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Twenty five years after the Alma Ata declaration and the dream of "Health for All" has yet to be realized. While substantial successes have been achieved, healthcare for all is still a distant goal.

In its premiere Asia-Pacific issue, Health Alert discusses the successes and the pitfalls of the Alma Ata declaration. Have the goals of Alma Ata been achieved? What are the setbacks in the declaration's implementation? How have recent developments affected primary healthcare? How effective are grassroots programs in improving health care for the poor? How have governments enhanced access to primary health care?

But after looking backward at what was, it is more important to know what could be done. What current policies should go, and what new policies should be adopted? What lessons could be gleaned from experiences? How could governments help?

Indeed, the past 25 years have seen major improvements in health care – life expectancy is higher, infant mortality rates lower, AIDS awareness and understanding is much better, and old gender and racial prejudices have been reduced. Immunization programs reach more people more rapidly, and information is disseminated more efficiently.

However, the problems that ministers from 134 countries committed to eliminate in Alma Ata are still prevalent. Disparity in access to healthcare is still wide among and within countries. Poverty-related diseases like tuberculosis and cholera – both easily preventable – are still taking the lives of millions. Medicines are still beyond the reach of those who need them the most. HA

In this issue:

ILLUSTRATION BY BOY DOMINGUEZ/HAIN

TWENTY FIVE YEARS OF PRIMARY HEALTH CARE: KEY CHALLENGES FOR ITS REVITALIZATION

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In 1978, ministers from 134 countries met at the Alma-Ata Conference in the former USSR to declare a common mission for governments, international organizations, and health workers worldwide: "Health for All by the Year 2000." In proclaiming this declaration, these health and state leaders envisioned a not-so-far future in which all peoples of the world are to attain a level of health that will permit them to lead a socially and economically productive life. They thus declared the strategy of "Primary Health Care" as the key to realizing this vision. They called for urgent and effective local and global efforts to develop and implement Primary Health Care (PHC) throughout the world, particularly in developing countries.

Thus, in the twenty-five years following the Alma-Ata Conference, we have seen considerable gains in global health. Throughout the world, life expectancy and child mortality have improved, and cardiovascular diseases have decreased in males in industrialized countries. Immunization has increased globally in children under one year from 20% in 1980 to 80% in 1990, controlling the spread of certain communicable diseases over the last two decades.

ILLUSTRATION BY BOY DOMINGUEZ/HAIN

SETBACKS IN IMPLEMENTING PHC

The significant successes in implementing PHC are, however, mainly in the development and extension of particular health programs, rather than in the facilitation of social development though the promotion of community participation. Child health care provisions, for example, increased greatly in the 1980's, with the promotion of "Child Survival" techniques; namely, growth monitoring, oral re-hydration therapy, breastfeeding and immunization (GOBI).

However, strategies of "selective primary health care" such as these did not necessarily promote the need to establish sustainable and decentralized structures and systems, community participation, and equitable social and economic development – foundations of the Alma-Alta vision of Health for All (HFA) for rich and poor countries alike.

Thus, the nutrition situation in developing countries, particularly in Sub-Saharan Africa (SSA), remains serious, with the number of malnourished children increasing alarmingly over the last 25 years, paralleling increased poverty rates in the region. The gap in mortality rates between rich and poor, between and within countries, has widened significantly for certain age groups. Maternal mortality in developing countries remains unacceptably high, and, in a number of SSA countries, infant mortality rates have actually increased since the 1980s under the impact of economic recession, structural adjustment, drought, wars, civil unrest, and HIV/AIDS.

Furthermore, the control of both communicable and non-communicable diseases has proved elusive. In particular, HIV/AIDS, tuberculosis and malaria are affecting rapidly increasing numbers of people worldwide, especially the poor. Sustained success in combating these diseases is

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largely dependent on well-developed health systems, active participation by communities in disease-control campaigns, and improving living and working environments.

In the same manner, the major non-communicable diseases such as cardiovascular disease, cancers, diabetes, mental illness, violence, and injuries require better clinical management and lifestyle modification. However, it is clear that health systems in most developing countries, especially in SSA, have deteriorated in the past ten to fifteen years. This is most starkly illustrated by the decline in vaccination coverage of young children to well below 1990 levels, despite intensive polio vaccination campaigns and the regular measles vaccination campaigns.

