

## **An Assessment of Primary Health Care in the Caribbean Pre and Post Alma Ata Declaration and A way Forward**

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### **ABSTRACT**

*In a sense the very positive primary health care (PHC) experience of the Caribbean pre-dated the 1978 declaration of the Alma Ata. Prior to the 1978 declaration, many programmes in a number of Caribbean countries were executed with a PHC bias. This paper presents a review of PHC programmes in a number of Caribbean countries during 1950 and 2010 and presents a comparison of two actual health status indicators with pre Alma-Ata trend data. The results suggest that the method of implementation of PHC and other political and economic events which occurred at that time did not deliver on expectations.*

**Key Words:** Caribbean, Health Unit System, Alma-Ata, Comprehensive Primary Health Care

### **1. Introduction**

The official declaration of primary health care (PHC) as the vehicle for delivering an acceptable level of “health for all” was made at the Alma-Ata Conference in Kazakhstan (formerly of the Soviet Union). At that time the deadline for achieving such a noble feat was the year 2000. This brought to the fore the ambitious vision of “Health for all by the year 2000.” This 1978 Alma-Ata Declaration declared the following:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.” (WHO, 1978, Article VI)

The records show that variants of this model of universal access to basic health services already existed in many developing countries. Community-Based Health Programmes that were basic but comprehensive were being implemented in a number of developing countries; China<sup>1</sup>, Philippines, Tanzania and Latin America and the Caribbean and with great success and recognition (Sinha, 1988; Werner & Sanders, 1997). Health status data in the Caribbean for the pre Alma-Ata period show commendable improvements in both life expectancy and infant mortality. Although these indicators continued to improve in the post Alma-Ata period, the rate of improvement was less than was expected. A number of questions can be asked in order to find answers for this apparent slow down. What types of primary health care programmes were in operation in a number of Caribbean countries prior to the Alma Ata Declaration? What factors limited the effectiveness of PHC programmes after the Alma-Ata Declaration? What is the way forward for the Caribbean?

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<sup>1</sup> The “barefoot doctors” of China were mixed groups of village health workers who lived in the community they served. This programme was part of the expansion of rural medical services in Communist China in the 1960s and 1970s.

## 2. The Pre Alma-Ata Period

### 2.1 Public Health Programmes: The Health Unit System

The abolition of slavery brought many new challenges to the ex-slaves, of the Caribbean; among them obtaining health care without the aid of planters. Though many looked to the Colonial governments for such provision, assistance was curtailed by financial problems and inertia. However, public sector involvement began to germinate in the latter portion of the 19<sup>th</sup> century. The Colonial governments established General hospitals in the more developed areas and district medical officers, dispensers and dispensaries in rural areas. Unfortunately the care of the sick in hospitals became the main focus of the health services in these British colonies while many diseases continued to affect many communities (Sinha, 1988). Public Health programmes were introduced in the English-speaking Caribbean in the early part of the 20<sup>th</sup> century. Jamaica established a Hookworm Commission in 1919, the Bureau of Health Education in 1926, the School for Sanitary Inspectors in 1927 and conducted both malaria and tuberculosis surveys in 1928 (Sinha, 1988). In spite of these early public health programmes the emphasis remained on the curative services through hospitals and out-patient type care which resulted in the neglect of programmes geared towards prevention of diseases and those which serviced rural areas (Stockdale Report, 1943). A solution was urgently needed to improve the poor health condition of the Caribbean population.

**Table 1: Death rates (per 1000 population) and infant mortality rates (IMR) (per 1000 live births) in selected Caribbean territories, in 1928, 1932, and 1937**

Territory	Statistics	1928	1932	1937
Barbados	Death rate	30.1	19.0	18.5
	IMR	331.0	198.0	217.0
British Guiana	Death rate	27.9	21.1	21.9
	IMR	185.0	139.0	121.0
Jamaica	Death rate	19.7	17.2	15.3
	IMR	157.0	141.0	118.5
Nevis	Death rate	19.4	11.1	14.9
	IMR	286.6	102.2	107.1
St. Kitts	Death rate	39.8	27.5	36.5
	IMR	308.3	166.7	209.0

Source: Moyne L. West Indian Commission Report (1945)

**Table 1** shows that in all five territories infant mortality rate (IMR) exceeded 100 per 1000 live births while two of the five countries experienced rates in excess of 200 deaths per 1000 live births. Of note also is the pattern of increase in the IMR between 1932 and 1937 in both Barbados and St. Kitts.

