



The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care

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I present a historical study of the role played by the World Health Organization and UNICEF in the emergence and diffusion of the concept of primary health care during the late 1970s and early 1980s. I have analyzed these organizations' political context, their leaders, the methodologies and technologies associated with the primary health care perspective, and the debates on the meaning of primary health care.

These debates led to the development of an alternative, more restricted approach, known as selective primary health care. My study examined library and archival sources; I cite examples from Latin America.

DURING THE PAST FEW

decades, the concept of primary health care has had a significant influence on health workers in many less-developed countries. However, there is little understanding of the origins of the term. Even less is known of the transition to another version of primary health care, best known as selective primary health care. In this article, I trace these origins and the interaction between 4 crucial factors for international health programs: the context in which they appeared, the actors (personal and institutional leaders), the targets that were set, and the techniques proposed. I use contemporary publications, archival information, and a few interviews to locate the beginnings of these concepts. I emphasize the role played by the World Health Organization (WHO) and UNICEF in primary health care and selective primary health care. The examples are mainly drawn from Latin America. The work is complementary to recent studies on the origin of primary health care.¹

BACKGROUND AND CONTEXT

During the final decades of the Cold War (the late 1960s and early 1970s) the US was embroiled in a crisis of its own world hegemony—it was in this political context that the concept of primary health care emerged. By then, the so-called vertical health approach used in malaria eradication by US agencies and the WHO since the late 1950s were being criticized. New proposals for health and development appeared, such as John Bryant's book *Health and the Developing World* (also published in Mexico in 1971), in which he questioned the transplantation of the hospital-based health care system to developing countries and the lack of emphasis on prevention. According to Bryant, "Large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have . . . the most serious health needs cannot be met by teams with

spray guns and vaccinating syringes."²

In a similar perspective, Carl Taylor, founder and chairman of the Department of International Health at Johns Hopkins University, edited a book that offered Indian rural medicine as a general model for poor countries.³ Another influential work was by Kenneth W. Newell, a WHO staff member from 1967, who collected and examined the experiences of medical auxiliaries in developing countries. In *Health by the People*, he argued that "a strict health sectorial approach is ineffective."⁴ In addition, the 1974 Canadian Lalonde Report (named after the minister of health) deemphasized the importance attributed to the quantity of medical institutions and proposed 4 determinants of health: biology, health services, environment, and lifestyles.⁵

Other studies, written from outside the public health community, were also influential in challenging the assumption that health resulted from the transfer of technology or more doctors and more services. The

British historian Thomas McKeown argued that the overall health of the population was less related to medical advances than to standards of living and nutrition.⁶ More aggressively, Ivan Illich's *Medical Nemesis* contended that medicine was not only irrelevant but even detrimental, because medical doctors expropriated health from the public. This book became a bestseller and was translated into several languages, including Spanish.⁷

Another important influence for primary health care came from the experience of missionaries. The Christian Medical Commission, a specialized organization of the World Council of Churches and the Lutheran World Federation, was created in the late 1960s by medical missionaries working in developing countries.⁸ The new organization emphasized the training of village workers at the grassroots level, equipped with essential drugs and simple methods. In 1970, it created the journal *Contact*, which used the term primary health care, probably for the first time. By the mid-1970s, French and Spanish versions of the journal appeared and its circulation reached 10 000.

It is worth noting that John Bryant and Carl Taylor were members of the Christian Medical Commission and that in 1974 collaboration between the commission and the WHO was formalized. In addition, in Newell's *Health by the People*, some of the examples cited were Christian Medical Commission programs while others were brought to the attention of the WHO by commission members. A close collaboration between these organizations was also possible because the WHO headquarters in Geneva were situated close to the main

office of the World Council of Churches (and 50 WHO staff received *Contact*).⁹

Another important inspiration for primary health care was the global popularity that the massive expansion of rural medical services in Communist China experienced, especially the "barefoot doctors." This visibility coincided with China's entrance into the United Nations (UN) system (including the WHO). The "barefoot doctors," whose numbers increased dramatically between the early 1960s and the Cultural Revolution (1964–1976), were a diverse array of village health workers who lived in the community they served, stressed rural rather than urban health care and preventive rather than curative services, and combined Western and traditional medicines.¹⁰