This deterioration of public health systems in developing countries, and especially in SSA, has resulted from economic decline and structural adjustment programs, with the latter leading to reduced health budgets. This has been aggravated by health sector reforms, which have usually included introduction of user fees and private insurance schemes, as well as the decentralization of authority – often without accompanying resources.

REVITALIZING PHC

Twenty-five years after the Alma-Ata Conference, the vision of "Health for All" remains a dream to many developing countries. It is clear that progress towards Health for All has been uneven. Gains already achieved are under threat from a complex and accelerating process of globalization. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programs that have substantially reduced the impact of certain diseases, there is still a pressing need to revitalize PHC, this time taking into mind its socially mobilizing roles and bringing it up to inter-sectoral levels.

This revitalization requires three related broad actions, foremost of which is social sector investment. There is considerable evidence that equitable, broad-based and gender-sensitive development and social policies have led, in countries as diverse as Cuba and Sri Lanka, to health outcomes that are much better than those achieved in countries of similar wealth.

A second key in the attainment of the goals of PHC is the development of health policies. Policy development needs to involve those sectors, agencies and social groups critical to achieving better health. Such an inclusive approach has been the characteristic of health promotion efforts, with Healthy Cities and other settings-based initiatives providing the focus for such activities.

Lastly, the revitalization of PHC requires the implementation of comprehensive and participatory programs. The comprehensive development of health programs should be based on an assessment of the seriousness of the problem, analysis of its causes and the resources that can be used to address it. Programs that will address the priority problems should combine rehabilitative, curative and preventive activities. These programs then need to be structured into well-functioning district systems that require, to be considerably strengthened, particularly at the household, community and primary levels.

Comprehensive health centers and their personnel should be the focus of effort and investment, and the reinstatement of community health worker schemes should be seriously considered. This inevitably requires the transformation of both management systems and practice. A key primary step is the capacity development of district personnel through training and guided health systems research. Such human resource development must be practice-based and problem-oriented and drawn upon educational institutions and professional bodies.

Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here, partnerships with non-government organizations and expertise in various aspects of community development are crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. The identification of well-functioning organs of civil society, whether or not they are presently active in the health sector, needs to be urgently pursued.

Finally, in promoting the move from policy to action, the World Health Organization (WHO) has to play a much bolder role in the following:

• Advocating equity and legislation,

• Pointing out the dangers of globalization and liberalization to health,

• Stressing the importance of partnerships between the health sector and other sectors,

• Integrating its own internal structures and activities to ensure that comprehensive PHC programs are developed,

• Entering into partnerships with, and influencing other multilateral and bilateral agencies and donors as well as non-governmental organizations and professional bodies towards a common vision of PHC, and

• Arguing for major investment in health, especially in human resource development, without which HFA will remain a mere statement of intent. HA

ESSENTIAL DRUGS AND PRIMARY HEALTH CARE

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The Alma Ata Declaration on Primary Health Care (PHC) in September 1978 was a response to an international sense of urgency over the widespread inequities in health and healthcare that affected all countries, both developing and developed.

As the world commemorates the 25th anniversary of the Alma Ata Declaration, we find that the inequities in health and health care among and within nations have further widened. Recent issues of Human Development Reports (HDRs) have empirical data to support this. For example, the 1999 HDR reports that life expectancy in several sub-Saharan countries has fallen from 50 to 40 years in a period of ten years.

Why did Alma Ata fail? The best explanation can be understood from two of the questions posed at the International Conference on PHC. Participating countries were asked:

1. Are you ready to make preferential allocations of health resources to marginalized sectors as an absolute priority; and,

2. Are you ready to fight the political and technical battles required to overcome the social and economic obstacles to PHC?

High-level representatives from 134 member states of the World Health Organization (WHO) who participated in the International Conference answered in the affirmative because the conditions at that time were supportive.

At that time, United Nations agencies were debating on ways and means to usher in a new economic order that would take into consideration the special needs of developing countries. These included initiatives by UNCTAD to enhance country flexibility, plus negotiating a code of conduct for transferring technology without restrictive business practices. The WHO, for its part, published a list of drugs essential in promoting public health, and advised member states to formulate and implement national drug policies taking these drugs into account. Moreover, UNIDO did its part in facilitating technology transfer and constructing pharmaceutical plants in developing countries.

