and the training of auxiliary health workers.

The development of the community-orientated primary care approach in South Africa led to the emergence of an emphasis on outreach beyond hospitals to peripheral health centres and even to households. Such an approach called for a dramatic change in health service development. These events, coupled with the support of such community-orientated work by Dr Halfdan Mahler, the then Director-General of the World Health Organization (WHO), preceded, and in a sense gave rise to the Alma Ata conference.

Jointly convened by the WHO and the United Nations Children’s Fund (UNICEF), the 1978 Alma Ata conference elaborated on the underlying principles and characteristics of PHC and adopted it as a strategy to achieve the WHO’s ‘Health for All by the year 2000’. The now familiar summary of PHC was provided in the Alma Ata Declaration (see Box 1).

The definition has led to a number of divergent interpretations of PHC. The most common perception of PHC is one where it is seen as constituting the first point of contact with the health system or the primary level of care. This view of PHC is commonly held in industrialised countries, and is often equated with general / family practice. An opposed conceptualisation of PHC is that of a broad philosophy or approach to health care and a strategy for organising health care systems and society to promote health. It is this view that is commonly referred to as the comprehensive PHC approach, to distinguish it from the selective approach described later.

The latter perspective of PHC has strong socio-political implications. It explicitly advocates for: universal accessibility and coverage on the basis of need; comprehensive care with the emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; intersectoral action to address the social and environmental determinants of health; and appropriate technology and cost-effectiveness in relation to the available resources. The concept of social justice strongly informed the concept of comprehensive PHC. This concept explicitly recognised the importance of addressing the underlying social, economic and political causes of poor health. The importance of investigating the impact of such upstream determinants has been reaffirmed in the last decade, with the establishment of the WHO Commission on Macroeconomics and Health, and the Commission on Social Determinants of Health.

Table 1 is adapted from the Pan American Health Organization (PAHO) / WHO 2007 position paper, ‘Renewing Primary Health Care in the Americas’, which summarises the key differences between the terms primary care, comprehensive PHC and selective PHC.

Box 1: The definition of Primary Health Care: Alma Ata Declaration

“…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… It forms an integral part of the country’s health system of which it is the central function and main focus, and of the social and economic development of the community. It is the first level of contact on individuals, the family and community…bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”.

Source: World Health Organization and United Nations Children’s Fund, 1978. Given that this chapter attempts to provide an account of how PHC has been interpreted and implemented over a 30-year period, some of the earlier references to PHC, although possibly dated, have still been included as references as they represent seminal work in this field.
Table 1: Approaches to Primary Health Care

<table>
<thead>
<tr>
<th>Approach</th>
<th>Primary Health Care definition</th>
<th>Emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>Refers to the first point of contact with, or the entry point into, the health system. Primary care constitutes the first level of care in a continuing health care process and would commonly be delivered at a clinic, health post or a private practitioner’s surgery. Primary care focuses on personal health or individual health care and is predominantly curative (or therapeutic), preventive and rehabilitative in nature.</td>
<td>Level of care in a health services system.</td>
</tr>
<tr>
<td>Comprehensive PHC</td>
<td>The comprehensive PHC approach, as elaborated at Alma Ata, embodies a set of five key principles: 1. comprehensive care (which includes a combination of preventative, curative and rehabilitative and promotive services); 2. intersectoral collaboration and action; 3. active community participation and support of empowerment; 4. appropriate care and use of technology; and 5. equity. Given the pro-equity principle, universal coverage and access to health care and resources is the foundation of a comprehensive PHC-based health system. Other cornerstones of the comprehensive PHC approach include: + an integrated referral system, which facilitates the delivery of a continuum of care to clients, across different levels and places of care in the health care system without interruption; and + the notion of multidisciplinary health teams, including community-based health care workers. Rather than focusing on the individual, comprehensive PHC uses a public health lens and uses the family and community as the focus to assess risks, and prioritise and plan interventions. The ‘upstream’ social determinants of health are emphasised in this process. At a ‘minimum’ comprehensive PHC consists of a set of nine basic elements or core activities, ranging from an adequate supply of safe water and basic sanitation to the provision of essential drugs.</td>
<td>A strategy for organising health care systems and society to promote health.</td>
</tr>
<tr>
<td>Selective PHC</td>
<td>Focuses on a limited number of high-impact interventions to address some of the most prevalent health challenges in developing countries. Although initially conceptualised as an ‘interim’ form of comprehensive PHC, it became institutionalised as an approach on its own.</td>
<td>Specific set of health service activities geared towards the poor.</td>
</tr>
</tbody>
</table>


