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PRIMARY HEALTH CARE IN THE AMERICAS: LESSONS LEARNED OVER 25 YEARS AND FUTURE CHALLENGES

In 1978, the International Conference on Primary Health Care in Alma-Ata defined and granted international recognition to the concept of primary health care (PHC). The Conference identified primary health care as the principal strategy for reaching the goal of Health for All by the Year 2000 (HFA2000). This resolution was adopted by the Member States of WHO in 1977 (Resolution WHA30.43), and its subsequent plan of action. The vision of PHC laid out in Alma-Ata, expressed in the principles and recommendations of the Declaration of Alma-Ata and in a series of 22 recommendations, marked the beginning of a new strategy for improving public health for the peoples of the world and the establishment of a new platform for international health policy.

In the Region of the Americas, the countries endorsed the four basic principles of PHC recognized in the Alma-Ata conference: i) universal access and coverage based on health needs; ii) commitment, participation, and individual and community self-sufficiency; iii) intersectoral action for health; and iv) cost-effectiveness and appropriate technology, as the available resources permit. Since then, the Member States have devised and implemented national primary care strategies based on the development of priority components: expanded coverage of health services and improvements in the environment; community organization and participation to improve its well-being; the creation of intersectoral linkages; research and development of appropriate technologies; the availability and production of critical products and equipment; the training and utilization of human resources; sectoral financing; and international cooperation.

Twenty-five years after the historic landmark of Alma-Ata, the people of the Americas have made gains in health as a result of priority PHC activities in education and health promotion, food and nutrition, water supply and sanitation, maternal and child care and family planning, immunization, the prevention and control of endemic diseases, the treatment of prevalent illnesses and injuries, and access to essential drugs. The collective experience amassed in the implementation of primary care has enriched the theory and practice of public health. It has also led to new challenges and priorities for the achievement of equity in health, in public health policy and in population-based health interventions, underscoring the validity of the redistributive component inherent in the goal of HFA.

The Executive Committee adopted Resolution CE132.R5, which is now submitted for the consideration of the Directing Council.

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Introduction

1. This year marks the 25th anniversary of the Declaration of Alma-Ata of 1978 on primary health care (PHC). For many years, this declaration, together with the definition of the universal goal of Health for All by the Year 2000 (HFA2000), constituted the most important health policy platform for the World Health Organization and the Pan American Health Organization, as well as for many countries in the Region of the Americas and around the world. At the 30th World Health Assembly in 1977, the Member States unanimously decided that the principal social objective to be achieved in their respective countries was a level of health for all citizens that would enable them to lead socially and economically productive lives by the year 2000.
2. Primary health care, as defined in point VI of the Declaration of Alma-Ata, was adopted almost universally as the essential strategy for achieving the goal of HFA2000 and since then, has been the cornerstone of the reorientation and restructuring of many health systems. According to this original definition, 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.”
3. A quarter of a century later, the historical importance of this Conference and the definitions, commitments, and mandates it produced cannot be ignored. It is necessary to emphasize its contribution in terms of the conceptualization of PHC and the political legitimacy it gave to PHC by linking it organically with HFA2000.
4. Many things have changed around the world and in each of our countries since 1978. Economic, political, and social contexts have shifted, as a consequence not only of national historical processes, but, increasingly, of the configuration of an ever more interdependent world. Epidemiological patterns and the demographic profiles of populations have changed, within the framework of greater exposure to risks and transformations in the social and economic environment. Major changes have also taken place in health systems, the functions of the State, and citizen initiatives to take responsibility for their own health care.
5. PHC and HFA2000 have been present throughout this complex process, with different degrees of prominence in different cases and different countries, as a political and ethical reference point at the center of decisions that governments and societies have had to make.

6. The underlying values of PHC and HFA2000 remain valid, and many of the problems and challenges that gave rise to them have yet to be overcome. This is another reason to take stock, reflect, and ponder the future. It is an opportunity to reflect on the impact and relevance of PHC and HFA2000 in light of the challenges faced by our countries and the world. Some of these are addressed in the Millennium Development Goals, Agenda 21, the resolutions of the Johannesburg Summit, and, almost universally in the political constitutions of the Member States of the Pan American Health Organization.

