

'Socialising' primary care? The Soviet Union, WHO and the 1978 Alma-Ata Conference

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ABSTRACT

In September 1978, the WHO convened a momentous International Conference on Primary Health Care in Alma-Ata, capital of the Soviet republic of Kazakhstan. This unprecedented gathering signalled a break with WHO's long-standing technically oriented disease eradication campaigns. Instead, Alma-Ata emphasised a community-based, social justice-oriented approach to health. Existing historical accounts of the conference, largely based on WHO sources, have characterised it as a Soviet triumph. Such reasoning, embedded in Cold War logic, contradicts both the decision-making processes in Geneva and Moscow that led the conference to be held in the Union of Soviet Socialist Republics (USSR) and the reality that the highest Soviet authorities did not consider it a significant ideological or political opportunity. To redress the omissions and assumptions of prior accounts, this article examines the Alma-Ata conference in the context of Soviet political and health developments, drawing from Soviet archival and published sources as well as WHO materials and interviews with several key Soviet protagonists. We begin by outlining the USSR's complicated relationship to WHO and the international health sphere. Next, we trace the genesis of the proposal for—and realisation and repercussions of—the primary healthcare (PHC) meeting, framed by Soviet, Kazakh, WHO and Cold War politics. Finally, we explore misjudgements and competing meanings of PHC from both Soviet and WHO perspectives, in particular focusing on the role of physicians, community participation and socialist approaches to PHC.

TAGLINE

The well-known narrative around the most remembered international health event of the 20th century omits a crucial dimension of the story...

INTRODUCTION: REMEMBERING ALMA-ATA

From 6–12 September 1978, the WHO, together with the United Nations Children's Fund (Unicef), convened the momentous International Conference on Primary Health Care in Alma-Ata, capital of the then-Soviet republic of Kazakhstan. This unprecedented gathering of 3000 health delegates, including

Summary box

- ▶ The history of the 1978 Alma-Ata conference has been analysed almost exclusively based on Western and English-language documentation, presuming that it represented a Soviet victory.
- ▶ This analysis presents the Soviet side of the Alma-Ata story based on previously unexplored Soviet and Kazakh archival and published sources, and interviews with key protagonists.
- ▶ Notwithstanding the enthusiasm of Soviet delegates to WHO around developing a primary health care (PHC) agenda, Soviet authorities did not initially seek to host a conference.
- ▶ The highest level of Soviet leadership did not consider the conference to be a significant ideological or political event for broad international consumption, even as the conference was used to showcase Soviet advances in health.
- ▶ The Alma-Ata conference had distinct meanings for WHO and Soviet players in part due to divergent expectations around the meaning and importance of PHC.

government officials from 134 countries and representatives of 67 non-governmental organisations, signalled a rupture with WHO's long-standing technically oriented, top-down disease eradication approach.

The purpose of this meeting was to 'exchange experiences' regarding PHC implementation 'within the framework of comprehensive national health systems and overall development' and to 'further promote' PHC's uptake by governments and international agencies.¹ At the core of this approach was the idea of universal accessibility, equity, integration of prevention and

¹WHO, Declaration of Alma-Ata, Presented at the International Conference on Primary Health Care (6–12 September 1978, Alma-Ata, USSR). Model letter of invitation to International Conference on Primary Health Care, from Halfdan Mahler, Director-General, WHO, and Henry Labouisse, Executive Director, Unicef, Folder P21/87/5, Box A. 1401, WHO Archives, Geneva, Switzerland.



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treatment, government responsibility for the health of populations and community participation. These ideas were further articulated in a joint report by the directors of WHO and Unicef, together with background reports from the six regional offices of WHO presented at the conference.

The meeting concluded with the adoption of a set of 22 recommendations and accompanying Declaration of Alma-Ata calling for ‘health for all the people of the world by the year 2000’. These documents crystallised principles of health as ‘a fundamental human right’ and ‘important worldwide social goal’, defining PHC as ‘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’. Another aspect of the event’s lore was the declaration’s censure of the ‘gross inequality’ in health status between and within countries—deriving from an unjust global order—as ‘politically, socially, and economically unacceptable’.ⁱ

The conference and declaration generated enormous visibility for a PHC approach and its centrality to any healthcare system. The event gave impetus to efforts to reshape health policy in member countries and reorient WHO’s own agenda. In 1979, the World Health Assembly (WHA), WHO’s governing body, endorsed the declaration, and 2 years later, the United Nations (UN) General Assembly passed a special resolution exhorting all member countries to implement the Global Strategy for Health for All by the Year 2000 under WHO’s coordination.¹

Despite falling short of these aspirations, the Alma-Ata meeting and PHC declaration have become a perennial rallying cry in the international/global health community.ⁱⁱ Indeed, unlike most such conferences, which 40 years later might have been long forgotten except by lead protagonists, Alma-Ata’s symbolic importance endures. In the context of repeated economic and political crises across the world as well as multiple challenges to WHO’s leadership, invoking—and rescuing the ideals embodied in—the Alma-Ata declaration still offers both inspiration and a putative set of guiding norms towards a more socially just approach to health and healthcare.

This durability of Alma-Ata’s vision points to the importance of remembering what was said at the meeting and how and why the events and declaration unfolded as they did. Yet, remarkably, while available historical accounts note (usually in passing) that the Alma-Ata conference was a Cold War story and—according to some authors’ assertions—represented a Soviet victory, a crucial side of that story has yet to be told: that of the Soviet Union.

ⁱⁱ See, for example, Koivusalo and Baru,⁴⁶ Pan American Health Organization,⁴⁷ People’s Health Assembly⁴⁸ and WHO.⁴⁹

The Union of Soviet Socialist Republics (USSR) was not merely a backdrop to the meeting’s deliberations: Soviet officials had prodded WHO into holding a conference and ultimately hosted and presided over it. During the weekend that fell in the middle of the conference, the Soviet hosts invited attendees to visit healthcare facilities in the Alma-Ata region, as well as in neighbouring Uzbekistan and Kyrgyzstan, to witness the advances in these previously ‘underdeveloped’ regions, showcasing the USSR’s own socialist healthcare system as a PHC success as understood according to Soviet criteria.

To redress the omissions and assumptions of prior accounts, this article examines the Alma-Ata conference in the context of Soviet political and health developments, drawing from WHO materials and from Soviet archival and published sources, supplemented by interviews with several key protagonists. We begin by outlining the USSR’s complicated relationship to WHO and the international health sphere from the late 1940s to the 1960s. Next, we trace the genesis of the proposal for—and realisation and repercussions of—the PHC meeting, framed by Soviet, Kazakh, WHO and Cold War politics. Finally, we explore misjudgements and competing meanings of PHC from both Soviet and WHO perspectives, in particular focusing on the role of physicians, community participation and socialist approaches to PHC. While certainly a Cold War story, the making of the Alma-Ata conference—like the story of the Cold War writ large—was not a simple tale of victors and victims, global superpowers and local minor players but reflected a complex interplay of optimistic scientific cooperation, misunderstandings, missed and seized opportunities and distinct regional, national and international agencies and audiences.

