# **Global Conference on Primary Health Care**

## *25-26 October 2018 | Astana, Kazakhstan*

Media Coverage and Digital Highlights - Summary and Analysis



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## **MEDIA OVERVIEW**

On 25-26 October 2018, world leaders came together at the Global Conference on Primary Health Care in Astana, Kazakhstan, to renew a commitment to primary health care as key to Health for All. Co-hosted by WHO, UNICEF and the Government of Kazakhstan, the Global Conference on Primary Health Care commemorated the 40th anniversary of the Declaration of Alma-Ata. On 26 October, representatives from 140 countries, including 60 ministers of health, pledged to strengthen their primary health care systems, and all WHO Member States unanimously agreed to the new [Declaration of Astana](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf).

The Communications Working Group, comprised of communications staff from WHO, UNICEF, Kazakhstan Ministry of Health and Global Health Strategies, led advocacy, communications and stakeholder engagement around this historic occassion. In addition to raising the visibility of the conference itself, communications activities amplified materials and moments such as the [*Lancet*](https://www.thelancet.com/journals/lancet/issue/vol392no10156/PIIS0140-6736(18)X0044-0) special report on primary health care and the Declaration of Astana.

Together, these communications efforts resulted in global media coverage of the urgent need for greater investment in primary health care. As of 8 November, efforts to promote the Global Conference and highlight its historic outcomes resulted in **130** media hits, including **109 original pieces** spanning **33 countries**:

* **18 pieces in 5 top-tier** **publications** (*The Lancet, Foreign Policy, BMJ*, *Financial Times and The Guardian*)
* **72 pieces** in Global South outlets
* **37 pieces** in Global North outlets

Highlights include coverage in global outlets such as the [***Financial Times***](https://www.ft.com/content/46f2d448-d85f-11e8-a854-33d6f82e62f8)and[***The Guardian***](https://www.theguardian.com/global-development/2018/oct/25/ebola-has-shown-global-health-system-strong-as-weakest-link-ellen-johnson-sirleaf)*,* and leading national and regional outlets including [***Hindustan Times***](https://www.hindustantimes.com/india-news/who-astana-declaration/story-rmrXrDoH8vHWYWMZiIYrIL.html)(India)*,* [***Daily Nation***](https://www.nation.co.ke/news/world/Declaration-on-primary-health-care-adopted/1068-4824430-8jfsaaz/index.html) (Kenya), [***Daily Graphic***](https://www.graphic.com.gh/news/general-news/ghana-benefits-from-primary-health-care-initiative.html) (Ghana), [***Folha de S.Paulo***](https://www1.folha.uol.com.br/equilibrioesaude/2018/10/saude-nao-e-brinquedo-politico-diz-diretor-da-oms.shtml?utm_source=whatsapp&utm_medium=social&utm_campaign=compwa) (Brazil) and [***Eurasianet***](https://eurasianet.org/as-kazakhstans-economy-regains-vigor-concerns-shift-to-healthcare) (Central Asia). Pick-up of press releases and original stories resulted in an **additional 21 media hits**. These numbers are expected to grow as more articles, particularly more in-depth pieces, are published in the upcoming weeks.

The Declaration of Astana was the most widely covered global story during the conference**. The new declaration was featured in 22 original stories** (approximately 20% of the total coverage), with notable coverage from [***UN News***](https://news.un.org/en/story/2018/10/1024102) (picked up by three outlets), [***La Nación***](https://www.lanacion.com.ar/2184825-en-kazajistan-lideres-todo-mundo-llaman-impulsar) (Argentina) and [***Hindustan Times***](https://www.hindustantimes.com/india-news/who-astana-declaration/story-rmrXrDoH8vHWYWMZiIYrIL.html) (India). In addition,the majority of articles in Global South outlets covered statements from countries’ Ministers of Health on the state of countries’ primary health care systems.

Pope Francis’s meeting with Dr. Tedros, where the two leaders discussed the Health for All movement ahead of the conference, and the Pope’s subsequent statement on [Twitter](https://twitter.com/Pontifex/status/1055421214129377280) endorsing Health for All, also generated media attention in [***Vatican News***](https://www.vaticannews.va/es/papa/news/2018-10/papa-salud-derecho-universal.html) and other global outlets.

The conference was also covered in widely-circulated global health newsletters, including **Global Health NOW** and **The Kaiser Family Foundation**.

## MEDIA FELLOWSHIP PROGRAM

With financial support from the Gates Foundation, the Global Conference co-hosts supported **eight media fellows** to attend and report on the conference and elevate the issue of primary health care around the world. Media fellows traveled to Astana from Brazil, Argentina, Kenya, Ghana, Rwanda, the US, Ukraine and India. The group included senior health editors and reporters from the leading news outlets in many of these countries.

The media fellows’ **15 pieces to-date** provide in-depth coverage of the Global Conference, the value of primary health care, and specific reporting on the state of primary health care in their national contexts. Stories include:

* **Sanchita Sharma,** Health & Science Editor, *Hindustan Times*, India
  + [The community’s health can drive great economic and social progress](https://www.hindustantimes.com/analysis/the-community-s-health-can-drive-great-economic-and-social-progress/story-2ag82kBKbtOVbZgXtz2u2M.html) (24 October)
  + [WHO’s Astana Declaration stresses on moving from disease treatment to health promotion](https://www.hindustantimes.com/india-news/who-astana-declaration/story-rmrXrDoH8vHWYWMZiIYrIL.html) (25 October)
* **Nora Bär,** Editor, *La Nación*, Argentina
  + [In Kazakhstan, leaders from around the world call for the promotion of primary health care](https://www.lanacion.com.ar/2184825-en-kazajistan-lideres-todo-mundo-llaman-impulsar) (24 October)
  + [In a meeting of the WHO and UNICEF, unanimously agree a new course for health care](https://www.lanacion.com.ar/2185136-En) (25 October)
  + [Adolfo Rubinstein: "Primary care is the key to achieving health for all"](https://www.lanacion.com.ar/2185141-adolfo-rubinstein-la-atencion-primaria-es-clave) (25 October)
  + [Mental health: there are countries in Africa with 19 million people and a single psychiatrist](https://www.lanacion.com.ar/2186163-salud-mental-hay-paises-africa-19-millones) (28 October)
* **Cláudia Collucci**, Health Journalist, *Folha de S.Paulo*, Brazil
  + [Half the world's population does not have access to basic health care](https://www1.folha.uol.com.br/colunas/claudiacollucci/2018/10/metade-da-populacao-mundial-nao-tem-acesso-aos-cuidados-basicos-de-saude.shtml?loggedpaywall?loggedpaywall) (23 October)
  + [Health is not a political toy, WHO director says](https://www1.folha.uol.com.br/equilibrioesaude/2018/10/saude-nao-e-brinquedo-politico-diz-diretor-da-oms.shtml?utm_source=whatsapp&utm_medium=social&utm_campaign=compwa) (25 October)
  + [Celebrated worldwide, achievements of SUS are at risk](https://www1.folha.uol.com.br/colunas/claudiacollucci/2018/10/comemoradas-mundialmente-conquistas-do-sus-correm-riscos.shtml) (27 October)
* **Elizabeth Merab**, Reporter, *Daily Nation*, Kenya
  + [Declaration on primary health care adopted at global conference](https://www.nation.co.ke/news/world/Declaration-on-primary-health-care-adopted/1068-4824430-8jfsaaz/index.html) (26 October)
* **Rosemary Ardayfio,** Deputy Chief Sub Editor, *Daily Graphic*, Ghana
  + [Ghana benefits from primary health care initiative](https://www.graphic.com.gh/news/general-news/ghana-benefits-from-primary-health-care-initiative.html) (1 November)
  + [Ghana committed to achieving health-related SDGs — Agyeman-Manu](https://www.graphic.com.gh/news/general-news/ghana-committed-to-achieving-health-related-sdgs-agyeman-manu.html) (7 November)
  + [Make primary health care services free](https://www.graphic.com.gh/news/general-news/make-primary-health-care-services-free.html) (8 November)
* **Iryna Reshniuk**, Society Section Editor, *Ukrainska Pravda*, Ukraine
  + [Ukraine and UN countries have signed a document on the "primary". What does it mean](https://life.pravda.com.ua/health/2018/10/25/233800/) (25 October)
  + [And they lived long and happy ... while they appreciated their family doctor](https://life.pravda.com.ua/columns/2018/10/29/233865/) (29 October)

Most articles published by media fellows included country-specific angles, highlighting successes or areas of growth for their countries’ primary health care systems. Fellows mentioned the **Astana Declaration in six articles** and the ***Lancet* special report in three articles**. Five articles quote either Henrietta Fore or Dr. Tedros’s remarks from the conference and six articles quote health ministers or delegates from the author’s respective countries who they had the opportunity to interview in Astana. Additional coverage from the media fellows is anticipated in the weeks and months ahead.

## OPINION PIECES

Opinion pieces were a significant driver of media coverage, making up approximately 23 percent of total coverage. The **25 opinion pieces** published to date– including op-eds by [Chris Elias](https://medium.com/@ChrisJElias/putting-people-at-the-center-of-the-health-care-picture-d5e13f1d4f97), [Ellen Johnson Sirleaf](https://www.theguardian.com/global-development/2018/oct/25/ebola-has-shown-global-health-system-strong-as-weakest-link-ellen-johnson-sirleaf), and [Jakaya Kikwete](https://www.project-syndicate.org/commentary/keys-to-universal-health-coverage-by-jakaya-kikwete-2018-11) – were generally optimistic and focused on the potential of this moment to drive improvements to primary health care.

Eight of the 25 opinion pieces were in Global South outlets including [***Daily Times***](https://dailytimes.com.pk/313743/health-for-all-a-badly-misunderstood-initiative/) (Pakistan) and [***Folha de S.Paulo***](https://www1.folha.uol.com.br/colunas/claudiacollucci/2018/10/comemoradas-mundialmente-conquistas-do-sus-correm-riscos.shtml)(Brazil). As part of its [primary healthcare special collection](https://www.bmj.com/primaryhealthcare), **BMJ published five opinion pieces** exploring subjects such as primary health care in Europe, frontline healthcare providers and the history of the Alma-Ata declaration. **The *Lancet* special report on primary health care also featured six opinion pieces** in the series, including a [commentary](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)32556-X.pdf) by the conference co-hosts – Henrietta Fore, Dr. Tedros and Yelzhan Birtanov.

Other notable pieces include aHenrietta Fore and Seth Berkley op-ed in [***CNBC Africa***](https://www.cnbcafrica.com/news/east-africa/2018/10/26/op-ed-protecting-africas-invisible-children-the-case-for-birth-registration-and-a-digital-identity/) underscoring the importance of integrating digital identity technology into the primary health care system. Githinji Gitahi – CEO of Amref Health Africa and Global Co-Chair of UHC2030 – also authored a piece in [**Thomson Reuters Foundation News**](http://news.trust.org/item/20181030113612-7d05l/)highlighting the achievements of Rwanda’s primary health care system.

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## **FULL COVERAGE REPORT**

*\*Indicates top-tier coverage*

**Press Releases**

* ***IOM***: [Evidence Shows Primary Healthcare for Migrants is Cost-saving](https://www.iom.int/news/evidence-shows-primary-healthcare-migrants-cost-saving) (26 October)
  + Reposted by [*Relief Web*](https://reliefweb.int/report/world/evidence-shows-primary-healthcare-migrants-cost-saving) (Global)
* ***PAHO/WHO***: [Countries of the Americas to renew their commitment to primary health care in a bid to achieve universal health](https://www.paho.org/hq/index.php?option=com_content&view=article&id=14742:paises-de-las-americas-renovaran-el-compromiso-con-la-atencion-primaria-de-salud-para-alcanzar-la-salud-universal&Itemid=135&lang=en) (22 October)
  + Reposted by [*La República*](https://larepublica.pe/sociedad/1342813-oms-paises-americas-renovaran-compromiso-atencion-primaria-salud-ops)(Peru)*,* [*Presa Latina*](https://www.prensa-latina.cu/index.php?o=rn&id=221813&SEO=las-americas-renovaran-compromiso-de-atencion-primaria-de-salud)(Latin America)*,* [*St. Lucia News Online*](https://www.stlucianewsonline.com/countries-of-the-americas-to-renew-their-commitment-to-primary-health-care-in-a-bid-to-achieve-universal-health/)(St. Lucia)and[*United News of India*](http://www.uniindia.com/americas-to-renew-commitment-to-primary-healthcare/world/news/1386647.html) (India)
* ***PHCPI***: [Countries Commit to Improving Primary Health Care, Starting with Better Data](https://improvingphc.org/sites/default/files/PHCPI_Vital_Signs_Press_Release_24Oct2018.pdf) (24 October)
  + Reposted by [*News Hours*](https://newshour.online/2018/10/25/a-commitment-to-improving-primary-health-care/)(Bangladesh) and [*The Dayspring*](http://thedayspring.com.pk/new-vital-signs-profiles-provide-country-by-country-snapshot-of-primary-health-care-enabling-leaders-to-identify-problem-areas-and-make-improvements-over-time/) (Pakistan)
* ***UNICEF, WHO* and *Government of Kazakhstan***: [New global commitment to primary health care for all at Astana conference](https://www.unicef.org/press-releases/new-global-commitment-primary-health-care-all-astana-conference) (25 October)
  + Reposted by [*Kaiser Family Foundation*](https://www.kff.org/news-summary/u-n-member-states-agree-to-astana-declaration-to-strengthen-primary-health-care-systems/) (US), [*IntraMed*](https://www.intramed.net/contenidover.asp?contenidoID=93288)
* ***WHO***: [HH Pope Francis and WHO Director-General: Health is a right and not a privilege](http://www.who.int/news-room/detail/23-10-2018-hh-pope-francis-and-who-director-general-health-is-a-right-and-not-a-privilege) (23 October)
  + Reposted by [*The Eagle Online*](https://theeagleonline.com.ng/phc-pope-who-say-health-is-right-not-privilege/)(US)*,* [*The Independent*](https://www.independent.ng/health-is-right-not-privilege-pope-francis-tells-buhari-others/)(Nigeria)*,* [*MediBulletin*](https://medibulletin.com/tedros-meets-pope-francis-to-discuss-healthcare-access/)(India)*,* [Quotidianosanità.it](http://www.quotidianosanita.it/cronache/articolo.php?articolo_id=67068) (Italy)and [*Vanguard*](https://www.vanguardngr.com/2018/10/phc-pope-francis-who-say-health-is-right-not-privilege/)(Nigeria)
* ***WHO***: [WHO launches new guideline on health policy and system support to optimize community health worker programmes](http://www.who.int/hrh/community/guideline-health-support-optimize-hw-programmes/en/) (26 October)

**Global Media Coverage**

* ***\* BMJ***: [Alma Ata and primary healthcare: back to the future](https://www.bmj.com/content/363/bmj.k4434) By: Zulfiqar A Bhutta, Rifat Atun, Navjoyt Ladher and Kamran Abbasi (22 October)
  + Reposted by [*Kaiser Family Foundation*](https://www.kff.org/news-summary/principles-of-alma-ata-declaration-must-be-translated-to-action-on-primary-health-care-universal-coverage/) (US)
* ***\* BMJ***: [Alma Ata, Astana and beyond—patients and communities as the core of universal primary healthcare](https://blogs.bmj.com/bmj/2018/10/24/alma-ata-astana-and-beyond-patients-and-communities-as-the-core-of-universal-primary-healthcare/) By: Anya de Iongh, Sarah Markham and Rakhal Gaitonde (24 October)
* ***\* BMJ***: [Empowering frontline providers to deliver universal primary healthcare using the Practical Approach to Care Kit](https://www.bmj.com/content/363/bmj.k4451) By: Lara Fairall, Ruth Cornick and Eric Bateman (24 October)
* ***\* BMJ***: [The extricable links between health, wealth, and profits](https://www.bmj.com/content/363/bmj.k4418) By: Gavin Yamey, Devi Sridhar, Kamran Abbasi (22 October)
* ***\* BMJ***: [Unfulfilled potential of primary care in Europe](https://www.bmj.com/content/363/bmj.k4469) By: Luke N Allen, Shannon Barkley, Jan De Maeseneer, Chris van Weel, Hans Kluge, Niek de Wit and Trisha Greenhalgh (25 October)
* ***Center for Global Development***: [The Declaration of Alma-Ata at 40: Realizing the Promise of Primary Health Care and Avoiding the Pitfalls in Making Vision Reality](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls) By: Amanda Glassman, Janeen Madan Keller and Jessie Lu (24 October)
* ***\* Financial Times***: [FT Health: Health for all or health for some?](https://www.ft.com/content/46f2d448-d85f-11e8-a854-33d6f82e62f8) By: Andrew Jack and Darren Dodd (26 October)
* ***\* Foreign Policy***: [Inside Trump’s Plan to Scale Back U.N. Resolutions on Sexual Health, Violence Against Women](https://foreignpolicy.com/2018/10/30/inside-trump-state-department-plan-to-scale-back-united-nations-resolutions-on-sexual-reproductive-health-violence-against-women-abortion-global-gag-rule-gender-equality/) By: Robbie Gramer, Colum Lynch (30 October)
* ***Global Health NOW:*** [Better Primary Health Care? Get Better Data](https://www.globalhealthnow.org/2018-10/better-primary-health-care-get-better-data) By: Brian W. Simpson (31 October)
* ***\* The Guardian***: [As Ebola has shown, the global health system is as strong as its weakest link](https://www.theguardian.com/global-development/2018/oct/25/ebola-has-shown-global-health-system-strong-as-weakest-link-ellen-johnson-sirleaf) By: Ellen Johnson Sirleaf (24 October)
  + Reposted by [*Daily Trust*](https://www.dailytrust.com.ng/global-health-system-is-as-strong-as-its-weakest-link.html) (Nigeria)
* ***Health Affairs***: [Implementing The Astana Declaration—What Alma-Ata Taught Us](https://www.healthaffairs.org/do/10.1377/hblog20181024.24072/full/) By: The Alma- Ata 40 Roundtable (25 October)
* ***\* The Lancet***: [Alma-Ata at 40 years: reflections from the *Lancet* Commission on Investing in Health](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) By: David A. Watkins, Prof. Gavin Yamey, Marco Schäferhoff, Olusoji Adeyi, Prof. George Alleyne, Prof. Ala Alwan, et al. (20 October)
* ***\* The Lancet***: [Building the case for embedding global health security into universal health coverage: a proposal for a unified health system that includes public health](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) By: Ngozi A. Erondu, Jerry Martin, Robert Marten, Prof. Gorik Ooms, Robert Yates, Prof. David L. Heymann, et al. (20 October)
* ***\* The Lancet***: [Effectiveness and sustainability of a diagonal investment approach to strengthen the primary health-care system in Ethiopia](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) By: Yibeltal Assefa, Dessalegn Tesfaye, Prof. Wim Van Damme and Peter S. Hill (20 October)
* ***\* The Lancet***: [How primary health care can make universal health coverage a reality, ensure health lives, and promote wellbeing for all](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext) By: Hans Kluge, Ed Kelley, Shannon Barkley, Pavlos N. Theodorakis, Naoko Yamamoto, Alexey Tsoy, et al. (20 October)
* ***\* The Lancet***: [Primary health care and universal health coverage: competing discourses?](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext) By: Peter S. Hill (20 October)
* ***\* The Lancet***: [Primary health care for the 21st century, universal health coverage, and the Sustainable Development Goals](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site) By: Tedros Adhanom Ghebreyesus, Henrietta Fore, Yelzhan Birtanov and Zsuzsanna Jakab (20 October)
* ***\* The Lancet***: [Putting nursing and midwifery at the heart of the Alma-Ata vision](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext) By: Nigel Crisp and Elizabeth Iro (20 October)
* ***\* The Lancet***: [Reform of primary health care in Pakistan](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext) By: Sadia M. Malik and Zulfiqar A. Bhutta (20 October)
* ***\* The Lancet***: [Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals?](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) By: Thomas Hone, Prof. James Macinko and Prof. Christopher Millett (20 October)
* ***\* The Lancet***: [The Astana Declaration: the future of primary health care?](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32478-4/fulltext) By: The Lancet (20 October)
* ***Medibulletin***: [Astana declaration reaffirms Alma Ata commitment](https://medibulletin.com/astana-declaration-reaffirms-alma-ata-commitment/) (25 October)
* ***Medium***: [Putting People at the Center of the Health Care Picture](https://medium.com/@ChrisJElias/putting-people-at-the-center-of-the-health-care-picture-d5e13f1d4f97) By: Chris Elias (24 October)
* ***PLOS***: [After Astana: The post-conference agenda for global primary health care](https://blogs.plos.org/globalhealth/2018/10/after-astana-the-post-conference-agenda-for-global-primary-health-care/) (30 October)
* ***Project Syndicate:*** [The Keys to Universal Health Coverage](https://www.project-syndicate.org/commentary/keys-to-universal-health-coverage-by-jakaya-kikwete-2018-11) By: Jakaya Kikwete (5 November)
  + Reposted by [*MenaFN*](https://menafn.com/1097666933/Somali-The-Keys-to-Universal-Health-Coverage)(Middle East Regional)
* ***Thomson Reuters Foundation News***: [Can Rwanda be the blueprint for delivering primary health care?](http://news.trust.org//item/20181030113612-7d05l/) By: Githinji Gitahi (30 October)
  + Reposted by [*All Africa*](https://allafrica.com/stories/201810310150.html)
* ***UN Dispatch***: [Countries Around the World Just Pledged to Provide Decent Primary Health Care to All Their Citizens](https://www.undispatch.com/countries-around-the-world-just-pledged-to-provide-decent-primary-health-care-to-all-their-citizens/) By: Alanna Shaikh (30 October)
* ***UN News***: ‘[Essential step’ towards universal health care made at pivotal UN conference](https://news.un.org/en/story/2018/10/1024102) (25 October)
  + Reposted by [*India Blooms*](https://www.indiablooms.com/health-details/H/4037/lsquo-essential-step-rsquo-towards-universal-health-care-made-at-pivotal-un-conference.html), [*United News of India*](http://www.uniindia.com/-necessary-step-towards-universal-health-care-made-at-un-conference/world/news/1389051.html) and [*Insurance News Net*](https://insurancenewsnet.com/oarticle/essential-step-towards-universal-health-care-made-at-pivotal-un-conference#.W9cKtJNKhPY)(US)
* ***Vatican Insider***: [Francesco: health is a universal right, health services are accessible to everyone](http://www.lastampa.it/2018/10/25/vaticaninsider/francesco-la-salute-un-diritto-universale-i-servizi-sanitari-siano-accessibili-a-tutti-GEV4pKV9LFLdnrN1VFH2SP/pagina.html) (25 October)
* ***Vatican News***: [Pope: health is a universal right](https://www.vaticannews.va/es/papa/news/2018-10/papa-salud-derecho-universal.html) (25 October)

**Africa**

* ***Business Daily*** (Kenya): [Dons should participate more in the global arena](https://www.businessdailyafrica.com/analysis/ideas/Dons-should-participate-more-in-the-global-arena/4259414-4838348-d87ywo/index.html) By: Boniface Oyugi (5 November)
* ***Business Ghana*** (Ghana):[Ghana on course for universal health coverage — Minister](https://www.businessghana.com/site/news/general/175307/Ghana-on-course-for-universal-health-coverage-Minister) (29 October)
* ***CNBC Africa*** (Regional)***:*** [Protecting Africa’s invisible children, the case for birth registration and a digital identity](https://www.cnbcafrica.com/news/east-africa/2018/10/26/op-ed-protecting-africas-invisible-children-the-case-for-birth-registration-and-a-digital-identity/) By: Henrietta Fore and Seth Berkley (26 October)
* ***Daily Graphic*** (Ghana)[Ghana benefits from primary health care initiative](https://www.graphic.com.gh/news/general-news/ghana-benefits-from-primary-health-care-initiative.html) By: Rosemary Ardayfio (1 November)
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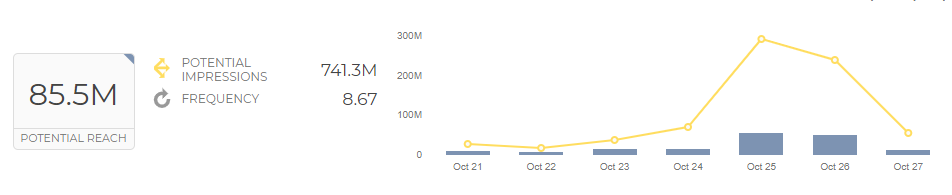
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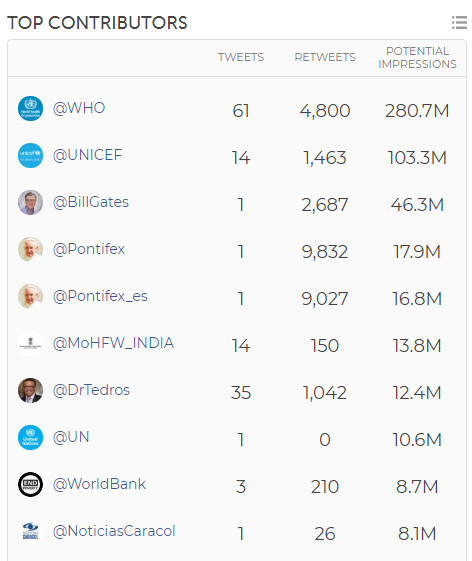
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* ***Tehran Times*** (Iran): [WHO recognizes Iran as ‘good example’ of healthcare services](https://www.tehrantimes.com/news/429069/WHO-recognizes-Iran-as-good-example-of-healthcare-services) (29 October)

## 

## **DIGITAL OVERVIEW**

From 21-27 October, more than **37,000 users** shared over **62,000 total tweets** (tweets & retweets) using #PrimaryHealthCare, #HealthForAll, #Astana2018, #AA40, #PHC, #PHC4UHC and #UHC. These tweets **reached** **85.5 million** **individual accounts** and generated **741 million potential impressions**.

* **Twitter activity peaked on the first day of the conference**. Both **impressions and reach rose by about 75%** between Wednesday, 24 October and Thursday, 25 October.
* The three official conference hashtags **(#PrimaryHealthCare, #HealthForAll, #Astana2018**) were the top three hashtags used in the conversation, followed by #EveryChildALIVE and #UHC.
* High-level influencers who were top contributors included [WHO](https://twitter.com/WHO) (4.61 million followers), [UNICEF](https://twitter.com/UNICEF) (7.39 million), [Bill Gates](https://twitter.com/BillGates) (46.3 million) and [Pope Francis](https://twitter.com/Pontifex) (17.9 million).
* According to TweetReach, [WHO](https://twitter.com/WHO/status/1055534267369951232)’s top performing post had **20.5M potential impressions and 166 responses**.
* According to TweetReach, [UNICEF](https://twitter.com/UNICEF/status/1055383619185885186)’s top performing post had **8.5M potential impressions and 80 responses**.
* The [Ministry of Health Kazakhstan](https://www.instagram.com/p/BpdopM_FWIH/?utm_source=ig_web_copy_link)engaged new audiences over [Instagram](https://www.instagram.com/aa40_global_conference/), bringing in tens of thousands of views on their content, and through the official Global Conference [Facebook](https://www.facebook.com/aa40GlobalConference/) page, which grew to 1000 followers. As the majority of content was posted in Russian, this increased engagement across languages.
* Based on tweets, the top engagement languages were English, Spanish, and Russian.

**Tweets with the most overall engagement were posted by** [**Bill Gates**](https://twitter.com/BillGates/status/1055818077437333505) **and Pope Francis (**[**English**](https://twitter.com/Pontifex/status/1055421214129377280) **and** [**Spanish**](https://twitter.com/Pontifex_es/status/1055421214053842945)**):**

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## #ASTANA2018 CHAMPION RELAY

The #Astana2018 Relay built a drumbeat of conversation in the lead up to the conference, elevating voices from a number of key populations and advocacy communities. Each weekday from 1-26 October, at least one individual or organization shared a Twitter thread on why primary health care is important to the people or issues they care about.

Throughout the month, #Astana2018 relay participants showed up as some of the top tweets in #Astana2018, #HealthForAll and #PrimaryHealthCare hashtags. Other than the co-host leadership, threads with the most engagement were [*The Lancet*](https://twitter.com/TheLancet/status/1053256080615104512)[aggregate: 1K retweets, 4.1K likes], [Melinda Gates](https://twitter.com/melindagates/status/1055465284461649920) [aggregate: 417 retweets, 914 likes] & the [Nursing Now Campaign](https://twitter.com/NursingNow2020/status/1050676173053673473) [aggregate: 116 retweets, 201 likes].



In chronological order, below is the list of participants, links to their threads and their follower count:

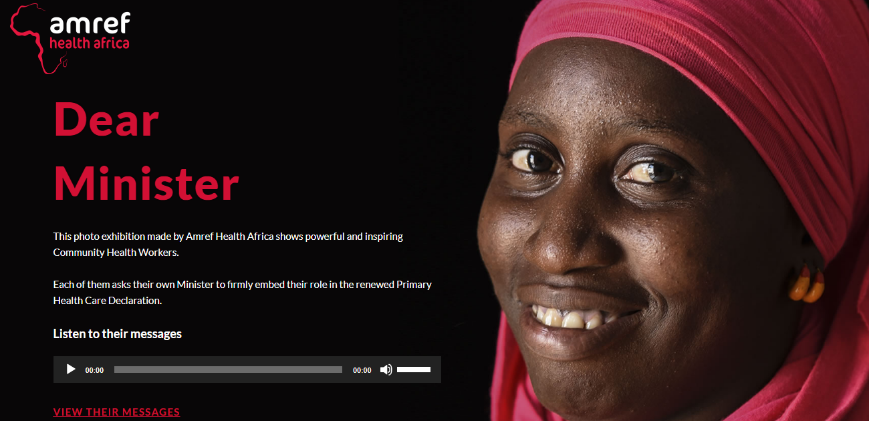
* [Tedros Adhanom](https://twitter.com/DrTedros/status/1046749485605564416) (354K)
* [Henrietta Fore](https://twitter.com/unicefchief/status/1047150501245198337) (20.1K)
* [Yelzhan Birtanov](https://twitter.com/byelzhan/status/1047372306299985921) (2,323)
* [The Elders](https://twitter.com/daktari1/status/1048060603087179777) (123K)
* [Githinji Gitahi](https://twitter.com/daktari1/status/1048060603087179777) (8,540)
* [Katja Iversen](https://twitter.com/Katja_Iversen/status/1049298924262100992) (12.6K)
* [Raj Panjabi](https://twitter.com/rajpanjabi/status/1049745199142977538) (7,345)
* [Johanna Ralston](https://twitter.com/johanna_ralston/status/1050026526153027584) (1,853)
* [IFMSA](https://twitter.com/johanna_ralston/status/1050026526153027584) (22.1K)
* [Nursing Now](https://twitter.com/NursingNow2020/status/1050676173053673473) (7,208)
* [Global Citizen Impact](https://twitter.com/GlblCtznImpact/status/1051935093340680193) (90.4k)
* [World Council of Churches](https://twitter.com/Oikoumene/status/1052170954653294592) (24.3K)
* [Harvard School of Public Health](https://twitter.com/HarvardChanSPH/status/1052594709414256640) (284K)
* [PAI](https://twitter.com/pai_org/status/1052937278383947779) (14.2K)
* [*The Lancet*](https://twitter.com/TheLancet/status/1053256080615104512) (344K)
* [Seth Berkely](https://twitter.com/GaviSeth/status/1054300834396336128) (40.7K)
* [Sania Nishtar](https://twitter.com/SaniaNishtar/status/1054657004776628224) (8,612)
* [Joannie Bewa](https://twitter.com/BEWAJ/status/1055083677812690945) (3,421)
* [Jim Yong Kim](https://twitter.com/JimYongKim/status/1055227357651501059) (99.6K)
* [Melinda Gates](https://twitter.com/melindagates/status/1055465284461649920) (2.36M)

## PARTNER ENGAGEMENT HIGHLIGHTS

The primary health care conversation spanned the health and development sectors, with PHC being mentioned by government agencies, such as [USAID](https://twitter.com/USAID/status/1055413849334136833), and government officials from across the world, including Indian Minister of Health [Jagat Prakash Nadda](https://twitter.com/JPNadda/status/1055702877182799873) and Ecuadorian Minister of Health [Verónica Espinosa S.](https://twitter.com/MVEspinosaS/status/1055543380409761792). Publications such as [*The Lancet*](https://twitter.com/TheLancet/status/1055464102984933379) and academic organizations such as [Johns Hopkins](https://twitter.com/Jhpiego/status/1055550821159657472) joined the conversation to promote primary health care research; organizations such as [IFMSA](https://twitter.com/IFMSA/status/1053984739416330241), [Women Deliver](https://twitter.com/WomenDeliver/status/1055592357993816064) and [NCD Alliance](https://twitter.com/ncdalliance/status/1055546834398121986) posted multiple [toolkit](file:///C:\Users\ehill\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\5ZOWFBVP\PHCToolkit.org) graphics and messages, conference [co-hosts](https://www.facebook.com/WHO/videos/930586617136868/) and other international organizations such as the [International Pharmaceutical Federation](https://www.facebook.com/FIPpharmacists/photos/a.215669678469650/1943414722361795/?type=3&theater) and [World Bank Health](https://twitter.com/WBG_Health/status/1055421283679305729)joined the conversation on Facebook & Twitter.

Various organizations produced original multimedia content for the conference. Highlights included:

* Video of Dr. Marcella Davies, who read Alma-Ata Declaration for first time in 1978, produced by the [Rockefeller Foundation](https://twitter.com/RockefellerFdn/status/1055214082398306306)
* [Dear Minister](https://amref.org/dearminister/) Campaign by [Amref Health Africa](https://twitter.com/Amref_Worldwide/status/1055442087548764161)
* [BJM video](https://twitter.com/bmj_company/status/1055845016432709633) looking back on Alma Ata
* Primary health care worker images published in a [series](https://twitter.com/TheLancet/status/1056131899083624448) of GIF tweets by[*The Lancet*](https://twitter.com/TheLancet/status/1055753974173917184)
* More content can be found at [PHCToolkit.org/partner-content](http://www.phctoolkit.org/partner-content)



## SOCIAL MEDIA CONVERSATION THEMES

According to TweetReach, in the primary health care subject area**, 62.4% of tweets during the conference week were positive.** The following is the breakdown of positive/neutral/negative tweets:

|  |  |
| --- | --- |
| Positive | 62.4% |
| Neutral | 32.1% |
| Negative | 5.6% |

On the whole, the conversation remained full of [hope](https://twitter.com/CWYouthHealth/status/1056483223201562624), rather than focusing on the negative. While some tweets in the negative category focused on lack of [youth inclusion](https://twitter.com/GASNNurses/status/1055082190491525120) in the final declaration, these were outweighed by more positive tweets highlighting the efforts to bring youth to the conference and successes of the [preconference](https://twitter.com/UNFPAyouth/status/1054956621795860480). In the lead up to and during the conference civil society organized in various ways to ensure their voices were heard. For instance, People’s Health Movement put forward an [alternative statement](https://twitter.com/kentbuse/status/1053198409363058689) on primary health care, and other organizations launched campaigns or started petitions. These initiatives include the [#HealthForAll Pledge](https://act.pih.org/page/s/healthcare-pledge?utm_source=twitter&utm_medium=organicsocial&utm_content=pledge&utm_campaign=uhcpledge&source=organictwitter_uhcpledge) by [Partners in Health](https://twitter.com/PIH/status/1055651230545051653) and the [CSO statement](https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/UHC2030_civil_society_engagement/Civil_Society_Statement-Global_Conference_on_Primary_Health_Care_FINAL_FOR_ENDORSEMENT__2_.pdf) facilitated by the UHC2030 Civil Society Engagement Mechanism.

The need to [spotlight](https://twitter.com/WHOAFRO/status/1055061497729159168) health workers was a positive and ongoing theme throughout conference tweets. Organizations including [Amref Health Africa](https://twitter.com/Amref_Worldwide/status/1055782975600840704) and [Global Health Workforce Network](https://twitter.com/GHWNetwork/status/1055734735715160064) praised the new WHO CHW guidelines, while [individuals](https://twitter.com/blaserv/status/1054971338669129728) applauded sessions that focused on health workers. People also applauded Dr. Tedros’ acknowledgment of the [importance of the health workforce](https://twitter.com/EllisIsabelle/status/1055336627227242496) and the need to [invest](https://twitter.com/JimC_HRH/status/1055814923652161537) in it to reach health for all.

## PHCTOOLKIT.ORG

* [PHCToolkit.org](file:///C:\Users\ehill\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\5ZOWFBVP\PHCToolkit.org) hosted more than 1,120 unique visitors from the launch date (16 October) to Saturday, October 27.
* Visitors hailed from every continent. Top access locations were the US, UK and Kazakhstan.
* Suggested messages and toolkit graphics helped to drive the social media conversations on [Facebook](https://www.facebook.com/GAVI/photos/a.126742141406/10156778384061407/?type=3&theater) and [Twitter](https://twitter.com/FP2020Global/status/1054364250452430849). Organizations and individuals who posted toolkit messages and graphics, in addition to those listed in the Partner Engagements Highlights above, include the following (\* indicates they have shared multiple toolkit messages):
  + [Drive for Health Foundation Ghana](https://www.facebook.com/driveforhealthfoundationghana/posts/1376847122486532)
  + [Family Planning 2020](https://twitter.com/FP2020Global/status/1054364250452430849)
  + [Frontline Health Workers Coalition](https://twitter.com/FHWCoalition/status/1054429825048473600)\*
  + [Gavi](https://twitter.com/gavi/status/1054744851470827520)\*
  + [The George Institute](https://twitter.com/GeorgeInstIN/status/1054126896471072768)\*
  + [IntraHealth International](https://twitter.com/IntraHealth/status/1055185915801493504)
  + [Itai Josh Rusike](https://twitter.com/Itairusike/status/1054278696075517952)\*
  + [Ifeanyi Nsofor](https://twitter.com/ekemma/status/1056226956893667328)
  + [Nigeria Health Watch\*](https://twitter.com/nighealthwatch/status/1055710102911619073)
  + [Mamaye Nigeria](https://www.facebook.com/MamaYeNigeria/videos/249135049282072/?__xts__%5b0%5d=68.ARBDXBTGp6b2lAcWZzIv7Rbj7qJbQijDbkWssjCly-z9Vq2O1tL4Zf9IDKe-LyShGYk75MFlC5nqOCkJvXSDjpD2U3h1nsLd18Kbko4SIaT4RHrxg7G8YK3EryK4lr1IE7BZNjMllw2HCuUYpMeUHFLi_QWFHpmxco-al0GRIiYP21jiAYdoWggaduGovDTMUGv93LTh202WcM_OWaPoZczu1BftvO4hJYCwJSFIJKUwfqY&__tn__=-R)\*
  + [Options in Health](https://twitter.com/OptionsinHealth/status/1055434806966796288)\*
  + [PHCPI](https://twitter.com/ImprovingPHC/status/1054031306403835906)
  + [Toyin Saraki](https://www.instagram.com/p/BphDIKnhT16/?hl=en&taken-by=toyinsaraki)\*
  + [UHC2030 Civil Society Engagement Mechanism](https://twitter.com/CSOs4UHC/status/1053803786911862784)
  + [UNICEF](https://twitter.com/UNICEF/status/1055353441185357825)\*
  + [WHO EURO](https://twitter.com/WHO_Europe/status/1055439786750685184)\*
  + [WONCA](https://twitter.com/WoncaEurope/status/1054281259772530693)
  + [World Health Run](https://www.facebook.com/worldhealthrun/videos/2101414093242086/?rp_creation_time=%7B%22name%22%3A%22creation_time%22%2C%22args%22%3A%22%7B%5C%22start_month%5C%22%3A%5C%222018-10%5C%22%2C%5C%22end_month%5C%22%3A%5C%222018-10%5C%22%7D%22%7D&filters=eyJycF9jcmVhdGlvbl90aW1lIjoie1wibmFtZVwiOlwiY3JlYXRpb25fdGltZVwiLFwiYXJnc1wiOlwie1xcXCJzdGFydF9tb250aFxcXCI6XFxcIjIwMTgtMTBcXFwiLFxcXCJlbmRfbW9udGhcXFwiOlxcXCIyMDE4LTEwXFxcIn1cIn0ifQ%3D%3D)

After the homepage, the most popular sections were the Champion Relay & Partner Content pages.

## **FULL TEXT – PRINT & ONLINE MEDIA**

## Press Releases

**IOM**

**Evidence Shows Primary Healthcare for Migrants is Cost-saving**

*26 October 2018*

**Astana –** IOM, the UN Migration Agency, pointed out that “leaving no one behind” as formulated in the UN 2030 Sustainable Development Goals does not necessarily mean a greater burden to health budgets.

During the side-event at the Global Conference on Primary Health Care held in Astana, Kazakhstan, yesterday (25/10), Jacqueline Weekers, IOM’s Migration Health Division Director noted that “High costs are often cited by governments as the main reason to not include migrants in health systems. Meanwhile, migrants contribute more in taxes than they receive in benefits, send remittances to home communities and fill labour market gaps in host societies. Equitable access for migrants to low cost primary health care can reduce health expenditures, improve social cohesion and enable migrants to contribute substantially towards the development.”

Weekers opened the experts’ forum Primary Health Care for Migrants – the Economic Argument, presenting cutting-edge research on experiences both in Europe and Asia on the cost of excluding migrants and asylum seekers from healthcare.

The panel discussion was co-chaired by Santino Severoni, Public Health and Migration Coordinator at the World Health Organization Regional Office for Europe and Lyazat Aktaeva, Vice Minister of Health of the Republic of Kazakhstan.

Both key note speakers – Ursula Trummer, Head of the Center for Health and Migration and Kai Hong Phua, Professor at the Lee Kuan Yew School of Public Policy – emphasized that the human rights discourse on migrants’ health must be complemented with an economic optimization model.

“Adding the economic perspective can provide the costs and benefits in order to arrive at a balanced consensus,” said Hong Phua. “The necessity of migrant workers in the economy, of keeping private costs for business firms low and ensuring the welfare of migrant workers justifies economically a fair health care policy for migrants,” he added.

Trummer said: “Different studies on the most vulnerable migrant groups such as asylum seekers and undocumented migrants all come to similar conclusions: It is not cost saving to restrict access to health care. Evidence from our vignette study in Europe shows the potential cost savings of timely treatment in primary care of 49 per cent to 100 per cent of the costs that occur for treatment of more severe medical conditions in hospital.”

This view was supported by the Ministry of Health of Thailand, which has almost two decades of experience with health insurance both for its migrant workers and their dependents, and the Ministry of Health of Turkey, which is ensuring the coverage of primary health needs of Syrian refugees under temporary protection in the country.

In her remarks, Weekers also referred to the Global Compact for Safe, Orderly and Regular Migration (GCM) – which is scheduled to be adopted by Member States in Marrakesh in December – and provides a unifying framework of common principles and commitments among member states in a world increasingly marked by migration.

“The GCM presents us with a historical opportunity to improve the lives and dignity of migrants as well as the ability of States to manage migration. Health must be there, and it is there, throughout the 23 objectives of the GCM. The implementation of the GCM can work hand in hand with the universal health coverage and the primary health care agenda,” she said.

For more information please contact Joe Lowry at the IOM Regional Office in Vienna, Tel: +436603776404, Email: [*jlowry@iom.int*](mailto:jlowry@iom.int)

**PAHO/WHO**

**Countries of the Americas to renew their commitment to primary health care in a bid to achieve universal health**

*22 October 2018*

*The Global Conference on Primary Health Care, hosted by the government of Kazakhstan, WHO, and UNICEF will take place on 25-26 October in Astana, Kazakhstan*

Washington D.C, 22 October 2018 (PAHO/WHO) – Delegations from Member States of the Pan American Health Organization (PAHO) will renew their commitment to primary health care (PHC) this week, as a vital part of achieving universal health and the Sustainable Development Goals (SDGs) by 2030.

The renewal of this commitment will take place within the framework of the [Global Conference on Primary Health Care](http://www.who.int/primary-health/conference-phc), to be held on 25-26 October, in Astana, Kazakhstan, on the occasion of the 40th anniversary of the Alma Ata Declaration, which defined PHC as a vital strategy for achieving health for all. The Conference is organized by the Government of Kazakhstan, WHO and UNICEF.

Since the Declaration of 1978, the values and principles of primary health care, which include the right to health, equity, solidarity, social justice and participation, and multisectoral action, to name but a few, have formed the basis of many of PAHO’s mandates and have guided the transformation of health systems throughout the Region.

World leaders will now support a new declaration, emphasizing the role of PHC in reorienting efforts to ensure that all people, everywhere, can enjoy the highest possible level of health. Countries of the Americas that are PAHO Member States, participated in the preparation of this declaration.

Universal health means that all people have access to quality, comprehensive services without having to face discrimination or financial difficulties. Universal health can only be achieved through health systems that are based on PHC, which is the foundation for an effective health care system.

Primary health care services, which are closer to individuals and communities, are able to meet the vast majority of a population’s health care needs throughout their lives, from prevention and treatment to rehabilitation and palliative care. Good primary health care leads to better health outcomes, better quality of care and longer life expectancy.

Government, civil society and academic delegations from Argentina, Belize, Brazil, Canada, Chile, Cuba, Ecuador, El Salvador, United States, Haiti, Guatemala, Nicaragua, Mexico, Panama, Paraguay, Peru, Puerto Rico and Suriname are all expected to participate during the global conference in Astana.

**PHC and universal health in the Americas**

Throughout the 40 years following the historic Alma-Ata Declaration, the Americas have made important achievements that PAHO has highlighted in the publication, “[From Alma-Ata to Universal Health: 40 years in the Americas Region](https://www.paho.org/hq/index.php?option=com_docman&view=download&alias=46634-timeline-40years-of-alma-ata-english-and-spanish&category_slug=sistemas-servicios-salud-1934&Itemid=270&lang=es)”

This year, the Annual Report of the PAHO Director, Carissa F. Etienne, also focused on primary health care, and PAHO dedicated the last special issue of its Pan American Journal of Public Health to the subject, with articles on the innovations that countries in the region have implemented in order to improve primary health care.

In 2014, countries of the Americas approved a [resolution on access and universal health coverage in PAHO](https://www.paho.org/hq/index.php?option=com_content&view=article&id=10058:2014-health-officials-from-the-americas-chart-a-path-toward-universal-health-coverage&Itemid=1926&lang=en). This resolution outlines a road map for progress towards universal health in the Region, which seeks to address inequalities in access to health systems and services that prevent some of the population in the Americas from accessing care due to financial or geographical barriers.

Links

— [From Alma-Ata to Astana](https://www.paho.org/hq/index.php?option=com_content&view=article&id=14725:from-alma-ata-1978-to-astana-2018&Itemid=39594&lang=en)— [From Alma-Ata to Universal Health](https://www.paho.org/hq/index.php?option=com_docman&view=download&alias=46634-timeline-40years-of-alma-ata-english-and-spanish&category_slug=sistemas-servicios-salud-1934&Itemid=270&lang=es)—[Special issue on primary health care in the Americas: 40 years after Alma-Ata](https://www.paho.org/journal/index.php?option=com_content&view=article&id=251:primary-health-care-alma-ata&Itemid=861)— [Video Primary Health Care: The time is now. Annual Report of the Director 2018](https://www.youtube.com/watch?v=pkIH5GyMUe8)— [Video Alma-Ata: 40 years in the Americas](https://www.youtube.com/watch?v=Rv8GfnjMgy4)

**PHCPI**

**Countries Commit to Improving Primary Health Care, Starting with Better Data**

*24 October 2018*

*New Vital Signs Profiles provide country-by-country snapshot of primary health care, enabling leaders to identify problem areas and make improvements over time*

**ASTANA (24 October 2018)**– Today, on the sidelines of the Global Conference on Primary Health Care, countries from around the world joined the [Primary Health Care Performance Initiative](http://www.improvingphc.org/) to launch the Vital Signs Profiles, which provide a snapshot of the strength of primary health care in low- and middle-income countries.

The Vital Signs Profiles offer a more complete picture of the state of primary health care in different countries than ever before, providing insights into where systems are strong and where they can be improved. The Vital Signs Profile helps answer several key questions on primary health care systems:

* **Financing:** How much money does the country spend on primary health care?
* **Capacity:**Does the country have policies that prioritize primary health care? Does the system have enough drugs, supplies and health care providers?
* **Performance:** Are people able to get the care they need, without financial or geographic barriers standing in the way? Is the care people receive of high quality?
* **Equity:**Does the system reach the most marginalized people in society?

PHCPI – a partnership between the Bill & Melinda Gates Foundation, World Bank Group and World Health Organization, in collaboration with Ariadne Labs and Results for Development – developed the Vital Signs Profiles to help policymakers, donors, advocates and citizens better understand and ultimately improve primary health care. Governments and donors can use each Vital Signs Profile to identify priority areas for improvement, track and trend progress over time, and ultimately improve primary health care. Advocates and citizens can use the Vital Signs Profile to hold leaders accountable and call for specific financing or policy reforms.

“I’ve said it before, and I’ll say it again – primary health care is the most important step that countries can take toward achieving health for all,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization. “With the data and insights that the Vital Signs Profiles provide, countries can understand where their systems are weak and take concrete steps to improve them.”

***More and Better Data Needed to Improve Primary Health Care***

Today, half the world’s population still lacks access to essential health services, the majority of which can be delivered through strong primary health care. Primary care is a person’s first and main point of contact with the health system, and connects people with trusted health care providers who can meet most of their health needs throughout their lives.

Recognizing the importance of primary health care, policymakers, donors, advocates and partners from around the world are coming together this week for the Global Conference on Primary Health Care in Astana, Kazakhstan to sign a new declaration committing them to strengthen primary health care as the foundation of health for all.

“Strengthening the front lines of the health system to ensure universal health coverage is a great investment,” said Dr. Tim Evans, Senior Director of Health, Nutrition and Population at the World Bank Group. “It promotes good health, saves lives and builds human capital – the foundation of inclusive economic growth and an accelerator for poverty reduction.”

Despite its importance, primary health care is often the weakest link in a country’s approach to improving the health of its people. Significant data gaps make it hard to see where primary health care is falling short, and the data that does exist is often of poor quality or difficult to understand and use. Only a handful of low- and middle-income countries have public data on primary care service delivery, including information on whether patients can see trained providers when they need to, or if they receive the correct diagnosis.

The Vital Signs Profiles are an important step to filling some of these data gaps for the first time, but show the need for countries to continue collecting more and better data on primary health care– especially service delivery and the capacity of the system to deliver quality care.

“This exercise [of developing a Vital Signs Profile] helped to identify measurement gaps in the health care system,” said Dr. Noor Hisham bin Abdullah, Director General of the Ministry of Health of Malaysia. “These gaps are pertinent and relevant to the policymakers of the health system who will have to prioritize the areas of concern and propose strategies for remedial actions.”

“Lack of measurement has made the condition of primary health care invisible to the public and to leaders,” said Dr. Atul Gawande, Executive Director of Ariadne Labs. “It is essential to make the invisible visible. By not doing so, we are guaranteeing that this cornerstone of health will be deprived of smart investments and fail to ultimately reach those in need.”

***Countries Leading the Way to Achieve Health for All***  
By partnering with PHCPI to develop and launch Vital Signs Profiles, countries are making a public commitment to collect more and better data on primary health care, and use it to improve the health of their citizens.