Background

7. As the 1970s drew to a close, more of half of the world's population was not receiving adequate health care, as noted in point V of the Declaration of Alma-Ata. In the Region of the Americas, this had become a matter of great concern to governments, societies, and the Pan American Health Organization.

8. At the III Special Meeting of Ministers of Health, held in Santiago, Chile, in 1972, the ministers reached the conclusion that health services were not delivering benefits to the entire population. They estimated that one-third of the Region's population did not have access to health services. This led to the policy to expand coverage in order to address what was then called "an access crisis." The low level of access was considered the most important of the crises confronting the health systems (cost crisis, effectiveness crisis, and access crisis).

9. In terms of health, the 1970s were characterized by national efforts to expand the population's access to health services. The advent of PHC and the commitment to HFA2000 in the Region of the Americas represented the reinforcement of policies and strategies to expand coverage throughout the Region.

10. The economic context was also critical. Populations were becoming primarily urban, with a full demographic transition under way. With certain exceptions, the political context was characterized by military dictatorships in many countries and unstable democracies in others.

11. It should be pointed out that centralist approaches prevailed in health services organizations at the time. However, the policy to expand coverage, the planning approaches in effect (the so-called CENDES-PAHO model, with its criterion of openness to local programming), and PHC in particular promoted the gradual strengthening of local service units and capacity (which in several countries came to be called the primary care level). These would later serve as the basis for new approaches to social policies.

12. The 1980s were characterized by economic decline, with limited growth in national revenues, low investment rates, persistent balance of payment deficits, high foreign debt, and an intensification of inflationary pressures. In that context, the PHC strategy became the principal orientation for health policy in the countries of the Region. Nevertheless, it should be pointed out that in most countries, the health sector was also characterized by a series of problems, including lack of coordination, both internally and with other sectors, by a shortage of financial resources, and by weak citizen participation in decision-making.

13. During this decade, progress in achieving goals in health was less than was anticipated. Notwithstanding the declarations and commitments, in the general context of health systems, the "primary level" was actually given less importance than other levels of the health services. The bulk of public spending continued to go to hospitals.

14. Toward the second half of the 1980s, the countries decided to strengthen the role of PHC as one of three key areas that needed to be developed. In 1988, the 33rd Directing Council of PAHO adopted Resolution CD33.R15 on the development and strengthening of local health systems. Within the concepts and strategies for developing local health systems, greater relative weight was given to the primary care level. The emphasis on decentralization, social participation, new models of care, and the development of managerial capacity as conditions for developing local health systems highlighted the significance of PHC in the organization of national health systems.

15. Implementation of the PHC strategy in the Region of the Americas was characterized by heterogeneity and discontinuities. At the conceptual level, PHC has been subject from the start to different interpretations that reflect divergent political and health perspectives.

16. Under the original definition, PHC was implicitly a health development strategy, as well as a level of health care services. In the Americas, primary health care was adopted and adapted by each country, according to its own realities and its own health and socioeconomic conditions. Within that context, many countries understood PHC as the primary level of care—that is, as the point of contact with the community and the population's gateway to the health system. This concept has tended to predominate in countries that have achieved adequate levels of coverage for basic health services.

17. In another perspective, in some countries—within the context of segmented health care, a model increasingly based on technology development and specialization, but with the exclusion of broad social sectors—PHC has been considered a health-care strategy based on the principles of social justice and has been envisioned as the possibility of providing health care to poor and marginalized populations who lack access to services. In the face of attempts to reduce the PHC strategy to a simplified set of low-

cost interventions, known as “selective” PHC, the prevailing vision of PHC in the Region is categorically the opposite: PHC is not a “limited package of interventions for poor people,” but the basic strategy of the health systems to secure greater coverage and equity.

18. In another variation in the development of PHC, generalist physicians or nurses are seen as gatekeepers, or those responsible for managing access to the health system. This perspective relies on the capacity of primary care units and personnel to manage a wide variety of health problems that make up most of the demand for health care. The emphasis is on filtering cases that may require specialized care by other organizational levels in the system.

