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Research Paper

Alma atar declaration of health promotion: a tool in emergency preparedness for prevention and mitigation of re-emerging infectious disease outbreaks

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ABSTRACT

Alma-Ata Declaration stated that health is a fundamental human right and stressed the relevance of addressing political, socio-cultural and socio-economic determinants of health. The Declaration defined Primary Health Care (PHC) as an essential healthcare made universally accessible to individuals and families in the community, through their full participation and at a cost the community and country can afford. This review evaluated the impact of Alma Atar Declaration on health promotion emergency preparedness for prevention and mitigation of re-emerging infectious disease outbreaks in Nigeria. Previous literatures were reviewed using search engines including google scholar, Mendeley reference library, and Pubmed. Results showed that Alma-Ata Declaration had significant impact on global health policy, structuring health as a holistic, human rights-based issue. Many countries adopted PHC strategies such as expanding immunization programs, maternal and child health services, and community-based intervention programmes in prevention and control of infectious diseases by empowering individuals and communities with knowledge, skills, and resources required to protect their own health and reduce disease transmission. The integrated approach ensures that PHC services are delivered alongside other essential health interventions, including maternal and child health and nutrition programs in order to strengthen health systems, improve resource efficiency, community trust, and vaccine acceptance.

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1. INTRODUCTION

The Alma-Ata Declaration, proclaimed in 1978, marked a critical breakthrough in global public health by redefining health as a core human right and positioning Primary Health Care (PHC) as the most effective method for achieving non-discriminatory and long-termed health impacts nationwide [1]. The declaration emerged at a time when health systems in many nations were characterized by inequities, inequalities, disjointed service delivery, and an extreme reliance on curative, hospital-based healthcare that broadly excluded rural, vulnerable and marginalized populations. By Reinforcing prevention, equity, and community participation, Alma-Ata provided a revolutionary conceptual framework for addressing population health needs.

Gathered jointly by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), the International Conference on Primary Health Care was held in Alma-Ata (now Almaty, Kazakhstan) from September 6–12, 1978 [2]. The conference mobilized representatives from 134 countries and numerous international agencies, demonstrating an international agreement on the urgent need to restructure healthcare systems toward people-focused and community-oriented approaches. Before the Alma-Ata Declaration in 1978, majority of healthcare services in many countries operates as hospital-based in urban setting. Often times, those services were unreachable, unavailable, unaffordable, and culturally unsuitable for significant portions of the population, especially the vulnerable groups such as children, pregnant women and elderly. To mitigate this, WHO and UNICEF sought to address these health disparities by promoting universal access, equity, and capacity building through PHC to all age at all-time [3]. The Alma-Ata Declaration clearly defined health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. This simply means that health is significantly shaped by culture, social, economic, and political determinants. It also recognized that improving health outcomes requires multi-sectoral collaboration including; agriculture, education, water and sanitation, housing, security and employment. The Declaration highlights the importance of community participation, intersectoral collaboration, appropriate technology, and affordability as core components for effective healthcare systems. The key principles of the Alma-Ata Declaration are illustrated in Figure 1, [2].

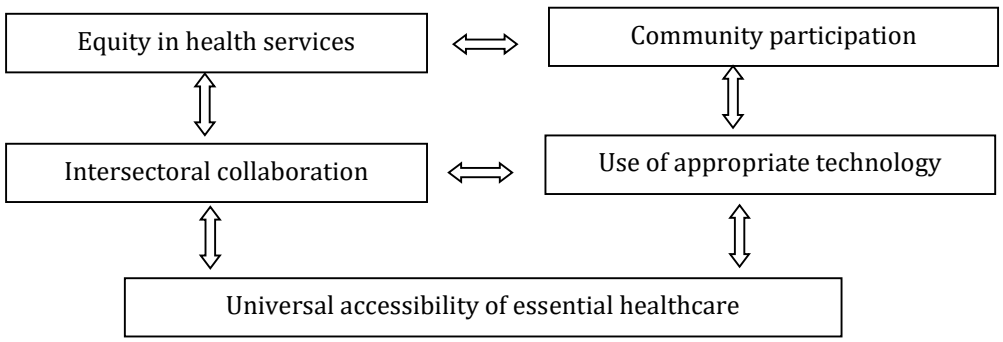

Figure 1. Principles of Alma-Ata Declaration

In current setting, the relevance of Alma-Ata remains deeply impactful. Of a particular note is the COVID-19 pandemic, which exposed structural deficiencies and highlighted the critical need for resilient,

