Since 1978, many countries have taken the comprehensive multisectoral, community-led, equity-focused primary health care (PHC) vision of Alma-Ata to heart and as a reality. The preceding chapters have described these efforts across time, across cultural and political contexts, and from different perspectives. In 2018, the Astana Conference on Primary Health Care rededicated leaders of the world’s health systems to make comprehensive PHC the foundation upon which to achieve universal health coverage (UHC) (World Health Organization 2018). Participants at both Alma-Ata and Astana Conferences agreed on a vision of PHC that insisted on promotive, preventive, curative, and rehabilitative aspects of the health system—not just financing and delivering (primary) sickness care. In this final chapter, we synthesize some of the takeaway messages and suggest some priorities and opportunities for the coming years.

One of the main goals of this book has been to correct the common misimpression that the comprehensive PHC declarations of Alma-Ata and Astana have been primarily idealistic aspirations. The cases we purposively selected aim to describe different approaches in different contexts to engage communities and address health and social determinants of health within local populations as well as at scale as part of the overall health system of a country. The stories of Bangladesh, Ethiopia, Nepal, Ghana, Sri Lanka, Vietnam, and Cuba all show that the vision of Alma-Ata has been a viable strategy that has led to sustainable, scalable good health at low cost. This is an irony. Proponents of selective interventions met in Bellagio in 1979 under a banner of “good health at low cost” to convince global health leaders to depart from comprehensive PHC in order to be “practical.” Under a premise
that urgent needs mandated deferring comprehensive approaches, the selective interventions emphasis on global health was launched and labeled as “an interim strategy” (Walsh and Warren 1979) to achieve the most lives saved for the least amount of money. This is false economy.

This book shows clearly that low-income countries can marshal the resources to build functional platforms that engage citizens and local health workers in understanding and supporting the multiple policy changes that are required to alter the upstream social genesis of ill health. At the same time, selective disease control interventions are indeed effective. Programs that promote vaccinations, malaria control, human immunodeficiency virus (HIV) treatment, tuberculosis control, and so on effectively mobilize billions of dollars of global financing that has saved millions. There never should have been a perceived contest between vertical disease control and horizontal public health systems. None of the country case studies in this book refrained from implementing vertical disease control programs or deferred them because their strategy had emphasized a systems strengthening approach. As stated clearly by Svea Closser in chapter 4, comprehensive PHC makes disease control programs easier to support and operate.

Although horizontal approaches pave the way for vertical disease control programs to succeed, the reverse may not always be true. It is too easy for health policy to devolve into an alphabet soup of acronyms for all the disease control programs vying for the attention of the health ministry. An array of vertical programs staffed by narrow specialists is not comprehensive PHC and does not routinely evolve into comprehensive PHC. Sometimes, however, disease control programs can evolve this way, with leadership, a supportive context, and a clear strategy. The case of Ghana (chapter 10) shows how what was originally a regional vitamin A distribution project using community health workers (CHWs) morphed over the course of a decade into comprehensive PHC that scaled up nationally.

An exclusive focus of the health sector on delivering and paying for medical care (whether primary medical care or other) often crowds out policy attention focused on engaging other elements of society, such as schools, law enforcement, agriculture, public works, and transport, from rising to the vision of comprehensive PHC.

There is a fundamental asymmetry shown in figure 14.1.

Vertical approaches that equate health policy with the masterful allocation of funds to various disease control packages do not automatically lead to horizontal community platforms that help citizens and local health workers become the ongoing solution to arising health threats. Comprehensive PHC
is a deliberate choice and not a natural consequence of disease control efforts. Countries had to choose and champion strong comprehensive PHC. Their choice required political will to raise and allocate funds toward PHC activities rather than toward hospital-centric health system plans. With comprehensive PHC comes the ability to mobilize and “pull” vertical programs into the population. Comprehensive PHC programs such as those in Cuba, Nepal, and Ethiopia generated a workforce of CHWs who were trusted because they came from the community and were also trained to provide valued services to those communities. Public health leaders can implement public health cycles to engage whole communities in the genesis of shared solutions, as described in chapter 3. A public health cycle requires conducting assessments of health threats followed by participatory policy development and the assurance of solutions delivered and paid for across multiple sectors of government and private enterprise.