19. In many national health systems characterized by growing complexity, in an effort to respond to populations with different characteristics and organizational arrangements based on segmentation, these various interpretations and applications coexist, generating more than a few disputes and misunderstandings, with a resulting lack of effectiveness and efficiency.

Impact of Primary Health Care on Health in the Americas

20. From a historical perspective, in the 25 years since Alma-Ata, the PHC strategy has become the centerpiece of national health policies and sectoral responses to health problems in the countries of the Americas. The countries have stressed that “the conceptual and operational core of primary care is procuring the desired *impact* on population health, with the maximum social efficiency and productivity of resources allocated to the sector.” Therefore, the net gain in life expectancy at birth achieved in the Region over this period can be considered an indirect indicator of the positive impact of the PHC strategy on the health of the population.

21. From 1980 to 2000, regional population increased by 217 million, reaching a total of 833 million. The regional population growth rate is now 1.3% a year. However, for the urban population, 76% of the total population in 2000, the growth rate was 1.7%. The population 65 or more years old is growing at a rate of more than 2% a year, and the population 85 and older, the group with the fastest growth, is increasing at 3% to 5% per year. This evidence reveals three demographic trends of particular importance in the current scenario for assessing the impact of population on the PHC strategy: population growth, urbanization, and demographic aging.

22. In the last two decades of the twentieth century, the countries of the Americas experienced real economic growth, judging by the growth rate of the gross national product (GNP) per capita. Around 1980, the median value of the regional annual GNP per capita, adjusted by purchasing power parity of the currency, was US\$ 2,349 (with a range of \$1,300 to \$15,000). Around 2000, the comparable value was \$4,614 (with a range of \$1,600 to \$25,000); that is, the income level doubled. However, this favorable macroeconomic trend was not distributed equitably, disproportionately favoring the highest income tercile. As a consequence, the absolute income gap between the richest third of the population and the poorest third tripled, going from \$3,551 in 1978 to \$10,361 in 1998. The evolution of the socioeconomic context during the period when the PHC strategy was applied in the Americas thus shows the presence and persistence of inequalities that must be considered when evaluating the impact of the PHC strategy.

23. In the 25 years since the Alma-Ata conference, the Americas witnessed a 25% reduction in the risk of dying (from 9 to 7 per 1,000 population). As a result, life expectancy at birth for both sexes increased, on average, by 6 years (from 66 to 72 years). Nearly 50% of this increase in life expectancy is attributable to a reduction in the risk of dying from communicable and cardiovascular causes during this period. In fact, at the regional level at least two years of life expectancy were gained just by reducing the risk of dying from communicable diseases (60%) and perinatal disorders (25%) in populations of children under 5.

24. The impact of the PHC strategy has been greater in countries with less inequality in income distribution, regardless of absolute income levels. In contrast, the impact of PHC has been much lower in poor countries with high inequality of income distribution. For example, total fertility rates closer to the replacement level, indicating a more advanced stage of demographic transition, were reached in countries with more equitable income distribution—not necessarily in the richest countries. Aspects directly associated with the implementation of the PHC strategy, such as public health expenditure, access to safe drinking water, births attended by a trained professional, or literacy, reveal significant geographical, gender-based, and socioeconomic inequalities when disaggregated by level and, above all, by income. This evidence documents the impact of the goal of HFA and the need to incorporate an equity perspective into PHC, which was the fundamental inspiration of the Declaration of Alma-Ata.

Lessons Learned

25. In the Region of the Americas, PHC was a pioneering experience for the development of health policies. In many ways, PHC marked the beginning of a paradigm shift in public health practice. In fact, PHC has been a central strategy. Several health initiatives have similar goals. By changing the health service delivery model, PHC prefigured the sectoral reform processes of the 1990s. Similarly, PHC advanced

rationalization processes by establishing a package of essential health services. PHC innovatively made social and community participation and intersectoral coordination strategic components of change in health. It prioritized health promotion, calling for health action to be forward-thinking and demedicalizing public health.