The implications of the PHC approach, even at the time of the Alma Ata Declaration, were recognised to be far-reaching if the strategy was to be properly applied. The principles would have to be translated into changes not merely in the health sector, but also in other social and economic sectors, as well as in community structures and processes. Some of the changes required would include: the redistribution of existing resources (financial, material and human) for health; a reorientation and a broadening of the skills of health personnel, to enable them to respond to the challenges of implementing PHC, and to work in teams as well as with other sector professionals and communities; and improved design, planning and management of the health system to facilitate greater community involvement, intersectoral collaboration and decentralisation.

Related to this is another phrase that is commonly associated with the PHC approach: the ‘Global Strategy for Health for All by the year 2000’. Popularly referred to as HFA 2000, it came into being in 1977 when the World Health Assembly resolved that, “the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life” should be a target that the WHO and its Member States ought to collectively strive for and operationalise through complementary regional and country level policies and plans in health, and the related social and economic sectors.

Launched with the endorsement of the Alma Ata Report and Declaration in 1979, HFA 2000 was seen as the motivational vision for the world. Recently, Dr Mahler suggested in an interview at the 61st World Health Assembly that HFA 2000 was, and can still be seen as, “…the spiritual dimension of primary health care (or) the value system” and the essential foundation on which a PHC strategy rests.

As PHC became more entwined with the goal of HFA 2000, the original or intended complementary distinction...
between these two concepts became confused, just as the concept of PHC was confused. Less open to a range of theoretical interpretations, the district health system was conceptualised as the unit within which the implementation of PHC by the public and private sectors, and health-related sectors and communities could best be organised and coordinated. Born out of an attempt to improve the somewhat piece-meal, and poorly coordinated activities of various health programmes and institutions post-Alma Ata, and reflecting the spirit of PHC, the district management structures were envisaged as a focus for decentralisation of political power and resources, and increased democracy and equity. Together the PHC approach and the district health system model were considered to form the conceptual and organisational pillars respectively for the attainment of HFA 2000.

In light of the above understanding of these key concepts, this chapter will now reflect on some of the key successes and failures of PHC implementation over the past 30 years. It will then consider the more recent opportunities that have emerged to support its renewal.

A balance sheet of Primary Health Care implementation

The challenges to the fulfilment of the PHC vision in the 30 years since the Alma Ata Declaration have been previously documented. The Declaration coincided with the 1970s debt crisis, economic stagnation and the growing dominance of global economic policy by more conservative approaches. These included macroeconomic interventions such as structural adjustment and accompanying reductions in social and health sector expenditure by governments.

At the same time, the comprehensive approach advocated at Alma Ata was supplanted by a selective approach to PHC. This proposed the narrowing down of the original concept to focus on a circumscribed number of diseases with high morbidity and mortality, and which could be feasibly controlled, largely by effective therapeutic or personal preventive interventions. While Baum suggests that selective PHC “...robbed primary health care of its community engagement, broader social change and re-distributive vision and placed it firmly back in the medical framework”, MacDonald described selective PHC as appealing given that it was “...no threat or particular challenge to anyone...(and suited) the style and objectives of many donor agencies and fits well into the engineering model of health care”.

Progress in implementing the programme elements of Primary Health Care

In reflecting on the extent to which PHC has been implemented, particularly in sub-Saharan Africa over the last three decades, each of the basic programme elements of PHC will now be considered (see Box 2). Although neither precise nor comprehensive, this review will serve to quantify some of the more tangible progress that has been made in relation to each of the elements.

Box 2: The Alma Ata Declaration’s eight basic programme elements

The Alma Ata Declaration suggested that PHC, at the very least, should include a set of eight basic elements, namely:

- an adequate supply of safe water and basic sanitation;
- the promotion of food supply and proper nutrition;
- maternal and child health care, including family planning;
- immunisation against the major infectious diseases;
- the prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries;
- health education; and
- the provision of essential drugs.


There has been limited progress in improving access to an adequate supply of safe water and basic sanitation. According to UNICEF and WHO in 2006, 58% of the population in sub-Saharan Africa used an improved drinking source, with only a 9% increase in access from 1990 to 2006. The same report noted that improved sanitation facilities cover 31% of the population in sub-Saharan Africa, with a 5% increase having occurred between 1990 and 2006.