A socialist alternative? The early Cold War years and the USSR’s rupture with WHO

To understand the USSR’s international health stance in the early Cold War, it is essential to briefly sketch out domestic healthcare developments following the 1917 Russian Revolution. From its very establishment in July 1918, the Soviet Ministry of Health Protection (Narkomzdrav) had primary purview over preventive and curative medical services via polyclinics, dispensaries and secondary and tertiary care units.ⁱⁱⁱ Together, medical care, research, production of pharmaceuticals and vaccines, medical devices and public health activities were all integrated into a unified, centrally administered whole, implemented via a network of local administrative units. Social protection measures—including those around housing, pensions, work compensation, paid

ⁱⁱⁱ In July 1918, the People’s Commissariat of Health Protection (Narkomzdrav) was established in the Russian Soviet Federated Socialist Republic (RSFSR), a development later emulated in other republics of the Union of Soviet Socialist Republics (USSR), formed in 1922. In 1936, the All-Union Narkomzdrav was created to coordinate the activities of the republican agencies. In 1946, the commissariats were renamed ministries.^{50 51}

maternity leave, nutrition, employment conditions and other elements of social welfare—were addressed and overseen by a range of state agencies in consultation with Narkomzdrav. This centralised, hierarchical health protection system displaced the local level healthcare (*zemstvo*) system, which had been developing in Imperial Russia since the 1860s.²³

As early as the 1920s, the Soviet regime began to employ health as a tool of diplomacy, with the dual aim of learning from other countries and showcasing domestic developments under Narkomzdrav.⁴ Within two decades, the achievements of the Soviet system became particularly visible during and in the aftermath of World War II (WWII) with the successful control of infectious diseases. Even without antibiotics and dichlorodiphenyltrichloroethane (DDT), Soviet WWII-era disease control was in stark contrast with the aftermath of World War I. Moreover, medical cooperation was a high point of the Allied war effort, giving rise to expectations for postwar health cooperation.

Indeed, Soviet officials, like many Western counterparts, believed that health cooperation offered a neutral realm for addressing common problems and charting progress. However, by WHO's 1946 founding conference in New York City, the wartime alliance to defeat the Nazis had ruptured, and the Cold War was underway. Still, into 1948, when WHO was officially inaugurated, both Americans and Soviets sought to ensure that the other would participate. As a Rockefeller Foundation executive fretted in 1947, 'If ... Russia will not join ... it will not be a World Health Organization'.^{iv} As it turned out, it was the Americans who stalled, not the Soviets. When the USA belatedly agreed to join in July 1948 (after passage of a joint Congressional resolution stipulating the possibility of a unilateral US withdrawal), it was the USSR delegate who formally proposed WHO's acceptance of US membership.^v

Given the sacrifices of the Soviet people during WWII (20 million military and civilian casualties), USSR health authorities expected WHO to offer needed resources for rebuilding damaged infrastructure. However, it was rapidly apparent that WHO would not help the Soviet bloc; for example, it failed to intervene in response to US efforts to block the United Nations Relief and Rehabilitation Administration's postwar cooperation in establishing the first penicillin factories in Poland and Czechoslovakia.⁵

In early 1949, after the Berlin crisis confirmed the intractability of the Cold War standoff, the Soviets pulled out of WHO. Soviet Health Minister Nikolai Vinogradov

informed WHO's first director-general, Canadian psychiatrist Brock Chisholm, that the Ministry was 'dissatisfied with [WHO's] activities' and that 'maintenance of the Organization's swollen administrative machinery involves disproportionately heavy expenses for Member States.' Therefore, the USSR 'no longer considers itself a member...'^{vi} Although WHO's Executive Board and various countries, led by Canada, implored the Soviets to reconsider, they remained firm; soon, other Eastern European countries severed their relations to WHO. To be sure, Soviet bloc countries did not exit WHO following a Soviet master plan. Several delegations had grown dissatisfied with WHO's insufficient response to addressing medical shortages in their countries and its one-size-fits-all approach.⁶ The concerns expressed by Soviet authorities—that country dues far exceeded cooperative assistance, that WHO's technical missions were of little use, and that WHO headquarters 'discriminated against Soviet experts in hiring practices'—were also shared by many 'developing countries'. Unlike the Soviet bloc, however, they were not in a position to quit WHO.^{vii}

During the almost decade-long period when the USSR, plus Poland, Czechoslovakia, Hungary, Mongolia, Bulgaria and Romania were 'inactive' in WHO, the socialist bloc forged its own system of health cooperation,⁷⁻⁹ with the Soviets drawing from their model to help their allies rebuild their health services.¹⁰ Additionally, as early as 1951, the Soviet Union, German Democratic Republic (GDR), Romania and other Eastern European countries began to engage in 'proletarian' health solidarity in North Korea and Vietnam,^{11 12} building on the 1930s medical cooperation extended by the Soviets and Eastern European health leftists to fight Franco's fascists in Spain and the Japanese occupation of China.

Starting in 1956, these cooperative arrangements became institutionalised through annual meetings of public health ministers of socialist countries.^{viii} By the 1960s, questions of housing, sanitation, health infrastructure, pensions and social security had been addressed by most of the 'socialist camp'. Accordingly, meeting agendas turned to issues of medical research and technical developments. Two main priorities emerged: integration and sharing of knowledge and practices across member countries, and country specialisation in particular areas of medical research and production.^{ix} For

^{vi} N.A. Vinogradov to Brock Chisholm, 15 February 1949, 16/1/1, WHO Archives.

^{vii} These problems escalated with the UN's Expanded Program in Technical Assistance launched in 1949, obligating governments to contribute the equivalent of billions of dollars in cash and in-kind services as a condition of "receiving" cooperation. See Beigbeder⁵³ and Siddiqi.⁵⁴

^{viii} Later, Vietnam, North Korea and Cuba joined, but China, Yugoslavia and Albania never did.

^{ix} See, for instance, materials of the 13th Meeting of the Ministers of Public Health of Socialist Countries held in Ulan Bator (Mongolia) from 28 of June to 4 of July 1972 in the collection of documents of the USSR Ministry of Public Health kept in

^{iv} Rolf Struthers, Associate Director of the Rockefeller Foundation's Medical Sciences Division: RRS diary, May–June 1947, Box 363, Folder 2457, RG 2 Series 1947/100, Rockefeller Foundation Archives, Rockefeller Archive Center, Sleepy Hollow, New York, USA.

^v RG 2, Series 1948/100, Box 401, Folder 2708, Rockefeller Foundation Archives. Also see Birn.⁵²

example, Hungary, and later Poland, became centres of pharmaceutical research and manufacturing, GDR and Czechoslovakia focused on medical devices, and the USSR produced the bulk of vaccines and sera.

Bilateral cooperative health relations also extended beyond the socialist bloc. India's health minister visited Moscow in 1953, and the first agreements on technical and economic assistance to India and Afghanistan were signed the following year. By 1960, the Soviet Union had similar agreements with 14 countries in Asia and Africa, by 1969 with 39, soon reaching some 70 Third World countries, including in Latin America.^{13–15} Activities encompassed construction of health facilities, medical equipment and drug distribution, health education, training and secondment of medical personnel. Unlike Western aid in this period, the USSR sought, where possible, to provide cooperation aimed at building national health systems along the Soviet model of free, universal, public systems organised around a system of polyclinics and secondary and tertiary care facilities.¹³

Complementing overseas cooperation, the USSR became a hub for professional training.¹⁶ Starting in the 1960s, student fellowships, such as those held at the famed Patrice Lumumba Moscow Peoples' Friendship University (so named shortly after the 1961 assassination of the Congolese liberation leader), trained tens of thousands of doctors, engineers, social scientists, agriculturalists and other professionals from across Asia, Africa and Latin America (with roughly one-third from each region), who served as important interlocutors encouraging support for socialism (if not necessarily the Soviet variant) to thrive in distinct milieus.^{17–20}

The Soviet Union also developed bilateral relations with capitalist countries. In 1969, a cooperative public health agreement involving exchanges of personnel, information and technology was signed with France, in 1970 with Italy, in 1972 with the USA²¹ and in 1975 with the UK. The Soviet leadership considered these agreements of utmost importance for they allowed Soviet researchers access to the latest Western medical technologies, such as the artificial heart.^x However, this was a two-way street: Western countries were also interested in Soviet technologies, particularly in areas such as space medicine, cancer therapeutics and cardiac surgical techniques.^{xi}

In sum, WHO, like its interwar predecessor, the League of Nations Health Organisation, was never central to Soviet international health efforts; the Soviets distrusted

the intentions of these organisations and believed they did not serve the USSR's national interests. Despite such suspicions—and the decision to direct the bulk of their health cooperation efforts elsewhere—the Soviets did recognise the potential utility of participating in WHO.