Chapter 1 opened with a review of the historical challenges obstructing the path to implementation of PHC approaches due to (1) lobbying and pressure for specific, vertical, and contained interventions; and (2) political and financial dynamics, nationally and globally. Critical aspects and holistic approaches to furthering the mission of health for all have emerged and matured. While having a strong PHC foundation has been a consistent feature in the health systems of countries that are able to produce improvements in population health, being able to maintain adequate resources and commitment to this unglamorous component of many health systems has been problematic.

Figure 14.1. Asymmetric relationship between horizontal programs on the right supporting vertical approaches but not always vice versa.
(chapter 2). While there is growing appreciation for the potential of comprehensive PHC systems to complement vertical programs such as polio eradication, in practice vertical programs have repeatedly crowded out PHC systems due to their ability to reveal and resolve urgent needs for commodity delivery. If a health commodity (e.g., zinc or an antiviral) is urgently needed, then it is a demonstrable result to have delivered it regardless of how. Resources gravitate to programs that can show short-term results.

Investments in distributing drugs and products related to a single issue have appeal to donors and agencies pressed to quantify immediate progress toward targets and goals. Attention to integrated, comprehensive PHC systems will be essential to achieving UHC, the Sustainable Development Goals (SDGs), and the implementation necessary to fulfill the Astana Declaration. Attentiveness to PHC is not the natural equilibrium of a health system, and the countries discussed in this book required deliberate effort by dedicated and perceptive leaders to develop and support PHC models.

There are specific implementable strategies that countries can use to build up “muscles” in comprehensive PHC. These include: (1) developing the workforce to deliver core public health and PHC services, (2) using principles of community organizing and coalition-building to engage multiple stakeholders, (3) creating the political will as well as clear strategies to enable scale-up of PHC structures such as CHW programs and different modes of services delivery in communities, and (4) building and honing the case for how a strong PHC system supports the rest of the health system—including the goals of various vertical programs.

Chapter 3 outlined the use of workforce capacity development built around measuring the performance of essential public health functions. Report cards that are accompanied by supervisory coaching can assist workers in being mindful of their own professional development as data-driven community organizers. One of the foci for integration of PHC into the rest of health systems is the utilization and support for human resources—from CHWs to physicians—who are able to deliver integrated packages of services and mobilize and engage communities when given appropriate training, supervision, and support. CHWs in particular have a unique and essential role in this bridging or interface function. Recently, more attention has been paid to concerns about economic hardship, exploitation, and gender for CHWs, leading to advocacy for professionalization, payment, and higher status of CHW cadres (Maes et al. 2014, 2015a, 2015b). CHW cadres have diverse expectations, workloads, and competing opportunities for economic and social advancement, so supporting their professionalization remains a context-
specific undertaking without a one-size-fits-all solution (Cometto et al. 2018). Nepal’s female community health volunteers have been largely uncompensated. In Ghana and Ethiopia, more and more CHWs are being compensated.

Chapter 6 offered several field-based examples of the type of community organizing that is the basis of comprehensive PHC. The acronym SALT (stimulate and support; appreciate, authenticity; listen, learn, link; and transfer, team, trust, and transform) has been put into practice in many contexts to build partnerships in the health system. What is constant across contexts is the necessity of community buy-in and a widely perceived value of the CHWs and PHC tier of the health system. This requires an ongoing dialogue between communities and the health system to adapt priorities, address challenges, build trust, and celebrate successes (Rigoli and Dussault 2003; Molyneux et al. 2013).

The second half of this book relayed country experiences related to institutions and structures that helped PHC go to national scale. Government policies have been critical, but comprehensive PHC does not occur by edict. Successful governments have built social spaces and a facilitating workforce congenial to multiple stakeholder involvement in health policy. Governments have also drawn upon, included, and greatly valued the experience, resources, and collaboration of donors, implementing partners, health workers, communities, and other stakeholders. Exemplars in this kind of institution strengthening include Ethiopia, Cuba, Vietnam, and Ghana. Variations, such as Bangladesh’s system that relied heavily on nongovernmental organizations for service provision parallel to a public sector framework, have also proven effective as long as there is a healthy partnership and communication process in place.