All these developments, particularly the Alma Ata Declaration, worried multinational companies (MNCs) and the more developed countries (MDCs), who saw the events as a threat to their economic dominance.

In response, beginning in the 1980s, the World

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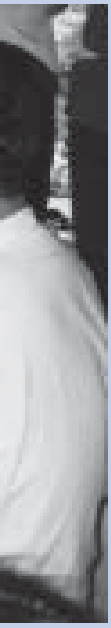

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Bank (WB) and the International Monetary Fund (IMF) imposed Structural Adjustment Programs (SAPs) on indebted developing countries. Alma Ata was thus set aside as these countries were forced to implement the following:

- Budgetary cuts in healthcare, education and subsidies to farmers and the poor,
- Privatization of state-owned industries,
- Devaluation of local currencies,
- Liberalization of local markets, and
- Reduction of duties and tariffs on imports.

This was a prescription for disaster for developing countries. Budgetary cuts led to a deterioration of social services, and premature market liberalization led to unfair competition from MNCs, forcing local industries to shut down.

For almost two decades the IMF-WB ignored protests from developing countries and NGOs that provided empirical data showing the adverse impact of SAPs on their economic and social development. Eventually, the World Bank and IMF scrapped the SAP program and replaced it with Poverty Reduction Strategy Papers (PRSPs), which are drafted by the developing countries themselves so that these become "country-owned" strategies. However, even this program did not adequately meet the health needs of developing countries.

Improved health plays an important role in reducing poverty. Health should be an integral and key component of a development strategy. This was underscored in the Alma Ata Declaration. PRSPs, on the other hand, characterize health as an outcome of economic development and not as means of achieving it. PRSP strategies are designed to increase the rate of economic growth and to maintain macroeconomic stability, focusing on sectors traditionally considered productive such as business, tourism and manufacturing.

In this vein, essential drugs and primary health care need to be discussed in the context of two factors: PRSPs and the TRIPS Agreement.

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Poverty Reduction Strategy Papers

WHO's review suggests that under the framework of PRSPs, health will remain neglected, and opportunities to

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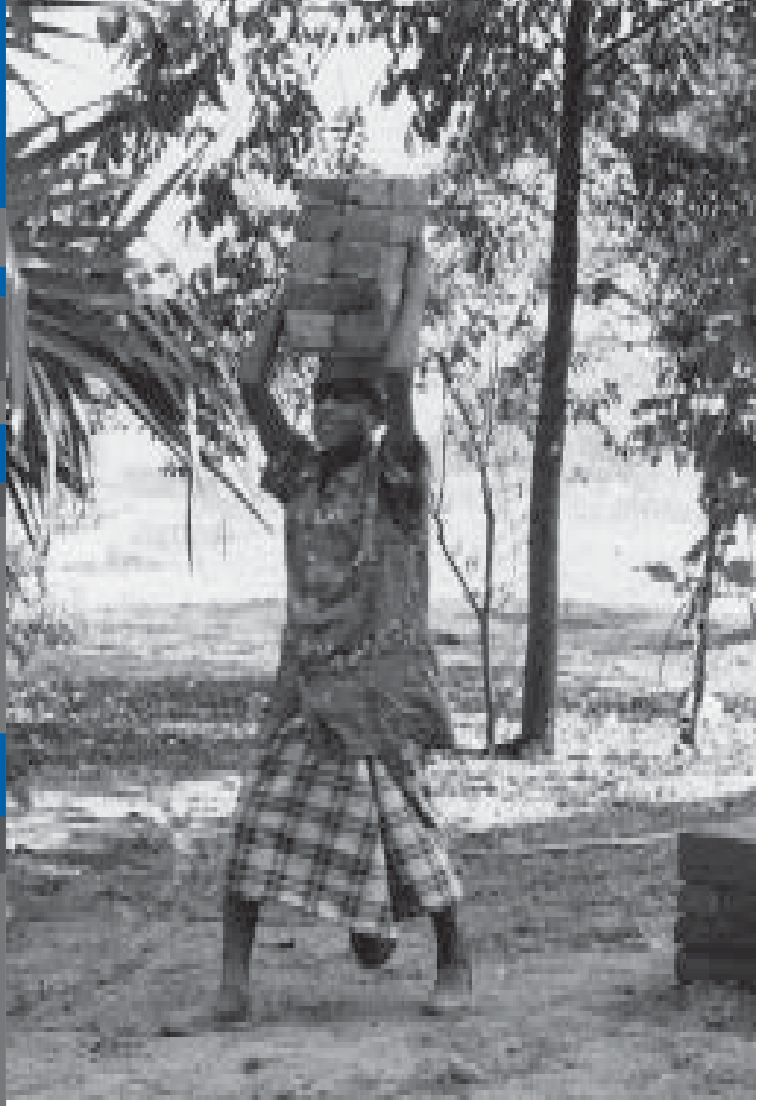
reduce poverty through promoting and improving health will be missed. The PRSP process is in a relatively early stage. There is still an opportunity to influence this trend by rewriting them. If nothing is done, PRSPs will guide development in developing countries, and it will be extremely difficult and very expensive to change course at mid-stream when adverse health impacts will likely be felt.

