WHO: reaching out to all

By the early 1970s a new idea was taking shape in WHO. Medical services were failing to reach vast numbers. Health would have to emerge from the people themselves. In the heat of discussion the new strategy was clarified and given a name—primary health care. And an ambitious target was set for it—no less than health for all by the year 2000.

On 15 May 1973, the World Health Assembly began to discuss a report whose repercussions are still being felt by the international health community. Twelve months earlier, the Executive Board had appointed a five-person working group to study the seemingly innocuous subject of “Methods of promoting the development of basic health services”. It was hardly a new topic for WHO. As early as 1953 the Executive Board, in a resolution later endorsed by the Sixth World Health Assembly, stated that “assistance in the health field should be designed primarily to strengthen the basic health service of the country and to meet the most urgent problems affecting large sections of the population, with due regard to the stage of social or economic development of the country concerned”/(1).

Throughout the 1950s and 60s, and as recently as 1971, the World Health Assembly had passed resolutions to the same effect. The achievements, however, had been limited, especially from the point of view of the newly independent countries of Africa.

In 1948, when WHO came into existence, Liberia had been the only African country represented at the First World Health Assembly in Geneva. Twenty-five years later, 31 independent African countries took their seats for the annual meeting of the Assembly. In 1948, fewer than half the Organization’s Member States were developing countries. But 25 years later, 97 of WHO’s 137 Member States were from the developing world. And for the first time, the developing countries (and some of the industrial ones too) were starting to ask serious questions about the type of technical assistance they were receiving from their Organization.

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Four members of the working group appointed in 1972 to study the basic health services approach were from developing countries—Kenya, the Syrian Arab Republic, Thailand, and Trinidad and Tobago. The Danish Chairman, Esther Ammundsen, had a long-standing commitment to the cause of Third World development. Their report (2), only nine pages long, began by stating briskly that the term “basic health services” was no longer useful since it had “grown with time until it hardly excludes any form of service”. The authors therefore proposed dropping the word “basic” and using the more general term “health services” instead. Thus, at one stroke, the term that had symbolized WHO’s approach to health services development for the previous decade was unceremoniously knocked from its pedestal.

The report continued in forthright vein, stating bluntly that “in many countries the health services are not keeping pace with the changing populations either in quantity or in quality. It is likely they are getting worse.”

Public dissatisfaction with the health services, said the report, was widespread and by no means confined to developing

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The voice of the community. All over the world, women are taking an increasingly greater part in decision-making.

Photo: WHO/UN.
countries. "The causes can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness on the part of the consumer." In short, the world health scene was one of crisis, not susceptible of improvement through minor changes in detail but requiring radical changes in "the key features of the wider picture".

In future, said the report, WHO would have to take account of each country's health services as a whole, and its assistance "should be participatory rather than advisory and should be directed towards a visible and objectively defined improvement in the health services". Although WHO had no direct responsibility for the people of any country, it did have certain global responsibilities. What it could do was to act as a "world health conscience".

The debate in the 1973 World Health Assembly proved that the report on basic health services had struck a sensitive chord. Delegates warmly welcomed the proposal for a more cooperative type of WHO assistance, which would consider each country's health services as a whole and develop practical guidelines for national health service systems. Exactly what direction these guidelines would take could not yet be defined. It was obvious that there was now a need to study the experiences of a range of countries in more depth. Delegates strongly endorsed the suggestion that WHO should collect and disseminate information about the experiences of various countries in developing their health services, especially those in which innovative approaches had been tried.

The Assembly of May 1973 also marked the end of Marcolino Candau's 20-year-long reign as Director-General of WHO. For the past two decades he and his Deputy, Pierre Dorel— who was now resigning as well—had led the Organization with great distinction. Highly professional administrators, extremely skilled in the diplomatic arts required of international civil servants, they had led a highly complex, global organization through a period of rapid expansion, steering it safely through a number of potentially disastrous crises along the way.

The new Director-General, Halldan Mahler, had begun working for WHO in 1951, when he headed the Organization's tuberculosis team in India. In 1970, Candau had appointed him Assistant Director-General with special responsibility for health systems analysis. Mahler was destined to lead WHO through the most exciting—and the most precarious—period of its history yet.

**A watershed report**

A quick start was made with the task of studying a range of successful or promising health systems and analysing the factors
reorientation of health policies at the global level.

Cumbersonely entitled *Alternative approaches to meeting basic health needs in developing countries*, the report pulled no punches. In most health service systems, said the authors, a “virtual revolution” was needed to develop firm national policies for providing health care for the underprivileged majority. Such a revolution should bring about “changes in the distribution of power, in the pattern of political decision-making, in the attitude and commitment of the health professionals and administrators in ministries of health and universities, and in people’s awareness of what they are entitled to.”

