Alma-Ata: Rebirth and Revision 8

Primary health care: making Alma-Ata a reality

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The principles agreed at Alma-Ata 30 years ago apply just as much now as they did then. "Health for all" by the year 2000 was not achieved, and the Millennium Development Goals (MDGs) for 2015 will not be met in most low-income countries without substantial acceleration of primary health care. Factors have included insufficient political prioritisation of health, structural adjustment policies, poor governance, population growth, inadequate health systems, and scarce research and assessment on primary health care. We propose the following priorities for revitalising primary health care. Health-service infrastructure, including human resources and essential drugs, needs strengthening, and user fees should be removed for primary health-care services to improve use. A continuum of care for maternal, newborn, and child health services, including family planning, is needed. Evidence-based, integrated packages of community and primary curative and preventive care should be adapted to country contexts, assessed, and scaled up. Community participation and community health workers linked to strengthened primary-care facilities and first-referral services are needed. Furthermore, intersectoral action linking health and development is necessary, including that for better water, sanitation, nutrition, food security, and HIV control. Chronic diseases, mental health, and child development should be addressed. Progress should be measured and accountability assured. We prioritise research questions and suggest actions and measures for stakeholders both locally and globally, which are required to revitalise primary health care.

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Revisiting Alma-Ata

30 years after the Alma-Ata Declaration for primary health care, "health for all"[1] remains a long way off for many countries, even those that are on track for mortality reduction goals, yet it remains the ultimate vision. The Millennium Development Goals (MDGs), which were adopted in 2000 as the next generation of the "health for all goals", specify eight aims and measurable targets, including reduction in maternal and child mortality and in the burden of HIV, malaria, and tuberculosis, and associated development targets for education and gender equity.[2] These goals have been accepted by the widest constituency of any set of health and development goals in history. The health targets correctly aim at reducing deaths as the first priority, yet reducing non-fatal diseases and improving quality of life are also important.

Primary health care is an approach to achieve both the MDGs and the wider goal of universal access to health through acceptable, accessible, appropriate, and affordable health care. Thus primary health care, if implemented, would advance health equity in all countries rich and poor and, as a result, promote human and national development.[3] Effective primary health care strengthens the integration of community, primary, and district health-care and prevention services.[4] Health depends on more than the health-care sector alone, and primary health care has from the beginning stressed the importance of intersectoral collaboration, social justice with community participation, and empowerment. Finally, the broad range of preventive and curative services provided within primary health care makes it a particularly cost-effective approach to address the large population health challenges in low-income and middle-income countries.

In retrospect, one concern with the primary health-care approach was the scarcity of a proposed strategy for implementation and its monitoring for accountability and scale-up purposes.[3] Furthermore, the ideals adopted in Alma-Ata and the energy created by the declaration lost their initial power in arguments between comprehensive or selective approaches. This tension is now being resolved in many countries by integration of vertical approaches (programmes for priority diseases) with horizontal approaches (to strengthen services for all health problems), thus developing integrated primary health-care services in a phased or step-wise manner. Recognition of the need to train and retain competent staff is also leading to more effective implementation.[5]

The variability of progress in the primary health-care approach, and the move towards integration, are well shown in the area of maternal, newborn, and child health.[3] Substantial progress is being made for child survival, whereas maternal and newborn health have been comparatively neglected until recently. The emphasis has shifted to provision of a continuum of care—including skilled attendance at birth for mothers and neonates and strengthening early postnatal care—as well as maternal, newborn, and child health, but most countries with high burden of disease still have very low coverage of such services.[3,6] Access to family planning, previously a priority, has fallen off the global priority list, despite it being one of the most cost-effective interventions for maternal, newborn, and child health.[7] Newer disease burdens, such as chronic diseases[8] and mental health,[9] are becoming more apparent. Hunger is an enduring threat, and an unacceptably high proportion of children and mothers remain undernourished, mainly in south

Asia and Africa.[10] Integration of nutrition services within primary health care and improved links to other relevant non-health sectors remain as important now as they were 30 years ago.

Over the past decade, assistance agencies have substantially increased funding through global funds to address specific diseases, particularly HIV/AIDS, tuberculosis, and malaria. Even for these diseases much still remains to be done—eg, coverage for HIV prevention interventions is only around 20%.[11] The challenge is to implement an achievable but comprehensive integrated approach to primary health care together with phased, long-term health-system building.[3]

Where are we now, and what are the gaps?