PHC continues to gain traction (Bryant and Richmond 2008; Shi 2012; Chou et al. 2012; Cometto et al. 2018). It retains relevance because it can fundamentally support all other programs and goals of a health system. Rather than being prone to duplication or siphoning off of human resources—as vertical programs have tended to be—PHC aims to establish relationships, structures, processes, evidence, and engagement that can support an ever-evolving set of programs needed to meet population demand. For example, Ghana, Vietnam, and Cuba as well as recent efforts of the Global Polio Eradication Initiative have aimed to manage communicable diseases and specific health improvement goals through investing in Integrated Management of Childhood Illness, sanitation, and other preventive and integration-oriented approaches. In addition, these investments in prevention, education, and
behavior change are more and more clearly essential to improving maternal and child health outcomes (as in polio) and addressing emerging issues within the SDG targets, including noncommunicable diseases (NCDs) and other rising contributors to ill health. Further, there are increasing efforts to integrate disease-oriented programs—such as HIV, tuberculosis, and malaria as well as polio eradication—into PHC systems, though this is not yet done consistently.

The country cases in part II illustrate the diversity of social, political, and cultural environments that were receptive to the pursuit of bottom-up approaches to multisectoral, participatory, and prevention-oriented solutions. Bangladesh and Vietnam particularly emphasized self-reliant communities. Governments with a socialist perspective also facilitated the integration of these strategies. Direct engagement of communities, as was achieved in Ethiopia and Ghana, has also created social support and essential buy-in for PHC systems. The Comprehensive Rural Health Project in Jamkhed has been historically famous for doing exactly this as well, and its work has informed India’s accredited social health activist and Anganwadi worker programs, though the fully developed philosophy has not consistently scaled across the country (Arole and Arole 1994).

Emerging Themes for Primary Health Care after Astana

The current social and epidemiological landscape looks quite different from that pondered by global leaders and communities in 1978 at Alma-Ata. To name a few of the health-related changes that are now central but were peripheral or largely unconsidered a few decades ago: Double burden of disease and rising chronic disease rates across the world, climate change, migration, urbanization, and changes in population demographics all present complex and pressing concerns for the health of populations. Many of the country cases described in this book are actively working to address these challenges. Bangladesh is facing imminent threats of climate change and managing migration and the needs of refugees. Ethiopia is grappling with a growing urban population and change in the disease profile. Vietnam is also facing serious climate change threats. All countries are having to look closely at their populations’ knowledge and awareness level and the information they can access, largely instantly, via media and technology. Remote populations are now using data to navigate the services offered by the health system. The role of the health workforce is shifting from being a sole source of health information to being a checkpoint for accurate and appropriate information and
also in building the capabilities to respond to the changing—and generally increasing—demands of a more informed, globalized clientele.

What Is Needed Going Forward in the Twenty-First Century?

As we look toward the coming decade and beyond, the challenges are daunting and awe-inspiring. The opportunities are also exciting and hope-inducing. Focusing on utilizing and channeling the tools, evidence, resources, and momentum that are available and continually being developed further to create the desired outcomes and impact is the next great phase of work. The Astana Declaration and accompanying operational framework (World Health Organization and United Nations Children’s Fund 2018) both recognize diversity in the contexts that will implement PHC. This diversity requires national—and subnational—adaptation of the PHC strategy. It requires national and subnational buy-in. Political will to sustain the level of investment and attention necessary to strengthen PHC across the world can come from a growing realization that bottom-up PHC is essential for sustainable success. The polio eradication experience is testament to this. Comprehensive PHC is a philosophy and a set of strategies and criteria for building political will and engaging communities for better public health across the board. As pointed out in chapter 3, the public health cycle underlies PHC and brings data-informed community deliberation of policies and execution based on shared collective resources.

Furthermore, meaningful community engagement is critical in order to make the essential linkage within PHC between community realities that need to be understood and addressed, and the rest of the health system that is needed to support PHC. Importantly, such engagement cannot be merely a token or symbolic kind of engagement but must truly enable community voices, hear their stories, and determine possibilities for joint responses and action (Jewkes and Murcott 1998; Morgan 2001; Head 2007). Many countries have invested a great deal in these structures and processes, including Bangladesh, Cuba, Ethiopia, and Ghana. Chapter 6 outlined a stepwise approach to engage and involve community members in the understanding and solution of local health concerns.