In the developing countries, said the report, a new type of health worker was called for—the primary health worker, who would be chosen by the people from among themselves and be responsible to the community but who would be supported by the entire health system with training, supervision, referral facilities, and logistic support. This was a radical proposal indeed, and likely to cause concern among those responsible for providing health care. The mass disease campaigns of the 1950s and 60s had mobilized auxiliaries trained in specific medical skills, such as taking blood samples or giving injections, but always as part of the health service. Now the international health community was being asked to endorse a new type of health worker who would be largely outside the control of the health services—an approach that seemed to

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**Family planning, a shared responsibility.** More and more fathers are recognizing their role in matters of family health. Photo: WHO/E. Schwab.

Deemed to be responsible for their success. Nine countries were chosen: Bangladesh, China, Cuba, India, Niger, Nigeria, the United Republic of Tanzania, Venezuela, and Yugoslavia. Joint WHO and UNICEF teams visited each country, and over 80 public health experts throughout the world contributed papers. The resulting report (3) was a watershed in the

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**In virtually all countries, the emphasis on curative care would have to be balanced by an equal emphasis on prevention.**
threaten the standing of the medical profession itself.

The idea of the village health worker drew much of its inspiration from China. Largely isolated from the rest of the world for over two decades, China had developed a health care system covering the essential health needs of the great majority of its people. This system operated at low cost, used medical technologies that were appropriate to the country’s situation, and enjoyed the active participation of the community. In rural areas, where 80% of the population lived, the success of the Chinese system was due largely to part-time health workers, the so-called “barefoot doctors”, who received a few months’ training after being chosen from—and by—the community, which also remunerated them for their services. Virtually unnoticed by the international health community, China had produced a new type of health worker, apparently ideally suited to the needs of developing countries. Now that the news was out, the Chinese barefoot doctor was well on the way to becoming the international health hero of the decade.

"Health for all" is born

The major achievement of the Alternative approaches study was to launch the concept of “primary health care”, not yet clearly defined but soon to become the flagship of the World Health Organization. The report urged WHO and UNICEF to adopt an action programme aimed at extending primary health care to populations in developing countries, particularly those that were inadequately provided with such care. Significantly, the emphasis was on the developing world; the relevance of primary health care for the industrial countries was apparently not perceived at the time.

The World Health Assembly of 1975 warmly endorsed the proposal to develop a programme of activities in the field of primary health care. Largely at the suggestion of the delegate of the USSR, the
1976 Assembly decided to hold an international conference to discuss ways of developing primary health care in the developing countries. UNICEF agreed to act as co-sponsor. But it was another two-and-a-half years before the conference took place (at Alma-Ata, capital of the Kazakh Soviet Socialist Republic), and in the meantime a huge amount of groundwork had to be done. While the general direction in which the Organization wanted to move was now becoming clearer, the roads to follow had not yet been mapped out.

Over the next two years, in a series of national, regional, and international meetings, and at innumerable working sessions in Geneva and New York, the new health strategy was hammered into shape. Further fuel for the debate was provided by a book published by WHO in 1975, entitled Health by the people (4). The title emphasized the direction in which the new health strategy was evolving — away from the idea of people's health being in the hands of a small élite of professionals in white coats behind hospital walls and towards the idea of people taking greater responsibility for their own health care.

Underlying all these concerns was the increasingly shared conviction that gross inequalities in health status, both internationally and within countries, were no longer tolerable. This led to a major landmark along the road to Alma-Ata — a resolution of the World Health Assembly of 1977 which declared that "the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (5).

The "health for all" movement had been born, a blueprint of its essential ingredient — primary health care — sketched out, and a deadline set for its achievement.

The Declaration of Alma-Ata

On 6 September 1978, delegates from 134 countries and 67 United Nations organizations, specialized agencies, and

Healthy mind, healthy body. Alcohol consumption and smoking, sharply increasing in developing countries, undermine efforts to improve health. Photo: WHO/H. Anenden.
nongovernmental organizations met at Alma-Ata in the USSR for a six-day conference on primary health care.

The conference had been organized with the object of achieving widespread international agreement on the principles of primary health care and the means of attaining it, and of launching a global movement for its promotion. At first, it was not obvious that this was going to be a conference with a difference.

"Many delegates", recalls Sir John Reid, Chairman of WHO's Executive Board at the time, "came to Alma-Ata thinking it would be just another international conference. But they soon realized that this was going to be something rather special, even historic." (6).