The promotion of food supply and proper nutrition, which is closely linked to household food security in developing countries, remains under threat. According to the Food and Agriculture Organization of the United Nations (FAO), sub-Saharan Africa accounts for 25% of the under-nourished people in the developing world and has the highest proportion (one-third) of people suffering from chronic hunger. In addition, nutritional status is showing no improvement as demonstrated by stunting rates of 30% and above in 29 countries in sub-Saharan Africa, of which 11 have stunting rates of 40% and above. It seems likely that given the current food crisis this situation might further deteriorate.
Although there have been some spectacular achievements in maternal and child health care and family planning, levels of maternal mortality and morbidity from largely preventable causes in developing countries remain unacceptably high. This is specifically so in Africa, where the lifetime risk of maternal death is one in 16, compared with one in 2 800 in rich countries. The WHO Regional Office for Africa (AFRO) noted the low contraceptive prevalence rate of 13%. The best known application of selective PHC was UNICEF’s Child Survival Initiative, sometimes known as GOBI (growth monitoring, oral rehydration therapy (ORT), breastfeeding and immunisation), and sometimes included food supplementation, female literacy, and family planning (GOBI-FFF). This initiative resulted in significant advances in child survival with child health care provision increasing greatly over the past two decades. Immunisation showed the most dramatic improvement and global coverage of children under-1 year increased from 20% in 1980 to 79% by 2006. Access to health services in sub-Saharan Africa improved considerably during the period 1980 to 1990, but worsened in the 1990s as reflected in the Expanded Programme on Immunisation (EPI) coverage data. Despite the intensive polio vaccination campaigns and regular measles vaccination campaigns in more recent times, the EPI coverage data for the period 1999 to 2005 showed only modest improvements following a drop in coverage of all routinely administered antigens in the 1990s. In relation to the prevention and control of locally endemic diseases and appropriate treatment of common diseases and injuries, the following is noted:

- In 2005, 11 of the 48 countries in sub-Saharan Africa had a lower life expectancy than in 1970, while 12 countries have seen an increase in infant mortality rates (IMR) between 1990 and 2005. Twelve countries have shown an increase in under-5 mortality rate, and in half of the countries in sub-Saharan Africa, life expectancy decreased between 1999 and 2005, probably through a combination of extreme poverty, the impact of the HIV epidemic, the decline in health service provision and conflict.

- The majority of countries where life expectancy has decreased, also have a high prevalence of HIV, affecting in particular the 15-45 age range. At the end of 2007, the number of HIV-infected people in sub-Saharan Africa was estimated at 24.7 million, over two-thirds (67%) of the total of HIV-infected people globally. Whilst in the past the prevention and control of endemic diseases in the African region largely focused on communicable diseases, in the last decade or so, non-communicable diseases, like cardiovascular diseases, cancers and diabetes have been included.

- Over the past two decades, injuries and violence have become a significant contributor to the burden of disease. Moreover, in Africa large scale violent conflicts have also resulted in displacement and ensuing morbidity and mortality. Thirteen of the 48 countries in sub-Saharan Africa have recently been or are still involved in conflict, while neighbouring countries are affected because of population movements across international borders.

In relation to health education, the understanding and application of this has evolved significantly, from a preoccupation with individual behaviour change towards a broader set of activities termed health promotion. The scope of health promotion has been extended to incorporate individual as well as social action. This has been further elaborated at international conferences starting with Ottawa (1986), and more recently in Bangkok (2005). However, in 2001, a health promotion strategy was developed for the African region which has shifted away from the ideals of the Ottawa Charter. It has focused more on individual behaviour change, probably caused by the limitations imposed by the deterioration of the economic and social environments in many countries. Since 1978, when the Action Programme on Essential Drugs was established, some progress has been made at a policy level in relation to essential drugs, with 95% of developing countries having a published national essential medicines list. However, it has been noted that access to essential medicines in the public sector in these countries is still inadequate. It has been estimated that the average public sector availability of essential medicines was only 35% in 27 of the countries for which data was available.

The process of trade liberalisation accompanying globalisation has also impacted on countries’ abilities to regulate the inflow and use of medicines. Specifically, the agreement on trade-related intellectual property rights (TRIPS) has in many countries circumscribed their policy options.