community-centered, and equitable health systems grounded in PHC core values. Furthermore, the Alma-Ata Declaration aligns closely with the Sustainable Development Goals (SDGs), especially SDG 3, which aims to promote healthy living and prolong life for all at all ages [4], [5], [6]."

2. RELATED WORK

According to Alma-Ata Declaration, PHC is an essential healthcare, made universally accessible to individuals and families in the community, through their full participation, and at a cost the community and country can afford" [7]. This definition signified a notable transition from treatment-focused, hospital-oriented systems toward a preventive, community-focused, and equity-driven approach of healthcare service delivery. Furthermore, the conference highlighted that in order to achieve health for all, proactive and orchestrated action would be require by all countries involved, reinforcing cooperation, fairness, and collective responsibility for community-oriented health [2]. Critical to the Declaration was the recognition of health promotion and disease prevention as foundational components of PHC. The declaration identified public health education on prevention and control of health-related problems, encouraging community participation, prevention and control of locally endemic diseases, and provision of maternal and child healthcare such as family planning, as part of the eight core elements of PHC [8].

Health promotion is defined as "the process of enabling people to increase control over and improve their health in everyday life". It involves prioritizing health on the agenda of all sectors and encouraging stakeholders to take responsibility for health outcomes. Obligations for healthcare are distributed among individuals, family members, community groups, healthcare professionals, and governments [8], [9]. This shared-responsibility framework closely aligns with the Alma-Ata perspective, which reinforces community-empowerment, community-participation, and multi-sectoral partnership as essential to sustainable healthcare delivery. After the Declaration, many countries adopted PHC tactics by expanding their immunization programs, consolidate maternal and child services, and implemented community-based intervention programs aimed at preventing infectious diseases. These interventions showed that community participation and decentralized service delivery could significantly enhance access to healthcare outputs. Nevertheless, critics argued that Alma-Ata Declaration was unrealistic and complex to implement, especially in low-resource settings facing economic hardship and fragile healthcare structures. These conflicting argument led to introduction of Selective Primary Health Care (SPHC) in the 1980s, which focused on affordable and evidence-oriented actions including immunizations, oral rehydration therapy, child growth monitoring, and breast-feeding promotion [10], [11]. Despite these critiques, PHC remains a core aspect of national healthcare systems and serves as focal point for socio-economic development at the community level. It is acknowledged as the first level of contact between individuals, families, communities and the national healthcare system, to provide continuous, comprehensive, and integrated healthcare [1].

Worldwide Conference on PHC in 2018 held in Astana (modern-day Almaty) reinvigorated international agreements to the core values of Alma-Ata. At the Astana Conference the principles of equality, equity, community participation, and inter-sectoral collaboration were reaffirmed, while adopting them to present-day emergencies including non-communicable diseases, ageing population, migration, urbanization, and healthcare system resilience. Alma-Ata called on all governments to develop national policy frameworks, approaches, and action plans to flag-off and sustain PHC as a fundamental aspect of national healthcare systems, allowing each country to modify based on its distinct environment and resources [12].

In Nigeria, PHC facilities were established in both rural and urban areas to promote equity and improve accessibility, availability and affordability to essential health services. However, empirical data suggests that rural populations remain significantly marginalized compared to their urban peers. Factors such as lack of government commitment, fund inadequacy and mismanagement, weak inter-sectoral collaboration, personnel shortages, and governance conflicts between local and state governments continue to hinder effective PHC implementation [1], [13]. These structural challenges restrain the capacity

of PHC to fully support health promotion, emergency preparedness, and control of re-emerging infectious diseases.