“I am so encouraged by the countries that are stepping forward and making bold commitments to improve primary health care,” said Ms. Gina Lagomarsino, President and CEO of Results for Development. “With the data and insights that the Vital Signs Profiles provide, countries can take important steps to improve the health of their citizens.”

While primary health care looks different in each “Trailblazer” country, they all share a commitment to better measure, and ultimately improve, primary health care for their people and communities. In 2019, PHCPI will continue working with these countries to gather and analyze additional data on primary health care systems, and look to engage new government partners to create Vital Signs Profiles for their countries.

“The process of developing the first set of Vital Signs Profiles has started important conversations in several countries about what it will take to achieve health for all,” said Beth Tritter, Executive Director of PHCPI. “PHCPI is excited to work with additional countries in the future to develop Vital Signs Profiles, and help connect different countries to share insights and innovations in data collection and use.”

“The exercise [of developing the Vital Signs Profile] was a great learning experience and inspired reflection on our programs, capacities, financing, evaluation systems and improvement processes,” said Dr. Diane Gashumba, Minister of Health of Rwanda. “We are eager to engage even further on the primary health care improvement journey, eager to share best practices and learn from others and meet our national and international goals.”

*For more information about the Vital Signs Profiles, follow this link: www.improvingphc.org/vital‐signs‐ profiles*

**UNICEF**

**New global commitment to primary health care for all at Astana conference**

*25 October 2018*

**ASTANA, KAZAKHSTAN, 25 October 2018** – Countries around the world today agreed to the Declaration of Astana, vowing to strengthen their primary health care systems as an essential step toward achieving universal health coverage. The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care.

“Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO). “We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health.”

While the 1978 Declaration of Alma-Ata laid a foundation for primary health care, progress over the past four decades has been uneven. At least half the world’s population lacks access to essential health services – including care for non-communicable and communicable diseases, maternal and child health, mental health, and sexual and reproductive health.

“Although the world is a healthier place for children today than ever before, close to 6 million children die every year before their fifth birthday mostly from preventable causes, and more than 150 million are stunted,” said Henrietta Fore, UNICEF Executive Director. “We as a global community can change that, by bringing quality health services close to those who need them. That’s what primary health care is about.”

The Declaration of Astana comes amid a growing global movement for greater investment in primary health care to achieve universal health coverage. Health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems – a gap highlighted by several health emergencies in recent years.

“Adoption of the Declaration at this global conference in Astana will set new directions for the development of primary health care as a basis of health care systems,” said Yelzhan Birtanov, Minister of Health of the Republic of Kazakhstan. “The new Declaration reflects obligations of countries, people, communities, health care systems and partners to achieve healthier lives through sustainable primary health care.”

UNICEF and WHO will help governments and civil society to act on the Declaration of Astana and encourage them to back the movement. UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in cooperation with other partners.

**Notes to editors:**

The [**Global Conference on Primary Health Care**](http://www.who.int/primary-health/conference-phc)is taking place from 25-26 October in Astana, Kazakhstan, co-hosted by WHO, UNICEF and the Government of Kazakhstan. Participants include ministers of health, finance, education and social welfare; health workers and patient advocates; youth delegates and activists; and leaders representing bilateral and multilateral institutions, global health advocacy organizations, civil society, academia, philanthropy, media and the private sector.

The [**Declaration of Astana**](http://www.who.int/primary-health/conference-phc/declaration), unanimously endorsed by all WHO Member States, adopted at the conference, makes pledges in four key areas: (1) make bold political choices for health across all sectors; (2) build sustainable primary health care; (3) empower individuals and communities; and (4) align stakeholder support to national policies, strategies and plans.

**WHO**

**HH Pope Francis and WHO Director-General: Health is a right and not a privilege**

*23 October 2018*

The Director-General of WHO, Dr Tedros Adhanom Ghebreyesus, has met with His Holiness Pope Francis to discuss ways to ensure that all people can obtain the healthcare they need, whoever they are, wherever they live.

His Holiness Pope Francis and Dr Tedros have both reiterated that health is a right, and should not be a privilege, and share a commitment to improving the health and wellbeing of the most vulnerable and marginalized – in both rich and poor countries.

“I am honoured and humbled to have met His Holiness Pope Francis and to discover that we share so many of the same concerns,” said Dr Tedros.

“For many years, in our previous occupations as well as our current positions, we have both worked to improve the lives of poor and vulnerable people. I am delighted to have Pope Francis’ support for our effort to extend the right of life and health to all people. I particularly welcome the Pope’s emphasis on the welfare of children. I am encouraged to hear him say that he is beside us and all those working with us in the attempt to bring health to all,  especially the many people, including children, who live on the periphery of society, and who suffer ill health and hunger.”

Pope Francis and Dr Tedros met in Rome in advance of the [Global Conference on Primary Health Care](http://www.who.int/primary-health/conference-phc), to take place on 25-26 October in Astana, Kazakhstan. The conference marks the fortieth anniversary of the historic Alma Aty Declaration and its commitment to achieve Health For All. Delegates in Kazakhstan will endorse a new declaration to revitalize primary health care around the world.

The goal is to ensure that health care focuses on care for people, rather than simply treatment for specific diseases or conditions – factoring in all aspects of people’s individual lives and situations.

Primary healthcare is at the heart of the global drive to achieve universal health coverage, itself one of the core foundations of the Sustainable Development Goal of better health and wellbeing for all people.

**WHO**

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*25 October 2018*

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UNICEF and WHO will help governments and civil society to act on the Declaration of Astana and encourage them to back the movement. UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in cooperation with other partners.

**Notes to editors:**

The [**Global Conference on Primary Health Care**](https://web-prod.who.int/primary-health/conference-phc) is taking place from 25-26 October in Astana, Kazakhstan, co-hosted by WHO, UNICEF and the Government of Kazakhstan. Participants include ministers of health, finance, education and social welfare; health workers and patient advocates; youth delegates and activists; and leaders representing bilateral and multilateral institutions, global health advocacy organizations, civil society, academia, philanthropy, media and the private sector.

The [**Declaration of Astana**](http://www.who.int/primary-health/conference-phc/declaration), unanimously endorsed by all WHO Member States, makes pledges in four key areas: (1) make bold political choices for health across all sectors; (2) build sustainable primary health care; (3) empower individuals and communities; and (4) align stakeholder support to national policies, strategies and plans.

**WHO**

**WHO launches new guideline on health policy and system support to optimize community health worker programmes**

*26 October 2018*

**Geneva, 26 October 2018 -**The new [WHO guideline on health policy and system support to optimize community health worker programmes](http://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1) was launched today at the Global Conference on Primary Health Care. The guideline uses state-of-the-art evidence to identify effective policy options to strengthen community health worker (CHW) programme performance through their proper integration in health systems and communities.

In 1978, the Declaration of Alma-Ata recognised community health workers as part of a diverse, sustainable team that responds effectively to the health needs of communities. Forty years on, in Astana, the global health community gathers to affirm and reinvigorate its commitment to primary health care as fundamental to ensuring that everyone everywhere is able to enjoy the highest possible attainable standard of health. The health workforce agenda remains as relevant today as it was in 1978: addressing health workforce shortage, maldistribution and performance challenges is essential for progress towards all health-related goals, including universal health coverage. Further, the health sector has the potential to be a driver of economic growth through the creation of qualified employment opportunities, in particular for women.

Effective health workforce strategies include the education and deployment of a diverse and sustainable skills mix, harnessing in some contexts the potential of community health workers operating in inter-professional primary care teams. Successful delivery of services through CHWs requires evidence-based models for education, deployment and management of these health workers. The guideline is intended as a tool for national policy makers and planners and their international partners to use in the design, implementation, performance and evaluation of effective community health worker programmes. It contains pragmatic recommendations on selection, training and certification; management and supervision: and integration into health systems and community engagement.

“By fully harnessing the potential of community health workers, including by dramatically improving their working and living conditions, we can make progress together towards universal health coverage and achieving the health targets of the Sustainable Development Goals.”

**Dr Tedros Adhanom Ghebreyesus, Director-General of WHO**

The development of this guideline followed the standardized WHO approach. This entailed a critical analysis of the available evidence, including 16 systematic reviews of the evidence, a stakeholder perception survey to assess feasibility and acceptability of the policy options under consideration, and the deliberations of a Guideline Development Group which comprised representation from policy makers and planners from Member States, experts, labour unions, professional associations and CHWs.

Critical to the success of these efforts will be ensuring appropriate labour conditions and opportunities for professional development, as well as creating a health ecosystem in which workers at different levels collaborate to meet health needs. Adapted to context, the guideline is a tool that supports optimizing health policies and systems to achieve significant gains to meet the ambition of universal access to primary health care services.

## Global Media Coverage

**BMJ**

**Alma Ata and primary healthcare: back to the future**

**By: Zulfiqar A Bhutta, Rifat Atun, Navjoyt Ladher and Kamran Abbasi**

*22 October 2018*

After 40 years, global health is returning to the vision of the Alma Ata declaration

In 1978, when the world looked different geopolitically, the Soviet Union hosted a landmark international conference on primary healthcare. Organised by the World Health Organization and Unicef, the conference took place at Alma Ata (now Almaty) and considered the role of primary healthcare in population health. It finished with a declaration that promised “health for all by the year 2000.”[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1)

The Alma Ata declaration was signed by 134 countries and 67 international organisations and was groundbreaking in several ways. The declaration promoted a holistic definition of health “as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” The 10 statements of the Alma Ata declaration stressed the large inequality in health and its social determinants and recognised primary healthcare as integral to achieving health for all by 2000.

The conference and declaration also espoused three important principles. Firstly, primary healthcare is an integral part and central function of health systems. Secondly, it is essential to social and economic development. Thirdly, primary healthcare must be universally accessible through full community participation and based on practical, scientifically sound, and socially acceptable methods and technologies.[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1)

Although the response to the declaration was generally enthusiastic, its implementation met with many challenges. For some countries, the model of primary healthcare proposed was “poor care for poor people, a second-rate solution for developing countries.”[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1) Others had fundamental misgivings about the principles of universality and social justice championed by the declaration, which they thought seemed impractical and smacked of radicalism.[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1)

Indeed, the declaration lacked a pragmatic plan to translate its laudable goals into meaningful actions and results. Within a year of the declaration, a conference hosted by the Rockefeller Foundation in Bellagio, Italy, debated universal versus selective approaches and recommended interim measures of selective primary healthcare, focusing on a narrow set of high impact and cost effective strategies to tackle major causes of death and ill health.[**2**](https://www.bmj.com/content/363/bmj.k4433.full#ref-2)[**3**](https://www.bmj.com/content/363/bmj.k4433.full#ref-3) The outcome was a package for reducing child mortality based on growth monitoring, oral rehydration, breastfeeding, and immunisations (GOBI). Once expanded to include food supplementation, female literacy, and family planning, GOBI-FFF became a rallying cry for Unicef and other agencies for more than a decade.

Hence, although some countries in Latin America—notably Brazil, Cuba, and Nicaragua—introduced a new model of comprehensive primary healthcare inspired by the Alma Ata declaration,[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1) the vision lost momentum in most countries. Instead, a more selective version of primary healthcare gained prominence—a vertical or disease specific approach proposed by some development agencies, notably USAID, and supported by development economists at the World Bank.

Implementation of robust primary healthcare strategies was hindered by a view that the burden of disease in less developed nations was socially and economically sustained, requiring political will to tackle social determinants.[**4**](https://www.bmj.com/content/363/bmj.k4433.full#ref-4) Another alternative to primary healthcare was to focus on technological solutions to reduce poverty and improve living conditions.[**5**](https://www.bmj.com/content/363/bmj.k4433.full#ref-5)

Despite the competing claims of selective and comprehensive approaches,**[4](https://www.bmj.com/content/363/bmj.k4433.full" \l "ref-4)** most settings had ample scope for both strategies to coexist and deliver integrated care.[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1) Some countries implemented these combined strategies successfully with a “diagonal” progression of healthcare.[**6**](https://www.bmj.com/content/363/bmj.k4433.full#ref-6) Nonetheless, the millennium development goals reinforced the argument for selective programmes as the best approach to reducing maternal and child mortality. The Global Fund to Fight AIDS, Tuberculosis, and Malaria, Gavi (the vaccine alliance), and the President’s Emergency Fund for AIDS Relief (PEPFAR) continued this trend by financing global initiatives targeting large scale immunisation programmes, HIV, tuberculosis, and malaria diagnosis and treatment.[**7**](https://www.bmj.com/content/363/bmj.k4433.full#ref-7)

While these selective and vertical efforts were intended to create positive synergies to strengthen health systems,[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1) and the principles of equity and gender equality were picked up early, they did not extend beyond their target conditions**—**for example, by mobilising community health workers[**8**](https://www.bmj.com/content/363/bmj.k4433.full#ref-8) or financial support mechanisms.[**9**](https://www.bmj.com/content/363/bmj.k4433.full#ref-9) The conclusion from the experience of the millennium development goals was that targeted programmes alone were not enough. Countries needed universal health coverage as now envisaged by the sustainable development goals: strong health systems, underpinned by comprehensive primary healthcare and multisectoral approaches to reduce inequalities and ill health.[**1**](https://www.bmj.com/content/363/bmj.k4433.full#ref-1)

Much has changed since the Alma Ata declaration, although the world is still grappling with socioeconomic disparities, health inequalities, and preventable deaths.[**10**](https://www.bmj.com/content/363/bmj.k4433.full#ref-10) Alma Ata’s vision of health for all by 2000 proved to be a mirage. Yet hope remains alive. The principles are as fresh and relevant today as they were 40 years ago. A renewed commitment by WHO and the United Nations to universal health coverage means that decades after its introduction, the approach championed by the Alma Ata declaration remains an enlightened and forward thinking blueprint for countries striving to achieve health for all.

In support of these principles and to further the debate, The BMJ is creating a special collection of content on the progress and future of primary healthcare ([www.bmj.com/primaryhealthcare](http://www.bmj.com/primaryhealthcare)). We will add relevant articles and multimedia as we publish them.

At its 40th anniversary, revived by the impetus of the sustainable development goals and universal health coverage, the principles of Alma Ata must be translated into firm actions to achieve equitable health, wellbeing, and sustainable development for generations to come.

**BMJ**

**Alma Ata, Astana and beyond – patients and communities as the core of universal primary healthcare**

**By: Anya de longh, Sarah Markham and Rakhal Gaitonde**

*24 October 2018*

As the 40 year anniversary of the Alma Ata Declaration on Primary Health Care arrives, it prompts a range of reflections, on primary healthcare and its position in the wider landscape of health, as well as the virtues and realities of bold global visionary documents.

The original declaration of Alma Ata in 1978 urged us away from the medical model with its acknowledgement of health as a human right, the social determinants of health, and centering the participation of people and their communities. While progress has been made, we are faced with widely varying gains and stubborn inequalities along various axes. There remains much for us to do in order to reach the aims that the declaration originally set out to achieve.

On the 25-26 October 2018, world leaders will meet in Astana, Kazakhstan, to renew a commitment to primary healthcare and to achieve universal health coverage and the Sustainable Development Goals (SDGs). The proposal for the [Astana Declaration on Primary Health Care 2018](http://www.who.int/primary-health/conference-phc/DRAFT_Declaration_on_Primary_Health_Care_28_June_2018.pdf) is clear on the role of primary healthcare as a “[necessary foundation to achieve Universal Health Coverage](http://www.who.int/primary-health/conference-phc/declaration).”

The dynamic relationship between primary healthcare and universal health coverage was critiqued by the People’s Health Movement, a global network of grassroot health activists and civil society organisations from over 70 countries. They commented that “Primary healthcare is broader and indeed subsumes universal health coverage, which is, in many countries, being implemented by private health insurance companies and aggravating health inequalities.”

In response to this, The People’s Health Movement have released an “[Alternative Civil Society Astana Statement on Primary Health Care.](http://phmovement.org/alternative-civil-society-astana-declaration-on-primary-health-care/)”

The 2018 Astana Declaration, proposed by the World Health Organisation, is structured to highlight our collective assets (political will, knowledge, technology, and people), before detailing the challenges and actions required. This reflects an asset-based approach, which is an important principle of partnership and development praxis.

“People” are rightly considered an “asset” in themselves, however it is important to highlight the integral role that people (patients and communities) play in strengthening other assets, and the health system as a whole. Political will has grown due to the emergence of new partners and stakeholders, with patient advocates, campaigners, and activists central to the process, as the patient movement expands.

Knowledge must be understood as inclusive of epistemic justice; regard for the knowledge of the individuals and communities, as both patient and participant. Having a collective appreciation of epistemic justice and governance is the foundation on which to build and critique our knowledge beyond formal academic and clinical research to inform primary healthcare development.

Technology brings enormous positive potential, together with risks of further extending inequalities through the digital divide. Many of the best examples of accessible, practical, and impactful health technology have been developed by people as patients or carers, or via co-production.

As strong and increasingly agile as these assets are, the challenges are still considerable. There is no indication as to why these assets did not achieve WHO’s goal of “[Health for All](https://en.wikipedia.org/wiki/Health_For_All)”, which formed the basis of WHO’s primary healthcare strategy. Open and transparent discussion and acknowledgment of these reasons is needed to transform good intentions into reality.

The actions put forward to address these challenges focus first and foremost on “empowering people to take ownership of their health and healthcare” which is to be welcomed.

We believe that empowered citizens with knowledge, motivation, confidence, and skills can have an enormous impact in terms of individual resilience-building, wellbeing, and health outcomes, and in developing and managing healthcare systems. However, they cannot be seen as a cover-up/sticking plaster negating the need to address the [wider social and environmental determinants of health and inequalities](https://blogs.bmj.com/bmj/2018/07/03/how-can-patient-advocates-work-together-to-reduce-health-inequalities/) that underpin so many health needs. One important example is the impact of climate change, which is having—and will increasingly have—a significant impact on global health. PHM is suggesting that healthcare should be provided in a way that is aligned to the [Earth Charter](http://earthcharter.org/), and thereby recognises that healthcare is a major global industry that has a contributing role to play in supporting the health of our planet.

Exploration of these declarations and reflection in the context of their anniversaries raises another debate regarding their impact. In a world of evidence based medicine and “informed policy”, do we know how many of these ambitious global goals are achieved, and how the benefits are distributed among people more vulnerable and marginalised? Indeed, how much progress made towards them is attributable to the vision in the original declarations?

The bold declaration in the original 1978 declaration of “an acceptable level of health for all the people of the world by the year 2000…” has not been achieved. Has the progress that has been seen in the past forty years happened because of or despite global declarations?

The 1978 and the 2018 declarations are both short and succinct, which hopefully gives them more impact. But it leaves unanswered questions about how this will be funded, and the specific responsibility that still sits with individual governments and how corruption and industry influence will be monitored, regulated, and countered for the greater good.

The principle of universal primary healthcare for all is undisputed. We are one, but we are all uniquely different. It requires courage, honesty, and solidarity to translate these visions of universality and individuality into reality. Patients, carers, and communities at large continue to inspire and innovate towards this—are those with power ready to do what it takes as well?

**BMJ**

**Empowering frontline providers to deliver universal primary healthcare using the Practical Approach to Care Kit**

**By: Lara Fairall, Ruth Cornick and Eric Bateman**

*24 October 2018*

Forty years ago, when world leaders met in Alma Ata, the world was home to 4.3 billion people. The resultant declaration provided a bold vision where everyone had access to healthcare and affirmed the pivotal role of primary healthcare in achieving this. But the declaration was soon dismissed as an idealistic dream, and multilaterals, academia, and clinicians instead busied themselves with the low hanging fruits, in particular specific drivers of mortality, in what became known as selective primary healthcare.

These efforts were not without successes: childhood mortality halved; conditions like polio and river blindness almost eliminated; hundreds of thousands of lives saved by the scale-up of antiretroviral treatment; and Ebola and other outbreaks contained. But such programmatic achievements have not yielded robust health systems.

When the World Health Organization, Unicef, and government health leaders meet in Astana on 25-26 October 2018, they will consider a world population that has swelled to 7.4 billion, of whom half have limited access to essential health services and 400 million no access to any health service. Governments have still to figure out how to deliver quality healthcare that is effective, safe, and person centred. Health systems, especially primary healthcare systems in low and middle income countries (LMICs), remain rudimentary or non-existent at worse, and fragile and fragmented at best, unable to meet current realities of inequality, global migration, and changing disease burdens.

At the coalface are frontline providers, often portrayed as poorly qualified, unskilled, and even uncaring. In reality most are overworked, unsupported, poorly paid, and feel unrecognised, isolated, and traumatised by the demands made on them. Global efforts to strengthen primary healthcare have generally not focused on the critical interface between provider and patient but rather on policy, financing, and infrastructure.

In many countries providers are non-physician clinicians who lack the knowledge and skills to provide effective person centred care. Over the past two decades the Knowledge Translation Unit at the University of Cape Town has worked with government, academic, and non-governmental organisation partners to develop and evaluate health systems innovations that empower frontline providers. This began with a local adaptation of WHO’s Practical Approach to Lung Health (PAL), which used an integrated approach to the diagnosis and management of respiratory diseases, including tuberculosis.

The unit built on its experience of implementing PAL in rural South Africa, and, in response to requests of providers and their managers, progressively expanded its scope to include most problems that people present with at clinics in South Africa and evolved a programme that covers primary healthcare needs across the life course. Now called the Practical Approach to Care Kit (PACK), the programme has crossed borders and has been implemented in diverse settings in several LMICs.

This experience is described in a collection of papers in BMJ Global Health (https://gh.bmj.com/content/3/Suppl\_5). The collection is not intended to showcase best practice but rather is an attempt to describe this journey, both successes and challenges, during this time of reflection on the role of primary healthcare and the people who make it possible. PACK programme PACK is designed to support frontline providers who act as the first point of contact with health services (fig 1).

To date it has focused on clinicians working in primary care facilities in LMICs. At the centre of the programme are concise clinical decision support tools (guides) comprising standardised and user friendly algorithms and checklists that provide a comprehensive and integrated approach to screening, diagnosing, and treating common symptoms and chronic conditions in adults, adolescents, and children.

All medications are drawn from the 2017 WHO essential medicines list. Although most editions of the But PACK is much more than a book. The accompanying training programme uses case-based, short training sessions delivered by existing health staff to support frontline providers and their teams. The training time commitments are modest, mindful of the need to support scalable implementation and not withdraw providers from clinical service for prolonged periods to attend offsite training.

The culture of implementation and training is paramount. PACK draws on adult learning theory and practice, assuming that frontline providers bring with them much knowledge and experience. It models interprofessional respect and the shift from “all knowing” hierarchical knowledge systems to one that is “all learning,” non-judgmental, and supportive.

Training focuses on health priorities, which differ across settings, and aims to equip health workers to use the full content of the guide. The components for strengthening health systems are varied and setting dependent. In some, attention to resourcing of drugs and investigations by health facilities must precede training of health workers.

One universal aspect is the translation of task sharing policies into actionable, clear, and consolidated messages to the range of health workers who staff facilities. PACK uses a simple system, colour coding all medications every time they are listed, by indication and dose for different types of health worker, localised for the particular health system. This seemingly simple classification requires extensive engagement with health managers, policy makers, regulatory policies, and clinicians and is a key component of localising PACK to a particular setting.

The aim is to shift responsibility for determining scope of practice from health workers under pressure navigating patients, guidelines, and new policies, to governance structures and regulatory frameworks by clarifying what governments think is appropriate to ask of their health workers under the current circumstances. Areas where there is a lack of clarity or large unmet needs are presented in terms of clinical situations: “What should this type of health worker be able to offer the person in front of them at this time?” Regular revision assures policy makers that they can revisit their decisions.

The outcome is a common “hymn sheet” used by all types of primary healthcare worker to understand their role in the healthcare system. Routine monitoring and evaluation of the programme is less well developed and has focused on tracking training coverage both across and within facilities (fig 2). We have completed four large pragmatic implementation science trials, including 33 000 patients from 166 clinics.

Qualitative evaluation has shown substantial positive effects on health worker confidence and teamwork. We have found consistent, reproducible improvements in quality of care across several indicators (prescribing, referral, case detection) mainly in the area of communicable diseases. Absolute effect sizes are in line with implementation science literature, and effects extend to health outcomes and economic benefits, including fewer and shorter hospital admissions.

Further four trials involving almost 50 000 patients from 88 clinics are underway, with components evaluating mental health and non-communicable diseases, as well as preliminary work for a trial of PACK Child. Less is known about the performance of PACK outside these trials, but the pragmatic orientation of these trials suggests that it should be no different in other situations. Numerous efforts are underway to establish routine monitoring and evaluation systems that can track training uptake in a health workforce that has high rates of turnover; to explore relations between training and simple indicators of care; and to assess fidelity to the principles of training.

PACK has been widely adopted in South Africa, where it forms part of the government’s ideal clinic realisation and maintenance programme across 3500 primary care facilities. It is also used in Botswana, Nigeria, and Brazil, and forms a central component of the Ethiopian Federal Ministry of Health’s health sector transformation plan.

To date around 200 000 hard copies of 42 editions of the guide have been distributed and more than 30 000 health workers trained. PACK is gaining widespread traction among health ministries seeking to strengthen their primary healthcare systems. It is currently being considered in China, Vietnam, Uganda, and Bangladesh. Since 2015 a further 28 countries across six continents have asked about localisation and implementation. Ministries report being attracted by the comprehensive and integrated approach, consolidating and unifying guidance across communicable and non-communicable diseases, age range, and the scalable, carefully designed programme for training multiprofessional teams together on-site instead of separately at centralised venues.

Language of “clinician”—a novel approach to strengthening health systems. During the late 2000s we started noting how introducing PACK at facilities often catalysed local, clinician-led efforts to improve healthcare delivery in their own facilities.

For example, Botswana’s adaptation of PACK proposed 36 new additions to the local essential medications list for primary care, including making statins available for secondary prevention of cardiovascular disease as well as for antiretroviral induced dyslipidaemias. Enthused clinicians engaged with government pharmaceutical services to ensure that their facilities had adequate supplies of drugs recommended in PACK, even compiling their own lists of medications by painstakingly identifying each one from the guide or sourcing drugs previously not provided to the clinic. Others identified patients with chronic conditions and reviewed their treatment plans to ensure that they reflected the evidence and policy aligned recommendations in the guide.

Some teams worked together to review patients’ experience of care in their facilities, streamlining flow to avoid duplication of roles and conserve valuable consultation time. Initially such feedback was heartening, but as this pattern started repeating across facilities and countries, it prompted reflection on what was happening. All these efforts seemed to be deeply rooted in the clinical content of the PACK programme rather than parallel quality improvement processes.

Clinicians seem to have claimed “system agency” based on an intervention that resonated with their primary identity as providers concerned principally with the welfare of the person sitting in front of them. This warrants further exploration, recognising that delivering healthcare is not only about optimising efficiencies but is fundamentally a human endeavour at the heart of which lies the critical interaction between two people, one of whom is in the provider role and one in the patient role. Reconciling comprehensive and selective approaches to primary healthcare.

How best to structure primary healthcare is the subject of much debate. Should we continue with the basket of low cost, high impact interventions targeting high burden, measurable diseases? Or has the time come to strive for comprehensive integrated person centred care? The answer lies not with a pros and cons list of these polarised views, but with a more nuanced understanding of the factors that have contributed to perpetuated the priorities approach and an honest appraisal of why an integrated approach is imperative but seemingly beyond reach.

Disease based approaches are embedded in health worker training curriculums worldwide.30 When graduates enter health systems they view health as a group of systems that work alongside each other. Identifying which of these is dysfunctional and targeting interventions is considered the basis of healthcare delivery.

Health systems replicate this siloed approach in career paths and specialisation, in how ministries organise themselves, in research and donor funding, in reporting systems, among patient and community advocacy groups, and in the media. We all relate to a cause, whether it be AIDS, mental illness, or the leading causes of childhood deaths. Protagonists of person centred care emphasise that patients and communities should set the agenda of healthcare and point out that appropriate uptake and demand are unlikely to materialise without tackling what matters most to them.

The solution lies in crafting a workable compromise, whereby patients and communities experience satisfying contacts with frontline providers, building their trust and use of healthcare systems and the interventions they provide. People who feel heard and cared for when seeking care for common non-life-threatening illnesses are more likely to seek care from that service at critical moments when effective treatment can substantially influence their morbidity and mortality. This is especially relevant to hard-to-reach populations, including adolescents around the world, men in sub-Saharan Africa, and women in South East Asia.

But the gains achieved by focused interventions cannot be ignored. Ultimately it would be myopic not to appreciate the fact that some, like antiretrovirals and vaccinations, are more effective than others and save many lives when implemented at scale. An all learning approach is essential to balance the tension between comprehensiveness and focus.

The Knowledge Translation Unit has insisted that local editions of PACK guides be comprehensive and not extract selected components to augment a disease based intervention. Prospective adopters of PACK often perceive this as extraneous work that will delay implementation.

Delays can be ameliorated by streamlining the localisation process as far as possible and strengthening mentorship of in-country teams. Training, however, is always focused on disease priorities in each setting and uses a tailored curriculum drawn from a global bank of cases. Providers appreciate the inclusion of common non-life-threatening conditions as this empowers them to manage a high proportion of their patients, often overlooked by disease focused initiatives. For example, although pneumonia and diarrhoea remain leading causes of childhood mortality, snotty noses and skin rashes continue to be common reasons for encounters with health services.

The shift towards meeting the needs of people with chronic conditions offers an opportunity to build primary healthcare systems that can respond to both acute and chronic illnesses in a timely, cost effective way. Work environments characterised by long patient queues, out-of-stock drugs, and inaccessible tests and referrals make provision of person centred care near impossible. Societal problems such as poverty, interpersonal violence, and marginalisation can overwhelm even the most straightforward of consultations. Containment of situations and connection to appropriate resources are essential skills for frontline providers.

PACK aims to contribute by starting with clear guidance on how best to manage the clinical aspects of a consultation, recognising that clinicians who fear missing a potentially fatal diagnosis or are uncertain about how to start assessing a particular complaint are in no position to provide person centred care. We have developed clinical communication skills focused on mental health in our training programmes and are raising awareness of the understanding that person centred care includes care of clinicians too. Building learning health systems PACK is unusual in that it has been built on a series of nine large pragmatic trials (fig 2), which have facilitated rapid adoption of evidence into policy and practice in what has been promoted as “learning health systems.”

In South Africa the trials have supported a move away from centralised training to a cascade system that is team based and on-site and has been adopted by other training providers and programmes. The trials have also underpinned and informed the adoption of nurse initiated and managed antiretroviral treatment, and contributed to policy decisions to adopt the South African version of PACK.

The second and third trials helped establish a province-wide health information and monitoring system for HIV, which additionally highlighted the big effect of antiretroviral treatment and high mortality among patients waiting a prescription, 32 motivating the decision to switch to nurse initiation. But routine data collection outside of communicable diseases is near absent in many LMICs, and the four trials evaluating the effects on these conditions have required years of fieldwork with as many as 19 000 patient interviews. Disappointing results in a trial evaluating hypertension, diabetes, and depression care prompted intense reflection on the nature of the intervention. We had to justify a national decision to adopt PACK despite the results, which required engagement of policy makers in a discourse that considered context, the urgent need to tackle non-communicable disease, interpretation of pragmatic trials, and consideration of several secondary outcomes that indicated better care.

We decided not to undertake such research in future without extensive mixed methods formative and summative evaluation, irrespective of funding restraints. Rigorous research in these contexts is difficult, but, because of its capacity to outlive annual budget cycles and political terms and to refine complex health systems interventions, it is needed to guide evidence informed strengthening of health systems.

Future of PACK: is global expansion possible? The future of PACK depends on several factors: the need, the performance of PACK in meeting that need, alternative approaches, and sustainability. The demand we have had for PACK, even though it is not endorsed by official agencies, is testament to the need and the appeal of the approach. Although alternatives exist, the localisation, comprehensiveness, and training methods of PACK and its record of development have gained traction with both clinicians and policy makers.

Unquestionably, the greatest challenge should be the easiest to address: consolidating this international resource and continuing to develop regional and local hubs to maintain, develop, and support countries that are looking to PACK to strengthen provision of primary healthcare.

The current structure of funding in LMICs does not permit this. Provision of health services in many of these countries depends on donors, who require that countries deliver return on investment in the short term, typically in annual cycles, and attempt to meet unrealistic targets or face big cuts or even funding withdrawal. Poor investment by LMICs in health research has resulted in research agendas that are set by high income country donors and remain almost exclusively disease based. Even groundbreaking initiatives such as the Global Alliance Against Chronic Disease organised three of its four funding rounds by disease. In contrast the Knowledge Translation Unit’s efforts have been almost entirely supported by grant funding and the budget is paltry compared with the budgets of disease specific initiatives supported by global and national donors.

The revised Alma Ata declaration commits international agencies, including WHO, Unicef, and other UN agencies, to investments towards realising universal health coverage through people centred primary healthcare systems consistent with the sustainable development goals. It’s time for the international community to take heed of the role PACK can play in LMICs and invest in a programme that assists these countries to deliver on universal health coverage.

**BMJ**

**The extricable links between health, wealth, and profits**

**By: Gavin Yamey, Devi Sridhar and Kamran Abbasi**

*22 October*

A new BMJ series will examine the latest evidence

We live in critical times for global health. Big gains made during the millennium development goals era, including a halving of child mortality from 1990 to 2015,[1](https://www.bmj.com/content/363/bmj.k4418" \l "ref-1) fuelled optimism about unabated—or even accelerated—progress. We hear talk of the end of AIDS,[2](https://www.bmj.com/content/363/bmj.k4418" \l "ref-2) universal health coverage by 2030,[3](https://www.bmj.com/content/363/bmj.k4418#ref-3) and a pandemic-free world.[4](https://www.bmj.com/content/363/bmj.k4418#ref-4) But in the current political climate these outcomes are a distant dream. Our era is one of retrenchment and disinvestment in global health, throwing cold water on utopian rhetoric and threatening to reverse recent gains.

After health aid tripled between 2000 and 2010 from around $10bn (£7.6bn; €8.7bn)to $30bn annually, such investments are now stagnating “amid political uncertainty, expanding and ag[e]ing populations, and emerging pandemics.”[5](https://www.bmj.com/content/363/bmj.k4418#ref-5) The HIV pandemic is not on track to end,[6](https://www.bmj.com/content/363/bmj.k4418" \l "ref-6) yet last year eight out of 14 bilateral donors cut their support for HIV programmes.[7](https://www.bmj.com/content/363/bmj.k4418#ref-7)

The only feasible way to reach universal health coverage and other health related sustainable development goals is through mobilisation of domestic resources by low and middle income countries. But this remains elusive. Indeed, the trend in low income countries is in the wrong direction: the World Health Organization found that since 2000 these countries have reduced their allocation of domestic resources to health.[8](https://www.bmj.com/content/363/bmj.k4418#ref-8) Health is being deprioritised in national budgets worldwide, not just in low income countries. Health and social spending in the United Kingdom, for example, has slowed down in recent years, a plausible explanation for several deteriorating health outcomes.[9](https://www.bmj.com/content/363/bmj.k4418#ref-9)

A paradox lies at the heart of this retreat from health. It comes at a time when the evidence on the benefits of increasing donor and domestic health investments is at its strongest. In response, The BMJ is launching a new series to capture this evidence and restate the profound social and economic benefits of investing in health.

The launch is timed with two events that can help restore health to the top of the global development agenda. Firstly, the global conference on primary healthcare in Astana, Kazhakstan, intends to reinvigorate global commitments to universal health coverage. It will mark the 40th anniversary of the Alma Ata declaration, which launched the global primary healthcare movement.[10](https://www.bmj.com/content/363/bmj.k4418#ref-10) Secondly, the World Bank has just released a new index that ranks countries on their human capital, defined by the bank’s president as “the sum total of a population’s health, skills, knowledge, experience, and habits.”[11](https://www.bmj.com/content/363/bmj.k4418#ref-11) The rankings primarily reflect national investments in health and education.

TheBMJ series on health, wealth, and profits has three themes. The first is the link between health and wealth, documented by 2001’s influential Commission on Macroeconomics and Health.[12](https://www.bmj.com/content/363/bmj.k4418#ref-12) Since then, several avenues of research using newer economic approaches show that the returns on investing in health are even greater than previously believed.[13](https://www.bmj.com/content/363/bmj.k4418#ref-13)

But where can the greatest gains be made? Non-communicable diseases, which encompass cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases, are responsible for 41 million deaths a year (71% of all deaths globally), of which 15 million are in people aged 30 to 69.[14](https://www.bmj.com/content/363/bmj.k4418#ref-14) Over 85% of these early deaths occur in low and middle income countries.[14](https://www.bmj.com/content/363/bmj.k4418#ref-14)

Thus, the second theme in our series will be the rising cost of non-communicable diseases to societies, and the losses in both health and wealth to households, health systems, and national economies. Four modifiable risk factors drive the non-communicable disease epidemic: tobacco consumption, alcohol misuse, poor diet, and physical inactivity.[14](https://www.bmj.com/content/363/bmj.k4418#ref-14) The first three of these are heavily influenced by the marketing, sponsorship, and promotion strategies of large multinational corporations such as Philip Morris, Heineken, and Nestlé.[15](https://www.bmj.com/content/363/bmj.k4418#ref-15)

How then can governments, citizens, and societies begin to make progress on regulating large private stakeholders in global health? International collective action, global regulatory frameworks, and other efforts to tackle key risk factors for poor health form the third theme of our series. As tobacco control is most often pointed to as a success, we will analyse lessons from the Framework Convention on Tobacco Control and consider where new instruments and approaches are necessary.

Our broad vision for this series is to reignite the debate on investing in health and healthcare systems, with a focus on non-communicable diseases. Policy makers can no longer point to a lack of evidence on the links between health and wealth, ill health and losses to the economy, and the influence of commercial determinants of health. We invite contributions to this series that are relevant to our three themes. As the commissioned papers in this series will show, a solid evidence base drawn from public health, epidemiology, economics, and political science already exists on how to move forward and create a world focused on healthier lives instead of corporate profits.

**Footnotes**

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**BMJ**

**Unfulfilled potential of primary care in Europe**

**By: Luke N Allen, Shannon Barkley, Jan De Maeseneer, Chris van Weel, Hans Kluge, Niek de Wit and Trisha Greenhalgh**

*25 October 2018*

To mark the 40th anniversary of the Alma Ata declaration on primary healthcare in October 2018,**[1](https://www.bmj.com/content/363/bmj.k4469" \l "ref-1)** world leaders gathered in Astana to renew their commitment to health for all. Although primary healthcare is about much more than primary care services, getting this element right is crucial to supporting the overarching principles of equity, population level primary prevention, and action on the social determinants of health. In the context of increasing chronic multimorbidity and ageing populations we consider why European primary care has broadly failed to engage with the prevention oriented approach set out 40 years ago, and what conditions are required to realise its potential.

## **Contemporary challenges in primary care**

Primary care has been defined as “first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system.”[**2**](https://www.bmj.com/content/363/bmj.k4469#ref-2) A stronger primary care sector is associated with greater equity, better health outcomes, and, in some settings, lower overall costs.[**3**](https://www.bmj.com/content/363/bmj.k4469#ref-3)[**4**](https://www.bmj.com/content/363/bmj.k4469#ref-4) Primary care can manage 90% of all health system interactions, making it central to the realisation of universal health coverage.[**5**](https://www.bmj.com/content/363/bmj.k4469#ref-5)[**6**](https://www.bmj.com/content/363/bmj.k4469#ref-6) Over recent decades, improvements in the quality and coverage of primary care have delivered important population health gains around the world.[**3**](https://www.bmj.com/content/363/bmj.k4469#ref-3)[**7**](https://www.bmj.com/content/363/bmj.k4469#ref-7)[**8**](https://www.bmj.com/content/363/bmj.k4469#ref-8)[**9**](https://www.bmj.com/content/363/bmj.k4469#ref-9)[**10**](https://www.bmj.com/content/363/bmj.k4469#ref-10)[**11**](https://www.bmj.com/content/363/bmj.k4469#ref-11)[**12**](https://www.bmj.com/content/363/bmj.k4469#ref-12)

Primary care teams are commonly led by family doctors (also known as general practitioners or family practitioners), who have received postgraduate specialty training to provide comprehensive family and community oriented medical care. In recent decades they have come under pressure from substantial increases in workload, including paperwork and delegation of care from hospitals to the community setting.[**6**](https://www.bmj.com/content/363/bmj.k4469#ref-6)[**13**](https://www.bmj.com/content/363/bmj.k4469#ref-13)Task shifting to primary care is often appropriate, but reallocation of responsibility is rarely followed by adequate reallocation of resources.[**13**](https://www.bmj.com/content/363/bmj.k4469#ref-13) Primary care teams have been on the front lines of this century’s major demographic and epidemiological challenges, including ageing, socioeconomic inequalities, chronic diseases, rising consultation rates, and multimorbidity.[**13**](https://www.bmj.com/content/363/bmj.k4469#ref-13)[**14**](https://www.bmj.com/content/363/bmj.k4469#ref-14)[**15**](https://www.bmj.com/content/363/bmj.k4469#ref-15) The future sustainability of our health systems depends on primary care successfully meeting increased need with affordable, person centred, high quality care.

By shifting the emphasis of primary care from treatment towards proactive care, prevention, and health promotion at the local population level, it may be possible to deal with health challenges at an earlier stage.

This idea is not new; in fact it is the central thesis of the Alma Ata declaration, which set out to distinguish primary healthcare ([**box 1**](https://www.bmj.com/content/363/bmj.k4469#boxed-text-1)) from the status quo of care oriented around sickness. Although moving towards more proactive primary healthcare requires the collective actions of policy makers, communities, and many different health professionals, the primary care sector is uniquely invested with the legitimacy and authority to lead this change.

Box 1

### **Article VII of the 1978 Alma Ata declaration**

#### **Primary healthcare**

* Reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical, and health services research and public health experience
* Addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly
* Includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs
* Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors and demands the coordinated efforts of all those sectors
* Requires and promotes maximum community and individual self reliance and participation in the planning, organisation, operation, and control of primary healthcare, making fullest use of local, national, and other available resources, and to this end develops through appropriate education the ability of communities to participate
* Should be sustained by integrated, functional, and mutually supportive referral systems, leading to the progressive improvement of comprehensive healthcare for all and giving priority to those most in need
* Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Primary care systems are currently configured around sequentially consulting unwell individuals, but many of the current challenges in health require upstream action. Population level interventions[**16**](https://www.bmj.com/content/363/bmj.k4469#ref-16) tackle environmental risk factors as well as social and economic determinants of health. Community level interventions include investment in green spaces, housing, active transport networks, smoke-free zones, traffic calming measures, and local licensing and zoning regulations.

Many practices are taking first steps towards dealing with social determinants through social prescribing. However, this is an individual level approach rather than seeking to influence structural or system determinants that affect whole subpopulations.

Policy makers may be reluctant to invest in pivoting primary care systems towards population prevention for numerous reasons. It is much easier to blame individuals for making poor lifestyle choices than it is to change the environment; prevention and health system reforms require upfront political and capital investment but the benefits are invariably conferred to political successors; it is hard to take credit for things that haven’t happened (such as deaths averted); and it is difficult to obtain robust evidence for the effectiveness of population level interventions within the current evidence model. Policy makers also face complex trade-offs between investing in prevention versus other elements of the universal health coverage and primary healthcare agendas, such as improving access to services.

## **Structural determinants**

In many European countries the remit of primary care extends only as far as diagnosing and treating disease in individuals (and only those with the means and motivation to seek care).[**17**](https://www.bmj.com/content/363/bmj.k4469#ref-17) Although patients may be opportunistically screened for hypertension or offered support with smoking cessation, there is often no systematic approach to engaging with the broader health determinants at the community level.[**18**](https://www.bmj.com/content/363/bmj.k4469#ref-18)

This is a lost opportunity. In concert with public health teams, primary care teams are well positioned to identify the local drivers of morbidity and mortality, including transport, the food environment, pollution, poverty, early years education, housing, road safety, exercise spaces, and the availability and affordability of alcohol and tobacco. These non-medical factors are responsible for up to 90% of health outcomes.[**19**](https://www.bmj.com/content/363/bmj.k4469#ref-19) Primary care teams see these local social determinants at work every day[**20**](https://www.bmj.com/content/363/bmj.k4469#ref-20) and have overlapping moral, professional, and (where they are paid by capitation) financial interests in tackling them.

Through collaboration with public health, social care, and other community organisations, primary care professionals are uniquely placed to translate their insights into priorities for community level prevention. Primary care teams have detailed patient datasets and a unique ecobiopsychosocial perspective, and they often develop a high stock of community trust and a rich ethnographic understanding of the local population.[**21**](https://www.bmj.com/content/363/bmj.k4469#ref-21)Although the Alma Ata declaration called for population level prevention to become the central organising activity of primary healthcare, teams that operate this way remain rare.

## **Restricted remit**

Early general practitioners such as William Pickles and Frans Huijgen felt responsible for population and individual level practice,**[22](https://www.bmj.com/content/363/bmj.k4469" \l "ref-22)** but the role of contemporary primary care teams is much narrower in many European countries.[**11**](https://www.bmj.com/content/363/bmj.k4469#ref-11)[**23**](https://www.bmj.com/content/363/bmj.k4469#ref-23)[**24**](https://www.bmj.com/content/363/bmj.k4469#ref-24)[**25**](https://www.bmj.com/content/363/bmj.k4469#ref-25) Sutchfield and colleagues argue that an overemphasis on specialisation and the evolving professionalisation of primary care and public health as distinct specialties during the 20th century led to GPs eschewing public health roles.[**26**](https://www.bmj.com/content/363/bmj.k4469#ref-26) Primary care came to focus more on biomedical curative services for individuals and developed its own set of definitions around population health.[**27**](https://www.bmj.com/content/363/bmj.k4469#ref-27) Recent efforts to bring the two isolated specialties back into alignment have been under-resourced and often meet resistance from powerful doctors’ organisations.[**28**](https://www.bmj.com/content/363/bmj.k4469#ref-28)

Financing has also played a large role. Once ubiquitous fee-for-service systems can lead to the underuse of preventive services,[**29**](https://www.bmj.com/content/363/bmj.k4469#ref-29)[**30**](https://www.bmj.com/content/363/bmj.k4469#ref-30) and it is difficult to make people contribute to action on the social determinants as the benefits are a “public good” (that is, one person benefitting does not reduce the benefit for others and no-one can be excluded.)[**31**](https://www.bmj.com/content/363/bmj.k4469#ref-31) The international move to capitation has helped provide capital for investment in primary prevention at the community level, but growing multimorbidity often seems to absorb any additional money, as in the UK.[**13**](https://www.bmj.com/content/363/bmj.k4469#ref-13)[**32**](https://www.bmj.com/content/363/bmj.k4469#ref-32) Governments tend to govern and finance public health and primary care functions separately, and insurance companies have been reluctant to pay for community prevention delivered through primary care.[**33**](https://www.bmj.com/content/363/bmj.k4469#ref-33)

The degree to which primary care teams engage with even basic individual preventive activity varies widely across Europe, with variation underpinned by differing financing arrangements.[**11**](https://www.bmj.com/content/363/bmj.k4469#ref-11)[**23**](https://www.bmj.com/content/363/bmj.k4469#ref-23)[**34**](https://www.bmj.com/content/363/bmj.k4469#ref-34)[**35**](https://www.bmj.com/content/363/bmj.k4469#ref-35) Experience from other continents shows that state regulators often restrict the practice of primary care professionals to individual level functions and disproportionately direct regulatory measures to public sector practices (which may be more likely to consider public health than their private counterparts).[**8**](https://www.bmj.com/content/363/bmj.k4469#ref-8)[**36**](https://www.bmj.com/content/363/bmj.k4469#ref-36)

Anecdotally, our primary care colleagues believe that social determinants simply aren’t their responsibility, even though they appreciate that these issues affect their work. And can we blame them when modern primary care teams are not trained, paid, held accountable, or given time for delivering community level prevention?[**37**](https://www.bmj.com/content/363/bmj.k4469#ref-37)

## **Realising the potential of primary care**

We have argued that European primary care teams are well positioned to assess and tackle structural determinants of health at the community level, but what does this look like in practice?

The Hedena Health GP practice in Oxford has worked with housing developers, the city council, public health teams, and NHS England to develop a health promoting housing development in a deprived area. The “healthy new town” gives primacy to cyclists, pedestrians, and public transport as well as focusing on social inclusion, safe housing, and the food environment.[**38**](https://www.bmj.com/content/363/bmj.k4469#ref-38)[**39**](https://www.bmj.com/content/363/bmj.k4469#ref-39)

In Belgium, the Botermarkt Community Health Centre in Ghent has led several preventive initiatives prompted by assessment of the local population’s health needs. These have included leading a coalition of community stakeholders to redesign a dangerous road section and successfully lobbying the council for a new playground. These activities have helped to reduce road traffic injuries and childhood obesity.[**21**](https://www.bmj.com/content/363/bmj.k4469#ref-21)[**40**](https://www.bmj.com/content/363/bmj.k4469#ref-40)

The “deep end” practices serving deprived areas inGlasgow and Clyde work closely with members of the local community to assess and reduce local drivers of disease through initiatives like walking groups, financial advice, community gardens, and supporting the reforestation of disused land. Recognising that tackling social problems can reduce demand by improving health outcomes, Garscadden Burn medical practice closes one afternoon a month to train staff in this area.[**41**](https://www.bmj.com/content/363/bmj.k4469#ref-41)[**42**](https://www.bmj.com/content/363/bmj.k4469#ref-42)

Primary care professionals in the Dutch city of Utrecht work with community nurses and social workers to deliver a city-wide programme that supports frail elderly people, identified using routine primary care data.[**43**](https://www.bmj.com/content/363/bmj.k4469#ref-43)

## **System recalibration**

Certain conditions are required to facilitate this style of working, starting with financing. The Botermarkt practice successfully lobbied for capitated payment, which they used to employ a community health worker to engage with issues like housing, playgrounds, street lighting, healthy food availability, and active transport.[**21**](https://www.bmj.com/content/363/bmj.k4469#ref-21)[**44**](https://www.bmj.com/content/363/bmj.k4469#ref-44)England and Estonia’s quality bonus schemes could be modified to encourage action at the local population level.

Moving away from fee-for-service and towards mixed payment models that include population based weighted capitation is important for sustainability and encouraging population based practice.[**21**](https://www.bmj.com/content/363/bmj.k4469#ref-21)[**45**](https://www.bmj.com/content/363/bmj.k4469#ref-45)[**46**](https://www.bmj.com/content/363/bmj.k4469#ref-46) More important is ensuring that the primary care sector is adequately financed. Even in countries like the UK, where primary care is well developed and delivers over 90% of all health system interactions, primary care receives around 10% of government health spending.[**47**](https://www.bmj.com/content/363/bmj.k4469#ref-47) Many of our English primary care colleagues believe that this is not enough to provide a bare bones individual level service, let alone expand to include social determinants. Long time horizons are required to realise the gains of investing in primary prevention.