In recognition of the burden of mental disorders and their costs in human, social and economic terms the WHO, post the Alma Ata conference, added mental health as the ninth programme element. The WHO developed a set of recommendations for action in relation to mental health.
Many of these incorporated the core principles of PHC. Although robust data on the burden of disease resulting from mental ill health are difficult to obtain for sub-Saharan Africa, it is generally accepted that mental ill health is much more prevalent and serious than earlier thought. As Prince et al. noted “(t)he burden of mental disorders is likely to have been underestimated because of the inadequate appreciation of the connectedness between mental illness and other health conditions.”

The challenges faced in implementing Primary Health Care and areas of continuing concern

As can be seen from the above, progress in relation to many of the basic programme elements of PHC, post the Alma Ata Declaration, has been slow and limited. This section will offer a reflection on some of the key global developments, which have constrained and continue to challenge the implementation of the PHC approach as was envisaged so boldly at Alma Ata.

The influence of macro-economic factors

By the late 1980s the momentum around PHC was being lost. Even the great success of the dramatically improved immunisation coverage began to stagnate. Indeed, there was no increase in global immunisation coverage between 1990 and the early 2000s, with the most difficult-to-reach population being the group experiencing a disproportionate burden of vaccine-preventable disease. Similarly, acute respiratory infection (ARI) and diarrhoeal diseases, remain leading causes of death in children under-5 years globally, with disappointing improvements in coverage of life saving ORT and antibiotic treatment of pneumonia.

This stagnation in improvement was mainly due to the weakening of the health systems as a result of a fiscal austerity. This austerity was a feature of the global economy of the past three decades. Baum notes that this global economic crisis, which “…was accompanied by a political shift to the right in a number of major industrialized countries…set the scene for the introduction of Structural Adjustment Programs (SAPs) by the World Bank and the International Monetary Fund (IMF) as a condition for receiving bailout loans”. As Baum notes, “these adjustment policies – which lowered real wages, reduced food subsidies, and slashed budgets for public health and education – harmed rather than benefited the health of poor people”.

Health sector reforms

Another important issue to consider in relation to how the PHC approach was implemented post-Alma Ata is that of health sector reforms, which in the late 1980s were undertaken in many industrialised and lower income countries as a response to the fiscal crisis, demographic changes and increasing costs of health services. These reforms essentially included: the restructuring (including downsizing) of national health agencies; a focus on greater economic efficiencies and the introduction of user fees for public health services; introducing managed competition between service providers; and working with the private sector through contracting, regulating and franchising different private providers. The ascendance of neoliberalism during the time of President Reagan and Prime Minister Thatcher added an ideological impetus to the privatisation of health care.

A distinctive feature of these reforms in the past approximately 20 years, has been a focus on cost-effective interventions, which have been grouped as essential or basic ‘health service packages’. With its emphasis on cost-effectiveness, this approach narrows down the scope of PHC to a set of technical interventions, giving little consideration to the determinants of ill-health and thus resembles the technicist emphasis that informed selective PHC. Pavignani and Colombo, citing Tarimo, note that the package concept is prone to misconstructions and abuses, and go on to highlight a range of potential shortcomings that can occur in formulating such packages.

Some components of health sector reform have aggravated inequities (e.g. introduction of user fees in several countries). Others led to a deterioration of local health services (e.g. decentralisation of responsibility), which has occurred mostly without the accompanying decentralisation of resources and enhancement of local capacity.

Another consequence of the health sector reform process has been the increasing commercialisation of health care. The Global Health Watch, citing Hilary and Shaffer et al. suggest that: “(m)ore recently, the World Trade Organization (WTO), together with a number of bilateral and regional trade agreements (usually involving the United States), have influenced the design of health care systems by reducing the capacity of governments to regulate health care markets, encouraging cross border ‘trade’ in health care, and facilitating the entry of corporate health businesses to operate more freely within health care systems of other countries.”
Amongst other things, these have in turn reduced access to health care, reinforced existing socio-economic inequities and rather than considering health as a common good, have seen it as a market commodity. As noted in the Commission on Social Determinants of Health: “Underlying these reforms is a shift from commitment to universal coverage to an emphasis on the individual management of risk. Rather than acting protectively, health care under such reforms can actively exclude and impoverish”.