Public policy on the future of health care in the Caribbean was articulated in the Sir Frank Stockdale Report for 1940-1942. The establishment of 'health unit systems' was proposed in an attempt 'to promote the health of the whole population while continuing adequately for the care of the sick' (Stockdale Report 1943). The Health Unit System was established in Caribbean in 1942. It ushered in a new era of health care in the region. Although its implementation was severely curtailed by inadequate financing and inexperienced personnel, it was founded on sound principles and formed the foundation for the establishment of the "extensive network of health services in the Caribbean" (Sinha, 1988, p.127).

A 'health unit' was designed to provide health services to a small community. The services were to be similar to those provided by a more developed urban health-department, but it was to be characterized by simplicity and frugality. The typical unit was led by a Medical Officer of Health with a supporting staff of Sanitary Inspectors, Health Visitors, Nurses and Midwives (Sinha, 1988). This group of health care workers was later enhanced in the 1960s and 1970s<sup>2</sup> by workers such as public health nurses, nutritionists, school dental nurse and dental assistant, community health aides and nurse practitioners (Sinha, 1988; Mullings and Paul 2007). Sinha (1988) also identified that the functions or programmes undertaken by such a unit included: ante-natal and maternal care; child welfare; school medical work; control and prevention of endemic diseases, smallpox, typhoid, dysentery; venereal diseases, yaws, tuberculosis, leprosy, malaria, and helminthiasis; sanitation and hygiene; good housing and health education.

<sup>2</sup> During the 1960s and 1970s many countries in the English speaking Caribbean acquired their independence from European colonizers and this much desired status was accompanied by the burning desire to improve the standard of healthcare and other services.

The Health Unit System was intended to be multi-sectoral, having links to social welfare, agriculture and education in order to improve the living standards in the rural communities. The programmes in the various islands were initiated with the establishment of demonstration centres. Similar health centres were built in other territories. However in spite of war concerns at that time, a number of health centres were built and personnel trained and employed during the 1940s and 1950s. The programmes of these centres mainly focused on “maternal and infant welfare, improvement of sanitation and health education.” (Sinha, 1988, p. 127). Through this system infant mortality declined but was still relatively high in the Caribbean<sup>3</sup> (Sinha, 1988). A notable contribution to health care during this period in the Caribbean was the establishment of the West Indies School of Public Health geared towards the training of public health nurses and inspectors. In addition doctors were trained at the newly established University College of the West Indies (Mullings and Paul, 2007). These two efforts greatly contributed to the primary health care system that was being set up.

The Health Unit System was an innovative approach to the provision of health care and was supplemented by vertical programmes aimed at controlling some of the endemic diseases. Therefore by the commencement of the 1960s the efforts of organizations and institutions such as the Colonial Development and Welfare Funds, PAHO/WHO, UNICEF, UNESCO and the Rockefeller Foundation were able to substantially reduce the incidence of diseases such as malaria, yellow fever, hookworm, tuberculosis, smallpox, syphilis and yaws (Sinha, 1988). The 1960s was the decade of national independence and internal self-government for a number of English-speaking Caribbean countries. Eager to throw off Colonial shackles, and to meet the needs of all their peoples, national governments embraced and adopted the more comprehensive system of health care. Hence as early as 1962 Jamaica focused on programmes such as improving water supplies, immunization of children against communicable diseases and nutrition in its inaugural five year plan (Sinha, 1988). In addition around the mid 1960s a number of governments in the Eastern Caribbean proposed the adoption of an “Integrated Health Programme.” This programme included the provision of basic health needs to the community and human resource development at both the administrative and health care staff levels to ensure the best use of resources and the implementation of the programme (Sinha, 1988; Mullings and Paul, 2007). However in the 1960s what could be observed were improvements in both the quantity and quality of services and in the utilization of the available health centres (Sinha, 1988).

The establishment of a number of regional and national institutions and specialized units occurred in several countries by the end of the 70s. These aided in the support and improvement of the growing health care services. The work of the PAHO/WHO funded Caribbean Food and Nutrition Institute (CFNI) in Jamaica and Trinidad and the Caribbean Epidemiology Centre (CAREC) in Trinidad as well as the government funded National Nutrition Centre in Barbados assisted greatly in the battles against malnutrition and endemic diseases in the region. The work of these agencies spread throughout most of the islands. By the end of the 1970s Caribbean governments had undertaken programmes in human resources development, established specialized institutions and units and implemented a number of strategies which were specifically geared towards further improving both maternal and child health in the region (Sinha, 1988).

### ***3. The Alma-Ata Declaration and primary Health Care***

This 1978 declaration is often described as a landmark event for primary health care. This PHC approach was proposed and unanimously embraced as the model for global health policy by 3000 delegates from 134 governments and 67 international organizations (Cueto, 2004). The Conference organized by the World Health Organization (WHO) and the UNICEF reaffirmed that the enjoyment of health was a basic right of every human and that health constituted more than just the absence of disease or illness but included the achievement of total physical, mental and social wellbeing. The Alma-Ata Declaration outlined eight essential components of PHC. A close examination of these components reveals striking similarities between the Health Unit System already in place in the Caribbean and the presumably new approach outlined in the declaration. A comparison of these two is presented in the Table 2.