Empanelment is a second prerequisite as primary care teams need to know who they are serving and the characteristics of their patient population.[**48**](https://www.bmj.com/content/363/bmj.k4469#ref-48) Staff also need better training on how to identify and deal with social determinants, complemented by easy access to public health specialists. Deeper integration can be achieved through co-location, regular meetings, and shared information systems, work plans, and budgets.[**32**](https://www.bmj.com/content/363/bmj.k4469#ref-32)Qualitative and quantitative primary care data should be used routinely to develop public health interventions.[**49**](https://www.bmj.com/content/363/bmj.k4469#ref-49)

Scotland[**50**](https://www.bmj.com/content/363/bmj.k4469#ref-50) and Catalonia[**51**](https://www.bmj.com/content/363/bmj.k4469#ref-51) have tried to improve the coordination of multiple health and social care services around the needs of patients and populations. This integrated working allows primary care teams to engage directly with agencies working on social determinants of health.[**52**](https://www.bmj.com/content/363/bmj.k4469#ref-52)

Finally, a cultural shift is required within modern medicine, from specialist hospital treatment to community led prevention and care. The NHS Five Year Forward View[**53**](https://www.bmj.com/content/363/bmj.k4469#ref-53) and Astana declaration[**54**](https://www.bmj.com/content/363/bmj.k4469#ref-54) are good examples of policy commitment to prevention oriented care. Medical associations carry enormous weight and will need to catch the vision of what primary care can accomplish for patients when their sphere of concern enlarges to encompass more than consultation rooms. Commissioners and individual practitioners also need to be convinced that this enlarged scope is good for their patients.[**55**](https://www.bmj.com/content/363/bmj.k4469#ref-55)[**Box 2**](https://www.bmj.com/content/363/bmj.k4469#boxed-text-2) outlines a few suggested enablers of reform.

Box 2

### **Enablers of primary care reform**

Governance:

* Health in all policies
* Intersectoral collaboration and coordination
* Merging of health and social sectors
* Align professional health curriculums towards skill gaps
* Financing:
* Ear marked funding for population level prevention activity
* Strategic purchasing—mixed payment models that include population based weighted capitation
* Allocate resources for transformation in operations
* Monitoring and evaluation:
* Performance management—devising financial and non-financial incentives and key performance indicators aligned with overall health system goals
* Accountability—holding primary care teams accountable for delivering activities
* Enabling environment:
* Seeking out and disseminating examples of best practice
* Lowering barriers to safe innovation through accountability structures and payment mechanisms that prioritise outcomes over processes.

#### Managers

* Commissioning and managing local services
* Training
* Building and maintaining relations with community stakeholders
* Convening stakeholders
* Data analysis and performance management
* Routine reporting to providers on the health status of their population
* Improving the financial and human resources allocated to health promotion and disease prevention

#### Practitioners

* Working with public health and community members to:
* Monitor population health status
* Survey risks and threats to public health
* Identify local social determinants of health
* Risk stratify the population
* Develop and deliver appropriate interventions
* Monitor and evaluate interventions with community involvement
* Survey risks and threats to public health
* Identify local social determinants of health
* Risk stratify the population
* Develop and deliver appropriate interventions
* Monitor and evaluate interventions with community involvement

## Time for action

Primary care teams provide invaluable medical care for individuals, and this will always be required. However, they are also well positioned to help identify and influence the local social determinants that make their patients ill. Given that primary care workers are not currently trained, paid, or managed to think about community drivers of disease, it is not surprising that this approach is rare. Policy makers in Astana talked the talk, recommitting to orienting health systems around prevention. Introducing empanelment, population weighted capitation, enhanced training, unified budgets, and intersectoral working arrangements would show that they are willing to walk the walk.

**Center for Global Development  
The Declaration of Alma-Ata at 40: Realizing the Promise of Primary Health Care and Avoiding the Pitfalls in Making Vision Reality**

By: Amanda Glassman, Janeen Madan Keller and Jessie Lu

*24 October 2018*

At the Global Conference on Primary Health Care (PHC) in Astana on October 25–26, 2018, world leaders will redouble their commitment to PHC as a cornerstone of universal health coverage (UHC).[[1]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn1" \o ") The event marks the 40th anniversary of the Declaration of Alma-Ata, which enshrined health as a basic human right and underscored the potential of equitable, high-quality PHC to deliver “health for all.”

There is a solid case for investing in PHC: strong PHC can, at least theoretically, meet up to 90 percent of a population’s health needs and, in turn, reduce waste from unnecessary care elsewhere in the system ([Tollman et al](https://www.ncbi.nlm.nih.gov/books/NBK11789/#A9463). 2006). Moreover, investing in PHC is cost-effective and represents good value for money ([Disease Control Priorities 3](https://openknowledge.worldbank.org/bitstream/handle/10986/28877/9781464805271.pdf?sequence=2&isAllowed=y) 2018).[[2]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn2" \o ")Yet, in many low- and middle-income countries (LMICs), PHC remains under-prioritized, under-resourced, and under-utilized.

The renewed global commitment to PHC is an opportune time to distill lessons learned and identify key challenges from the past 40 years. Even more importantly, it is an opportunity to acknowledge the work that remains to be done to make vision reality.

The promise of primary health care

Since the 1978 declaration, the world has made important strides in deploying PHC services to improve health outcomes. Brazil’s Programa Saude da Familia, launched in 1994, and Thailand’s Universal Coverage Scheme, introduced in the early 2000s, are examples of large-scale nationally led efforts to strengthen health systems with a focus on PHC; both led to remarkable health gains ([Glassman and Temin](http://millionssaved.cgdev.org/) 2016). Indeed, governments the world over are acknowledging PHC as a building block of health systems and an important stepping stone to UHC. The Nigerian government, for example, recently announced a US$150 million investment in the Basic Healthcare Provision Fund, alongside support from the Global Financing Facility and the Bill and Melinda Gates Foundation ([Global Financing Facility](https://www.globalfinancingfacility.org/government-nigeria-global-financing-facility-and-partners-co-finance-effort-improve-health-and) 2018).

Despite well-known success stories and high-level endorsements, the reality of PHC is complex. Almost half of the world’s population still lacks access to basic primary care services—such as family planning, antenatal care, and tuberculosis treatment—highlighting the limited, and in some cases uneven, progress made by countries ([World Bank and WHO](http://www.worldbank.org/en/news/press-release/2017/12/13/world-bank-who-half-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses) 2017). Even in Ethiopia, which has made great strides, a 2016 household survey found that only 38.5 percent of children 6-23 months of age were fully vaccinated, despite major support from UNICEF, Gavi, and other international agencies ([Ethiopia DHS 2016](https://dhsprogram.com/publications/publication-FR328-DHS-Final-Reports.cfm), [Gavi 2018](https://www.gavi.org/country/fact-sheets/ethiopia.pdf)). And as the burden of non-communicable diseases rises, already-weak primary care systems face added pressures to meet growing demands for complex and continuous care.

Moreover, expanding access is necessary but not enough; investments to improve quality of care are also vital. Poor quality of care is responsible for close to 5 million of the more than 8 million deaths from treatable conditions occurring annually in LMICs—far more than the 3.6 million deaths resulting from insufficient access ([Kruk et al.](https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2931668-4) 2018).

These statistics reveal where efforts have fallen short and, in turn, point to much work that remains to be done to move beyond the rhetoric of global declarations. Indeed, efforts to improve PHC must consider the unique set of challenges and complexities across different country contexts. Even just looking across country income groups highlights important variations: in low-income countries, donor financing accounts for a large share of resources for many key PHC elements; in several lower-middle-income countries, households tend to pay out-of-pocket for their health needs; and an increasing number of upper-middle income countries are adopting national health insurance schemes to cover more complex forms of care.[[3]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn3" \o ")Even within countries, there are significant geographic and socioeconomic variations.

This note highlights four political economy challenges that explain why it is so hard to achieve strong PHC, with a focus on policy and implementation pitfalls that frequently go overlooked. With an eye towards the 2030 milestone, we offer ideas for country policymakers and global health funders to ensure greater equity, quality, and efficiency in PHC. While we acknowledge that the relevance of the challenges and ideas in this note may vary depending on context, we nonetheless hope they contribute to a deeper understanding of how to strengthen PHC systems going forward.

**Why strong PHC is so difficult to achieve: Four underappreciated political economy challenges**

**Challenge 1:** Competing demands within highly constrained public budgets means low PHC investment

LMIC governments face an already large and expanding menu of health technologies coupled with rapidly growing demand for health care, forcing them to make allocative tradeoffs within extremely limited budgets.

An expanding and increasingly educated “middle class” in urban areas means governments face growing citizen expectations for a wider range of health products and services. And a shift in disease burdens towards non-communicable diseases means governments are under pressure to deliver more complex health care. Unmet needs are huge, especially in lower-middle-income and low-income countries.

In India, less than 30 percent of end-stage kidney disease patients receive dialysis, while an estimated 200,000 new patients require treatment each year ([BS B2B Bureau](https://www.business-standard.com/content/b2b-pharma/less-than-30-of-kidney-patients-manage-to-get-dialysis-in-india-study-117022800641_1.html) 2017). Nigeria has fewer than 40 trained radiation oncologists, who must use “obsolete or non-functional” treatment centers to address 100,000 new cancer cases per year ([Unah](https://www.theguardian.com/global-development-professionals-network/2017/mar/20/nigeria-cancer-mortality-rate-addressed-ngo) 2017). And in low-income countries, challenges are underpinned by a lack of available technology. Senegal’s only radiation machine—bought in 1989—stopped working last year, leaving cancer patients to seek treatment in Morocco at the government’s expense ([Quist-Arcton](http://www.npr.org/sections/goatsandsoda/2017/07/09/524534109/a-country-where-it-can-be-tough-to-get-cancer-treatment) 2017).

Globally, 30 of the 36 countries with measured demand for radiotherapy but no available technology are low income and lower-middle income ([Yap et al.](http://ascopubs.org/doi/pdfdirect/10.1200/JGO.2015.001545) 2016). This unmet demand for complex and costly nephrology and cancer care is increasingly present in public hospitals today, even in the poorest countries, and public pressure to cover treatment and management of these diseases with public budgets is mounting.

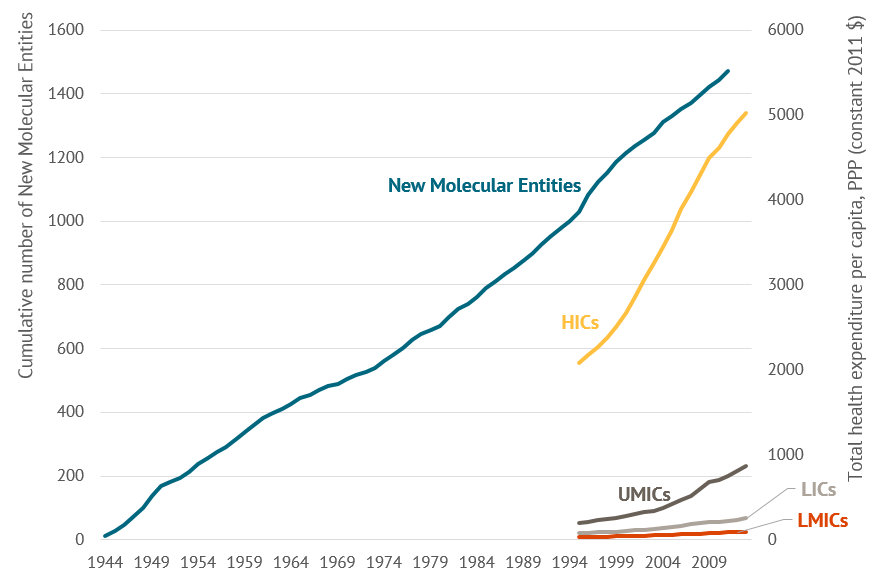
Ad hoc and inertial processes for budget allocation exacerbate the situation. Contrary to trends observed in OECD countries, which typically devote between 25 and 45 percent of total health expenditure to hospitals, hospitals often claim more than half of health expenditures in LMICs [(Hatefi et al. 2017](https://www.healthaffairs.org/do/10.1377/hblog20170216.058672/full/), [2016 OECD data](https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT)). Some large middle-income countries that are moving towards UHC, like China, Brazil, and Nigeria, spend as much as 70 percent of their health budgets on hospital care ([Lewis 2015](https://www.cgdev.org/blog/hospitals-are-key-reaching-universal-health-coverage)). This may be explained in part by the underlying reality that people tend to seek curative and acute care for conditions that cause tangible distress, which are oftentimes treated in hospitals. If governments allocate resources in response to explicit demand, spending is naturally biased toward hospitals.

Without an intentional PHC financing and payment strategy and fair, systematic efforts to assess and address the efficiency of non-PHC spending, the prioritization of hospitals in health budgets combined with the growing demand for more complex care diverts resources away from primary care. In India, for example, dialysis has been fully subsidized under the Pradhan Mantri National Dialysis Programme since 2016, when less than two-thirds of children between the ages of 12 and 23 months were fully immunized ([Government of India National Dialysis Services Programme](http://pib.nic.in/newsite/PrintRelease.aspx?relid=157978) 2017, [Government of India National Family Health Survey 4](http://rchiips.org/nfhs/pdf/NFHS4/India.pdf)2015-2016).

The result is that PHC is often under-prioritized in public spending. Moreover, as many countries decentralize public administration, more and more public health money is subnational, but resource allocation does not necessarily trace to outcomes or impact ([Glassman and Sakuma](https://www.cgdev.org/sites/default/files/CGD-Consultation-Draft-Glassman-Sakuma-IGFT-Health.pdf) 2014). And in some low-income countries, allocation decisions are further complicated by the fact that there are simply not enough resources. In Malawi, for example, paying for full coverage of male circumcision, one of the most cost-effective interventions to improve health, would alone consume US$147 million—almost all of the available US$168 million health budget ([Ochalek et al](https://gh.bmj.com/content/3/2/e000607). 2018).

In high-income countries, the availability of new health technologies (medicines, devices, etc.) grew alongside public spending on health, enabling most new technologies to be accommodated within public budgets if they were deemed effective (see figure 1). In low-income and lower-middle-income countries, average public health spending per capita in 2015 was less than 1 percent of per capita health expenditure in the United States ( [WHO Global Health Expenditure Database](http://apps.who.int/nha/database)). Yet, these countries face the full set of health technologies and related patient and market pressures to cover new technologies with public monies within miniscule budgets, and often without institutional mechanisms in place to decide which technologies are best value-for-money or to negotiate prices. This—combined with the inertial or ad hoc budget allocation—can also wrap up scarce public resources in less cost-effective care.

Figure 1. Growth of new molecular entities compared to per capita health expenditure across different income levels



Source: [Kinch et al. 2014](https://www.sciencedirect.com/science/article/pii/S1359644614001032?via%3Dihub), [WHO Health Expenditure Data](http://apps.who.int/nha/database)

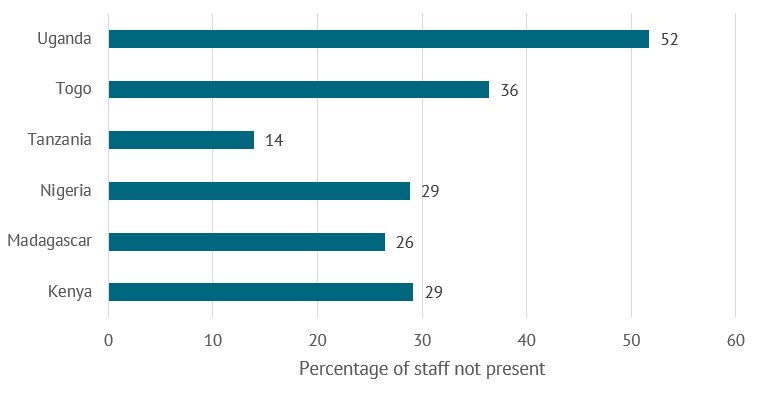
**Challenge 2:** A vicious cycle of low productivity paired with provider absenteeism and poor quality of care results in underinvestment and underuse

Public PHC clinics in many LMIC settings simply do not produce many services due to such factors as provider absences and lack of quality infrastructure, and provide poor quality care ([Kruk et al](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31668-4/fulltext). 2018). Compounding this is the reality that families do not always seek care in public clinics, in part because of multiple cost barriers and lack of faith in the system. Instead, they oftentimes go directly to hospitals for conditions that could be addressed at the primary level, or turn to the private sector, or simply don’t seek care at all. And the way PHC clinics and teams are paid sometimes fails to create compelling incentives for greater productivity or quality, further exacerbating these challenges.

Publicly provided PHC services in many LMICs remain grossly inefficient. These inefficiencies can partly be attributed to high rates of staff absenteeism ([Lewis](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=984046) 2006). Despite variation across and within countries, absentee rates in the public sector are staggering. In India, 40 percent of medical providers are absent in public health centers on a typical day, and in Uganda the absentee rate is as high as 50 percent ([Muralidaharan et al](http://econweb.ucsd.edu/~kamurali/papers/Working%20Papers/Is%20There%20a%20Doctor%20in%20the%20House%20-%2012%20April,%202011.pdf). 2011, [Chaudhury et al](https://www.aeaweb.org/articles?id=10.1257/089533006776526058). 2006, [World Bank Service Delivery Indicators](http://databank.worldbank.org/data/source/service-delivery-indicators)) (see figure 2). Furthermore, many public primary care clinics see very few patients per day. In Nigeria, for example, health workers in primary health care facilities in 12 states complete less than three outpatient visits per day ([Kress et al](https://www.tandfonline.com/doi/full/10.1080/23288604.2016.1234861). 2016).

Poor infrastructure, including limited availability of medicines, supplies, electricity, and trained staff, is also correlated with low use of services ([Kumar and Dansereau](https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0103927) 2014). These issues are further exacerbated by the lack of professional status for primary care physicians as well as urban bias among nurses and physicians. Low productivity not only limits access and use but also adversely impacts the quality of care that people receive once they get to clinics. A survey in 18 LMICs found that, on average, consultations by primary care physicians lasted under five minutes ([Irving et al.](https://bmjopen.bmj.com/content/7/10/e017902) 2017).

Figure 2. Share (percent) of staff not present in public facilities



Source: [World Bank Service Delivery Indicators](http://databank.worldbank.org/data/source/service-delivery-indicators)

Notes: Absence from health facility is defined by average share of staff not in the facilities as observed during one announced visit; note that in some countries, including those shown in the figure, private clinics have similarly high levels of absenteeism. Most recent available data are as follows: Kenya (2012), Madagascar (2016), Nigeria (2013), Tanzania (2014), Togo (2013), and Uganda (2013).

A potentially reinforcing factor is that demand for primary care is disproportionately low. Families are especially less likely to seek products and services related to health promotion and disease prevention. Uptake is significantly reduced when user fees are charged for preventive health products like bed nets or deworming tablets ([J-PAL Policy Insights](https://www.povertyactionlab.org/policy-insight/impact-price-take-and-use-preventive-health-products) 2018, [Cohen and Dupas](https://doi.org/10.1162/qjec.2010.125.1.1) 2010, [Kremer and Miguel](https://doi.org/10.1162/qjec.122.3.1007) 2007). Many other direct and opportunity costs also limit demand for PHC; indeed, it is common for household surveys in LMICs to report the myriad problems associated with access to care, even when a health condition is considered serious enough to merit medical care.[[4]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn4" \o ") More and more evidence suggests that perceptions of low quality and lack of trust in the system lead families to bypass primary care facilities ([Kruk et al](https://doi.org/10.1016/S0140-6736(18)31668-4). 2018).

In addition, the way incentives are structured limits the ability of primary facilities to serve as gatekeepers to the rest of the health system. For example, one pillar of India’s new Ayushman Bharat Initiative will provide poor families with health insurance, allowing beneficiaries to receive “cashless” inpatient care in both public and approved private hospitals ([Kazmin](https://www.ft.com/content/d13af884-a046-11e8-85da-eeb7a9ce36e4) 2018). While still in the early implementation stages, the scheme aims to expand access to affordable hospital services among the poor and prevent impoverishment due to catastrophic health expenditure. However, there is concern that it may incentivize beneficiaries to bypass PHC facilities and turn to hospitals ([Brundtland](https://doi.org/10.1016/S0140-6736(18)32387-0) 2018).

On the other hand, both Costa Rica and Thailand incentivize PHC providers to act as gatekeepers to the rest of the health system, referring patients to higher levels of care. Under Costa Rica’s Caja Costariciense de Suguridad Social, patients are turned back from higher levels of care if certain steps are not completed at the primary care level ([OECD](https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-costa-rica-2017_9789264281653-en#page1) 2017). In Thailand, patients receive subsidized hospital care only if they are properly referred by their PHC providers ([Tangcharoensathien et al.](https://www.ncbi.nlm.nih.gov/pubmed/25378527) 2015). Moreover, strategic purchasing is spreading, but more work is required to understand how capitation or fee-for-service models can create incentives for better outcomes.

Together, these factors can result in a vicious cycle of low productivity and poor quality of care, which in turn results in low demand for and underinvestment in primary care.

**Challenge 3**: Private providers are frequently the first point of contact, but it is not always clear if and how they are part of the plan

Private providers are frequently the first point of contact in many LMICs; they can provide alternative options to low-efficiency public clinics and can potentially expand access to quality care. But, to do so they need to be effectively integrated into primary health care systems and, in many settings, public policies simply ignore the private sector or claim to regulate without adequate resources or enforcement.

Private primary care providers are oftentimes preferred over public options. In Uganda for example, 60 percent of parents with children experiencing fevers choose private sector providers as the first point of contact with the healthcare system ([Buregyeye](https://malariajournal.biomedcentral.com/track/pdf/10.1186/s12936-017-1842-8) et al. 2017). Informal private providers account for around three quarters of all visits in India and Bangladesh, almost half in Nigeria, and almost a third in Kenya ([The Economist](https://www.economist.com/special-report/2018/04/26/the-importance-of-primary-care) 2018). Even in countries that have achieved UHC, insured patients seek care in the private sector due, in part, to poor perceptions of and low confidence in the public system’s ability to address health needs, resulting in a waste of public resources ([Kruk et al](https://doi.org/10.1016/S0140-6736(18)31668-4). 2018).

Nonetheless, the prevalence and use of primary care providers vary across health services, countries, and socioeconomic strata. Data from 70 LMICs show that the share of services provided by the private sector may vary from 60 percent for childhood illnesses to 30 percent for family planning and 15 percent for deliveries ([Grepin](https://doi.org/10.1377/hlthaff.2015.0862) 2016). Another study found that the share of care sought from private providers for specific services varies drastically across LMICs from as much as 9 to 56 percent for safe deliveries to as little as 37 to 39 percent for family planning services ([Campbell et al](https://doi.org/10.1016/S0140-6736(16)31528-8). 2016). Furthermore, use of private providers is generally more prevalent among wealthier, more educated, and urban populations, potentially exacerbating inequalities ([Campbell et al](https://doi.org/10.1016/S0140-6736(16)31528-8). 2016, [Grepin](https://doi.org/10.1377/hlthaff.2015.0862) 2016).

However, rigorous empirical studies to adequately evaluate the quality of primary care across public and private providers in LMICs are few and far between, and therefore miss the opportunity to influence policy in favor of PHC-related outcomes. Two existing systematic reviews on this comparison arrive at conflicting conclusions: one suggests the private sector is marginally better in terms of drug availability and service delivery and the other finds no measurable difference. The disagreements between these two reviews can at least in part be attributed to the low quality of data in the underlying studies ([Coarasa et al](https://doi.org/10.1186/s12992-017-0246-4). 2017).

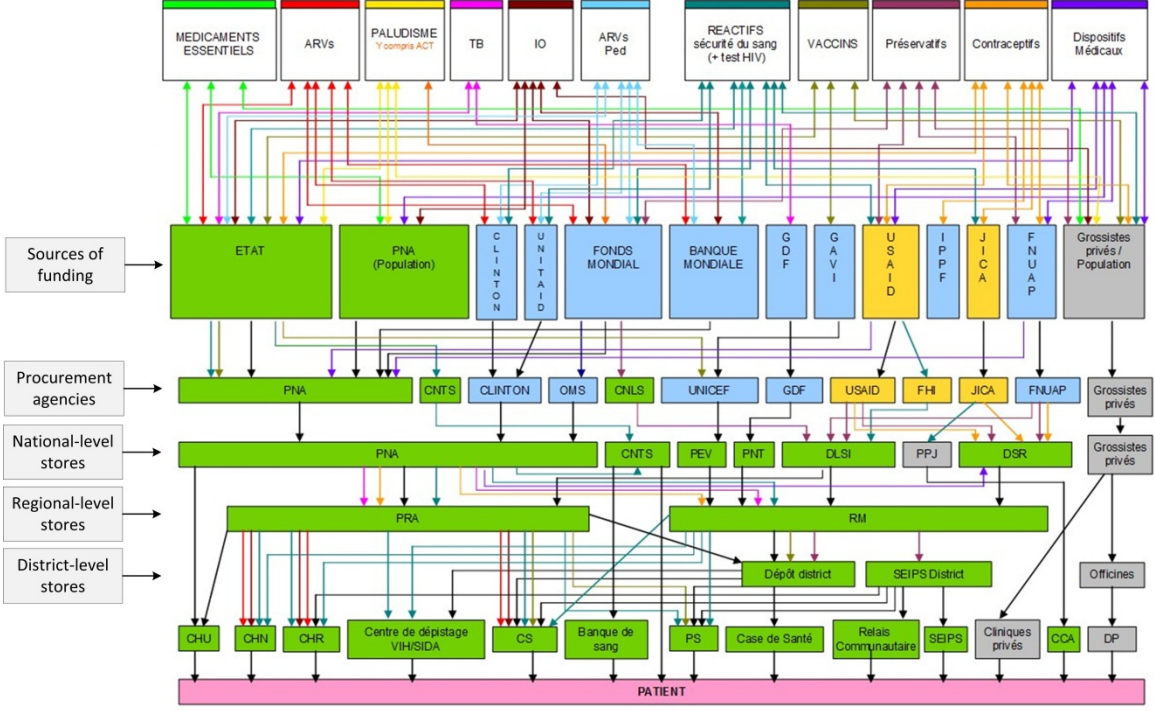
Ultimately, the ability of private providers to contribute to strong PHC systems may be shaped in large part by the institutions and policies that govern them. Indeed, there is growing acknowledgement among country governments and donors alike that partnering with the private sector and integrating private providers into national primary health care systems can help accelerate progress towards UHC. Nonetheless, doing so successfully in practice involves data and decisions on how to effectively regulate the private sector to ensure equitable and quality service delivery.

**Challenge 4:** PHC elements are siloed and reliant on donor funds

In many low-income and lower-income country settings, PHC elements are organized “vertically” in siloes and not integrated into broader healthcare provision. In some cases, siloes can be functional, as in immunization programs where campaigns are needed to complement routine PHC. In other cases, fragmentation and stove-piped funding persist and can be dysfunctional for better PHC outcomes across the board.

Within countries, PHC elements can be siloed; each component can have its “own” investment case, national plan or strategy, set of implementers, pots of money and financial flows, and reporting structure. In low-income countries, donors may reinforce this fragmentation, often funding PHC elements individually. This is especially the case for HIV, tuberculosis, malaria, family planning, and maternal and child health. Country supply chains for basic health commodities reflect this current practice. In Senegal, supply chains are divided by at least 13 different sources of funding, and even single commodity groups such as contraceptives and HIV diagnostic tests have multiple pipelines for procurement and delivery, resulting in parallel systems and a duplication of efforts (see).

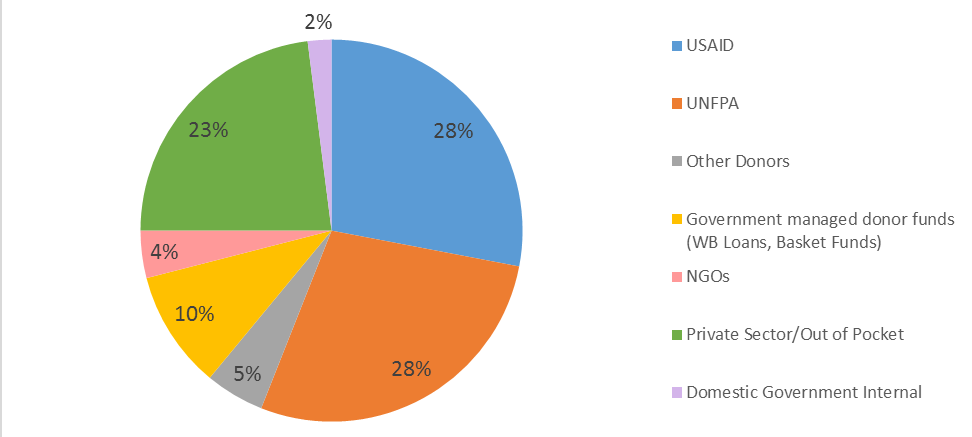
Figure 3. Fragmented supply chains in Senegal



Source: Senegal Ministry of Health/Central Medical Store; cited in [WHO 2013](http://www.who.int/immunization/programmes_systems/supply_chain/optimize/optimize_senegal_report.pdf) report.

Moreover, key PHC elements in some of the poorest countries are particularly reliant on donors. Donor funding as a share of total immunization financing ranges from 60 percent in Ethiopia to nearly 90 percent in Senegal ([WHO Immunization Financing Indicators](http://www.who.int/immunization/programmes_systems/financing/data_indicators/en/), 2015). Moreover, only about a third of funding for malaria control and elimination is provided by governments of endemic countries ([WHO World Malaria Report 2016](http://www.who.int/malaria/publications/world-malaria-report-2016/report/en/)). Provision of contraceptives is particularly dependent on donor support; in some low-income countries, a mere 2 percent comes from domestic resources (see figure 4).

Figure 4. Proportion of contraceptive funding by source in low-income countries



Source: [Silverman](https://www.cgdev.org/blog/global-family-planning-funding-what-should-funders-be-thinking-about-now) 2016

The persistence of vertical siloed plans and funding makes it difficult for country governments to fully coordinate and ultimately achieve strong PHC. Tanzania is just one example where fragmentation across more than 100 distinct health information systems can stand in the way of efforts to effectively diagnose problems, ensure accountability, and drive evidence-informed improvements ([Health Data Collaborative](https://www.healthdatacollaborative.org/where-we-work/tanzania/)2017). Furthermore, the sustainability of services and commodities reliant on external financing may be at risk in light of countries transitioning away from donor support. Countries are also highly vulnerable to shifting domestic priorities in donor countries that drive aid policies, particularly investments in family planning. Finally, when decentralization occurs, vertical programs can lose their funding and constituency ([Williamson et al.](https://www.healthpolicyproject.com/pubs/445_FPDecentralizationFINAL.pdf) 2014).[[5]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn5" \o ")

There is growing recognition of the importance of addressing the fragmentation in global health and the need for a shift towards a systems-wide approach ([Ooms et al](https://doi.org/10.1016/S0140-6736(18)32072-5). 2018). Indeed, integration across the health system is becoming a greater priority with calls for a “new era of global health” [(Bekker et al](https://doi.org/10.1016/S0140-6736(18)31070-5). 2018). A strong PHC system underpinned by integrated services can be more efficient and affordable; in practice, however, this is still very much a work in progress.

From aspirations to reality: Ideas to advance better primary health care for all

We highlight below a few priority actions—by no means an exhaustive list—to help close the gaps between aspirations and reality:

 carefully consider trade-offs between alternate spending decisions

 conduct robust performance measurement and evaluation

 provide PHC where people currently seek primary care services

 put fit-for-purpose incentive structures in place

Adopt explicit resource allocation and budgeting processes with a focus on population health

Policymakers around the world must balance the needs of primary care with other levels of the health system while covering promotion, prevention, treatment, and rehabilitation all within a limited budget. Therefore, ensuring adequate resources are available to fund and staff PHC systems requires attention to the bigger picture of resource allocation and demands.

More systematic resource allocation and budgeting processes can enable governments to make evidence-based decisions about where and how to spend scarce public monies. By highlighting trade-offs between alternate spending decisions, a fair and transparent process—such as defining an explicit benefits package—can help decision makers rationalize certain investments over others ([Glassman et al](https://www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage). 2017). Ultimately, by minimizing spending on health services and products with little evidence of cost-effectiveness, countries can get the most out of scarce resources for health.

Thailand’s Health Intervention and Technology Assessment (HITAP) stands out as one example of an evidence-based process for resource allocation. As part of the country’s Universal Coverage Scheme, HITAP systematically assesses the costs and benefits associated with including certain health services in the country’s health benefits plan. The country has achieved enormous strides in population coverage, providing a wide range of services at a low per capita budget (Glassman and Temin 2016).

At the global level, the International Decision Support Initiative, or iDSI, helps support national intuitions to drive better decisions about what a healthcare system should and should not cover, but it still operates at a small scale.[[6]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn6" \o ") Systematically applying such an approach to allocation and investment decisions for primary care services is an important starting point to ensure the foundation of the health system is delivering quality, affordability, access, and equity.

Insist on rigorous, independent performance measurement and evaluation—and allocate sufficient resources for this

Rigorously and independently measuring performance is fundamental, but efforts that simply track inputs and outputs fall short; it is critical to clearly measure the outcomes of PHC that matter most: quality of care and health outcomes, including as measured by patient-recorded outcomes and patient experiences. Performance metrics together with evidence can help ensure that that resources poured into the PHC system map to measurable improvements in service coverage, quality of care, and most importantly, health outcomes.

Indeed, there is a growing body of evidence on different interventions that address the challenges underpinning PHC systems. Technological innovations, including mobile phones and other m-health interventions, have been shown to increase vaccination coverage in some contexts; overall, however, efforts have had mixed results ([Farmer](https://www.telegraph.co.uk/news/2018/10/01/smartphones-plugged-vaccine-gaps-rural-pakistan/?platform=hootsuite) 2018, [Oliver-Williams et al](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5647459/). 2017, [Kazi](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30088-8/fulltext) 2017, [Uddin et al](https://www.sciencedirect.com/science/article/pii/S0264410X15016667). 2016). And while punitive pay-deductions or financial incentives that reward performance increase provider attendance, impacts on service utilization, quality of care, and health outcomes are similarly mixed ([Huillery and Seban](https://www.povertyactionlab.org/evaluation/pay-performance-health-sector-evidence-democratic-republic-congo)2017, [Ngo et al](https://academic.oup.com/heapol/article/32/1/11/2555400). 2017, [Walque et al](https://www.rbfhealth.org/sites/rbf/files/Using%20provider%20performance%20incentives%20to%20increase%20HIV%20testing%20and%20counseling%20services%20in%20Rwanda.pdf). 2015, [Gertler and Vermeersch](https://openknowledge.worldbank.org/handle/10986/9316) 2012, [Banerjee et al](https://www.povertyactionlab.org/evaluation/incentives-nurses-public-health-care-system-udaipur-india). 2008). The bottom line: despite progress, there are still too few rigorously evaluated at-scale health programs and significant gaps remain in what we know does and does not work ([Kruk et al](https://doi.org/10.1016/S0140-6736(18)31668-4). 2018; [Glassman and Temin](http://millionssaved.cgdev.org/) 2016).

It is critical to keep trying and testing different models and approaches using a wide range of assessment methods. Performance evaluations, implementation science studies, impact evaluations, and cost-effectiveness studies contribute to the different types of evidence that feed into decision making. Simply conducting more evaluations is not sufficient; these evaluations must also be of high-quality to be relevant to policy. And, sufficient investment—from donors and country governments—is paramount.

Provide PHC where people currently seek primary care services

Providing greater PHC services where people seek care can underpin a more people-centered approach. There are many possible approaches that have shown effectiveness in delivering PHC, from publicly owned and operated team care as in Brazil and South Africa, to privately owned and operated general practitioners who have contractual relationships with the rest of the health systems as in Canada and the UK, to social contracting with nongovernmental organizations to provide care.

Team-based models of community care with population empanelment and referral mechanisms to higher levels of care show promise. Brazil’s Programa Saúde da Família, for example, has provided comprehensive, cost-effective primary care services with a measurable impact on child survival and other outcomes ([Glassman and Temin](http://millionssaved.cgdev.org/) 2016). Although still in the early stages, results from a similar program in South Africa suggest that outreach teams can improve the overall performance of local PHC systems ([Assegaai et al.](https://www.ncbi.nlm.nih.gov/pubmed/29629685) 2018).

As a different approach, integrating private providers into PHC systems can improve equity and coverage and also drive increased productivity and quality. Canada’s health system, for example, has successfully integrated the private sector by administering a public universal insurance program that subsidizes PHC, which is provided in large part by the private sector and mostly through a fee-for-service model that rewards production and efficiency ([Mossialos et al. 2016](http://wwww.issuelab.org/resources/25100/25100.pdf)). In the UK, most general practitioners are private, self-employed contractors, and referrals are required for specialist care ([Mossialos et al. 2016](http://wwww.issuelab.org/resources/25100/25100.pdf), [Greenfield et al.](https://www.bmj.com/content/354/bmj.i4803.full) 2016). The UK has further attempted to incentivize high-quality care from general practitioners through the Quality and Outcomes Framework (QOF), a pay-for-performance scheme that provides financial rewards for good practice as determined through set indicators. Although the framework has led to modest improvements in quality, it has significantly decreased delivery gaps ([Roland and Guthrie](https://www.bmj.com/content/354/bmj.i4060.full.print) 2016).

Other countries have contracted nongovernmental organizations to provide a package of PHC services in underserved geographical areas—experiences in countries as diverse as Afghanistan, Bangladesh, Cambodia, Guatemala, Honduras, Nicaragua, Ghana, Tanzania, and South Africa among others all stand out as successful in delivering key services and increasing coverage in some of the neediest areas across LMICs ([Rao et al.](https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0846-5) 2018, [Edward et al.](https://www.ncbi.nlm.nih.gov/pubmed/21814499) 2011, [Garcia-Prado et al](http://documents.worldbank.org/curated/en/785231468034851801/Contracting-and-providing-basic-health-care-services-in-Honduras-a-comparison-of-traditional-and-alternative-service-delivery-models). 2010, [Regalia and Castro](https://www.cgdev.org/doc/books/PBI/11_CGD_Eichler_Levine-Ch11.pdf) 2009, [La Forgia et al.](http://www.who.int/management/country/latinamerica_carribean/HealthSystemInnovatonsCentralAmerica.pdf#page=21)2005, [Bitran et al.](http://dspace.itg.be/handle/10390/1493) 2003).

Whatever approach is taken, it is important to focus on identifying and enrolling the populations that can benefit most, and on how payment and referral work together to enable providers to manage care holistically and with a focus on patient outcomes. While we point to a number of examples, a core question is how to sustain and drive resource allocation and effort continually to PHC, whatever form it takes. Some of the private participation options may generate a constituency for PHC that would not otherwise exist.

Improve incentive structures to encourage greater domestic priority to PHC

As more and more countries face upcoming transitions from global health aid, donors must restructure their current funding to create incentives for governments to begin to sustainably fund and arrange for the rational provision of key PHC elements. One case in point is funding for family planning, particularly contraceptives, which comprise an important component of PHC. Family planning programs in countries like Nigeria and Kenya are heavily reliant on donor funding, with few incentives for co-financing. Introducing co-financing policies for family planning commodities—a strategy used by donors like Gavi—could help increase domestic spending ([Silverman and Glassman](https://www.cgdev.org/publication/aligning-2020) 2016).

Both LMIC governments and external funders must also grapple with the reality that public monies will not come close to covering the universe of cost-effective PHC interventions and medicines. This means a persistent need for selectivity in what is covered with public monies, but also attention to enhancing the affordability of medicines and related products in the private sector, where much of health spending will persist as countries transition from middle- to high-income status.[[7]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftn7" \o ")

Conclusion

Failure to address these challenges head on can result in missed opportunities to drive efficiencies throughout the health system and, most importantly, to improve access to quality care and to save lives. But doing so will take much more than a global declaration; commitments backed by resources are a good start, but investments will have little impact without adequate policies and institutions to efficiently channel them to where they are most needed. Now more than ever, the global health community must adjust and adapt its approaches to protect hard-won gains and accelerate progress.

Thanks to Kalipso Chalkidou and Rachel Silverman for their feedback and thoughts.

[[1]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref1" \o ") For this note, we adopt the technical definition of primary health care developed by [the Primary Health Care Performance Initiative](https://improvingphc.org/), a partnership to strengthen measurement of PHC and link data to improvements; see here for more details: <http://improvingphc.org/sites/default/files/PHCPI%20Technical%20Definition%20of%20Primary%20Health%20Care.pdf>.

[[2]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref2" \o ") The Disease Control Priorities (third edition) found that more than half of all health interventions assessed cost less than 200 USD per DALY averted; almost all of these interventions involved treatment and prevention of basic infectious diseases, vaccinations, and basic surgical interventions, all of which are provided through PHC; see: <https://openknowledge.worldbank.org/bitstream/handle/10986/28877/9781464805271.pdf?sequence=2&isAllowed=y>.

[[3]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref3" \o ") See [here](https://www.cgdev.org/publication/initial-estimation-size-health-commodity-markets-low-and-middle-income-countries) for one example of this variation in the context of purchasing for health commodities across country income groups; in low-income countries donors purchase roughly half of all health commodities; in lower-middle-income countries, the private sector is the primary purchaser of health commodities; and in upper-middle countries, the government purchases a much larger share compared to the other groups.

[[4]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref4" \o ") For example, in Malawi, close to 8 out of 10 DHS respondents reported experiencing at least one barrier to care, including, but not limited to, perception that no drugs would be available or no providers would be present, distance to facility, paying for treatment; see [DHS 2010](https://dhsprogram.com/pubs/pdf/fr247/fr247.pdf) and [DHS 2015-2016](https://dhsprogram.com/publications/publication-FR319-DHS-Final-Reports.cfm).

[[5]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref5" \o ") For example, many countries initiating decentralization have deprioritized family planning; decentralization also fragments national family planning strategies and, in some cases, excludes stakeholders in the decision-making process. Kenya is one example where family planning and reproductive health were overlooked during recent decentralization reforms.

[[6]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref6" \o ") More information is here: <https://www.idsihealth.org/>

[[7]](https://www.cgdev.org/publication/declaration-alma-ata-40-realizing-promise-primary-health-care-and-avoiding-pitfalls" \l "ftnref7" \o ") See [Table 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30873-5/fulltext?elsca1=tlxpr) on expected health spending by source in [Dieleman et al.](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30873-5/fulltext?elsca1=tlxpr)2017; see also this [CGD note](https://www.cgdev.org/publication/initial-estimation-size-health-commodity-markets-low-and-middle-income-countries), which estimates the share of health commodities purchased by private, government, and donor/NGO financing across country income groups.

**Financial Times**

**FT Health: Health for all or health for some?**

**By: Andrew Jack and Darren Dodd**

*26 October 2018*

A lot has changed in the world since the 1978 Alma-Ata declaration called for “health for all”.

Since then, the Soviet Union — which had convened that gathering of health ministers — has imploded, the Berlin Wall has fallen, China has risen, and the host Kazakhstan has moved its capital to Astana. But this week’s Astana declaration suggests the aspiration four decades ago remains unmet. Half the world’s population still lacks access to essential health services.

As an article in the BMJ argued, the bold vision of the 1978 conference was less exploited by Soviet officials for international health diplomacy than is often perceived. But it was swiftly diluted in the west with a return to “vertical” interventions such as vaccination, a focus on a smaller group of cost-effective programmes and the encouragement of private sector involvement.

The new declaration from now-independent Kazakhstan marks a strong political commitment to improve access to services through primary care. It aims to address prevention as well as treatment, to reach the poorest and most remote communities, and to cover non-communicable as well as infectious diseases. What is lacking is detail: agreement on approaches, milestones, money or timelines. Without that, further progress will remain patchy.

**Three questions Tedros Adhanom Ghebreyesus, director-general of the World Health Organization**

**How satisfied are you with the Astana meeting this week?**

It has gone very well. We have a declaration. You see a renewed commitment, a real seriousness. A declaration is just a [piece of] paper till it’s implemented. People are asking for us to start immediately. Let’s act while the iron is hot. It has given me confidence that participants are now asking how we address the human resources gap, the financing gap, the information issue, the use of technology — not just the “what” but the “how”. You can see people are serious.

**Was there resistance from the US and other donors?**

The draft declaration was discussed openly, and had more than 1000 public comments. Then the member states took over to negotiate. We reached an agreed document, with a footnote from the US, but we have an agreed text. We had about 60 ministers of health in Astana and 140 countries represented. It doesn’t matter at what level they attended the conference. All WHO member states are signatories. This adds to the WHO’s strategic plan and the Hamburg declaration of the G20. There is consensus on universal health coverage.

**What are the next steps?**

There is already political commitment by governments to build sustainable primary healthcare. That needs predictable multiyear financing. We hope governments and donors will honour their commitments with both domestic and international support. We have already selected trailblazer countries, with indicators on progress, gaps and where investment is needed. We need to move quickly to support them to do more. Another meeting won’t help: We have to get on the ground and try to do something.

**Foreign Policy**

**Inside Trump’s Plan to Scale Back U.N. Resolutions on Sexual Health, Violence Against Women**

**By: Robbie Gramer, Colum Lynch**

*30 October 2018*

The State Department is directing American diplomats around the world to scale back U.S. support for a raft of overseas sexual and reproductive health programs that proponents see as vital to women’s health, but conservatives believe promote abortion and sexual activity among young people.

New State Department directives, outlined in internal memos obtained by Foreign Policy, show how the Trump administration is instructing U.S. diplomats at the United Nations to push back on U.N. resolutions on women’s issues, outlining so-called red lines on language related to sexual health and sexual harassment.

The memos underscore the growing influence under President Donald Trump of Christian social conservatives, who have scored a series of successes in recent weeks, including the White House decision to consider [rolling back](https://www.nytimes.com/2018/10/21/us/politics/transgender-trump-administration-sex-definition.html) rights for transgender Americans in federal civil rights law.

Much of the administration’s effort is focused on the U.N., where diplomats are discussing a raft of General Assembly resolutions on health, education, and social issues. In these discussions, U.S. diplomats have sought to strike references to the word “gender,” as the *Guardian*[first reported](https://www.theguardian.com/world/2018/oct/24/trump-administration-gender-transgender-united-nations) on Oct. 25.

The administration’s positions have driven a wedge between the United States and its Western partners from Europe to Latin America, drawing it closer to more socially conservative countries, including Russia and Saudi Arabia.

One of the memos obtained by FP says the United States can no longer use the phrases “sexual and reproductive health” or “comprehensive sexuality education,” saying such terms promote abortions and normalize sexual activity for young people.

The first phrase, “sexual and reproductive health,” is broadly accepted in international forums and enshrined in U.N. resolutions and treaties involving international organizations. Usage of the second phrase, “comprehensive sexuality education,” is still subject to debate at the United Nations.

It remains unclear whether the United States is willing to break consensus in the 193-member U.N. General Assembly if it fails to secure the changes it is seeking.

In previous U.N. meetings, including a major conference in March on the Commission on the Status of Women, the United States ultimately backed down from some of its most hard-line positions.

Last week, the United States backed down on demands to eliminate the phrase “sexual and reproductive health” from a final [document](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf) at a Global Conference on Primary Health Care in Astana, Kazakhstan. But in exchange for joining the consensus, the United States insisted on including a footnote affirming that “in no case should abortion be promoted as a method of family planning.”

But the latest pushback has privately angered some U.S. diplomats, who worry that in the service of an anti-abortion agenda, the administration might hamper broader U.N. initiatives on global and women’s health.

**Global Health NOW**

**Better Primary Health Care? Get Better Data**

**By: Brian W. Simpson**

*(31 October)*

When representatives of UN Member States gathered last week in Astana, Kazakhstan, the past and future were very much on their minds.

The 40th anniversary of the 1978 Alma-Ata declaration recognized the historic, first global commitment to health for all—though essential health services still aren’t available to half the world’s population. Last week’s conference resulted in the [Declaration of Astana](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttp-253A-252F-252Fwww.who.int-252Fprimary-2Dhealth-252Fconference-2Dphc-252Fdeclaration-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703378257-26sdata-3DQpYeQjPKrn48tDMDpYFuZJBoNY71SN-252FYBdPu8tccyGY-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=FRPnaehak8wrmw04yaDh-bx-UFu8nHIsO8l-JHrM8Pw&e=), in which national representatives pledged to do step up their support for primary health care.

On the ground in Astana was Beth Tritter, executive director of the Primary Health Care Performance Initiative. In an exclusive Q&A with GHN, Tritter reflects on the future impact of of Astana, what else besides money is needed to improve primary health care, and a new data tool that her organization launched in Astana.

**What are your biggest takeaways from this week’s conference in Astana?**

I’m encouraged by the breadth of support we’re seeing for primary health care. [Last] week’s conference shows that primary health care is increasingly seen as a foundation not just of the health system, but of sustainable development more broadly.

**The Alma-Ata conference in 1978 came to be seen as a huge historic moment. Will Astana be seen similarly in the future?**  
The Alma-Ata conference in 1978 was the first time global leaders committed to achieving health for all. While the world has achieved tremendous health gains since then, the challenges we faced in the late 20th century resulted in steering resources toward addressing individual health priorities rather than comprehensive primary health care.  
   
This week's conference in Astana marks a renewed opportunity to establish primary health care as the foundation of health for all. To ensure we deliver on this promise, we need tangible tools and strategies for improvement, and ways to hold leaders accountable to the commitments made today.

**Universal health coverage is perceived as a valuable goal, of course, but where will sustainable funding come from for low- and middle-income countries?**  
I believe that today, the world is better equipped and prepared to achieve universal health coverage than ever before, and that governments, donors, development partners, advocates and citizens all have important roles to play in driving progress. There are already encouraging signs: In recent years, we've seen countries around the world rapidly scale up their investments in primary health care—demonstrating that governments, with the support of donors and development partners—can lead the way toward financing health for all.

**What else besides money is essential?**  
To improve primary health care, we need better data. Currently, data gaps make it hard to see where primary health care is falling short, and the data that does exist is often of poor quality or difficult for governments and donors to understand and use. Governments and donors can use data to pinpoint areas for improvement and make the case for better investment, and advocates and citizens can use it to track changes over time and hold leaders accountable.

**Your organization recently launched the Vital Signs Profiles tool. What is it and how do you envision it being used to improve health?**[Countries] often don't have the information needed to understand the system and drive targeted improvements. The Vital Signs Profiles aim to change this by providing a snapshot of the strength of primary health care in different countries around the world.  
   
The Vital Signs Profile is a tool for both improvement and accountability. Governments and donors can use it to identify where primary health care is strong and where it can be improved, and citizens and advocates can use it to track changes over time and hold leaders accountable.  
   
**What are the best ways to help countries improve data collection? What examples would you point to?**  
Moving forward, we hope to help build platforms to share insights and innovations in data collection, use and analysis across countries.  PHCPI has collaborated with valuable platforms for cross-country learning … to design common but flexible approaches to collecting data that countries can adapt.

**Which low- to middle-income countries have done the best job in really delivering on primary health care and could serve as models for others?**  
Last week in Astana, PHCPI launched the first set of Vital Signs Profiles in partnership with 11 Trailblazer country governments – Argentina, Burkina Faso, Cote d’Ivoire, Ghana, Kenya, Rwanda, Senegal, South Africa, Malaysia, Nepal and Sri Lanka. While all of these countries still have areas for improvement, I am encouraged by their commitment to improve primary health care through better data.

Ed. Note: This Q&A has been edited for length and clarity.