To date, 46 countries in sub-Saharan Africa have embarked on a process of health sector reform, with the contexts and contents of their reform programmes varying from one country to another. The implications of the adjustment policies were also felt at a district level, where attempts to establish functional district health systems were similarly undermined by this economic crisis. As early as 1994, it was noted that despite recognition of the district health system’s potential as a mechanism for decentralised health systems management, there were in fact few countries where district health systems were functioning fully and effectively. In part, Tarimo and Webster saw the lack of district health systems development as a result of many interventions being externally funded and based on ‘blue print’ models, which neither created local ownership of the district system, nor a sense of commitment amongst those responsible for implementing the changes.

More recently, in its report on the review of PHC in the African Region, the WHO Regional Office for Africa noted that despite there being a commitment by Member States in the African region to implement decentralisation “…the decentralization of resource allocation and planning to the districts has not been fully achieved, leaving the lower structures as mere recipients of guidelines and instructions”. It is thus not surprising that Jeppsson and Okuonzi in comparing the vertical process of decentralisation in Zambia with that of Uganda, where a broader approach involving all government departments was adopted, and not just the health sector alone, concluded that neither form of decentralisation had so far led to a clear and appreciable improvement of health services.

Experiences such as those described above, have led many to conclude that structural adjustment and ill-considered health sector reforms have been accompanied by significant weakening of the health systems. For example, China (often cited as having a model PHC approach through its so-called barefoot doctor programme) has experienced effects such as these with “…the collapse of the health-care system – especially in rural areas – after market reforms (leaving) hundreds of millions of poor people without access to basic health care”. During this same period the emergence of new diseases, especially HIV, and the resurgence of old ones such as tuberculosis (TB), malaria, cholera, dengue, as well as an alarming rise in the prevalence of non-communicable diseases and violent trauma, especially amongst the poor in developing countries, has led to rapidly widening inequalities in health experience between and within countries. There have even been reversals in health status in some African and former Soviet bloc countries.

The emergence of global health initiatives

In response to this health crisis, starkest in Africa, and in line with greater engagement by the private sector, a plethora of global health initiatives (GHIs) or global health partnerships (GHPs) emerged in the 2000s. These include the Global Alliance on Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, TB and Malaria (GFATM), the World Bank Multi-country AIDS Program (MAP) and the United States President’s Emergency Plan for AIDS Relief (PEPFAR). Although these GHIs have brought much welcomed increased funding for priority diseases, they have at the same time reinforced the selective approach to PHC by privileging vertically implemented and managed programmes. These mainly emphasise therapeutic (e.g. antiretroviral therapy (ART)) and personal preventive (e.g. prevention of mother-to-child transmission (PMTCT)) interventions while neglecting upstream determinants of these diseases and their broader consequences. Although recently the importance of harmonising and aligning the activities, funding mechanisms and reporting requirements of the various GHIs has now been highlighted, yet there still remains a lack of coordination and synergy between the various GHIs.

As a result of their interventions over the past few years, GHIs have also exposed critical weaknesses in the capacity of resource-constrained health systems to respond to more generalised health needs. GHIs have brought significant levels of funding to lower and middle income countries and some GHIs have attempted to concurrently support health systems strengthening initiatives. However, a concern still exists that their vertical and selective orientation is likely to have major implications for the sustainability of programmes after the funding from a particular GHI declines or ends. There is so far little evidence on the system wide effects of the disease-specific GHIs. However, there is a concern that these target driven, performance-based funding mechanisms may put pressure on countries to “focus on more easily reached target populations and politically high profile treatment campaigns, thereby exacerbating inequities and neglecting population-wide public health programmes” and comprehensive PHC.
One of the unfortunate side effects of the GHIs in relation to PHC is that they have been able to sideline the WHO on the global health stage. In other words, the WHO, which should be prominent in advocating for the comprehensive strategies essential to promote health, has been marginalised. In the absence of a strong WHO, supported by its rich Member States to take such an advocacy position, the only groups pointing to the dangers of the currently dominant global health care reform agenda, and the risks from vertical imposition of programmes are civil society groups, such as the People’s Health Movement.46

**The crisis in human resource development**

Running parallel to this health systems crisis has been another crisis; that of human resource development. The two crises are interlinked given that the successful functioning of health systems is totally dependent on adequate numbers and competence of personnel, who typically account for over 42% of total government health expenditure.47 Consequently, human resource development (HRD) assumes a priority place in health systems development.