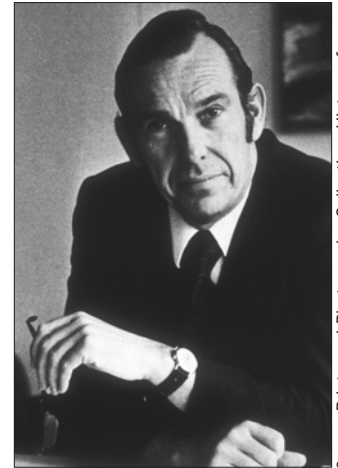
Primary health care was also favored by a new political context characterized by the emergence of decolonized African nations and the spread of national, anti-imperialist, and leftist movements in many less-developed nations. These changes led to new proposals on development made by some industrialized countries. Modernization was no longer seen as the replication of the model of development followed by the United States or Western Europe. For example, Prime Minister Lester B. Pearson of Canada and Chancellor Willy Brandt of West Germany chaired major commissions on international development emphasizing long-term socioeconomic changes instead of specific technical interventions.¹¹ In a corollary decision, in 1974 the UN General Assembly adopted a resolution on the "Establishment of a New International Economic Order" to uplift less-developed countries.¹²

NEW ACTORS AND NEW HEALTH INTERVENTIONS

New leaders and institutions embodied the new academic and political influences. Prominent among them was Halfdan T. Mahler of Denmark. He was elected the WHO's director general in 1973 and was later re-elected for 2 successive 5-year terms, remaining at its head until 1988. Mahler's background was not related to malariology, the discipline that dominated international health during the 1950s. His first international activities were in tuberculosis and community work in less-developed countries. Between 1950 and 1951, he directed a Red Cross antituberculosis campaign in Ecuador and later spent several years (1951–1960) in India as the WHO officer at the National Tuberculosis Program. In 1962, he was appointed chief of the Tuberculosis Unit at the WHO headquarters.¹³ In Geneva, Mahler also directed the WHO Project on Systems Analysis, a program that implied improving national capabilities in health planning.

More importantly, Mahler was a charismatic figure with a missionary zeal. His father, a Baptist preacher, helped shape his personality. Many years after his retirement from the WHO, he explained that for him, "social justice" was a "holy word."¹⁴ The strong impression he produced in some people is well illustrated by a religious activist who met Mahler in the 1970s: "I felt like a church mouse in front of an archbishop."¹⁵

Mahler had excellent relations with older WHO officers. The Brazilian malariologist Marcolino Candau, the WHO director general before Mahler, appointed the



Halfdan T. Mahler, director general of the World Health Organization, 1973–1988.

Source: Prints and Photographs Collection, History of Medicine Division, National Library of Medicine, Bethesda, Md.



“From the late 1960s, there was an increase in WHO projects related to the development of “basic health services” (from 85 in 1965 to 156 in 1971). These projects were the institutional predecessors of the primary health care programs that would later appear.”

Dane as an assistant director general in 1970. Thanks to his close relationship with the WHO’s old guard, Mahler could ease the transition experienced by this agency under his command. Some of these changes occurred before Mahler assumed the post of director general. From the late 1960s, there was an increase in WHO projects related to the development of “basic health services” (from 85 in 1965 to 156 in 1971).¹⁶ These projects were institutional predecessors of the primary health care programs that would later appear. Another early expression of change was the creation in 1972 of a WHO Division of Strengthening of Health Services. Newell, a strong academic and public health voice for primary health care, was appointed director of this division (Newell’s career with the WHO started in 1967 as director of the Division of Research in Epidemiology and Communications Science).

In 1973, the year of Mahler’s appointment as the WHO director general, the Executive Board of WHO issued the report *Organizational Study on Methods of Promoting the Development of Basic Health Services*.¹⁷ This report was the basis for a redefinition of the collaboration between the WHO and UNICEF (which could be traced to the years immediately following World War II). Mahler established a close rapport with Henry Labouisse, UNICEF’s executive director be-

tween 1965 and 1979, who had his own rich experience with community-based initiatives in health and education. The agreement produced in 1975 a joint WHO–UNICEF report, *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*, that was widely discussed by these agencies. The term “alternative” underlined the shortcomings of traditional vertical programs concentrating on specific diseases. In addition, the assumption that the expansion of “Western” medical systems would meet the needs of the common people was again highly criticized. According to the document, the principal causes of morbidity in developing countries were malnutrition and vector-borne, respiratory, and diarrheal diseases, which were “themselves the results of poverty, squalor and ignorance.”¹⁸ The report also examined successful primary health care experiences in Bangladesh, China, Cuba, India, Niger, Nigeria, Tanzania, Venezuela, and Yugoslavia to identify the key factors in their success.