**The Guardian**

**As Ebola has shown, the global health system is as strong as its weakest link**

**By: Ellen Johnson Sirleaf**

*24 October 2018*

In the city of Beni, in the north-east corner of the Democratic Republic of the Congo, an outbreak of Ebola is simmering. Fear of this lethal disease and all that goes with it – grief over lost loved ones, exhausted emergency response workers and ongoing insecurity – might once have felt distant, foreign, unknowable. But, tragically, these emotions are all too familiar. Almost five years ago, a two-year-old boy from Meliandou – a tiny rural village in southern Guinea, bordering Liberia and Sierra Leone – fell sick with a strange illness. His symptoms were the stuff of nightmares: internal bleeding, black stools, vomiting and a high fever. Just two days later, he died. At the time, no one in the village knew what the cause of death was; no one could anticipate the chain of consequences that was about to rip through the region and fuel a global panic.

From Meliandou, the disease slipped across Guinea’s porous border and spread unabated through west Africa for four months, before it was correctly identified as Ebola. The world watched in horror as the largest Ebola outbreak in history engulfed my country and the rest of the region, infecting over 27,000 people in total and killing more than 11,000. Ebola consumed every aspect of daily life. The economy faltered as international trade halted, schools were shut and hard-fought progress on child and maternal mortality was wiped out overnight. Beyond west Africa, isolated outbreaks around the world spread panic and reflected the darker consequences of how interconnected global health has become.

We learned that the world’s health system is only as strong as its weakest link. Investing in primary healthcare is the best way to detect and stop local outbreaks before they become global pandemics. Local healthcare services are a person’s first and main point of contact with the health system – the place in their community where they can go to see a provider able to address the majority of their health needs. When this primary system is strong, patients develop trusted relationships with their healthcare providers, who can encourage them to seek the care they need, including in times of crisis.

Primary healthcare providers are also best positioned to spot the early warning signs of outbreaks – and sound the alarm bell when needed. In Liberia, we saw that communities with strong primary healthcare were better able to stem the spread of Ebola. We are now applying these lessons to more effectively protect the health of our people should another outbreak strike. We have prioritised investments in primary healthcare to ensure that citizens can secure essential health services free of charge and see primary healthcare providers in their own communities, even in the most remote parts of the country. Liberia’s national community health assistant programme was launched in July 2016 and will serve more than 4,000 remote communities in the hardest to reach areas of our country by 2021.

Each community health assistant is critical to the health of their community, and is trained, paid and supervised to deliver common screening, treatment and preventive health services. The 3,000 community health assistants deployed to date have identified more than 1,700 warning signs of outbreaks in the past year alone, and have been instrumental in addressing these before they spin out of control. They are critical links to keeping communities across remote Liberia healthy, ensuring that we are better prepared to weather the next storm.

But I know we do not have the complete blueprint to build stronger health systems on our own. Countries must learn from each other – and not just in times of crisis. I am closely watching the work of the primary healthcare performance initiative, which is partnering with country governments to measure the strengths and weaknesses of existing health systems. The initiative’s new “vital signs profiles”, which are launching this week, are designed to help leaders pinpoint opportunities for maximum impact when investing in the systems that guard the health of our people. West Africa still feels the lasting effects of Ebola, while our brothers and sisters in DRC are working urgently to bring an end to the current outbreak before it spirals out of control.

Unless we learn the hard lessons, the global health system will remain like a house without a foundation. Ensuring that everyone, everywhere, has access to essential health services is our best shot at avoiding the all too familiar cycle of health emergencies. Now is the time to act with conviction.

**The Lancet**

**Alma-Ata at 40 years: reflections from the *Lancet* Commission on Investing in Health**

**By: David A. Watkins, Prof. Gavin Yamey, Marco Schäferhoff, Olusoji Adeyi, Prof. George Alleyne, Prof. Ala Alwan, et al.**

*20 October 2018*

**Executive summary**

In 2013, the Lancet Commission on Investing in Health published its report, “Global health 2035: a world converging within a generation” (GH2035). The report concluded that a grand convergence in health—a reduction in infectious, child, and maternal mortality to rates seen in the best-performing middle-income countries—is technically and financially feasible for all but the poorest countries by 2035. Mortality from non-communicable diseases could be reduced through inexpensive population-based and clinical interventions, especially fiscal policies such as heavy tobacco taxation. Pro-poor pathways to universal health coverage, such as publicly financed insurance, would provide financial protection and essential health-care interventions to everyone—ensuring high-quality, low-cost services at the point of care. And the returns on investing in health, based on methods that include both the benefits of improved economic productivity and the intrinsic value of health, would far exceed the costs.

The 40th anniversary of the Alma-Ata Declaration gave the LancetCommission on Investing in Health an opportunity to assess progress towards grand convergence, and to reflect on the future of primary health care in the context of the modern universal health coverage movement. We also reflected on the future of official development assistance for health and its role in achieving grand convergence and the health-related Sustainable Development Goals.

In GH2035, we emphasised the dynamic features of unprecedented demographic and epidemiological changes and the threats associated with globalisation. In this report, we re-evaluated the feasibility of grand convergence, given that several factors appear less favourable now than in 2013 (eg, rates of economic growth in middle-income countries, deceleration in mortality rates from some infectious diseases). The good news is that if the global trends in mortality achieved in 2010–16 were to continue, the convergence targets for under-5 and HIV/AIDS mortality would be achieved worldwide close to the year 2035. However, if the rates of decline for maternal mortality and tuberculosis remain similar to 2010–16, the convergence targets would not be achieved until 2067 and 2074, respectively. This slow progress underscores the need to identify underperforming countries, and assist them in scaling up proven interventions. For tuberculosis in particular, there is a clear need for new health technologies.

For this report, we adopted a definition of primary health care that centres on the platforms required to deliver essential interventions close to the population: population-based (public health) interventions, community-based interventions, health centres, and first-level hospitals. We refer to public financing (understood to include social insurance) of a package of priority interventions as essential universal health coverage. Interventions included in essential universal health coverage provide financial protection and prioritise the people who most need them. In addition to the GH2035 convergence agenda of maternal, child, and infectious disease mortality, essential universal health coverage includes prevention, care, rehabilitation, and palliation for non-communicable diseases, such as cancer and cardiovascular disease, as well as for injuries and mental health problems. Cardiovascular disease is likely to be an early priority.

Based on our projections of available domestic resources for health and cost estimates of essential universal health coverage, by 2035 most middle-income countries will be able to afford primary health-care platforms for delivery of essential universal health coverage. However, for many middle-income countries achieving the mortality reduction target for non-communicable diseases from the third Sustainable Development Goal will remain out of reach in the 2030 timeframe. For many low-income countries, domestic health financing systems lack the capacity to complete even the unfinished agenda of grand convergence.

This report develops and sharpens the case made by GH2035 for reorienting health official development assistance to areas where governments have natural incentives to underinvest. Although direct support of high priority health interventions in the poorest countries will still be needed, international collective action for health to support global functions needs to be emphasised. Such functions include supplying global public goods (eg, product development and research), managing negative cross-border externalities (eg, pollution and drug resistance), market shaping, and fostering global health leadership and stewardship. Ensuring support for these global functions is particularly relevant to middle-income countries that will transition out of health official development assistance in the coming years. Global functions can also help middle-income countries reduce internal inequalities in population health, which are often large.

From a long list of potential high return investments in international collective action for health, five priorities emerge:

* Development of improved drugs and vaccines against tuberculosis;
* Preparedness for pandemics, especially a severe influenza pandemic (eg, accelerating efforts to develop a universal influenza vaccine, building reserve vaccine manufacturing capacity, and financing national preparedness and international response efforts);
* Providing international support to national non-communicable disease control programmes (eg, through distribution of best practice guidelines and collective purchase of drugs and other key commodities);
* Development of measurement tools and an evidence base to improve the quality of health systems and their resilience to heterogeneous health threats;
* Providing the resources for WHO and other UN agencies to strengthen their financial and legal capacity to reduce cross-border transmission of drug resistance (eg, to tuberculosis), pollution, harmful substances (eg, tobacco, alcohol, and highly processed foods), and counterfeit drugs and vaccines.

**Introduction**

In December, 2013, the Lancet Commission on Investing in Health (CIH) published “Global health 2035: a world converging within a generation” (GH2035).[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

 Written by an international group of 25 economists and health experts, the report laid out an ambitious investment framework for achieving global health transformation within just one generation. Four major propositions were offered.

The first proposition by GH2035 pointed to the historically unique opportunity for low-income countries (LICs) and middle-income countries (MICs) to reduce infectious disease, child, and maternal mortality to rates seen in the best-performing MICs. Existing medical and public health tools, coupled with emerging health technologies, would enable this grand convergence by 2035 at a cost affordable to all but the poorest countries. To fulfil this opportunity for grand convergence, national decision makers need to make a set of priority health investments. The CIH estimated that achieving convergence would cost an additional US$70 billion annually from 2016 to 2035 (in 2011 US$). Given the projected economic growth of LICs and MICs, the CIH made the case that most of these costs could be paid through domestic financing, if governments invested around 1–3% of such growth to the grand convergence agenda.

The second proposition by GH2035 was that mortality from non-communicable diseases (NCDs) could be reduced in LICs and MICs. As the threat from infection declines, cardiovascular disease, cancers, chronic respiratory diseases, and injuries become dominant determinants of life expectancy. Mortality rates resulting from such conditions have markedly reduced in high-income countries (HICs) in the past decades. The CIH made the case for scaling up packages of clinical “best buy” population-wide interventions, such as multidrug therapy for cardiovascular risk reduction and pain relief for palliative care. Fiscal policies such as heavy taxation of tobacco were also discussed in detail as particularly strong levers for reducing cardiovascular disease and cancer incidence and mortality. However, no claim was made that a convergence around NCDs would be feasible in the 2035 timeframe.

A third proposition by GH2035 was that LICs and MICs could make marked progress towards the goal of universal health coverage (UHC) through public finance (understood to include social insurance), with an approach termed progressive universalism. The essence of progressive universalism is to publicly finance and ensure population-wide delivery of an initially limited set of high-quality, very cost-effective interventions that disproportionately benefit poor people. As resource availability improves, the number of interventions in the benefit package can increase. The CIH pointed to policies that could reasonably balance the sometimes competing goals of assuring adequate resources to fund the package of interventions for grand convergence, providing protection against the financial risks that households bear from medical treatment costs, and countering inherently strong pressures for expensive but unproductive expenditures on health.

Lastly, GH2035 conveyed the importance of countries to realise the exceptionally high economic value of successful investment in health relative to cost. The CIH showed that the returns to investing in health have been underestimated because economic studies often only capture the effects of health on economic productivity (the so-called instrumental value of health), measured by household or national income. Such studies do not capture the inherent benefits of better health (the so-called intrinsic value of health). GH2035 estimated that, with a full income approach that captures both the instrumental and intrinsic values of health, the economic benefits of achieving grand convergence between 2015 and 2035 would exceed costs by a factor of about nine to 20, making the investment highly desirable.

In light of these extraordinary opportunities, GH2035 made a case for reorienting official development assistance (ODA) for health to areas where national governments have natural incentives to underinvest: research and development, in particular product development for neglected diseases; pandemic preparedness; and control of cross-border transmission of drug resistance, pollution, and marketing of unhealthy substances. The Commissioners concluded that adequately financing these investments, which requires international collective action for health, should become the top priority for health ODA.

This follow-up to the GH2035 report was written by a team of 15 members of the original CIH,[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) together with eight new authors. Although the original messages of the CIH remain relevant, there are compelling reasons for us to revisit the analyses and recommendations of GH2035 5 years on.

In this report, we test our original message about grand convergence in mortality from infectious diseases and maternal and child health conditions. We estimate recent trends in mortality for different diseases and conditions, country groups, and age groups to establish whether, in 2018, the world is on track for convergence by 2035. [Figure 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig1) shows the country groups that were used in this report. The classifications of countries within country groups and the rationale for our choice of country groups are in the [appendix (pp 21–24)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1).

We then focus on the future of UHC and primary health care (PHC), beginning with the health challenges that countries face beyond the convergence agenda, including NCDs and injuries. We describe essential PHC platforms to deliver UHC, and discuss intersectoral policies to accelerate progress and complement the health sector agenda. We update GH2035's projections of potential domestic resources for expanding UHC, and refine its messages on resource mobilisation, financial risk protection, and cost containment.

We go on to discuss the future of ODA for health, and for international collective action for health. As MICs transition out of health ODA, we propose a reallocation of such ODA over time, away from direct country support, towards international collective action for health. We summarise the best available information on current financing flows to international collective action for health and on the financing gap. We also identify a number of priority actions for international collective action for health.

We renew the call for national governments to invest in health. We continue to find that such investments boost wellbeing and prosperity, and provide perhaps the greatest economic returns in the field of development. The vision for domestic and international health policy presented in this report is our effort to provide a concrete and realistic roadmap towards achievement of the aspirational goals of the Alma-Ata Declaration 2.0, the health-related Sustainable Development Goals (SDGs), and health for all within a generation.

### The Alma-Ata Declaration 2.0

The upcoming 40th anniversary of the 1978 Declaration of Alma-Ata[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) provided the first incentive to revisit the analyses and recommendations of GH2035. The anniversary will be marked at the [WHO global conference on primary health care](http://www.who.int/primary-health/conference-phc) on Oct 25–26, 2018, in Astana, Kazakhstan, at which a new declaration, the Alma-Ata Declaration 2.0, will be written.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

We intend that our new report will inform the deliberations in Kazakhstan and contribute to valuable discussion and debate on the future of PHC. A key motivation for developing this new report was to explicitly define a vision for packages of essential interventions and PHC delivery platforms that could become part of national UHC systems.

Herein, we focus on only one dimension of the important goals proposed by Alma-Ata: reducing mortality, disability, and suffering due to injury and illness. We draw inspiration from Alma-Ata's concept of PHC, adopting a definition that centres on the platforms required to deliver UHC services close to the population: population-based (public health) interventions, community-based interventions, health centres, and first-level hospitals.[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Investments in PHC would need to efficiently address specific and common acute and chronic health conditions with interventions that are included in a UHC health benefits package. Alma-Ata's goal of “Health for All” carries over into the CIH's argument for public finance of progressive realisation of UHC, a concrete and achievable vision for the SDG era.

### A changed global health landscape

A lot has changed in the global health landscape over the past 5 years, and we wanted to revisit GH2035 and explore how recent changes could affect the CIH's initial key propositions. We have grouped these shifts into seven categories ([appendix p 20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). Some trends are new since GH2035, and others were already underway but have accelerated or intensified in the past 5 years.

13 days after GH2035 was published, an 18-month-old boy in Meliandou, Guinea, developed fever, black stools, and vomiting, and died 2 days later.[8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

He was identified as the index case in west Africa's 2014 Ebola outbreak—one of several recent emerging infectious disease epidemics that have shown the weaknesses of our preparedness systems, including the inability of health systems to avert loss of life. Although GH2035 was written before the 2014 Ebola outbreak, it had already raised the alarm about the underfunding of global public goods and other forms of international collective action for health, including product development for neglected diseases, and pandemic preparedness. The two further Ebola outbreaks in the Democratic Republic of the Congo that happened in quick succession in 2018[9](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) underscore the importance of international collective action for health. Looking to the future, the greatest known threat to global health aside from nuclear war is a severe influenza pandemic, for which we are clearly not prepared—because among other reasons, a universal influenza vaccine has not been developed yet.

Alongside emerging infectious diseases with epidemic and pandemic potential, the magnitude of the global threat from NCDs has substantially increased.[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Progress in implementing the commitments initially made by countries during the UN High-Level Meeting on NCDs in 2011 has been slower than expected.[12](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Among the key constraints that impede effective action are the so-called commercial determinants. These are market factors that drive consumption of products that increase the risk of cardiovascular disease and cancer. A series of investigative news reports in 2017 showed the remarkable effort multinational food and drink companies make to penetrate LIC and MIC markets with unhealthy products.[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext), [14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

LICs and MICs continue to see rising rates of NCDs and injuries on top of their unfinished agenda of avertable deaths from infections and maternal and child health conditions. The need for medical care for complex and chronic conditions has continued to grow with the shifting epidemiology in these countries, especially in MICs, where the shift has been most pronounced.[15](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The rapid rise in obesity worldwide could undercut recent health gains, if aggressive measures are not taken to reduce its prevalence.[16](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

This transition in disease incidence and prevalence is closely tied to a multifaceted demographic transformation. Generally, populations are ageing, putting enormous pressures on provision of health and social care. At the same time, in many LICs and MICs adolescents now make up a third of the population, and they must often confront a range of health threats unique to this age group, particularly road injuries, HIV/AIDS, suicide, and interpersonal violence.[17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[18](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Further complicating these demographic transformations is the mass migration and movement of people in unprecedented numbers. Many countries are poorly equipped to make immigration a healthy and socially productive process.[19](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

There are indications that some traditional donors, such as the USA, are retreating from their previous positions as champions of global health. In April, 2017, the current US administration withdrew funding to the UN Population Fund, and proposed a 23% cut in US global health funding from fiscal year 2018 to fiscal year 2019 (from $10·8 billion to $8·3 billion).[20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Just as these traditional donors are in retreat, new donors have emerged over the past few years, including China and the United Arab Emirates,[21](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) in a geopolitical realignment that could have profound effects on global health.[22](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

For example, a recent analysis[22](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) of China's proposed global health investments under its Belt and Road Initiative suggests that these investments could substantially increase global access to low-cost Chinese pharmaceuticals and medical technologies, and provide new health infrastructure in several LICs and MICs.

GH2035 was published at the end of the era for the Millennium Development Goals (MDGs), which have been superseded by the ambitious SDGs. Although the process and deliberations of the CIH were intentionally kept independent of the SDG development process, there are multiple recommendations common to both ([panel 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box1)). Where does health sit within an expanded agenda of 17 SDGs and 169 targets?

**Panel 1**

**Common elements between Global health 2035, the Millennium Development Goals, Sustainable Development Goals, and universal health coverage**

**Global health 2035: an independent effort with strong links to the Sustainable Development Goals**

Published in December, 2013, “Global health 2035: a world converging within a generation” (GH2035)[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) was well timed to feed into the Sustainable Development Goal (SDG) development process. It was published at a time when the Millennium Development Goals era was coming to an end and a new set of SDGs were being debated. To ensure strong links to the SDG process, the Lancet Commission on Investing in Health (CIH), which wrote GH2035, worked closely with the UN and had several Commissioners who were in the UN system. The convergence modelling in GH2035 was also done in close collaboration with the UN. At the same time, the CIH was deliberately convened as an independent group, with both the chairs and the secretariat based at universities. Although being outside the UN was an advantage to ensure independent analysis, the Commission maintained close ties with official agencies, including those in the UN system. For our Commission meetings, we brought together senior representatives from Roll Back Malaria, Stop TB, UNAIDS, and Gavi, the Vaccine Alliance.

The CIH collaborated with the authors of a Global Investment Framework for Women's and Children's Health[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) that modelled a scale-up of key reproductive, maternal, newborn, and child health interventions. The HIV interventions included in the GH2035 convergence modelling were based on those suggested by the Investment Framework Study Group.[25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The malaria control tools were those suggested by the Roll Back Malaria Taskforce's Global Malaria Action Plan.[26](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

We published details of the modelling both with a 2030 endpoint to synchronise with the SDG target year of 2030, and with a 2035 endpoint.[27](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The CIH shared its cost and outcome estimates at multiple timepoints during the SDG drafting process, so that they fed into the development of the SDG targets. For example, the CIH estimated that by 2030 an under-5 mortality rate of 27 deaths per 1000 livebirths could be achieved across low-income countries (LICs) and lower-middle-income countries (lower-MICs)—a rate similar to target 3.2 of the third SDG to reduce under-5 mortality to at least 25 per 1000 livebirths in all countries. Our modelling of grand convergence captured multiple conditions in an integrated way.

**Universal health coverage (UHC) and the primary health care agenda**

The 2014 Lancet Editorial[28](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

“Grand convergence: a future sustainable development goal?” emphasised the unifying function of grand convergence. It argued that the global health community was driven by rivalries between different disease communities, and that grand convergence could help overcome these tensions by being an all-encompassing goal that the whole community can rally behind.

A major proposition by GH2035 was that LICs and MICs could make marked progress towards the goal of UHC through public finance (understood to include social insurance). The entire cost of an initially limited set of interventions for the whole population would be publicly funded. As such, Alma-Ata's goal of “Health for All” would be carried over into the CIH's progressive universalist approach.

Although GH2035 did not include quantitative modelling on non-communicable diseases and injuries, the CIH collaborated on a follow-on study[29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) published in September, 2014, that estimated feasibility of mortality targets for all conditions by 2030. The study showed that all countries could reduce deaths in people under 70 years of age by 40% in their 2030 populations (at 2010 death rates), by achieving 2030 grand convergence targets and reducing premature deaths from non-communicable diseases and injuries by a third. The “40 by 30” target of reducing deaths in people under 70 years of age by 40% by 2030 and the grand convergence targets have taken on additional relevance over the past 5 years in framing discussions about what should be included in an essential package of UHC interventions. For example, based on disease burden, intervention outcomes, cost effectiveness, and feasibility of implementation, the third edition of Disease Control Priorities made the case that essential UHC should begin with interventions to achieve grand convergence.

On the one hand, experts have argued that health has become greatly diluted. Compared with the MDGs, which had three out of their eight goals dedicated entirely to health, only one of the 17 SDGs specifically focuses on health. This could indicate that health has slipped down the development agenda, with development experts arguing that other sectors such as agriculture should now take centre stage.[30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

On the other hand, experts have pointed to how the SDGs have given a far more comprehensive picture of the challenges that must be addressed to achieve a successful transformation in population health. Unlike the MDGs, SDGs target NCDs, injuries, substance abuse, and environmental risks, focus on achievement of UHC, and lay out multiple means of implementation to reach their targets.[31](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) Additionally, all SDGs are connected, and most can be linked back to health.[32](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Although the global momentum towards achieving UHC has continued to grow since 2013, at a country level, UHC is hindered by weaknesses in health systems such as the health workforce crisis and poor access to medicines and technologies.

Additionally, some confusion remains about what is defined as UHC—the term can be a catch-all, with multiple proposed interpretations, frameworks, and monitoring approaches. Gaining consensus on what constitutes UHC will be important in monitoring whether UHC is achieved.[33](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

We believe that achieving universal coverage of quality PHC for priority health conditions is feasible.

Nevertheless, simply covering people with a package of defined interventions is not enough on its own. Around 8·6 million lives are lost in LICs and MICs as a result of conditions that are treatable in the health system. Of these deaths, as many as six out of ten could be due to poor quality of care.[15](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[34](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

With the stagnation of health ODA since 2010,[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) LICs and MICs must now find most of the annual funding to achieve the SDG health targets themselves. A 2017 study[36](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) estimated that achieving these targets will require an additional $371 billion (in 2014 US$) per year by 2030 across 67 LICs and MICs, representing 95% of the total population living in all LICs and MICs. Most of this additional funding will need to come from domestic resources in LICs and MICs.

Domestic funding for health in LICs and MICs increased more than five-fold between 2000 and 2015, exceeding $1·5 trillion.[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Nevertheless, the economic picture that was painted by GH2035, in which LICs and lower-MICs were estimated to be on course to add almost $10 trillion annually to their gross domestic product (GDP) by 2035, is not as clear today as it was in 2013. The International Monetary Fund has downgraded its growth projections, so mobilising domestic resources for health will likely be more challenging.[38](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Furthermore, increasing evidence points to health receiving lower budgetary priority in many countries.[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The 2015 Rockefeller Foundation–Lancet Commission on planetary health[39](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) argued that unsustainable exploitation of the natural environment will lead to the deterioriation of ecological resources that support human life and health. The Commission documented the health effects from a variety of environmental threats, including climate change, loss of biodiversity, land degradation, water scarcity, and overexploitation of fisheries. Examples of health effects included increased rates of water-borne infectious diseases, malaria, air pollution-related respiratory diseases, and injuries due to natural disasters.

### New avenues of research and analysis

We also revisited and updated GH2035 to capture new research findings. In a recent review[40](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) of the lessons learnt from the CIH, we noted that GH2035 initiated several new directions for global health policy research. ([appendix p 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). Since 2013, a range of new analyses have been made as an extension to the analyses by the CIH, and this report provides an opportunity to disseminate these results.

New research has focused on four main areas. The first area of research involves defining the crucial global functions of ODA for health—those that tackle challenges that all countries share—and estimating levels of donor financing that flow to these functions. [41](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The second one estimates the funding needs and requirements of high priority global functions, in particular product development for neglected diseases, and epidemic and pandemic preparedness.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The third one involves developing policy proposals to tackle the so-called middle-income dilemma—over 70% of the world's poorest people now live in pockets of poverty and high mortality in MICs, yet many of these countries have reached a national average income level that disqualifies them from receiving health ODA.[45](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

This phenomenon is relatively new; just two decades ago, over 90% of the poorest people were in LICs.[46](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The fourth area of research focuses on the global need for palliative care and pain relief and the magnitude of the gap in palliative care services, and on establishing the nature and cost of an essential package of services that fill this gap.[47](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Several new streams of evidence have also informed our report, in particular the third edition of Disease Control Priorities[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) (DCP3), new sources of global epidemiological and demographic data, [48](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) the emerging work of the [Task Force on Fiscal Policy for Health](https://www.bloomberg.org/program/public-health/task-force-fiscal-policy-health), chaired by Michael Bloomberg and Lawrence Summers, and several LancetSeries and Commissions on NCDs and economics, palliative care and pain relief, HIV/AIDS, sexual and reproductive health, and planetary health. [31](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[39](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[47](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[50](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

**Is grand convergence by 2035 still feasible?**

In GH2035 we modelled the effects of a package of essential interventions on population health, including an aggressive scale-up of today's health technologies to a coverage of 90–95%, improved health delivery systems, and implementation of new technologies that will become available by 2035. Countries that adopt new health tools will have an additional 2% reduction in child mortality per year. [52](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

We showed that with these interventions, by 2035 average maternal, child, HIV/AIDS, and tuberculosis death rates across LICs and lower-MICs could fall to rates seen in 2011 in the best-performing MICs: Chile, China, Costa Rica, and Cuba (known as the 4C countries). Although GH2035 did not include incidence targets, the priority interventions included in the grand convergence agenda would reduce both incidence and mortality.

Based on the performance of the 4C countries ([appendix p 25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)), the 2035 convergence goals were set to 16 per 1000 livebirths for child mortality, an annual HIV/AIDS death rate of eight per 100 000 population, and an annual tuberculosis death rate of four per 100 000 population (in short, “16–8–4”). Although no 2035 target was set for the maternal mortality in GH2035, for the purposes of this new analysis, we used 64 per 100 000 livebirths as the target, in line with the 2011 rates of maternal mortality in the 4C countries. As a result, the full set of convergence targets is now named “64–16–8–4”. The convergence goals were intended to be global targets, though we recognise that lower-MICs could generally achieve lower death rates than LICs by 2035.

For this report, we analysed these four indicators, looking at mortality rates from 2000 to 2010 and from 2010 to 2016 across age groups, causes of death, countries, and country groups. To assess progress towards the 64–16–8–4 targets, we calculated the average annual rate of change (AARC) in maternal, child, HIV/AIDS, and tuberculosis death rates from 2000 to 2010 and from 2010 to 2016, the AARC that would be required from 2016 to 2035 to meet the grand convergence target, the percentage of the 2035 target that had already been achieved by 2016, and the projected year that the target would be reached if the AARC calculated for 2010–16 remains unchanged. Details of the methods and data used for these estimates are in the [appendix (pp 4–6)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1).

In our analysis of progress towards convergence, we found that the world is on track to achieve convergence by 2035 for child mortality and HIV/AIDS death rates, but off track for maternal mortality and tuberculosis death rates. Recent progress in tackling neglected tropical diseases is summarised in [panel 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box2). We also reflected on the level of ambition and feasibility of the GH2035 convergence targets.

**Panel 2**

**Progress on neglected tropical diseases**

Using mortality to discuss progress towards grand convergence targets for under-5 mortality, maternal mortality, HIV/AIDS, and tuberculosis is both feasible and reasonable since mortality burden correlates with morbidity burden. “Global health 2035: a world converging within a generation” (GH2035)[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) also included convergence of selected neglected tropical diseases, and those included in the analysis generated substantial morbidity burden and could be prevented by implementation of highly cost-effective mass drug administration programmes. GH2035 established no quantitative targets for addressing these conditions; mortality targets would in any case have been inappropriate since these conditions have a very high ratio of morbidity consequence to mortality consequence. Although our review of progress towards grand convergence is thus unable to relate goals to accomplishments for neglected tropical diseases, progress has been and continues to be substantial.

Worm infections in children provide an important example. In 2013, an estimated 400 million children under 15 years of age carried one or more worm infections and almost 900 million lived in regions of sufficiently high transmission to justify use of mass drug administration. [53](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Between 2009 and 2013, global coverage of mass drug administration increased from 31% to 47%, and in Africa coverage increased from 32% to 51%. [53](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Globaly, this implies an 8·3% increase in coverage per year over this 5-year period. Similar improvements in coverage were observed for other neglected tropical diseases (such as lymphatic filariasis and trachoma) and in other age groups. [53](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[54](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Overall, it is plausible that the neglected tropical diseases that are preventable by mass drug administration will cease to be a problem by 2035.

### Progress towards grand convergence

#### Child mortality

Impressive progress has been made to reduce child mortality since 2000, and the world is generally on track to achieve the convergence target for under-5 mortality. If the global rate of a 4·1% reduction in under-5 mortality per year achieved from 2010 to 2016 were to continue, then the convergence target would be reached by around 2038, with a delay of just 3·7 years from the 2035 target date. An acceleration in the AARC to −4·9% would mean that the goal could be reached by 2035. These encouraging data are reflected by the narrow gap between the blue and red lines in [figure 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig2). Nevertheless, maintaining the current rate of decline might be challenging, as averting residual mortality might require more advanced interventions and a higher quality of care than is available in all countries.

By contrast, new data from the UN Inter-agency Group for Child Mortality Estimation [55](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) suggest the need to move from under-5 mortality to more comprehensive indicators of progress on child health. We propose under-15 mortality as one such measure. This indicator captures antepartum stillbirths, perinatal deaths (including intrapartum stillbirths, occurring after labour begins), early neonatal deaths (after birth but before the seventh day of life), late neonatal deaths (from seventh to 27th day), post-neonatal deaths (from 28th day to 1 year), deaths in early childhood (1–4 years), and deaths in middle childhood (5–14 years). The under-15 mortality rate is highly associated with the under-5 mortality rate ([appendix p 84](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

By 2015, over 5 million fewer children under 15 years of age were dying each year, compared with under-15 mortality in 2000. The number of deaths fell in every country group, but there were wide variations in the AARC. China achieved the fastest AARC, followed by India, and Latin America and the Caribbean. The pattern was similar for deaths in infants aged 0–4 years, with the fastest rates of decline observed in China, India, Latin America, and the Caribbean. Compared with 2000, the number of stillbirths in sub-Saharan Africa increased by 2015 but fell in every other country group, with China having the fastest rate of reduction yet again ([appendix p 26](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

The highest number of deaths under age of 15 years both in 2000 and 2015 occurred in the perinatal period ([figure 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig3)). In contrast with the progress made reducing deaths in the postnatal period and early childhood, little progress has been made in reducing antenatal stillbirths and deaths in middle childhood.

#### Maternal mortality

In contrast with under-5 mortality, the world is not on track to reach the 2035 target for maternal mortality. Only 18% of the convergence target had been achieved by 2016.

The AARC for maternal mortality in 2010–16 was just at −2·4%, and at this rate the target would only be reached in 2067, representing a delay of 32 years. Achieving the target by 2035 would require the AARC to accelerate to −6·3%, a rate of change that was not achieved for maternal mortality anywhere in the world in 2010–16 (India came closest with −4·6%). The worrying situation of maternal mortality is shown by the wide gap between the blue and red lines in [figure 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig2).

#### HIV/AIDS mortality

HIV/AIDS mortality has been reduced with remarkable success. The decline in death rates from HIV/AIDS has accelerated dramatically, from −1·3% per year in 2000–10 to −7·3% per year in 2010–16. If this accelerated AARC continues, the convergence target would be achieved by 2023, 12 years early.

The AARC for HIV/AIDS that has already been achieved is faster than what is required to reach the 2035 target ([figure 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig2)). China and India in particular have achieved astonishing rates of decline, with −13% and −12% per year from 2010 to 2016. In both countries, mortality rates were rising from 2000 to 2010. Progress in sub-Saharan Africa has also been remarkable, accelerating from −3·4% per year in 2000–10 to −9·8% per year in 2010–16. However, the data also show that HIV/AIDS mortality in Eurasia and the Mediterranean has increased since 2000. Although the rate of increase slowed after 2010, this country group should not be complacent.

#### Tuberculosis mortality

Compared with HIV/AIDS, the outlook for tuberculosis mortality is far bleaker. If 2010–16 trends continue, the convergence target for tuberculosis will not be achieved until 2074. By 2016, only 18% of the target for tuberculosis mortality had been achieved.

From 2010 to 2016, the global AARC for tuberculosis was only at −2·5% per year. In six of our eight country groups, the rate of decline in tuberculosis deaths was lower in 2010–16 than it had been in 2000–10, the reverse of what had been observed for HIV/AIDS ([appendix pp 29–30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). The slowest rates of progress in 2010–16 have been in fragile states, where the AARC for tuberculosis has only been −0·9% per year, and in sub-Saharan Africa, where the AARC for tuberculosis has only been −1·2% per year ([appendix p 30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). For a global reduction of tuberculosis death rates to four per 100 000 population, the AARC would have to accelerate to −7·7% per year. No country group came close to achieving such an AARC over 2010–16, although some individual countries, such as Zimbabwe and Turkey, did achieve it ([appendix pp 50–55](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

The favourable rates of decline in HIV/AIDS mortality are probably capturing some progress in reducing tuberculosis-related mortality among people with HIV. HIV/AIDS is assigned as the underlying cause of death in people with HIV who also have tuberculosis,[57](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) and about 40% of deaths in individuals with HIV/AIDS result from tuberculosis.[58](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Although tuberculosis treatment can reduce case fatality, antiretroviral drug therapy can reduce tuberculosis incidence as well as case fatality, and systems of care and follow-up are often better for people with HIV than for the general population, especially when delivered through targeted (vertical) programmes. Continuous global efforts to scale up HIV care will continue to reduce the burden of tuberculosis in this population. Our conclusions about the challenges in achieving convergence in tuberculosis death rates are therefore mostly related to reducing tuberculosis mortality among individuals who are HIV negative, who comprise around 80% of new cases of tuberculosis globally.[57](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

#### Regional and national variation

We looked at the feasibility of adopting the global convergence targets at regional and national levels. Our analysis of historical trends in 2000–16, and future progress that would be required for each region or country to meet the four global “64–16–8–4” grand convergence targets, is in the [appendix (pp 27–55)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1). Considerable improvements in the historical performance of AARC would be required to meet these global targets at regional and national levels. For example, sub-Saharan Africa and the fragile states would struggle to meet all four convergence targets, and Eurasia and the Mediterranean and India would struggle to meet the tuberculosis convergence target ([appendix p 85](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

#### Heterogeneous progress towards grand convergence

Modelling the scale-up of convergence interventions in GH2035 showed that by 2035 grand convergence would be feasible and affordable for most LICs and lower-MICs, but the poorest and most fragile nations would need more time. The modelling showed the progress that countries could potentially achieve if they chose to prioritise targeted investments that would tackle convergence conditions.

This report shows that if the trends from 2010 to 2016 are maintained, convergence by 2035 will still be feasible for child and HIV/AIDS mortality but not for tuberculosis or maternal mortality. The striking progress in tackling child and HIV/AIDS mortality might reflect the relatively high amounts of ODA that have been targeted to these two focus areas.[59](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Declines in such ODA could affect progress, unless these declines are compensated by increased domestic funding. About 70% of people with HIV live in sub-Saharan Africa, and most of the heavily affected countries in this region are LICs or lower-MICs. These countries will probably require health ODA for many years to prevent catastrophic resurgence. However, rather than doubling down on recent success, eight out of 14 bilateral donors cut their support to HIV/AIDS last year.[60](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Many people in the HIV community have expressed concern that the recent gains in HIV/AIDS mortality are fragile and could quickly be undercut by a lack of progress to reduce new infections and by increases in drug resistance.[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

One key message from the International AIDS Society–Lancet Commission on HIV/AIDS was that there is no end in sight to the HIV pandemic, and that a dangerous complacency has set in, which has weakened the global resolve to end HIV/AIDS.[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Given the slow progress to reduce tuberculosis mortality in recent years, four deaths per 100 000 population as a convergence target seems overly optimistic now. When we established this target in GH2035, it implied an ambitious AARC of −6·8% from 2011 to 2035. Hence, convergence on tuberculosis is unlikely, unless breakthrough tuberculosis technologies are developed that could shift the mortality curve. Our modelling in GH2035 assumed that new health technologies could reduce tuberculosis mortality by an additional 2% per year. However, mortality reductions need to progress at substantially faster rates in many countries to reach convergence. Doubling or tripling the national resources devoted to tuberculosis treatment could help to change the trajectory of tuberculosis mortality in countries where the disease has the greatest burden.

Accelerating progress on maternal mortality will not be quite as difficult as for tuberculosis, but it will still be challenging. New technologies will play a crucial part. Other strategies to catalyse progress include an aggressive scale-up of the package of maternal health interventions described in DCP3, which would require structural investments in the health system (including the PHC system); improvements in quality of care; reduction of inequities in coverage; and use of robust evidence in a timely way for policy decisions and accountability.[61](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[62](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

When it comes to achieving grand convergence, we cannot predict the effect of technological innovations that might become widespread by 2035. Countries are experimenting with a range of approaches that could help lower the price of health commodities (eg, using e-procurement), deliver medicines to remote places (eg, using drones), and improve overall management of health systems (eg, using blockchain technology). These technological innovations are also opportunities to reinvent PHC systems.

### Other threats to grand convergence

Unaffordability of GH2035's package of health interventions for the poorest countries, and low prioritisation of health on the national agenda in several large countries such as India, threaten the achievement of grand convergence. The countries with the greatest needs—including fragile, post-conflict nations—are likely to require ongoing, direct financial and technical assistance leading up to 2035 to be on track for convergence. MICs with large populations of refugees, such as Lebanon and Jordan, will require international assistance to cope with increased pressure on their health systems. Nevertheless, analyses by GH2035, DCP3, and many other groups support our contention that increasing ODA for both global functions and for direct support to the countries with the greatest needs would have a very large health and economic payoff.[63](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Other obstacles to reaching grand convergence are the very large inequities within MICs. In GH2035 we argued that achieving convergence would be impossible without tackling the large pockets of poverty and mortality in MICs. Many MICs will transition away from ODA for health in the coming years, if they reach an income level that disqualifies them from receiving concessional financing. One of the best ways that donors can continue to support communities living in pockets of poverty in MICs is through funding of global public goods and other global functions (eg, market shaping to reduce vaccine prices).

The national level indicators (eg, of child mortality) in MICs such as China, where national convergence targets have already been achieved, might mask vast differences between subnational units. Stark contrasts were shown in a recent subnational analysis of under-5 mortality in China.[59](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

In 2012, the rate of under-5 mortality ranged from 3·3 per 1000 livebirths in the Huangpu District in Shanghai (on par with Japan) to 100 per 1000 livebirths in Zamtang County in Sichuan (on par with South Sudan). A study of trends in state-level mortality in India found substantial differences between states in fertility and child and maternal mortality, and in the rates by which these outcomes changed over time.[64](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Of course, MICs are not homogeneous and the size and nature of the regional health inequities are likely to vary. One reason why some MICs have pockets of high mortality is because poorer populations are not receiving life-saving drugs and vaccines, sometimes because of high prices. The international community plays a crucial part in reducing these pockets of high mortality, if they use mechanisms such as market shaping to reduce health commodity prices.

For grand convergence to be possible, interventions must be sufficiently effective and inexpensive, so that LICs can achieve rapid declines in mortality with the right policies. Croghan and colleagues[65](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) and DCP3 suggest focusing financial and technical attention on widespread implementation of a few highly effective interventions. The experiences of China and India illustrate the importance of policy ([panel 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box3)). China's famine of 1959–61 has been widely interpreted as a failure of economic and social policy, resulting in 20–40 million excess deaths ([appendix pp 57–58](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). In the decades that followed the famine, however, successful health policies in China led to sustained, rapid reductions in mortality long before China emerged from poverty ([appendix p 59](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). Later, slower progress in India yielded substantial consequences for mortality: excess deaths in India between 1970 and 2010 were four times the number of excess deaths resulting from the Chinese famine ([appendix pp 86–89](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). In recent years, India's life expectancy has begun to converge with China's, and India is now developing health policies that will accelerate the decline in mortality, if these health policies receive enough funding.[66](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

**Panel 3**

**Policy and mortality in China and India, 1950–2010**

In 1950, China emerged from a civil war that followed a decade of war with other nations. India had very recently ended its colonial status. The world's two most populous countries thus started their modern development trajectories at about the same time. Their trajectories of income and demography suggest lessons about the importance of political factors, and of income and health sector policies, in determining mortality rates. Both countries, but particularly China, had success over the six decades after 1950 in increasing income per person and extending life expectancy. However, the patterns of change differed substantially between the two countries.

The Chinese famine of 1959–61 provides a dramatic example of the importance of political factors. The famine resulted in part from bad weather and ensuing bad harvests, but most observers have also concluded that the Great Leap Forward and other dimensions of public policy amplified the mortality consequences of the famine into one of the major global mortality shocks in the 20th century ([appendix pp 57–58](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). The famine ensured that China's early mortality trajectory was markedly adverse. India, on the other hand, maintained steady reductions in mortality rates from 1950 to 2010.

In the two decades after the famine, China's policy focus on improving population health led to increases in life expectancy in excess of 1 year every year, resulting in an increase of about 23 years from 1965 to 1985. India, starting from a slightly lower life expectancy than China in 1950, managed to increase only half as much life expectancy than China in this period ([appendix p 59](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). Per person, initial income levels were slightly higher in India than in China, but China's income growth rate was noticeably higher. From 1980 to 2010, China's income growth rate grew to about 9% per year, bringing China well into the ranks of upper-middle-income countries. However, during this period of rapidly growing income in China, India reduced the gap in life expectancy between the two countries by 5 years. China's substantial increase in life expectancy occurred while its income remained low, and India has maintained steady but unremarkable increases in life expectancy at relatively low income levels. Country policy can thus make great progress toward grand convergence at low income levels—if the country chooses to do so.

How substantial are the consequences of falling behind on the path to grand convergence? The answer places the consequences of China's famine of 1959–61 into a broader perspective. We addressed this question in the context of India and China by calculating the number of deaths in India that would have occurred if India's age-specific mortality rates had declined (from their initially somewhat higher levels) at the same rates as China's age-specific mortality rates, using UN time-series data of the age distributions of the population and of the number of deaths. We then subtracted this number from the number of deaths that did in fact occur. The resulting difference provides an estimate of the number of excess deaths that occurred in India as a result of its health policies and other related policies that were lagging behind those of China. We also calculated the number of deaths in children under 5 years of age, deaths under the age of 70 years, and excess deaths occurring between ages 5 to 70 years ([appendix pp 86–89](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). We assumed that the total excess deaths from the Chinese famine were 30 million, of which 28 million were in people under the age of 70 years.

In 1950–60, India had about 5 million fewer premature deaths than it would have had if its rate of mortality decline had tracked that of China's, reflecting the consequences of the famine. However, in each of the four decades from 1970 onwards, India's excess mortality exceeded a reasonable estimate of the total excess mortality resulting from the Chinese famine.

What can we conclude from this analysis? We can see a spectrum of health losses that result from policy failures. At the one end are major shocks, such as the great Chinese famine or the 1918 Spanish influenza pandemic, where the losses are concentrated in time and highly visible. At the other end are missed opportunities to improve health using existing technologies. India's poor gain in life expectancy relative to its level of development illustrates these missed opportunities. Because these losses are spread out over time, they are less visible, but they are just as important.

**The future of domestic health policy, universal health coverage, and primary health care**

Fully implementing GH2035's recommended package of interventions related to grand convergence would be an important milestone in domestic health policy, and would lead to substantial improvements in population health. However, since the publication of GH2035 new evidence has shown the continued rapid pace of demographic and epidemiological change, and, therefore, the value of focused investments in prevention and care of cardiovascular disease, cancer, mental health problems, and injuries.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

 The 40th anniversary of the Alma-Ata Declaration provides an opportunity to reflect on the future of PHC as the principal delivery platform for the interventions included in UHC, and assess the need for PHC and UHC in LICs and MICs to tackle an expanding set of health topics.

We build on the grand convergence agenda by updating the messages of GH2035 on essential UHC, specifically reflecting on priority interventions for PHC in LICs and lower-MICs. We also discuss the current state of domestic health finance and specific ways in which ministries of health and finance should be preparing for the fiscal challenges that lie ahead.

### Health challenges that lie beyond grand convergence

As progress on grand convergence is made, PHC systems will increasingly need to broaden their scope from simple, episodic, preventive, or curative models of care to include integrated, longitudinal models of care for many chronic health conditions. HIV/AIDS practitioners have been faced with this widening of scope for several years,[67](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) and the future of health care will require complex and sustained interventions in addition to the simple and powerful interventions that are currently more widely available. Emerging economies now face the challenge of retooling their health systems to successfully deliver future interventions for a broader set of health issues. We identified three health challenges that go beyond grand convergence: expanding grand convergence to a broader set of health conditions; aggressively dealing with high-burden NCDs and injuries in the face of strong demographic shifts; and putting functional PHC systems in place that integrate more effectively with social protection policies and are adaptive and resilient to environmental, demographic, epidemiological, and technical change. Initially, PHC systems could emphasise building capability to tackle common conditions that have cost-effective solutions, such as ischaemic heart disease, but reforms could be designed to be applicable to a range of health conditions.

#### An expanded set of conditions for grand convergence

The grand convergence package in GH2035 dealt with major adult infectious diseases (HIV/AIDS, tuberculosis, and malaria), neglected tropical diseases, family planning, maternal mortality, and infectious disease mortality in children under 5 years of age. If this package represents the most basic set of UHC interventions for LICs and MICs, then what is next?

Historical experience in HICs and the 4C countries suggests that convergence could also be possible for an additional set of infectious diseases and NCDs attributable to infections. These health conditions affect older children and adults, and include sexually transmitted infections (syphilis, most importantly), diarrhoeal diseases, lower respiratory infections, cervical cancer, hepatitis B-related chronic liver diseases, and rheumatic heart disease. Age-specific mortality rates for these conditions can be drastically reduced by use of existing interventions, making them great candidates for setting convergence targets.

Excluding the 4C countries, this additional set of health conditions accounted for 1·8 million premature deaths in LICs and MICs in 2016 ([table 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#tbl1)). If mortality rates for these conditions in LICs and MICs would have been the same as those observed in the 4C countries in 2016, 1·3 million premature deaths worldwide could have been prevented that year. Prevention of these deaths would represent a 72% reduction in premature deaths from this additional set of health conditions, and a 5·8% reduction in premature deaths from all causes. These rates are probably underestimates of avertable mortality, since age-specific mortality is likely to decline further in the 4C countries as the benefits of immunisation against human papillomavirus and hepatitis B virus begin to take effect. DCP3 and WHO's analysis of the cost of reaching the SDG health targets recommend a number of specific cost-effective interventions for these additional health conditions.[36](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Such interventions could readily be integrated with the grand convergence interventions on existing PHC platforms.

Avertable deaths were calculated by applying death rates specific to age, sex, and cause observed in 4C countries to population estimates in low-income and middle-income countries. Only deaths occurring between the ages of 5 and 69 years were included. Diarrhoeal diseases and lower respiratory infections in children under 5 years of age are already covered in the global health 2035 [1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) grand convergence package. 4C countries=Chile, China, Costa Rica, and Cuba. Data from the 2016 Global Health Estimates. [49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Emerging infections with epidemic and pandemic potential pose an ongoing threat to achieving grand convergence. The greatest threat is a severe influenza pandemic, which could strike any time; 100 years after the great 1918 pandemic, the world remains grossly unprepared. The risk of severe influenza is global, but mortality in LICs and MICs caused by severe influenza would probably exceed mortality in HICs by a factor of 5–10.[69](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[70](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

We suggest that the major efforts to prepare for pandemics need to happen at the international level. LICs and lower-MICs in particular have little incentive to prepare for low-probability events in the face of so many pressing health needs. Thus, health ODA and international collective action for health should fund national preparedness and mitigate externalities of epidemics that often start out in LICs and MICs. Countries with sufficient domestic resources, including upper-MICs and HICs, should consider investing more in pandemic preparedness as part of the expanded grand convergence agenda.

#### Divergence of progress with non-communicable diseases and injuries

In 2016, two-thirds of deaths that occurred before the age of 70 years in LICs and MICs were due to cardiovascular disease, cancer, other NCDs, or injuries. [49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

[Figure 4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig4) shows the AARC in age-adjusted mortality for NCDs and injuries from 2000 to 2016. Trends have been less favourable overall than for those conditions included in the grand convergence agenda, and there appears to be a divergence in mortality taking place, with some country groups experiencing large declines in mortality rates, and other country groups experiencing stable or increasing rates. [Table 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#tbl2) shows the demographic and epidemiological factors affecting premature mortality from ischaemic heart disease, as an example. The divergence in mortality rates for NCDs has been well documented in the Million Death Study in India and is a natural consequence of continued inequalities in case fatality across countries. [71](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[72](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Premature mortality refers to deaths occurring before the age of 70 years. Population growth AARC is the average annual rate of change in the number of deaths that are due to changes in population size. Population ageing AARC is the average annual rate of change in the number of deaths that are due to changes in population age structure. Total demographic shifts are combined effects of these two types of demographic effects. Epidemiology AARC is the average annual rate of change in the number of deaths that are due to reductions in age-specific death rates (ie, reductions in disease incidence and case fatality). The sum of the effects of demographic shifts and epidemiology AARC equals the AARC of premature deaths. Methods for the decomposition of crude death rates are in the [appendix (pp 7–8)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1). Fragile states are 33 states that were included in the World Bank list of fragile states for at least 3 out of 5 years between 2010 and 2015 ([appendix p 24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). The fragile states are not a separate country group but instead are included in the other country groups. AARC=average annual rate of change. Premature mortality data from the 2016 Global Health Estimates. [49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

* [Open table in a new tab](https://www.thelancet.com/action/showFullTableHTML?isHtml=true&tableId=tbl2&pii=S0140-6736%2818%2932389-4)

Similar to grand convergence conditions, there has also been great heterogeneity in mortality rates for NCDs and injuries at the subnational level, especially in large MICs such as India, where these differences in mortality rates are common between urban and rural areas and across states. [72](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[73](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

However, trends in risk factors for NCDs and injuries differ from risk factors for grand convergence conditions, in that, globally, most behavioural and environmental risk factors for NCDs are increasing rapidly (or are already at crisis levels), whereas risk factors for infectious diseases have been steadily declining since 1990 and now contribute substantially to disease burden only in the poorest countries and subnational units. [74](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

In fact, current trends in risk factors for NCDs might even begin to cut into, or even reverse, recent progress ([appendix p 8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

#### Other demographic and epidemiological challenges

Hundreds of millions of individuals worldwide are currently living with chronic health conditions (such as diabetes and depression), even billions in the case of hypertension, and the prevalence of most of these conditions is increasing.[75](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

High rates of non-fatal disability from chronic conditions add stress to health systems and reduce economic productivity, adding urgency to the arguments to implement population-level prevention strategies and to prepare health systems for provision of high quality chronic disease care. [31](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Multimorbidity and population ageing are two issues that further complicate the problems brought about by the rise in NCDs, injuries, and their associated risk factors. The [appendix (pp 9–10)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1) explores these issues in more detail and outlines possible consequences for ministries of finance and health systems.