Since 1978, in line with the PHC approach, there has been a considerable expansion in human resources for health. This has occurred particularly at the ‘auxiliary’ or ‘paramedical’ level in developing countries, and especially in the immediate post-Alma Ata period, in the community health worker (CHW) cadre. Despite this, many poor countries, especially the least developed, have too few health workers to provide universal coverage, and in all countries there continues to be significant misdistribution of, and imbalances between, various types of health workers.

In 2007, the Lancet noted that the WHO, in their World Health Report 2006, had drawn attention “...to the human-resource crisis in many parts of the world and suggests that 57 countries presently have severe shortages equivalent to a global deficit of 2.4 million doctors, nurses and midwives”.47 The problem of international migration, a consequence of the inability of low income countries to retain skilled health workers as they migrate to high income countries, was noted as significantly contributing to the human resource crisis.

Another aspect of HRD outlined in the Alma Ata Declaration is that of teamwork which, it has been suggested, has on the whole been poorly developed.48 Associated with the idea of creating a health team (comprised of a range of health professionals and auxiliary workers), has been the idea to increase the involvement of traditional practitioners in the health system. However, achievements in this regard have been limited, with the notable exceptions of China and India where progress largely antedated Alma Ata.

Another area of concern, and probably one of the most significant impediments to the successful implementation of PHC, has been the substantial failure of most tertiary education health science institutions to adapt their missions and activities to the human resource development challenges posed by the Alma Ata Declaration. The Declaration noted the need for health workers to be “suitably trained socially and technically to work as a health team and to respond to the expressed needs of the community” and by implication, to implement the comprehensive and integrated approach advocated by PHC.49 However, there remains an unfortunate separation of the clinical health care and public health components, and limited exposure to primary and community levels of care within most tertiary health science educational programmes.49

In addition, the continuing dominance by clinical specialties within curricula, has not facilitated an openness to adopting the challenges associated with a policy-based PHC, nor the entertaining of such discussions around the relevance and content for example, of sub-specialties such as ‘community paediatrics’ and ‘community obstetrics’ to take place. These deficits have contributed to the persisting dominance of specialist and hospital-based health care and training in many countries, and a limited orientation to interdisciplinary work and intersectoral collaboration.

As can be seen from the above, the changes in the economic and political climate post-Alma Ata, and the shift in orientation about how health services ought to be delivered in the developing world, had made the international climate hostile to the ideals of the Alma Ata Declaration.50 This has been specifically exemplified in the World Bank’s 1993 report ‘Investing in Health’, which advocated for minimum packages of care and health care reforms. Hall and Taylor note that since this report, the World Bank and other similar agencies made very little reference to PHC as was endorsed at Alma Ata.51 Baum suggests that in the late 1990s, with the exception of PAHO, the entire WHO and its continental branches had figuratively ‘dropped the Alma Ata baton’ and rather engaged with the agenda of the World Bank.7,52

As has previously been discussed, PHC had become entwined with the goals of HFA 2000. Its focus had as a result “…broadened to include a whole range of outcomes that were outside the responsibility of the health system”.53 Moreover, “…as the millennium approached it became increasingly clear that Health for All would not be attained. For some, the failure of reaching this goal came to be associated with the perceived failure of PHC itself”.8
Although the above balance sheet provides a mixed picture, there are examples of large scale initiatives that have embodied the PHC approach and have been sustained over time. The following section provides an overview of some of these.

**Examples of successful Primary Health Care initiatives**

Several programmes embodying the PHC principles were initiated before the Alma Ata Declaration and some still continue to operate (see Box 3). Some of the best known are in India (e.g. Jamkhed Comprehensive Rural Health Project and Deenabandhupuram Project) and the Bangladesh Rural Advancement Committee (BRAC), which also has a substantial research and evaluation division. However, there are others in Asia and in South America.\(^{54,55}\)

Although they manifest only some of the attributes of the PHC approach, there is also a set of countries that have achieved significant and durable improvements in health. These have shown consistent commitment to equitable development that is broad-based and multisectoral. They include Sri Lanka, China, Costa Rica and Kerala State in India, all of which invested substantially in the social sectors, and particularly in women’s education, health and welfare.\(^{62}\) Sri Lanka in particular has illustrated how intersectoral action for health can be implemented.\(^{63}\) The political commitment to social and health provisioning in these countries has been sustained through strong citizen participation. This has been achieved in Costa Rica through a long history of democracy and egalitarian policies and in Kerala through activism by disadvantaged political groups, and through social revolution in China.\(^{62}\)