Back to the WHO: the making of a PHC conference

In 1956, the Soviet Union 're-activated' its WHO membership after a Soviet UN delegate announced that WHO was doing 'constructive work'.^{xii} Among the rejoined USSR's first actions was to propose, at the 11th WHA in 1958, that WHO sponsor a global campaign against smallpox. Such an effort was consistent with prior WHO efforts against yaws, tuberculosis and, most prominently, malaria through a global eradication programme launched in 1955.²² Not only did Soviet experts regard smallpox's biological and social particularities as ideally suited to a global campaign, but they also considered themselves disease control trailblazers, with expertise in plague, malaria and smallpox control, as well as mass production of vaccines¹⁴; after all, such preventive armamentaria were the foundation of the USSR's public health system. Soviet interest was also domestic: although the USSR had eliminated smallpox in the 1930s, it faced a reintroduction threat via bordering Asian countries and the thousands of Third World students it welcomed each year. Additionally, the Soviets recognised the prospects of their concrete contribution in terms of vaccine production, serving as a counterweight to the US's dominance of DDT production for the malaria campaign.²³ Although the smallpox resolution passed, WHO's Secretariat paid little attention to its implementation for almost a decade.^{xiii} Meanwhile, the Soviets bypassed (but informed) WHO to offer smallpox vaccine and medical experts to India, Pakistan and other countries.^{xiv}

This expression of support for Third World countries took on a more political tone at the 1961 WHA when the Soviet Union, together with Poland and Cuba, proposed a Declaration Concerning the Granting of Independence to Colonial Countries and Peoples and the Tasks of the World Health Organization. Debate over this call for WHO to 'help in eliminating the consequences of colonialism in the field of health' was vitriolic, with accusations by the UK delegate, for example, that the USSR was making 'false assumptions' about 'the factors responsible for' health problems in colonies and 'was distorting

the State Archive of the Russian Federation (*Gosudarstvennyi arkhiv Rossiiskoi federatsii*—hereafter GARF), *fond* (collection) 8009, *opis'* (directory) 50, *delo* (folder) 3363, *listy* (pages) 1–16. Hereafter such references will be given as GARF, f. 8009, op. 50, d. 3363, ll. 1–16.

^xSee Geltzer⁵⁵; Venediktov⁵⁶; Venediktov⁵⁷; GARF contains more than ten thousand files directly related to Soviet international activities in the health arena, GARF, f. 8009, op. 34 (1934–1967); op. 50 (1968–81), op. 51 (1981–1991).

^{xi}See, for instance, Nicogossian,⁵⁸ US Congress, Office of Technology Assessment⁵⁹ and Raymond.⁶⁰

^{xii}See World Health Organization.⁶¹ The USSR resumed paying its required dues plus arrears, furnishing 6% of WHO's budget in the mid-1950s and 13% by 1959 (U.S. Congress, Senate Committee on Government Operations 1959).

^{xiii}In 1967, smallpox eradication took off, with the USSR providing the bulk of vaccines, and the United States—now fully cognizant of the campaign's diplomatic potential—purveying logistical and infrastructural support, until 1980, when smallpox was declared eradicated. See Manela⁶² and Reinhard.⁶³

^{xiv}Zhdanov to Candau, 30 January 1959, Folder N 52/372/2 USSR, Box A.0954, WHO Archives.

the medical and historical facts'; the resolution was shelved despite wide support from African and socialist countries.²⁴

Subsequently, the Soviets homed in on WHO's malaria campaign, voicing concern about its 'insufficient methodological and organizational grounds', compared with the USSR's own experience in eliminating the disease: even in a temperate climate, eradication required 'the creation of a vast network of anti-malaria stations, training of special cadres, medical treatment of all the infected, along with a number of other medical and state measures' (p. 196).^{14 xv} This critique opened years of confrontation between Soviet and Western delegates regarding WHO's budget, agenda-setting, leadership and modus operandi.

By this time a new Soviet delegate was posted to WHO, Dr Dmitry Venediktov (1969–1980). Having worked in the USA as the medical advisor to the Soviet delegation to the UN,²¹ Venediktov was a protégé and favourite student of Boris Petrovskii, the USSR's minister of public health (1965–1980) as well as its most esteemed cardiac surgeon and the personal physician of Soviet leader Leonid Brezhnev. This relationship, in turn, led to Venediktov's appointment as deputy-minister in charge of international affairs and head of the Soviet delegation to WHO.

Venediktov quickly identified similar problems to those that had provoked the USSR's withdrawal from WHO 20 years earlier: WHO's sizeable spending on 'technical assistance' mostly went to 'experts and consultants from capitalist countries', making 'many developing countries such as India, Pakistan, Indonesia, Congo ... wary of inviting these highly paid "international bureaucrats" and "temporary" experts' (p. 201).¹⁴

These criticisms were consistent with concerns of the non-aligned movement that had emerged out of the 1955 Bandung (Indonesia) Conference, which gathered leaders from newly decolonised nations of Africa and Asia seeking to challenge neocolonialism and replace it with cooperation 'on the basis of mutual interest and respect for national sovereignty'.^{xvi} The Group of 77 (non-aligned countries), formed in 1964, articulated similar concerns at the UN.^{25 26} In the 1970s, non-aligned countries called for a New International Economic Order (NIEO) to ensure trade equity and justice for developing countries, a call also invoked in the Alma-Ata declaration.²⁷

By 1970, echoing such critiques, the Soviet delegation, supported by other socialist country representatives, demanded that WHO focus more on 'actual needs and health problems of all member-countries and give them not words, but effective methodological and technical

assistance'. The Soviets proposed that 'the main functions and tasks of the organization be defined more precisely' and that 'the most important and effective principles of building national public health services and systems appropriate to all countries be formulated' (p. 201).¹⁴ For the USSR and other socialist countries, this recommendation reflected the approach they had long been implementing domestically and had also been employing in bilateral cooperation for almost two decades and in an ongoing fashion. Some Western observers held that in highlighting these accomplishments, the Soviet delegation was aiming to maximise 'political advantage' (p. 712).²⁸

The Soviet proposal was accepted by the 23rd WHA in 1970, resulting in adoption of two resolutions: 23.59 and 23.61. Resolution 23.59 noted 'important functions of the Organization' that should be considered in WHO's forthcoming fifth general programme of work for the 1973–1977 period, including 'identification of the most rational and effective ways of helping Member States to develop their own health systems'. Meanwhile, 23.61 outlined 'the most effective principles for the establishment and development of national health systems'.²⁹ As Socrates Litsios has discussed, intense debate around the wording of Resolution 23.61, especially regarding *gratis* health services and the role of state provision, ensued. The US delegation pushed for language specifying that care be provided 'without financial or other impediments' rather than 'free'. The US likewise insisted that 'a nation-wide system of health services' be recommended instead of 'a system of national health services based on a single national plan' (p. 712).²⁸

With this line drawn in the sand, a number of key events unfolded. In 1972, the Unicef/WHO Joint Committee on Health Policy undertook a study on the organisation and provision of basic health services, and tropical community health specialist Kenneth Newell, of New Zealand, became head of WHO's Division of Strengthening of Health Services. The following year, long-time WHO Director-General Marcolino Candau, a Brazilian physician who had worked with the Rockefeller Foundation earlier in his career, was succeeded by his deputy, Halfdan Mahler, a Danish tuberculosis specialist with an almost evangelical commitment to health justice.