Multimorbidity—living with multiple chronic health conditions—is a well described phenomenon in HICs and an emerging issue in LICs and MICs. [76](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[77](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Studies in HICs have found that individuals with multimorbidity have health-care costs that are orders of magnitude higher than healthier individuals, and the quality of their care is usually worse.[78](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[79](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Most health systems, especially in LICs and lower-MICs, are not equipped for the complex care that multimorbidity requires. [78](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Contributing to these clinical challenges are gaps in evidence. Most clinical trials and economic evaluations exclude the effects of comorbidity and patient complexity, calling into question the generalisability of research findings. [80](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[81](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Changing demographics will also continue to place increasing demands on health systems ([table 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#tbl3)). Population growth and ageing will lead to larger numbers of middle-aged and older adults (often with multimorbidity) seeking ongoing care for management of NCDs. Furthermore, care for individuals with long-term disability, including older people with frailty, is already consuming a substantial portion of public budgets in HICs.[82](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

For cardiovascular disease, diabetes, and cancer, we estimate that demographic shifts caused an increase in deaths due to population growth and ageing at a rate of about 2–3% per year across country groups ([table 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#tbl3), [appendix pp 60–62)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1). The implications of these shifts for health-care finance cannot be emphasised enough. Most LICs and MICs are facing historically unprecedented rates of population ageing, and have not had the resources to adapt in the way that HICs have. Increasingly, integration of health care and social care policies will be required to address the wide-ranging household and social consequences of long-term physical and mental disability ([appendix pp 9–10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).[83](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

It is clear that LICs and MICs cannot simply adopt the models of care practised by HICs, and cannot afford to only invest in the unfinished agenda of grand convergence. We propose that ministries of health and finance develop and adopt a PHC transformation agenda in parallel with this unfinished agenda, to help guide LICs and MICs through these changes in population growth and ageing.

### Transforming UHC and PHC through essential packages

Here, we consider some of the first steps of health system transformation in light of the UHC and PHC agendas. The health policy roadmap we present here has the potential to achieve substantial progress towards the goals that were set in the original Declaration of Alma-Ata and in the SDGs.

#### A concrete notion of UHC to inform the PHC agenda

The starting point for health system transformation is a concrete notion of UHC that makes use of an explicitly defined, guaranteed, publicly financed set of essential health interventions (a health benefits package).[84](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Our concept of UHC draws heavily on recommendations and findings from DCP3, which viewed interventions as essential when they provided high value for money, were locally relevant, and feasible in resource-limited settings.[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

[Panel 4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box4) provides some context for the evolution of the Disease Control Priorities effort and UHC-related innovations in DCP3. This UHC concept builds on the principle of progressive realisation of UHC put forward in GH2035. Although an explicitly defined health benefits package is of crucial importance to achieving health goals, this topic has been relatively understudied in academic and grey literature, compared with other topics like financing arrangements.[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

**Panel 4**

**Essential universal health coverage in the third edition of Disease Control Priorities (DCP3)**

DCP3 was a 7-year international collaborative effort to synthesise evidence and provide recommendations for health priorities in low-income countries (LICs) and middle-income countries (MICs). The history of the Disease Control Priorities efforts is summarised in a Lancet Review[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) published at the launch of the final volume of the series in London, UK, in December, 2017. DCP3 involved over 500 authors, 230 peer reviewers, and 33 editors who developed 172 chapters addressing specific health topics. These chapters were organised into nine volumes that were oriented towards specific professional communities (eg, surgery, cancer, and major infectious diseases).

One of the most important outputs from DCP3 was a set of 21 essential packages, presented throughout the nine volumes. The essential packages were also oriented towards professional communities and specific clusters of health topics (eg, reproductive health, palliative care and pain relief, and pandemic preparedness). Interventions were included in these 21 packages if they provided good value for money, were feasible to implement in LICs and MICs, and addressed a relevant burden of disease.

Volume nine of DCP3 contains two chapters that separate the content of the 21 essential packages into health sector interventions and intersectoral interventions.[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[83](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Duplicate interventions were removed and intervention phrasing was standardised. The final health sector package, termed essential universal health coverage (UHC), had 218 interventions.

The 218 health sector interventions were characterised by delivery platform: population-based health interventions (n=13), community-based health interventions (n=59), health centres (n=68), first-level hospitals (n=58), and referral and specialty hospitals (n=20). Although the specific ways in which platforms are defined will vary from country to country, DCP3 viewed platforms as a key part to the integration of health interventions. For example, in a community setting, the same school can deliver a range of interventions including deworming, vaccination against human papillomavirus, and health education and promotion. The same health centre can deliver antiretroviral therapy, cardiovascular disease screening, and treatment for depressive and anxiety disorders. The same first-level hospital can deliver surgical care for severe injuries, manage complicated cases of tuberculosis, and provide some specialised care in the outpatient department for less frequent and more complex non-communicable diseases (NCDs), such as rheumatoid arthritis and congenital disorders. Notably, all but 20 of DCP3's 218 essential UHC interventions are delivered on primary health-care platforms. Integration of interventions within platforms can facilitate high-quality care and produce natural economies of scope. Over time, well designed platforms can incorporate additional health interventions more easily, if resources allow.

An additional suggestion by DCP3 to improve health system design and quality was the characterisation of interventions as urgent, chronic, or time-bound (non-urgent). Urgent and chronic interventions such as stabilisation of fractures or long-term management of diabetes must be easily accessible (ie, delivered close to where people live). Interventions that are not time-constrained can be delivered by accumulating cases over time and space to improve quality and reduce costs. Examples include immunisation and cataract repair.

DCP3's cost analyses found that about 50–60% of the incremental costs of essential UHC and highest priority package interventions would be for interventions based in health centres, with about 25% of the costs for first-level hospitals and 10–20% for community-based interventions. About 40–50% of incremental costs would be for chronic interventions, with about 25–33% for urgent interventions and the remaining 25% for interventions that were time-bound. Compared with current spending patterns (especially in LICs), these costs would represent a substantial shift towards facility-based services, especially for chronic diseases (including NCDs, HIV, and tuberculosis) and injuries.

Beyond essential UHC, new interventions would ideally be incorporated on the basis of explicit criteria, such as those used in DCP3, perhaps guided by a national health technology assessment programme. Expanding the UHC benefits package itself could also be accompanied by structural reforms and new models of care that better address issues like multimorbidity and the needs of ageing populations. A crucial final point is that the delivery of UHC needs to be accompanied by measures that improve quality of care as well as population uptake of these interventions.[85](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[86](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

These measures are summarised briefly in DCP3's UHC chapter, and in detail throughout various chapters in the series.[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) DCP3 provides a comprehensive and specific set of normative recommendations on the contents of UHC health benefits packages in LICs and lower-MICs.[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The intention behind providing normative guidance is to establish a starting point for country-specific discussions rather than to prescribe specific actions. The model package was termed essential UHC, and consisted of 218 unique health interventions across five health sector delivery platforms ([panel 4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box4)). For this report, we adopted the DCP3 framing of health care delivery platforms and use the term PHC to denote the four platforms that serve as the first point of contact for most health needs: community platforms, health centres, first-level hospitals, and population-based health interventions. All but 20 of DCP3's 218 essential UHC interventions are delivered on PHC platforms, illustrating the high degree of overlap between essential UHC and PHC.

A major objective of UHC is to provide protection against the financial risks of seeking care. UHC initiatives in HICs with robust PHC systems tend to allocate large amounts of resources to acute and specialised (often tertiary-level) services, which could be major sources of financial risk in the absence of prepayment. These types of financial risk do exist in LICs and MICs, but the need for financial protection must be balanced against the high-value investments in PHC that are crucial to preventing acute illness or injury, and help to reduce a substantial amount of financial hardship in the first place. Relative to HICs, efficient pathways to UHC in LICs and MICs will probably emphasise essential PHC interventions that include first-level hospital care, rather than specialised and referral care. Essential UHC is DCP3's solution to balancing health gains and financial protection. An extended cost-effectiveness analysis[87](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) of health interventions in Ethiopia illustrates one potential analytic approach to making these trade-offs explicit.

For many LICs, even DCP3's essential UHC package will be challenging to implement, because of reduced governance capability and human capacity and financial limitations. DCP3 introduced the concept of a highest priority package, tailored to the health needs and resource limitations of very poor countries.[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Highest priority package interventions were extracted from the essential UHC list according to criteria derived from the final 2014 report of the WHO Consultative Group on Equity and Universal Health Coverage:[88](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) very good value for money, priority to the most disadvantaged, and high likelihood of providing financial protection. The highest priority package had 108 of DCP3's 218 recommended interventions for essential UHC. Its core was an updated version of the GH2035 grand convergence package, but it went substantially beyond GH2035 to include more interventions for adult infectious diseases, chronic NCDs, and injuries, as well as palliative care and pain relief. Although sparser in content, the highest priority package was designed to be catalytic and forward-thinking for the range of interventions that will be needed as LICs undergo epidemiological transition and their health systems become more advanced. Similar to essential UHC, most of the interventions in the highest priority package were based on PHC platforms.

To what extent could a concrete notion of UHC help countries reach the third SDG: “ensure healthy lives and promote well-being for all at all ages”? A modelling analysis of the essential UHC package and highest priority package in LICs and lower-MICs found that they both had potential for substantial progress towards achieving SDG 3. The analysis was framed within an overarching SDG 3 40 × 30 target of reducing premature mortality from all causes in people aged under 70 years by 40% by 2030.[29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Progress towards this target would depend on the extent of intervention coverage achievable by 2030 and ability to deliver high-quality care. If essential UHC could be extended to the whole population, and if interventions were delivered as well as what had been achieved in clinical trials, the 40 × 30 target could be reached ([appendix p 92](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). A 95% coverage of the essential UHC package would allow LICs and lower-MICs to reduce premature deaths from grand convergence conditions by two-thirds (preventing around 5·5 million deaths by 2030). Realistically, in the absence of considerable new investment to expand intervention access and improve quality, reductions in mortality from tuberculosis and the major NCDs would not be sufficient to meet specific SDG 3 targets, or overall targets such as the 40 × 30 target.

One clear conclusion from DCP3's analyses is that the technical effectiveness and efficiency of health interventions is only one factor involved in reaching SDG targets. Without simultaneously addressing systemic barriers, gaps, and bottlenecks, such a package of interventions would not translate into better health. A summary of common barriers to delivering essential UHC and PHC interventions is in the [appendix (pp 10–11)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1).

#### The importance of engaging other sectors in health policy

Another indispensable set of tools to achieve health for all are intersectoral policies. DCP3 provides a comprehensive set of recommendations for policies that are typically implemented by ministries other than ministries of health, and have the potential to provide substantial benefits to population health.[83](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

These policies might take the form of fiscal measures (eg, tobacco taxes), laws and regulations (eg, to increase air quality), changes to the built environment (eg, road safety measures), or information and education programmes (eg, about the nutrient content of food). The intersectoral policy agenda is especially relevant to SDGs that do not focus on health, as many of these specific policies also benefit targets in other sectors and SDGs. The [appendix (pp 12–14)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1) presents a detailed discussion of intersectoral policy priorities as summarised in DCP3.

We identified two major emerging themes within the intersectoral policy agenda: transformation of human diets and transformation of urban environments. These themes coincide with the ongoing need for greater progress on tobacco control in LICs and MICs.[74](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Controversy remains about the effect of dietary sugar, refined carbohydrates, fats, and proteins on the risk of obesity, cardiovascular disease, and selected cancers. Efforts to improve the relevant science base hold clear priority, given the major implications for health outcomes and the financial consequences of dietary choices for households. That said, several clear messages have emerged around the desirability of fruits and vegetables and the undesirability of added sugar ([appendix p 13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). A multifaceted and comprehensive approach to dietary risk will be required that includes implementation of taxes (especially on sugar-sweetened beverages) and removal of ineffective subsidies ([appendix pp 12–13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). The capacity for implementing fiscal policies will differ by country, but in many countries taxation of sugar-sweetened beverages would be an early priority, followed eventually by taxes on sugar. Some countries could also consider removing ineffective subsidies on agricultural commodities (eg, corn). A comprehensive approach would also include a variety of regulations on harmful additives, and bolstering of consumer education.

Similarly, rapidly developing urban environments have created a number of interrelated challenges, including polluted air, unsafe roads, and insufficient infrastructure to support physical activity and exercise.[48](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

In view of the health consequences that might follow, and the long-term threat of climate change, an important initial step required for all countries is to put in place fiscal and regulatory measures to reduce harmful levels of air pollution. In 2015, global subsidies (broadly defined) for fossil fuels were about 6·5% of global GDP.[89](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

A range of urban infrastructure reforms will likely be appropriate for different types of cities; however, the key element in any setting will be to systematically incorporate health considerations into urban planning and development.

Of course, a number of other important issues remain on the intersectoral agenda, many of which intersect with the two major emerging themes and with SDGs not related to health. For example, in addition to raising the risk of obesity, current global food systems result in environmental degradation, reductions in water availability and quality, and depletion of fish stocks, to name a few.[39](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Thus, ministries of health have an important part to play in advocating for “Health in All Policies” as part of sustainable development,[75](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) alongside achieving SDG 3 through PHC and essential UHC.

### Implications of essential universal health care for domestic health finance

A shift in health priorities towards the types of interventions summarised in this report will require strengthening of financing systems, mobilisation of additional domestic resources (or at least channelling of more resources towards the prioritised PHC package), and proactive steps to contain unproductive cost escalation. In the following section, we briefly review the state of domestic health financing worldwide and estimate the potential domestic resources for health during the grand convergence period. Then, we remark on some measures that can improve the fiscal sustainability of essential UHC and PHC. The [appendix (pp 15–19)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1) provides more detail on each of these issues.

#### Recent trends in domestic spending

In 2015, $7·3 trillion was spent on health worldwide, accounting for 7% of global GDP. Since 2000, the health sector of the global economy has grown at a faster rate annually (4%) than the overall global economy (2·8%), and in LICs and lower-MICs health sector growth has been even faster (6%).[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Growth in health spending has been primarily driven by increased domestic rather than external resources; external resources are only an important source of finance in LICs, where they represent 30% of current health expenditure.[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Yet LICs have generally decreased the allocation of domestic resources to health and have become even more reliant on ODA for health since 2000.[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

In our re-analysis of WHO's Global Health Expenditure Database, we break down trends in the growth of public expenditure on health (from domestic sources) and out-of-pocket spending by households ([appendix pp 64–65](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). Although a major objective of UHC is to reduce out-of-pocket spending, trends have been mixed across country groups, with more progress in MICs (although less so in India). As countries move forward with UHC, we strongly believe that they should clarify that their primary objective is to minimise financial barriers created by out-of-pocket spending on the publicly subsidised UHC package. The UHC package should be guaranteed for everyone, and poor people should be exempted from copayments. It will also be important for countries to minimise the share of public spending on interventions outside of the UHC package. To disincentivise its use, out-of-pocket spending could be redirected towards low-value, non-essential health interventions, although this must be done carefully to avoid increasing medical impoverishment from services for which the public perceives a need.

Another important recent trend is the lack of improvement in prioritisation of health sector spending in many countries. From 2000 to 2015, the percentage change in the ratio between public expenditure on health (from domestic sources) and general government expenditure—a measure of increasing prioritisation—was only weakly positive or even negative in most country groups, with China and sub-Saharan Africa reprioritising health to a greater extent than the other country groups ([appendix p 64](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). Nevertheless, insufficient economic growth and high amounts of debt in some countries might hinder prioritisation of health in sub-Saharan Africa. We note that although growth in health sector prioritisation might have been modest, some governments are prioritising health by investing in services outside of the health sector, such as water, sanitation, and hygiene. Intersectoral spending on measures that improve health is generally not reflected in national health accounts.

#### Mobilising resources for essential UHC

Many LICs and lower-MICs are currently underinvesting in essential health interventions, and slow growth in future health spending will likely create barriers to achieving grand convergence and the SDG 3 targets. We do not advocate for increased public expenditure on health overall, but rather for increased spending, through national UHC systems, on specific interventions that provide good value for money and improve health equity. This distinction is crucial to reassuring ministries of finance that additional resources will be spent well and will lead to substantial economic returns. But what sorts of resources might be required to finance this disciplined approach to UHC?

We updated DCP3's estimates of the cost of essential UHC and highest priority packages in LICs and lower-MICs, focusing on PHC-based interventions ([appendix p 16](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

[Figure 5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#fig5) shows incremental costs of priority health interventions by delivery platform and area of focus. The total annual cost (the sum of current spending and incremental costs) of essential PHC interventions across LICs and lower-MICs at 80% population coverage would be about $350 billion, or about $97 per capita on average (in 2016 US$). About $29 per capita in total would be spent annually on the grand convergence conditions and $68 per capita on other conditions, including other infectious diseases, NCDs, and injuries, and cross-cutting services like rehabilitation, surgery, and palliative care. Overall, most investments would be in health centres and for chronic health conditions that affect adults.

Can countries mobilise enough domestic resources to finance essential UHC in the coming decades? We projected domestic resources in 2035 under two scenarios ([appendix p 17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). The baseline scenario assumes that only GDP growth would generate additional resources. Domestic resources for health in 2035 would be about $20 per capita in fragile states, $30–40 per capita in India and sub-Saharan Africa, and $200–700 across China, Eurasia and the Mediterranean, and Latin America ([appendix p 66](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). The more optimistic scenario assumes that public spending on health from domestic resources as a share of GDP would grow by an additional 1% per year. In addition to the resources generated by GDP growth alone, this reprioritisation would provide about $5 more per capita in fragile states, $10 more per capita in India and sub-Saharan Africa, and $30–100 more per capita in China, Eurasia and the Mediterranean, and Latin America ([appendix p 66](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

Comparing these projections with essential UHC and highest priority package cost estimates suggests that essential UHC is currently affordable for most MICs, except for India. Most LICs, and sub-Saharan Africa as a region, are currently unable to afford the essential UHC package and even the more focused highest priority package (which could cost about $49 per capita on average). India might be able to afford the highest priority package by 2035, but only through a combination of economic growth and increased prioritisation. Many countries in sub-Saharan Africa (a number of which are also classified as fragile states) will continue to have difficulties financing even the highest priority package from domestic sources, unless their institutional and macroeconomic conditions improve substantially.

Our analysis implies that raising more revenue is the principal means of generating resources for the prioritised PHC package. Other analyses have noted additional measures that could be considered,[91](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) such as tackling inefficiencies in spending programmes that exist even in HICs. In some contexts, rationalisation of expenditures could release as many resources as those that would be gained from revenue increases in the coming years.[92](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Finally, although a variety of alternative and innovative financing sources have been explored in recent years,[93](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) evidence suggests that the approaches discussed here (macroeconomic growth, increased prioritisation, and increased efficiency) will provide the majority of new resources in most countries ([appendix p 17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).[91](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[93](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

#### Sustainable growth in health spending

This report has advocated for a UHC package comprised of interventions that provide good value for money, among other criteria. Yet even countries that use rational priority-setting processes struggle to contain growth in health spending. We briefly reflect on a few measures that can help ensure the sustainability of health financing and are likely to be important to LICs and MICs working towards UHC.

For many countries, collecting revenue is less challenging than pooling it effectively.[94](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

A key determinant of the success and sustainability of essential UHC will be the development and integration of risk pools—preferably, a single pool or a few large pools that allow for cross-subsidisation between wealthy and poor patients and between high-risk and low-risk patients.[95](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The demographic and epidemiological transitions that we reviewed in this report suggest that pre-emptive action should be taken in the design of risk pools, to mitigate risk selection and adverse selection problems that will naturally emerge as a result of a growing number of older, chronically ill individuals with multimorbidity ([appendix p 18](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

Aside from challenges in risk pooling, most countries moving towards UHC struggle to contain costs.[96](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The biggest problem is not the amount of spending on health overall, but the widespread spending on low-value care. The [appendix (pp 18–19)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1) summarises a few lessons from the informative but sparse literature on cost containment. In light of the growing concern over cost escalation in LICs and MICs, particularly in those that are early adopters of UHC, a priority area for research—funded through international collective action for health—is the study of cost containment measures for health systems in diverse demographic and epidemiological environments.

**The future of health ODA and international collective action for health**

### *Trends in donor funding for health*

A number of LICs and MICs are projected to experience substantial economic growth in the next two decades. These countries will increasingly be able to reduce their dependence on donor support and finance their health goals through domestic resources alone.

However, income projections also indicate that there will still be at least 25 LICs in 2026 that will need continued donor support. Additionally, emergency situations such as conflict and drought undermine progress in global health, with a disproportionate effect on the health of women and children. In 2017, 535 million children were living in countries affected by emergencies, conflict, and state fragility.[97](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Despite the continued need for donor funding, health ODA (plus funding from the Bill & Melinda Gates Foundation, which counts as private flows) has stagnated in recent years ([appendix p 93](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)). In 2016, donor funding for health amounted to $21·1 billion—the same as in 2013.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The sum does not include any private flows, except for the funding from the Gates Foundation. It therefore differs from the higher estimate of $37·4 billion provided by the Institute for Health Metrics and Evaluation in 2017.[98](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The institute's estimate contains additional funding beyond ODA, including private flows, other official flows, and debt repayments. This stagnation in health ODA potentially threatens a grand convergence in the poorest countries dependent on financial aid.

### Funding for international collective action for health

The transition of MICs out of health ODA in the coming years should be accompanied by a reallocation of ODA to areas where governments have natural incentives to underinvest. In 2013, the CIH argued that donors had been underinvesting in international collective action for health (global functions of health ODA that are characterised by their aim to address transnational challenges).[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Support for global functions is distinct from country-specific health ODA, which aims to tackle time-limited problems within individual countries that arise from constrained national capacity. A natural response of finance ministries to country-specific health ODA is to reduce domestic public finance—ie, money is often fungible.

The CIH has developed a taxonomy of international collective action for health with three categories: supplying global public goods (eg, generating and sharing knowledge); managing negative cross-border externalities (eg, preparing for pandemics); and fostering global health leadership and stewardship (eg, priority setting).[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

New analyses made in a Health Policy paper[41](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) as an extension to the analyses by the CIH found that about a fifth of all health ODA was directed to these three global functions in 2013 ([appendix p 94](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

### Supplying global public goods

#### Product development

In GH2035, we emphasised the pronounced effect technological progress has on health, and the need to invest in product development for neglected diseases, including HIV/AIDS, malaria, tuberculosis, pneumonia, diarrhoeal diseases, and neglected tropical diseases. Annual global spending from public, private, and philanthropic sources on product development for such diseases is about $3 billion.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

A new study from 2016 suggests the annual funding gap for advancing the current pipeline and developing crucial missing products is at least $1·5–2·8 billion over the next five years.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

This study also shows that the current pipeline of vaccine candidates is unlikely to lead to launches of highly efficacious vaccines for HIV, tuberculosis, malaria, and hepatitis C by 2030, although these tools could be game changers. For example, a 70% efficacious HIV vaccine could reduce new HIV infections by 44%.[99](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

As discussed previously, there is a particular need for additional investment in new tuberculosis products. Studies suggest that current funding might be sufficient for short-term success—for example, to develop a triage test and regimens for drug-resistant tuberculosis based on repurposed drugs.[100](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

However, the development of truly transformative treatments and prevention tools (eg, a test for incipient tuberculosis, or new vaccines) requires substantially more funding.[100](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Without new technologies, which would need to go hand-in-hand with improved quality of care, global tuberculosis targets will not be met. Furthermore, unless new technologies are quickly implemented and tested, the incentives for product developers will be greatly reduced.

#### Market shaping

Developing new technologies is crucial, but making them accessible to countries is just as important. Market shaping involves LICs, MICs, donors, and procurers using their purchasing power, financing, influence, and access to technical expertise to address the root causes of market shortcomings and influence markets for improved health outcomes.

Gavi, the Vaccine Alliance, is the main global funder of vaccines for LICs and lower-MICs. Gavi has transformed the market for vaccines through market shaping, pooling demand from countries, and guaranteeing long-term funding through country cofinancing and donor financing mechanisms. By 2017, for example, the price of the pentavalent vaccine dropped to a fifth of the price that was offered in 2001 ([panel 5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box5)). The percentage of LICs and MICs supported by Gavi that introduced rotavirus vaccines and pneumococcal conjugate vaccines is similar to the percentage of HICs that introduced these vaccines, and substantially higher than the percentage of MICs not supported by Gavi that introduced these vaccines.[101](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

**Panel 5**

**Market shaping by Gavi, the Vaccine Alliance**

Since Gavi, the Vaccine Alliance, was founded in 2000 it has worked with its partners, UNICEF and the Bill & Melinda Gates Foundation, to shape markets for new and underused vaccines. Before Gavi's founding, uncertain demand and funding provided weak incentives for manufacturers to expand capacity for existing vaccines and invest in new vaccines for low-income and middle-income countries. These barriers resulted in long delays between the introduction of new vaccines in industrialised countries and their introduction in the rest of the world. Market shaping by Gavi is intended to ensure an adequate and secure supply of high-quality vaccines, reduce vaccine prices to affordable and sustainable levels, and incentivise the development of suitable and high-quality vaccines and related products. Key elements of market shaping include the regular provision of demand forecasts as well as desired product characteristics (particularly to manufacturers in low-income and middle-income countries); the certainty of Gavi funding; pooled procurement by the UNICEF Supply Division for Gavi vaccines; and prequalification of specific products by WHO.

To date, one remarkable achievement has been made in the market for pentavalent DTP-HBV-Hib vaccines. Gavi has supported the introduction of pentavalent vaccines; Kenya was the first to introduce it in 2001, and South Sudan was the last of 73 countries to introduce the vaccine in 2014. As the demand and secured funding for pentavalent vaccines has grown, so have the number of manufacturers supplying this market. The price has fallen as well. The pentavalent vaccine had one supplier to the UNICEF Supply Division in 2001, offering the vaccine at US$3·50 per dose for Gavi-eligible countries. By 2017, there were five manufacturers supplying the vaccine to the UNICEF Supply Division, with the lowest price offered at $0·68 per dose—about 20% of the price offered in 2001. Furthermore, the benefits of this fall in price and excess production capacity now go beyond Gavi-eligible countries. The manufacturers will also supply the vaccine at these prices for any procurement through UNICEF Supply Division for the period 2017–19, regardless of whether the countries are supported by Gavi.

Market shaping is still in its infancy for improving access to NCD and palliative care products in LICs and MICs, although there have been some promising developments in recent years. One example is the Pan American Health Organization (PAHO) Strategic Fund, a pooled procurement mechanism that brings drug prices down by pooling demand and purchasing for several countries at the same time.[102](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Since 2013, countries in the Americas have been able to use the fund to purchase medicines for chronic cardiovascular and respiratory diseases, cancer, and diabetes.

#### Knowledge generation and sharing

Progress in global health is being hindered by a large delivery gap—the gap between our knowledge of evidence-based interventions and their actual delivery. The delivery gap is compounded by a technical gap in high burden countries, in which national planning and implementing bodies are often underfunded, resulting in reduced capacity to define health priorities, appraise and use scientific evidence, and plan and evaluate health programmes.[103](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The CIH argued that one of the most important roles for international collective action for health is helping to close the delivery gap by supporting population, policy, and implementation research (PPIR).[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

PPIR captures both the emerging field of implementation science and its sister domain, health policy and systems research. The goal of PPIR is to identify best practices and to facilitate their diffusion across countries. PPIR is a priority area for international collective action for health, but individual governments have few incentives to invest in knowledge-generating activities that have positive externalities.

Investments in PPIR are needed across many health areas. However, given the ongoing shifts in the global burden of disease, PPIR will be particularly important for NCDs. PPIR is a major focus of the Global Alliance for Chronic Diseases and the US National Heart, Lung, and Blood Institute's Center for Translation Research and Implementation Science. Global health donors—particularly those who currently do not support the implementation of NCD programmes—could fund PPIR for NCDs to find out which areas require priority health investments. Financing PPIR related to health systems quality and resilience will also be crucial.

### Managing negative cross-border externalities

#### Global health security

The 2014–16 Ebola outbreak in west Africa brought attention to the consequences of poor support for global functions, and how they relate to infectious disease control. There was no Ebola virus rapid diagnostic test, vaccine, or treatment, and regional surveillance capacity was weak. WHO was widely criticised for its lack of leadership, although it is important to consider that their budget is declining in real terms, and WHO leadership made the difficult decision to reallocate international resources to the larger problem of NCDs.[44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Such outbreaks are potential challenges to grand convergence, because they disproportionately affect the health of women and children, and they also disproportionately affect LICs, which are generally furthest from grand convergence.[104](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The greatest known risk to global health, aside from nuclear war, is a severe influenza pandemic. In the past 100 years, there have been four influenza pandemics of varying severity: the 1918 Spanish influenza with 50 million deaths, the 1957 Asian influenza with 1·5 million deaths, the 1968 Hong Kong influenza with 750 000 deaths, and the 2009 swine influenza with 18 000 laboratory-confirmed deaths by WHO (although others have suggested mortality was actually much higher).[105](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Global capacity to produce enough vaccines for a major influenza pandemic still falls short of the WHO goal of 10 billion doses per year, and maintaining such surge capacity is expensive.[106](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

A universal influenza vaccine that would provide long-term immunity against a range of influenza viruses is also required. Vaccine researchers believe that developing such a vaccine would take at least another decade. Estimates suggest that bringing a new influenza vaccine to launch costs at least $1 billion per year, with only a 5% chance of success at the start.[107](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

However, these costs are small compared with the expected annual health losses from a severe influenza pandemic,[69](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) and there is an unmet need for greater investment in influenza pandemic preparedness ([appendix p 7, 56](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).

Investments in disease surveillance systems are crucial for countries to avoid infectious disease outbreaks and ensure that these can be rapidly stopped if they do occur. The risk of outbreaks is increasing as a consequence of climate change, increased urbanisation, globalisation, and weak PHC systems, so investments to improve detection capability and emergency response capacity will be essential.

Managing cross-border externalities also involves tackling antimicrobial resistance, a large and growing threat.[108](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[109](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Common fatal infections are becoming resistant to treatment with first-line antibiotics. For example, drugs that had been used for decades to treat tuberculosis no longer work for 20% of patients in some countries. Likewise, in a number of settings where malaria is endemic, the parasite has become resistant to nearly all classes of drugs except for artemisinins. 2018 was also the first year an outbreak of extensively drug resistant typhoid occurred in Pakistan.[110](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Today, 700 000 people die from drug-resistant infections every year—a number that could increase in the absence of improved policy. In addition to the development of new antibiotics, vaccines, and point-of-care diagnostics, inappropriate use of existing antibiotics must be restricted. Developing global rules to curb the overuse of existing antibiotics to protect their efficacy will therefore be crucial.[111](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[112](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

#### Spread of unhealthy products across borders

The spread of commercial determinants of health across borders—encouraging consumption of tobacco, alcohol, and ultraprocessed foods and beverages—is an important driver of the rising global burden of cardiovascular disease and cancer.[113](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The growth of markets for junk food in LICs and MICs is largely unchecked. Curbing this international flow of risk factors for NCDs requires international collective action for health.

Growing evidence has shown the multiple strategies by which the multinational tobacco, alcohol, and processed food and beverage industries have expanded globally to rapidly penetrate LIC and MIC markets, in response to saturation of markets in HICs.[114](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[115](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Public health experts argue that public regulation of transnational companies is the best way to reduce the spread of these risk factors across borders. Public regulation strategies include restrictions on product marketing, taxation of products, and regulation of nutrition labelling.[116](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The WHO Framework Convention on Tobacco Control has succeeded in shaping global and national health policies, although implementation of these policies has been patchy in many countries and regions (eg, sub-Saharan Africa and China). Effective policies dictated by this convention include taxation, plain packaging, warning labels, and marketing restrictions. Experts have argued that WHO should replicate the model of the 2003 Framework Convention on Tobacco Control and convene a similar convention on healthy diets.[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

International collective action for health is also necessary to ensure both effective access to essential medicines for palliative care (including opioids for pain relief) and to prevent diversion and non-medical use of medicines,[47](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) a consequence of inadequate safeguards to minimise such diversion in HICs.

### Fostering global health leadership and stewardship

Exercising leadership and stewardship is crucial in facilitating negotiation and building consensus on health agendas and priorities. WHO has a unique leadership role within global health, through norm-setting and global consultative processes—a role built into its constitution ([appendix p 67](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1)).[117](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

WHO contributes to the development of health data and global knowledge sharing on health policies and practices. As part of its leadership and stewardship function, it also contributes to monitoring and accountability for results and resources.

However, although [WHO's income](http://www.who.int/about-us/planning-finance-and-accountability/financing-campaign) has more than doubled since 2000, this increase is almost entirely based on rising voluntary contributions, 95% of which were earmarked in 2017 for particular projects and programmes that had been chosen by the donor.[118](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

In WHO's 2018–2019 programme budget, voluntary contributions account for almost 80% of WHO's funding.[119](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

For example, polio eradication, humanitarian response plans and other appeals, tropical disease research, and human reproduction research are fully funded by voluntary contributions.[120](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Overall, the earmarking also results in serious underfunding of many WHO programmes, including those for NCDs and pandemic preparedness.

[118](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

The agency is struggling to fund its core functions, undermining its capacity to supply global public goods and other global functions, including the management of negative externalities.[121](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

A top priority for international collective action for health is to ensure that WHO and other UN agencies have access to funding that enables them to fully realise their unique role.

### How investments in international collective action for health help to address the middle-income dilemma

Although most poor people now live in pockets of poverty in MICs and face high mortality rates, these countries are regarded as too rich to qualify for health ODA, an issue termed the middle-income dilemma. Investments in international collective action for health might help solve this dilemma. Poor individuals in MICs will benefit from donor support for international collective action for health, including research and development, knowledge sharing, market shaping, and management of cross-border externalities. Countries such as China and India would benefit substantially from increased international efforts to control multidrug-resistant tuberculosis, and from market shaping to reduce drug prices. Other policies that would improve accessibility of products through affordable prices are pooled procurement mechanisms, revolving funds, procurement guarantees, and prequalification of certain products. WHO is already piloting pre-qualification for biosimilars of cancer treatments and insulin.[122](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Designing global procurement mechanisms in a way that allows MICs to benefit from them is crucial. MICs that are not eligible for support by Gavi often pay much higher prices for vaccines than countries supported by the partnership.[101](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

However, because of a healthy vaccine marketplace, MICs can purchase pentavalent vaccines for the reduced price from 2017 to 2019, regardless of whether they are supported by Gavi.

#### Aid substitution

Donor funding can lead to aid substitution or displacement (also known as fungibility), if a government that receives external support responds by reducing its own domestic financial contribution to the health sector. One study [123](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) found that for every dollar that LICs and MICs receive in development assistance for health, they remove $0·44 of their own domestic health spending, although other studies have found lower amounts of aid displacement. One additional advantage of supporting international collective action for health is that it is likely to be less fungible than direct country support, and might therefore be a more efficient way for support to reach poor individuals.

Although fungibility is troubling to donors, who ultimately wish to see an increase in domestic health spending by LICs and MICs, the long-term effects of substitution will ultimately depend on what happens to the displaced funds. The outcome is detrimental to development if the displaced funds end up paying for weapons, which is what happened in Uganda,[124](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) but helpful if the funds are used to fund girls' education, for example. Very little research has been done to find out which of these outcomes happens most often, although a recent case study in Tanzania

[125](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) found that “fungibility of external funds may not necessarily be detrimental to Tanzania's development (as evidence suggests the funds displaced may be reallocated to education)”.

### How much health official development assistance is required for international collective action for health?

GH2035 recommended a reorientation of health aid over time towards international collective action for health. Reallocation towards international collective action for health can be achieved by redirecting country-specific aid from countries experiencing substantial economic growth. Careful transition management will be required, especially given that every funder has policies on eligibility and transition. Country-specific aid will still be required for the countries in greatest need, many of which are in sub-Saharan Africa, including fragile countries and those suffering from conflict and natural disasters. In view of the emerging challenges, opportunities, and evidence presented in this report, we identified a number of potential investment priorities for international collective action for health in the coming years ([table 4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#tbl4)).

Overall, we estimate that at least $9·5 billion per year will be required for international collective action for health, roughly double the amount that is currently provided by donors for international collective action for health. An additional $3 billion per year is needed for product development for neglected diseases, with a focus on new tuberculosis drugs and vaccines. Alongside basic research, health ODA should be used to fund game-changing technologies that promise higher returns, and health technologies that are critically needed but have lower success rates at each phase of the development pipeline. One example of a funder supporting this kind of research is the Wellcome Trust's Leap Fund, a £250 million investment into early stage and high risk endeavours. The Commission on a Global Health Risk Framework for the Future [126](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) calculated that LICs and MICs need $3·4 billion per year to upgrade health systems to prevent infectious disease outbreaks. This could be a serious underestimate if pandemic preparedness were to require a substantial amount of new and dispersed investments in vaccine manufacturing capacity. Additionally, the activities of the Global Polio Eradication Initiative are estimated to cost about $1 billion annually.[127](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

WHO needs at least an additional $240 million annually; a financial estimate published by WHO in May, 2018, shows that the agency needs $14·1 billion to finance its 13th general programme of work (2019–2023).[128](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext),[129](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

This represents a $1·2 billion increase in funding over 5 years. $1·2 billion is needed for a pooled procurement mechanism for NCDs to expand the model tested by PAHO to other regions, like sub-Saharan Africa. Overall, additional funding for market shaping and pooled procurement mechanisms, such as Gavi, will be crucial. An additional $600 million is needed for PPIR and other knowledge generation and distribution activities.

Our estimate of $9·5 billion per year for international collective action for health does not include the costs of malaria eradication, which will be estimated by the new Lancet Commission on Malaria Eradication.[130](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Throughout this report, we have argued that resource constraints in the poorest countries threaten the achievement of a grand convergence. Thus, the future of ODA must include continued direct support to these countries. Implementing the grand convergence PHC interventions in DCP3's highest priority package at 95% coverage in LICs and lower-MICs by 2035 would require total annual spending of $27 per capita on average. Countries unable to mobilise and channel such resources will require direct support to reach grand convergence and related SDG 3 targets.

We acknowledge the highly tentative and approximate nature of the estimates we have made. We have chosen to be conservative in our estimates; there is little doubt that an investment in international collective action for health of $9·5 billion a year would yield high health and economic returns.

**Conclusions**

In GH2035, we concluded that substantial health gains could be achieved by 2035, through grand convergence, a sharp reduction in the incidence and consequences of NCDs, and with the promise of UHC. We were optimistic about the prospects for a transformation in the global health landscape within a generation.

This report reiterates GH2035's conclusion that the benefits of achieving better health can far outweigh the costs. Unfortunately, in this era of declining internationalism and reduced domestic prioritisation of health, some countries are not fully realising the benefits of investing in health. [Panel 6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#box6) gives as an example our estimate of the historical opportunities foregone in Nigeria.

**Panel 6**

**The value of increased life expectancy in Nigeria**

When assessing the value of public sector policies, the Organisation for Economic Co-operation and Development and the governments of many high-income countries apply standardised approaches to placing monetary value on small changes in mortality risk. These approaches were recently summarised by Robinson and colleagues,[131](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) and “Global health 2035: a world converging within a generation” (GH2035) used variants of these to estimate the value of increased life expectancy in low-income countries (LICs) and middle-income countries (MICs). The value of increased life expectancy has often been substantial in terms of increases in national income; GH2035 estimated that from 1990 to 2011, the annual value of the mortality decline in LICs and MICs was typically on the order of 1·5% of national income.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Using Nigeria as an example, we illustrate the opportunity for countries to attain major increases in national welfare through increases in life expectancy. The [appendix (p 83)](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext#sec1) shows estimates of life expectancy in Nigeria for the period 1990–2015 and compares Nigeria to Africa as a whole. Despite the interruption of the AIDS epidemic, estimated life expectancy in Africa increased from 51·7 to 62·4 years in this period, with an average annual rate of increase of 0·43 years per year between 1990 and 2015. Nigeria's life expectancy started at 45·9 years in 1990 and increased by only 0·33 years annually, so that by 2015 the difference in life expectancy between Nigeria and Africa had grown to 8·3 years from 5·8 in 1990.

What is a reasonable estimate of the monetary value of Nigeria's increase in life expectancy over this period? How much larger would that value have been if Nigeria had kept pace with the growth in life expectancy in Africa as a whole? GH2035 presented a method for calculating the answer to these questions that depends on the value of a small change in mortality, and how that value varies with age of death and national income. Few empirical estimates have been made of the value of mortality reduction and the extent to which this value changes with age, and different analysts make different assumptions in their estimates. Chang and colleagues [132](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) carefully assess the sensitivity of estimates made by GH2035 of the monetary value of mortality reduction. Robinson and colleagues [131](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext) provide major updates to the relevant literature from what was available to GH2035. In light of these updates, we believe that the value of a unit of mortality reduction is substantially smaller than what we estimated in 2013. Two-thirds of the value used in GH2035 would be a reasonable adjustment, but the exact value remains a subject for discussion and further research.

Nigeria's gross national income per capita grew at an average annual rate of 2·5% per year from 1990 to 2015, although substantially slower at the start of this period. After multiplying the value of a 1-year increase in life expectancy in sub-Saharan Africa presented in GH2035 by two-thirds, we estimated the value to be about 8·4% of national income.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Given that life expectancy in Nigeria was increasing at about 0·33 years per year, the associated value of the increase in life expectancy has averaged about 2·8% of income per year.

By any reasonable historical standard, Nigeria's life expectancy improved substantially between 1990 and 2015—hence, the high estimated value of mortality decline relative to growth in gross national income. The opportunities made available by modern medicine and public health were importantly realised, but at the same time, affordable policies could have led Nigeria to the better outcomes achieved elsewhere in Africa, so in that sense important opportunities were missed.

5 years on from GH2035, we are almost a quarter of the way towards the 2035 grand convergence target date. New data from 2010–16 have been encouraging in terms of progress, especially for global trends in child and HIV/AIDS mortality, but there are also areas of slow progess that are of great concern, including maternal mortality and tuberculosis mortality rates, and there has been grand divergence of progress on NCDs. However, the reasons we were optimistic in 2013 remain the same today. Many LICs and MICs are achieving astonishing improvements in health, through pathways that are feasible to replicate elsewhere. Countries in all regions and at all income levels, such as China, Ethiopia, Bangladesh, Mexico, and Thailand, have consistently made smart health investments and have helped to set global standards for the level of health that can be achieved at relatively modest cost.[133](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32389-4/fulltext)

Scientific innovation will continue to provide new health tools and methods of delivery. And economic growth in LICs and MICs, although less impressive today than 5 years ago, can go a long way in financing PHC. Achieving essential UHC and making “Health for All” a reality are options that remain open to all countries.

**The Lancet**

**Building the case for embedding global health security into universal health coverage: a proposal for a unified health system that includes public health**

**By: Ngozi A. Erondu, Jerry Martin, Robert Marten, Prof. Gorik Ooms, Robert Yates, Prof. David L. Heymann, et al.**

*20 October 2018*

**Summary**

In the wake of the recent west African Ebola epidemic, there is global consensus on the need for strong health systems; however, agreement is less apparent on effective mechanisms for establishing and maintaining these systems, particularly in resource-constrained settings and in the presence of multiple and sustained stresses (eg, conflict, famine, climate change, and globalisation). The construction of the International Health Regulations (2005) guidelines and the WHO health systems framework, has resulted in the separation of public health functions and health-care services, which are interdependent in actuality and must be integrated to ensure a continuous, unbroken national health system. By analysing efforts to strengthen health systems towards attaining universal health coverage and investments to improve global health security, we examine areas of overlap and offer recommendations for construction of a unified national health system that includes public health. One way towards achieving universal health coverage is to broaden the definition of a health system.

## Introduction

Following the Ebola outbreak in west Africa in 2013–16, several calls have been made for the strengthening of national health systems to prevent health system failures during public health emergencies.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Kluge and colleagues[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) provide an important demonstration of the need for strengthening of global health security by embedding International Health Regulations (IHR) core capacities into the functions of national health systems. The authors highlight the importance of resilient health systems for achieving the IHR (2005), and conclude with a call for more strategic investments towards resilient national health systems.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Similarly, WHO Director General Tedros Ghebreyesus wrote, “it is possible for all countries to achieve universal health coverage (UHC), including key public health interventions”.[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Both perspectives imply an expectation that global health security (GHS), as a result of achieving IHR core capacities and well functioning population-health services, should be an inherent part of the health system and, therefore, UHC. Both perspectives also highlight the tensions in trying to integrate distinct and separate systems that, in practice, result in distinct outcomes.

Although a 2015 Public Policy paper in The Lancet[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) reframed the concept of biosecurity from international epidemics and pandemic threats to fortification of both collective and individual health security through strong national public health capacities, GHS traditionally emphasises the role of health system capacities and technical areas in the prevention, detection, and response to emerging and re-emerging infections. Health system strengthening, on the other hand, is often conceptualised in the six building blocks of the WHO health system framework. To achieve the Sustainable Development Goals, and global confidence in what is needed for UHC, examination of existing health system policies is necessary as well as interrogation of the assumption that UHC, as it is currently defined, meaningfully incorporates GHS and prevention-focused interventions—in addition to the current primary focus on health services and access.

In this Health Policy paper, we review aspects of the health system as conceptualised in the GHS and UHC frameworks and explores the potential effects of current global policies and international funding on the ability of health systems in low-income countries (LICs) to serve and protect their citizens. We do this by first analysing the two concepts of UHC and GHS; second, we explore areas of potential coordination and outline specific components of a robust public health-integrated health system; third, we propose how to invest in and ensure sustainable national health systems; and fourth, we conclude by providing concrete recommendations for the next steps toward a unified health system. This Health Policy paper synthesises expert opinions from the Consultative Meeting on Public Health Solutions in a Post-Ebola World, held on July 12, 2017, in London, UK, evidence from scientific literature, policy analysis, and international discussions, and offers recommendations for global health policy and strategy development for a unified health system.

**The two systems for UHC and GHS**

Building on the successful effort against smallpox, in the 1950s and 60s, vertical disease control was the dominant policy in LICs and was advanced by international development aid. In 1978, the Alma-Ata Declaration introduced a horizontal health approach that we now know as primary health care. This new concept promoted comprehensive care, which challenged disease-specific solutions supported by bilateral initiatives, multilateral-funded programmes, and private corporation commodity and drug profits.[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Thus, a new distinction between clinical (primary care) and public health services emerged.

Closing primary care gaps, including prevention and health promotion, is the first step towards UHC progress.[8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

In practice most schemes to improve primary care access and UHC interventions focus more on personal health services and health insurance than infectious disease threats.[9](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Additionally, because of inadequate resources for the entire health system (ie, UHC and GHS) and political pressures (both domestic and international), countries often must choose where or how to invest limited resources. For example, a country might have to choose whether to increase lab capacity or make more nurses available for consultations. During the Ebola outbreak, this choice was evidenced in all three affected countries, as more people died from untreated malaria due to reduced health-care services and overburdened systems.[12](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

The WHO Health Systems Framework was developed to provide a model to capture the interlinked and complex nature of health systems.[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

The building blocks (ie, service delivery, health workforce, information, and medical products, vaccines, and technologies, as well as financing, leadership, and governance) approach to strengthening health systems is the means to achieve the UHC policy goal outlined in the 2010 WHO report.[14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Although Kluge and colleagues [5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) and others maintain that the framework reflects health system components, it is difficult to reconcile how in practice certain population-level services, including emergency preparedness (eg, surveillance, diagnostics, trust, and surge capacity) and health promotion activities (eg, screening, vaccination, and anti-smoking campaigns), are covered within these building blocks. The analysis by Kluge and colleagues[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) poses more questions and, although they emphasise that the two policies reinforce each other, they offer few details on the entirely different areas they occupy, which include different funders, actors, activities, and priorities.

The WHO framework for strengthening public health capacity, or the IHR, was established to boost global commitment to reducing the likelihood of outbreaks and reinforcing national health system functions that prevent, detect, and rapidly respond to public health risks and emergencies of international concern.[15](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

The assumption of this framework is that through eight core capacities (national legislation, policy and financing, coordination and National Focal Point communications, surveillance, response, preparedness, risk communication, human resources, and laboratory[16](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)) outbreaks can be prevented or detected in their early stages, thereby reinforcing GHS. However, the conspicuous absence in the IHR of curative services, patient management, and clinical surge capacity during outbreaks means it does not address treatment of patients up to recovery and effective containment and resolution of outbreaks and epidemics.

There is a need to go further than Kluge and colleagues'[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) proposal to review cross-cutting activities and areas of coordination between the two frameworks, and to completely dissect and reassemble what we call a health system, to address and repair current system failures that can affect both individual and population health.

**Towards one complementary system**

To improve integration of GHS and health systems objectives within UHC, areas of coordination as well as challenges, which have resulted in national health systems created in the wake of the division of UHC and GHS, must be highlighted. A more inclusive, unified health system would perhaps start to break down this division, including the underfinancing and separation of community health services. We argue that attaining UHC, with the explicit inclusion of population-level health services and emergency preparedness and response functions, will be the best way to contruct this proposed inclusive health system.

Whether these systems are two ends of one continuum or two distinct systems remains unclear, possibly due to the differing focus of stakeholders involved in personal health services and population-level health. The UHC lexicon (eg, service quality, patient-care, provider, and out-of-pocket payments) is notably different from that of GHS (eg, public health surveillance, detection, and response). The fact that UHC primarily deals with universal access to quality health services and protection from financial hardship has provided WHO and other policymakers with a very clear directive in developing programmes and initiatives towards achieving these aims (ie, improve access to care and increase financial protection).

However, in both frameworks, a few common concepts exist (though not consistently defined) that are often highlighted as crucial elements of optimal implementation. One example is the concept of increasing or equipping the health worker.[17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[18](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

The health systems building block human resources for health emphasises the national availability and capability of the entire health workforce that partakes in organisation and delivery of health services.[19](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

The IHR framework also targets human resource competency by focusing on strengthening the skills of public health personnel explicitly for sustaining public health surveillance and response.[20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

A thoughtful delineation of the inputs of these approaches, followed by selection of essential components for one definition, could provide useful instruction on how to strengthen and equip the health workforce to meet the needs for surge capacity during an outbreak as well as to provide quality health services for daily health care.