The financing of health systems and PHC also looks quite different than it did forty years ago. Health services are becoming more sophisticated and rapidly expensive as care needs shift toward management of chronic diseases and in response to populations’ rising demands for additional curative services—as has happened in Ethiopia, Bangladesh, and many other countries.
At the same time, international development assistance—at least from the United States—has stagnated in recent years (USAID 2019). Although many countries—particularly middle-income countries and those with strong government plans oriented toward health and societal well-being—have resources of their own to invest, large new investments will be needed in the coming years in order to progress toward the SDGs. As much as an additional $371 billion per year is needed to reach ambitious SDG targets (Stenberg et al. 2014, 2017). In a polarizing global political climate, building shared understanding for what resources are needed, mobilizing those resources, and then allocating them toward PHC could be a great challenge. Many are now looking to low- and middle-income countries—who have a duty to ensure the health of their populations—to set an example of establishing policies and criteria for adequate and equitable financing for health, including allocation of domestic resources (Rottingen et al. 2014). While this is necessary and appropriate, similar pressure and accountability for external financing is necessary: to ensure that high-income countries contribute to global public goods and help countries not yet able to bear the full cost of their health systems, and that they do so in a way that is transparent, coordinated, and supportive of recipient country policies and priorities (Rottingen et al. 2014).

The history of PHC is woven together by a lineage of thinkers, leaders, and inspiring personalities (captured in chapter 1) whose philosophies and actions have demonstrated what is possible and also what is required to achieve the vision of health for all. We will need future generations of leaders whose vision matches the complexity and scale of the barriers to achieving PHC goals and who dedicate themselves with equal fervor, humbleness, and compassion as those who have come before them.

Closing Thoughts

In the decades since Alma-Ata, we have accumulated vastly more experience, models, and evidence for why comprehensive PHC is important, in large part thanks to the many country- and local-level efforts to adapt and implement the definition of PHC in their own contexts. The 2018 conference in Astana, which commemorated the fortieth anniversary of the Alma-Ata Declaration, brought forward the same core themes but with additional granularity about where investment is needed and how to proceed toward health for all in the SDG era. The cases in this book described countries that are investing in the core elements of PHC in order to be able to address some of the underlying dynamics and determinants rather than just symptoms and short-term out-
comes. The seven core elements were all laid out in Article VII of the original 1978 Alma-Ata Declaration:

1. pay attention to the sociocultural, political, and economic background;
2. address local epidemiology with promotive, preventive, curative, and rehabilitative services accordingly;
3. respond at the population level as well as provide individual services;
4. use a multisectoral approach;
5. maximize community and individual self-reliance in organizing and controlling the health system;
6. integrate systems, giving priority to those in need; and
7. include multiple counterparts (auxiliary workers).

(The full original text of Article VII is given as an annex in table 14.1.)

Table 14.1. ANNEX Article VII of the Alma-Ata Declaration

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; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors, and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care, making 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 progressive improvement of comprehensive health care for all and giving priority to those most in need; and
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.
The authors of the Alma-Ata Declaration had experience in addressing the perpetual challenge of aligning diverse stakeholders across many different contexts with different jargon, numerous and sometimes competing priorities, and constantly shifting targets and aspirations. Some of the countries that implemented the Alma-Ata Declaration faced severe disagreements about their political order. Bangladesh, Vietnam, Nepal, and Sri Lanka all had civil wars that preceded a top-level commitment to comprehensive PHC. Cuba had a socialist revolution before embarking on this path. However, other countries, like Ethiopia and Ghana, as well as Thailand (not covered in this book), chose to endorse PHC because their initial experiences with that approach were persuasive. Thanks to the authors of the preceding chapters, more public health leaders can now know enough about what to do to make a strong argument for comprehensive PHC and strategies that work to implement the approach. In order for more people to achieve health for all and the SDGs, readers can share these chapters and write their own. It will be our own collective action that keeps making health for all a reality.

REFERENCES