The tone was set at the opening ceremony, when Dr Mahler, the Director-General of WHO, challenged the delegates with eight questions (7).

1. Are you ready to address yourselves seriously to the existing gap between the health "haves" and the health "have-nots" and to adopt concrete measures to reduce it?

2. Are you ready to ensure the proper planning and implementation of primary health care in coordinated efforts with other relevant sectors, in order to promote health as an indispensable contribution to the improvement of the quality of life of every individual, family and community as part of overall socioeconomic development?

3. Are you ready to make preferential allocations of health resources to the social periphery as an absolute priority?

4. Are you ready to mobilize and enlighten individuals, families and communities in order to ensure their full identification with primary health care, their participation in its planning and management, and their contribution to its application?

5. Are you ready to introduce the reforms required to ensure the availability of relevant manpower and technology, sufficient to cover the whole country with primary health care within the next two decades at a cost you can afford?

6. Are you ready to introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care as the overriding health priority?

7. Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care?

8. Are you ready to make unequivocal political commitments to adopt primary health care and to mobilize international solidarity to attain the objective of health for all by the year 2000?

Over the next five days, in plenary sessions, working groups, and drafting committees, the delegates gave their responses and contributed their ideas — usually positive, sometimes uncertain or sceptical. WHO and UNICEF, however, had done their homework well. The key document for the conference was jointly prepared by Halfdan Mahler and Henry Labouisse, Executive Director of UNICEF. The 49-page document — a model of lucidity — was an invaluable work of reference and a source of inspiration for the Declaration of Alma-Ata, which was read out in the final plenary session of the conference by Marcella Davies of the Sierra Leone delegation and carried by acclamation.
Primary health care

The Declaration of Alma-Ata describes primary health care as follows.

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.... 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.

Primary health care... 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;
— provision of essential drugs.

Only 1000 words long, and divided into 10 Articles along the lines of a treaty, the Declaration of Alma-Ata was to become a landmark document in the history of international health (8).

Proclaimed three decades after WHO's birth, it heralded a new era for the Organization. During the 1950s and well into the 1960s, WHO’s teams of experts had led campaigns against communicable diseases using technical know-how derived from the industrial world. Then, half-way through this period, came the realization that campaigns had to be integrated into an infrastructure of basic health services. But the approach to basic health services, which overlapped with the second decade of the campaigns, was still essentially technocratic and paternalistic: health care was something to be “delivered” to passive recipients by medical professionals whose knowledge and skills were shrouded in mystery.

Now the purely technological approach to health was to be dethroned. Health was no longer to be the exclusive preserve of a small group of health professionals and their trained assistants. Health was now to be everybody’s business. The community itself had to be involved in planning and implementing its own health care, but to be able to participate in this way people needed more knowledge of the causes of ill health. In many developing countries, community health workers and traditional health practitioners would have to be trained. And in virtually all countries, the emphasis on curative care would have to be balanced by an equal emphasis on prevention.

Underpinning the primary health care approach was a commitment to equity in health—or the health-for-all value system. It was no longer tolerable for health care to be accessible only to those fortunate enough to be able to pay for it. Since health care was a
fundamental human right and an integral part of social justice, governments had to give the highest possible priority to making a decent level of health care accessible to the poorest sections of society. But health for all could not be attained simply by the health sector alone, even with the active involvement of the community. Other sectors of national development—agriculture, industry, housing, education, public works, and social services—also had a powerful bearing on health and had to be brought into the process of national health planning and development.

In May 1979, the World Health Assembly unanimously endorsed the Alma-Ata Declaration. Every one of WHO’s Member States was now committed, at least in theory, to a public health strategy that implied fundamental changes in the distribution of resources and power within the health system, government, and society. But what would it amount to in practice—a group of armchair revolutionaries talking big and acting small, or the start of a process of fundamental social change? At the very least, a fascinating prospect was in store for the 1980s.

Between rhetoric and reality

The Alma-Ata Conference on Primary Health Care might well have been a mere flash in the pan. But unlike most international conferences, Alma-Ata has been followed up systematically by steps designed to translate the rhetoric of health for all into reality at all levels—country, regional, and global.

WHO’s first step was not to design a grand master plan for implementing primary health care throughout the globe but to work out the practical implications of the health-for-all strategy at national and regional levels, where local problems and needs could be taken into account. Only in 1981, after regional plans had been formulated, did the World Health Assembly approve a global strategy for health for all and agree on a set of minimum indicators for monitoring and evaluating progress in its implementation. This global strategy, as the Director-General reminded the World
Health Assembly, amounted to the first international “social contract for health”, voluntarily agreed on by all independent countries.