3. METHODOLOGY

This study utilized a non-systematic review design to generate existing literatures on the relevance of Alma-Ata Declaration to health promotion and emergency preparedness, for the prevention and mitigation of re-emerging infectious disease outbreaks. A non-systematic approach was considered appropriate because it allows for a comprehensive and contextual examination of historical and empirical literature related to PHC, health promotion, and infectious disease preparedness, especially within low- and middle-income country settings. A total of sixty-six (66) published literatures were initially identified through systematic searches of electronic databases including PubMed, Google Scholar, African Journals Online and Mendeley reference library. Additional articles were obtained through manual searches of reference lists of relevant studies. Key words used included 'Alma-Ata Declaration', 'primary health care', 'health promotion', 'community engagement', 'immunization', 'maternal and child', 'disease surveillance', 'emergency preparedness', 're-emerging infectious diseases', 'disease outbreak', 'preparedness', and 'health system resilience'. Boolean operators such as "AND" and "OR" were applied to refine search outputs.

Inclusion criteria comprised peer-reviewed journal articles, conference reports, and global or national health proceedings published in English that explicitly focus-on PHC, Alma-Ata principles, health promotion, or emergency preparedness in relation to infectious disease prevention and control. Research articles published within the last five years were given preference in order to ensure relevance. Although, older publications were included due to their empirical and historical significance. Majority of the articles included were studies that focused on Nigeria, sub-Saharan Africa, as well as other low- and middle-income countries due to shared geographical and environmental settings.

Duplicated publications, proceeding without empirical or policy relevance, studies lacking methodological clarity, and articles that focused solely on non-communicable diseases without linkage to infectious disease preparedness were excluded. After which, titles and abstract screening resulted in 42 articles being shortlisted, and full-text review resulted in 30 studies being included in the final reviewed manuscript.

4. RESULTS AND DISCUSSION

The Alma-Ata Declaration of 1978 marked a landmark achievement in global public health by galvanizing the international community around Primary Health Care (PHC) as the cornerstone for achieving "Health for all." Although the Declaration initially focused on communicable diseases, maternal and child health, and health equity, its broader principles; people-centered care, community participation, prevention-oriented services, and inter-sectoral collaboration have demonstrated enduring relevance in addressing contemporary public health challenges, including the prevention and mitigation of re-emerging infectious diseases. These core values have modelled health promotion strategies that highlight empowerment, community ownership, and resilience within healthcare systems.

Health promotion, as enshrined within the Alma-Ata framework, extends beyond individual behavior change to involve social mobilization, policy advocacy, community engagement, and environmental advancement. In the context of re-emerging infectious diseases, including cholera, tuberculosis, monkey pox, lassa fever, measles, Ebola, and COVID-19, health promotion serves as a fundamental tool for preparedness and response by strengthening health literacy, encouraging early and decisive health-seeking behavior, and fostering trust between communities and healthcare providers [14]. The results from reviewed literature demonstrate that countries that adopted Alma-Ata–inspired PHC frameworks were better stationed to detect outbreaks early, organize responses, and sustain essential healthcare services during emergencies.

4.1 Primary Health Care and Disease Surveillance

Strengthening and consolidating community-oriented disease surveillance systems within the PHC systems are major impact created from the Alma-Ata Declaration. This make PHC facilities serve as the first point of contact to individuals susceptible to health risk, as well as early detection of infectious disease outbreaks. Diseases such as cholera, tuberculosis, malaria, and measles, many of which have re-emerged due to urbanization, climate change, population displacement, antimicrobial resistance, and weak health systems are frequently identified first at the community level through PHC centers [4]. Community health workers, nurses, and primary care clinicians play a pivotal role in identifying unusual disease patterns, reporting suspected cases, and initiating timely responses. This early detection capability reduces delays in outbreak recognition, limits transmission, and minimizes morbidity and mortality.