26. At different levels of scope and intensity, the countries of the Region adopted the PHC strategy as a framework for the development of human resources in health. PHC became the frame of reference for adopting and implementing policies to allocate human resources to community health services. It laid the groundwork and promoted the formation of local multiprofessional teams, whose joint efforts revived and enriched the discussions on interdisciplinary cooperation. PHC brought health personnel closer to the community and opened the way for community work. In some cases, interdisciplinary work and community participation led to the definition, development, and evaluation of comprehensive health care competencies at the local level, thus revitalizing the clinical and public health capacity of the teams.

27. The incorporation of PHC content into basic programs of training of health care professionals occurred to a greater degree in nursing education than in physician education. Recent studies indicate that a substantial proportion of nursing schools in Latin America adopted PHC as a key element in the curriculum and widely incorporated PHC content into teaching. In medical schools, in contrast, PHC was integrated for the most part into specific courses. There has been considerable debate about the impact on the health services of including PHC in the basic training of personnel. Some cases indicate that it had a significant impact, contributing to the creation and organization of PHC services. Other cases, in contrast, show that it did not have the expected effects in terms of the reorientation of health education in general or on the health services.

28. Progress in expanding the coverage of basic health services in several countries is credited to the regional experience in the development of PHC—progress that led to greater community outreach, greater resource mobilization, and greater participation by community actors in such areas as immunization programs, maternal and child care, essential drugs, health education, and basic water supply and sanitation. However, inequity in access to health services still persists, and there is considerable exclusion from mechanisms for social protection in health. Traditionally, populations with less access to health services have been low-income groups, people living in rural areas, and individuals belonging to specific marginalized ethnic groups within society. More recently, the access barriers for people living in the periurban areas surrounding the major cities have been substantial. These inequities are caused by a wide variety of barriers, including geographical, cultural, economic, as well as the perceived quality of the services.

29. Also the PHC experience has led many countries of the Region to modify health care models to incorporate disease prevention, health education, and community action, including intersectoral activities. Nevertheless, the emphasis on curative medicine still prevails in health care models. Despite the call for health promotion and disease prevention in the Declaration of Alma-Ata and the appeal for the reorientation of health services in the Ottawa Charter, the prevailing models of health care in the Region are still primarily curative, based on specialized medical and hospital care. In primary care facilities, curative care still predominates over preventive and developmental activities such as health promotion and health counseling. Likewise, initiatives for intersectoral coordination have not become part of daily practice at the local level of health in all the countries. In some specific cases, there is also a lack of coordination between personal and public health services, between health promotion activities in communities and those carried out in hospital clinics.

30. Concern has also emerged over the problem of the poor quality of health care. Every country in the Region faces major challenges in this respect. These include aspects of technical quality and of quality as perceived by users. Problems with quality show up in low levels of efficacy, efficiency, acceptability, legitimacy, and safety in health services. Their manifestations are multiple and include, inadequate problem-solving capacity at the primary health care level, lack of coordination between levels of care, inefficient use of resources, and user dissatisfaction with services. Regional experience shows us that some of the problems with quality are due to determinants imposed by the model of care.

31. Although the Region has stressed the incorporation of community personnel and social participation in health care, there is a recognized need to continue the strengthening of social participation in health. The Region has made significant progress in developing a corps of nonphysician health workers and community agents and in strengthening social participation in health. However, these advances are insufficient in many countries. In many local contexts, community participation is limited to sporadic consultation. Additionally, not every country in the Region has a political and institutional framework that includes community personnel, traditional medicine, and adequate social participation.

32. The inherent expectation of the PHC strategy was that natural dissemination of the benefits would lead to equity in health. This was not achieved. Another weakness in conceptualization was that social integration could be achieved by implementing actions aimed at reducing social fragmentation. PHC did not adequately anticipate the dramatic changes in demographic profiles—particularly demographic aging—and the epidemiological evolution that occurred in the Americas in the final decades of the last century. Furthermore, implementation of the strategy was not accompanied by an

accurate estimate of the actual costs implied by the change in health that PHC entailed and the goal of HFA2000.