In 1982 the World Health Assembly went a step further by approving a detailed plan of action—with a five-year timetable—for implementing the global strategy. The countdown to health for all by the year 2000 had now begun in earnest. In country after country, WHO began (or intensified) a process of dialogue with Ministry of Health officials to plan the structural, organizational, manpower, and financial changes required to make primary health care the main thrust of national health systems. This was the acid test of whether governments that had, at the World Health Assembly, solemnly committed themselves to the strategy of health for all were actually prepared to honour that commitment, however difficult the choices they had to make.

By 1985, WHO felt that the time was ripe to evaluate the progress made by countries in formulating and implementing health-for-all systems, in which bureaucratic inertia and resistance to change were generally endemic.

Perhaps more important than any of the conclusions of the evaluation report (9, 10) was the fact that almost 90% of WHO’s Member States were prepared to share with one another such detailed information about the problems facing their health systems—to reveal, in fact, the blemishes on the body politic. Only two decades earlier such openness would have been unthinkable. But here, at last, the international health community had shown itself capable of working in the cooperative spirit intended by its founders in the aftermath of the Second World War.

The evaluation report concludes, perhaps surprisingly, that health-for-all strategies appear to be making most progress in the industrial world. At Alma-Ata, the countries of Europe and North America had seen little relevance in primary health care for their technologically advanced health systems. Now, however, they were beginning to realize that sophisticated medical technology was no guarantee of good health. Alarmed by the rapidly rising cost of health care and the inability of medical technology to prevent major health problems such as cancer, cardiovascular diseases, and AIDS (acquired immunodeficiency syndrome), the affluent countries were searching for an alternative approach. Health for all through primary health care offers such an alternative. It emphasizes prevention rather than cure, the promotion of healthy behaviour rather than reliance on medical technology, community responsibility rather than government control, and the reorientation of health care services so that they are accessible to those who need them most.

Governments of the industrial world have responded far more positively than expected to the challenge of setting specific
health-for-all targets. The 34 governments of WHO's European Region have agreed on a set of 38 specific targets as a means of monitoring progress towards the goal of health for all (11), and by 1985 almost a third of them were reported to be initiating national health-for-all policies. The medical profession is also becoming increasingly involved. In the United Kingdom, for example, the Royal College of Physicians has published Health for all by the year 2000: Charter for action which has attracted considerable interest from health professionals, the media, and the general public (12).

Many developing countries have also been ravaged by war, drought, and the destruction of the environment, which is the source of life. In such conditions, health care is reduced to crisis management, with all thoughts of organizational change postponed to an indefinite time in the future.

**Industrial countries were beginning to realize that sophisticated medical technology was no guarantee of good health and that health for all through primary health care offered an alternative.**

Air is the most vital of the elements. One of the worst environmental evils to which people in industrialized countries are exposed is the pollution of their essential breathing matter.

Photo: WHO/J. Mohr.
Nevertheless, the global evaluation found that many developing countries had achieved substantial progress in expanding the health infrastructure, especially through networks of health posts and health centres. Had previously had no access to modern health care. Coverage of maternal and child health services had increased most rapidly, especially vaccination of young children against the six target diseases of the Expanded Programme on Immunization. Progress was also reported in the availability of essential drugs for common illnesses. In particular, the use of oral rehydration salts has contributed significantly to a reduction in diarrhoea mortality among children. In many countries, there has been a growing tendency for local communities to involve themselves in decision-making about health care, through neighbourhood health committees, village councils, development associations, women’s groups, consumer organizations, and youth movements.

 Millions of health workers have been trained, extending services to low-income groups that had no access to modern health care.
Despite these gains, the distribution of health care remained highly inequitable. "In the capitals of many developing countries", says the report, "ultra-modern hospitals have facilities for open-heart surgery and organ transplantation, while only 20 kilometres beyond the city limits children still die of tetanus or diarrhoea because basic services and supplies are lacking."

The majority of developing countries reported that the intermediate level of the health system — the district level — was very weak. Moreover, inadequate numbers and lack of transport greatly limited the ability of district health staff to give community health workers the necessary supervision and technical support.

A large majority of countries reported low motivation of health professionals, especially doctors, for primary health care. Lack of understanding of the primary health care concept and insufficient concern for social equity, says the report, remain the principal constraints. The concentration of doctors in urban centres and in the private sector, and the difficulty of deploying or retaining them in rural areas, still persist.

