Right to Health – From Alma Ata to Doha

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Alma Ata Declaration

The **Alma Ata** declaration in 1978 proposed a new concept of health, what we can call today the human rights approach to health, health seen as a human right. Today, when health and health services are seen as a commodity, since they are "non-productive" expenses for the State and health care systems all over the world, not just in developing countries are threatened by market-economy thinking and are being prostituted, the declaration of Alma Ata and its emphasis on primary health care assumes special significance.

The Alma Ata declaration came from a long series of field experiences, mainly from developing countries, especially in the post-colonial periods, when newly independent countries in Africa, Asia and Americas were often motivated by ideals of equality, justice and progress of their people and activists were going to rural areas, to work with people and to understand their needs. Experiments with bare foot doctors in China, the work of **Paulo Freire** in Brazil with his pedagogy of oppression and the philosophy of Sarvodaya enunciated by **Mahatma Gandhi** in India, are linked to the ideas of Alma Ata declaration. In some ways, perhaps the mass protests by young people in Europe in late sixties were also linked to it.

Negation of ideals of Alma Ata Declaration

There are two basic ideas in Alma Ata declaration – the **State responsibility** to guarantee basic health services and the fundamental importance of **people's control** in deciding about their health needs and health services. While the State responsibility to provide basic health services was accepted initially, the ideas of people's control over their health needs and health services were rejected by medical professionals and were never implemented. Even the State responsibility is under attack over the last twenty years through **Structural Adjustment Programmes** (SAPs) forced by international financial institutions like International Monetary Fund and World Bank on countries crushed under the burden of external debt, asking countries to reduce their "non-productive" expenses like health care, education and social services. Concerned about the rising public expenditure, they want services to be reduced but at the same time, do not ask for any reductions in defence budgets and military expenses, perhaps because that would hurt the export income of developed countries?

The negative forces of **economic globalisation**, promoting privatisation and corporatisation of services have further strengthened this tendency of reducing national commitments towards health rights of people, especially the poorest and most vulnerable population groups.

The trend of creating new international bodies and commissions like **Global Fund**, duplicating the work of World Health Organisation, means creation of **vertical programmes**, looking for standard universal **donor-driven** approaches to problems like AIDS, malaria and tuberculosis. This has two dangers – on one hand, it takes essential resources away from basic health services for investing in special interventions, which can be "measured and controlled" by donors. On the other hand, it negates the holistic nature of human body and the complex mechanisms governing health and disease states, by giving partial answers to problems. The emphasis of AIDS programmes on condoms, TB programmes on DOTs and malaria programmes on chemically treated bednets are examples of such an approach. None of these measures is wrong, but diseases can not be fought and controlled by only single measures and the approaches must be holistic and multi-sectoral.

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As it is, the national budgets for health services are decreasing and even from the diminished budgets, most resources go for a few big hospitals in capitals and big cities. For example, in Kenya, more than 40% of national health budget goes only for the Kenyotta hospital in Nairobi, while the primary health care services receive a meagre 1.5% of this budget.

Without effective basic health services in communities, how can the vertical programmes reach them? Even if we have drugs, if there are no health centres or health services or health workers, how are the poor going to receive these?

Fight for Right to Health

The areas for the fight for right to health must necessarily be **multi-sectoral**. We can not just look only at health services for guaranteeing health care to people if people do not have drinking water or sanitation services. For example, every year more than 10 million children die due to causes that can be easily prevented – most of these deaths are due to diseases like diarrhoea and respiratory infections. More than 50% of these are concentrated in just six countries and almost 25% only in one country (India) – all in areas where there is lack of access to drinking water, very low literacy especially for women and girls and high levels of poverty.

In fact **poverty and hunger** are the biggest killers. Experiences have shown that hunger is there not because there is not enough food, but also because poor do not have the capacity to buy the food. For example in India, hunger deaths were reported from Kalahandi district in Orissa and Indian newspapers reported that parents were selling their children for as low as 300 rupees (about 6 Euros), to be able to survive. Yet in the same year, Kalahandi district had the highest yield of rice ever and warehouses were over-flowing with rice.

People and organisations fighting for right to health must make links with those engaged in fight for right to food, right to water, right to seeds, use of genetic sciences, use of patents, issues of biopiracy, right to basic education, role of international financial institutions, impact of chemicals on the environment, etc. since these all affect the health and well-being of people.

There is a special need to be careful about the claims of big companies and institutions since they have learned the language of development and use words like well-being, holistic, empowerment, etc. as a mask to continue doing their work. The publicity campaign of petrol giant Shell about its support for poor children in Africa, the big corporations creating public-benefit foundations are all examples of this. It is easy to fall in this trap, as shown by the agreement between UNICEF and Macdonald for helping the poor children of the world, cancelled only because of mass popular protests and letters in the media.

Institutions like World Bank come with nice reports like **World Development report**, using all the right words and showing concern about the poor and vulnerable groups. They even give some token millions for supporting work in favour of these poor and vulnerable groups. Yet, at the same time, their policies of forcing poor countries to accept the logic of Structural Adjustment Programmes, cutting down of health, education and social budgets, privatisation of essential services like water supply, continues unabated, not withstanding the enormous amount of evidence already available showing the harmful impact of such measures on the poor of these countries.

The developed world makes **big promises** in front of the TV cameras and yet they do not honour their commitments. In 1991, they agreed to lower the infant mortality to less than 70 per thousand by the year 2000. In 2000, it was found that the infant mortality had actually increased in many countries of sub-Saharan Africa and the vaccination coverage had gone down. So in 2001, they

have made even a better promise – to reduce infant mortality by two-thirds by the year 2015. The strategy is to cover the lies with even **bigger lies**.

Challenges

In such a situation the challenges are many. One of the challenges is that of not losing the big picture, of forgetting the inter-connectedness of issues and focussing only on our own areas of interest. **Networking** and linking with others engaged in fight against negative effects of economic globalisation is a must.

While we need to continue to talk about Alma Ata and its ideals, we have to update it with all the changes occurring in the world in the 25 years after the declaration. Ideas of what is health and what health services are needed by people have changed and we have to look at that. For example, Brazil has initiated one of the biggest reform processes in the world by promoting decentralisation and delegating decision making power to municipalities. This is in line with ideas of people's control contained in Alma Ata declaration. Yet, if municipalities if they believe in bio-medical model of health care based on big hospitals and sophisticated technology, they will continue to ignore basic health services and issues of equity and access to the poor groups. We have to look at issues like this and develop strategies.

It is not enough to think of the things, which are not working with the present system but we have also to come with ideas of alternative systems.