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<sup>3</sup> The Development and Welfare in the West Indies, 1957 report highlighted the fact that in four countries infant mortality rates were four times higher than in the United Kingdom and five times higher in a fifth territory.

**Table 2: Comparison of the operation of Health Unit System (1942) and Primary Health Care Approach (1978)**

<ul style="list-style-type: none"> <li>• Health Unit System</li> <li>• Coverage of maximum population through health centres and sub-centres.</li> <li>• Health centres managed by medical officer of health supported by a variety of public health workers of different categories managing clinics.</li> <li>• Sub-centres with resident nurses/midwives performing simpler jobs.</li> <li>• Community visits and work in the community.</li> <li>• Arousing health consciousness in local people and seeking their participation.</li> <li>• Link with social welfare, agriculture, education and others.</li> </ul>	<ul style="list-style-type: none"> <li>• Primary Health Care: Alma-Ata Approach</li> <li>• Complete coverage through health centres and sub-centres in order of complexity of services utilizing different categories of health staff.</li> <li>• Community participation</li> <li>• Intersectoral coordination</li> <li>• Appropriate technology</li> </ul>
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Source: *Development and Welfare in the West Indies, 1940-42, and Report of the International Conference on Primary Health Care, Alma-Ata, 1978*

**Table 3: Comparison of the Functions of Health Unit System (1942) and Primary Health Care Approach (1978)**

HEALTH UNIT SYSTEM	PRIMARY HEALTH CARE: Alma-Ata Approach
<ul style="list-style-type: none"> <li>• Ante-natal and maternal care</li> <li>• Child welfare</li> <li>• School medical work</li> <li>• Control of endemic diseases.</li> <li>-Venereal disease, yaws, tuberculosis, leprosy, malaria, helminthiasis <ul style="list-style-type: none"> <li>• Control of enteric diseases</li> <li>-smallpox, typhoid and dysentery</li> </ul> </li> </ul> <p>Sanitation and hygiene: covering housing, latrines, scavenging and refuse disposal, water supplies, food and food handling</p> <p>Health education</p>	<ul style="list-style-type: none"> <li>• Maternal and child health including family planning</li> </ul> <p>Promotion of food supply and proper nutrition</p> <ul style="list-style-type: none"> <li>• Prevention and control of locally endemic diseases</li> <li>• Immunization against major infectious diseases</li> <li>• Control of common diseases and injury</li> <li>• Provision of essential drugs</li> </ul> <p>Adequate and safe water supply and basic sanitation</p> <p>Education concerning prevailing health problems and methods of preventing and controlling them.</p>

Source: *Development and Welfare in the West Indies, 1940-42, and Report of the International Conference on Primary Health Care, Alma-Ata, 1978*

Tables 2 and 3 respectively show the striking similarities between the health care structure and health care programmes which existed in many Caribbean countries before the Alma -Ata Declaration and those which were proposed in the declaration. The obvious expectation was that primary health care would improve the health status, not of some, but of all the world's population, enabling all to live socially and economically productive lives. What impact did the introduction of PHC have on the health status of the Caribbean population? We will look at two health status indicators to determine the efficacy of the PHC programmes introduced after 1978 in the Caribbean.

#### 4. Health Status Indicators

Life expectancy at birth is regarded as one of the key indicators of a nation's health status (Gafar, 2005).

Life expectancy at birth estimates the average number of years of life a new born can expect to live if the current patterns of mortality at the time of birth were unchanged over the child's life (WHO, 2006). The mean length of life in the Caribbean increased from 53.3 years in the period 1950-1954 to 70.5 years in the 2000-2004 period, a difference of 17 years (Table 4). In most cases life expectancy in the Non-English speaking Caribbean countries with the exception of Haiti exceeded that of the English speaking Caribbean countries by the 2005-2010 period. Barbados experienced about 20 years increase in life expectancy over the period rising from 57.2 years in 1950-1954 to 77.2 years in 2005-2010. This was the largest increase for the English speaking Caribbean. The level of longevity achieved in the Caribbean by 2005-2010 is commendable, it exceeds the world average but this level is equivalent to that enjoyed in North America thirty years before (Guzman et al., 2006)<sup>4</sup>. This means that in the Caribbean countries there is still room for improvement in those factors which contribute to increasing life expectancy. These include living conditions such as housing, sanitation and nutrition; educational attainment and the organization and equipping of the health system (IADB and PAHO/WHO, 1996). Movements in two indicators affect life expectancy in any country. These are infant mortality rates and the adult mortality rates. It is certain that a reduction in either or both will increase the life expectancies in the countries of the Caribbean (Gafar, 2005). Apart from other social and economic factors greater emphasis on comprehensive primary health care has been identified as one of the factors to reduce both infant and adult mortality rates (ECLAC, 2004; Gafar, 2005).