This report shaped WHO ideas on primary health care. The 28th World Health Assembly in 1975 reinforced the trend, declaring the construction of “National Programs in primary health care” a matter “of urgent priority.” The report *Alternative Approaches* became the basis for a worldwide debate. In the 1976

World Health Assembly, Mahler proposed the goal of “Health for All by the Year 2000.” The slogan became an integral part of primary health care. According to Mahler, this target required a radical change. In a moving speech that he delivered at the 1976 assembly, he said that “Many social evolutions and revolutions have taken place because the social structures were crumbling. There are signs that the scientific and technical structures of public health are also crumbling.”¹⁹ These ideas would be confirmed at a conference that took place in the Soviet Union.

ALMA-ATA

The landmark event for primary health care was the International Conference on Primary Health Care that took place at Alma-Ata from September 6 to 12, 1978. Alma-Ata was the capital of the Soviet Republic of Kazakhstan, located in the Asiatic region of the Soviet Union. According to one of its organizers, the meeting would transcend the “provenance of a group of health agencies” and “exert moral pressure” for primary health care.²⁰ A Russian co-organizer claimed that “never before [have] so many countries prepared so intensively for an international conference.”²¹

The then-current tension among communist countries played an important role in the selection of the site. The Chinese delegation to the WHO originated the idea of an international conference on primary health care. Initially, the Soviet Union opposed the proposal and defended a more medically oriented approach for backward countries.

However, after noticing that the primary health care movement was growing, the Soviet delegate to the WHO declared in 1974 that his country was eager to hold the meeting. The offer also resulted from the growing competition between the traditional communist parties and the new pro-Chinese organizations that emerged in several developing countries. However, the proposal of the Soviet Union had one condition: the conference should take place on Soviet soil. The Soviet Union was willing to fund a great part of the meeting, offering \$US 2 million.²²

For a while, the WHO searched for an alternative site. The governments of Iran, Egypt, and Costa Rica entertained the idea but finally declined. Nobody could match the economic offer of the Soviet Union, and in the case of Iran there was fear of political instability. Finally, the WHO accepted the Soviet offer but asked for a different location than Moscow, suggesting a provincial city. After some negotiations Alma-Ata was selected, partly because of the remarkable health improvements experienced in what was a backward area during Tsarist Russia. The event was a small Soviet victory in the Cold War.

The conference was attended by 3000 delegates from 134 governments and 67 international organizations from all over the world. Details were carefully orchestrated by the Peruvian David Tejada-de-Rivero, the WHO assistant director general who was responsible for the event.²³ Most of the delegates came from the public sector, specifically from ministries of health; of 70 Latin American participants, 97% were from offi-

cial public health institutions. It was expected that many of the delegates would be planning officers and education experts, who would be able to implement an effective intersectorial approach, but few of them were. The meeting was also attended by UN and international agencies such as the International Labor Organization, the Food and Agriculture Organization, and the Agency for International Development. Non-governmental organizations, religious movements (including the Christian Medical Commission), the Red Cross, *Medicus Mundi*, and political movements such as the Palestine Liberation Organization and the South West Africa People's Organization were also present. However, for political reasons—the Sino-Soviet conflict had been worsening since the 1960s—China was absent.

At the opening ceremony, Mahler challenged the delegates with 8 compelling questions that called for immediate action. Two of the most audacious were as follows:

- 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?
- 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]?²⁴

When the conference took place, primary health care was to some degree already “sold” to many participants. From 1976 to 1978, the WHO and UNICEF organized a series of regional meetings to discuss “alternative

approaches.” The conference’s main document, the Declaration of Alma-Ata, which was already known by many participants, was approved by acclamation. The term “declaration” suggested high importance, like other great declarations of independence and human rights. The intention was to create a universal and bold statement. This was certainly unusual for a health agency used to compromising resolutions. The slogan “Health for All by the Year 2000” was included as a prospective view.