33. The experience in implementing the PHC strategy in some of the countries in the Region indicates that progress can be made toward equitable access to health services through:

- (a) a strong political commitment to combat inequalities in access to health services, as part of a national strategy to reduce socioeconomic inequalities. This commitment is more effective when it becomes permanent State policy and is not limited to the efforts of a particular government administration;
- (b) the allocation of sufficient financial resources and incentives of all types that are sustainable and consistent with the proposed objectives. Moreover, formulas for allocating resources must be based on population needs rather than on the existing supply of services;
- (c) mechanisms centered on quantitative and qualitative improvement in health expenditure and the delivery of health services to excluded populations; and
- (d) more extensive coverage of insurance plans that provide a guaranteed package of health services for the general population or specific population groups, contributing to the expansion of social protection in health through social dialogue.

34. Regional experience indicates the health services can be reoriented toward health promotion and disease prevention through:

- (a) the firm political will to redesign the model of health care. In this case, transformation of the model of care implies not only changing the content of the health services by incorporating health promotion and disease prevention strategies, but also searching for models of care that promote outpatient care, health services in nonclinical environments (for example, schools, the workplace, the home, etc.), and use of family and community approaches that facilitate adequate knowledge about the physical, social, economic, and cultural realities of the user population;
- (b) assignment of intersectoral coordination functions to local, regional, and national governments, as the case may be, and

- (c) integration or coordination of personal health services with public health services. Although many public health activities are not within the health care arena, there are many cases in which both types of services can be improved through integration at the local level of care.
35. Global and regional trends over the past 25 years indicate that the quality of health services can be improved through:
- (a) the development and implementation of models of care focused on the family and community. This trend is complemented by the search for health service delivery models that are more comprehensive, complete, coordinated, and regular;
 - (b) improvements in the capacity of local health teams and the community to evaluate and meet the population's needs, expectations, and demands in health within the framework of decentralization. This demands a sustained effort to develop and improve staff competencies through educational activities and to create and maintain incentive systems to attract and retain well-qualified health personnel at all local levels of care. At the same time, efforts should be made to improve local capacity to manage change (for example, to adjust the supply of health services to changes in the demographic and epidemiological profiles of the user population);
 - (c) the establishment of a political and institutional framework that considers and integrates strategies for quality assurance with strategies for continuous quality improvement; and
 - (d) adequate motivation and development of the technical, clinical, public health, and administrative competencies of health workers. This effort should also include competencies that promote teamwork. To accomplish this, the existing human resources development and management practices should be reviewed and adapted to incorporate the proposed changes.
36. Regional experience shows that social participation in health can be strengthened through:
- (a) the establishment of a political and institutional framework to guide and facilitate the involvement of community workers and social participation in national, regional, and local agencies;
 - (b) the establishment of a gradual process that requires the health authority to transfer decision-making powers to social participation agencies; and

- (c) the development of models of care and health care management models that link the different levels, programs, and health care providers in an integrated continuum.

Challenges for the Future

37. Monitoring and evaluation of the goal of Health for All by the Year 2000 have revealed significant progress in health among the peoples of the Americas, attributable to the adoption and application of the principles of the primary care strategy. In addition, the persistence of conditions that militate against full achievement of the goal is also apparent, as is the need to revive HFA as a powerful vision of health that will guide health policy and achieve levels of health that will make socially and economically productive lives possible for all the people of the Hemisphere. Renewal of the HFA vision, in turn, requires reviewing the principles of PHC and reaffirming their adoption as the key strategy for health development.

38. The values that 25 years ago served as the foundation for the goal of HFA and the PHC strategy are still valid, and many of the problems and challenges that led to their definition are still present. However, the health situation and its context have changed in many basic areas. Renewing the commitment to PHC will imply modifications and adjustments to the two broad understandings of the term: as a “policy approach,” PHC must be viewed as the trigger and foundation of policies that foster equity in health; as a “level of care,” it must be viewed as the key component in the development of health services systems in the Region.