Infant mortality rate indicates the rate at which babies die during the first twelve months of their lives measured per 1000 live births (WHO, 2006). Table 5 shows that in the Caribbean the infant mortality rates have declined dramatically since the 1950s. In 1950-1954 the infant mortality rate for the entire Caribbean region averaged over 100 per thousand and even exceeded 200 per thousand in Haiti. However over the next fifty year period the rate decreased rapidly, moving from approximately 125 per thousand in 1950-1954, to roughly 35 per thousand in 2005-2010 (Table 5). Of the English speaking Caribbean Barbados again experienced the greatest improvement in infant mortality status, with rates falling from 132 per thousand in 1950-1954, to 10 per thousand in 2005-2010. A number of factors have contributed to this decline over the decades. Guzman et al. (2006) have identified some of the factors responsible for reducing infant mortality in Latin America and the Caribbean as: "the development of low-cost, high-impact mother-and-child programmes; focusing mainly on primary health care (massive vaccination campaigns, oral rehydration, medical follow-up of children), has coincided with major socioeconomic and demographic changes such as the extension of basic services (notably drinking water and sewerage), improved education and lower fertility" (Guzman et al., 2006, p. 552).

**Table 4: Caribbean: Life Expectancy at Birth by five-Year Period, 1950-2010 (male and female)**

CARIBBEAN REGION	Life expectancy at birth (years)											
	1950-1954	1955-1959	1960-1964	1965-1969	1970-1974	1975-1979	1980-1984	1985-1989	1990-1994	1995-1999	2000-2004	2005-2010
<b>Caribbean</b>	52.3	55.5	58.5	61.1	63.1	64.4	65.4	66.8	68.0	69.4	70.5	71.7
<b>Netherlands Antilles</b>	60.5	64.6	66.6	68.3	70.4	72.1	73.8	74.5	74.5	74.6	75.4	76.2
<b>Bahamas</b>	59.8	62.4	64.2	65.8	66.5	67.2	68.3	69.9	69.8	69.0	71.4	73.4
<b>Barbados</b>	57.2	62.6	65.9	67.6	69.4	71.3	72.8	74.2	75.0	75.1	75.9	77.2
<b>Belize</b>	57.7	60.2	62.7	65.2	67.6	69.7	71.4	72.1	72.4	73.6	74.7	76.2
<b>Cuba</b>	59.5	62.4	65.4	68.6	71.0	73.1	74.3	74.6	74.8	76.2	77.1	78.6
<b>St. Vincent and Grenadines</b>	51.2	52.2	56.5	59.6	61.6	64.7	66.8	68.6	69.8	70.2	76.6	71.6
<b>Grenada</b>	62.6	63.1	63.6	64.1	64.6	65.0	65.5	67.4	70.7	72.6	74.3	75.3
<b>Guadeloupe</b>	56.5	61.6	64.6	65.8	67.8	69.9	72.5	73.6	75.8	77.2	78.4	79.1
<b>Guyana</b>	52.3	54.8	57.3	59.2	60.0	60.7	61.0	62.8	62.4	62.5	64.2	66.8
<b>French Guyana</b>	53.3	56.1	59.4	64.2	65.7	66.5	69.4	71.2	72.8	74.2	75.1	75.9
<b>Haiti</b>	37.6	40.7	43.6	46.3	48.0	50.0	51.4	53.7	56.2	58.6	59.6	61.2
<b>Jamaica</b>	58.5	62.6	65.6	67.5	69.0	70.1	71.5	71.0	71.3	71.2	70.9	71.8
<b>Martinique</b>	56.6	60.8	64.2	66.7	69.2	71.8	73.7	75.4	76.3	77.7	78.8	79.6
<b>Puerto Rico</b>	64.3	68.5	69.6	71.1	72.2	73.4	73.8	74.6	74.3	74.9	77.8	78.7
<b>Dominican Republic</b>	45.9	49.9	53.5	56.8	59.7	61.6	63.9	66.4	68.8	70.2	71.6	72.4
<b>St. Lucia</b>	54.1	56.8	59.7	62.5	65.3	68.0	70.5	71.0	71.4	71.5	72.5	73.7
<b>Suriname</b>	56.0	58.7	60.5	62.5	64.0	65.1	66.5	67.1	67.6	68.1	68.1	68.9
<b>Trinidad and Tobago</b>	59.1	61.8	64.9	65.4	65.9	67.0	67.7	68.6	69.1	68.8	68.3	69.4

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2008 Revision, <http://esa.un.org/unpp>

<sup>4</sup> Guzman (2006) notes that life expectancy for the Caribbean exceeds that which exists in Asia and Africa but lags behind Europe, North America and Oceania.