Three key ideas permeate the declaration: “appropriate technology,” opposition to medical elitism, and the concept of health as a tool for socioeconomic development. Regarding the first issue, there was criticism of the negative role of “disease-oriented technology.”²⁵ The term referred to technology, such as body scanners or heart-lung machines, that were too sophisticated or expensive or were irrelevant to the common needs of the poor. Moreover, the term criticized the creation of urban hospitals in developing countries. These institutions were perceived as promoting a dependent consumer culture, benefiting a minority, and drawing a substantial share of scarce funds and manpower. Mahler’s used the story of the sorcerer’s apprentice to illustrate how health technology was out of “social” control.²⁶ In contrast, “appropriate” medical technology was relevant to the needs of the people, scientifically sound, and financially feasible. In addition, the construction of health posts in rural areas and shantytowns, instead of hospital construction, was emphasized.

The declaration’s second key idea, criticism of elitism, meant a

disapproval of the overspecialization of health personnel in developing countries and of top-down health campaigns. Instead, training of lay health personnel and community participation were stressed. In addition, the need for working with traditional healers such as shamans and midwives was emphasized. Finally, the declaration linked health and development. Health work was perceived not as an isolated and short-lived intervention but as part of a process of improving living conditions. Primary health care was designed as the new center of the public health system. This required an intersectorial approach—several public and private institutions working together on health issues (e.g., on health education, adequate housing, safe water, and basic sanitation). Moreover, the link between health and development had political implications. According to Mahler, health should be an instrument for development and not merely a byproduct of economic progress: “we could . . . become the *avant garde* of an international conscience for social development.”²⁷

The 32nd World Health Assembly that took place in Geneva in 1979 endorsed the conference’s declaration. The assembly approved a resolution stating that primary health care was “the key to attaining an acceptable level of health for all.” In the following years, Mahler himself became an advocate of primary health care, writing papers and giving speeches with strong titles such as “Health and Justice” (1978), “The Political Struggle for Health” (1978), “The Meaning of Health for All by the Year 2000” (1981), and “Eighteen Years to Go to Health

for All” (1982).²⁸ However, despite the initial enthusiasm, it was difficult to implement primary health care after Alma-Ata. About a year after the conference took place, a different interpretation of primary health care appeared.

SELECTIVE PRIMARY HEALTH CARE

The Alma-Ata Declaration was criticized for being too broad and idealistic and having an unrealistic timetable. A common criticism was that the slogan “Health for All by 2000” was not feasible. Concerned about the identification of the most cost-effective health strategies, the Rockefeller Foundation sponsored in 1979 a small conference entitled “Health and Population in Development” at its Bellagio Conference Center in Italy. The goal of the meeting was to examine the status and interrelations of health and population programs when the organizers felt “disturbing signs of declining interest in population issues.”²⁹ It is noteworthy that since the 1950s, international agencies had been active in population control and family planning in less-developed countries.

The inspiration and initial framework for the meeting came from the physician John H. Knowles, president of the Rockefeller Foundation and editor of *Doing Better and Feeling Worse*, who strongly believed in the need for more primary care practitioners in the United States.³⁰ (Knowles died a few months before the meeting took place.) The heads of important agencies were involved in the organization of the meeting: Robert S. McNamara, former secretary of de-

fense in the Kennedy and Johnson administrations and, since 1968, president of the World Bank; Maurice Strong, chairman of the Canadian International Development and Research Center; David Bell, vice president of the Ford Foundation; and John J. Gillian, administrator of the US Agency for International Development, among others. The influential McNamara was trying to overcome the criticism that the World Bank had ignored social poverty and the fatigue of donor agencies working in developing countries. He promoted business management methods and clear sets of goals, and he moved the World Bank from supporting large growth projects aimed at generating economic growth to advocating poverty reduction approaches.³¹

The conference was based on a published paper by Julia Walsh and Kenneth S. Warren entitled “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries.”³² The paper sought specific causes of death, paying special attention to the most common diseases of infants in developing countries such as diarrhea and diseases produced by lack of immunization. The authors did not openly criticize the Alma-Ata Declaration. They presented an “interim” strategy or entry points through which basic health services could be developed. They also emphasized attainable goals and cost-effective planning. In the paper, and at the meeting, selective primary health care was introduced as the name of a new perspective. The term meant a package of low-cost technical interventions to tackle the main disease problems of poor countries.