WHO recommends the following in reviewing and rewriting PRSPs:

- A conceptual change in the understanding of health's contribution to development—from a basic service that helps mitigate the impact of poverty, to a pre-requisite of growth and poverty reduction.
- Health outcomes must be distinguished from the provision of health services. The latter are necessary, but not sufficient conditions to ensure the health of the poor. Explicit health objectives need to be incorporated into other sectors that influence, and are influenced by health.
- Ministries of Health should take a more active role in the development of PRSPs and other poverty reduction strategies. This will require improved capacity within health



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The Doha Declaration represented a political victory for developing countries. It is a strong statement that provides a degree of security for developing countries in adopting measures necessary to meet public health objectives without the fear of costly legal battles.

ministries and more openness among those leading the PRSP process.

• Health and health-related programs must be adequately and equitably financed. This means greater resource allocation for health, and a shift of resources within the health sector to favor the poor.

The TRIPS Agreement and the Doha Declaration

The WTO Ministerial Conference in Doha in November 2001, for the first time, noted with concern the negative impact of the TRIPS (Trade Related Intellectual Property Rights) Agreement on the prices of, and access to essential drugs in developing countries. The Ministers' response to the concern was the Doha Declaration on the TRIPS Agreement and Public Health, which was unanimously adopted.

The Doha Declaration represented a political victory for developing countries. It is a strong statement that provides a degree of security for developing countries in adopting measures necessary to meet public health objectives without the fear of costly legal battles. These measures include provisions on:

• Compulsory licensing – governments could grant licenses to local manufacturers to initiate generic drugs competition even while drugs remain on patent,

• Government use provisions that enable governments to use any patented drug, without prior negotiation with the patent holder, conditioned only on payment of a reasonable royalty to the patent holder, and

• Parallel importation, which allows a country to import patented drugs from other countries where the drug's patent has expired. These imports are permissible without the permission from the patent holder.

One problem facing developing countries with no capability for manufacturing pharmaceuticals is their inability to import low-priced generic drugs. The WTO Ministerial Conference thus instructed the Council for TRIPS to find an expeditious solution to this problem by the end of 2002. Unfortunately, the council has not been able to find a solution due to the objections of some member states.

Despite this setback, developing countries should proceed to enact national legislation on intellectual property rights, with adequate provisions for the three measures provided for in the Doha Declaration.

The following two documents provide guidelines to aid developing countries enact legislation with adequate provisions for these safeguards.

1. Implications of the Doha Declaration on the TRIPS Agreement and Public Health. By Carlos M Correa, June 2002 – Health Economics and Drugs, EDM Series No 12, WHO, Geneva

2. Manual on Good Practices in Public Health Sensitive Policy Measures and Patent Laws Third World Network, Penang, Malaysia, March 2003 HA

THE PEOPLE'S CHARTER FOR HEALTH

On December 4-8, 2000, several international organizations and civil society movements, NGOs women's groups and other groups committed to the principles of primary health care organized the People's Health Assembly, which took place at GK Savar in Bangladesh. About 1453 participants from 92 countries came to Assembly.