**Table 5: The Caribbean: Estimated Infant Mortality Rate by Five-Year period, 1950-2010 (males and Females)**

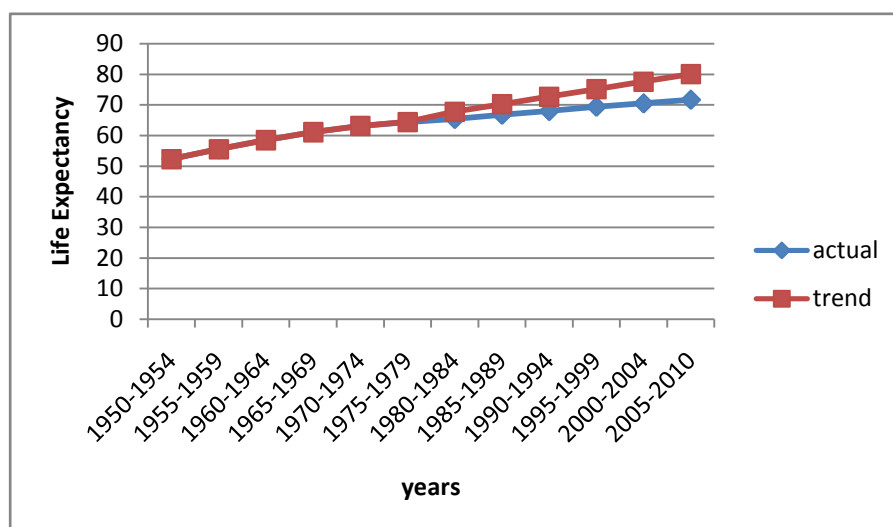
CARIBBEAN REGION	Infant mortality rate (per thousand)											
	1950-1954	1955-1959	1960-1964	1965-1969	1970-1974	1975-1979	1980-1984	1985-1989	1990-1994	1995-1999	2000-2004	2005-2010
Caribbean	124.5	110.4	93.9	82.7	73.1	69.9	65.6	57.2	49.0	41.7	38.2	34.5
Netherlands Antilles	69.0	51.0	42.0	35.0	28.0	22.0	18.0	17.0	15.1	15.5	14.0	12.8
Bahamas	78.8	56.3	48.3	41.2	38.2	35.4	18.9	16.6	16.6	13.7	12.4	9.0
Barbados	132.0	87.0	61.0	46.0	33.0	27.0	19.3	16.1	14.0	13.5	12.1	10.1
Belize	88.0	78.0	69.0	60.0	52.0	45.0	33.5	31.2	30.0	24.6	19.3	16.7
Cuba	80.6	69.9	59.4	49.7	38.5	22.3	17.4	15.9	15.3	9.6	6.1	5.1
St. Vincent and Grenadines	115.6	109.7	88.2	73.3	64.0	50.8	41.9	34.6	30.0	28.2	26.7	23.3
Grenada	60.6	58.3	56.1	53.8	51.7	49.5	47.4	39.5	26.5	20.2	15.5	13.4
Guadeloupe	79.5	60.0	48.9	44.9	38.5	31.9	24.7	22.0	9.2	8.3	7.3	6.8
Guyana	119.0	105.0	95.0	82.0	79.0	67.0	69.5	67.1	62.7	57.3	49.5	42.4
French Guyana	103.4	89.1	73.1	51.4	45.9	42.9	32.0	25.0	19.9	16.4	14.8	13.4
Haiti	219.6	193.5	170.5	150.2	134.9	130.9	120.6	107.6	91.6	74.0	69.5	62.4
Jamaica	91.9	78.3	61.4	51.6	45.0	37.0	33.8	28.7	26.9	26.5	25.9	23.3
Martinique	64.7	55.7	47.7	42.3	34.7	21.9	14.0	10.1	9.4	8.0	7.0	6.6
Puerto Rico	63.4	51.4	44.8	33.3	25.3	19.7	17.2	13.8	11.6	10.9	8.1	7.2
Dominican Republic	153.2	138.7	123.9	109.0	95.9	86.0	75.2	63.1	47.9	41.6	35.1	29.6
St. Lucia	114.6	105.3	81.1	47.7	39.1	29.3	22.7	20.1	16.9	16.7	14.6	12.6
Suriname	89.2	76.2	63.5	54.6	48.8	44.0	42.0	38.8	34.1	28.6	23.8	22.2
Trinidad and Tobago	76.0	63.0	48.0	45.6	41.1	35.0	31.4	29.1	28.2	28.8	28.9	26.0

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2008 Revision, <http://esa.un.org/unpp>.