At first, the content of the package was not completely clear. For example, in the original paper, a number of different interventions were recommended, including the administration of antimalarial drugs for children (something that later disappeared from all proposals). However, in the following years, these interventions were reduced to 4 and were best known as GOBI, which stood for growth monitoring, oral rehydration techniques, breast-feeding, and immunization.

The first intervention, growth monitoring of infants, aimed to identify, at an early stage, children who were not growing as they should. It was thought that the solution was proper nutrition. The second intervention, oral rehydration, sought to control infant diarrheal diseases with ready-made packets known as oral rehydration solutions.³³ The third intervention emphasized the protective, psychological, and nutritional value of giving breastmilk alone to infants for the first 6 months of their lives.³⁴ Breastfeeding also was considered a means for prolonging birth intervals. The final intervention, immunization, supported vaccination, especially in early childhood.³⁵


These 4 interventions appeared easy to monitor and evaluate. Moreover, they were measurable and had clear targets. Funding appeared easier to obtain because indicators of success and reporting could be produced more rapidly. In the next few years, some agencies added FFF (food supplementation, female literacy, and family planning) to the acronym GOBI, creating GOBI-FFF (the educational level of young women and mothers being considered crucial to

many health programs). Interestingly, acute respiratory infections, a major cause of infant mortality in poor countries, were not included. These were thought to require the administration of antibiotics that non-medical practitioners in many of the affected countries were not allowed to use.

Selective primary health care attracted the support of some donors, scholars, and agencies. According to some experts, it created the right balance between scarcity and choice.³⁶ One participant of the Bellagio meeting that was greatly influenced by the new proposal was UNICEF. James Grant, a Harvard-trained economist and lawyer, was appointed executive director of UNICEF in January 1980 and served until January 1995.³⁷ Under his dynamic leadership, UNICEF began to back away from a holistic approach to primary health care. The son of a Rockefeller Foundation medical doctor who worked in China, Grant believed that international agencies had to do their best with finite resources and short-lived local political opportunities. This meant translating general goals into time-bound specific actions. Like Mahler, he was a charismatic leader who had an easy way with both heads of state and common people. A few years later, Grant organized a UNICEF book that proposed a “children’s revolution” and explained the 4 inexpensive interventions contained in GOBI.³⁸

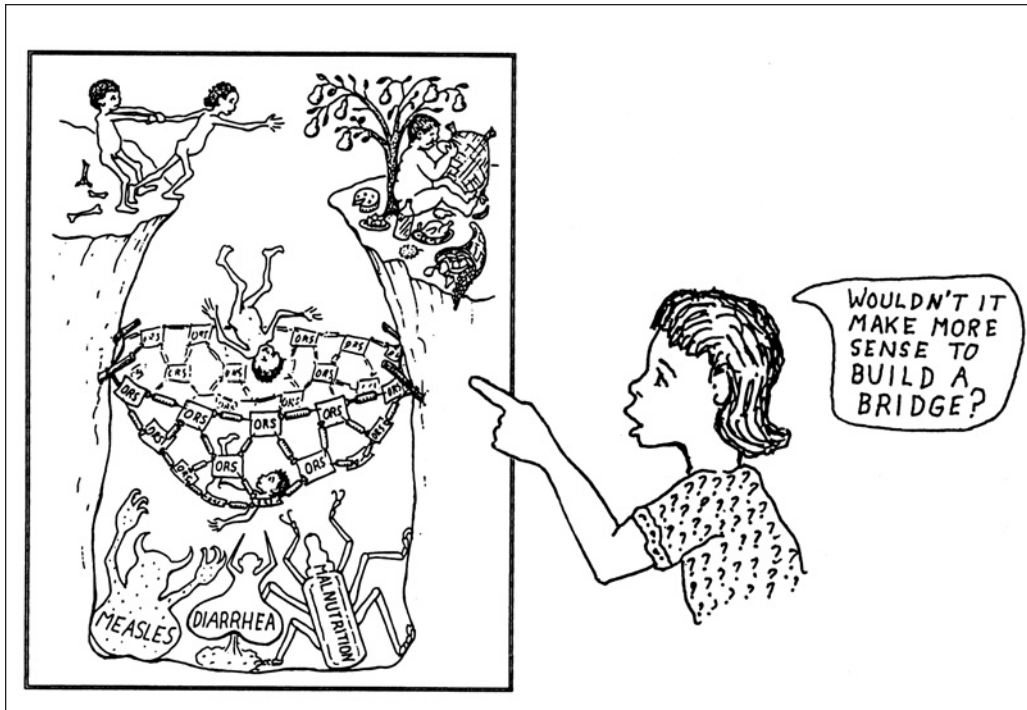
Mahler never directly confronted this different approach to primary health care. After some doubts, Mahler himself attended the Bellagio Conference, and although there is evidence that he did not get along with