39. In the context of the changes that have occurred in the Americas and the renewed vision of Health for All, PHC has great potential as a relevant vehicle for meeting five challenges to the future of health in the Americas: i) intensifying efforts to guarantee the right to health for all citizens, together with universal access, while giving priority to the health of the least privileged groups and to reducing inequalities in health and health care systems; ii) securing a general improvement in the health of the population, with significant reductions in the risk of maternal and child death, an increase in life expectancy, and a better quality of life; iii) improving health care, within a network of effective, high-quality services for individuals, families, and communities, in which all participate, iv) developing integrated health services delivery providers; and v) strengthening infrastructure and institutional capacity for satisfactory performance of the essential public health functions.

40. Especially relevant as a context for renewing the PHC strategy in the Americas are the changes in the Region’s demographic and epidemiological profiles. Of particular importance are urbanization and demographic aging; chronic diseases, violence, and disabilities; AIDS and other emerging diseases; vulnerability to disasters and other

environmental impacts; cultural, ethnic, gender, and lifestyle diversity, and other macrodeterminants of health; political/administrative decentralization; changes in health care- and health services management models; and the diversification of traditional health responses.

41. Within the larger framework of PHC as a development strategy aimed at improving the living conditions of communities, reducing the burden of disease, and fostering equity in health, the principles of PHC need to be harmonized with and adjusted to the Millennium Development Goals. Because of its capacity to strengthen health services, PHC can serve as a basic strategy for achieving these international objectives.

42. A review of more than a decade of changes (sectoral reforms) in the health care systems of the Region reveals a series of goals that have not been met and issues that have not been fully addressed. These pending matters constitute a new agenda for reform in the near future and a new policy framework for the PHC strategy, whose contribution will be essential. Reducing inequities in health, reorienting models of care toward health promotion and disease prevention, guaranteeing collective mechanisms for health care financing, making social protection in health part of the institutional framework, developing quality human resources, and building an efficient, effective steering capacity to guide and manage health development will serve as the future political and strategic framework for PHC.

43. Similarly, implementation of the PHC strategy must be linked with the performance of the essential public health functions, in terms of operational plans and the standards set by the health authority at the national level—the steering role in health. Of special note are the strategic importance of maintaining information systems and health monitoring; strengthening institutional capacity for health situation analysis, the production of health intelligence for management, and the monitoring and evaluation of demographic interventions; and support for training the human resources of local health teams.

44. In this context, the principal lines of action for the renewed PHC strategy must be emphasized as the heart of PAHO corporate policy. At the same time, the commitment of the Member States to this fundamental strategy for action to improve the health of the Hemisphere's inhabitants must be renewed.

45. The 25th anniversary of the launch of PHC is a good time for a joint review of the Region's experience with the strategy and for assessing the validity and appropriateness of PHC for tackling the new challenges in the immediate future. The Secretariat proposes to the Member States that a year-long review be promoted and conducted in all levels of the health systems and different areas of society. Commencing at this year's Directing Council and ending in September 2004, it would be geared not only to commemorating

the anniversary of PHC, but to a review, analysis, and broad democratic discussion of the contributions of the PHC strategy, as well as the problems and obstacles to its implementation in the Region.

46. The Secretariat will actively promote:
- (a) the drafting of a Regional Declaration, in the spirit of the Declaration of Alma-Ata, calling for the development and implementation of public policies and effective strategies at regional and national levels, for improving the health of the peoples of the Americas. This would be a consensus-based document containing a political commitment to implementing PHC, promoting equity and social protection, strengthening health promotion, improving the quality of care, and carrying out activities and interventions to meet the Millennium Development Goals.
 - (b) the preparation and implementation of a one-year program, developed with the countries, which contains a variety of activities stressing the importance of PHC. This would be accomplished through a series of interventions involving the mass media, the preparation and dissemination of materials, special studies, and PAHO participation in meetings, forums, and congresses—both political and technical—to disseminate information about the contributions and validity of the PHC strategy and the goal of Health for All.

Action by the Directing Council

47. The Directing Council is requested to propose activities to commemorate the 25th anniversary of PHC and promote their realization in its Member States.

48. In addition, the Council is invited to consider Resolution CE132.R5 (see annex), recommended by the Executive Committee.