**Creating robust and sustainable national health systems**

Formulation of a broader, more comprehensive, and thus more secure national health system under UHC would protect and serve the health needs of a population. This national health system must, by design, have several levels of implementation (ie, from community to national administrative levels) and must be multisectoral. Partnerships and systems must understand shared risks and vulnerabilities, and ultimately have shared actions to respond to health events early, and be effective in stopping outbreaks, managing patients affected by outbreaks, and continuing to offer routine curative services to those in need. Countries must first build better internal collaborations within the health sector, starting with a more informed exchange between disease surveillance and disease-specific programmes. Multisectoral coordination through the One Health approach should be used in cases of suspected zoonotic disease outbreaks. Countries and their development partners must develop plans for the care of people with endemic infectious diseases and chronic communicable or non-communicable diseases during outbreaks and epidemics.[21](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[22](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Though a thoughtful and proactive approach to building and financing unified health systems between development partners and LICs is required, it is not the norm. The US National Academy of Medicine estimated that if global investments were directed in building systems that prevent outbreaks, the global economy could save 13 times more than what was spent to respond to emergencies in just one year,[23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) yet core and long-term investments to build and maintain health systems in poor countries remain inadequate. Although LICs need to raise domestic funding to (a minimum of) 5% of gross domestic product,[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) several analyses[25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[26](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[27](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) have shown that, to achieve UHC, overseas development aid is still necessary to fill the gap between government spending on health and the estimated minimum target spend of US$86 per capita per year. To sustain this newly proposed model for one national, public health-integrated health system, new funding strategies must be developed that include changes to local and international commitments. Donors must establish stable funding and core investments in accessible and robust health systems. Several nascent government overseas development aid programmes exist that include targeted investments to connect UHC and GHS, including the Tackling Deadly Diseases in Africa Programme from UK's Department for International Development, the Infectious Disease Detection and Surveillance project from the US Agency for International Development, the Public Health England IHR Strengthening Project, and the Fleming Fund program for antimicrobial resistance. The effects of these initiatives on health system-related outcomes must be monitored and measured against standardised indicators.

Furthermore, the process of unifying GHS and UHC and reforming the national health system could and should be driven by countries if they and their ministries of health can provide a health system development plan that gives due attention to health security. A plan that details how prevention, preparedness, and promotion activities could be incorporated to support health care delivery ought to be very difficult to bypass, even for donors who are primarily interested in health security. An example of country-led reform could be observed when reviewing how Ethiopia implemented a rapid scale-up of antiretroviral therapy in 2006. Adding HIV prevention activities (including a ten times increase in counselling and testing services) improved antiretroviral therapy coverage indicators and HIV knowledge in the population, improved diagnosis and treatment of tuberculosis, and increased childhood immunisation coverage, in addition to other system wide-effects. These positive health system effects were mostly attributed to task shifting prevention activities from physicians to health officers and health extension workers.[28](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

A similar health system advantage was found when Rwanda integrated HIV clinical services into their primary health care system. In this case, significant positive increases across preventive services (eg, reproductive health) occurred with no associated reduction in other health-care delivery services.[29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Moreover, as mentioned, LICs continue to allocate inadequate levels of domestic financing to both public heath functions and personal health services, reflecting a low political prioritisation of health.[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

An essential first step would be to look at health risks and resources and opportunities to unify health financing and planning from prevention to response. For example, the success of Thailand's efforts to reach universal health coverage (ie, practically 100% population coverage using three financial protection schemes)[31](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) has included progress in health promotion and prevention. As part of these reforms, an innovative tripartite financing mechanism has evolved to provide vital public health services. The first entity, ThaiHealth, is the predominant finance source for population-health activities and is funded by earmarked revenues from tobacco and alcohol taxes. The second, the National Health Security Office, is an independent public fund that purchases and provides service-based preventive and curative care through primary care units, is allocated 10% to 15% of the universal coverage capitation budget, and is also paid for through subdistrict insurance schemes. The third, the Ministry of Public Health, is the primary regulator and provider for public health and is funded through a fixed budget line from general taxes.[32](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Although this arrangement might not be practical in every country, and was not without challenges in Thailand, it does provide a real-life and innovative model for sourcing and pooling of funds focusing on UHC curative services that also finance public health activities. Most observers of this policy formulation attribute political commitment and community involvement as the key factors to achieving this end.[33](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

To guide needed investments, an in-depth risk mapping exercise should include a country-level discussion about the areas of shared risks between the ministries of human and animal health, planning, agriculture, and defence. The WHO Service Availability and Readiness Assessment (SARA) helps countries monitor the physical availability of health services and the capacity for the health sector to deliver health services. This widely used tool assists countries to annually measure the quantity and distribution of human and infrastructure resources. The preferred tool to assess a country's preparedness for an international understanding of GHS is the World Health Organisation's [Joint External Evaluation](https://www.jeealliance.org/global-health-security-and-ihr-implementation/joint-external-evaluation-jee/) (JEE) and, to date, 79 assessments have been completed. This tool aims to provide transparent [assessments](https://www.ghsagenda.org/assessments) of the progress towards achieving IHR through a collaborative process involving multiple stakeholders that assesses individual core capacities to prevent, detect, and respond to health threats. The JEE does not, however, examine health facilities for surge capacity or sustainability during outbreaks. The JEE is the starting point for an evidence-based, cross-sectoral national action plan for improving health security capacity.

The SARA and JEE are two tools with different aims which, if used together, could provide the health service and public health measures that enable a country to jointly serve and protect its population before, during, and after public health emergencies. Other tools with similar complementary emphases could provide a more comprehensive understanding of the readiness and strengths of a health system.

**Conclusions**

One way of achieving universal health coverage is to broaden the definition of health systems and health services. A unified health system should be able to prevent or control preventable outbreaks and epidemics while also providing affordable and accessible health services. We have provided insight on the current distinction between the IHR framework and the health system-strengthening framework. We have discussed how current global health policies and strategies sustain the inability to embrace a clear and unified health system in efforts towards a UHC that provides both individual and collective health security. We identified several places to start to redefine and reconstruct a more inclusive health system, including: (1) development of new models of overseas development aid and re-examination of means of funding that perpetuate the divided health system, (2) design of health development plans that include integration opportunities between prevention and health care delivery services, (3) development of innovative domestic finance strategies to fund public health activities, and (4) attainment of a comprehensive understanding of health system gaps by combining health security and health care delivery risk mapping and assessment tools. The remaining questions must now guide the development of strategies and policies for comprehensive investments in public health-integrated health care systems in LICs. The upcoming Lancet Commission on interactions between universal health coverage, health security, and health promotion will be important in reconciling and recovering the health system. This Commission will review the feasibility of certain recommendations in this Health Policy paper, especially exploring possible coordination between the JEE and SARA processes ([panel](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext#box1)).

**Panel**

**Recommendations for the next steps toward a unified health system**

* 1 We call for a new conceptualisation of a unified health system that incorporates International Health Regulations and public health functions within universal health coverage (UHC). We recommend a new, broader definition of health system within UHC, which includes more explicit references to providing population-level and preventive services, surveillance, disease detection, emergency response, and available surge capacity, as well as strong and resilient patient management for routine and endemic diseases before, during, and after outbreaks.
* 2 There must be a coordinated and renewed effort to strengthen the national health workforce in all countries, especially in low-income countries. Proactive measures to ensure an adequate health workforce for the future is needed and should include collaboration with ministries of education, finance, and planning to quantify population health needs and forecast future estimates for sufficient health staff. Institutions must support and reinforce policies and strategies that reduce the risk of infection for front-line health workers at all times.
* 3 It is time to map national risks and opportunities, to understand existing capacities, identify crucial gaps, and estimate associated costs. Assessment of risks extends to exploring models to broaden both local and global understanding of outbreak risks, using the results of mapping to create outbreak scenarios.
* 4 The Joint External Evaluation (JEE) and Service Availability and Readiness Assessment (SARA) should be reviewed for their utility in domestic and international health system performance appraisal for joint assessments. The JEE for global health security and SARA for strengthening of health systems could provide a truer reflection of country readiness and reactivity ability than we have now, thereby highlighting gaps and informing strategic investments and planning.
* 5 New funding strategies must be developed with changes to local and international commitments to sustain this new model for one national public health system. Low-income countries must raise domestic funding to 5% of gross domestic product[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext) and overseas development aid should cover the gap between this amount and health financing levels compatible with attaining universal health coverage (ie, around US$86 per capita per year).[25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext),[26](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32332-8/fulltext)

Donors must establish long-term and core investments in accessible and robust health systems that will be effective in decreasing the individual risks of daily health threats.

**The Lancet**

**Effectiveness and sustainability of a diagonal investment approach to strengthen the primary health-care system in Ethiopia Effectiveness and sustainability of a diagonal investment approach to strengthen the primary health-care system in Ethiopia**

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*20 October 2018*

**Summary**

Weakness of primary health-care (PHC) systems has represented a challenge to the achievement of the targets of disease control programmes (DCPs) despite the availability of substantial development assistance for health, in resource-poor settings. Since 2005, Ethiopia has embraced a diagonal investment approach to strengthen its PHC systems and concurrently scale up DCPs. This approach has led to a substantial improvement in PHC-system capacity that has contributed to increased coverage of DCPs and improved health status, although gaps in equity and quality in health services remain to be addressed. Since 2013, Ethiopia has had a decline in development assistance for health. Nevertheless, the Ethiopian Government has been able to compensate for this decline by increasing domestic resources. We argue that the diagonal investment approach can effectively strengthen PHC systems, achieve DCP targets, and sustain the gains. These goals can be achieved if a visionary and committed leadership coordinates its development partners and mobilises the local community, to ensure financial support to health services and improve population health. The lessons learnt from Ethiopia's efforts to improve its health services indicate that global-health initiatives should have a proactive and balanced investment approach to concurrently strengthen PHC systems, achieve programme targets, and sustain the gains, in resource-poor settings.

**Introduction**

The 1978 Declaration of Alma-Ata[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) advocated primary health care (PHC) as the main strategy to achieve the goal of health for all.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The principles underlying PHC systems continue to be recognised as essential to the achievement of universal health coverage (UHC).[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

However, the debate between advocates of comprehensive PHC approaches and those of more targeted strategies represents an ongoing challenge.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Some have argued that comprehensive PHC is too idealistic and expensive, and that UHC should be pursued with a more selective model that focuses on diseases with cost-effective interventions.[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

As a result, during the past two decades, there has been an increase in the number of disease control programmes (DCPs) and disease-specific global-health initiatives (GHIs) that leverage additional resources for targeted health interventions.[9](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Estimates suggest that The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), the President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank have contributed more than two-thirds of all development assistance for health (DAH) to prevent and control HIV/AIDS, tuberculosis, and malaria in resource-poor settings.[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Since 2005, GHIs have provided Ethiopia with substantial resources to support DCPs. However, the implementation of these DCPs was soon found to be compromised by underlying weaknesses in the Ethiopian health system, and the strategy of targeted funding was found to undermine efforts to strengthen the health system.[12](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Criticisms have also been raised by the global health community that weak health systems hinder progress towards DCP targets and that GHIs overburden already fragile health systems.[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Acknowledging these issues, key GHIs—ie, PEPFAR, The Global Fund, and Gavi, the Vaccine Alliance (Gavi)—have collaborated with other donors to increase their financial support towards health-systems strengthening,[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) in what has been called the diagonal investment approach.[14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[15](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

A diagonal investment approach is a proactive and balanced approach that concurrently strengthens PHC systems and scales up DCPs. The diagonal investment approach addresses the requirements of specific priorities while providing opportunities for strengthening health systems.[16](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[18](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The approach has been employed in Mexico, where specific intervention priorities (such as immunisation services) were used to drive improvements to the health system.[14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[15](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Other resource-poor countries, such as Rwanda and Malawi, have also benefited from this approach as HIV/AIDS investments have been channelled to strengthen health systems.[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[19](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**Key messages**

* Weak primary health-care (PHC) systems have hindered progress in meeting the targets of programmes in resource-poor settings
* Ethiopia has embraced a diagonal investment approach to strengthen its PHC systems and scale up disease control programmes (DCPs); this approach has led to increased PHC-system capacity and has improved programme coverage and health status
* Despite the decrease in development assistance for health, Ethiopia has sustained its financial support for health and has promoted PHC systems' capacity with increased domestic resources (such as public, private, and out-of-pocket funds)
* The lessons from Ethiopia have implications for future investments on DCPs so that effective, sustainable, and resilient PHC systems can be built to progressively realise universal health coverage in resource-poor settings

With this Review, we aim to present the experience of Ethiopia as a case study of how diagonal investments from key GHIs can be used to broaden funding effectiveness (ie, the degree to which the objectives of targeted and complementary health systems are achieved) and sustainability (ie, the ability to maintain achievements at the desired standard after the intervention is completed). Our manuscript combines a narrative review of both published and grey literature and a quantitative analysis of national programmes and health-account data from government offices and financial-disbursement data from GHIs.

**Advocacy for strengthening primary health-care systems in Ethiopia**

Ethiopia's health-service delivery is structured in a three-tier system: primary, secondary, and tertiary levels. The primary level is the most accessible service-delivery point, where basic health care is provided and managed ([panel](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#box1), [figure 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#fig1), and [appendix](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#sec1)).[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**Panel**

**Primary health-care units of Ethiopia**

Primary health-care (PHC) units comprise five satellite health posts, a referral health centre, and a primary hospital. A primary hospital provides inpatient and ambulatory services to an average population of 100 000. The primary hospital is also a referral centre for close health centres and a practical training centre for nurses and other paramedical professionals.[20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[21](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

A health centre provides both preventive and curative services to approximately 25 000 people,[22](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) accepts referrals from the five health posts, and offers training for health-extension workers. [24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The Health Extension Programme (HEP) is an innovative community-based programme to deliver preventive and promotive services and selected high-impact curative interventions at the community and household levels. This programme was introduced in 2003 to enhance PHC services, especially for the rural population.[26](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The HEP includes 17 packages under four main categories: hygiene and environmental sanitation, disease prevention and control, family health services, and health education and communication.[27](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

These are delivered at health posts at the village (locally called Kebele) level to an average 5000 people.[28](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The health-extension workers, who manage the health posts, report to health centres and village administrations. The HEP has substantially improved the knowledge, attitudes, and practices of rural people on hygiene, environmental sanitation, disease prevention, and family health.[29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Since 2005, the Ministry of Health (MOH) of Ethiopia has embraced the vision, committed to, and sustained the technical requirements for the establishment of strong PHC systems. To reconcile the divergence between DCPs and health systems, and to make DAH effective and sustainable, Ethiopia implemented a diagonal approach. Dr Tedros Adhanom Ghebreyesus, former minister of health of Ethiopia (2005–12), now director general of WHO, actively promoted PHC as the preferable way to extend health-service coverage. Dr Tedros argued that the weakness of health systems was one of the greatest challenges that would be addressed through strategic strengthening of PHC systems and a community-based Health Extension Programme ([HEP](http://www.uhep.jsi.com/)).[31](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

This advocacy led to a series of discussions with development partners, including The Global Fund, PEPFAR, Gavi, and others, which acknowledged that the country could not expand services from DCPs without strengthening the PHC system.

As a result, these GHIs have used a diagonal investment approach in Ethiopia.[17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Gavi introduced a health-systems support programme in 2007 to help countries expand immunisation services by addressing critical health-system constraints such as infrastructure, supply chain, human resources, and information systems.[32](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The Global Fund's 2008 institutional strategy reaffirmed its commitment to support country-led health-system strengthening initiatives.[33](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The commitment of GHIs and successive MOH administrations to strengthen the PHC system has been maintained. Subsequently, the MOH and its partners developed a policy document to coordinate GHIs for the implementation of the health-sector development plan. This document provides details about the one-plan, one-budget, and one-report model to successfully implement the plan. The creation of the Millennium Development Goals (MDGs, currently replaced by the Sustainable Development Goals [SDGs])[34](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)performance pool fund, based on the International Health Partnership Compact framework, formalised structures to enable direct contributions from donors into a pooled fund for health-systems strengthening. This fund has provided flexible resources for critical services with funding gaps at the PHC-unit level. The major contributors were the Department for International Development (43·9%), Gavi (20·1%), and the Netherlands Embassy (15·4%). The Global Fund and PEPFAR did not contribute to the pool.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**Health-care financing in Ethiopia**

Ethiopia's health sector is financed by multiple sources including the government treasury, bilateral and multilateral donors, household out-of-pocket expenditures, non-governmental organisations, and private and parastatal employers.[36](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Substantial resources have been mobilised from different GHIs, such as The Global Fund, Gavi, the US Government, and other sources. This increase in resources has resulted in a marked growth in total health expenditure, [35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[38](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) which has increased from US$357 million in 2000, to more than $2·4 billion in 2015 (ie, about seven times its initial value).[39](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The per-capita spending on health—which includes both domestic and external sources—increased from $4·1 in 1995–96, to $28·7 in 2013–14 (ie, about seven times its initial value), at an average annual growth rate of about 12% ([figure 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#fig2)).[40](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Most of the spending occurs at the PHC units, consistently with the effort to strengthen PHC systems.[41](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

In 2013–14, the PHC units received 54% of the total government recurrent expenditure, with 43% of the recurrent government health expenditure spent on health centres and health posts, and 26% of the recurrent government health expenditure spent on hospitals.[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

DAH is estimated to make up 73% of government expenditure on PHC.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The contributions from GHIs increased from 16% of the total health expenditure in 1995, to 50% of the total health expenditure in 2010. PEPFAR, The Global Fund, and Gavi have been the major contributors to the health sector. PEPFAR donated $2·75 billion between 2007 and 2017, The Global Fund donated $2 billion between 2003 and 2018 (which represents an average of 13·5% of the total health expenditure per annum and peaked at 20% of the total health expenditure in 2010), [44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) and Gavi donated $940 million between 2000 and 2018.[45](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

These GHIs focus on reducing the burden of HIV, malaria, and tuberculosis, ensuring the availability of essential PHC services, and achieving key MDGs. The largest donors to Ethiopia's HIV response are PEPFAR (51%) and The Global Fund (26%). The Global Fund is the largest contributor to the malaria programme (41%), and the US President's Malaria Initiative contributes 27%. Close to 24% of the tuberculosis programme is financed by The Global Fund and 18% by the US Government.[46](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**Strengthening the primary health-care systems in Ethiopia**

Ethiopia has been designing and implementing several reforms, such as the business-process re-engineering (ie, analysis and renewed design of workflows and structures).[47](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

These reforms have resulted in the development of system-wide strategies: the Pharmaceutical Logistic Master Plan, the Laboratory Master Plan, the Health-Management Information Reform Scale-Up, the Health-Sector Financing Reform and Health Insurance, the Human Resource For Health (HRH) strategy, and second-generation HEP.[48](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

These reforms and initiatives have also been accompanied by strategic investments to strengthen the PHC system and expand access to health services.

The Global Fund, PEPFAR, and Gavi have contributed substantially to the development of the PHC systems. For instance, Gavi has invested $254 million (27% of its total support to Ethiopia) on non-vaccine activities (such as cold-chain equipment, injection safety, and health systems) between 2002 and 2018. This donation included $173 million (18·4% of the total Gavi support to Ethiopia) spent on health-systems strengthening between 2007 and 2018, which was largely focused on the construction of PHC facilities, strengthening of the supply chain and laboratory management, and training PHC staff.[45](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

One-third of The Global Fund investments has also been calculated to have been used to support health systems in the period leading up to 2018.[50](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext), [51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

In 2015, the Government of Ethiopia and The Global Fund signed a 3-year grant of of $551 million, to strengthen health systems, including supply-chain management, data systems, and training of PHC workers.[52](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

As a result, Ethiopia has made substantial improvements to its health infrastructure, which include the construction and renovation of more than 250 hospitals, 3000 health centres, and 12 000 health posts between 2003 and 2016. Subsequently, the total number of health centres increased from 519 in 2004, to 3727 in 2016, and the total number of health posts increased from 2899 in 2004 to 16 480 in 2016. The total number of hospitals also increased from 146 in 2004 to 394 (more than 60% of them are primary hospitals) in 2016.[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Ethiopia also used the support from PEPFAR to develop its laboratory system (for example, a national reference laboratory and six regional reference laboratories were constructed).[53](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[54](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Some of these regional laboratories have now evolved into fully operational regional public-health institutes.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[55](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Staffing the increased PHC infrastructure has been a challenge in Ethiopia.[56](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[57](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The World Health Report 2006 [58](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) estimated that Ethiopia had a collective density of doctors, nurses, and midwives of 0·25 per 1000 citizens. The country has been implementing a flooding strategy to address its HRH gaps since 2008, which consists in increasing exponentially the number of training facilities and setting ambitious targets for health graduates to ensure an excess of HRH that will not be offset by attrition.[59](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[60](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

In the past decade, the government has allocated up to 4·6% of its GDP on education, which has caused a marked increase in training and education.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The number of graduates from higher education institutions has increased from 1041 in 2000, to 16 017 (16 times the initial number) in 2013.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

PEPFAR, through its Medical Education Partnership Initiative, has contributed to these developments. [61](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The Global Fund and PEFAR have supported the training of health extension workers and the implementation of the HEP.[44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[52](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

As a result, the HRH density has increased from 0·25 per 1000 people in 2006, to 1·3 per 1000 people in 2013.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Logistics and supply chain were recognised as bottlenecks for scaling up PHC services. Therefore, the MOH developed a Pharmaceutical Logistics Master Plan, which led to the establishment of the Pharmaceuticals Fund and Supply Agency in 2008. This agency became the sole purchaser and distributor of health commodities. [55](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The Global Fund supports the construction of warehouses, the purchase and maintenance of trucks, and the procurement of laboratory and diagnostic equipment that can benefit the entire health system.[44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The agency's annual distribution capacity increased to six times its initial value between 2010 and 2015. The completion of 17 modern warehouses increased the national storage capacity from 46 260 m3to 531 000 m3, and the cold-chain storage capacity from 50 m3 to 800 m3. A 2014 national survey indicated that the availability of essential tracer medicines at health facilities increased from 65% in 2006, to 89% in 2014. [24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext), [62](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[63](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Ethiopia has upgraded its Health Management Information System, which has been used by the government as a major source of information for decision making since 2008. One of the achievements of this initiative is the introduction of family folders, which provides a great opportunity to strengthen evidence-based planning and service delivery, and establishes the base for vital events registration in the country.[64](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Institutes financed by PEPFAR, such as Tulane University and John Snow, Inc, have supported this national endeavour.[65](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Involvement and empowerment of communities has been the major driver of PHC improvement in Ethiopia. Community engagement has increased considerably since 2003, when the HEP was launched, and has been further enhanced by the initiatives of the Health Development Army.[66](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The Global Fund, PEPFAR, and Gavi have been supporting these initiatives,[44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[45](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[52](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) which have played a pivotal role in improving accesses to essential health services.[30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

This support has also enabled the health sector to mobilise resources from communities, both in kind and in cash, for the construction of health posts, improvement of environmental health, and other activities.[67](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**Improved health status in Ethiopia**

Enhanced PHC-system capacity through increased and strategic investment, which have accompanied the health-reform initiatives, has substantially improved service coverage and health status in Ethiopia.[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Given that the MDGs were effective proxies for essential PHC services, Ethiopia achieved most of the health-related MDGs, with a 67% reduction in mortality of children younger than 5 years, a 71% decline in maternal mortality ratio, and a greater than 50% decrease in mortality due to malaria, tuberculosis, and HIV from its 1990 baseline.[69](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[70](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Coverage of PHC services and health outcomes have consistently improved between 2000 and 2015, but underwent the most pronounced change since 2010, as improvements in health-systems capacity reached critical mass ([table](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#tbl1)).[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[69](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext), [72](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[73](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Even though it might not be possible to establish a causal link between PHC-system strengthening and health-status improvements, there is evidence of temporal association between the two: access to services and their use have progressively increased in the country since its PHC-service capacity started to improve.[74](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[75](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[76](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[77](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[78](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[79](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[80](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Moreover, progress accelerated after 2005, when the annual rate of reduction in mortality of children younger than 5 years increased from 3·3% in 1990–2005, to 7·8% in 2005–13.[72](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

However, it is important to note that the improved PHC-service capacity has benefited only strong vertical programmes, but not weaker ones, such as the non-communicable diseases programmes.[81](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Furthermore, we acknowledge that the improvements in health status are also partly due to progress in the socioeconomic status in the country.[70](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Despite these successes, Ethiopia still faces challenges to achieve equity and offer quality services in health, which need to be addressed within the SDGs framework. Towards this objective, the country has developed a health transformation plan that aims to sustain the gains achieved through the MDGs and address the equity and quality gaps. The leadership, once again, has recognised that further transformation of the PHC system is fundamental to sustain the gains and achieve UHC.[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**Decreasing development assistance for health in Ethiopia**

Ethiopia is now experiencing a decline in DAH ([figure 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#fig3)). The share of DAH for the total health expenditure has also decreased from 50% in 2010–11, to 36% in 2013–14.[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

This decline is substantial, since the cuts in funding from The Global Fund (which contributes 59% of the total DAH) and PEPFAR (which contributes 30% of the total DAH) have resulted in a combined decrease of total funding of almost 50%.[82](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[83](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The national health accounts [42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) indicate that the resources for HIV/AIDS decreased from 20% of the total health expenditure in 2007–08, to 10% of the total health expenditure in 2013–14, because of the decline in the DAH contributions (particularly from PEPFAR and The Global Fund), which decreased from 86% of HIV/AIDS funding in 2007–08, to 20% in 2013–14. The funding from PEPFAR declined from $894 million in 2007–09, to $710 million in 2013–15.[82](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[84](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The support from Gavi has also started to decline since 2015 ([figure 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#fig3)).[45](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The rapidly decreasing assistance from PEPFAR and The Global Fund has mainly affected the supply-chain and laboratory system, the functioning of the AIDS resource centre, the HIV/AIDS advanced clinical monitoring systems, and mentorship activities, and has caused qualified staff, both internal and external, to leave the country.[85](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

These effects could have implications for quality of care. For example, commodities for the laboratory programme have declined to the point that some services (such as clinical chemistry) have become unavailable to people living with HIV/AIDS and the public. Activities such as laboratory quality assurance and specimen referral are downsizing. Quality assurance for HIV rapid testing can only be implemented in 54% of HIV testing points. The specimen-transportation service has decreased by more than 45%.[86](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

MOH personnel and external analysts have become seriously concerned that the decline in DAH and technical support will affect the continuity of service delivery and compromise the gains already achieved.[82](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Others, such as PEPFAR, contend that Ethiopia can substantially support further development of its PHC services, regardless of reduced external support.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

In light of these critiques, we analyse any available evidence of sustainability of the investments made thus far and we identify the most vulnerable areas of progress, as the country is facing a decrease in support from its major global-health partners.

**Sustaining the gains from investments by GHIs in Ethiopia**

Ethiopia has visibly stronger health systems now than a decade ago. The remarkable progress that has been made can be identified, in particular, in the increased number of PHC facilities and HRH, the improvements to the supply-chain management, and the decentralisation of services.[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Furthermore, programme activities have been transferred from PEPFAR to local authorities smoothly, so that continuity of care will not be compromised.[87](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[88](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

This successful transition was possible because of the increased number and capacity of health workers in the PHC system.[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Other factors have also contributed to sustain the PHC systems. The per-capita health expenditure and the total health expenditure have continued to increase even after the drop in DAH since 2010–11 ([figure 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext#fig1)).[39](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The share of the total health expenditure coming from domestic sources (which include public, private, and out-of-pocket funds) has increased substantially, from about 50% of the total health expenditure in 2010–11, to almost 64% in 2013–14. Government spending on health increased substantially (to 257% its initial value), as did its contribution to the total health expenditure, which increased from 16% to 30% between 2010–11 and 2013–14. Health spending increased from 4·5% of general government expenditure in 2007–08, to 6·7% in 2013–14.[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Household out-of-pocket spending is also a major source of financing for health. It has almost doubled in absolute terms, but its contribution to the total health expenditure has remained essentially the same, decreasing only slightly from 34·0% in 2010–11, to 33·0% in 2013–14.[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The substantial increase in domestic financing and its share of overall spending on health is encouraging; however, the excessive out-of-pocket spending on health is a real concern because it precludes the country from gradual progression towards UHC. The introduction of community-based health insurance and social health insurance is designed to address the challenge of high out-of-pocket spending during use of health services.[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[89](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

To achieve UHC, the country needs to accelerate the implementation of initiatives for health insurance, while also advocating for increased allocation of funds from public-sector budgets and development partners to the PHC system.[90](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

A projection model that was used to estimate Ethiopia's ability to finance its PHC system indicated that the country can substantially support further development of PHC services even if external support is decreasing.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

The projection shows that the increasing out-of-pocket payments represent a challenge of concern. The possibility of addressing this concern will largely depend on substantial economic growth, increased mobilisation of government funding for PHC, and efficient use of resources. [43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

Finally, we would like to underline that health-development initiatives in Ethiopia have benefited from socioeconomic development, peace, and stability in the country. However, we currently observe that there are instabilities that might compromise the gains achieved thus far. The political turmoil in the country, which has been ongoing since 2015, might challenge the financial support to the health system, the ability to retain the health workforce, the distribution of supplies to health facilities, and the overall possibility of providing health services. Hence, the country's pursuit of UHC and SDG 3 (ie, “ensure healthy lives and promote wellbeing for all at all ages”) [91](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext) is at risk again.[92](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

To face this risk, all concerned bodies need to fundamentally rethink every action and weigh their benefits and drawbacks toward democratisation, social justice, and economic equity.

**Conclusions**

A diagonal investment approach has enabled Ethiopia to attain both short-term goals (ie, MDGs 4, 5, and 6) and long-term goals (ie, strengthened PHC system). [70](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

It is commendable that the government is responding to a decrease in DAH with additional domestic resources, which are essential to sustain the gains that have been achieved in health development. However, achieving UHC necessitates greater and more consistent political awareness and commitment than has been displayed thus far, increased government expenditure, and reduced out-of-pocket payments. The reduction of out-of-pocket expense, moreover, requires overall socioeconomic development, which includes the achievement of social justice and peace in the country. The lessons learnt from Ethiopia's efforts to improve the country's health services can affect future investments on DCPs that already exist, are emerging, or are re-emerging, and thus help countries to build effective, sustainable, and resilient PHC systems towards a progressive achievement of UHC. [50](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext),[93](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32215-3/fulltext)

**The Lancet**

**How primary health care can make universal health coverage a reality, ensure health lives, and promote wellbeing for all**

**By: David A. Watkins, Prof. Gavin Yamey, Marco Schäferhoff, Olusoji Adeyi, Prof. George Alleyne, Prof. Ala Alwan, et al.**

*20 October 2018*

40 years on from the Declaration of Alma-Ata in 1978, [1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext) primary health care (PHC) is at a defining moment. Progress in the uptake of PHC across the world has contributed to raising global standards of health care and improving health, including a revolution in child survival and dramatic improvements in life expectancy. However, we are still far from addressing the determinants of health and the growing health needs of the 21st century and from realising a vision for health supported by health systems oriented around PHC.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

The Declaration of Alma-Ata, widely perceived as the birth certificate of the global movement for PHC, made three fundamental contributions. It affirmed the commitment of governments, WHO, UNICEF, and major global health actors to the fundamental values of solidarity around health as a human right. The declaration presented a shared definition of PHC and a vision for the PHC orientation of health systems; it set out the aims, activities, and core responsibilities of PHC providers and services, and emphasised people's right and duty to participate in the planning and implementation of their own care, thereby providing a framework for the redesign of health systems around PHC. Just as importantly, the Declaration of Alma-Ata was supported by a conference report and a joint report by WHO and UNICEF on how PHC could be operationalised through national strategies.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

The combined effect was to place PHC prominently on the global political agenda for the first time, shaping subsequent multilateral action and cooperation across the world.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

Countries that adopted PHC have enjoyed rapid improvement in the health of their populations and, in many cases, have made social and economic progress that outstripped countries with weak PHC.[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

However, the boldness and ambition of the Declaration of Alma-Ata, along with global political trends, were partly responsible for efforts to maximise immediate impact through an emphasis on selective interventions, an approach that has ultimately undermined progress.[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

Although inevitably appealing, this selective approach compromised the comprehensiveness of the PHC orientation of the Alma-Ata vision, and has contributed to the fragmentation of efforts and delivery systems resulting in inefficiency, waste, and rising out-of-pocket health expenditures. By focusing on single diseases, selective PHC reinforced health systems built on targeted programmes, specialists, and, in many settings, hospitals that rely on intensive use of medical technology. This approach contributed to overestimating the benefits of efforts to cure rather than to prevent disease or to promote health.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

An absence of consistent political commitment also resulted in insufficient intersectoral engagement, ineffective community participation, inadequate funding, unregulated commercialisation, and suboptimal use of evidence-based policies and local data to direct priorities, assess progress, and ensure quality and safety. Ultimately, these factors have acted together to impair access to essential health care, and leave health needs and inequities unaddressed.

Against this backdrop, the new Declaration of Astana can provide the impetus needed for health systems to confront existing challenges afresh and overcome barriers to the design, development, and implementation of PHC that is fit for purpose.[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

To strengthen commitment and maximise the chances of success, the Declaration of Astana can place PHC firmly in the context of current political, socioeconomic, and health systems. The new declaration should recognise the challenges that threaten countries' efforts to achieve sustainable development: ageing populations, unhealthy environments and lifestyles, epidemics, health emergencies, climate change, and migration and internal displacement due to poverty, environmental disasters, violence, and war.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

The Declaration of Astana provides an important opportunity to communicate four key inter-related messages. First, support for PHC is rooted in core values and knowledge accumulated over the past 40 years. A renewed impetus for PHC is the pathway to reach the Sustainable Development Goals and universal health coverage.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32482-6/fulltext)

Acknowledging that health makes a substantial contribution to global and national socioeconomic development means making affordable, high-quality health care a reality in a way that is responsive to the needs of empowered people. Global health partners will need to invest in PHC for health as a global priority and for sustainable health systems. This work cannot be achieved without coordinated multisectoral action across government, non-government, and private sectors.

Second, efforts to reinvigorate PHC are more likely to succeed than in the past. The alignment of renewed political will with improved knowledge about health systems, and the availability of accessible information and communication technologies, with a clear focus on the population served and the health professionals tasked with PHC delivery, offers an opportunity that cannot be missed.

Third, key measures are needed to make firm progress towards the PHC vision that revolve around the three main components of PHC: the delivery of comprehensive integrated care centred on strong and high-quality primary care services and supported by essential public health functions across the lifecourse and through early action along disease trajectories and care pathways; evidence-based public policies and actions across all sectors to address the multifactorial determinants of health; and the empowerment of people, families, and communities so that they can take control of their own health and health care. For true action on PHC, bold policies are needed that enable people, families, and communities to acquire the skills and resources needed to take care of their own health and the health of those for whom they care. In turn, strengthening PHC and essential public health functions will rely on improving capacity and infrastructure, including workforce, especially at the frontlines. All these efforts should be underpinned by high standards of accessibility, comprehensiveness, continuity, and coordination that prioritise health promotion and disease prevention and support research. At a national level, evidence-based policies, strategies, and plans should be aligned across sectors to ensure coherence and consistency. There must be effective mechanisms in place to hold decision makers accountable for results.

Finally, success will demand all stakeholders to join a concerted effort. The relevant partners include governments; WHO and UNICEF; other UN agencies; bilateral and multilateral funds, alliances, and donors; other international organisations; the private sector; health professionals; academia; and other partners, such as patients' advocacy groups, community-based organisations, youth organisations, social and community workers' groups, faith-based organisations, and funding agencies. All people, countries, and organisations should be encouraged to join and support this movement.

For this commitment to be credible and actionable, an operational framework is needed to support this renewed vision. This framework, based on lessons learned from the past, should cover a range of key areas, including: political commitment and leadership; policy frameworks, governance, and accountability structures; funding and allocation of resources; participation; models of care; high-quality and safe care delivery; private sector engagement; workforce; infrastructure and technologies; information and communication technology; purchasing and payment systems; research; and monitoring and evaluation.

The vision in the Declaration of Astana should be about health and wellbeing for all, leaving no one behind, centred on PHC as reframed for the 21st century, and acknowledging past successes and failures. This vision needs to set out a clear set of principles and measures to move towards these goals and calls for partners to be resolute in implementing them.

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**The Lancet**

**Primary health care and universal health coverage: competing discourses?**

**By: Peter S. Hill**

*20 October 2018*

In October, 2018, WHO celebrates 40 years since the International Conference on Primary Health Care (PHC) and offers a renewed vision of PHC—building on, but not replacing, the Declaration of Alma-Ata.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

In those four decades, PHC has faced challenges. Undermined early by the divisive selective-comprehensive debate, PHC was marginalised by structural adjustment and sectoral reforms in the 1990s.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

PHC was, however, acknowledged in the World Health Report 2000 Health Systems: Improving Performance as a precursor of the new universalism: “high quality delivery of essential health care, defined mostly by the criterion of cost-effectiveness, for everyone, rather than all possible care for the whole population or only the simplest and most basic care for the poor”.[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

The essential values of PHC—social justice and the right to better health for all, participation, and solidarity [1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext) —have endured. They were rearticulated in World Health Report 2008 Primary Health Care: Now More Than Ever in interconnected reforms that addressed the gaps between the promise of PHC and its delivery: universal access and social protection through universal coverage; people-centred, responsive, integrated service delivery; health policy across all sectors; and inclusive, participatory, accountable leadership.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

Those universal coverage reforms became the theme of the World Health Report 2010 Health Systems Financing: the Path to Universal Coverage,[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext) echoing earlier references in the 2005 World Health Assembly Resolution that argued access to health should not risk financial hardship.[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

The economic emphasis of universal health coverage (UHC) on domestic financial strategies would shape early perceptions that conflated it with social health insurance[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext) and raised concerns over its potential vulnerability to political and financial pressure and the privileging of clinical interventions over public health strategies.[8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

Despite this, former WHO Director-General Margaret Chan advocated for UHC and secured its inclusion as a target in the Sustainable Development Goals (SDGs).[9](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

Given the rhetorical importance of UHC to WHO's global health leadership, does the resurrection of PHC threaten this investment? The development of UHC as a target in the SDGs has redefined UHC in ways that point to its conceptual origins in PHC. The context has changed: the progress under the Millennium Development Goals built on PHC foundations, and the active involvement of civil society at Alma-Ata has now expanded to engage the private sector and philanthropy. But universality is a persisting theme, and the comprehensive scope of the SDGs locates UHC in the multisectoral vision of PHC and its essential components.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

Gorik Ooms and colleagues[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext) argue for UHC as the embodiment of the right to health, the reference frame for PHC.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

The assessment matrix for monitoring UHC expands on the Alma-Ata essentials—family planning and maternal and child health care, immunisation coverage, food and nutrition, water and sanitation, prevention and treatment of common and endemic diseases, and the provision of essential drugs [1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext) —to include tobacco control, antiretroviral coverage for HIV, prevention of neglected tropical diseases, management of hypertension and diabetes, cataract interventions, and indicators of financial protection.[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30699-8/fulltext)

And in the final configuration of SDG3.8, the three dimensions of UHC have been supplemented with an emphasis on access to services and essential medicines, reiterating PHC core values.

There is clear conceptual overlap, as expected from frameworks that have co-evolved. But the synergies between PHC and UHC are what should be celebrated at the 40th anniversary Global Conference on Primary Health Care in Astana, Kazakhstan, with UHC operationalising the progressive realisation of the PHC vision and the right to health.

**The Lancet**

**Primary health care for the 21st century, universal health coverage, and the Sustainable Development Goals**

**By: Tedros Adhanom Ghebreyesus, Henrietta Fore, Yelzhan Birtanov and Zsuzsanna Jakab**

*20 October 2018*

Good health and wellbeing are fundamental to the prosperity of societies. By many measures, modern humanity enjoys better health than earlier generations.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site)

But the benefits of modern health care are not accessible to all. Even as the incidence of infectious diseases such as HIV, tuberculosis, and malaria are reduced, many countries struggle to cope with the growing burden of non-communicable diseases, and the complex and growing health needs of ageing populations.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site),[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site)

The Declaration of Alma-Ata in 1978 [4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site) was the first international call for primary health care as the main strategy for achieving universal health coverage, otherwise known as “health for all”. Guided by its values of equity, solidarity, and social justice, signatories to the Declaration of Alma-Ata agreed that all people in all countries have a fundamental right to health, and that governments are responsible for upholding that right. [4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site)

The vision of the Declaration of Alma-Ata was to change how we think about health and move away from hospitals, professionals, and disease, and towards a recognition that health is not only about illness and services but also about the social, economic, and environmental factors that affect the health of individuals and populations. Thought about this way, health services are designed and delivered in response to the expressed needs and expectations of individuals and communities, and are easily accessible where people live and work.

40 years later, that vision has gone largely unfulfilled. Realisation of the vision and values set forth in the Declaration of Alma-Ata has been hampered by inadequate political leadership and circumstances beyond the health sector (eg, economic crises and political instability) and within the health sector (eg, global epidemics, vertical disease-specific approaches, unregulated private health care, and overinvestment in specialised curative care).

The 40th anniversary of the Declaration of Alma-Ata is a time to reaffirm the principles of the original declaration and underline the importance of primary health care for achieving health and wellbeing for all. The anniversary also provides an opportunity to revitalise primary health care, bringing to bear the potential of innovation and technology and empowering young people to participate more meaningfully in their own health.

Primary health care is based on three pillars: community empowerment, multisectoral policies and action, and integrated delivery of quality primary care and public health services. With good design and delivery, primary health care provided to all—irrespective of who they are or where they are from—can effectively meet most health needs people encounter throughout their lives.

Decades of evidence show that health systems developed around strong primary health care deliver better health outcomes at a lower cost, and can mitigate the impact of poor economic conditions on health.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site)

High-quality primary health care is the best platform for responding to evolving health needs, demographics, environmental challenges, and emergencies.[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32556-X/fulltext?code=lancet-site)

Strong primary health care, rooted in community participation and action, is the foundation of every health system, and no country can achieve health for all without it.

Investing in primary health care will support tangible improvements in health and wellbeing and drive progress towards achievement of the health targets of the Sustainable Development Goals.

Achieving health for all and ensuring health care that is truly universal requires a renewed focus on quality primary health care that is designed around people. We are meeting at the Global Conference on Primary Health Care in Astana, Kazakhstan, on Oct 25–26, 2018, to recall and build on the original Alma-Ata vision, and embrace lessons learned since 1978. A new commitment, the Declaration of Astana, developed with the input of UN member states, will call for primary health care that puts people at the centre of health systems, instead of diseases, institutions, donor objectives, or vertical funding streams. We must transform this vision into a practical reality for the benefit and development of humankind.

**The Lancet**

**Putting nursing and midwifery at the heart of the Alma-Ata vision**

**By: Nigel Crisp and Elizabeth Iro**

*20 October 2018*

The Alma-Ata vision of a health system rooted in primary health care, which is person-centred and multisectoral, is as relevant now as it ever was. Nursing and midwifery can play a more central part in making this vision a reality. The health workforce has always been central to the 1978 Declaration of Alma-Ata that recognised the important role of health workers in achieving this vision.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

More recently, the World Health Assembly adopted resolutions on the Global Strategy on Human Resources for Health in 2016[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext) and the Working for Health 5-year action plan in 2017[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext) that committed countries to develop a primary health care workforce responsive to population needs as part of universal health coverage.

Nurses and midwives are expected to assume a more extensive and influential role in the future.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

One reason for this changing role arises from epidemiological changes accelerating over the past 40 years. Ageing populations and the increase in non-communicable diseases requires a far more holistic and person-centred approach that fits well with nursing philosophy and practice. Epidemiological change is only one of many changes in every area of life over the past 40 years: in science and technology, politics, economics, demography, and the environment. All affect health and influence how primary health care can be delivered. We examine three of them here in relation to a nurse-based primary health care system suitable for the future.

First are the great opportunities for improving health that come with today's technology. Examples in primary health care include the Kenyan midwives who use point of care ultrasound in rural areas to identify risk factors in expectant mothers with support from radiologists and the ultrasonography team in a distant teaching hospital.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

The Apollo Hospitals Group in India has used technology for telemedicine services, which include providing support to clinicians and patients in remote areas. Elsewhere, a young primary care nurse in Australia, Nurse Robbie, has created a suite of tools to support self-care available free to the population and linked to his practice. Meanwhile, in the UK there are now virtual primary care practices. These few examples reveal something of the scale, diversity, geographical spread, and impact that new information and communications technology can have. Together with advances in the biomedical and other sciences, they can bring decision support for clinicians and treatment, information, and advice to patients in their own communities and homes.

Second is the greater understanding and recognition of the wider social determinants of health. The Declaration of Alma-Ata was ahead of its time in recognising the importance of both a cross-sectoral approach and the engagement of communities and citizens. It was not until 30 years later with the 2008 report of the Commission on the Social Determinants of Health that the social determinants of health started to receive wider attention.[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

Policy developments such as health in all policies[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext) and asset-based care [8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext) reflect these ideas, although neither are yet central to policy making in most of the world.

Alongside these policy developments, there has been growth in many community-based projects, such as the St Paul's Way Transformation Project in London, UK, that bring together actors from all sectors with local residents to improve the area—with improved health as only one of the desired outcomes, alongside educational and economic development. Nursing Now Jamaica has targeted violence against women as one of the biggest issues it must confront in improving health for the country's population. Elsewhere, mothers2mothers in southern Africa has mobilised mothers with HIV to help HIV-positive pregnant women avoid mother-to-child transmission of HIV.

The third development is in human resources. There has been growth in community health workers building on the examples developed by pioneers such as Miriam Were in Kenya at the time of the Declaration of Alma-Ata.[9](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

Community health workers are being strongly promoted as one of the best ways to bring health care to millions of people living in the most rural areas, as highlighted in the One Million Community Health Workers Campaign.

At the same time, nurses have expanded their practice considerably—eg, prescribing, managing non-communicable diseases, undertaking procedures, being first responders in emergencies.[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

There are now studies that show how effectively nurses can deliver primary care services. A 2018 Cochrane review, for example, concluded that “Delivery of primary healthcare services by nurses instead of doctors probably leads to similar or better patient health and higher patient satisfaction.”[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

In many parts of the world, nurses are the first, and sometimes the only, health professional that patients see. They work close to the community, are able to understand local culture, and influence behaviour. As the 2018 report from the WHO High-Level Commission on Non-Communicable Diseases stated: “nurses have especially crucial roles to play in health promotion and health literacy, and in the prevention and management of NCDs…nurses are uniquely placed to act as effective practitioners, health coaches, spokespersons, and knowledge suppliers for patients and families throughout the life course”.[12](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

It is a statement in the tradition of Alma-Ata.

Medical practice, too, has changed in 40 years with far greater specialisation and a decline in the number of health professionals going into the general specialties. This trend seems set to continue: in the USA between 2001 and 2010, there was a 6·3% decrease in the number of graduate residents entering primary care, but a 45% increase in the medical and surgical subsubspecialties.[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

In Egypt, India, Jordan, Tunisia, and Turkey, less than 10% of physicians choose family medicine.[14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32341-9/fulltext)

Taken together these developments suggest a model of primary health care with nurses at its centre, able to call on other medical and specialist support where necessary and refer on to more specialised facilities. In this model, nurses and midwives will provide much of the hands-on care, including the management of non-communicable diseases. They will coordinate, supervise, and support the work of community health workers. Finally, nurses will work with local people and local community groups, such as health coaches and knowledge suppliers, and support self-care, promote health, and prevent diseases.

**The Lancet**

**Reform of primary health care in Pakistan**

**By: Sadia M. Malik and Zulfiqar A. Bhutta**

*20 October 2018*

With a neonatal mortality rate exceeding 45 per 1000 livebirths, a UNICEF report ranked Pakistan as the riskiest place to be born on earth.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

Although the recent Demographic and Health Survey indicates that the situation has improved, the neonatal mortality rate in Pakistan is among the highest in the world.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

Other health indicators, particularly those pertaining to maternal and child health and nutrition, are worse than other countries in the region with comparable or lower socioeconomic indicators.[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

Pakistan is one of only two countries in the world where polio remains endemic and the country had little success in achieving the Millennium Development Goals (MDGs), especially those related to maternal and child health outcomes.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

In the past decades, global advocacy measures, such as the 1978 Declaration of Alma-Ata, the MDGs, and the growing emphasis of international donor community on maternal and child health have contributed to the emergence of some initiatives around primary health care in Pakistan. These initiatives, however, have been underfunded and poorly implemented due to various factors such as political volatility, poor civil military relations, a fragile democracy, and a political culture based on patronage, kinship, and identity, all of which reduce the incentives of politicians to secure sufficient political and financial commitment for universal primary health care.

The uninterrupted continuation of democracy since 2009 has been unprecedented in Pakistan's political history. The newly inducted Government of Pakistan, headed by Prime Minister Imran Khan, is one of the first to underscore the importance of maternal and child health and nutrition as major developmental bottlenecks. However, it remains to be seen what tangible actions will be taken to address the situation. We argue that the only route to address the abysmal health indicators in Pakistan is through the provision of universal primary health care. However, placing this issue on top of the national agenda and achieving results will not be possible without addressing structural issues.

First, the national security paradigm that has traditionally been built around the potential threats from external aggression needs to be redefined. A broader notion of human security that emphasises freedom from want, as much as freedom from fear, needs to be incorporated into the traditional policy discourse on national security. The imbalance between military and human development expenditures needs to be reset to align limited public resources with the sources of threats to human security. Public spending on health has remained less than 1% of the gross domestic product (GDP) for the past few decades. The share of out-of-pocket expenditure in total health expenditure by households on health in Pakistan is higher than the average for other regions, including low-income countries, and private health spending contributes substantially to impoverishment in Pakistan.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

It is, therefore, time for the government to gear up its health financing to at least 3% of GDP.

Second, allocations within the health sector between the primary, secondary, and tertiary care need to be revaluated. At present 70% of Pakistan's total health sector allocations are directed to tertiary care in large urban centres, leaving less than 30% for preventive measures and health facilities and only 0·1% for maternal and child health.[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

This pattern of health sector allocation is inefficient since the burden of disease and causes of mortality in Pakistan are still largely dominated by communicable diseases and maternal and perinatal conditions that can be prevented through low-cost preventive care.[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

It is also inequitable because poor people generally use basic health facilities more than the rich and the incidence of preventable diseases is higher among the poor than the rich. Also, given the distance and limited human resources for health and nutrition in poorer and remote populations, the primary care system is effectively the only way to reduce geographical disparities in Pakistan.[8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32275-X/fulltext)

Clearly, there is a need to invigorate Basic Health Units and the Lady Health Worker programme. This approach in no way undermines the need to invest in hospital care. Given the rapidly growing population and its health needs, tertiary care is increasingly becoming scarce in Pakistan. However, in view of the overall resource constraint, poor quality of government hospitals, and the high unit costs of providing hospital care, it might be prudent to encourage the private sector in the provision of specialised hospital care while the government maintains regulatory oversight and provides targeted vouchers to low-income groups to access good quality secondary and tertiary care. Effective preventive care strategies and quality primary and secondary health care provided by the public sector in district settings can reduce the burden on tertiary hospital care by preventing the major causes of hospital admissions.

Third, simply increasing health sector allocations is not enough if services are underused or poorly managed. It is encouraging that the new Government of Pakistan has committed to improving governance. Although this will take time, the government should take steps in the immediate future and strengthen the district health system to increase the accountability of local health-care providers. The watchdog role of media and civil society is especially crucial at this level. Innovative implementation mechanisms such as Social Impact Bonds, adopted by some countries to implement social sector welfare programmes, could also be explored in the short run.

Fourth, the culture of patronage in politics must end. In the past, political interference, an absence of accountability, and failure to pay salaries to staff undermined the delivery of primary health care programmes. At the macro level, the practice of granting development funds to favoured individual ministers to spend in their own constituencies has been a hurdle to secure adequate funds for universal primary health care.

Finally, while Pakistan is a signatory to universal health care and the Declaration of Alma-Ata, it needs to recognise health as a human rights issue at the domestic level by granting it constitutional protection. While the 18th Constitutional Amendment inserted a new article (26A) about the right to basic education, an opportunity was lost for inserting a similar article on the right to basic health. In moving forward to improve health and nutrition in Pakistan, implementation of integrated strategies that promote equitable access to services at primary care level must be the cornerstone of any new policy.