the new director of UNICEF, he asked a WHO assistant director to nourish a good relationship between the 2 organizations. However, a debate between the 2 versions on primary health care was inevitable.³⁹ Some supporters of comprehensive primary health care, as the holistic or original idea of primary health care began to be called, considered selective primary health care to be complementary to the Alma-Ata Declaration, while others thought it contradicted the declaration. Some members of the WHO tried to respond to the accusation that they had no clear targets. For



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example, a WHO paper entitled “Indicators for Monitoring Progress Towards Health for All” was prepared at the “urgent request” of the Executive Board.⁴⁰ Another publication provided specific “Health for All” goals: 5% of gross national product devoted to health; more than 90% of newborn infants weighing 2500 g; an infant mortality rate of less than 50 per 1000 live births; a life expectancy over 60 years; local health care units with at least 20 essential drugs.⁴¹ However, most of the supporters of primary health care avoided these indicators,



Oral rehydration salts promoted by selective primary health care were criticized in this drawing as a “Band-Aid.” (Drawing by Alicia Brelsford, reprinted with permission from David Werner. David Werner and David Sanders, with Jason Weston, Steve Babb, and Bill Rodriguez, *Questioning the Solution: the Politics of Primary Health Care and Child Survival, with an In-Depth Critique of Oral Rehydration Therapy* [Palo Alto, CA : HealthWrights, 1997].)

arguing that they were unreliable and failed to demonstrate the inequities inside poor countries.⁴² The debate between the 2 versions of primary health care continued.

THE DEBATE

The supporters of comprehensive primary health care accused selective primary health care of being a narrow technocentric approach that diverted attention away from basic health and socioeconomic development, did not address the social causes of disease, and resembled vertical programs.⁴³ In addition, critics said that growth monitoring was difficult since it required the use of charts by illiterate mothers (recording data was not an easy operation, weighing scales were frequently deficient, and charts were subject to misinterpretation). Breastfeeding confronted powerful food industries. In 1979, it was estimated that global sales of

artificial infant formula were \$2 billion a year (Third World nations accounted for 50% of the total).⁴⁴ Companies argued—incorrectly—that infant formulas had to be used in developing countries because undernourished mothers could not provide proper nourishment and prolonged lactation would aggravate their health.⁴⁵ In contrast, for health advocates, who launched a boycott against the Swiss multinational Nestlé, one of the main problems was the use of unsafe water for bottle-feeding in shantytowns. This fascinating controversy helped to change maternal practices in several countries but did little to excite the enthusiasm of donor agencies.⁴⁶

To supporters of comprehensive primary health care, oral rehydration solutions were a Band-Aid in places where safe water and sewage systems did not exist. However, this intervention, together with immunization, became popular with agencies

working in developing countries,⁴⁷ partly thanks to an important achievement: the global eradication of smallpox in 1980. Beginning in 1974, the WHO’s Expanded Program on Immunization fought against 6 communicable diseases: tuberculosis, measles, diphtheria, pertussis, tetanus, and polio, setting a target of 80% coverage of infants or “universal childhood immunization” by 1990. This program contributed to the establishment of cold-chain equipment, adequate sterilization practices, celebration of National Vaccination Days, and expanded systems of surveillance.⁴⁸

Immunization campaigns accelerated in the developing world after the mid-1980s. They also gained the important support of Rotary International.⁴⁹ Colombia, for example, made immunization a national crusade. Starting in 1984, it was strongly supported by the government and by hundreds of teachers, priests, policemen, journalists, and Red Cross volunteers.⁵⁰ In 1975, only 9% of Colombian children aged younger than 1 year were covered with DPT (a vaccine that protects against diphtheria, pertussis, and tetanus, given to children younger than 7 years old). By 1989, the figure had risen to 75% and in 1990 to 87%.⁵¹ In a corollary development, the infant mortality rate decreased. These experiences were instrumental in overcoming popular misperceptions such as that vaccination had negative side effects, was not necessary for healthy children, and was not safe for pregnant women.