While Mahler was less beholden to the USA and other Western powers than his predecessor, his stance against overly medicalised healthcare systems made him wary of what he perceived as the Soviet Union's medicalised approach to healthcare. Mahler's own vision of PHC—and of how to steer WHO away from technically based disease campaigns—were key to how Health for All would play out. To wrest control of public health from the medical profession and accompanying technical, professional, industry and paternalistic imperatives, Mahler stressed bottom-up approaches centred on community participation, integrated prevention, cure and health promotion, collaboration across different sectors, national self-reliance (rather than dependence on Western aid)

^{xv}Venediktov D, *Mezhdunarodnye problemy zdavoookhraneniia*, 196. Due to "insurmountable" barriers, malaria eradication was formally replaced by a malaria control programme at the 1969 WHA.

^{xvi}Final Communiqué of the Asian-African Conference, 24 April 1955, Bandung.

and self-determination in agenda-setting—all consistent with NIEO principles.^{30 31} Despite Mahler's implicit and explicit critiques of the Soviet healthcare system, it actually featured most of his desired elements except for bottom-up agenda setting and approaches.

Amid these developments, at the 1974 WHA, Venediktov proposed that WHO sponsor a special conference on 'exchange of experiences as regards the development of national health services' (p. 715).²⁸ According to Dr Oleg Shchepin, a member of the Soviet delegation, 'to our great surprise, at the next several key meetings of the organization, nobody supported that idea, that is, nobody expressed the desire to host such a conference'.^{xvii} At the January 1975 Executive Board meeting, a repeat proposal by Venediktov to hold an 'international conference on the same scale as the World Population Conference' (most recently held in Bucharest in 1974) was rejected. Instead Newell proposed a smaller meeting, not international but nonetheless 'representative'. For his part, Mahler expressed reluctance to 'embark upon a new and challenging enterprise', particularly '[a]fter so many failures in the past', unless assured of 'full moral backing' from WHA and the Executive Board.^{xviii} In November 1975, Mahler again questioned 'whether it is opportune to hold a large international meeting or conference on the subject at the present time', preferring instead to study the subject in greater depth and hold regional meetings.^{xix}

Also in 1975, Unicef and WHO issued a joint report, *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*, which contested the dominant vertical disease campaign approach and challenged the appropriateness of Western medical systems for developing countries. Instead, it pointed to the centrality of improving social conditions, presenting examples of successful PHC experiences in China, Cuba, India, Tanzania and Yugoslavia, among others. The same year, Newell's influential edited volume, *Health by the People*, was issued, proffering further and more detailed models of effective PHC among some of the 'poorest rural populations' in the 'developing world' (p. 191).^{32 33} Although Soviet influence was mentioned in chapters about China, Cuba and Venezuela, no 'underdeveloped' Soviet Central Asian republics were included. Moreover, Newell only vaguely alluded to 'overall political ideology' as a crucial factor in enabling mobilisation of 'national will' (p. 199).³³

Venediktov was a sometime nemesis to Newell even as both believed in a 'systems approach' to health services. As Venediktov recalled, 'We knew that he was trying to

find an alternative to socialism (as a form of organizing PHC), and this we could not tolerate... but we tried to understand his position'.^{xx}

Newell appeared to be stymying any possibility for the Soviet Union to host a conference, though in reality none of the early proposals entailed a Soviet invitation. In January 1975, for example, Venediktov had suggested that a meeting be held in Geneva or 'where it was possible to observe various forms of organization of health services'.^{xxi} He later recounted, 'We had ... no idea of having such a conference in the Soviet Union'.^{xx} Indubitably, an invitation would have required prior approval by one of the highest-level Soviet governing bodies—the Communist Party's Politburo or Secretariat. The Soviet delegate simply lacked the authority to make such an invitation without a special resolution by one of these agencies.

It was only after his second proposal was rejected—and in the absence of other invitations—that Venediktov secured his government's approval, which Minister of Health Petrovskii managed to push through the Communist Party Secretariat.^{xx} Thus, at WHO's January 1976 Executive Board meeting, Venediktov transmitted 'the official invitation of the Soviet government to hold the conference in the USSR, in any of its republics in 1977', noting that the Soviet Union was 'ready to take upon itself a part of expenses for the conference'. Venediktov indicated his country's interest in a wide exchange of experiences, including those 'accumulated during more than 50 years in the USSR and its union republics'.^{xxii} As Venediktov relayed to Petrovskii, a sharp division of opinions ensued.

Backed by representatives of Western countries, including Australia, Canada, France and West Germany, 'Dr. Newell doubted the expediency of holding the conference in the nearest future, referring to the lack of necessary experience' in primary care. However, Third World Executive Board members, namely Somalia and Swaziland, two of the world's poorest countries, supported holding a conference in a country with a modern public health system and a willingness to fund it. Newell then announced that the Egyptian Minister of Health had already invited the conference to his country which, according to Venediktov, 'came as a total surprise to all those present. Behind the scenes, it became clear that neither WHO's Secretariat nor the Arab country representatives knew anything about Egypt's invitation'.^{xxii} Were there an actual offer, Venediktov questioned that Egypt could take on even minimal expenses, implying that Newell had orchestrated an alternative to the Soviet invitation at the last minute. Meantime, China, referring to its experiment with barefoot doctors, 'supported the necessity of exchange of experiences'

^{xvii} Shchepin O, personal interview with the authors, 17 July 2007, Moscow.

^{xviii} WHO, Executive Board 55th Session, EB55/SR/6, EB55/SR/7 (January 1975).

^{xix} But if an international conference were approved, Mahler would request a host "preferably in the developing world" that would "participate in the conference committee." WHO, Executive Board 55th Session, EB57/20 (November 1975).

^{xx} Venediktov D, personal interview, 15 June 2004, Moscow.

^{xxi} WHO, Executive Board 55th Session, EB55/SR/6 (January 1975).

^{xxii} GARF, f. 8009, op. 50, d. 6055, ll. 191–196.

and that the conference should be convened in a developing country, such as Egypt.^{xxiii} In fact, in October 1975 Egypt had offered to host the meeting in Cairo only to withdraw the invitation shortly after the Executive Board meeting,^{xxiii} perhaps due to diplomatic pressure or financial constraints.^{xxiv} This left Mahler scrambling to find another venue, but country after country—from Belgium to Yemen, Rwanda, the UK, Kuwait, the Dominican Republic and so on—turned him down (Costa Rica assented but could not provide funding).^{xxv}

In the end, the Soviet offer to host prevailed and China did not object. ‘Western countries’ only managed to postpone the conference until 1978 and ensure that it not take place in Moscow, according to Assistant Director General David Tejada-de-Rivero, a Peruvian physician.³⁴

Back to the USSR: towards the Alma-Ata Conference

Newell’s last pitch and Executive Board manoeuvres notwithstanding, preparations were soon underway for a meeting in the USSR. WHO set up a steering committee on PHC without Soviet representation, though Venediktov was periodically invited to attend. In late May 1976, the WHA formally approved holding the conference in the USSR; a few weeks later, Petrovskii informed the health ministers of the Soviet republics about this decision, indicating that Tashkent, the capital of Uzbekistan, was the likely site for the conference. Completely rebuilt after its devastating 1966 earthquake, Tashkent in the mid-1970s was a recognised ‘window to the East’ and Central Asian hub, hosting numerous international gatherings.³⁵ The city had the necessary facilities and infrastructure for a large international conference. It was the obvious choice. To Venediktov, too, it was clear that the conference needed to be held on the ‘periphery’ of the Soviet Union to display ‘health and development’ activities germane to the majority of WHO member states.^{xx}

However, Turgel’dy Sharmanov, Kazakhstan’s ambitious minister of public health, wanted to hold the conference in his hometown—Alma-Ata, Kazakhstan’s capital. He secured support for this idea from his patron, Dimash Kunaev, the secretary of the Kazakh Communist Party and a member of the Politburo. During a September 1976 visit to Moscow, Tashkent and Alma-Ata by Tejada and other WHO officials, the choice of Alma-Ata was sealed and the September 1978 date was set. As long as the meeting was not held in Russia (especially Moscow or Leningrad), WHO authorities concurred. Soviet authorities, meanwhile, did not appear overly concerned with the decision over the locale.