At the Assembly, the participants reviewed their problems and difficulties, shared their experiences and plans, and formulated and endorsed the People's Charter for Health. The Charter is now the common tool of a worldwide citizen's movement committed to making the Alma-Ata dream a reality.

We call upon all individuals and organizations to join this global movement and invite others to endorse and help implement the People's Charter for Health.

For more details and full view of the document, you may visit www.phmovement.org

VISION

- A world with equity, ecologically sustained development and peace
- A world in which a healthy life for all is a reality
- A world that respects, appreciates and celebrates all life and diversity
- A world that enables the flowering of people's talents and abilities to enrich each other
- A world in which people's voices guide the decisions that shapes our lives

RECOGNIZING HEALTH CRISIS

- Economic changes affecting people's health and access to health/social services
- Poverty and hunger increasing
- Gaps between rich and poor nations widened; inequalities within countries increasing
- Large proportion of the population lack access to basic needs (food, water, sanitation, land, shelter and education)
- Planetary resources being rapidly depleted
- Upsurge of conflicts/violence
- The world's resources increasingly concentrated in the hands of few who strive to maximize their profit
- New economic/political policies affecting lives, livelihoods, health and well-being of people in south and north
- Public services deteriorating, unevenly distributed and inappropriate
- Privatization undermining access and equity principles

PRINCIPLES

- Health is a fundamental human right
- Primary health care (1978 Alma Ata Declaration) as the basis for policy
- Government's fundamental responsibility to ensure access and quality
- People and people's organization is essential to the formulation, implementation, evaluation of health programmes
- Political/economic/social/environmental factors are primary determinants of health and must get top priority in policy making
- Action at all levels to tackle crisis - individual, community, national, regional and global

COMMUNITY HEALTH PROGRAMS: SOWING THE SEEDS FOR PRIMARY HEALTH CARE

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The Martial Law era of the 1970's was undoubtedly one of the darkest periods in Philippine history. The country's economy was at its lowest, and human rights violations by the State tried to suppress public dissent. It was not surprising, therefore, that the health of the people suffered; malnutrition, tuberculosis, and other so-called diseases of poverty were rampant.

Responding to this scenario, the Rural Missionaries of the Philippines organized a Health Team composed of three nuns from different congregations – Sr. Xavier Marie Bual of SPC, Sr. Mary Grenough, MM, and Sr. Eva Varon, MMS. The team began to form community-based health programs by training community members themselves. Volunteers were given basic health training so they could act as the community's first line of defense against illness. The seed for community-based health programs (CBHP) was thus planted.

It was an uphill climb for the Health Team and the volunteers as they had to go against superstitious beliefs, patronage politics, and crippling poverty. The CBHP pioneers thus became painfully aware that ill health is invariably linked to the prevailing socio-economic conditions.

They began to question why the food producers themselves were the most malnourished, why workers toil in sub-human conditions for hours. They then assessed their approach, and decided that to improve the health of the people a holistic approach must be adopted. They, together with their early co-workers, pioneered the CBHP concept in response to the systemic economic, cultural and political problems plaguing the country. As a holistic approach to health care, CBHP targets the overall well being of the people, not just by treating their diseases but by raising their social awareness and action as well. This was done by helping develop people's organizations within communities.

Working with the Catholic Bishops' Conference of the Philippines' National Secretariat for Social Action, the Health Team conducted a survey on the health needs and capacities of the different dioceses throughout the country. From the results, they picked three areas for the pilot

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programs – the Ilagan Diocese in Isabela for Luzon, the Palo Diocese in Leyte for the Visayas, and the Iligan Diocese in Lanao del Norte for Mindanao. From its humble beginnings the idea caught on, attracting many health professionals and other volunteers who offered time and services to spread the concept. There are now 53 member programs providing health services throughout the country.

One of the challenges of CBHP work is teaching abstract health concepts to peasants, the majority of whom are unable to finish even their primary schooling. Community health workers (CHW) and health professionals have learned to adapt to the situation. Lessons have to be simplified and new concepts must be related to the life and experience of the trainees. In some cases, symbols instead of words are used to convey medical concepts.