Despite the ideals and enthusiasm after Alma-Ata, primary health care continues to be inadequately supported and resourced.[12] The coverage and quality of services in some countries has deteriorated because of conflict, poor governance, structural adjustment, population growth, and disinvestment in health.[13,14]

There are notable exceptions, as shown by the 30 low-income countries that have made steady progress to reduce deaths in children younger than 5 years and, in some cases, also newborn and maternal deaths.[15] For instance, Thailand, with a gross per-head income less than US$3000 a year, has achieved remarkable progress and is at the top of the list of 30 low-income countries making rapid progress for child mortality reduction and equity in facility-based maternal-health services.[15] Success in progress towards health goals is affected by a country's political and social commitment to health and development. When stability, good governance, and stewardship for primary health care and other health services has been exhibited, progress is obvious.[15] However, even in countries with major challenges, a sustained political commitment makes a difference. In Malawi, for example, primary health-care services have been maintained despite the additional burden from HIV/AIDS. Sri Lanka and Haiti provide good examples of successful sociopolitical commitment despite political instability. In Haiti, this commitment has largely been through non-governmental and faith-based organisations.[15] Progress is possible with a willingness to innovate—eg, with different types of partners and health workers used to access hard to reach populations.

Community care, empowerment, and active social participation in improvement of health services might be the most neglected part of Alma-Ata.[3,16] Chronic diseases and mental-health disorders are emerging health problems. Key aspects of primary health-care services that need to be strengthened include district health-management systems with local use of data for decision making and coherent use of community health workers and other primary health-care personnel. The reality of intersectoral linkage between health and development is variable, with some countries achieving great progress in education, water and sanitation, and nutrition, and others not progressing and continuing to dichotomise development and health.[15]

Despite the challenges and restrictions in implementation so far, the ideals expressed at Alma-Ata and the primary health-care approach are as valid now as ever. We also now have evidence for a much greater range of cost-effective interventions than we did 30 years ago.[17] Unlike at Alma-Ata, specific health targets have now been set for 2015 and progress is being monitored. However, only 7 years remain in which to achieve the MDGs. Should we be considering a further set of goals for an extended timeframe, such as over the coming 20 years, which would go beyond mortality reduction and help to sustain action for health after 2015? If so, now is the time to start, since such goals would take time to develop as measurable targets owned by countries and the global health community.

Revitalisation of primary health care at scale

All levels—individual, family, community, facility, district, provincial, national, and global—have a role and responsibility if health for all is to be achieved. To deliver results with a primary health-care approach will need partnerships, links, and an enabling environment including bottom-up support from empowered communities, top-down support from responsible governments and across municipal and state levels, and external support with technical and financial resources, when needed and appropriate.[5,18] Primary-care services and facilities need to be strengthened and linked to the communities that they serve. But primary health care is wider than the health system, and needs greater action. The emphasis on community participation and intersectoral collaboration given by the Alma-Ata Declaration is even more relevant now with increasing complexity of the development architecture. We need pragmatic and measurable approaches that build evidence on how these strategies can best be implemented in various settings. The table outlines some priority actions that can be taken and their measurement at each level. The seven priorities for revitalisation of the Alma-Ata commitment to a primary health-care approach are described below.

(1) Making and keeping health and health equity a priority

Although mortality is an important indicator, the vision that health is a state of wellness, not solely an absence of death or disease, should not be lost.[19] The MDGs, which have measurable outcomes and build on health and development for all, will continue to be valid and relevant for many countries beyond 2015 and need to be held as a benchmark of success. However, measurable targets are also needed to extend beyond the MDGs' target date of 2015 and cover the broader health agenda as envisioned in Alma-Ata.

(2) Implementation of integrated primary health care at scale

When unified national health plans, including those for maternal, newborn, and child health and wider components of primary health care do not exist, investments of time, expertise, and funds are urgently needed to put them into place. Even more important than national strategic plans are specific implementation planning processes, leading to district action. National to district planning and management systems need to be systematic, and human and material resources strengthened.[5] Good governance has to be fostered and, where it exists, an increased proportion of donor funds should be channelled through budget support and sector-wide approaches, while partnerships with civil society are strengthened. Public, non-governmental, faith-based, and private providers need to be linked into a coherent health system under responsible government stewardship. Countries with such frameworks in place are overperforming for health outcomes despite major challenges—eg, Malawi has an essential health package and a national agreement with Christian Health Association of Malawi, which provides 40% of health-care services.[15]