SMM declares no competing interests. ZAB is a member of the Government of Pakistan's Task Force for Health. The views expressed in this Comment are the personal views of SMM and ZAB.

**The Lancet**

**Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals?**

**By: Thomas Hone, Prof. James Macinko and Prof. Christopher Millett**

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**Summary**

The Sustainable Development Goals (SDGs) are now steering the global health and development agendas. Notably, the SDGs contain no mention of primary health care, reflecting the disappointing implementation of the Alma-Ata declaration of 1978 over the past four decades. The draft Astana declaration (Alma-Ata 2·0), released in June, 2018, restates the key principles of primary health care and renews these as driving forces for achieving the SDGs, emphasising universal health coverage. We use accumulating evidence to show that countries that reoriente their health systems towards primary care are better placed to achieve the SDGs than those with hospital-focused systems or low investment in health. We then argue that an even bolder approach, which fully embraces the Alma-Ata vision of primary health care, could deliver substantially greater SDG progress, by addressing the wider determinants of health, promoting equity and social justice throughout society, empowering communities, and being a catalyst for advancing and amplifying universal health coverage and synergies among SDGs.

**Introduction**

The Sustainable Development Goals (SDGs) are now steering the global development agenda and are key drivers of international action on social and environmental determinants of health. The 17 goals cover poverty reduction, hunger, health, education, inequalities, sanitation, energy, social justice, the environment, and climate change. Like their predecessors, the Millennium Development Goals, the SDGs include specific targets, but additionally emphasise broader interlinked aspects, such as sustainability and social justice, promoting a more integrated development agenda. Notably, the SDGs contain no mention of primary health care (PHC)[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)—one of the principal strategies for reshaping health care, promoting health-enhancing policies across sectors, and developing more equitable and fairer societies. Sept 12, 2018, marked 40 years since the Alma-Ata declaration, the bold and ambitious statement that proposed PHC as a platform for improving global health.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The 1978 Alma-Ata declaration's vision for societal health included reorienting health systems towards primary care and addressing the social and environmental determinants of health and inequality ([panel 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#box1)). It emphasised social justice and equitable access to health-care services, key elements of the modern universal health coverage (UHC) agenda ([panel 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#box2)), and advocated for empowering communities to participate in health-care planning and delivery. In October, 2018, the international community will commemorate [Alma-Ata in Astana](http://www.who.int/primary-health/conference-phc/en/), Kazakhstan, with an updated declaration which reiterates PHC's indispensability in improving health, and emphasises the need for strengthening and sustaining health systems, and achieving UHC.

**Panel 1**

**Primary health care and primary care**

**Primary health care**

Primary health care (PHC), as set out in the 1978 Alma-Ata declaration, is a comprehensive approach to health system organisation and intersectoral action for health. It arose from health system inadequacies present in the 1970s, many of which persist today. These inadequacies included the following approaches: disease-orientated technology, which was expensive, promoted consumerism, and delivered minimal wider population benefit; the overspecialisation and lack of person-centred approaches among many health professionals; poor understanding of the importance of health in social and economic development; and inadequate commitment to primary care as the core of health systems.[4](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Importantly, Alma-Ata proposed a role for PHC in addressing social and environmental determinants of health, by considering health a human right, equity an essential value, and community participation a necessary condition for a just society.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Alma-Ata also first articulated what has since been termed the Health in All Policies approach, which recognised that all sectors have a role in promoting and coordinating efforts to improve health. The PHC approach emphasised responsiveness—adapting to local economic, social, and political realities—with a strong community focus. Importantly, the Alma-Ata declaration highlighted the responsibilities governments have in improving the health of their populations.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Today, these principles remain ever more pertinent with major global efforts underway to promote progress towards them. A diverse range of movements can be accommodated under the PHC umbrella, despite having their own aims, terminologies, and implementation strategies. These movements include intersectoral action for health and Health in All Policies;[6](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) health promotion;[8](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) addressing the wider social determinants of health;[9](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) universal health coverage; reducing health inequalities, including early childhood development and life course approaches; and community-focused and person-oriented primary care. Thus, PHC can be interpreted in the modern day as a societal vision for health and development, and a wide platform to engage those diverse movements built upon common key principles.

**Primary care**

Within the health sector, PHC is often implemented through primary care services. These services are a vital component, yet only comprise the service-fronting elements of the broader PHC concept. They are provided to and are in collaboration with populations, and include promotive, preventive, curative, and rehabilitative services; health education; maternal and child health care (including family planning); and immunisation. Primary care is the locus for integrated referral systems that facilitate access to comprehensive health care, and services are staffed by multidisciplinary professionals. It also integrates public health actions towards improving food supply and nutrition, ensuring safe water and sanitation, and communicable disease control,[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and should be able to resolve most health needs.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care is often misconstrued as involving basic tasks, procedures, and technologies, with complexity within health systems equated with specialist or technologically intensive interventions. In reality, primary care is inherently complex, since it has challenges regarding the delineation of what should and what should not be managed in community settings, flexible rules governing actions (eg, patients' expectations and wishes), frequent adaptation of services, and non-linearity in clinical conditions.[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[12](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The complexity is exemplified by the fact that primary care providers have to manage ill-defined clinical symptoms, respond to changes in patients' circumstances and health status, understand social and environmental drivers of health in local communities, and work at the forefront of implementing many health system reforms.

**The interaction between primary care and PHC**

A defining feature of a complex system is how embedded it is in other systems and how it has co-evolved with them.[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Although primary care is the more visible, service-oriented, centrepiece of PHC, the two are intrinsically linked with mutually reinforcing roles. PHC is a requisite for strong primary care, as it facilitates equitable and intersectoral approaches to health, community-orientated services, and participatory governance structures.[5](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Low-income and middle-income countries with stronger government commitments to health, and investment in social assistance sectors, provide more comprehensive primary care services and achieve better health outcomes.[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Additionally, broader determinants of health, including social capacity and education, affect access to and the effectiveness of primary care,[14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and wider principles of equity are associated with stronger health and social welfare systems across countries.[15](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[16](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Conversely, primary care services have a role in fostering wider uptake of PHC. Community-based health professionals, engaging with local groups and registering populations, can identify and draw attention to local determinants of health and community needs, and facilitate intersectoral engagement and linkages, especially through participatory action approaches.[17](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[18](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

However, challenges exist in fostering such interactions. Despite relatively strong primary care, coordination and wider integration remain weak in many countries.[19](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The UK and the Netherlands, for example, have strong primary care systems,[16](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) but each has difficulty integrating them with secondary systems, community, and social care, and in engaging communities.[20](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[21](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

There are challenges in incorporating health aims within objectives of non-health sectors and overcoming different funding mechanisms and cultures between health and non-health sectors.[22](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Beyond the broader principles, best practices for developing interfaces and connections between primary care and PHC, and mechanisms to strengthen them, remain under-researched and under-documented. Processes of engagement, agreement, and compromise are needed to develop local, context-specific actions for fostering wider PHC approaches and improving the interactions with primary care and other health and social services.[11](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

**Panel 2**

**Primary health care and the concept of universal health coverage**

The Alma-Ata declaration outlined several broad principles, some of which drive the modern universal health coverage (UHC) agenda. It specifically called for health care “made universally accessible” and initiated a visionary, yet ambitious, call for “health for all”,[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) by the year 2000. Although “health for all” was not met,[23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) including UHC as target 3.8 of Sustainable Development Goal (SDG) 3 has emboldened its ambitions with sharper calls to action—specifically ensuring universal access to high quality, comprehensive health services without impoverishing health-care services.[24](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The draft Astana declaration[25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) aligns primary health care (PHC) more closely with UHC, stating

the importance of quality PHC for effective and sustainable UHC.

PHC and UHC interact in multiple ways. Firstly, with growing recognition that persistent health challenges require substantial health system reform, primary-care oriented health systems have become essential to increase appropriateness and efficiency, by focusing on people and their wellbeing. Strong primary care is essential to expand and sustain UHC, and UHC should promote equitable approaches to health system financing to support their reforms.[26](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Secondly, the importance of addressing the social and environmental determinants of health in relation to the UHC agenda has grown. There are concerns that UHC might focus too much on curative services, which disproportionately benefit wealthier populations.[27](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Embedding UHC within the broader vision of PHC is necessary to avoid such unintended consequences.[28](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Finally, PHC's emphases on equity and the right to health support UHC, and adopting and institutionalising these principles are prerequisites for maximising UHC. The benefits of reorienting systems to primary care across the SDGs will be dependent on coverage of the world's most deprived and vulnerable populations. PHC is key to guaranteeing adequate and equitable coverage within UHC.

The Alma-Ata declaration played an important role in the inception of UHC and renewed calls for PHC, including through the Astana declaration, which will be vital for UHC in the modern era, supporting its progress and maximising its impact.

Nevertheless, will the Astana declaration succeed in advancing the implementation of PHC against a backdrop of 40 years of lacklustre uptake? Despite efforts to revitalise Alma-Ata in 2008, with WHO's World Health Report on PHC [29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and a Lancet Series on Alma-Ata, [23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) global action remains disappointing. This disappointing uptake stemmed from misinterpretation of Alma-Ata, minimal political motivation for societal reform, and constrained finances.[14](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Confusion between primary care and PHC ([panel 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#box1)) led to criticism that Alma-Ata was too broad, [23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) with the misinterpretation arising from the perspective that primary care should be responsible for addressing broader determinants of health and advancing social justice, far beyond the remit of health services. The proposal of selective PHC in the 1980s, focusing on vaccination, growth monitoring, oral rehydration therapy, and breastfeeding, was viewed as a pragmatic approach to implement primary care in resource-constrained settings, but diverged from Alma-Ata's defining principles.[1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[30](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

In the past decade, attention to PHC's broader principles has gained pace ([panel 3](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#box3)). This attention builds on efforts in some countries to embrace elements of comprehensive PHC, including community engagement and participation—eg, in Costa Rica,[77](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) Brazil,[78](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) Chile,[79](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and as part of family medicine or general practice in many European countries.[56](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Building on this momentum, the current focus on UHC is welcome ([panel 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#box2)), but it is crucial that this focus on UHC does not create a narrow focus on health services, diverting attention away from broader PHC principles and the potential to advance many of the SDGs.

**Panel 3**

**10 years of revitalising primary health care?**

WHO's 2008 Health Report on primary health care (PHC)[29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) marked 30 years of the Alma-Ata declaration and aimed to place PHC firmly back on the global agenda. It outlines PHC reforms for policy makers and was instrumental in translating the Alma-Ata declaration into actions and priorities for the modern global health community. Concurrently, a parallel health system strengthening (HSS) agenda was growing. Recommended policy reforms were structured around the six WHO health system building blocks to achieve health systems objectives of financial protection, better health, equitable service coverage, responsiveness, and efficiency.[31](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The PHC agenda has become intertwined with HSS efforts.[32](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The previous Lancet Series[23](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) on Alma-Ata in 2008 highlighted how, following the Alma-Ata declaration in 1978, structural adjustment programmes and neoliberal economic policies had eroded PHC approaches in health systems. The series noted how vertical interventions were developed instead of comprehensive approaches, and how community participation and intersectoral collaboration remained weak.[33](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Although the Series reviewed the evidence on key PHC domains, noting key successes,[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[34](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[36](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[37](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) wider-reaching comprehensive PHC approaches are clearly scarce, under-resourced, and under-evaluated. Reflecting WHO's World Health Report,[29](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) the Series called for a revitalisation of PHC through better integration of primary care services, prioritisation of equity, management of human resources for health, and improvements in quality of care, community empowerment, and accountability.[38](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[39](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Given these efforts to re-invigorate PHC, the question is how revitalised has PHC become? There are promising signs, reflected in specific movements encompassing PHC principles, including intersectoral action to address the health challenges that countries face.

[40](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

 In 2008, WHO's Commission on Social Determinants of Health

[41](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

 and the 2012 Rio declaration

[42](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

 encouraged countries to act on the social determinants through intersectoral action and the Health in All Policies framework. Similarly, in Europe, the 2008 Tallinn Charter called for wider health-improving actions and intersectoral action for health, with re-affirmation in 2018.[43](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Health has grown as a priority in other sectors. For example, the UN Habitat's New Urban Agenda (2016) mentions health and embraces PHC-related concepts of local democracy, equity, integrated systems, and cross-sector engagement.[44](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Global agencies and funders have increasingly adopted key principles of PHC as part of their strategies.[45](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[46](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

For example, UNICEF now includes gender equity as a cross-cutting theme;[47](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) the US Agency for International Development has promoted HSS;[48](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) the Global Fund to Fight AIDS, Tuberculosis, and Malaria includes the goals of resilient and sustainable health systems, human rights, and gender equity;[49](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and Gavi, the Vaccine Alliance mentions equity, HSS, service integration, and community ownership.[50](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Evidence has grown on the benefit of primary-care focused health systems,[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[52](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[53](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) with increased attention to primary care in many recent health system reforms and policies, including Canada[54](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and Taiwan.[55](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Research on primary care has also shown how stronger primary care, notably the comprehensiveness and coordination elements, is associated with better health and lower inequalities in Europe.[56](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Countries are increasingly encouraging comprehensive, person-centred primary care, and community participation.[57](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Efforts have been made to incorporate comprehensive PHC approaches in many countries, particularly those with strong government commitments to equity, health, and UHC. Platforms such as the [PHC Performance Initiative](http://phcperformanceinitiative.org/) are bringing together stakeholders, advancing data collection, and learning from country examples. Civil society, such as through the People's Health Movement, references Alma-Ata, and has vocally advocated for better integration between health services and multisectoral approaches to the health improvement and advancement of social equity.[58](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

There has also been country action, political buy-in, and recognition of the social determinants agenda in the past 10 years,[59](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[60](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and Health in All Policies activities have increasingly been undertaken (and showcased) across the world.[7](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[61](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

These efforts in the past 10 years follow longer-term transitions, which are shaping the PHC agenda. Institutional decentralisation in many countries, including in health, aims to improve efficiency and bring services closer to communities.[62](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext), [63](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[64](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The importance of empowerment and education of women and girls has grown, including within the health sector.[65](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[66](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

This empowerment includes efforts to offer gender-appropriate health services, incorporate gender issues into medical education, remove gender-related barriers to access, and, in a few countries, bring gender issues to the mainstream across government sectors.[67](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[68](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[69](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

However, major challenges remain. Reforms and government commitments to PHC have not always delivered sizeable gains, especially to vulnerable groups, and there are areas in which little action has occurred. This limited action is reflected in the persistence of substantial health inequalities in many settings.[70](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

In European countries, inequalities have reduced over the past decade,[71](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) although other studies in the USA [72](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and France [73](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) point to widening inequalities across populations. Inequalities in under-5 mortality have declined in many, but not all, low-income and middle-income countries (LMICS) since 2002.[74](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

A study of 64 (LMICs) showed relative inequality has grown in nearly half of the countries since the 1990s, despite greater equity in coverage of key health interventions, potentially reflecting lower quality health services accessed by vulnerable groups and higher exposure to adverse social and environmental determinants of health.[75](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Although important global consensus building around the PHC agenda has been done over the past 10 years, robust uptake and rigorous evaluation remain scant, especially in relation to equity, Health in All Policies, and intersectoral action. Much of the evidence comes from high-income countries or interventions with reduced scope in LMICs. Stakeholder perspectives are often overlooked.[76](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The convergence of PHC and the Sustainable Development Goals (SDGs) provides a new opportunity to integrate PHC into policy planning for the SDGs and for a more structured approach to investment, monitoring, and evaluation.

The draft Astana declaration[25](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) identifies PHC as a driving force for achieving the SDGs. However, a clear articulation of how PHC contributes to the SDG agenda is absent. In this Review, we argue that reorienting health systems towards primary care can accelerate achievement of SDG3 ([figure 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#fig1)).[56](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[79](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[80](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[81](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[82](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

We then build a case for why both primary care and an even broader PHC approach could make essential contributions to achieving many of the non-health SDGs ([figure 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#fig2)), and advocate for countries to engage with the Alma-Ata's vision of PHC as a mean to maximise efforts towards achieving their SDG targets and to capitalise on the synergies among them.

**How could reorienting health systems towards primary care contribute to the SDGs?**

Reorienting health systems towards primary care will not only deliver major health gains, but also promote wider sustainable development. In their most basic role, primary care services contribute to achievement of SDG 3 (health), with preventive interventions and treatments, such as vitamin and nutritional supplements, vaccinations, and therapeutic drugs, which can avert many causes of illness and death, especially for children ([figure 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#fig1)).[83](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[84](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Indeed, most basic cost-effective essential interventions identified in the third edition of Disease Control Priorities are community or health centre based.[85](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care also targets risk factors and behaviours, such as hypertension, low physical activity, poor diet, and harmful behaviours (eg, smoking and alcohol), with benefits for non-communicable diseases (NCDs),[86](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[87](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) reproductive and maternal health,[88](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and substance abuse-related harm.[89](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care delivers health promotion and education interventions, and fosters continuity of care and long-term relationships with health professionals, increasing benefits,[90](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[91](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) such as better treatment adherence.[92](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext), [93](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care coordinates specialty, diagnostic, and hospital care. This coordination protects patients from unnecessary examinations and treatments, and serves as an individual's medical home. Therefore, countries with strong primary care have been found to have better and more equitable health outcomes and greater health system efficiencies.[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[53](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[56](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Beyond more immediate health-improving actions, primary care can contribute to other SDGs. Poor health associated with infectious diseases, NCD morbidities, and injuries can contribute to impoverishment (SDG 1), might limit education and employment opportunities (SDGs 4 and 8), and contribute to malnutrition (SDG 2). These conditions often affect the most disadvantaged, further increasing inequality within or among countries (SDG 10).[94](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[95](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[96](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care is ideally placed to manage conditions that restrict employment or educational opportunities in the short term, but also acts through prevention and early intervention throughout the life course. Primary care is often the setting for services contributing to SDG 2 (ie, zero hunger),[35](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[97](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) in addition to diet counselling, promoting physical activity, and weight management in response to the growing obesity epidemic.[98](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[99](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[100](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[101](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care can also help reduce health and wider social inequalities (SDG 10), since it is more effective than specialist care in addressing the larger unmet health needs and access barriers faced by deprived populations.[10](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[81](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[102](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Moreover, primary care services are large employers, demand an educated workforce, and provide continuing professional and educational development opportunities.[103](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

This fact can further contribute to SDG 4 (education) and SDG 8 (employment), and, where women compromise a large part of the health system workforce,[103](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) can promote female empowerment and gender equality (SDG 5). Although health services are large energy consumers and polluters, a large proportion of this energy consumption and pollution comes from hospitals and not from primary care services.[104](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[105](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Community-located care and reduced treatments in hospitals through early prevention can contribute to more climate-friendly health systems (SDG 13).

Primary care also has a growing role in surveillance and monitoring progress towards SDG achievement. Electronic health records are increasingly used to monitor health and determinants of health, and offer benefits over costly and infrequent national surveys.[106](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[107](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[108](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Electronic health records can also help document the adverse effects of conflict, including human rights abuses (SDG 16), recognise harms from poor working conditions (SDG 8), and identify and monitor vulnerable individuals,[109](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) including women subjected to violence, child labour, modern slavery, and human trafficking (SDG 5 [gender equality] and SDG 8 [employment]).[110](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Primary care can also act as a referral point for access to other services, including social protection programmes,[111](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) adult education,[101](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and judicial and protection systems for vulnerable populations,[110](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) thus contributing to SDG 1 (poverty), SDG 4 (education), SDG 5 (gender equality), SDG 10 (inequalities), and SDG 16 (justice).

**How might embracing a more comprehensive PHC approach contribute to the SDGs?**

Beyond re-orienting health systems to primary care, the Alma-Ata vision of PHC supports the achievement of the SDGs. The PHC and SDG agendas are linked because they both address the broader determinants of health, through intersectoral action and Health in All Policies, the promotion of equity and social justice, and the empowerment and participation of communities and individuals. Furthermore, PHC and UHC are strongly aligned ([panel 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#box2)). However, little robust evidence exists on the effect of implementing the wider principles of PHC (in contrast to interventions and vertical programmes implemented in primary care), mainly because these wider approaches have not been taken up systematically, or evaluation of such initiatives is weak or difficult. Nonetheless, country-level investments in comprehensive PHC approaches have great potential for achieving many aspects related to both health and non-health SDGs ([Figure 1](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#fig1), [Figure 2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext#fig2)).

Addressing the social and environmental determinants of health through intersectoral action is central to PHC. The “agriculture, animal husbandry, food, industry, education, housing, public works, communications” sectors were explicitly mentioned by the Alma-Ata declaration.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

PHC's efforts to improve the social determinants of health can improve opportunities to advance many SDGs. These opportunities include poverty alleviation (SDG 1), as health and poverty are intrinsically linked.[112](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Similarly, nutrition and hunger (SDG 2) relate to poverty and are key determinants of health. Action within commercial and agriculture sectors, in addition to education and access to clean water, are important to access secure, nutritional food sources.[97](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[113](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[114](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Evidence suggests that improvements in nutritional outcomes from nutrition-sensitive interventions—eg, improving agriculture and food security and conditional cash transfers, are maximised within a broader focus on social and gender equity.[115](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[116](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

PHC recognises the importance of education (SDG 4) and full and productive work (SDG 8) as vital for good health,[112](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and so necessitates actions to resolve labour market failures, introduce regulatory protections, strengthen trade unions, and improve job security.[117](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Although strengthening primary care services can advance some aspects of SDG 3 (health), only comprehensive PHC approaches can provide the needed public health and intersectoral actions to meet health targets.[27](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[118](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Environmental factors (such as pollution and the built environment) contribute to a fifth of the global burden of infectious, parasitic, neonatal, and non-communicable diseases,[119](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and actions to address these factors lie outside the health sector. Regulation and taxes, such as smoke-free legislation,[120](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[121](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) tobacco and alcohol taxes,[122](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[123](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[124](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and action within the food and beverage sectors,[113](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) are important, and health-focused urban planning, agriculture, and housing systems are necessary to reduce pollution, chemical hazards, unsafe sanitation, low physical activity (eg, active commuting), injuries, road traffic accident mortality, vector-borne diseases, and homelessness.[125](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[126](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[127](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

PHC's actions on environmental determinants of health can also contribute to the SDGs by promoting clean, safe, and climate-friendly environments. Public health approaches and intersectoral action can improve access to clean water and sanitation (responsible for approximately 842 000 deaths in low-income and middle-income countries [LMICS])[128](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and contribute to monitoring and promoting cleaner energy production (SDG 6 and SDG 7).[129](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[130](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[131](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[132](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[133](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Health challenges in urban environments (SDG 11), such as air pollution, low physical activity, malnutrition, and inadequate sanitation,[134](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) can be improved through PHC's emphasis on sustainable and healthy approaches in urban sectors. These approaches include housing regulations and regeneration to improve heating, electricity, sanitation, and security; investing in public transport, redesigning road systems to reduce accidents, and reducing polluting vehicle usage; facilitating active transport; and promoting green space to reduce exposure to pollution, increase physical activity, and improve mental health.[134](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[135](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

PHC also offers contributions to environment-focused SDGs (12–15) through actions on environmental determinants of health, such as reducing pollution and hazardous chemicals, promoting clean energy production, fostering healthy food production, and recognising the importance of healthy ecosystems and the environment for human health.

Inequalities are a cross-cutting theme to many SDGs. The Alma-Ata declaration acknowledges health inequalities as “politically, socially and economically unacceptable”.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

PHC's commitment to equity is strongly linked to actions on the wider determinants of health since it targets the poor and most vulnerable. Thus, actions to achieve PHC and SDG 10 are largely indistinguishable. PHC also aims to address discrimination against women because women's health is negatively affected by lower societal investment and not having the right to good health.[67](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Beyond the broader health determinants, PHC's promotion of social justice, equity-enhancing policies, and the empowerment of communities and individuals are vital to directing action towards the poor and vulnerable. Broader movements of social justice and equity are important for embedding actions, such as rights-based approaches to health. They can draw attention to governments' responsibilities for health and promote access for disadvantaged populations, but inequalities, conflict, and inappropriate allocation of resources can occur, if not strategically implemented with a broader equity approach.[136](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[137](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Furthermore, equity and social justice contribute to SDG 16 (peace, justice, and strong institutions)—a cross-cutting SDG underpinning nearly all other SDGs.

The Alma-Ata declaration states that PHC “requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care”.[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

In the SDG era, there is a focus on sustainability,[138](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) with community mobilisation and empowerment increasingly recognised as important facilitators. Evidence highlights that community empowerment and participation are essential for acceptability, sustainability, long-term effectiveness, and uptake of health interventions.[127](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[139](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[140](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[141](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[142](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Health facility committees offer one potential way of promoting quality and coverage of primary care,[143](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and community participation is important for the success of local government initiatives for intersectoral action.[60](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Although community participation approaches will also be essential for sustainability of other actions towards the SDGs, promoting participation in decision making for health is likely to translate into policy coherence, stronger accountability mechanisms, and valuable public, public–private, and civil society partnerships (SDG 17, partnerships for the goals).

## Promising opportunities and challenges for PHC in the SDG era

The absence of PHC in the SDG documents and policies remains a crucial oversight. The evidence base for PHC's potential contribution to many of the SDGs is stronger than ever. Countries with prioritised investments in primary care are better placed to achieve the SDGs than those with hospital-focused systems or limited investments in health. Those countries adopting a broad PHC approach can deliver substantially more—namely through actions to address the wider determinants of health, promoting equity and social justice throughout society, empowering communities, and capitalising on synergistic actions.[86](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

A wider PHC approach additionally serves as an important catalyst for advancing and amplifying UHC beyond a focus on the provision of curative health services. However, PHC is not a panacea for all problems in the world—in fact, this misinterpretation of Alma-Ata contributed to its poor uptake. It is not the role of health services (primary care) to deliver all these actions. PHC is a societal vision that provides a platform for all sectors to engage in. Importantly, the global consensus on the SDGs and commitments from governments, international organisations, and civil society to achieve them, provides an unprecedented opportunity to promote PHC. Global actions around financing, measuring, and institutionalising approaches to reach SDG targets are, perhaps for the first time, an opportunity to fully realise PHC's great promise.

Considerable barriers to implementing pro-PHC and pro-SDG policies remain in many countries. Political commitment is still weak in several key areas. Government commitment to health is vital for stronger primary care,[13](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) intersectoral action, and Health in All Policies approaches.[60](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[61](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[144](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Health goals and priorities should be integrated into non-health sectors' strategies by demonstrating common objectives and synergies.[61](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[144](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Social justice and equity also remain under-prioritised in many locations, and as evidenced by policies following economic recessions, policy makers have not only eroded many previous gains, but also damaged the public's trust in such institutions.[80](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[145](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Without a clear pro-equity focus, including gender equity, inequalities can widen because disadvantaged populations are likely to benefit less from new interventions or expanding coverage than are higher-income populations.[51](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[75](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[146](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[147](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Policy makers should be reminded of the intrinsic value of health and equity, by embedding these basic human rights in constitutions and implementing legislation.[144](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The technical and administrative capacity for delivering necessary changes and sustaining PHC approaches also needs to be strengthened, given they are crucial for institutionalising PHC approaches.[144](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[148](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[149](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The complexity of PHC and interconnected systems must be recognised,[22](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[149](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) and understanding of the structural and systematic challenges that limit progress in local contexts needs to be improved.[150](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

The evidence to inform optimal PHC approaches to achieve SDG goals in different contexts, including financing, is limited. However, progressive, public, taxation-based financing is vital to build robust PHC systems.[151](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[152](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext),[153](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Regressive consumption-based taxation runs contrary to PHC, especially when healthy foods, transport, and environmental services are taxed.[152](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Many countries need to implement health budget reforms and introduce strategic purchasing arrangements to align resources with priorities, and increase flexibility, responsiveness, and accountability.[153](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Opportunities for context-appropriate funding mechanisms also exist, such as shared funds for joint intersectoral activities,[60](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) participatory budgeting for local issues, and tailoring incentivisation mechanisms.[149](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

PHC can only fulfil its potential to advance the SDG agenda with strong, sustained support from politicians, civil society, the public, and all other related sectors. Building trust in public institutions, transparent policy making, and redistributive efforts of governments are important for fostering social capacity, mobilising civil society, and effective bottom-up approaches.[146](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext)

Policy makers should plan mechanisms to involve communities in a more meaningful and substantial way in policies and interventions, and communities should take up these roles and challenge politicians to initiate and maintain their engagement. To help foster uptake, further understanding, research, and debate on PHC are urgently needed. It has become evident that intersectoral action on the broader determinants of health is essential, and a better understanding of how to improve these determinants is needed. Particularly, there is a need to understand the different forms PHC has taken at country level, identify facilitators and barriers to PHC adoption and sustainability, and evaluate its effect on both health and non-health-related outcomes.

**Conclusions**

The SDGs provide a unique opportunity to make the case for renewed attention and investment in PHC as envisaged in the Alma-Ata declaration. As the global community considers its future direction for the coming decades, Alma-Ata's 40th anniversary is the time to reaffirm commitments to PHC and recognise its importance across societies. The Alma-Ata declaration stated that PHC “reflects and evolves”,[2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext) hence its vision is relevant today and has great potential to contribute to the SDGs and other global initiatives, to foster more sustainable and equitable human progress.

**The Lancet**

**The Astana Declaration: the future of primary health care?**

**By: The Lancet**

*20 October 2018*

Primary health care is in crisis. It is underdeveloped in many countries, underfunded in others, and facing a severe workforce recruitment and retention challenge. Half the world's population has no access to the most essential health services. Yet 80–90% of people's health needs across their lifetime can be provided within a primary health-care framework—from maternity care and disease prevention through vaccination, to management of chronic conditions and palliative care. As populations age, and multimorbidity becomes the norm, the role of primary health-care workers becomes ever more important.

In 1978, the Declaration of Alma-Ata was ground-breaking in uniting health leaders behind the importance of primary health care as key to delivering better health for all, and to the value of social justice, health equity, and the social determinants of health. But 40 years later, this vision has not been realised. Instead, the focus has been on individual diseases with variable results. Now the Sustainable Development Goals provide new impetus to reach universal health coverage via strengthened primary health care.

This week, on Oct 25 and 26, the Global Conference on Primary Health Care will be co-hosted by the Government of Kazakhstan, WHO, and UNICEF. 1200 leaders (including heads of state; ministers of health, finance, education, and social welfare; non-governmental organisations; researchers; health practitioners; and youth leaders) will meet in Astana, Kazakhstan, to endorse the Astana Declaration. The aim is to renew political commitment from member states and global organisations to developing people-centred primary health care, building on the principles of the Alma-Ata Declaration.

A renaissance in primary health care is essential to provide health for all, including the most vulnerable. An example is Pakistan, where the provision of universal primary health care is likely to be the only route to address the country's abysmal health indicators. Include, invest, innovate—the themes of the Tallinn Charter in 2018—put primary health care at the heart of sustainable health systems.

Investing in primary health care through four delivery platforms (community-based care, health centres, first-level hospitals, and population-based interventions) is one of the messages from the *Lancet* Commission on Investing in Health. The Commission's proposed package of primary health-care interventions provides a blueprint for what should be available in each of the platforms. In Ethiopia, a diagonal investment approach has led to strengthened primary health-care capacity and improved health status. The *Lancet* Commission on Primary Health Care in China, which will be presented in Astana and Beijing, outlines many opportunities for the Chinese government, such as integrating primary health-care and public health services.

The health workforce is a key contributor to the performance and sustainability of health systems—no more so than in primary health care. The World Organization of Family Doctors (WONCA) has strengthened efforts to train doctors in developing countries, but there has been insufficient investment in primary health-care staff in the past 30 years. Interprofessional teams focusing on the needs of the patient are one important way of introducing innovation. Teams in which nurses provide much of the care, including health promotion and the management of non-communicable diseases, is one possible model.

Recruitment and retention of community health workers, nurses, and doctors must improve in most regions of the world. Making primary health care a more attractive working environment is crucial to recruit and retain the best staff. Evidence presented at the European Health Forum Gastein, Austria, on Oct 3–5, documented the need for new curricula, multiprofessional settings, and more organisational support. In most European countries, there is a shortage of general practitioners (family doctors), especially in rural areas. General practice is often seen as low status, with low prestige for doctors, linked with a high administrative workload and lack of peer support. Despite some innovation, such as new roles for nurses and pharmacists in primary care, there is a need to offer more professional development and more infrastructure support, including technological innovations. Primary care clerkships, and exposing students to working in rural areas, can help to recruit into the most remote areas.

The joy depicted in the photographs in this issue illustrates just some aspects of primary health care at its best. The Astana Declaration marks the beginning of a better future for primary health care. Leadership after the Astana meeting is essential to rejuvenate and revitalise all aspects of primary health care.

**Health Affairs**

**Implementing The Astana Declaration – What Alma-Ata Taught Us**

**By: The Alma- Ata 40 Roundtable**

*25 October 2018*

This month, health leaders from United Nations member states [convene in Kazakhstan’s capital Astana](http://www.who.int/primary-health/conference-phc) to reconfirm the world’s commitment to comprehensive primary health care as the keystone of universal health coverage. Forty years earlier in Alma-Ata, 134 countries committed themselves to health for all. They defined “primary health care as an inclusive, community-led, multi-sectoral approach to promoting population health and preventing illness, as well as a means to provide curative and rehabilitative services.

Primary health care investments in the past decade have improved life expectancy and [decreased mortality globally](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926992/). Today, recognizing how the ideals declared in Alma-Ata drove effective action, and understanding the ‘best practices” that are available to continue those advances, are crucial to the coming work of transforming the Astana declaration into better health for all.

# **The Need For People Centered Primary Health Care: Then And Now**

Forty years ago, despite ongoing global crises, international stakeholders gathered in Alma-Ata and agreed on the need for people in communities, districts, nations, and regions to work together to strengthen public health measures. Health leaders of the 1970s condemned the fact that millions of people were living with and dying from preventable conditions.

Since then we have witnessed significant progress; mortality for children under five [has halved since 1990](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4197219/). Primary health care investments in the past decade have improved life expectancy and[decreased mortality globally](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926992/). Yet today far too many preventable deaths still occur. Additionally, one billion people live beyond the reach of a modern health system and do not benefit from the public health efforts that others can take for granted.

# **The Opportunity To Leverage Momentum And Lessons Learned In 2018**

In the last 40 years, two reinforcing approaches have been fundamental to saving lives millions at a time: access to primary health care and community-level public health practice. Each approach works better when coupled with the other. Furthermore, each approach works better when the people whose health hangs in the balance are at the center of efforts to improve their health and are included in understanding the problems and designing solutions.

The vision and spirit of both Alma-Ata and Astana is that the coming era demands inclusion of people alongside evidence-based interventions. Responses to the changing global epidemiological landscape now hinge on individual and social behavior. Collective cross-sectoral responses are at the center of preventing non-communicable diseases such as heart disease, cancer, addiction, injuries, violence, and climate-based disasters. Strategies of inclusion and collective action must be joined with evidence to ensure legitimacy and to sustain political momentum.

Most social and regulatory changes that create healthier societies will trigger obstructive reactions by powerful interested parties. Success comes from building up the trust-building institutions that help the people affected gain the power to confront the drivers of health inequities across and within populations globally. Pathways to strengthen these institutions have been known even before the Alma-Ata declaration.

In Alma-Ata in 1978 there was unanimity that better health starts with people themselves--people who are informed about health choices and have the opportunity to access primary health care services relevant to their needs throughout the life cycle. Part of the template for this approach came from community health work in Jamkhed, India, where health workers went door to door – as they did in US and European cities in the 1920s -- promoting home hygiene and breastfeeding. Alma-Ata delegates were also inspired by examples from the barefoot doctors of China and Cuba’s policies of universal primary care.

Leading up to this year's meeting in Astana, there has been a recognition that there are best practices in including people and communities as executors of collective action for better health. These methods have been tested and improved by health leaders from both North and South, from governments and nongovernmental organizations (NGOs). They work in places as diverse as Detroit and Delhi. As the world rallies to implement the Astana Declaration, let’s take stock of known examples of best practices for implementation.

# **Community-Based Strategies: Community Stakeholders And Community Health Workers**

Convening community stakeholders in health starts with creating “spaces” and platforms that gather them. The convener can be an NGO, a government health officer, or someone like Destiny Watford. She began organizing in her south Baltimore high school to protest the poor air quality in her predominantly African American neighborhood, and built a movement that spread to activate her whole community. She took the battle all the way to the state legislature and ultimately prevailed in stopping an incinerator project. For her efforts she was awarded the [Goldman Prize](https://www.goldmanprize.org/recipient/destiny-watford).

On the other end of the spectrum are multilateral agencies like UNICEF that have prioritized building trust through community engagement with their primary health care and public health interventions. In between are NGOs like World Vision, whose Citizen Voice and Action (CVA) work in[Uttar Pradesh](http://journal.cjgh.org/index.php/cjgh/article/view/177) developed the capacity of Village Health Sanitation and Nutrition Committees, enabling villagers to access resources to rebuild Auxiliary Nurse Midwife subcenters and reducing travel time to family planning services. Local government health departments can also become backbone organizations for collective action, as Baltimore’s Health Department did in gathering 20 city organizations together as partners in the infant mortality reductions achieved by [B’More for Healthy Babies](http://www.healthybabiesbaltimore.com/).

Teams of Community Health Workers (CHWs) have been essential for Baltimore’s success, and they are the visible face of many community efforts. Countries like [Bangladesh](https://www.chwcentral.org/blog/brac-shasthya-shebika-community-health-worker-bangladesh), [Ethiopia](http://iifphc.org/), [Nepal](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5519587/), [Sri Lanka](https://www.eldis.org/document/A36196), [Ghana](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3250-3), and[Liberia](https://blogs.bmj.com/bmj/2018/05/22/paying-and-investing-in-last-mile-community-health-workers-accelerates-universal-health-coverage/) have trained, supervised and deployed thousands of CHWs to achieve dramatic improvement in population health indicators. The evidence base on CHW program performance is replete with [75 systematic reviews](https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-018-0304-x) of their promise and pitfalls.

A recurring issue is the need to finance CHWs and sustain performance indicators. Community health programs provide a promising[return on investment](http://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf) and are a critical investment for governments in extending equity based UHC. The [Primary Health Care Performance Initiative](http://improvingphc.org/) works alongside countries and development partners to improve the global state of primary health care, beginning with better measurement. Investments like [the Challenge Initiative](https://tciurbanhealth.org/indias-challenge-initiative-for-healthy-cities-to-provide-high-quality-health-services-in-urban-slums/)support coaching CHWS to enhance their capacity and effectiveness.

# **Multi-sectoral Approaches**

Community-based strategies naturally include non-health sectors. The education sector is a traditional ally. In Nepal, the [Bashkar Initiative](http://www.bhaskarmemorialfoundation.org.np/about.html) is a great example of community-based efforts to bring health education for cardiovascular disease prevention to rural school children and adolescents. The new [UNICEF Strategic Plan](https://www.unicef.org/publications/index_102552.html), 2018–2021, commits to further operationalizing community health as part of primary health care and includes a multi-sectoral integration of high-impact interventions regarding health; water, sanitation, and hygiene,(WASH); nutrition; HIV/AIDS prevention and treatment; child protection; education; and early childhood development.

# **Addressing Equity In Health**

Questions of ‘who holds the talking stick’ and ‘who gets around the table’ tend to get settled by the prevailing traditions of the local culture. Inclusion does not happen naturally just because community-based processes are in play. When local public health practitioners become involved in community convening they can organically establish more equitable structures to include the voices of women, the poor, and the marginalized.

The [Jamkhed Project](http://jamkhed.org/crhp-approach/stages-of-development/), which was part of the inspiration for the Alma-Ata declaration, deliberately works to break down barriers of gender, caste, and religion in the formation of community groups to insure voice and inclusion in governance. Within countries the use of tools such as [UNICEF’s EQUIST](http://www.equist.info/) or [WHO’s Equity Assessment Toolkit](http://www.who.int/gho/health_equity/assessment_toolkit/en/) can assist planners to identify and prioritize the most vulnerable communities.

# **From Past To Future**

Countries that implemented the Alma-Ata declaration learned strategies to 1) include people in designing and controlling health systems; 2) achieve integration of multiple sectors like education, agriculture, transport, commerce, religion, housing, trade, and health; and 3) protect everybody, especially the most vulnerable groups, with the umbrella of health promotion, disease prevention, and primary medical care. Getting the first step right turned out to be the key to enabling the other steps.

Like any UN declaration, the Astana declaration calls out governments and ministries to be accountable. However, unlike most UN Declarations, the Astana Declaration writes everyone into the script. The Astana Declaration needs and demands every one of us to take actions in the places where we live and work. We are called on to convene with our fellow people, to deliberate on local solutions to our health threats. We are called on to learn from others who do this well.

**Health for all has become health with all. There is no other choice.**

Editor’s note: This post is authored by The Alma-Ata 40 Roundtable, a group of policymakers and scholars who met on Sept 12, 2018 to recognize the 40th Anniversary of the Alma-Ata Declaration and assess its impact and current relevance. Members include: Kedar Baral Patan, Academy of Health Sciences; David Bishai, Johns Hopkins University; William Brieger, Johns Hopkins University; Dennis Cherian, World Vision; Anbarasi Edward, Johns Hopkins University; Laurel Hatt, R4D; Adnan Hyder, George Washington University; Nikita Japra, Rockefeller Foundation; Jean Kagubare, Gates Foundation; Alice Kuan, Johns Hopkins University; Katey Linskey, Last Mile Health; Melanie Morrow, MCSP; Edgar Necochea, JHPIEGO; George Pariyo, Johns Hopkins University; Henry Perry, Johns Hopkins University; David Peters, Johns Hopkins University; Susan Rifkin, University of Colorado; Oying Rimon, Gates Institute; Meike Schleiff, Johns Hopkins University; Eric Sarriot, Save the Children;  Ria Shah, Johns Hopkins University; Henry Taylor, Johns Hopkins University; Daniel Taylor, Future Generations University; and Rita Thapa Bhaskar, Memorial Foundation.

**Medibulletin**

**Astana declaration reaffirms Alma Ata commitment**

*25 October 2018*

Countries around the globe – including India – today signed the Declaration of Astana, vowing to strengthen their primary health care systems.

This, the declaration said, is an essential step toward achieving universal health coverage. The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care.

“Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO). “We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health.”

*Declaration of Astana comes amid a growing global movement for greater investment in primary health care to achieve universal health coverage*

Indian health minister J P Nadda is currently in Astana. The flagship NDA health scheme Ayushman Bharat has a primary care component in the form of health and wellness centres.

While the 1978 Declaration of Alma-Ata laid a foundation for primary health care, progress over the past four decades has been uneven. At least half the world’s population lacks access to essential health services – including care for noncommunicable and communicable diseases, maternal and child health, mental health, and sexual and reproductive health.

“Although the world is a healthier place for children today than ever before, close to 6 million children die every year before their fifth birthday mostly from preventable causes, and more than 150 million are stunted,” said Henrietta Fore, UNICEF Executive Director. “We as a global community can change that, by bringing quality health services close to those who need them. That’s what primary health care is about.”

The Declaration of Astana comes amid a growing global movement for greater investment in primary health care to achieve universal health coverage.

Health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems – a gap highlighted by several health emergencies in recent years.

“Adoption of the Declaration at this global conference in Astana will set new directions for the development of primary health care as a basis of health care systems,” said Bakytzhan Sagintayev, Prime Minister of Kazakhstan. “The new Declaration reflects obligations of countries, people, communities, health care systems and partners to achieve healthier lives through sustainable primary health care.”

UNICEF and WHO will help governments and civil society to act on the Declaration of Astana and encourage them to back the movement. UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in cooperation with other partners.

**Medium**

**Putting People at the Center of Health Care Picture**

**By: Chris Elias**

*24 October 2018*

When I was growing up, my family had a big black-and-white TV. It came equipped with a dial that let us tune the incoming frequency, and if the dial was turned too far in either direction, the image on the screen would collapse into narrow vertical or horizontal lines. The trick to getting a clear picture, I quickly learned, was to strike the right balance.

In many ways, the debate over universal health coverage is like tuning an old black-and-white TV. Some argue that global health funding has been too oriented toward AIDS, tuberculosis, malaria and vaccine-preventable diseases, while others note the enormous progress we have made using this approach.

I think the key to moving past this debate is to commit to a shared vision of global health that focuses on the needs of people in the world’s poorest communities and the most effective, affordable and sustainable strategies to reach the 3.6 billion people around the world who don’t get the basic health services they need.

That’s why I will be in Astana, Kazakhstan this week to attend the [Global Conference on Primary Health Care](http://www.who.int/primary-health/conference-phc). The meeting aims to renew the commitment of UN member states and global organizations to the principle of people-centered primary health care, as captured in the [Alma-Ata Declaration of 1978](http://www.who.int/publications/almaata_declaration_en.pdf).

The Bill & Melinda Gates Foundation believes that access to quality primary health care (PHC) is the first and most critical step to delivering on the promise of universal health coverage. PHC is the front line of health for communities everywhere. It’s where people go for essential services like vaccinations, maternal and newborn care, family planning, and prevention, testing, and treatment for infectious diseases. When managed well, it’s a powerful tool for health equity that delivers up to 90 percent of an individual’s lifetime health care needs so that people can rely on hospitals or specialists only when necessary.

The foundation’s movement toward this approach reflects the global community’s own journey. When we first started working in Nigeria, for example, we aligned our programming around specific diseases or interventions. Today, while we still support some targeted programming, such as polio eradication, our investments focus on supporting the government’s integrated approach to primary health care delivery. We have also adopted this holistic approach in other countries that are pursuing PHC system reform.

To get a clear picture of what’s working with this approach, countries and donors need to commit to measuring what matters. While countries collect data on inputs, like money spent, or outputs, such as the number of children immunized, many don’t evaluate the quality of care or the experiences of both patients and providers. We need this kind of performance data to identify the barriers that still prevent hundreds of millions of people from accessing basic services. Through the [Primary Health Care Performance Initiative](http://improvingphc.org/) (PHCPI) — a partnership with the World Bank Group, the World Health Organization, Ariadne Labs, and Results for Development — we are working to find and fix key challenges. PHCPI aims to help countries see where they are falling short and learn from the successes of other countries.

There is also exciting work under way to help countries strengthen their PHC supply chains. Local experts with the skills to manage these complex systems are often hard to find and many countries struggle with managing multiple supply chains for different areas of service delivery. Through the [Africa Resource Centers for Supply Chain Excellence](https://africaresourcecentre.org/pages/about-us) (ARC) — a foundation investment working across the continent, with specific activities in South Africa, Nigeria, Kenya and Senegal — there is a concerted effort to focus on developing local supply chain talent, developing tools and solutions to fit government needs and brokering supply chain partnerships between the private sector, academia and government.

The foundation believes that the ultimate success or failure of universal health coverage, however, will depend on the degree to which countries are able to create affordable, high-impact primary health services that can be sustained by domestic resources. While international donors have played a key role in financing some specific interventions, countries themselves have always provided most of the funding for their primary health care systems.

Over the past two decades, the world has made unprecedented progress in reducing the global burden of infectious disease and shrinking major gaps in health equity. But these gains remain fragile and could be easily reversed if we don’t invest in the people and systems that will play an essential role in reaching the unreached and delivering on the principle that everyone deserves the opportunity to lead a healthy and productive life. The conversation shouldn’t be about whether we support vertical or horizontal programs. It should focus on what we must do to have a lasting impact on the lives of women, children and families.

**Thomson Reuters Foundation News**

**Can Rwanda be the blueprint for delivering primary health care?**

**By: Githinji Gitahi**

*30 October 2018*

Twenty years ago, I was a young doctor trying to make a difference in my local community in Nairobi, Kenya. Back then, child mortality rates were much higher, and it was not uncommon for children to die because of lack of access to basic immunisations, medicines or procedures. The child mortality rate in sub-Saharan Africa has dropped by more than [**50 percent since 2000**](https://urldefense.proofpoint.com/v2/url?u=https-3A__data.unicef.org_wp-2Dcontent_uploads_2018_10_Child-2DMortality-2DReport-2D2018.pdf&d=DwMF-g&c=4ZIZThykDLcoWk-GVjSLmy8-1Cr1I4FWIvbLFebwKgY&r=gssXmyXcGXpH00W5EjCJob8HCjM7iO4ljCyb0mnevlo&m=68CN_12zcCT7Wa5c3lv55dZLKMJn1bcjy_pMypw5oBI&s=HQRl5uEmwF4CIrwZSJTcmmwcwqphw5TKeAs7IqX8Nko&e=), and nothing has been more gratifying than seeing those numbers reflected in the lives of healthier children in my own community – and across the continent.

Improvements in primary health care over the past two decades have been key to this progress, but this trend is far from universal. While some countries,such as Rwanda, Ghana and Ethiopia, have made impressive strides in strengthening health systems and expanding coverage, others, such as Equatorial Guinea and South Sudan, have fallen behind. There is a great deal that we can learn from countries like Rwanda that have been prioritising primary health care to achieve quality, affordable health coverage for all their citizens.

Rwanda has made primary health care a cornerstone of its expansion of health services – as a matter of principle, but also of economic necessity. After all, approximately [**90 percent**](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.researchgate.net_publication_242783643-5FThe-5FCost-2DEffectiveness-5Fof-5FPrimary-5FCare-5FServices-5Fi&d=DwMF-g&c=4ZIZThykDLcoWk-GVjSLmy8-1Cr1I4FWIvbLFebwKgY&r=gssXmyXcGXpH00W5EjCJob8HCjM7iO4ljCyb0mnevlo&m=68CN_12zcCT7Wa5c3lv55dZLKMJn1bcjy_pMypw5oBI&s=5EgzPUPxD6wz0OKIzWvnMKHaDoiLDhzjnX0HDmYsiWQ&e=)of a person’s health care needs across his or her lifetime can be covered by primary health care, which is much more cost-effective than hospital-based care. Primary health care is where people turn for routine check-ups, where children access immunisation, where mothers receive prenatal and postnatal care, and where signs and symptoms for illnesses can be caught before they evolve into life-threatening conditions. Rwanda’s primary health care system also integrates services to address the leading causes of mortality in the country, which has led to drastic reductions in deaths from diseases like HIV, tuberculosis and malaria over the past several years.

Rwanda’s recognition of health care as a means to treat all people with dignity and also improve productivity is part of a growing global movement. In 1978, in Almaty, Kazakhstan, health experts and world leaders made a commitment to promote access to health care in their countries with the ground-breaking [**Declaration of Alma-Ata**](https://urldefense.proofpoint.com/v2/url?u=http-3A__www.who.int_publications_almaata-5Fdeclaration-5Fen.pdf&d=DwMF-g&c=4ZIZThykDLcoWk-GVjSLmy8-1Cr1I4FWIvbLFebwKgY&r=gssXmyXcGXpH00W5EjCJob8HCjM7iO4ljCyb0mnevlo&m=yDFhVUpiCd8u2UEDgu3Oj6mbnK4QWMBYvinygqTFq9Y&s=TD5OU9npQ4oQUY973_PqLV8Z9MtWGDKb9rK3D7hWHeo&e=), reaffirming the principle that health is a fundamental human right. This October – 40 years later – world leaders have come together once again in Kazakhstan for the [**Global Conference on Primary Health Care**](https://urldefense.proofpoint.com/v2/url?u=http-3A__www.who.int_primary-2Dhealth_conference-2Dphc&d=DwMF-g&c=4ZIZThykDLcoWk-GVjSLmy8-1Cr1I4FWIvbLFebwKgY&r=gssXmyXcGXpH00W5EjCJob8HCjM7iO4ljCyb0mnevlo&m=yDFhVUpiCd8u2UEDgu3Oj6mbnK4QWMBYvinygqTFq9Y&s=kzqVe8Trd10l62tl12fJEDm8PWY4EwS-pn3y39Nh3sI&e=)to endorse a new declaration, emphasising the critical role that primary health care plays in improving lives around the world.