For example, a CBHP program used zigzag lines and a thermometer to teach the concept of fever to *lumads* (highland-dwelling people of Mindanao). An upward zigzag line drawn beside a thermometer was used to convey high temperature. A lumad patient came to the clinic one day holding a referral form containing several upward zigzag lines and a thermometer. He explained that the lumad CHW who saw him diagnosed him as having typhoid fever – a symptom of which is recurring fever, thus the recurring zigzag lines. A doctor later confirmed the CHW's diagnosis.

CBHP work also has its share of danger. Working with the poor and the marginalized, CHWs and CBHP staff are often accused of being members of insurgent groups. There have been several incidents where the military would raid a clinic looking for subversive materials. For the staff, it is a reality that they have to deal with. Dr. Gene Nisperos, a community doctor in Bukidnon, says that in such cases they rely on the help of the community in which they serve. "You have to have trust in them," he asserts.

Despite these challenges, CBHP work is highly fulfilling. There is nothing more rewarding than seeing previously timid peasants suddenly standing up for their rights, or witnessing a barely educated housewife teach health education or perform minor surgery.

Community involvement is a testament to the success of the CBHP approach in empowering the people. This was demonstrated by a community in Surigao del Sur. Vicky Undangan, a CHW from the town of San Isidro, had to attend a six-day training on anatomy, parasitism, and tuberculosis. However, her husband had a kidney infection and was unable to attend to their children. Realizing that the lessons Vicky would learn in the training would benefit the entire community, her neighbors offered to look after her family while she attended the training.

CBHP work has never been easy, but testimonies of empowerment and community action make all the effort worth it. The road to good health and a just society remains long and bumpy, but so long as people are empowered and united in a common goal, the destination can be reached. HA

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SARS, HIV / AIDS AND PRIMARY HEALTH CARE

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TIME MAGAZINE

When the SARS (Severe Acute Respiratory Syndrome) epidemic broke out early in 2003, the international press mainly blamed China for suppressing news about the outbreak, and therefore allowing the disease to spread rapidly.

No doubt there was a cover-up, but a focus on the Chinese government's censorship for the spread of SARS (as well as HIV/AIDS) often becomes, itself, a cover-up of sorts for deeper inadequacies in health care, not just in China but throughout the world.

Peter Goff, writing in Hong Kong's *South China Morning Post* (May 4, 2003), says it all in his article's title: "Virus exposes the weakness of China's health care". Goff describes how China's health care system has, reflecting its shift to a free market economy, become increasingly fragmented, decentralized, and less and less responsive to people's health needs.

Reading Goff's article reminded me of how China had, in fact, been one of the most important role models for health professionals looking for an alternative health care system in the 1960s and 1970s. Long before Alma-Ata and its endorsement of primary health care, China's system of barefoot doctors had fascinated health care workers throughout the world, especially in developing countries.

The system of barefoot doctors involved the training of often illiterate peasants to handle preventive and curative health care. The training was quite extensive, including minor surgery. *A Barefoot Doctor's Manual,* produced for these frontline workers, was so comprehensive and impressive that it was translated into other languages, including an English version by the US National Institute of Health. Other programs produced their own manuals, a very good example of which was David Werner's *Where There is No Doctor,* originally produced in Spanish *(Donde no hay doctor)* for Mexico, which was also translated into many languages.

The barefoot doctor was "reincarnated" in many different versions in other countries, from community health workers to *promotores de salud* (health promoters), but the training programs were based on similar principles: trust people to learn about health so they can deal with health care issues.

There were, of course, variations in the range of roles of these health workers. In some places, the health workers were trained mainly to handle health work, often acquiring very specialized skills. Back in 1983 I visited Werner's program in Mexico and found health workers who could do dentistry, physical rehabilitation and other highly specialized health work.

In other programs, notably those in the Philippines, the emphasis was on training health workers for community organizing and mobilization. These programs saw health workers as more important for raising fellow villagers' consciousness about the structural causes of ill health – from the lack of safe water supplies to landlessness – and to organize for their rights.

Whatever the approach used, the Chinese barefoot doctor model saw villagers themselves as frontline workers, forming the most important defense against disease. These health workers were the heart of primary health care, and the vision here was that a strong primary health care infrastructure would form the foundation for building all the other levels of a health care system.

There were no illusions, certainly, about barefoot

TIME MAGAZINE

doctors or community health workers handling all health care needs. Health professionals continued to be seen as essential to health care; in fact, the idea here was that primary health care and community health workers could tackle much of health education and preventive health care, freeing health professionals to give more time to curative health care and some of the more difficult tasks in medicine.