More recently, there have been some countries which have attempted to roll out PHC as statewide or nationwide programmes. For example, Thailand began implementing PHC in 1977, using village health volunteers and village health communicators, supported by paid health workers, to extend coverage of priority interventions at community and household level. Universal access to health services was ensured through introduction of prepayment of a nominal

**Box 3: Examples of effective initiatives embodying Primary Health Care principles**

<table>
<thead>
<tr>
<th>The <strong>Mitanin</strong> community health worker programme supports child survival in Chhattisgarh state, India</th>
</tr>
</thead>
<tbody>
<tr>
<td>✦ The <strong>Mitanin</strong> programme of Chhattisgarh state in India is a significant example of a large scale community health worker programme. Established in 2000 it aimed to provide outreach services to the 18 million rural inhabitants of Chhattisgarh state through the creation of a network of 54 000 women community volunteers or <strong>Mitanins</strong>.(^{56}) <strong>Mitanins</strong> deliver family-level outreach activities (focusing on child survival and the essential care of newborns), and rights-based activities at a community-level (such as facilitating access to public services and supporting the empowerment of women). Although difficult to attribute the precise contribution that the Mitanin programme made, it is considered to have lent valuable support to improving child survival in Chhattisgarh state (as evidenced by the decrease in infant mortality from 85 deaths per 1 000 live births in 2002 to 65 deaths per 1 000 live births in 2005).(^{57})</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participatory intervention with women’s group meetings impact on birth outcomes in Makwanpur district, Nepal</th>
</tr>
</thead>
<tbody>
<tr>
<td>✦ With the help of a one year community-based participatory educational intervention delivered through monthly women’s group meetings convened by local women in the Makwanpur district, Nepal was shown to reduce neonatal mortality by 30%.(^{58}) Conducted between 2001 and 2003, the MIRA Makwanpur cluster randomised control trial, apart from illustrating the impact the intervention had on neonatal mortality, also indicated that women in the intervention arm of the trial were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than the controls.(^{58})</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The <strong>Navrongo</strong> experiment is scaled up across Ghana through the Community-based Health Planning and Service Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>✦ In 2000 the Ghana Health Service launched a national programme of scaling up the transformation of clinic-based PHC and reproductive health services to community-based health services; a model of community health service innovation that was developed and tested by the Navrongo Health Research Centre. Known as the Community-based Health Planning and Service (CHPS) Initiative, the programme is based on the Navrongo model that advocates for the active participation of communities in the provision of their own health care.(^{59})</td>
</tr>
<tr>
<td>✦ Essentially, the Navrongo experiment illustrated that by relocating nurses to communities and reorienting management systems to be more supportive of accessible community-based nursing care, childhood mortality was reduced by a third in seven years and the total fertility rate declined by one birth in a decade.(^{60,61})</td>
</tr>
<tr>
<td>✦ Since its launch, the CHPS has achieved variable degrees of coverage in the 10 regions of Ghana. In 2007 national coverage was 8% of the population. However, in the Upper East Region, a remote rural region where the original Navrongo experiment was based, coverage has reached nearly 50% of all households.(^{59})</td>
</tr>
</tbody>
</table>

Source: Derived using multiple sources.
Collaboration in community development with other sectors, notably education and agriculture, was key in this strategy. Child nutritional status improved from 47% showing normal growth in 1979-82 to 79% showing normal growth by 1989. Similar successes were achieved in immunisation status, access to clean water and sanitation, and the availability of essential drugs. Thailand’s PHC programme has now expanded to include HIV and AIDS and a focus on achieving the Millennium Development Goals (MDGs).

Accompanying democratisation in the mid-1980s, Brazil initiated a large-scale CHW programme, which preceded and contributed to the development of the national Family Health Programme (Programa Saúde da Família or PSF in Portuguese) in 1994. By 2007, this government-funded programme consisted of 26,730 community-based teams of physicians, nurses, nurse assistants and CHWs, and covered 85 million Brazilians. The Family Health Programme has significantly contributed to sharply reduced diarrhoea deaths and infant mortality rates.

Importantly, in both Thailand and Brazil, government has invested significant resources, not only in universal public provision, but also in the rapid development of teams of health personnel, equipped with practical clinical and public health skills required for implementation of their bold health plans.

