World Nutrition 2018;9(2):121-126

Commentary on the importance of the Alma Ata principles of equity and voice, through intersectoral investment and leadership, in achieving the health and nutrition Sustainable Development Goals by 2030. A reflection on the upcoming Astana Conference, to be held on the 40th anniversary of the Alma Ata Declaration of 1978.

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From Alma Ata to Astana: can renewed commitment to Health for All by 2030 be committed to in October 2018?

In October, around two hundred countries and international organisations will meet in Astana, Kazakhstan, to mark the 40th anniversary of the Alma Ata Declaration. Forty years ago, 134 countries and 67 international organisations including NGOs (Non- governmental organisations) met at an innovative three-day conference, to agree on the best approach to improve global health (World Health Organisation 1978). The Alma Ata Declaration called for global commitments to achieving Health for All by the year 2000. The agreed approach, to achieving Health for All was through Primary Health Care. The key principles of PHC included a focus on equity of access to health care, supported by active community participation in health planning and policy making and concurrent investments in other sectors such as nutrition, education, water and sanitation. The evidence presented at the meeting explored experiences from countries like Sri Lanka, Cuba, and Guyana who had managed to achieve good health care at a low cost. These countries focused on equitable access to health care close to local populations with systems to encourage active involvement of local communities while also investing in other key sectors (Werner and Sanders 1997, Mc Kay et al 2004). The meeting also explored the success of community approaches, used often by NGOs and FBOs (faith-based organisations), to ensure that health care was able to reach the most vulnerable populations (Fleck 2013).

> *"The concept of primary health care did not appear overnight. Some trace it back to an intergovernmental conference in Bandoeng, Indonesia, in 1937. That conference was held by the health organization of the League of Nations – a predecessor to WHO – that recommended that "the greatest benefit to the health of the rural populations, at the smallest cost, can be obtained through some process of decentralization" (Fleck 2013)*

Despite the promises made in 1978, political commitment and resources did not follow; investments favoured a narrow selective PHC approach which, combined with a global recession, resulted in the target of Health for all by the year 2000 not being realised.

In 2000, global leaders again determined to address the rising inequity of poverty, malnutrition and preventable deaths and committed to eight new goals entitled the Millennium Development Goals (UN 2000). Three of these goals focused on health, but not health for all. MDGs 4, 5 and 6 focused on improving the health of under five-year-old children, their mothers and those dying from infectious diseases such as HIV and Malaria. The goals set were supposed to be achieved by 2015 but again political commitment and investment failed to match the promises. In 2003, there were still 12 million under-fives and 529,000 women dying from preventable deaths each year. That year the Lancet launched a series of evidenced-based papers setting out where these children were dying and how their deaths could be prevented. In the same year, a UK based advocacy group, Grow up Free from Poverty, released a report warning that the health related MDGs would not be achieved by 2015, especially in the Sub Saharan African countries (Grow up Free from Poverty Coalition 2003). The report was launched in the UK Parliament by the UK Secretary of State, estimating that failing to meet the MDG 4 and 5 targets by 2015 would result in the loss of 80 million lives. This report echoed global concern calling for urgent action. The stage was set for the Make Poverty History campaign. Activists, communities and non-governmental organisations rallied together calling on the UK G8 meeting to agree to urgent investment into achieving the failing MDGs. (Keith 2001, 2003, 2005a, 2005b; Oxfam 2006). The G8 promised to double aid to reduce poverty.

In early 2005, WHO invited health practitioners, member states, donors and academics to a consultation on the development of the World Health Report 2005: Making Every Mother and Child Count (World Health Organisation 2005). This report highlighted the importance of the Alma Ata principles, with chapters on pro-poor health financing and the importance of community engagement in health policy and plans. The importance of investing in health systems and health workers, was clearly set out in the report. The report stated that health care needed to be financed in a pro-poor approach that did not pull populations into poverty:

> *"Ensuring universal access is not merely a question of increasing the supply of services and paying health care providers. For services to be taken up, financial barriers to access, have to be eliminated and users given predictable financial protection against the costs of seeking care, and particularly against the catastrophic payments that can push households into poverty….. To attain the financial protection that has to go with universal access, countries throughout the world have to move away from user charges, be they official or under-the-counter, and generalize prepayment and pooling schemes…" (World Health Organisation 2005)*