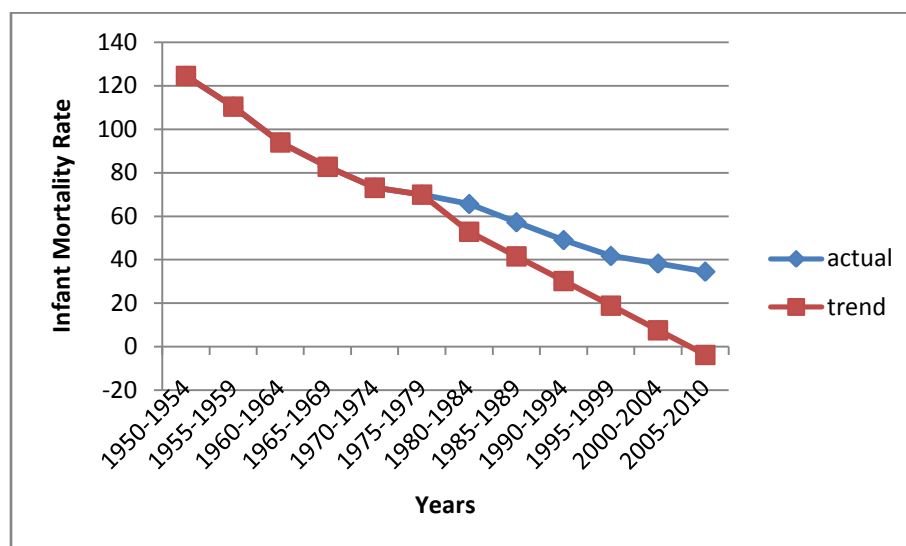
We have already indicated that the health status of the Caribbean population improved between 1950-1954 and 2005-2010. During this period, the mean length of life in the Caribbean region increased by about 20 years. Further analysis reveal that between 1950-1954 and 1975-1979, the pre Alma Ata period, the mean life expectancy for the Caribbean increased by approximately 12 years but increased only by 8 years for the post Alma Ata period, that is, between 1980-1984 and 2005-2010. This indicates that the pre-Alma Ata level of improvement was not maintained in the years following the declaration.

Figure 1 shows that if the pre Alma-Ata trend in life expectancy had continued in the Caribbean, after 1980 then the average life expectancy at birth would have exceeded that which actually existed between 1980-1984 and 2005-2010.

**Figure 1: A comparison of post Alma-Ata trend data and actual data for life expectancy at birth in the Caribbean between 1950-1954 and 2005-2010**



**Figure 2: A comparison of post Alma-Ata trend data and actual data of infant mortality rate in the Caribbean between 1950-1954 and 2005-2010.**



In Figure 2 above a similar pattern is observed when the trend is compared to the actual data. The projection is that if the pattern of reduction achieved in the Caribbean by the 1975-1979 period had been maintained thereafter then the level of infant mortality would have been lower than it is currently.

## 5. Limiting Factors

### 5.1 Reasons Identified

There are many factors which contributed to the failure of primary health care to achieve the desired goal of, health for all by the year 2000 as declared in the 1978 conference in Alma Ata. The early enthusiasm which was generated over this revolutionary approach to health care was dampened, especially in developing countries by the introduction of Selective Primary Health Care instead of Comprehensive Primary Health Care<sup>5</sup>. In addition, economic crises and the resulting structural adjustment packages; sharp reduction in public spending; political instability; lack of political will<sup>6</sup>, and emerging diseases all contributed to the missing of the target (Gillam, 2008; Werner and Sander, 1997).

### 5.2 Selective Primary Health Care

The fact is that Comprehensive PHC never got the support for a successful flight. It suffered because shortly after the Alma Ata Conference ended health experts and politicians from the developed countries began to trim the wings of PHC. They pronounced that a comprehensive or holistic approach would be impractical and too costly because of the dwindling health budgets of developing countries. Hence they focused on limited range of programmes to limited groups in the population as the strategy to bring improvement to the health statistics of these countries (Werner & Sanders, 1997; Hall & Taylor, 2003). This approach became known as Selective Primary Health Care (SPHC). It excluded the core elements required to make Primary health care comprehensive and developmental such as community participation and increased social and economic equity. PHC became concentrated mainly on reducing child mortality in the developing countries (Hall and Taylor, 2003). In 1983, UNICEF embarked upon its 'Child Survival Revolution' advocating a package of four low cost interventions known as GOBI (growth monitoring, oral rehydration therapy, breast feeding and immunization). Later, female education, family spacing and food supplements (FFF) were added to broaden the package, amidst cries that the package was too selective (Gillam, 2008; Werner and Sander 1997). A number of problems with this substitute approach resulted in PHC services being very limited in their range, coverage, and impact" (Gillam, 2008).