### Current interest in the revitalisation of Primary Health Care

The MDGs set out by the United Nations in 2000, outline a set of development targets related to the reduction of poverty and hunger, ill-health, gender inequality, a lack of access to education and clean water and environmental degradation, along with the proposed development of cooperative global partnerships. Like the Alma Ata Declaration, the MDGs clearly acknowledge how social and economic development is entwined, and how progress in reaching the socioeconomic targets is expected to simultaneously produce health gains, such as a reduction in child and maternal mortality and greater success in combating communicable diseases such as HIV and malaria.

The possibility of a number of low income countries being able to reach these health goals, or at the very least make substantial progress towards the targets, and within the given timeframe of 2015, is considered to be small unless the functionality of health systems is addressed. Despite the growing number of effective and affordable interventions to tackle the health problems highlighted by the MDGs, and the array of GHIs offering international aid to support such interventions, “…there is growing consensus that a primary bottleneck to achieving the MDGs in low-income countries is health systems that are too fragile and fragmented to deliver the volume and quality of services to those in need”.

A number of challenges contribute to the slow progress towards reaching the MDGs. These include: the growing health inequalities that exist; the threat of the epidemics discussed earlier, namely HIV and AIDS, TB and malaria; and the international experience of outbreaks of the severe acute respiratory syndrome (SARS) and avian influenza, which pose a threat to global health security. As a result the global community has to reconsider approaches which will provide some, if not all of the impetus required to meet these global targets.

The 30th anniversary of the Alma Ata Declaration this year thus appears to be opportune. This anniversary, along with pressure from WHO Member States and regions, notably Latin America, has led to renewed interest and activity in the PHC approach. A return to the values and principles of the PHC approach, and particularly its approach to the social determinants of health and inequality, has resulted in its recent identification as a potential strategy to manage what Dr Chan, WHO’s current Director-General, has described as “the ‘double crisis’ of devastating disease and overwhelmingly failing health systems in many low-income countries”. As Chan noted at the most recent World Health Assembly, “Countries with solid health infrastructures and efficient mechanisms for reaching vulnerable populations will be in the best position to cope” with the current threats to health security. Universal access to PHC was not, she suggested, to be considered another health programme, but rather a ‘way of doing health’, something that is core to a comprehensive national health system.

### What implications does this renewal of interest in the Primary Health Care approach have for South Africa?

It is important to consider the current interest in revitalising PHC and what implications this has for South Africa, which is the focus of a more detailed analysis by Kautzky and Tollman in the latter part of Chapter 2 of this publication. The PHC approach is already central to the South African health policy framework, and this was recently reaffirmed in a commitment to the principles in the Alma Ata Declaration. However, it is important to grasp this opportunity to learn from some of the key lessons of the past, namely; that selective PHC interventions produce short-lived gains and
disrupt health systems or delay their strengthening, and that notable gains can be made in health status when the PHC approach is applied comprehensively and with universal coverage, underpinned by State investment. South Africa’s expenditure on health exceeds that of any other African state and many other middle income countries. It is now urgent to focus these considerable resources on rapidly increasing the coverage of cost-effective interventions and simultaneously strengthening the health system, particularly its human resources, and relevant intersectoral actions. PHC, as envisaged at Alma Ata, and as implemented in Thailand and Brazil, shows us the way.

**Conclusion**

Growing inequities in health and health care, especially affecting Africa, call for a revision of currently dominant health policies. This imperative underpins renewed interest in PHC at global and regional levels. Profound challenges to its implementation remain, especially in poor countries. These challenges include the continued dominance of conservative macroeconomic policies, a trade regime that favours wealthy countries, as well as market-friendly health care reforms that are aggravating health inequity.

There are several examples, especially from the 1970s and 1980s, that demonstrate the positive impact of PHC, particularly when programmes also address the social determinants that underlie health problems. The more recent examples are the experiences of Brazil and Thailand, both of which have successfully pursued relatively autonomous economic development and implemented national health policies that differ markedly from those promoted as part of ‘mainstream’ health sector reform.

Replication of these experiences will be extremely difficult, if not impossible, for the poorest countries and sectors without radical changes in the currently dominant economic development paradigm and its accompanying health reforms and funding modalities. Health personnel can play a positive role by improving their understanding of these policies, and by collectively broadening the scope of their practice and training activities in both the clinical and public health domains, to include a much stronger emphasis on comprehensive PHC.

**Note from authors**

References


59 GHANA Community-based Health Planning and Service (CHPS) website [cited 2008 Aug 03]. URL: http://www.ghanachps.org