Moreover, and this was crucial to the Chinese health care system, the corps of community workers would function to alert authorities to new health problems, initiating whatever remedial measures they could assume while referring difficult cases to other levels.

The situation in China has changed drastically; the barefoot doctors system has now completely disappeared. Initially, when Deng Xiao Ping first initiated market reforms in the late 1970s, he was said to have ordered that barefoot doctors be given shoes, a metaphorical remark about upgrading their skills. It seems, though, the barefoot doctors have been phased out.

The changes in China's health care system have resulted in many problems, mainly in terms of equity. Rural areas, previously covered by primary health care, now have very little. Goff's article notes that rural areas, while accounting for 70 percent of China's population, receive just 20 percent of the health care budget. The World Health Report 2000 ranks China 188th out of 191 countries in terms of fairness in funding the health sector.

It is not surprising then that there are emerging gaps between rural and urban child mortality rates. While the western frontier province of Xinjiang has 68 deaths per thousand live births, the rates are ten times lower in Beijing and Shanghai.

China today has one of the highest economic growth rates in the world, but the growth is terribly uneven, with widening inequity. While city hospitals will have gleaming new state-of-the-art equipment, general standards for health care, even within the cities themselves, have declined.

It is in this context that one can understand why SARS broke out so rapidly, and furiously, in China. Epidemiologists are now quite certain that SARS first broke out in Guangzhou, probably in one of the cities. "City" should be used here with some qualification – Chinese cities will have a very urbanized center but sprawl out to include many very rural areas. The problems associated with market reforms all converge in these cities. With the neglect of rural areas, migrants flock to the cities, straining social services. Health problems are inevitable, not just because of the crowded living conditions and inadequate health services but also because the migrants come in from rural areas with little health education – the result of the dismantling of primary health care.

It is not surprising that as SARS spread through China, it did so with much more ferocity in poorer provinces, notably Jiangsu and Inner Mongolia. Mortality rates in these provinces were much higher than in Beijing and other urban areas affected by SARS.

Historians dislike "what if" scenarios, but in public health it is often useful to speculate as to what could have happened if health care services were in place when a disease first breaks out. Easily, one could speculate that if SARS had broken out in China when primary health care was stronger, there would have been more factors favoring containment of the outbreak: quick notification, health education, and instituting preventive measures including village quarantines. Instead, what we saw was confusion and chaos, "witch hunts" that sent patients underground, and people trying all kinds of quack remedies.

To some extent, the SARS outbreak stands in sharp contrast to the way HIV/AIDS has been handled. Responses to HIV/AIDS in many countries have taken a community-based approach more similar to that of primary health care. The emphasis has been on mobilizing families, communities and people living with HIV/AIDS to handle their needs. We have seen very powerful organizations of people living with HIV/AIDS lobbying against discrimination and stigma, and fighting for access to medicines. People suspecting they have been infected have actually been encouraged to come out to get tested, knowing there are support groups that will help. HIV/AIDS organizations have also been active in bringing health education to the community level, often working with very marginalized groups such as sex workers.

The HIV/AIDS pandemic is of course very serious but one can say, with confidence, that had it not been for the more community-based approaches, HIV/AIDS would have spread much more rapidly. Sadly, China provides a negative example, with HIV/AIDS spreading like wildfire. Again, the international press has focused on the suppression of news about HIV/AIDS spread. The suppression is really only a symptom of a more serious problem: panic and fear amid the inability to respond to the disease at the community level.

We see many other public health problems where primary health care can make a difference. Unfortunately, many countries are opting to use hospital-based approaches, emphasizing concepts like "surveillance" (mainly mass testing) and "patient compliance" (as in tuberculosis' direct observed therapy, short-term) rather than empowering communities to fight disease and promote health. HA

HEALTH ALERT Asia Pacific Resource List

Questioning the Solution: The Politics of Primary Health Care and Child Survival, 1997 by D Werner, et al. Analyzes why 13 million children die every year from preventable causes. It also challenges conventional Primary Health Care and Child Survival Strategies. Available from HealthWrights, 964 Hamilton Ave., Palo Alto, CA 94301, USA. Email healthwrights@igc.org