<sup>5</sup>In 1979 Julia Walsh and Kenneth Warren of the Rockefeller Foundation presented a paper entitled "Selective Primary Health Care: an Interim Strategy for Disease Control in Developing Countries.

<sup>6</sup> Werner and Sanders (1997) identify "the presence of political will" to meet the basic health needs of all citizens, as one of the keys, which enabled both Mozambique and Nicaragua, to carry out comprehensive PHC in the 1980s. The others identified were active popular participation and increased social and economic equity.

Hence while infant and child mortality rates declined during the decade of the 1980s there were increases in the levels of under nutrition and morbidity in many developing countries. As a result in the late 80s and early 90s the decline in child mortality rates had slowed, as observed in the Caribbean, in other countries it had halted, and even increased in a number of countries in sub-Saharan Africa (Werner and Sander, 1997). In addition the focus of Selective PHC on women and children ignored the health concerns of other vulnerable segments of the population such as the elderly and adolescents (PAHO, 2007). In addition to the narrow “vertical” public health campaigns which were carried out under the banner of SPHC, the primary health impact was also limited by the fact that the work of the Community Health Worker (CHW) was not fully appreciated and often resisted by other traditional medical personnel. Another contributing factor was that SPHC removed the important component of community participation in the planning and implementation of PHC programmes and placed the decision-making power in the hands of foreign technocrats and experts representing donors who desired “vertical, definable time-limited programs that could be changed every few years” (Hall and Taylor, 2003:19).

### **5.3 Economic Crises**

Economic problems in the decades of the 70s and 80s along with slow recovery in the 1990s also impacted negatively on the provision of health care services in general and PHC in particular in the Caribbean (PAHO, 1997). In the Caribbean the governments have generally been the principal agents in health financing. Therefore when most of the countries were faced with adverse economic growth during the 1980s along with chronic balance of payments deficits from 1970 to 1989, the governments were forced to reduce health expenditure to fulfill the requirements as outlined in the structural adjustment agreements into which they entered with international lending agencies (PAHO, 1997; Werner et al., 1997)). Structural adjustment policies led to worsening of the social and economic conditions of the Caribbean population, especially the poor. Cash strapped governments and politicians saw SPHC as “a way to reduce expenditure in health and lacked the political will to ensure that services were equitably shared and distributed. Programmes which could foster equity and benefit the poor such as water, sanitation and nutrition projects were discouraged under structural adjustment programmes. Most healthcare resources continued to be directed to the large urban-based hospitals” (Hall and Taylor 2007:19). Changes in economic conditions in the Caribbean and in other debtor countries of the Third World also resulted in the lowering of real wages, reduction in food and other subsidies as well as cuts in allocations for public health and education (Werner and Sanders, 1997). Internationally, economic changes along with political changes of the 1980s caused the Alma-Ata declaration to be criticised, distorted, taken over and restricted so that the full benefits of comprehensive PHC have not been attained (WHO, 1998).

### **5.4 Changing Health Issues**

The decade of the 80s also witnessed an epidemiological transition in the Caribbean. IADB and PAHO/WHO, (1996) states that non-communicable chronic diseases (NCCDs), cardiovascular diseases, diabetes mellitus and hypertension were responsible for the vast majority of deaths in some Caribbean countries during the 1980s. According to PAHO (1997) this trend began in the previous decade (1970s) when the Caribbean experienced a 10% increase in deaths caused by non-communicable diseases. In addition during this post Alma-Ata period some countries also witnessed a resurgence of some communicable diseases. While these re-emerging diseases were the main causes of death in some countries, it was noted that mortality from communicable diseases made a small but appreciable return to the Caribbean (IADB/PAHO/WHO 1996). In addition the Caribbean also faced the emergence of a new type of infectious disease, namely HIV and AIDS which has impacted on the mortality rate and life expectancy of the region (IADB/PAHO/WHO, 1996).

The adoption of SPHC and the resulting lack of coordination; the redundancy, overlap and waste of these vertical programmes have been identified as contributing factors to the prevalence of HIV/AIDS in developing countries among persons of the ages 20-39 (Magnussen et al., 2004). This resulted because a major shortcoming of the vertical programmes was the focus on mothers and children at the expense of other demographic groups in the population (Magnussen et al., 2004). There are other reasons why PHC initiatives did not achieve its target in the Caribbean Region. One such was those who were intended to benefit from PHC saw it as “a cheap form of health care and if they were able to, they bypassed this level to attend secondary and tertiary centres because of lack of staff and essential medicines at the PHC level” (Hall and Richards, 2003:18). This lack was also compounded by the view that the traditional western style model of medicine was the way to go at the exclusion of preventative approaches which forced the participation of people in determining their health affairs.