Disease surveillance is particularly relevant in low-resource settings where access to tertiary healthcare facilities and laboratory services is confined. Active community participation, a core principle of the Alma-Ata Declaration, serve as the building-block for community-centered disease surveillance (CCDS) systems. CCDS involves the systematic collection, analysis, and interpretation of health data at the community level, often coordinated by trained community health workers, volunteers, and community leaders [15], [16]. As a result, this approach promotes both the sensitivity the population to community health threats, as well as ensures culturally acceptance of surveillance systems. By empowering communities to participate actively in surveillance programs, Alma-Ata–inspired PHC frameworks enhance outbreak preparedness and emergency response.

4.2 Strengthening Community Participation

Community participation is one of the most sustained and effective principles of the Alma-Ata Declaration. The Declaration reinforces that health is a fundamental human right and that achieving it requires the genuine involvement of individuals, families, and communities in planning, implementing, monitoring and evaluating healthcare services. This explicitly shows that collaborative approach is indispensable when it comes to controlling infectious diseases, particularly in settings where distrust of health officials and misinformation prevail [2], [17], [18]. Put together, Alma-Ata declaration placed community engagements as active stakeholders instead of just passive beneficiaries by promoting community ownership and capacity-building in order to strengthens community trust, optimize service utilization, and increases compliance to prevention and control measures.

A good example is the 2014–2016 Ebola epidemic in Sierra Leone which demonstrated the critical roles of community participation. The outbreak was heightened by distrust of health officials, fear, traditional burial practices, and delayed healthcare-seeking behavior. In reaction, governments, World Health Organization, and non-governmental organizations collaborated with community leaders, women's groups, and religious organizations to deliver targeted health messages and conduct contact tracing. Community volunteers were trained to handle safe burials, provide health education, and support surveillance actions [19]. The use of community-oriented approaches helped in promotion of community trust, increased disease reporting, and subsequence reduction in disease transmission. During the COVID-19 global-outbreak, similar approaches were utilized especially situations where community and faith-based leaders made significantly disseminated reliable information, countering misinformation, and promote compliance to public health directives Table 1, [19], [20].

Table 1. Strategies and Outcomes of Community Engagement in Mitigation of Infectious Disease Outbreaks

Disease Outbreaks	Community Participation Strategies	Results
Ebola (2014–2016)	Contact tracing and surveillance Vaccination campaigns Training of community volunteers to handle safe burials Collaboration with community leaders	Better adherence with prevention interventions Enhanced public health information Decreased misinformation

	Health education	Improved community trust Improved disease notification
COVID-19	House-house health education Mobile-phone messaging Symptom-based screening Contact tracing Vaccination community outreach Collaboration with local and Faith-based leaders	Increased awareness Improved testing and vaccination rates Enhanced adherence to COVID-19 protocols

4.3 Promoting Inter-Sectoral Collaboration

Inter-sectoral partnership is a fundamental principle of the Alma-Ata Declaration, acknowledging that health indicators are shaped by factors beyond the healthcare sector alone. Integration of health measures with sectors including education, water and sanitation, housing, agriculture, transportation, and social development were the emphasis of the Declaration. The relevance of integrated approach is particularly notable for prevention and mitigation of infectious diseases that are influenced by environmental and social determinants [21]. Harmonized interventions such as access to adequate and safe water, improved sanitation, hygiene promotion, and food safety initiatives are of necessity to curb re-emerging infectious diseases such as cholera. Without such partnership, medical actions alone are inadequate to interrupt disease transmission.

The World Health Organization has consistently reinforced cross-sectoral collaboration as essential for enhancing health outcomes, especially among susceptible populations. WHO recommends that member states support synergistic actions between key health-producing sectors to extend coverage of essential interventions and address health inequities. By promoting inter-sectoral collaboration, the Alma-Ata Declaration acknowledged that improving population health requires policy coherence and coordinated action across sectors that influence daily living conditions. Evidence from literatures show that countries that established inter-sectoral structures were better equipped to mitigate complex public health emergencies. These structures facilitate information sharing, resource allocation, and coordinated responses, thereby improving overall operational efficiency during outbreaks [22].