The Life and Death of Primary Health Care, or, The McDonaldization of Alma Ata, 1993. by D Werner. Gives a coherent history of the three major attacks on PHC since Alma Ata: Selective Primary Health Care, User Financing and Cost-Recovery Schemes and the World Bank's Investing In Health Report. Talk given to Medical Aid for the Third World. Reprinted in Third World Resurgence. Email twnet@po.jaring.my. www.twnside.org.sg

Primary Health Care: Medicine In Its Place, 1993 by J McDonald. Traces the development of Primary Health Care since its inception at Alma Ata in 1978 to the present, providing strong arguments for the rationale of PHC. Emphasizes the need for equity and strong community participation. Available through Kumarian Press, 630 Oakwood Ave., Suite 119, West Hartford, CT 06110-1529, USA.

The State of World's Children by UNICEF. Annually updates progress in child survival. Has useful statistics and graphs on health, education and economic indicators in most of the world's countries with year by year comparisons. Available in English and Spanish at US$12.95 from publications@un.org.

Alma-Ata Revisited by DA Tejada de Rivero, 2003. Perspectives in Health 8(2):3-7. The author and general coordinator of the International Conference for Primary Health Care in 1978 recollects the event and its historical context in its original sense. However, the change in the global political and economic scenario completely contradicted and distorted the very sense of primary health care. The author now calls for Alma Ata II. Available from PAHO, 525 Twenty-third Street, NW, Washington, DC 20037, USA. www.paho.org

A Call for Action: Primary Health Care and Women's Reproductive and Sexual Rights, 2003. An advocacy tool in promoting comprehensive primary health care as a model for achieving health for all, particularly health for women. This pamphlet is available from Women's Global Network for Reproductive Rights (WGNRR), Vrlikstraat 453 D, NL 1092 TJ Amsterdam, The Netherlands. Email office@wgnrr.org , www.wgnrr.org.

Towards the People's Health Assembly Book Series: 1) What Globalization does to People's Health; 2) Whatever Happened to Health for All by 2000 AD?; 3) Making Life Worth Living; 4) A World Where We Matter; 5) Confronting Commercialization of Heath Care. Published by The National Coordination Committee for the Ian Swasthya Sabha. Available for Rs. 20.00@ from South Vision, 6, Thayar Sahib II Lane, Chennai – 600 002, India.

25 Years of Commitment and Service to the People – Onward with the Struggle for Social Change, 1998. Describes how CBHP started in the Philippines as an alternative approach to health care especially in the rural areas and how it became "a means to initiate social transformation." Available from Council for Health and Development (CHD) 3rd Fl. CDRC Building 72-A Times St., West Triangle, QC, Philippines. Email chd@compass.com.ph, www.compass.com.ph/~chd

The Right to Health, 2002. Presents the concept of "right to health" in a comics format, showing different races and cultures. Describes how empowerment plays a great role to achieve right to health especially for children. Available from Health and Human Rights, Strategy Unit, Director-Generals' Office, World Health Organization, 1211 Geneva, 27, Switzerland. nygrenkrugh@who.int, www.who.int/hhr

The Struggle for Health : Problems and Solutions: Reflections from the South, [2003.] A compilation of stories and critics analyzing the 25th year anniversary of Alma Ata Declaration and why Health for All 2000 was still not "patently achieved." Describes different developing country situations especially their struggle towards health for all. Available from IPHC, Apartado No. 6152, Managua, Nicaragua.

www.lists.kabissa.org/mailman/listinfo/pha-exchange

PHA-Exchange is an electronic discussion forum created to continue with the `networking and sharing of experiences to unite the commitment in the struggle for people's health. It evolved from the People's Health Assembly held in Bangladesh in December 2000.

www.phmovement.org

The goal of the People's Health Movement (PHM) is to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities. The People's Health Movement aims to draw on and support people's movements in their struggles to build long-term and sustainable solutions to health problems.

www.haiweb.org

Website of Health Action International – a non-profit global network of health, development, consumer and other public interest groups in more than 70 countries working for a more rational use of medicinal drugs. Campaigns for better control on drug promotion and the provision of balanced, independent information for prescribers and consumers.

HEALTH*alert*

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