## **6. The Public Sector and PHC Delivery**

In the Caribbean, the public sector is the main agency responsible for providing PHC services to the population. It is therefore not surprising that Filmer et al. (1997) have identified the low quality of public sector services, provided in public health clinics as a contributing factor, to the less than expected impact of PHC on the health status of developing countries. In the Caribbean like most other developing countries the following problems have plagued health care programmes and PHC programmes are not exceptions. These include: misappropriation of scarce funds; poor treatment and ridicule of patients by medical personnel; imposition of maternity fees<sup>7</sup>; the shortage of drugs because of theft and lack of finance and the lack of accountability on the part of health care workers (Filmer et al., 1997). These conditions and others often result in low-level, rural PHC facilities being “bypassed” in favour of better public hospitals and health centres or even expensive private facilities (World Bank, 1997). It is therefore instructive to ask, what features of the public health sector in the Caribbean may have contributed to the failure of PHC. What is the way forward?

The presence of systems in the public sector to monitor and discipline health workers can aid in improving the returns on public sector spending on PHC programmes. In developing countries doctors and nurses are often seen as “health professionals” and are expected to behave professionally by delivering high quality health care even when the necessary institutional controls, legal restraint, consumer power and economic inducements are absent. This is often not the case in these poorly functioning health systems. The absence or ineffectiveness of control mechanisms often leads to poor performances and lack of professionalism among health workers (Filmer et al., 1997). The necessary controls must therefore be put in place in the Caribbean. In addition Filmer et al. (1997) also note that the threat of competition from and comparison with a large efficient private health sector would often force public sector health workers to match private sector performances. However when mobility between these two sectors is either curtailed because the private sector is small or mobility is easy because health professionals provide services in both the private and public sectors at the same time, performance in public sector often declines. In the Caribbean many health workers, including doctors and nurses, are employed in both the private and public health sectors at the same time. A solution must be found to correct this situation if better results are to be seen in PHC programmes in the region.

Often omitted from the discussion on the impact of PHC programmes, is the right of individual consumers to choose. Consumers have the right to choose between private sector and public sector health care providers and their choices often impact on the effectiveness of some PHC programmes. Governments must therefore be aware that both the presence and actions of private sector providers can affect the overall impact of their spending on PHC. Filmer et al. (1997) note that, the size of the private sector; the degree of substitutability between the public and private health care providers for curative services and the ability of the private sector to expand in response to increased earning opportunities all vary inversely with the impact of public spending. Although there may be a role for private sector provision of PHC services, there is sufficient evidence to show that the poor derive proportionately greater benefit from public spending on PHC facilities, while the non-poor derive proportionately greater benefit from spending on hospitals (Filmer et al., 1997).

## **7. CONCLUSION**

A number of factors have surfaced as barriers to the effective implementation of PHC as envisioned in 1978. We have outlined that the deliberate investment of time and financial resource on selective PHC programmes and curative, hospital based health care by governments in the Caribbean have failed to deliver on the hopes of the Alma-Ata Declaration. In addition the limited political will even political resistance to the essential pillars of PHC-participation, equity and intersectoral partnerships- derailed the delivery of what seemed possible at that time, “health for all by the year 2000.” Central to all these is the recognition that the low quality of public sector services provided in PHC facilities negatively impacted on the outcome of PHC programmes. To improve the outcomes of PHC campaigns strong social, political and institutional monitoring and incentives are required for health workers (Caldwell, 1986; Tandler and Freedheim, 1994; Heller, 1996). These can be provided by increasing community participation, a key element stated in the 1978 Alma-Ata declaration but notably absent in PHC programmes implemented (Filmer et al., 1997). In addition financing of PHC initiatives by public spending or external agencies, whether specific or comprehensive in nature, should be accompanied by policies aimed at influencing and improving implementation practices in the public health sector.

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<sup>7</sup> In some Caribbean countries growing economic problems led to the implementation of user-fee charges as a means of health financing.

What policy considerations should therefore guide the allocation of resources to PHC programmes in the Caribbean in the future? Two points must be considered:

- How do people expect the public sector to perform under existing institutional arrangements? If expectations are low then extending PHC will not impact positively on health status.
- What is the degree of responsiveness of individuals' decisions to changes in public action? This requires that PHC interventions should focus on cost effective and critical health care services. Namely, those which focus on promotion and prevention aspects of health.

In the final analysis what really matters about PHC programmes in the Caribbean is the quality of the implementation effort. There must be greater commitment on the part of Caribbean Governments to ensuring that PHC programmes provided by the public sector are well planned and executed. This emphasis on improving implementation strategies will contribute to improved expectations and greater impact of PHC programmes in the Caribbean.

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