Also in 2005, Save the Children UK launched the findings from a seven country, five-year study which illustrated that WHO's concerns regarding the importance of pro-poor access to health care were well founded. The research highlighted numerous barriers to accessing health care in East and Central Africa. However, the direct and indirect cost of health care were identified as the biggest barriers to timely utilisation of health services. The research stated that, on average, 30% of the population did not seek care due to the cost, while a further 30% were pulled into deeper poverty by paying for health care (Save the Children UK 2005). To follow up on their research, Save the Children UK collaborated with academics, to determine the cost and impact of abolishing health user charges in the UK's priority twenty Sub Saharan African (SSA) countries. The analysis estimated that, in the twenty countries, 225,000 under five-year-old children could be prevented from dying each year if health care user charges, at the point of access, were removed (James et al 2005). This research was quoted in the UK Labour election manifesto and the UK prime minister pledged to protect

UK aid investments and to support 12 countries and, if elected, to move away from health user fees by 2015 (Keith & Shackleton 2006). These investments did have impacts, especially in ten African countries, where health spending increased by 40 % (Oxfam 2013). In Liberia child mortality rates were halved, despite the fragility of their health system (Keith, Cadge 2010).

The above events resulted in creation of global partnerships, such as the Countdown to 2015, the Partnership for Maternal New-born and Child Health, the Global Health Worker Alliance, and Women Deliver. These groups all played key roles in keeping the health-related MDGs high on the political landscape.

In 2008, on the 30th anniversary of the signing of the Alma Ata Declaration, WHO released their World Health Report focusing on the need to return to the principles of Primary Health Care (WHO 2008). The Lancet also launched their nutrition series identifying where the children with malnutrition were and how to prevent their deaths through impactful interventions such as exclusive breastfeeding and treatment of severe acute malnutrition (Black et al 2008).

In 2009 World Vision International launched their Global campaign: Child Health Now (World Vision 2009), bringing nutrition and health together. The report illustrated that although progress was occurring, with global child deaths reduced to 9 million annually, MDG 4 was still not likely to be achieved by 2015.

In 2010 many of the above global stakeholders fed into the development of the United Nations Secretary General's Global Strategy for Women and Children's Health, to ensure that every woman and child would count (UN 2010), which was launched in 2010 in New York. Increased commitments and resources did occur and some countries such as Ethiopia, Malawi, Liberia, and Bangladesh all achieved dramatic reductions in their under-five mortality rates to achieve their targets for MDG 4 (Countdown to 2015). Also, in 2010, the launch of the Scaling up Nutrition coalition renewed the call for malnutrition to be addressed, and in 2012 the World Health Organisation established global nutrition targets to be achieved by 2025 (Scaling up Nutrition 2012, World Health Organisation 2018).

Globally the number of under-five deaths has been reduced from 12.6 million in 1990 to 5.6 million in 2017, so progress has occurred (World Health Organization, 2017). However, the MDGs were not achieved and new pledges were made.

Seventeen new Sustainable Development Goals, agreed by the United Nations in 2015, are to be achieved by 2030 (United Nations, 2015). This time Universal Health Coverage is included as a target. To achieve this target, we must return to the key principles of PHC, focusing on equity, voice and addressing the social determinants of health. Evidence since 1978 clearly demonstrates that tax-based services provided free at the point of access are the most equitable and pro-poor (Save the Children 2005, Rannan-Eliya et al 2006). Evidence also demonstrates that bringing health services closer to the population, including their voices in the planning and assessment of the services, and addressing the social determinants of health are essential factors leading to improved health outcomes in low resource countries that have made progress (Grow up free from Poverty 2003, Mc Kay et al 2004, Keith and Cadge 2010, Merlin 2010, Countdown to 2015).

Today half the world's population still lack access to essential health care services and 100 million people are still pulled into poverty each year, paying for health care (World Health Organisation, World Bank, 2017). The Astana Declaration of 2018 can build on the ground-breaking pledges made in the Alma Ata 1978 Declaration and generate renewed commitment to health for all. We have the knowledge and resources, but do we have the political will and commitment? Will the Astana Declaration reflect on the lessons learned over the last 40 years and call for a return to the key principles of equity and voice through an intersectoral approach? Or will the Astana Declaration become another failed opportunity to promote the right to health for all?

It is up to all of us, to ensure that we learn from the past and use the evidence we have collected to make the Astana Declaration one that is finally realised. We can ask our political leaders to attend the Astana conference with renewed hope and urgency, to support the achievement of Health for all by the 2030. It is possible, if we are committed to it.

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