However, the achievements of immunization did not lessen the debate over primary health

care.⁵² Newell, one of the architects of primary health care, made a harsh criticism: “[selective primary health care] is a threat and can be thought of as a counter-revolution. Rather than an alternative, it . . . can be destructive. . . . Its attractions to the professionals and to funding agencies and governments looking for short-term goals are very apparent. It has to be rejected.”⁵³ US agencies, the World Bank, and UNICEF began to prioritize some aspects of GOBI, such as immunization and oral rehydration solutions. As a result, increasing tension and acrimony developed between the WHO and UNICEF, the 2 founding institutions of primary health care, during the early 1980s.⁵⁴

The debate between these 2 perspectives evolved around 3 questions: What was the meaning of primary health care? How was primary health care to be financed? How was it to be implemented? The different meanings, especially of comprehensive primary health care, undermined its power. In its more radical version, primary health care was an adjunct to social revolution. For some, this was undesirable, and Mahler was to be blamed for transforming the WHO from a technical into a politicized organization.⁵⁵

For others, however, it was naïve to expect such changes from the conservative bureaucracies of developing countries. According to their view, it was simplistic to assume that enlightened experts and bottom-up community health efforts had a revolutionary potential, and the political power of the rural poor was underestimated. They also thought that the view of “communities” as single pyramidal

structures willing to participate in health programs after their leaders received the necessary information was idealistic. In fact, they said, these communities and their learning process were usually diverse and complex.⁵⁶

In its mildest version, primary health care was an addition to preexisting medical services, a first medical contact, an extension of health services to rural areas, or a package of selective primary health care interventions. However, none of these features could avoid being considered second-quality care, simplified technology, or poor health care for the poor.⁵⁷ Two corollary criticisms from Latin American leftist scholars were that “primary” really meant “primitive” health care and that it was a means of social control of the poor, a debasement of the gold standard established in Alma-Ata. A related question not answered was, Is primary health care cheaper than traditional health interventions or does it demand a greater investment?⁵⁸

It was not clear just after the Alma-Ata meeting how primary health care was going to be financed.⁵⁹ In contrast to other international campaigns, such as the global malaria eradication program of the 1950s, where UNICEF and US bilateral assistance provided funding, there were no significant resources in the WHO for training auxiliary personnel, improving nutrition and drinking water, or creating new health centers. It was difficult to convince developing countries to change their already committed health budgets. A 1986 study examined several estimates of primary health care in developing countries (around US\$1 billion) and concluded that

“the wide range of costs . . . is indicative of how little is known about this area.”⁶⁰

As a result, most international agencies were interested in short-term technical programs with clear budgets rather than broadly defined health programs.⁶¹ In addition, during the 1980s many developing countries confronted inflation, recession, economic adjustment policies, and suffocating foreign debts that began to take their toll on public health resources. A new political context created by the emergence of conservative neo-liberal regimes in the main industrialized countries meant drastic restrictions in funds for health care in developing countries. According to Mahler, during the 1980s, “Too many countries, too many bilateral and multilateral agencies, too many individuals had become too disillusioned with the prospects for genuine human development.”⁶²

The changing political context was also favorable for deeply ingrained conservative attitudes among health professionals. For example, most Latin American physicians were trained in medical schools that resembled US universities, were based in hospitals, lived in cities, received a high income by local standards, and belonged to the upper and upper-middle classes.⁶³ They perceived primary health care as anti-intellectual, promoting pragmatic nonscientific solutions and demanding too many self-sacrifices (few would consider moving to the rural areas or shantytowns). A minority of medical doctors who embraced primary health care thought that it should be conducted under the close supervision of qualified professional personnel. Frequently,

they distrusted lay personnel working as medical auxiliaries.

In a 1980 speech, Mahler had already complained about the “medical emperors” and their negativism toward primary health care because of false “pompous grandeur.”⁶⁴ The confrontation made matters worse. The resistance of medical professionals became more acute since they feared losing privileges, prestige, and power. Confrontation continued since there was no steady effort to reorganize medical education around primary health care or to enhance the prestige of lay personnel. However, for a generation of Latin American medical students, primary health care became an introduction to public health and Mahler a sort of icon.