According to Litsios (at the time a WHO PHC analyst), as late as January 1977, Tejada and Mahler still had qualms, hoping that budgetary uncertainties would lead the conference to be ‘voted down!’ (ie, reversed by WHO bodies) (p. 709).²⁸ When this did not happen, and perhaps intending a delay or simply to sort out logistical matters, Mahler requested a formal letter of support from the USSR’s Ministry of Health. In late April 1977 (in time for the May WHA), Petrovskii sent him a long missive reiterating Soviet support for WHO, its promotion of PHC (especially in rural areas of low-income countries) and Health for All by the Year 2000. ‘Gratified’ at his country’s hosting of the conference and ‘deeply pleased’ about Unicef’s participation, he assured Mahler that the Soviet Union ‘wish[ed] to contribute in every way to the success of this conference on the broadest and most practical basis’.^{xxvi}

Disarming Mahler’s anxieties, Petrovskii reminded him that Tejada had visited the USSR at Mahler’s own behest, settling on Alma-Ata as the most suitable location. Petrovskii reported on Tejada and Venediktov’s excellent headway in planning. Most importantly, Petrovskii promised the Soviet government’s ‘substantial contribution’: use and equipping of the V.I. Lenin Palace of Culture in Alma-Ata for conference sessions; lodging for WHO and official member country delegates, technical staff and translators; transport in Alma-Ata; visas; and discounts on international and domestic Aeroflot flights. He also expressed his government’s ‘readiness, although not directly envisaged in the preliminary conference plan, to give all interested participants an opportunity to study experiences’ in organisation of PHC in Kazakhstan as well as Uzbekistan and Kirghizia (present-day Kyrgyzstan). In this sense, the Soviet Union was presenting itself—or at least its Central Asian republics—as a model of/for developing country achievement.^{xxvii}

The planned site visits likely rankled Mahler, who considered the Soviet system ‘overmedicalised’ and centralised—hardly an exemplar of PHC given that it lacked a community participation dimension, in which Mahler held great stock (p. 718).²⁸ Yet the Soviets were not negating the potential role of community participation, and Venediktov asserted that the USSR was not seeking to impose their model on the rest of the world.^{xx} That said, Soviet health specialists held that the best health outcomes came when the entry point of people into the health system was through a properly trained doctor, nurse or feldsher (physician’s assistant, used as

^{xxiii} See F. Mohieddin to H. Mahler, 28 October 1975; and Mission Permanente de la République Arabe de l’Égypte to Director-General, WHO, 12 February 1976, P21/87/5, Jacket 1, Box A. 1399, WHO Archives.

^{xxiv} Litsios suggests the former; Cueto the latter; neither provides evidence, so we can only speculate about this matter.

^{xxv} See correspondence in Folder P21/87/5, Jacket 1, Box A. 1399, WHO Archives.

^{xxvi} All quotations in this paragraph are from: Boris Petrovskii to Halfdan Mahler, 29 April 1977, Letter 77/1745.A. P21/87/5, Box A. 1399? (authors’ translation; also see WHO’s translation), WHO Archives; also in Socrates Litsios, personal papers, Baulmes, Switzerland.

^{xxvii} For a rather sketchy account of the historical development of public health and medical services in the region, see Michaels.⁶⁴ For an analysis of this book’s shortcomings, see Kremmentsov.⁶⁵ For further context on development in Soviet peripheries, see Kalinovsky.⁶⁶

temporary personnel in the Soviet context). In the leadup to Alma-Ata, the Soviets offered, as part of their larger commitment to the education of ‘medical cadres’ from developing countries, 25 fellowships to train physicians ‘under the aegis of’ WHO, which in turn would inform national health departments about the availability of the fellowships and ensure their ‘effective utilisation’.^{xxviii}

Mahler’s views on the medical profession as an obstacle to primary care undoubtedly exacerbated his concerns about holding the conference in the Soviet Union. However, he clearly misunderstood the role of doctors in the USSR, who neither constituted a profession nor controlled the healthcare system: as salaried state employees, they were champions of public health but lacked control over the health system’s orientation, which was a prerogative of the Communist Party apparatus. To be sure, all Soviet representatives to WHO came from the Ministry of Health (as was the case with most countries) and were doctors with interest and expertise in health services.¹⁴ Many, like Shchepin, had had first-hand international experience as practising physicians or government advisers in countries as varied as the USA, Cuba, India and Congo.

The clash of visions went even deeper. For the Soviets, demonstrating that their technological prowess operated on par with Western advances was a top priority, far more important than showing achievements in other aspects of social well-being (such as pensions, housing, sanitation, schools and maternal and child health protection). Moreover, intersectoral approaches—addressing the key social factors that shaped health in terms of social security, education, labour, industrial development and so on—were considered ‘resolved’ and not connected to health in operational terms.^{xxix}

With these differences festering, from 1976 to 1978, WHO and Soviet authorities operated on parallel planes, although with frequent communication and WHO technical personnel returning to Alma-Ata in December 1977 and April 1978. Mahler himself visited the USSR in late 1976 (having previously visited in 1974). Preparation of the conference documentation remained firmly in the hands of WHO officials, with the conference steering committee predominantly composed of Western European and US staff members, with two from the Middle East, one Hungarian and one Russian—Igor Poustovoi, a health economist and planner based at WHO’s European office in Copenhagen who attended meetings intermittently.

Venediktov’s wish to be ‘kept fully informed’ of conference arrangements was agreed to, but his request that a Soviet national familiar with Kazakhstan be recruited as a liaison to WHO’s PHC unit was rebuffed (unless the

Soviet government agreed to fund this post).^{xxx} Only in early 1978 did WHO agree to a ‘Russian’ liaison officer for the leadup to the conference, a position Venediktov sought to ensure would not supplant Poustovoi’s role.^{xxxi} Venediktov also ‘expressed concern’ about whether PHC site visits would ‘contradict’ the director-general’s report to the conference; the steering committee promised to share the report but only in June/July 1978.^{xxxii}

Newell, who in early 1977 had left WHO for a community health professorship in his native New Zealand, was contracted to write the first two drafts of the background report,^{xxxiii} with Carl Taylor—a famed PHC advocate with a long international health trajectory in South and East Asia and founding chair of the Department of International Health at Johns Hopkins—hired for the third draft.^{xxxiv} Tejada actually sent Newell’s initial June 1977 draft to Venediktov,^{xxxv} who considered this early-stage sharing ‘a mark of confidence’. Venediktov raised a range of concerns, including the inadequate attention paid to WHO’s European office’s working group discussions held in Moscow in 1973 around PHC requirements and developments, such as the use of PHC teams. He also expressed disagreement with the report’s generalisations about ‘widespread dissatisfaction with health services’ and its insistence that ‘no international standard or model of the development of primary health care is possible’. Instead, he argued, ‘the prospects of developing primary health care along the lines exemplified in those countries which have developed such services to a high degree [referring to the USSR and Eastern bloc without explicitly mentioning them] cannot be passed over in silence’.^{xxxvi}

While Venediktov’s ‘personal views’ were welcomed as ‘constructive’ and passed on to Newell,^{xxxvii} he does not appear to have received subsequent versions of the report, likely due to his critique of the first version.

^{xxx} “Minutes of a Meeting of the Steering Committee on Primary Health Care”, 17 May 1977 and 23 June 1977, Litsios personal papers.

^{xxxi} Tejada de Rivero to Venediktov, 9 January 1978, Folder P21-87-5, Jacket 4, Box A. 1400, WHO Archives; Tejada de Rivero to Venediktov, 11 April 1978, Folder P21-87-5, Jacket 5, Box A. 1400, WHO Archives.

