



‘Health for All’ Alma-Ata Declaration – an elusive Holy Grail

Exactly 30 years ago this month – on 6 - 8 September 1978 – member countries of the World Health Organization converged on the city of Alma-Ata (now called by its ancient name of ‘Almaty’) in the then Kazakh Soviet Socialist Republic, to hold the International Conference on Primary Health Care under the auspices of the WHO and UNICEF.

The conference launched two novel ideas, that health is ‘a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity’, and further, that health ‘is a fundamental human right, and ... the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector’.

Primary health care (PHC) was advanced as a means to attain these goals. In a rather longwinded description, the conference defined 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 the country can afford and maintain’. PHC planning must therefore be realistic and feasible, embrace proven strategies, and include the democratic participation of the communities it seeks to serve by decentralising PHC implementation to the district level. The conference undertook to strive for the attainment by the year 2000 of a level of health that would permit all people of the world to lead a socially and economically productive life.

In the years following the Alma-Ata Declaration, African nations enthusiastically embraced the Health for All (HFA) initiative. However, PHC implementation soon ran into a whole host of obstacles, not least the ever-deepening poverty in sub-Saharan Africa (SSA). In a 1996 *BMJ* editorial, Mozambican prime minister Pascual Mocumbi and Stefan Bergstrom of the Karolinska Institute described the HFA by the year 2000 initiative as ‘claptrap’ and ‘wishful thinking far away from the bitter reality of widespread poverty’ which they blamed on Africa’s debt burden, noting that every year there was a net drain from the poor to the rich countries of some \$150 billion largely in debt repayments, and that more wealth was extracted by rich countries each year than was invested in health and education for Africans. Rich countries also benefit from the brain drain that leaves poor countries with a bigger skills gap. HFA 2000 also did not foresee the political conflicts, military regimes, dictatorships and HIV/AIDS that would ravage SSA economies and governance in the ensuing decades. Happily, the latter-day resurgence of democracy in this region inspires hope for the future.

Nevertheless, in most SSA countries, HFA and PHC initiatives were stillborn. What PHC programmes there are have suffered from chronic drug shortages, poor equipment accessibility and maintenance, inadequate logistical support, weak management, and lack of systems and procedures to measure, monitor and improve the quality and effectiveness of health services provided. Importantly, PHC cannot bring about optimal health in isolation. Other services such as safe water, sanitation, food, female education, decent shelter, employment and a growing economy are indispensable prerequisites for HFA. Unfortunately, these services are all too often managed in administrative silos that don’t speak to one another in most SSA countries.

South Africa was just about 20 years late committing to the Alma-Ata HFA initiative. However, the country has accomplished a great deal in the short span of a decade in laying the foundation for effective PHC since the publication of the 1997 White Paper that pledged to create a ‘unified health system capable of delivery of quality health care to all citizens efficiently and in a caring environment’. Numerous new clinics have been commissioned, and access to care universalised, particularly for pregnant women and children. Notwithstanding its teething problems, the District Health System, fundamental to PHC, has been implemented. A PHC Package has been published setting out norms and standards for quality service, and a Health Monitoring and Evaluation Cluster has been set up at the Ministry to track the functioning of the system. A National Health Information System is in place to collect and store critical data on the utilisation profile of PHC services. An Essential Drug List has been formulated, and legislative and other attention devoted to drug availability, safety and affordability. Work on a plan for human resources for health is underway. And despite all the controversies, conflicts, political side-shows and gaping shortcomings, we have a functioning HIV/AIDS prevention and treatment programme in place.

However, PHC is not without some challenging implementation problems, showing that it is not enough simply to have systems in place. We will need to hone our health management skills, combat corruption, insist on competence and restore provider professionalism for HFA to be on a winning wicket.

Daniel J Ncayiyana

Editor