4.4 Resilience Against Health Emergencies

Health system resilience being the ability to prepare for, respond to, and recover from health emergencies, is a critical outcome of Alma-Ata–inspired PHC systems. Although, the Declaration did not specifically use the term “resilience,” its emphasis on community-oriented, person-centered care, prevention, and inter-sectoral collaboration laid essential foundation for resilient health systems [5], [17], [22]. PHC serve as the cornerstone for emergency preparedness by maintaining continuity of essential services during emergency. Countries with strong PHC systems demonstrated better outcomes during the COVID-19 pandemic, as PHC facilities functioned as frontline entry points and screening centers for public health communication [5].

A fundamental principle of the Alma-Ata Declaration is community empowerment, which improves resilience by ensuring that communities are informed, engaged, and prepared to respond to health-related threats [17]. Empowered communities can detect warning signals, adopt risk-reducing practices, and support localized interventions. This local capacity strengthens national preparedness and reduces dependence on international aid. Observations from the Ebola outbreak and COVID-19 pandemic underscore the relevance of strong, community-oriented PHC systems for maintaining essential healthcare services, protecting susceptible populations, and integrating multi-sectoral responses during crises [19], [23]. From these observations, it is noted that resilience against emergencies does not only involves functional facilities, it include community trust, community participation, and responsiveness to health threat.

4.5 Integration of Immunization Interventions

A well symbolic element of Alma-Ata framework is the integration of routine immunization programs into PHC services. This aimed to strengthen immunization being one of the most affordable public health interventions critical in averting outbreaks of vaccine-preventable infections such as measles, polio, diphtheria, and pertussis [10], [24]. Integration immunization program into PHC services such as maternal and child health, nutrition programs, and health education, rather than vertical, and isolated campaigns help to improve coverage, sustainability, and public acceptance [4], [10], [25].

Uptake, countering misinformation about vaccines, and addressing vaccine hesitancy was demonstrated in the success of Nigeria's polio eradication through the Alma-Ata–aligned strategies. These strategies include community engagement, religious leaders' efforts, door-to-door vaccination campaigns, and intensive media engagement, leading to Nigeria successfully halting the wild poliovirus transmission and the subsequent declaration of Africa being polio-free in 2020. Similarly, strengthened health promotion actions during measles outbreaks in other countries restored community trust in immunization programs and remarkably reduced incidence rate. These examples illustrated that integration of immunization programs, supported by resilient PHC systems and community engagement are essential for preventing re-emergence of vaccine-preventable infections [26], [27], Table 2.

Table 2. Causes, Strategies and Milestone Achievement of Integrated Immunization Interventions

Disease Outbreaks	Causes	Immunization Strategies	Milestone Achievement
Poliovirus in 2020	Low immunization coverage vaccine hesitancy False-information	Community engagement Religious leader participation Address fears and misconceptions Door-to-door vaccination campaigns Mass vaccination exercise Intensive media Engagement Underscoring the safety and benefits of vaccine uptakes	Polio Eradication in Nigeria Africa declared polio-free
Measles outbreak in 2019	Reducing public trust in vaccine uptake Argument over dengue vaccine	Aggressive public awareness Health promotion campaigns via television and social media Community leaders to restore trust in immunization programs Catch-up immunization targeting unvaccinated and under-immunized children	Restored public trust in immunization programs Reduce incidence rate of measles by > 50%

4.6 Increasing Public Knowledge and Awareness

Increasing public awareness and enhancing health literacy are fundamental components of health promotion under the Alma-Ata framework. Public education programs increase understanding of disease transmission, preventive practices, and available treatment options, enabling individuals and communities to make informed health decisions [7], [14], [28]. Health education campaigns addressing hand and environmental hygiene, safe food handling, immunization, insecticide-treated nets utilization, and early healthcare-seeking behavior have been shown to reduce health-risk behaviors and improve disease outcomes. When individuals and communities have good knowledge of the mode of transmission and complications of diseases, they will be able to recognize disease symptoms early and seek medical care timely.