References

Organización Panamericana de la Salud. *Salud para Todos en el año 2000: estrategias*. Documento Oficial N° 173; Washington, D.C.:OPS; 1980.

World Health Organization. *Primary Health Care Concepts and Challenges in a Changing World: Alma Ata Revisited*. WHO/SHS/CC/94.2. Geneva: WHO; 1994.

Pan American Health Organization. *Health Conditions in the Americas*, 1994 edition. Washington, D.C.:PAHO; 1994.

Pan American Health Organization. *Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000*. Washington, D.C.:PAHO; 1997. Document CD40/24.

Pan American Health Organization. *Health in the Americas*, 1998 edition. Washington, D.C.:PAHO; 1998.

Organización Panamericana de la Salud. *Simposio sobre estrategias nacionales para la renovación de Salud para Todos*. Informe Técnico OPS/DAP/98.3.39. Washington, D.C.:OPS; 1998.

Organización Panamericana de la Salud y Universidad de Chile. *Revisión de las políticas de atención primaria de salud en América Latina y el Caribe: informe final*. Santiago y Washington, D.C.:OPS; 2002.

Pan American Health Organization. *Health in the Americas*, 2002 edition. Washington, D.C.:PAHO; 2002. (Scientific and Technical Publication No. 587).

Annex



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



132nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 23-27 June 2003

CD44/9 (Eng.)
Annex

RESOLUTION

CE132.R5

PRIMARY HEALTH CARE IN THE AMERICAS

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having seen Document CE132/13 on primary health care in the Americas;

Bearing in mind the lessons learned in the 25 years since the implementation of primary health care began, as well as the challenges of its renewal for the future in the Region;

Recognizing the validity of primary care as a general strategy for improving the health of the population and human development; and

Taking note, moreover, of Resolution WHA56.6, adopted by the World Health Assembly in May 2003,

RESOLVES:

To recommend that the 44th Directing Council adopt a resolution along the following lines:

THE 44th DIRECTING COUNCIL,

Having seen Document CD44/9 on primary health care in the Americas;

Considering the Declaration of Alma-Ata (1978), as well as Resolutions CD27.R20 and CD27.R21 on the regional strategies to promote health for all by the year

2000 (HFA2000) and CD28.R11 on the plan of action for the implementation of the regional strategies to promote HFA2000; Resolutions CSP21.R12 and CSP21.R20 on the Regional Plan of Action on HFA2000; Resolutions CD31.R27, CD33.R17, and CD35.R19 on the monitoring and evaluation of the HFA2000 strategies; and Resolutions CD39.R4 and CD40.R11 on renewal of the call for HFA and the health for all strategies;

Observing the impact of a changing environment on primary health care in the Americas; and

Acknowledging the efforts of the countries of the Region to put policies and programs on primary care at the center of their health services systems to meet the goal of health for all—efforts in which the State, nongovernmental organizations, and grassroots community organizations have played a role,

RESOLVES:

1. To request the Member States to:
 - (a) ensure that the necessary resources are available for primary care and that its implementation helps to reduce inequalities in health;
 - (b) renew their commitment to ensuring the human resources development required for primary health care in the long term;
 - (c) boost the potential of primary health care to reorient the health services, fostering the adoption of a health promotion approach;
 - (d) promote the maintenance and strengthening of information and surveillance systems in primary health care;
 - (e) support local communities to participate actively in primary health care.

2. To request the Director to:
 - (a) take the principles of primary health care into account in the activities of all technical cooperation programs, especially those related to the attainment of the Millennium Development Goals;
 - (b) evaluate the different systems based on primary health care and identify and disseminate information on best practice with a view to improving application of the relevant policies;
 - (c) continue assisting the countries to improve training for health workers in the priority activities of primary health care;
 - (d) place renewed emphasis on support for locally defined primary health care models that are both flexible and adaptable;

- (e) promote and organize a celebration with activities devoted to underscoring throughout the Region the importance of the 25 years of experience with primary health care in the Americas. This would be a year-long process involving discussions, national commemorations, subregional forums, regional activities, etc.;
- (f) organize a regional consultation for the definition of future strategic and programmatic orientations in primary health care.

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