^{xxxii} “Minutes of a Meeting of the Steering Committee on Primary Health Care”, 17 May 1977, Litsios personal papers.

^{xxxiii} Tejada de Rivero to Newell, 9 February 1977, Folder P21-87-5, Jacket 2, Box A. 1399, WHO Archives; Newell to Tejada de Rivero, 3 May 1977; Tejada de Rivero to Newell, 1 August 1977; and Newell to Tejada de Rivero, 10 August 1977, Folder P21-87-5, Jacket 3, Box A. 1399, WHO Archives.

^{xxxiv} Taylor to Tejada, 7 November 1977; and Tarimo to Taylor, 29 November 1977, Folder P21-87-5, Jacket 4, Box A. 1400, WHO Archives.

^{xxxv} Tejada de Rivero to Venediktov, 8 July 1977, Folder P21-87-5, Jacket 3, Box A. 1399, WHO Archives.

^{xxxvi} Venediktov to Tejada de Rivero, 3 August 1977, Folder P21-87-5, Jacket 3, Box A. 1399, WHO Archives.

^{xxxvii} Tejada de Rivero to Venediktov, 24 August 1977, Folder P21-87-5, Jacket 3, Box A. 1399, WHO Archives.

^{xxviii} Venediktov to WHO, Director-General, 26 August 1977, 77/3610.A, Folder F 2/133/2, Box A. 413, WHO Archives.

^{xxix} See, for example, this popular contemporary textbook on the principles of Soviet public health: Batkis and Lekarev.⁶⁷



Figure 1 Members of the Delegation of the Union of Soviet Socialist Republics to the International Conference on Primary Health Care, Dr Dmitry Venediktov is on the right, Alma-Ata, Kazakhstan, USSR, 1978. Credit: WHO, 1978.

Further feedback was solicited mostly internally and from a few Unicef officials, with Mahler and his closest advisor, Israeli health planner Joshua Cohen, making the final touches. Cohen critiqued the ‘artificial [distinction] ... made between frontline health workers and community health workers’^{xxxviii} in Taylor’s draft, while Mahler was pleased that in the final version ‘the links between health and development, and indeed the interdependence of all sectors involved in furthering social and economic development, permeate the whole document’.^{xxxix}

As late as 1 August 1978, Venediktov requested a copy of the final draft recommendations and declaration, offering, futilely, that a Soviet contribution might be relevant and helpful.^{xl} Venediktov himself was keenly interested in the content of the declaration (see [figure 1](#)), although the Soviets had little input into its overall crafting.^{xx}

Meantime, Soviet logistics and site visit planning (which WHO continually stressed were not part of the official agenda) were decentralised and delayed. Only on 30 May 1978, with Kunaev chairing, did Kazakh Communist Party authorities hold a special meeting around conference preparations.^{xli} They approved a list of locales for

^{xxxviii} Cohen to Mahler, 2 January 1978, Litsios personal papers.

^{xxxix} Mahler to Labouisse, 14 March 1978, Folder P21-87-5, Jacket 5, Box A. 1400, WHO Archives.

^{xl} “Minutes of a Meeting of the Steering Committee on Primary Health Care”, 1 August 1978, Litsios personal papers.

^{xli} A copy of the protocols of this meeting is held in the Russian

site visits and allocated more than 3.5 million rubles to renovation of hotels, meeting halls, hospitals, polyclinics, rural epidemiological stations and other facilities. Over the course of the summer, hundreds of Soviet workers were busy preparing the venues, while WHO and Unicef officials were finalising the conference documentation, conference invitations and other planning details.^{34 36}

Finally, the appointed day arrived. At the opening ceremony on 6 September 1978, Soviet Minister of Health Petrovskii was elected president of the conference. Although Soviet leader Brezhnev was not in attendance, he did meet in Moscow with several high-ranking participants (including US Senator Ted Kennedy) on their way to Alma-Ata. Brezhnev’s greetings, likely prepared by Petrovskii and Venediktov and peppered with the expected superlatives, were read by Kunaev:

The Soviet Union shares the hopes of all the peoples, particularly from developing countries, who strive to do away with mass disease, famine and poverty. We are actively participating in international activities directed to solving the problem of providing medical care to the populations of (various) world countries, and this corresponds to the main goal written into WHO charter—achieving the highest possible level of health by all the peoples.

You are gathered on the hospitable land of Soviet Kazakhstan, and with this example of one of the union’s republics,

State Archive of Socio-Political History (RGASPI), f. 17, op. 147, d. 1809, ll. 142–191.



Figure 2 A helicopter sits in the background as two medical nurses treat a patient outside the entrance to the tent of a nomadic family, Kazakhstan, USSR, 1978. Credit: WHO, 1978.

you can see for yourself what great achievements the peoples of former underdeveloped backwaters of Tsarist Russia have achieved in the field of peaceful industrial construction, in science and technology, in culture and arts, in the protection of public health.

In the Soviet Union, the right to accessible and free medical care is guaranteed by the USSR Constitution and is provided by the state system of public health. The questions of public health always occupy a central place in the activity of the Communist Party and the Soviet state.^{xliii}

Like other countries holding international events, the hosts used the conference to showcase domestic achievements.^{37 38} In his speech, Kazakh Health Minister Sharmanov, undoubtedly rattling Mahler, focused on medical services infrastructure, detailing the number of hospitals, beds, medical personnel, sanitary stations and research establishments in the republic. He expressed hope that ‘learning about the Soviet system of public health in practice will be useful to the representatives of many countries’.³⁹ Further highlighting technical installations over social dimensions was a special exhibit of medical equipment produced by socialist countries. During the midconference weekend days (September 9 and 10), over 500 participants went on dozens of excursions (see [figure 2](#)) to Samarkand, Bukhara, Chimkent, Karaganda, Frunze and the Tashkent region. Others travelled along 70 different routes through the Alma-Ata region, visiting

more than 100 medical and public health facilities.^{xliii} At the end of the conference, some participants also toured similar facilities further afar, including Georgia and Latvia.^{xliv}

The events of the conference have been widely recounted.^{22 28 36 40} By all accounts, Kazakh preparations were ‘truly extraordinary’,³⁴ and aside from certain hiccups leading to last-minute changes in the site visits, the conference went off without a hitch.^{23 34} From the perspective of both the Soviet hosts (especially the Ministry of Health and Kazakhstan) and their guests, the conference appeared a great success.^{xx xlv} Participants united around the vision embodied in the declaration—approving it by acclamation—and WHO authorities received clear marching orders to push forward the 22 recommendations and the Health for All agenda. The hosts were able to show the world Soviet public health advances, and the international health community reached consensus around a reoriented approach—from top-down technical assistance to integrated socially based PHC—to tackling health.

^{xliii} See, for instance, Denisevich⁶⁸ and Anon.⁶⁹

^{xliv} See Ogurtsova⁷⁰ and Anon.⁷¹

^{xlv} Turgel'dy Sharmanov, personal interview with the authors, 14 April 2007, by phone. See Venediktov.⁷² See also the newspaper coverage of the conference cited in above notes. Also see WHO.^{73 74}

^{xliii} *Kazakhstanskaia Pravda*, 7 September 1978, 1.

However, a gaze behind the scenes (or behind the curtain!) suggests a more complicated story.