A good example of the impact of health promotion is the 2019 measles outbreak in Samoa. As a result of generalized refusal of the population to accept uptake of vaccine, the rate of vaccination dropped

drastically, resulting in thousands of people being infected including numerous deaths. In order to curb this health threat, the government, in collaboration with WHO and UNICEF launched intensive public health awareness and immunization campaigns through the channels of mass media, meetings with community stakeholder and religious leaders, as well as local influencers mitigated the spread of measles outbreak. These actions swiftly increased immunization coverage, vaccine uptake and successfully ended the outbreak [29], [30], Figure 2.

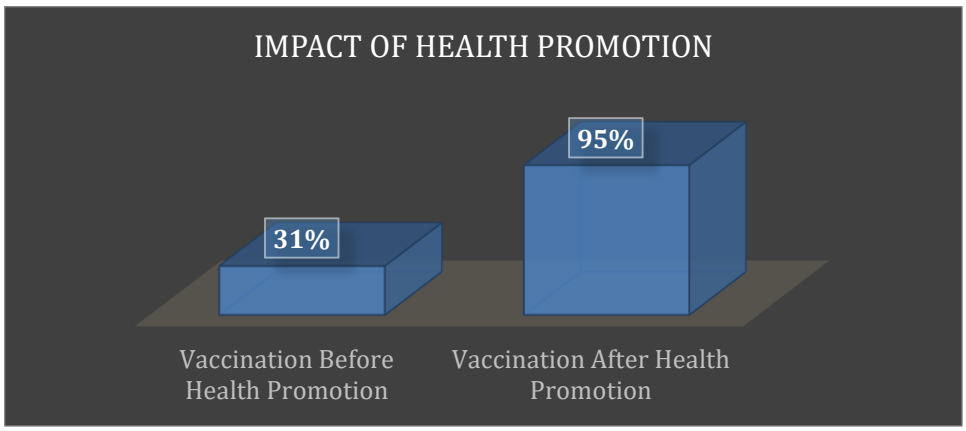

Figure 2. Impact of Health Promotion on Infectious Disease Outbreaks

5. CONCLUSION

This review demonstrated how Alma-Ata Declaration of 1978 positioned PHC as the pillar for achieving equitable and sustainable healthcare. The Declaration emphasized health as a core human right, achievable through community participation, inter-sectoral collaboration and health promotion to tackle contemporary public health challenges, especially through improved disease surveillance systems, prevention and control of re-emerging infectious disease outbreaks. Conventionally, community-based surveillance as well as the involvement of community health workers have enabled early detection, reporting, and response to infectious disease outbreaks, thereby reducing transmission, morbidity, and mortality. Furthermore, the integration of immunization programs and health education into PHC services are instrumental in preventing the resurgence of vaccine-preventable diseases, leading to improved immunization coverage and vaccine acceptance in hard-to-reach populations.

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John Esimaje Moyegbone	✓		✓	✓				✓		✓	✓	✓	✓	✓
Ezekiel Uba Nwose	✓	✓	✓					✓	✓	✓	✓			✓
Michael Ogorchuku Otutu			✓	✓						✓	✓		✓	
Obiajulu Emmanuel Uwaka	✓	✓				✓	✓			✓	✓	✓		

C : **C**onceptualization
M : **M**ethodology
I : **I**nvestigation
R : **R**esources
Vi : **Vi**sualization
Su : **Su**pervision

So : **So**ftware
Va : **Va**lidation
Fo : **Fo**rmal analysis
D : **D**ata Curation
O : Writing - **O**riginal Draft
E : Writing - Review & **E**diting
P : **P**roject administration
Fu : **Fu**nding acquisition

Conflict of Interest Statement

Authors state no conflict of interest.

Informed Consent

Not applicable.

Ethical Approval

Not applicable.

Data Availability

Data availability is not applicable to this paper as no new data were created or analyzed in this study.

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