Selection of a set of key evidence-based interventions for implementation in primary health-care settings is crucial.[4] Packages of care for maternal, newborn, and child health can be expanded to include interventions that address mental health, child development, and other long-term outcomes.[6] An integrated approach to the management of chronic disorders, irrespective of the cause, is not only feasible but desirable within primary health care.[8] Experience and evidence from successes of this approach need to be applied to other disease groups. For example, the systematic package for tuberculosis care has been successfully adapted to deliver HIV antiretroviral services within the general health services of Malawi.[20] This approach could be applied to other chronic diseases such as diabetes, epilepsy, and mental illness, and to a continuum of care approach to maternal, newborn, and child health at a district level. All innovations should be designed so as to be replicable and sustainable with available or realistically attainable human and material resources. Assessment embedded within early district implementation can be the basis for refining guidelines and other methods for implementation to ensure effective scale-up nationally and to learn from what works and why, or why not.[21]

When health systems are weak or the timeframe is short, interventions have been implemented vertically. This approach can be either to achieve important benefits at scale in as short a time as possible—eg, since 2000 for HIV antiretroviral services—or because donors are

	Action: implementation of PHC at scale	Measurement: measuring markers, progress, and accountability
Community, family, individuals	• Select and support CHWs • Actively participate in community health-promotion activities and development programmes (income generation, water and sanitation, self-reliance)	• Funding, training, and supervision for CHWs that is established and tracked, including attrition rates • Community mobilisation for health promotion and poverty eradication programmes which are established and have trackable indicators
Health centres, hospitals, practitioners	• Train, supervise, and use packages of care, guidelines, and management methods—eg, IMCI, IMAI, IMPAC • Provide outreach activities and links with CHWs and private sector to improve coverage of interventions and strengthen referral • Support community health promotion	• Health facility capability to provide services that are assessed regularly • Regular assessment of client satisfaction in place with use of available methods to measure quality • Effective functional plans to register and link public and private providers
District, subdistrict	• Plan and budget according to disease burden and related cost-effective packages of care and prevention • Build CHW, MNCH, and FP delivery, and strengthen referral strategies • Ensure equitable distribution and quality of health workers	• District level methods used for planning, linking burden with budget allocation, procurement, and management • District plan in place to integrate MNCH and FP interventions at community, health centre, hospital levels, and referral system • Track health worker knowledge, skills, performance, and the rate that they leave their place of work
National, state, or provincial	• Integrate health sector plans and use of methods for planning • Scale up proven health systems approaches on the basis of evidence • Coordinate funding with agriculture, food security, climate change, and population policies • Introduce phased removal of user fees for PHC services, at least for vulnerable populations and poor people	• One national health plan and national legislation for health promotion and sex equality in place • Documentation of content and process for programme priority setting to develop and refine integrated high-impact interventions adapted to context on the basis of local epidemiology and evidence • One national monitoring plan including coverage and quality of key interventions assessed, and disaggregated by equity, sex, or ethnic origin • One national general budget with a section with health allocations specified • User fees removed for PHC (or at least exemptions for MNCH and vulnerable populations)
Global	• Prioritise funding by burden of disease, cost-effective interventions, and health systems building over time • Provide predictable long-term financing for health • Provide budget support for sector-wide approaches in countries with good governance and where equity goals are pursued • Increase investment in implementation research for PHC and building local research capacity	• Coordination of development partners and national funds for health in accordance with the Paris Declaration (OECD tracking) • Unified or harmonised assessment frameworks available for MNCH and PHC, with funds allocated for continued assessment at scale • Methods for programme priority setting for programmes on the basis of peer-reviewed effectiveness and cost inputs, and which are user friendly for country use • Research funding on the basis of transparent priority setting methods

PHC=primary health care. CHW=community health worker. IMCI= Integrated Management of Childhood Illness. IMAI=Integrated Management of Adolescent and Adult Illness. IMPAC=Integrated Management of Pregnancy and Childbirth. MNCH=maternal, newborn, and child health. FP=family planning. OECD=Organization for Economic Co-operation and Development.