Safe water and sanitation constitute one of the eight essential elements of primary health care proclaimed by the Alma-Ata Declaration. In the first half of the 1980s — designated by the United Nations as the International Drinking Water Supply and Sanitation Decade — an additional 300 million people obtained access to clean water and 180 million received sanitation facilities. Most of these gains, however, were nullified by population growth and drought. Over a billion people still lack a safe water supply and 1.5 billion do not have adequate sanitation. Most countries reported that they would not be able to meet the goals of the International Decade, and are now aiming to achieve full coverage by the year 2000.

For many countries, the global evaluation was their first-ever attempt to carry out a comprehensive review of their health strategies. At the very least, it has provided health planners with the information they need to decide what actions or changes in emphasis are necessary in order to initiate or accelerate the process of developing primary health care. Whether this information is used effectively or not is another matter — and one over which WHO has no direct control.

**Health leadership**

One of the lessons WHO has learned — often through bitter experience — is that health cannot be divorced from politics. And the unpalatable truth is that relatively few political leaders believe that health is a worthwhile economic or political investment. In spite of the fact that 132 governments (80% of WHO's Member States) have endorsed the strategy of health for all at the highest political level, a gap remains between what is preached and what is practised. In many countries, the health sector has little political power or influence

Among health professionals, lack of understanding of the primary health care concept and insufficient concern for social equity remain the principal constraints.

on decisions about the allocation of public funds. Expenditure on health care tends to be viewed simply as a drain on scarce resources rather than as an investment in the nation's future. Whenever budgetary cuts
are made under the impact of financial pressures, the health sector is one of the first to suffer. And the cuts tend to fall mostly on the services that can least afford them—essential drugs, for example, or vaccines, or transport for reaching the people in rural areas.

Expenditure on health care tends to be viewed as a drain on scarce resources rather than as an investment in the nation’s future.

The challenge now is to persuade political and health leaders that money spent on primary health care is a worthwhile investment. This is a challenge facing not only WHO, but many different types of people and organizations with an interest in health. Health for all should be everybody’s business. What is still lacking is a “critical mass” of people with the knowledge, commitment, and leadership skills needed to turn health for all into an effective, self-sustaining movement. Skills of this sort are not taught in universities and schools of medicine or nursing.

To fill this gap, WHO itself has launched a major new initiative on health-for-all leadership development which focuses on political leaders, civil servants, health professionals, religious and community leaders, media workers, leaders of women’s organizations and youth movements, and senior WHO staff.

Towards health for all

Is the world any healthier after four decades of the World Health Organization? It is certainly a safer place for children. In 1950, worldwide, an estimated 25 million infants and young children died before reaching the age of five. By 1986, the figure had fallen to 14 million a year, even though the number of children under five years of age had increased by 68%. Great disparities, however, still exist, both within and between countries.

Life expectancy — another key indicator of health status — has risen from a worldwide average of 41 years in 1950 to 61 years in 1986. The greatest gains were recorded in China and East Asia, where it rose from 39 to 56 years. Even in Africa, however, life expectancy rose from 38 to 51 years. Many countries have also registered progress in the control of communicable diseases, especially malaria, diarrhoeal diseases, and diseases preventable by immunization. In the industrial countries too, where communicable diseases are no longer a major cause of death, life expectancy has risen—from 66 in 1950 to 73 in 1987.

But during the 1980s many developing countries have also seen gains in child survival and life expectancy threatened or even nullified by severe financial, ecological or military pressures. In Africa in particular, economic recession, drought, and warfare have greatly damaged the socioeconomic infrastructure, including health services, and taken a heavy toll of human life.

As WHO ends its fourth decade, the spectre of AIDS haunts every country in the world, whether industrial or developing, North or South, East or West. WHO is responding to this challenge with the determination and creativity which marked the smallpox eradication programme during the 1960s and 1970s.

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Throughout the first four decades of its history, WHO has been at its most effective as a catalyst and facilitator, paving the
way for achievements far out of proportion to the relatively modest resources at its disposal. The extent to which WHO is successful in helping to meet the global health challenges of the next decade depends very much on its own Member States. For in the end, the momentum of health for all can be sustained only by governments implementing at home the policies they have collectively agreed on at the World Health Assembly in Geneva.

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Said at the First World Health Assembly

Danger of unreasonable disagreement

Ever since we started work here in committees the spirit of mutual understanding, of cooperation and friendship, has furthered our common view. Now, for the first time, we are facing something different—a disagreement unknown yet to this Assembly. Do the delegates who are opposing the motion... think their work is going to benefit from dissension and dispute? Would the health of their countrymen be better served? The answer must be in the negative. Only the unity of our own endeavours can make the lot of the millions suffering innocently from disease a better one. This is our responsibility.

—Dr E. Ungár, Czechoslovakia
Twelfth Plenary Meeting, 10 July 1948.