Another problem of primary health care implementation was real political commitment. Some Latin American authoritarian regimes, such as the military regime in Argentina, formally endorsed the Alma-Ata Declaration but did not implement any tangible reform. Because most international agencies favored selective primary health care, many Latin American ministries of health created an underfunded primary health care program in their fragmented structures and concentrated on 1 or 2 of the GOBI interventions. As a result, the tension between those who advocated vertical, disease-oriented programs and those who advocated community-oriented programs was accepted as a normal state of affairs.

During the mid-1980s, Mahler continued his crusade for a more holistic primary health care in different forums. However, he was frequently alone, since he did not have the full

support of the WHO’s bureaucracy, and his allies outside WHO were not always available. For example, from 1984 to 1987, an important US scholar for primary health care, Carl Taylor, left Johns Hopkins and was a UNICEF representative in China. In 1985, Tejada-de-Rivero, one of Mahler’s main assistants at Geneva, moved permanently to Peru, where he became minister of health. In 1988, Mahler ended a 3-term period as director general of the WHO. Although he never officially launched a reelection campaign, no one appeared who was second-in-command or had sufficient energy to keep promoting primary health care against all odds. In a confusing election and an unexpected turn of events, the Japanese physician Hiroshi Nakajima was elected as the new director general.

Nakajima lacked the communication skills and charismatic personality of his predecessor. His election can be considered to mark the end of the first period of primary health care. The WHO seemed to trim primary health care, and most importantly, the WHO lost its political profile. In a corollary development, a 1997 Pan American Health Organization document proposed a new target, or a new deadline, entitled “Health for All in the 21st Century.”⁶⁵ Supporters of a holistic primary health care believed that the original proposal largely remained on the drawing board,⁶⁶ a claim still made today.

CONCLUSION

The history of the origins of primary health care and selective primary health care analyzed in

this article illustrate 2 diverse assumptions in international health in the 20th century. First, there was a recognition that diseases in less-developed nations were socially and economically sustained and needed a political response. Second, there was an assumption that the main diseases in poor countries were a natural reality that needed adequate technological solutions. These 2 ideas were taken—even before primary health care—as representing a dilemma, and one path or the other had to be chosen.

I have illustrated the crucial interaction between the context, the actors, the targets, and the techniques in international health. Primary health care and selective primary health care represent different arrangements of these 4 factors. In the case of primary health care, the combination can be summarized as the crisis of the Cold War, the prominence of Mahler at the WHO, the utopian goal of “Health for All,” and an unspecific methodology. The combination in the case of selective primary health care was neo-liberalism, the leadership of Grant as head of UNICEF, the more modest goal of a “children’s revolution,” and GOBI interventions.

A lesson of this story is that the divorce between goals and techniques and the lack of articulation between different aspects of health work need to be addressed. A holistic approach, idealism, technical expertise, and finance should—must—go together. There are still problems of territoriality, lack of flexibility, and fragmentation in international agencies and health programs in developing countries. Primary and vertical programs coexist. One way to enhance the integra-

tion of sound technical interventions, socioeconomic development programs, and the training of human resources for health is the study of history. ■

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Primary health care (PHC) is essential health care made universally accessible to individuals and acceptable to them, through full participation and at a cost the community and country can afford. It is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy. Primary health-care (PHC) has basic essential elements and objectives that help to attain better health services for all. Primary health care elements. Essential Elements of Primary Health Care (PHC): There are 8 elements of primary-health care (PHC). That listed below-

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3. Purpose of the conference: To review the status of world health and recommend a better, innovative primary care delivery system in the world. It was attended by delegations from 134 governments and 67 representatives of UN organizations, specialized agencies and NGOs in official relations with WHO and UNICEF who were the joint spons

There is debate over their effectiveness in primary health care, especially over their potential to change practitioners'™ behaviour. Despite their popularity, we could not identify broad surveys of the literature on quality circles in a primary care context. Our scoping review was intended to identify possible definitions of quality circles, their origins, and reported effectiveness in primary health care, and to identify gaps in our knowledge. We found that they originated in manufacturing industry and that many countries adopted them for primary health care to continuously improve medical education, professional development, and quality of care. Quality circles are not standardized and their techniques are complex.