***Table:* Implementation and measurement of primary health care at scale by level of responsibility**

focused on short-term goals. However, even if the start is vertical, over time interventions should be integrated and delivered by coordinated cadres of multipurpose and more specialised health workers within district management systems and with participation from communities.[3,5,15] As new evidence for an intervention becomes available, the feasibility and effectiveness of adding the intervention to primary health-care services should be assessed locally.[4] Some leading advocates of primary health care have suggested that 15% of all funds from vertical interventions should be invested in comprehensive primary health-care systems.[12]

To achieve quality and safety in primary health-care services, sufficient numbers of appropriately trained and supported health workers are needed. Properly supervised task shifting is required, as proposed by WHO in the context of HIV care.[22] Although evidence for task shifting from doctors to nurse practitioners and from health professionals to lay health workers does exist, the evidence base needs to be strengthened.[23] Pakistan provides an example of an effective national programme for community health workers.[24] There is a real danger of overloading health workers with too many tasks, hence careful and systematic tailoring of tasks to local health needs and available resources will be necessary.[3] Effective and supportive supervision is key to improvement of service delivery, and educational outreach visits have improved prescribing.[23]

The quality of care rests on the use of high-quality guidelines. Essential care and prevention packages have been developed for the major health disorders affecting children; for maternal, newborn, and child health; and for adults.[23] These packages include the integrated management of childhood illness; an essential practice guide for pregnancy, childbirth, post-partum, and newborn care;[25] and the integrated management of adolescent and adult illness,[26] which already includes chronic HIV and antiretroviral treatment guidelines, but diabetes and other chronic diseases could be added.[8] These technical interventions need to be designed in the broader context of primary health care and community development, including education, nutrition, water, and sanitation. Together with access to basic primary health care and prevention measures, essential drug lists and formularies remain important in implementation of primary health-care services.

(3) Ensuring equity and sex equality

Since the burden of disease is greatest for the poorest people, we must consider their needs first. Evidence shows that use of services by poor people is improved when user fees are reduced or withdrawn, providing that the resources are replaced,[23] or if incentives for care are provided through conditional cash transfers.[27] Services should specifically target and reach deprived rural and urban areas, with particular attention to women, children, and other disadvantaged and vulnerable groups (eg, indigenous people, inmates, elderly people, people with disabilities, refugees, and internally displaced populations). For example, working directly with women's groups can help address sex inequities and increase cultural acceptance and sustainability, while indirectly benefiting other family and community members. Community health workers can reach and serve populations that have limited access to facility care.[28]

(4) Facilitating community participation and empowerment

Active community participation is essential for effective community interventions such as those for maternal, newborn, and child health and environment-related diseases.[16] Community participation is not merely mobilising people to accept a health intervention.[29] Experience has shown the need for a shift from health education (provision of information) to health promotion (transformation of attitudes and behaviour) to empower people to have a more active role in their health.[30,31] Health promotion messages are not static—the epidemiological transition and a rise in chronic, non-communicable diseases related to ageing populations, changing diets, tobacco use, and more sedentary lifestyles will need appropriate messages and dissemination. Through education in schools and health promotion, communities can take control over their health.

One trial has shown that mobilisation of women and other community-based groups in Nepalese villages can lead to decreases in newborn and probably maternal mortality.[32] The challenge for the community mobilisation approach is to effectively replicate it at scale. Previously, the emphasis on community participation has been focused on poor people in rural areas. However, since a majority of the world's population now live in cities, the need is for community engagement for poor people living in urban areas and requires functional models of care. For example, the BRAC (formerly the Bangladesh Rural Advancement Committee) programme in Bangladesh delivers maternal and child health and family planning interventions in urban areas with good results.[33] Participatory research should be embedded within implementation projects, as with the tuberculosis public–private doctors' partnership in Nepal.[34]

(5) Linking health and development

Health professionals can easily overlook that health is affected by much more than health services, and conversely the development community can view health as a separate entity.[3] Both the Alma-Ata declaration and the MDGs have helped broaden this view by emphasising the importance of intersectoral approaches to poverty reduction and development. In practice, intersectoral collaboration is difficult to achieve since sectors tend to operate in isolation—eg, persuasion of the health and agricultural sectors to prioritise nutrition and food security is difficult, yet this need is greater than ever. That investment in

education, especially of girls, greatly affects health is well known. The WHO Commission on Social Determinants for Health recommends that countries address and monitor the inequitable distribution of resources, living and working conditions, and child development.[35] They should provide universal health-care coverage on the basis of the primary health-care model with "locally appropriate action for prevention and promotion in balance with investment in curative interventions, and an emphasis on the primary level of care".[35] It recommends ending user fees and financing the health-care system through general taxation or mandatory universal insurance. Generally, although intersectoral collaboration is difficult to measure, such evidence (or at least more assessment of experiences at scale in countries) will be crucial for the development of sound strategies to affect the health of this generation and the next.