Despite the remarkable worldwide coverage of the events, the highest echelons of Soviet diplomatic and political decision making expressed little interest in the conference, even as the medical community was deeply involved. To illustrate, the USSR's only medical newspaper, *Meditsinskaya Gazeta*, covered the conference extensively as did the local newspaper, *Kazakhstanskaya Pravda*. Yet neither of the Soviet Union's two official mouthpieces, *Pravda* and *Izvestiya*, even mentioned the conference. Most notably, there was virtually no Soviet coverage of the contents of the famed Declaration of Alma-Ata: the text itself was not published in any newspapers. This silence is further emphasised by contrasting coverage of the 1978 International Genetics Congress, held in Moscow just 2 weeks earlier, on August 21–30. The Genetics Congress received extensive government and press attention, including multipage articles and interviews with key international participants in both *Pravda* and *Izvestiia*.³⁷

Moreover, no high-level party functionaries or diplomats attended, though Kazakh authorities proudly highlighted regional advances, which visibly reflected long-time Soviet health protection policies. Soviet political authorities' ambivalence towards the conference—considering it important enough to finance without pulling out all the stops—seemed to continue in its aftermath. A 1978 Ministry of Health report on Soviet engagement with foreign countries mentioned the Alma-Ata conference only in passing, without any elaboration of its content, goals or impact.^{xlvi} Indeed, judging by the sparse national press coverage of the conference and the midlevel decision making involved in conference planning, once the initial decision to host was made, the conference was clearly not a top state priority.

Still, from his more international perch, Venediktov noted how important it was for conference participants (some of whom, not knowing what to expect, brought a month's supply of food) to witness 'previously undeveloped provinces in Russia having made such progress'. He boasted that 'the significance of Alma-Ata and its documents were acknowledged everywhere, marking a new stage in the development of international public health'.⁴¹ At WHO, Venediktov continued to press for recognition that the 'historical milestone' of the Alma-Ata conference had been enabled by the extensive and accelerated public health successes reached in some (namely, socialist) countries.^{xlvii}

However, in 1980 Venediktov's patron Petrovskii was forced out, and a year later, Venediktov lost his post as deputy minister. As a last gasp for the conference's progenitor, in 1981 Venediktov published a volume directed at Soviet public health personnel detailing the

right to health protection and its (potential) realisation in different countries, underlining his personal involvement in demonstrating Soviet leadership and contributions to this area.⁴² Yet at the 1983 WHA discussion of the Health for All strategy, Petrovskii's successor as minister of health—who had vainly sought to invite Mahler to plan for a second Soviet PHC meeting—did not even mention the Alma-Ata conference, instead outlining his country's bilateral efforts in realising these goals.^{xlviii}

In Alma-Ata itself, Sharmanov established an International Collaborative Center on Primary Health Care and continued to champion the importance of the conference and its declaration, decrying pessimistic and accusatory commentaries in *The Lancet*, *Nature* and other venues.⁴⁰ ^{xlix} Kazakhs seemed to be holding the USSR's PHC banner, serving as consultants, for example, at a 1981 symposium on medico-sanitary care in Europe, held in Finland.¹ However, after his patron Kunaev left the Politburo in 1987, Sharmanov was left without the requisite support.

Been there, done that? At and after Alma-Ata

This article has aimed to fill in the silences of existing histories of the Alma-Ata conference—and thus deepen understanding of it—by bringing in the role of the Soviet Union and the particular context in which WHO–Soviet relations evolved that led to the realisation of the conference. A further key, but little discussed, part of the story is the role of the larger context. The mid-1970s was a period of détente and cooperation between the superpowers—even as a proxy Cold War played out in the guise of brutal dictatorships in Latin America, Africa and Asia. This enabled both the Soviet and WHO champions to pursue their respective PHC agendas with few encumbrances, despite contrasting visions of what exactly PHC entailed.

Aside from the players most closely associated with the conference, high-level Soviet political authorities apparently failed to appreciate the significance of the meeting outside the USSR. Ironically, Mahler, who had been reluctant to proceed with the conference, came to deploy Alma-Ata as his signature achievement, while Soviet authorities underplayed it. The limited Soviet interest in the Alma-Ata conference and its results compared with its considerable global resonance, suggest different expectations around the meaning and importance of PHC.

Domestically, the meeting appeared to offer little new or noteworthy for the Soviet healthcare system, though it did offer public health administrators an opportunity to parlay the international event into a lobbying tool in negotiations with their Politburo patrons over health

^{xlvi} See GARF, f. 8009, op. 50, d. 7463, ll. 1–87, the only mention of the Alma-Ata conference appears on l.8.

^{xlvii} GARF, f. 8009, op. 50, d. 8874, ll.1–2.

^{xlviii} Burenkov SP, On the cooperation of the USSR with developing countries in the socio-economic field, including public health sector, distributed to WHA delegates, 3 May 1983, W3/87/4(26), 36th WHA Agenda. Box A. 1744, WHO Archives.

^{xlix} See Agarwal,⁷⁵ Passmore⁷⁶ and Robertson.⁷⁷

¹ GARF, f. 8009, op. 50, d. 9594, ll. 138–52.

ministry budgets. In a way, Brezhnev's 'greetings' to the conference represented exactly what the Soviets saw as a *fait accompli* in their own public health system: social advancement plus free universal healthcare access had been achieved. Sharmanov's speech and the site visits detailed these accomplishments and pointed to other areas (such as medical research and development) that still demanded attention. Press coverage of Mahler's speech on the second day of the conference emphasised his praise of Soviet accomplishments in public health and social justice, in particular 'subordination of public health development to social goals'.⁴³ *Kazakhstanskaia Pravda* and *Meditinskaiia Gazeta* published a selection of speeches by and interviews with conference participants, all of which also lauded 'the achievements of Soviet public health'.^{li} The general tenor of the press coverage was decidedly self-congratulatory: the Soviet health system was the best in the world and the Alma-Ata conference only proved the obvious.^{lii}

Cold War blinders also prevented Soviets from recognising the disconnect between divergent understandings of PHC. Two key points of contention were the Soviet system's lack of community participation—stressed by Mahler, Newell and other Western proponents of PHC—and its overmedicalisation, particularly troubling Mahler. Harking back to imperial Russia, debates raged around whether healthcare provision demanded a strong central state agency or should be in the hands of *zemstvo* (community-based and locally funded) physicians. In this formulation, community participation was equated with medicalised care, not its opposite. When the Bolsheviks came to power, they sidelined *zemstvo*'s community-based approaches, and a centralised state system prevailed.^{liii} Furthermore, this system focused on physicians trained in 'scientific medicine' and exclusion of 'non-specialists', such as traditional healers and midwives. These ideas and the Soviet vision were subverted by Newell, who was seeking a hybrid model of care applicable also to capitalist/industrialist and, especially, non-socialist low-income contexts, rather than a socialist healthcare system per se. For Newell and others, PHC needed to adapt to low-resource settings without highly trained medical cadres. Moreover, community-based participation was a hallmark of their PHC approach, with the Soviet system almost anathema to this ideal.

Soviet authorities certainly missed an opportunity to highlight what many outsiders considered the greatest socialist success—not only universal, free, equitable healthcare coverage, but health protection writ large, in terms of housing, sanitation, employment, nutrition, education, elimination of poverty and so on. Perhaps this was because the Soviets believed that, unlike scientific

and technological advances, these social dimensions were self-evident results of the socialist system; indeed, the Soviets did not display achievements in other sectors and did not take advantage of the conference's discussions of intersectoralism (which apparently almost nobody attended).

The muted reception of the conference and its promises by the highest Soviet authorities likely also derived from WHO's marginal importance to their international health cooperation interests.^{liv} For the most part, the USSR and socialist bloc countries operated outside of WHO's ambit—in large measure because WHO was so dominated by Western bloc countries—using their own system of experts, projects and exchanges.