(6) Measurement of change and ensuring accountability

Statements such as "health for all" are inspirational, yet difficult to measure. Effective tracking of primary health-care implementation needs definite outcome and process measures, including mortality measurement and measures of coverage of high-impact interventions, health systems functioning, and community action. A key challenge for primary health-care implementation is that of monitoring progress towards clearly defined and realistic targets. Such monitoring needs process indicators, including those reflecting health-system performance (human resources and management, infrastructure and maintenance, regulatory procedures, transparency and democratic governance arrangements, levels of sustained financing, budgeting, and planning). Measurement of equity is key to assessment of progress towards the MDGs and primary health care, particularly the way in which we are reaching people who are underserved. This approach should include monitoring process measures, such as vulnerable populations' access to services, service coverage, and health-care practices.

(7) Investment in innovation for drugs and technologies, and in implementation research

The early days after Alma-Ata resulted in innovation for drugs and technologies (such as oral rehydration solution), which was driven by need and feasibility in low-resource settings. Essential drugs policies advanced the use of appropriate and low-cost generic drugs. However, innovation for health technologies for poor people has again fallen off the global agenda, apart from some encouraging signs in specific initiatives: better medicines for children and affordable medicines for all, and drugs for neglected diseases. Strategic prioritisation for new drugs and technologies and effective partnerships are needed to address the gaps and make sure that the solutions reach poor people, as has been achieved very effectively for pneumococcal vaccines through the accelerated development and introduction plan.[3]

Panel 1: Research priorities for primary health care based on systematic scoring of research options

Overall PHC research priorities

- Assessment of substitution of nurse and professional tasks by lay workers (eg, CHWs, pharmacy assistants, etc)
- Cost-effective approaches to mapping PHC services against need
- Cost-effective monitoring systems to check coverage of PHC for marginalised populations
- Cost-effectiveness of substituting physician tasks with skilled nurses
- Assessment of different outreach models for essential PHC interventions

Research priorities for maternal, newborn, and child health in PHC

- Cost-effectiveness of various approaches to providing early postnatal and newborn care
- Cost-effectiveness of different service delivery models for integrated MNCH services
- Cost-effectiveness of supportive supervision and other linkage initiatives to make peripheral MNCH units and health centres interact effectively with referral units
- Comparisons of different models of scaled up community IMCI
- Assessment of methods to monitor child and maternal mortality on a yearly basis

Priorities for chronic disease research in primary health care are listed in reference 8. PHC=primary health care. CHW=community health workers. MNCH=maternal, newborn, and child health. IMCI=Integrated Management of Childhood Illness. See webappendix for the full list of research questions considered.

See Online for webappendix

Research and innovation are needed to improve health status, and the interaction between researchers, policy makers, and other stakeholders is essential to design, undertake, and use the results of research.[36] Implementation research and assessment should be embedded within new primary health-care services and approaches, so that locally produced evidence can support effective national scale-up.[21,37] Health policy and decision makers need to commission implementation research, and apply innovative and empirically supported approaches.[23] Policy makers also need to know the extent to which interventions are based on evidence. Research findings need to be disseminated widely and beyond the research community, in ways that non-academic people can understand.

Research priorities for primary health care

The so-called 10/90 gap indicates the imbalance of having a small proportion (10%) of research funding addressing the health needs of most of the population (90%) world-wide.[38] Identification of research priorities for primary health care is important for optimising the effective use of scarce resources. Reviews have established the scarcity of rigorous evidence for implementation and delivery of services generally and for human resources particularly, especially in low-income and middle-income countries.[39]

The child health and nutrition research initiative (CHNRI) has developed a systematic method for setting priorities for health research investments that can be applied globally and nationally and for different purposes.[40] We used this method, which has previously been used in several areas,[41] to identify research priorities for primary health care, with the following criteria: the likelihood that the research option would (1) be answerable, (2) be feasible to undertake, (3) fill a crucial