Only after the dissolution of the USSR that led to the crumbling of the country's welfare and health-protection systems did those most closely connected, Venediktov and Shchepin, recognise the significance of the vision expressed in the Alma-Ata declaration. With such distance, Venediktov himself came to understand that the Soviet system was overmedicalised.^{xx lv} As he intimated, it was not until 15 years after the conference that 'for the first time, we realized in Russia that Alma-Ata has goals beyond our expectation. That it has a much bigger impact than our government could understand [at the time]. And I am saying, this was a mistake'.^{xx} Both Shchepin and Venediktov, having worked overseas for so long, did not fully realise what was going on in their own country, such as the takeover of polyclinics and specialised services by megahospitals. Belatedly, they recognised that the Soviets were copying the West instead of further improving their own system that had been featured at the conference.^{xx lvi}

While the Soviets did not 'capitalise' on Alma-Ata as effective propaganda, PHC was invoked in various socialist bloc health venues. For example, at the 21st Meeting of the Ministers of Public Health of Socialist Countries in Bucharest in June 1980, participants echoed the Alma-Ata declaration, adopting various resolutions about the inseparability of Health for All, the establishment of a NIEO and world peace.^{lvii} Soon thereafter, the Soviets helped the People's Democratic Republic of Yemen create an integrated PHC programme, emphasising

^{li} See refs ^{78–82} and many others.

^{lii} See, for instance, an article in the popular magazine *Health* by Iappo.⁸³

^{liii} For a depiction of debates around the *zemstvo* and Soviet health systems, see Smirnova.⁸⁴

^{liv} This is evidenced by the small volume of material devoted to WHO in the archives of the Soviet Ministry of Health, which constitutes less than 10% of all materials on international cooperation in GARF. See GARF, f. 8009, op. 34 (1934–68); op. 50 (1961–82), and op. 51 (1982–91).

^{lv} See, for instance, his recent (12 February 2015) interview on the subject to *Kazakhstanskaia Pravda*, tellingly titled, "Primary medico-sanitary care: History and reality" in Dinara Akylzhanova, "Pervichnaiamediko-sanitarnaia pomoshch: Istoriia i real'nost' ", at <http://www.kazpravda.kz/articles/view/pervichnaya-mediko-sanitarnaya-pomoshch-istoriya-i-realnost/?print=yes>

^{lvi} Shchepin O, personal interview, 17 July 2007, Moscow; Venediktov D, personal interview, 15 June 2004, Moscow.

^{lvii} GARF, f. 8009, op. 50, d. 8801, ll. 14–15.

that participation of Western countries would necessarily entail the presence of their own experts, espousing 'ideology alien to democratic Yemen'.^{lviii}

It is important to underscore that these approaches reflected a marked difference in Western and Soviet attitudes to 'international health aid'. Westerners, even in the PHC approach articulated in the Alma-Ata declaration (rejecting vertical disease campaigns), tended to pursue lower cost, scaled down efforts that did not resemble healthcare delivery arrangements in most 'donor' countries. By contrast, the Soviet bloc's cooperation emphasised national health systems, supporting, where possible, the emulation of the Soviet model rather than a separate approach for 'developing' countries.

At the 24th Meeting of the Ministers of Public Health of Socialist Countries held in Havana in 1983, delegates again took up the language of Alma-Ata, declaring that Communist/Labour parties' protection of health of the people was 'possible thanks to social[ist] public health priorities'.^{lix} However, by this time, the Soviets were preoccupied with war in Afghanistan and the escalating arms race with the West, leaving only residual resources and dashed attention to health.

Indeed, the aspirations generated by the conference, to attain Health for All through 'better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts' (para. X)ⁱ were quickly complicated by geopolitics. The 1979 election of Margaret Thatcher in the UK and in 1980 of Ronald Reagan in the USA heralded a conservative ideological turn, coinciding with the imposition of neoliberal policies and a Third World debt crisis that, among other effects, shrank public sector coffers and reduced government (and bilateral/multilateral) spending on social well-being. Also, tensions between the US and Soviet blocs rose with the December 1979 Soviet invasion of Afghanistan and the ever-present threat of nuclear war and new generations of 'Star Wars' missiles.

As these events were unfolding, the idealistic content of the declaration—and its prospects for 'Western-style' implementation via WHO—faced a full-scale assault from rising neoliberal quarters. The Rockefeller Foundation sponsored a 1979 conference at Bellagio on *selective* PHC that advocated a technical version of PHC based on more feasible and cost-effective measures such as vaccines and vector control instead of the ample sociopolitical-health measures advanced at Alma-Ata that were 'unattainable... in an age of diminishing resources'.⁴⁴ Soon the declaration's overall vision was watered down into a package of 'child survival' interventions, whose application was spearheaded by Unicef.⁴⁵ ^{lx} It was further diluted in attempts to 'privatise' PHC,

as witnessed by the American Public Health Association's efforts to push WHO into 'mobilization of the private sector for primary health care delivery systems in the developing countries'.^{lxi} As such, the timing and Soviet provenance of the Alma-Ata conference were not propitious for the realisation of its goals set out in the declaration, even as many countries, international agencies and social justice non-governmental organisations sought to fulfil them then and continue to advocate for their revival today.

CONCLUSION

To date, historians of WHO have largely overlooked the actual role of the various Soviet players involved in organising and hosting the conference. Yet available historical accounts of the Alma-Ata conference have curiously portrayed it as a 'small Soviet victory in the Cold War' (p. 1867)³⁶ and the fruition of 'consistent and aggressive' pressure by the USSR to 'kidnap' WHO's PHC agenda (p. 710, 718).²⁸ Given the analysis presented, it is not clear what the Soviets 'won' nor whose agenda was kidnapped. (Venediktov's agenda for comprehensive healthcare systems seems to have been hijacked by WHO, not the other way around.) Such judgements conflate the holding of the meeting in the USSR with the Alma-Ata declaration's content and seem embedded in a Cold War logic that contradicts the decision-making processes in Geneva and Moscow. In sum, the reigning assessments are implausible, largely due to reliance on one-sided (mostly English language) sources that continue to circulate unquestioned,^{22 30} reducing the Soviet Union's part in the events to a Cold War caricature.

Our examination of Soviet materials shows that: (1) despite the enthusiasm of Soviet delegates to WHO around developing a PHC agenda, Soviet authorities did not initially seek to host a conference; (2) WHO leaders exaggerated differences between PHC and the Soviet approach to health in spite of considerable overlap; (3) the highest level of Soviet leadership did not consider the conference to be a significant ideological or political event for broad international consumption, even as the conference was used to showcase Soviet advances in a previously underdeveloped region to health officials from around the world; (4) high-level Soviet political authorities did not see the potential of the conference results for the domestic sphere; and (5) not only did the USSR not view Alma-Ata as a means of taking over WHO's PHC agenda, it bypassed WHO in its (prior and) subsequent cooperative efforts.

In the end, rather than representing a Cold War victory for the USSR or a Soviet scheme to kidnap WHO's PHC agenda, the landmark Alma-Ata conference had distinct

^{lviii} GARF, f. 8009, op. 50, d. 8878, ll. 96–98.

^{lix} GARF, f.8009, op. 51, d. 931, ll. 20–36.

^{lx} See Newell.⁴⁵ Yet critics on the left from outside the socialist world had repeatedly argued that the Alma-Ata agenda reflected the "hegemonic development establishments of

the Western world". See Navarro⁸⁵ and from Latin America, Breilh⁸⁶; Testa.⁸⁷

^{lxi} Herbert Dalmat, International Health Programs, APHA, to Edward Mach, WHO, 28 April 1980, P21/87/5, Box A. 1401, WHO Archives.

meanings for WHO and Soviet players on what to highlight and how to achieve Health for All: via community-based efforts for WHO and through centrally planned healthcare for the Soviets. This struggle persists to the present in the debate over 'Universal Health Coverage' which, to some, presents an opportunity to resurrect and extend 'free' national systems of universal, publicly delivered healthcare, while others favour a public-private mix that is nominally universal but not necessarily comprehensive or equitable. While there is no longer a Soviet Union able to say 'been there, done that' and the Soviet PHC system certainly had many flaws, the Soviet side of the Alma-Ata conference is undoubtedly worth understanding in greater depth as countries once again pursue (often inadequate) health reforms.

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