For the **drugs for neglected diseases initiative** see http://www.dndi.org/

Panel 2: Actions to increase commitment and resources for primary health care

- Join with other calls for global commitment to allocate more development assistance to health for the countries with the least favourable health indicators and most difficult health challenges, investing in comprehensive and selective primary health care to build strong health systems over time
- Mobilise strategic, consistent, and long-term investment from Ministries of Finance, linking with Ministries of Health in primary health care within health-sector planning with evidence of the cost-effectiveness and economic and development benefits of primary health care
- Develop a comprehensive human resource plan for primary health care that is tailored to every country, linking with existing national planning and targeting high-impact interventions for maternal, newborn, and child health, adult infections, and chronic diseases, especially in areas that are difficult to serve, delegating tasks when appropriate and strengthening team work, supervision, and coordination, and addressing staff retention issue for hard-to-serve settings
- Rationalise the use of drugs, because of their large budget requirements, with generic drugs and public funding for essential drugs, and promote innovation for development of essential dugs and appropriate technology that is needed for crucial primary health-care services
- Increase local capacity for collecting and using data for action to improve the coverage, quality, and equity of primary health-care services
- Promote community and civil society participation in the primary health-care process towards health and development for all

gap in knowledge, and that the resulting intervention would (4) improve deliverability of interventions in primary health care, (5) improve equity, and (6) have an important effect on disease burden.

The rationale, conceptual framework, and application guidelines have all been described in greater detail elsewhere[40,41] and in the webappendix.

Panel 1 shows the top five research options addressing overall primary health-care questions with the highest scores, along with the top questions for delivery of services for maternal, newborn, and child health. Research priorities for chronic diseases have been defined in a previous paper in this issue.[8] In each of the categories, a list of important research issues was identified by the *Lancet* Alma-Ata Working Group. In commissioning research to address these issues, local stakeholders and researchers (both clinical and health-service researchers) should be involved in further refining the research questions to develop effectiveness studies that are locally relevant. One opportunity is when the Global Ministerial Forum on Research for Health, in Bamako, Mali, November 2008, brings together policy makers and researchers to promote and support research on priorities identified to improve health in developing countries. As with clinical services, delivery of high-quality research, especially with an equity focus, first needs development and nurturing of local capacity.[42]

For information on the **Global Ministerial Forum on Research for Health** see http://www.bamako2008.org/

Renewing commitment and investment in primary health care

We call for the global health community, governments, national authorities, international agencies, and civil society to revitalise primary health care according to the original tenets of Alma-Ata and to monitor progress. We propose the establishment of a process to set new measurable targets that build on, yet go beyond, the MDGs to reflect the broader primary health-care agenda and to ensure continued momentum towards health for all after 2015. A possibility for one such goal could be a specified increase in average life expectancy in all countries, with defined targets for equity and quality of life.

We propose several actions to increase commitment and resources for primary health care (panel 2). The biggest challenge is implementation with community participation, especially scaling up known, cost-effective interventions for prevention and essential care. Priorities continue to be maternal, newborn, and child health; family planning; and the high burden of communicable diseases in many countries. However, there is also a growing need to address chronic, non-communicable diseases. Reaching high coverage for underserved people in rural and urban communities is essential and is the real test of social justice and sex equity. Resources should be increased and targeted towards evidence-based and integrated packages of care and towards the least served countries and communities. These resources can be delivered through strengthened primary and community care, together with community mobilisation and intersectoral collaboration for health. Individuals must be seen as active participants in their health, not passive recipients of supply-driven interventions. The emphasis has to shift from showing immediate results from single interventions to creating integrated, long-term, sustainable health systems, which can be built from a more selective primary health-care start. Research needs to be embedded within primary health-care activities, especially to be able to compare varying delivery approaches.

Margaret Chan, Director-General of WHO, has recently said "When I took office at the start of last year, I called for a return to primary health care as an approach to strengthening health systems. My commitment has deepened. If we want to reach the health-related Goals, we must return to the values, principles, and approaches of primary health care."[43] What is needed is for all stakeholders to renew their commitment to the principles of primary health care so that we do, after all, achieve health for all.

Contributors

JW, JEL, AT, and AdeF prepared the initial draft of the report, which was edited by all the named authors. MC, IR, and REB undertook the research priorities analysis. The other members of the *Lancet* Alma-Ata Working Group (listed below) participated in the research prioritisation analysis and commented on drafts of the report. All authors have seen and approved the final version.

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Conflict of interest statement

We declare that we have no conflict of interest.

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