As we reflect on these commitments and the remarkable progress that countries like Rwanda have made, we must also remember that much remains to be done – locally, regionally and globally. Countries from the US to India to South Africa can learn from Rwanda’s dramatic progress toward ensuring primary health care services reach the poorest and most marginalized – from funding and supporting health workers to political will at the highest levels of government to drive reforms. Rwanda will showcase its health systems roadmap at the [**Africa Health (AHAIC) 2019**](https://urldefense.proofpoint.com/v2/url?u=http-3A__ahaic.org_&d=DwMF-g&c=4ZIZThykDLcoWk-GVjSLmy8-1Cr1I4FWIvbLFebwKgY&r=gssXmyXcGXpH00W5EjCJob8HCjM7iO4ljCyb0mnevlo&m=68CN_12zcCT7Wa5c3lv55dZLKMJn1bcjy_pMypw5oBI&s=Hf9z8bsLJGpN8c1zCC1qj-Kcx6yLVAkwUvZhAVWqrgI&e=) global summit next March, so that other countries can learn from it how to build a health system that is fit for purpose to deal with the ongoing threat of pandemic outbreaks, growing drug resistance, and the increasing burden of cancer, diabetes, and other chronic diseases.

As Rwanda’s case demonstrates, it is possible for even a low-income country to provide publicly financed, quality health services to all, especially if those services are delivered through primary care. Achieving universal health coverage in Africa is an ambitious goal, but it is not an impossible one – the time to roll up our sleeves and get to work is now.

**UN Dispatch**

**Countries Around the World Just Pledged to Provide Decent Primary Health Care to All Their Citizens**

**By: Alanna Shaikh**

*30 October 2018*

Forty years ago, in the heart of Soviet Central Asia, the world made a groundbreaking commitment to health. The [Alma Ata Declaration](http://www.who.int/publications/almaata_declaration_en.pdf) set the stage for global health as we know it today. It reaffirmed health as a state of being that means more than just not being sick. It identified socioeconomic inequities as a cause of poor health, gave states responsibility for the health of their citizens, re-committed to health as a right and, finally, committed to first-level, frontline health care as the key to achieving health for all.

We’re not there yet. Economic inequities have gotten worse, not better. Governments continue to abdicate their responsibility for the health of their citizens. Front-line, primary health care remains inaccessible to far too many people.

Forty years later, the Global Conference on Primary Health Care re-committed to health for all, once again in Central Asia. Led by the World Health organization (WHO), the Ministry of Health Care of Kazakhstan, and UNICEF, the conference renewed the global commitment to primary health care to achieve universal health coverage and the Sustainable Development Goals.

It started off with a powerful call for equity. “Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the WHO, at the start of the conference.

This conference focused on primary health care as the approach to solve today’s health and healthcare challenges. Primary health care is front-line health care – the first health care worker seen by a patient. That may be a nurse, a community health worker, or a family physician. Strong primary health care systems ensure that people get the care they need before it worsens into an emergency. Chronic diseases, which make up the majority of the global burden of illness and death, are best addressed through regular, patient-centered health care. According to WHO, “At its heart, primary health care is about caring for people, rather than simply treating specific diseases or conditions. PHC is usually the first point of contact people have with the health care system. It provides comprehensive, accessible, community-based care that meets the health needs of individuals throughout their life.”

Finally, the Global Conference on Primary Health Care ended with [a new declaration](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf), the Declaration of Astana. The Alma Ata declaration shaped the entire discipline of global health and committed the world to health for all. The Declaration of Astana seeks to bring back that energy.

It begins:

*“We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.”*

The declaration goes on to call for a focus on primary health care in order to achieve universal health coverage, address the need to address chronic and noncommunicable diseases, and mention the link between health care expenses and extreme poverty. The commitment section leads with a promise to make bold political choices for health across all sectors. There was no such explicit mention of domestic politics as factor in health. The declaration ends with this,

“Together we can and will achieve health and well-being for all, leaving no one behind.”

That’s an ambitious goal, and it’s going to require serious top-level commitment to make it happen. There are a few signs that the commitment is there – the Astana declaration, unlike the Almaty declaration, explicitly calls for “bold political choices” in support of health for all. However, current global health funding levels simply aren’t high enough to bring this kind of change.

Global commitments on communicable diseases like TB and HIV consistently fall short of what is needed to stop their spread. In 2018, for TB alone, there was a funding gap of 3.5 billion dollars. In order to reach 2020 targets on HIV reduction, the world must increase the amount of resources available for the HIV response by 1.5 billion dollars each year between 2016 and 2020. As of 2018, the response was falling short. At present, most funding for chronic and noncommunicable disease care is paid out of pocket by patients. As referenced in the Astana declaration, this can drive families into extreme poverty, or keep them trapped there. Universal health coverage is the best way to address that trap. However, while UHC is good value for money, it is not cheap, and few governments in poor countries have shown a commitment to funding it. We had forty years and we didn’t manage it. Will the next forty be the time we need?

**Public Library of Science (PLOS)**

**After Astana: The post-conference agenda for global primary health care**

*30 October 2018*

The WHO/UNICEF Global Conference on Primary Care brought 80 Ministry of Health representatives and thousands of international delegates to Kazakhstan’s capital city to reaffirm the principles of the [1978 Alma-Ata Declaration](http://www.who.int/publications/almaata_declaration_en.pdf). The updated [Declaration of Astana](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf)is built around three pillars; community empowerment, working with non-health sectors to improve health, and integrating health services and disciplines around primary care and public health (figure 1).

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Kazakhstan hosted with aplomb. National pride, touchingly sincere commitment to primary health care and a celebratory spirit created a petrodollar-fuelled US$3m sensory overload that combined soviet-era imperialism with high-kitsch. Attendees enjoyed specially commissioned city transport, free food (heavily featuring horsemeat), an opulent reception at the mayor’s residence, and even an opera.

The conference itself was bookended with smoke machines, flashing lights and choreography, as well as unplanned on-stage drama when the US deputy secretary of health and the Russian government were called out by session panellists for regressive gender policies and illegal imprisonment respectively. Not everything was edge-of-seat action though: as a rule, each session had five panellists – two brilliant, two not so brilliant, and one ministry official who would drone through a lengthy and often irrelevant set-text.

**Back to the future**

The undisputed star of the show was the original Declaration. Even at 40 years old the principles remain fresh and audacious; calling for integrated, patient-centred health systems that engage with the wider social, political, and economic determinants of health. Primary care should be close to communities, responsive to local needs, delivered by multi-disciplinary teams, biased towards prevention, and equipped to manage the majority of health issues without referral. The content overlaps almost implausibly with contemporary blueprints like England’s [Five Year Forward View](https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf).

Plenary session provided a roadmap for developing nations: focus on upskilling primary care clinicians, improve quality, extend the spectrum of clinical care (to include health promotion, prevention, screening, rehabilitation, and palliative care) and employ primary care-based social workers, health promoters, and psychologists to move beyond the biomedical.

The question of funding has added pertinence given the international development narrative (crystallised in the [Addis Ababa Action Agenda](http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf)and the [Sustainable Development Goals](http://www.undp.org/content/undp/en/home/sustainable-development-goals.html)) that stress domestic self-reliance. The World Bank’s Tim Evans spoke on how health ministers can frame their arguments when dealing with treasury ministers, largely centring on the cost-effectiveness of primary care. There were also constant reminders that foreign investment can be attracted for primary care by linking it to pre-existing global commitments. Virtually all Member States have signed up to the Sustainable Development Goals which includes a commitment to [Universal Health Coverage](http://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc))– the tripartite aspiration of delivering universal access to comprehensive health services with adequate financial protection – strongly boosted by Gates, the World Bank, and WHO. Dr Tedros, WHO Director General, repeatedly stressed that primary care (PHC) is the best (and cheapest) platform for improving access and increasing services; ‘no UHC without PHC’.

**Integration**

For countries with well-developed primary care systems, the challenge was for better integration. Structuring medical training and hospitals around single organs is nonsensical in the age of multimorbidity. Primary care’s coordinating role should be extended to unite clinical services at all levels (primary, secondary, tertiary) around individual patient needs. Primary care teams should also integrate more deeply with local services, communities, and non-health agencies that influence local health outcomes. A third facet of integration concerns the marriage of individual and population management in primary care (an [element](https://blogs.plos.org/globalhealth/2018/10/primary-care-2-0/)that’s very close to my heart).

Most systems currently focus all activity on helping individuals, be that with sciatica or stopping smoking. Capitation and empanelment are prerequisites for incentivising primary care teams to focus on primary prevention at scale. The next step is following Slovenia, Belgium, and certain US practices in using primary care data to improve structural determinants that affect local subpopulations (housing, playgrounds, school meals, cycle lanes etc). This repeated aspiration exposed unanswered normative questions about the remit of clinical staff and the boundaries of primary health care.

These tension stem from a mismatch between primary health care’s sphere of influence and sphere of concern. Clinicians have a large stake in the welfare system, economic growth, social housing, tobacco taxation, and early years education because these factors are responsible for approximately [80%](https://www.health.org.uk/publication/what-makes-us-healthy)of health outcomes. But primary care clinics are not, and should not, become city councils – administering benefits, planting trees, and removing asbestos. Yet various speakers at the conference risked conflating primary health care with development, or simple good governance. The point is that whilst clinicians have a definite role to play in addressing social determinants, it probably does not extend far beyond documenting problems and advocating for patients. Nevertheless, even this limited role is markedly underdeveloped.9Defining the ways that primary care teams canagitate for social change within their local communities is a key post-conference priority.

**A cure for capitalism?**

The final element to report from the conference was the lack of debate around markets. The original declaration recognised the damage caused by capitalism and globalisation by, somewhat ambitiously, calling for a ‘new economic world order’. Global markets and economic development influence virtually every aspect of health (positively and negatively) including access to services, pharmaceutical pricing, and the spread of junk food, tobacco, and alcohol across international borders. Yet this vital topic was relegated to a single lunchtime café session: ‘Calling for a new economic argument – the forgotten element of the Alma-Ata Declaration’. The session was poorly attended and lacked nuance.

Ministers of health can hardly be expected to create a new global economic model, but there is an urgent need to explore regulatory approaches to mitigate the negative externalities of global trade whilst spreading its benefits. And there have been plenty of benefits: China’s economic liberalisation lifted 800 million people out of poverty, capitalism has generated enormous prosperity, improved living standards, built democratising middle classes and generated the tax revenue that pays for national health systems. Yet it has done so at the cost of planetary destruction and gross inequalities. The ‘winner-takes-all’ profit motive unleashed such astounding creativity and wealth that leaders have been blinded to the plight of those left behind. In the words of Dr Tedros, we have achieved health for some, not health for all. Global public health voices are needed more than ever in the volatile world of international trade, calling for risk-based regulation and the right to enforce appropriate regulatory measures to protect health.

**Now the work begins**

What next? The conference unpacked many of the steps required to realise primary health care including multidisciplinary teams, capitation, empanelment, and engagement with other sectors. Supporting [technical documents](https://www.who.int/primary-health/conference-phc/background-documents), [case studies](https://www.who.int/primary-health/case-studies), and a fully-engaged WHO provide additional support, but the path is not easy. To-date, many of the most impressive national examples feature messy compromise, open negotiation, engagement with local voices, and incremental reform.

Time in office is often fleeting for ministers of health, and it is tempting to focus on highly-visible quick wins. Advancing primary health care – efficient, effective, and equitable – requires personal commitment and difficult structural reform. I urge politicians and policymakers to honour the promises made in Astana in pursuit of ‘health for all’.

**Project Syndicate**

**The Keys to Universal Health Coverage**

**By: Jakaya Kikwete**

*(5 November)*

In 2015, the international community came together and committed to providing high-quality affordable health care to all 7.7 billion of the world's people. To achieve that goal, policymakers should focus on expanding primary care, sustaining political will, and harnessing the power of data.

DAR ES SALAAM – It has been three years since world leaders committed to one of the boldest goals ever set in global public health: achieving universal health coverage by 2030. Achieving this objective will mean that every person in every community has access to affordable care, both to prevent them from falling ill and to treat them when they do.

The stakes are simply too high not to deliver on this promise. We cannot eradicate poverty, protect people from pandemics, advance gender equality, or achieve any of the other 2030 Sustainable Development Goals (SDGs) without accelerating progress toward universal health coverage.

Fortunately, national leaders are starting to take concrete steps toward expanding access to health care. As I, along with many others, have come to realize, success depends on first overcoming one of the most significant challenges in health: overly fragmented approaches to delivering care. Instead of treating one disease at a time, we need to establish systs in which people’s diverse health needs are treated side by side. Every woman should be able to turn to a trusted provider in her community to receive family planning services for herself, routine immunizations for her children, or diabetes treatments for an aging relative.

The best way for countries to achieve a more integrated approach is to strengthen primary care, which is most people’s first point of contact with the health system. Primary-care providers can address more than 80% of health needs. And because primary care is delivered to rich and poor alike, it is the foundation of a fair and equitable society.

Having recognized these potential benefits, world leaders recently met at the [Global Conference on Primary Health Care](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttp-253A-252F-252Fwww.who.int-252Fprimary-2Dhealth-252Fconference-2Dphc-252F-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703388261-26sdata-3DbkXDGJPBORKzzez6TzHEhQkOen-252FmIsGocYzxFNJq6AQ-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=oP0wsh-usuE24Xw0RPL7_pfYLgpDGcMxoKk4aaGUqGo&e=) in Astana, Kazakhstan, to endorse a new declaration that commits them to strengthening primary-care systems within their respective countries. But now the hard work begins. With national leaders considering how best to meet their new commitment, I would emphasize two factors that are integral to making progress.

First, we need to maintain the political will to strengthen primary care and achieve universal health coverage. To that end, World Health Organization Director-General [Tedros Adhanom Ghebreyesus](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttps-253A-252F-252Fwww.project-2Dsyndicate.org-252Fcolumnist-252Ftedros-2Dadhanom-2Dghebreyesus-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703388261-26sdata-3Dx2exex-252FYbgCFyqePDXOi2zoszGRLQ3pOfBjGGC0LjrY-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=uG2BgOJvMSZB1i0jfRYj078-TgjzJCH-ev5-lRyCPms&e=) recently called on heads of state and government to undertake [concrete reforms](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttp-253A-252F-252Fwww.who.int-252Fdg-252Fspeeches-252F2018-252F142-2Dexecutive-2Dboard-252Fen-252F-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703398280-26sdata-3DFH-252BYT8eylpxqmRYU0yPKiS6y5NrzEpwcHbWDTBj-252FqE8-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=DKiPqOP1i9b7UmHCJVH6p6SYo7XATVJsUm7z4uh5rP8&e=) in that direction starting this year.

From my own experience as a former president of Tanzania, I know that persistent, firm, top-level leadership is necessary to move the complex machinery of government. That is why I joined with the health advocacy organization [Access Challenge](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttp-253A-252F-252Faccesschallenge.org-252F-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703398280-26sdata-3D9jUdSgxNb-252Fa2MRhGMvVte-252FG4sxpxifDHDY9jU17G-252Fyk-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=gYu8DNjjS4Kkyt7_i50MunJBtHyhEN-nVAP_Vas5oFI&e=)to launch the “One by One: Target 2030” campaign on the sidelines of the United Nations General Assembly this year.

As part of the campaign, I will be meeting with leaders throughout Africa to encourage them to take tangible steps toward strengthening primary care. The goal is to protect the basic [right to health](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttps-253A-252F-252Fwww.project-2Dsyndicate.org-252Fcommentary-252Fhealth-2Dis-2Da-2Dhuman-2Dright-2Dby-2Dmichel-2Dsidibe-2Dand-2Ddainius-2Dpuras-2D2017-2D11-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703408280-26sdata-3Dq-252BZZXIc68R8-252BeI0sYlIeX4vmb5j1SvUOrMDa9zHxoSc-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=CyqQE-K-M2EtTCEtc731TgB7MlEVhWSoyPoS6kf8qLk&e=) of every child, adolescent, mother, and family.

The second key to progress is improved data so that we can monitor what we have accomplished and what work remains to be done. Reliable data are needed to determine whether people are encountering financial or geographic obstacles to health care; whether care is being administered safely and effectively; and whether it is reaching the most marginalized groups in society.

National leaders and public health officials need to know all of this and more in order to identify weaknesses in the primary-care system and target areas for improvement. Data are also an important tool for health-care advocates and average citizens who want to track progress over time, hold leaders accountable, and demand the care they need and deserve. Yet too often, and despite its potential to drive improvement and foster accountability, data collection is treated as an afterthought.

The [Primary Health Care Performance Initiative](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttps-253A-252F-252Fimprovingphc.org-252F-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703418285-26sdata-3DAvaHPvTAt9T3FsAYn-252FVSiEWgHKHS4C-252FV8FofWQ4pZDc-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=zHC_J4-O9_zEPjsGwm4EkTB4jMup-Ssmuc7klGi3NAA&e=) is working to address precisely this issue. At the Global Conference on Primary Health Care, the PHCPI joined with several countries from around the world to launch a new tool to help policymakers and providers improve care. With [Vital Signs Profiles](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttps-253A-252F-252Fimprovingphc.org-252Fvital-2Dsigns-2Dprofiles-26data-3D02-257C01-257CDiane.Scott-2540gatesfoundation.org-257C5167e72d713b4a0cecda08d64341364b-257C296b38384bd5496cbd4bf456ea743b74-257C0-257C0-257C636770344703418285-26sdata-3DA5zF8aNblJLTRXc-252BXarPUgFVV7JiHPGsq5FnAJCwoDI-253D-26reserved-3D0&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=VaS-fhIQAde780wam8RtB-gaXcqNsZ_D3xSX6n52ZykGMwB2x5hxWVDF9D1blla9&m=DfskEIOVtETw9IPTTQ2NMR6N-o0ri8e6YqbiHAAMmT4&s=ZdiMsYdprisC4uNFM8uG00wWaK65BrrB-mbgeVSTAJY&e=), they can quickly access information on primary care that is both useful and easy to understand.

As I begin to reach out to African leaders one by one, I look forward to the day when we will have achieved universal health coverage for the world’s 7.7 billion people. With high-level political commitments and new tools for promoting access to care and fostering accountability, I am confident that we can make this ambitious vision a reality.

**UN News**

**‘Essential step’ towards universal health care made at pivotal UN conference**

*25 October 2018*

The commitment came at the [Global Conference on Primary Health Care](http://www.who.int/primary-health/conference-phc), being held in the capital of Kazakhstan this week. Known as the [Declaration of Astana](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf), it reaffirms the historic 1978 [Declaration of Alma-Ata](http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/), which was the first accord reached by world leaders on primary health care.

Thursday’s declaration is also intended to help the world achieve [Sustainable Development Goal 3](https://sustainabledevelopment.un.org/sdg3): “ Ensure healthy lives and promote well-being for all at all ages.”

**Today, instead of health for all, we have health for some - *Tedros Adhanom Ghebreyesus, WHO Director-General***

The 1978 declaration laid the foundation for universal primary health care, but progress over the past four decades has been uneven: today, half the world’s population lacks access to essential health services – including care for non-communicable and communicable diseases, maternal and child health, mental health, and sexual and reproductive health.

The new Declaration has been made as a global movement grows for greater investment in primary health care to achieve universal health coverage: so far, health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems – a gap highlighted by several health emergencies in recent years.

“Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the [World Health Organization](http://www.who.int/en/)([WHO](http://www.who.int/)). “We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health.”

The signatories to the Declaration made pledges in four key areas: for bold political choices for health to be made across all sectors; to build sustainable primary health care; to empower individuals and communities; and to align stakeholder support to national policies, strategies and plans.

The World Health Organization (WHO), UN Childrens’ Fund ([UNICEF](https://www.unicef.org/)) and the Government of Kazahstan are co-hosting the Global Conference on Primary Health Care, described as “pivotal” by the WHO, with participants including government ministers from around the world, health workers, activists and leaders from civil society and the private sector.

In a joint statement, UNICEF and WHO promised to help governments and civil society to act on the Declaration of Astana and support the implementation of the pledges made in the Declaration.

**Vatican Insider**

**Francesco: health is a universal right, health services are accessible to everyone**

*25 October 2018*

"Health is not a consumer good, but a universal right: we combine efforts to make health services accessible to all. *#HealthForAll* ». This is the tweet launched by Pope Francis on the Twitter account *@Pontifex* , on the occasion of the Global Conference on Primary Health Care underway today and tomorrow in Astana, Kazakhstan. The event is promoted by the World Health Organization, Unicef ​​and the Kazakh government to reiterate the principle that "everyone must have access to health care, whoever they are, wherever they live".

With the tweet Pope Bergoglio returns to express his concern for a sector "in which the culture of waste shows its painful consequences clearly", as he had said in the speech to the participants at the meeting of the Charity and Health Commission of the CEI in the 2017. "When the sick person is not placed at the center and considered in his dignity, attitudes are created that can even lead to speculating on the misfortunes of others. And this is very serious! », The Pontiff had said.

On several occasions, recalls *Vatican News* , Francesco also highlighted the risk that "the business model in the health sector, if adopted indiscriminately, instead of optimizing available resources risks producing human waste". And in his programmatic apostolic exhortation *Evangelii gaudium* had vigorously encouraged "the rulers and the financial power" to make sure that there is "health care for all citizens".

**Vatican News**

**Pope: health is a universal right**

*25 October 2018*

In a tweet on the occasion of the World Conference on Primary Health Care that is being held in Kazakhstan, Pope Francis calls on all to join efforts to make health services accessible to all.

**Vatican CITY**

Health is not a consumer good, but a universal right: let us join our efforts so that health services are accessible to all. Health for all: this is the tweet launched by Pope Francis on the occasion of the World Conference on Primary Health Care promoted today and tomorrow in Astana, Kazakhstan, by the World Health Organization, UNICEF and the Government of Kazakhstan, for reaffirm the principle that "every person must have access to health care, whoever he may be, wherever he lives".

## **The health business model can produce human waste**

A theme particularly dear to Pope Francis. "If there is a sector in which the culture of discarding clearly shows its painful consequences, it is precisely the health sector," he said in his speech to the participants in the meeting promoted by the Commission for Charity and Health of the Conference Italian Episcopal on February 10, 2017. "When the patient is not placed in the center and considered in their dignity, attitudes are generated that can even lead to speculation about the misfortunes of others." We have to be attentive, especially when patients they are elderly people with a very compromised health, if they suffer from serious and expensive illnesses for their care or if they are particularly difficult, such as psychiatric patients. The business model in the health sector, If it is adopted indiscriminately, instead of optimizing the available resources, it runs the risk of producing human waste. Optimizing resources means using them ethically and in solidarity and not penalizing the most fragile.

## **Catholic hospitals to protect themselves against the risk of corporatism**

In the Apostolic Exhortation *Evangelii Gaudium,* he had already strongly urged "the rulers and the financial power" to ensure that there is "health care for all citizens". On World Day of the Sick 2018, he urged Catholic hospitals to protect themselves "against the risk of corporatism, which all over the world seeks to bring health care to the market, finally discarding the poor." Organizational intelligence and charity require that the person of the patient be respected in their dignity and that they always remain at the center of the attention process. These guidelines must also be specific to Christians who work in public structures and who, through their service, are called to give a good witness to the Gospel. "

## **Defending the right to life is protecting the right to health**

And in his speech before the Diplomatic Corps on January 8, 2018, he said: "Defending the right to life and physical integrity means (...) protecting the right to health of the person and their family. This right has implications that go beyond the original intentions of the Universal Declaration of Human Rights, which sought to affirm the right of every person to have the necessary medical attention and social services. In international forums, efforts should be made to promote, above all, easy access for all to health care and treatment. It is important to join forces so that policies can be adopted to ensure, at affordable prices, the supply of essential medicines for the survival of the most needy, without neglecting the research and development of treatments that, although not economically relevant to the market, are crucial to save lives. "

## **Declaration of Astana: Equal access to health care**

The participants in the Astana Conference today published a Declaration, 40 years after the commitments made at Alma Ata in 1978, which, among other things, states the following: "We firmly affirm our commitment to the fundamental right of all human being to enjoy the highest possible level of health without distinction of any kind ". All people must have "fair access to the quality and effective health care they need, ensuring that the use of these services does not expose them to financial difficulties." It also highlights "the importance of health for peace, security and socio-economic development, and their interdependence." Recognize, unfortunately, that, "despite the considerable progress made, stay healthy"

## Africa

**Daily Business**

**Dons should participate more in the global arena**

**By Boniface Oyugi**

*5 November*

October was a very busy month in the global health arena. There was the biennial Global Health Symposium on health system research which took place at the ACC Liverpool in England.

It was chiefly advancing health systems for all in the Sustainable Development Goals (SDG) era. Then came the 10thWorld Health Summit that took place in Berlin Germany whose key themes were health system strengthening, access to medicine, and health digital revolution.

Finally, there was the Global Conference on Primary Health Care (PHC) in Astana, Kazakhstan supported by the WHO, Unicef and the government of Kazakhstan that was also marking the 40th year since Alma Ata primary care declaration.

The three events had two things in common. One, they were focusing on eliciting solutions to support the achievement of SDGs and Universal Health Coverage (UHC) in the primary healthcare and health system space.

This agenda is in line with one of the four pillars that jubilee government has been seeking to achieve by 2022: UHC. Second, they provided strategic avenues for development of critical discourse in the current global health agenda shaping the political economies of healthcare.

There was a lot of diversity within the conferences with interdisciplinary and international attendees from across the globe and the atmosphere was of academic freedom. Of the attendees, Kenya was well represented; however, nearly all Kenyan participants were from non-governmental organisations, private sector, local research institutions, and private universities. A few were from either the county or national governments. Notable absentees were dons, researchers, or students from our local public universities despite the meetings providing an enabling environment for participants from low- and middle-income countries to attend.

It was appalling not to have a single don or at least a student present research finding or even co-create ideas with such global audience especially amid the ongoing debate of Kenyan health system strengthening domain. Also astounding, was the fact that of all the PhD and master’s students in different domains of healthcare in our local public universities, none was out there to disseminate their findings to the larger global audience. Notable subjects that were being discussed were health economics, healthcare management, health policy, governance etc. for which Kenya is a leader. In fact, some of the success stories that were being presented and celebrated were based in Kenya but done by non-Kenyans. Thus, this left me wondering whether the absence of pubic university participants was due to lack of interest or lack of knowledge especially in the priority government discussions of PHC or UHC. So, what could be the problem?

Firstly, I acknowledge that local public universities have put in place some incentives to encourage and support lecturers to participate in research, attend conferences, and be a first author in a high impact peer reviewed publication. However, the problem is that most lecturers particularly in the research field see this as “peanuts” and hence look for better sources of finance in things such as short-term consultancies which are easy and provide quick money. With the current economic downfall, most dons in public universities are obsessed with get-rich quick schemes and running their own consultancy firms, clinics, and hospital in bids to compete and appear better than some of their rich students. The trade-off is significant: Money or research. The latter requires you to have done so much work in reading and writing before making the former. At what point do we say that the dons have made enough money and thus need to expose themselves or at least their students to such international events that shape the global healthcare discourse?

Secondly, public universities are still trailing behind in developing strategic collaborations particularly in health research. This could be explained by the fact that there is stiff competition for such collaborations or that we have little interest in them; hence, fewer research work. Where collaborations exist, majority of the dons are not capacity-building their student enough to compete for opportunities or even present their work in such global gatherings. We must appreciate that, aside from traditional teaching methods, appearance in such international sphere has a potential to catapult a university higher in terms of ranking.

Thirdly, to keep with the current requirement that lecturers must publish and present original work, majority are left to rely on their students to churn out work as part of their masters and PhD studies for which they present or publish together. A small part of the work is of high impact but is rarely disseminated to the global audience and only shelved as part of the achievement of the “degree”.

On the other hand, the bulk of students from local universities — both masters and PhD — are more concerned about finishing their degrees than acquiring knowledge. It is not uncommon to find a masters or a PhD graduate from our local public institutions in Kenya who cannot do a basic literature review or critiquing work without plagiarising or even apply basic research skills. Students are also not incentivised enough to learn the benefits of being exposed to such international symposia. Developing an abstract, the basic requirement for participation in the events, is an essential skill that takes little time to build.

Boniface Oyugi, PhD Fellow in Health Policy and Health Economics,Centre for Health Services Studies (CHSS),University of Kent.

**Business Ghana**

**Ghana on course for universal health coverage – Minister**

*29 October 2018*

Ghana is on course to achieving universal health coverage (UHC), particularly at the primary health care level, the Minister of Health, Mr Kwaku Agyeman-Manu, has said.

He said 40 per cent of the Ghanaian population had access to health care through the Community-based Health Planning Services (CHPS) system.

Mr Agyeman-Manu said this during a panel presentation on the topic: “Integrating Primary Health Care-based delivery”, at the Global Conference on Primary Care at Astana, Kazakhstan.

**CHPS**

He stated that the CHPS system, which addressed geographical access to health delivery, was now the basic healthcare system adopted by the country.

Ghana, he added, had 6,000 CHPS zones which catered for the population in each catchment area and 700 CHPS compounds which provided services for patients with minor ailments.

Providers of services in the CHPS compounds, some of whom were midwives, also lived in the facilities, so that they could be accessible easily, the minister added.

“Currently, 875 CHPS compounds perform deliveries and there are plans to increase the number, so that more childbirths could be handled at that level of health care,” Mr Agyeman-Manu said.

The CHPS compounds, he elaborated, were supervised by district health facilities managed by physician assistants.  
  
**Equipment**

The CHPS compounds were being equipped with the required basic tools and the minister indicated that each compound would be provided a means of transport, including vehicles, motorbikes for community health workers and bicycles for volunteers.

“All the equipment is in the country and distribution has started. By the first quarter of next year, all the CHPS compounds should be fully equipped,” he stated.

The equipment, funded by the United Kingdom Department for International Development (DFID) and the World Bank, includes weighing scales, delivery kits, blood pressure monitoring apparatus, clinical kits, thermometers, nutrition measurement equipment and nurses’ backpacks.

The Japanese International Cooperation Agency (JICA) is also providing additional support in the form of motorbikes for the Upper West, Upper East and Northern regions, while the Korean International Cooperation Agency (KOICA) is giving motorbikes for the Upper East Region.  
  
**NHIS**

Aside from the CHPS programme, Mr Agyeman-Manu said the National Health Insurance Scheme  (NHIS) provided financial accessibility to health care.

Forty per cent of active subscribers of the NHIS were in the rural areas, he added.

Contributing to the discussion, the Head of the Policy, Planning, Monitoring and Evaluation (PPME) Division of the Ghana Health Service, Dr Koku Awoonor-Williams, indicated that Ghana was the only country that had developed a primary healthcare system and trained the right cadre of service providers to drive the system. He said the country had 12,000 community health nurses distributed in all the regions providing care, with each CHPS zone having at least four nurses. Dr Awonoor-Williams disclosed that an assessment conducted by the ministry showed that not all the 6,000 CHPS zones were fully functional and so steps were being taken to address the shortfalls.

“For a CHPS zone to be fully functional, it must complete a 15-step process to be adequately prepared and positioned to provide the full complement of primary health care.

“This comprises health promotion, prevention, health education, treatment of minor ailments, effective referral, home visits, community mobilisation, family planning, maternal and child health and expanded programme on immunisation services,” Dr Awoonor-Williams said.

**CNBC Africa**

**Protecting Africa’s invisible children, the case for birth registration and a digital identity**

*26 October 2018*

Universal health coverage (UHC) is the vision that all countries provide affordable, quality preventive and curative healthcare to every person, everywhere. Besides helping to end extreme poverty and prevent 10 million deaths by 2035, this Sustainable Development Goal target is expected to also contribute to a grand convergence in health, where the poorest countries’ rates of mortality – infectious, infant and maternal – fall to levels currently only seen in the best performing middle income countries.

However, to achieve truly universal access will involve the strengthening and expansion of primary health care (PHC) in low and middle income countries. For example, building on those health interventions that most benefit vulnerable communities while simultaneously having the greatest reach—interventions like childhood immunisation.

Today, immunisations reach more children globally than any other child health intervention. Yet, despite progress in recent decades, we are still missing a large number of children.

To understand why, first consider how far we have come. This fall marks the 40th anniversary of the Alma-Ata Declaration, an international agreement that underlined the importance of PHC in achieving “Health for All”. Back then, barely 5 percent of the world’s children received routine immunization – measured as three doses of diphtheria-tetanus-pertussis-containing vaccine. Today that figure is 86 percent globally, or 82 percent if you just take into account the world’s poorest countries. That means considerably more children now have vaccination cards than birth certificates.

Despite such extraordinary progress, the challenge we now face is that the one-in-five children in the poorest parts of the world who are still missing out are not just the last to be reached, they are by far the hardest to reach. These children are living in the most impoverished and vulnerable communities, from remote rural villages to urban slums to conflict-affected communities. They are invisible to the health and welfare system of a country, not appearing in the often archaic, paper-based vital registration systems that  certify births, deaths, and marriages. Given the low political voice of these populations, the fact that these children do not appear in any official records makes them easy to ignore, particularly in the absence of political will to serve these populations.

Birth registration and the use of digital identity technology has the potential to bridge that gap, by ensuring that every child has a unique identifier that can be used for birth records, medical records, and education records that stays with them through life. This may sound like a tall order for low-income countries that often barely even have stable power grids, but it is nevertheless highly achievable in a rapidly changing world where families have more access to mobile phones than toilets.

In some regions of Tanzania, for example, when mothers give birth at health facilities their babies are immediately enrolled onto the digital tablet-based Electronic Immunisation Registry (EIR). Those born outside health facilities are enrolled by community leaders, or later by health workers during their first vaccination. This means that from birth there is a digital record for each child, enabling health workers to keep track of their immunization status across entire districts, even as families move between health facilities, clinics and outreach sessions.

This system then acts as a platform for broader health interventions, including access to nutritional supplements, malaria prevention and deworming treatments. And now the Tanzanian government is in the process of integrating all maternal health services, family planning and other services, meaning that once a child is registered she or he should be able to benefit from all services.

Created under the leadership of the Government of Tanzania and with support from key partners including the Bill & Melinda Gates Foundation, PATH, JSI and UNICEF, and with plans to roll the system out nationwide with Gavi support, the EIR is just one example of what can be achieved with digital technology. We need to see more of this. In particular, this is an opportunity for private sector engagement in the UHC agenda. Besides its current role in building stronger PHC through data systems, logistics, data and smarter financing, there is a need for the private sector to invest and engage with governments and bring its expertise and innovation to develop scalable digital identity solutions too.

We know that one-in-four children globally, and closer to one-in-two in Africa, do not formally exist because their birth was never registered. This is more than just administrative oversight. It’s at the heart of how governments improve the lives of its citizens. Beyond protecting children’s health, birth registration is capable of helping protect children’s futures. By linking into education and training services, we can not only achieve universal health coverage, but can also prevent the fifth child from becoming an invisible generation when they are older.

*\*Seth Berkley is the CEO of Gavi, The Vaccine Alliance and Henrietta Fore is the Executive Director of UNICEF*

**Daily Graphic**

**Ghana benefits from primary health care initiative**

**By: Rosemary Ardayfio**

*1 November*

Ghana is one of 11 countries that have benefitted from a Primary Health Care Performance Initiative (PHCPI) to identify measurement gaps in its health care system.

The initiative is a partnership among the Bill & Melinda Gates Foundation, World Bank Group and World Health Organisation, in collaboration with Ariadne Labs and Results for Development.

The PHCPI developed ‘Vital Signs Profiles’ to provide country-by-country snapshot of primary health care, highlighting where systems are strong and where they are weak, to enable leaders to identify problem areas and make improvements over time.

The Vital Signs Profiles are a new measurement tool that policymakers, donors, advocates and citizens can use to better understand, and ultimately improve, primary health care around the world.

**Launch of Vital Signs Profiles**

Countries from around the world joined the PHCPI to launch the Vital Signs Profiles on the sidelines of the Global Conference on Primary Health Care held in Astana, Kazakhstan.

With the data and insights that the Vital Signs Profiles provided, countries could understand where their systems were weak and take concrete steps to improve them, said Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organisation (WHO).

He emphasised that primary health care was the most important step that countries could take to achieve health for all.

“The process of developing the first set of Vital Signs Profiles has started important conversations in countries about what it will take to achieve health for all,” said Beth Tritter, Executive Director of PHCPI.

The Senior Director of Health, Nutrition and Population at the World Bank Group, Dr Tim Evans, noted that significant data gaps made it hard to see where primary health care was falling short and the data that existed were often of poor quality or difficult to understand and use.

“Lack of measurement has made the condition of primary health care invisible to the public and to leaders,” said Dr Atul Gawande, Executive Director of Ariadne Labs. “It is essential to make the invisible visible,” he added.

The President and CEO of Results for Development, Ms Gina Lagomarsino, also said with the data and insights that the Vital Signs Profiles provided, “countries can take important steps to improve the health of their citizens.”

**Ghana profile**

In his remarks, the Minister for Health, Mr Kwaku Agyeman-Manu, said the Vital Signs Profile had helped the country to access the performance and identified gaps in its primary health care system.

“Looking at the data we have now, Ghana has made modest progress but we still have to improve our performance.” he said.

Mr Agyeman-Manu said the profile showed that government spent 72 per cent of its health spending on primary health care, adding that that formed 32 per cent of the overall expenditure.

“The access index also indicates that service coverage is 55 per cent, which is slightly low so we must work to improve access to health care,” the minister added.

He said “the Vital signs Profile is a very good tool that Ghana is using to reconcile and improve on efficiency in the provision of health care.”

**Trailblazer countries**

The Deputy Director of the PHCPI, Jeff Markins, said primary healthcare measurement had been neglected in many ways, hence the need to design a tool for countries to comprehensively capture data.

The PHCPI, which began in 2015, was working with 20 countries but the ‘Trailblazer’ countries are the ones with profile measurements that can ultimately be used in improving primary health care for their people and communities.

The 11 low and middle-income ‘trailblazer’ countries include Malaysia, Argentina, Sri Lanka, Nepal, South Africa, Senegal, Rwanda, Kenya, Cote d’Ivoire and Burkina Faso.

Ghana, he added, was one of the first countries that got all the data required and took a leadership role in collecting, analyzing and compiling the data.

The Vital Signs Profiles offer information about country context and outcomes in four categories, which are financing, capacity, performance and equity.

**Daily Graphic**

**Ghana committed to achieving health-related SDGs — Agyeman-Manu**

**By: Rosemary Ardayfio**

*(7 November)*

Ghana is committed to making primary health care accessible to every Ghanaian as a means of achieving the health- related Sustainable Development Goals (SDGs).

Goal three of the SDGs, set by the United Nations General Assembly in 2015, aims to "Ensure healthy lives and promote well-being for all at all ages.”

Contributing to a discussion on what new measures can be adopted to facilitate the achievement of the health-related SDGs, Mr Agyeman-Manu noted that in their quest to develop their economies, many governments were grappling with competing demands on their resources.

Consequently, he said, health-related expenditure was sometimes shifted to other areas, resulting in dwindling capital expenditure in the health sector.

The discussions was held at a special ministerial session at the Global Conference on Primary Health Care held in Astana, Kazakhstan, which was organised by the Government of Kazakhstan, the World Health Organisation (WHO) and UNICEF.

It was to mark 40 years of the Alma-Ata declaration on Primary Health Care.

**Healthy lives**

The deliberations centered on the Action Plan for Healthy Lives and Well Being for All, the landmark commitment to find new ways of working together to accelerate progress towards achieving the United Nations’ SDGs which was recently signed by 11 heads of the world’s leading health and development organisations.

The commitment follows a request from Chancellor Angela Merkel of Germany, President Nana Addo Dankwa Akufo-Addo of Ghana, and Prime Minister Erna Solberg of Norway, with support from the United Nations Secretary-General, Antonio Guterres, to develop a global action plan to define how global actors can better collaborate to accelerate progress towards the health-related targets of the 2030 Sustainable Development Agenda.

The Global Action Plan will also enhance collective action and leverage funds to address gender inequalities that act as barriers to accessing health, and to improve comprehensive quality health care for women and girls, including sexual and reproductive health services.

The organisations that have already signed up to the Global Action Plan for Healthy Lives and Well-being for All are: Gavi the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Financing Facility, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, UN Women, the World Bank and WHO. The World Food Programme has committed to joining the plan in the coming months.

**Health infrastructure**

Discussing the topic, “Action Plan for Healthy Lives and Well Being for All: Uniting global health organisations to accelerate progress towards the health-related SDGs”, Mr Agyeman-Manu stressed that achieving the health-related SDGs calls expansion of roads and health infrastructure, retooling and tooling of health facilities, training and employment, among others.

He observed that to improve capacity and equity, countries must have the required human resource in health facilities at all levels “to do the work that will enable us to achieve the quality health care that we are all looking forward to, to enable us to achieve the SGDs on health.”

**Ghana’s example**

Citing Ghana, as an example, he said the government was providing free postgraduate training for medical officers as a means to improve the capacity of public facilities to provide quality care.

“We are using that policy to redirect training into primary health care and other specialties so that we can have people who can work in the rural areas and can manage general hospitals rather than specialist hospitals to enable access and equitable distribution of quality health care,” Mr Agyeman-Manu stated.

Ghana, he added, was also training about 50 nurses from Sierra Leone in some of its health training institutions, with sponsorship from Medicins san Frontiere.

**Other meetings**

During the conference, Mr Agyeman-Manu also had separate meetings with the WHO, Director-General, Dr Tedros Adhanom Ghebreyesus and Dr Yelzhan Birtanov, Minister of Health of Kazakhstan.

In his meeting with Dr Tedros, the two discussed the possibility of Ghana being used as a model to declare universal health coverage at the primary health care level.

**Daily Nation**

**Declaration on primary health care adopted at global conference**

**By: Elizabeth Merab**

*26 October 2018*

Forty years after World Health Organisation (WHO) highlighted the importance of primary health care in tackling health inequality in every country, through the historical Alma Alta Declaration, global health leaders converged in Kazakhstan to renew the declaration.

The leaders are also reassessing and reflecting on the reasons for the slow progress and the implications for today’s health systems.

Convened by the international health agency and the United Nations Children’s Fund (Unicef), the Alma Ata conference drew an estimated 1,200 delegates and representatives from different countries, international organisations, and many non-governmental organisations.

But 40 years on, almost half the world’s population lacks access to essential health services, and 100 million people are pushed into extreme poverty by the costs of paying for care out of their own pockets, said WHO’s Director General Dr Tedros Tedros Adhanom Ghebreyesus.

“The truth is, we have allowed the vision of health for all to become too small, too diluted. We have allowed ourselves to become too focused on fighting specific diseases, at the expense of strengthening health systems,” he went on.

According to Dr Tedros, there is still a 31-year discrepancy between the countries with the shortest and longest life expectancies. Some people enjoy the benefits of cutting edge medical technologies, while others don’t have the basics.

The new declaration for the first time acknowledge the need to create decent work and appropriate compensation for health workers working at the primary health care level. It also puts emphasis on investing in the education, training, recruitment, development, motivation and retention of the workforce, with an appropriate skill mix.

On Thursday, United Nations 193 Member States unanimously vowed to strengthen their primary health care systems as an essential step toward achieving universal health coverage. This commitment is part of the agreed to the Declaration of Astana 2018, which seeks to reaffirm the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care.

“This declaration, and the commitment it represents, lay a path for a healthier, more prosperous world, where quality, affordable health services are easily accessible to all,” noted UNICEF Executive Director Henrietta Fore.

To do this, leaders, among them a Kenyan delegation led by Health Ministry’s Cabinet Secretary Sicily Kariuki and Universal Health Coverage co-chair and Amref CEO Dr Githinji Gitahi, agreed that to achieve an efficient health system, a multi-sectoral action that includes technology, scientific and traditional knowledge, along with well-trained and compensated health professionals, and people and community participation is needed.

This will strengthen primary health care and provide quality “health for all”, the World Health Organisation said in its Astana Declaration on Primary Health Care released in the Kazakhstan capital.

After years of relative neglect, the WHO has recently given strategic prominence to the development of primary health care. Also known as PHC, Primary health care is a concept tailored to care for people, rather than simply treating specific diseases or conditions.

The WHO defines primary healthcare (PHC) as the first point of contact for individuals within a healthcare system, noting that it should “provide comprehensive, accessible, community-based care that meets the health needs of individuals throughout their life”.

It further notes that PHC ranges from health promotion to palliative care that can meet 80-90 per cent of an individual’s health needs over the course of their life.

Every few weeks a news headline pops up that one of the referral hospitals in Kenya is reeling with patients. Little wonder that the recent report on the congestion at Kiambu Level 5 Hospital caused merely minor ripples in the form of public outrage.

Even with the Treasury recently allocating Sh2 billion to free primary healthcare, more patients still prefer referral hospitals to their local clinics and health centres. On paper, patients are encouraged to visit the health centre nearest to their homes as their primary point of contact.

To strengthen the primary health care, Unicef, through its country representative Werner Shultink in August pledged Sh15 billion ($150 million) to support Kenya’s Universal Health Care programme through immunization and nutrition programs in the next four years.

Early efforts at expanding primary health care in the late 1970s and early 1980s were overtaken in many parts of the developing world by economic crisis, sharp reductions in public spending, political instability, and emerging disease.

**Ghana Web**

**CSO pushes for more resources to aid primary healthcare**

*30 October*

The Alliance for Reproductive Health Rights (ARHR), a Civil Society Organization (CSO) in health, has called on government to show more commitment towards strengthening primary healthcare delivery in the country.  
  
He gave thumps up to the government for the implementation of the National Health Insurance Scheme (NHIS), a proactive move to give the entire citizenry an unimpeded access to primary care, but said the current situation where card bearers had to pay for basic services when they visited health facilities, needed to be addressed urgently.  
  
Nii Ankonu Annobrah-Sarpei, Programme Manager of ARHR, who made the call said Ghana was not making any progress in ensuring that basic healthcare was affordable to the entire citizenry and called for a change.  
  
He added that access to primary healthcare by the ordinary people was a human right issue critical to achieving the Universal Health Coverage (UHC) which ties in with the Sustainable Development Goal 3 (SDG).  
  
The Programmes Manager was speaking at a stakeholders’ meeting in Kumasi to discuss Ghana’s progress towards achieving primary healthcare with particular focus on health financing and service delivery.  
  
The meeting, which coincided with the 40th anniversary of the International Conference on Primary Health Care by the World Health Organization (WHO), was held under the theme, “Primary Health Care: Ghana’s Progress”.  
  
It was attended by representatives of CSOs, Persons with Disability (PWDs), the media and some government agencies.  
The meeting also provided a platform to share with participants a comprehensive analysis of Ghana’s health budget over the last three years.  
  
“The NHIS should be able to cater for the primary health care needs of the people for Ghana to achieve SDG 3,” he added.  
  
Government, he noted, must ensure its commitment to primary health care at the global level was met to ensure affordable health care for all.  
  
Nana-Aisha Mohammed, a Budget Consultant to ARHR, said in spite of the critical role of primary health care, not much resources were committed to it in 2018 budget.  
  
She however praised government for the removal of 17.5 per cent VAT on selected pharmaceutical products, saying it impacted positively on the supply of certain essential medicines.

**Infos Plus Gabon**

# **WHO sets the course for universal health coverage**

*26 October 2018*

***Geneva, Switzerland, 26 October (Infosplusgabon) - Countries around the world adopted the Astana Declaration on Thursday, pledging to strengthen their primary health care systems, an essential step towards universal health coverage.***

The Astana Declaration in Kazakhstan reaffirms the foundations of the historic Alma-Ata Declaration of 1978, when world leaders committed for the first time to primary health care, said the World Health Organization (WHO).   
  
"Today, instead of health for all, we have health for some, we all have the solemn responsibility to ensure that today's declaration on primary health care allows every person, everywhere worldwide, to exercise its fundamental right to health, "said WHO Director-General Dr. Tedros Adhanom Ghebreyesus.  
  
WHO notes in a statement that while the 1978 Alma-Ata Declaration (Kazakhstan) laid the foundation for primary health care, progress over the past four decades has been uneven.   
  
At least half of the world's population does not have access to essential health services, including care for noncommunicable and communicable diseases, maternal and child health, mental health, and reproductive and physical health.   
  
"Although the world a healthier place than before, nearly 6 million children die each year before their fifth birthday, mostly from preventable causes, and more than 150 million suffer a delay of growth," deplored the Director-General of the United Nations Fund for  
  
"As a global community, we can change this situation by bringing quality health services to those who need them, which is what constitutes primary health care," she added.   
  
According to the statement, the Astana Declaration is part of a growing global movement for increased investment in primary health care to achieve universal health coverage.   
  
The vast majority of health resources have been focused on interventions targeting a single disease rather than on sound and comprehensive health systems, a gap identified by several health emergencies in recent years.  
  
"The adoption of the Declaration at this World Conference in Astana will set new directions for the development of primary health care as the basis of health care systems," said the Minister of Health of the Republic of Kazakhstan, Yelzhan Birtanov.   
  
"The new Declaration reflects the obligations of countries, individuals, communities, health systems and partners to live healthier lives through sustainable primary health care," he said.   
  
UNICEF and WHO will support governments and civil society in the implementation of the Astana Declaration and encourage them to support the movement and also support countries in reviewing the implementation of the Declaration.

**PM News**

**PHC, panacea to health for all – WHO**

*24 October 2018*

The Director-General, World Health Organisation (WHO), Dr Tedros Ghebreyesus, has declared that Primary Health Care (PHC) was the most important step that countries could take toward achieving health for all.

The director-general is quoted as saying this in a statement on Wednesday in Abuja by Ms Nisha Deolalikar, Manager, Global Health Strategies.

The statement explained that Ghebreyesus made the remarks after a Primary Health Care Performance Initiative at the Global Conference on PHC.

“With the data and insights that the Vital Signs Profiles provide, countries can understand where their systems are weak and take concrete steps to improve them,” it said.

According to the statement, the initiative offers a more complete picture of the state of PHC in different countries than ever before; it also provides insights into where systems are strong and where they can be improved.

Deolalikar said that the initiative helps answer several key questions on PHC systems such as Financing, Capacity and Performance, among others.

She explained that the initiative was a partnership between the Bill & Melinda Gates Foundation, World Bank Group and World Health Organisation in collaboration with Ariadne Labs and Results for Development.

She said the initiative would help policymakers, donors, advocates and citizens better understand and ultimately improve PHC.

“Governments and donors can use each Vital Signs Profile to identify priority areas for improvement, track and trend progress over time, and ultimately improve PHC.

“Advocates and citizens can use the Vital Signs Profile to hold leaders accountable and call for specific financing or policy reforms,’’ it said.

However, the statement noted that more and better data was needed to improve PHC system across the globe.

“Half the world’s population still lacks access to essential health services, the majority of which can be delivered through strong PHC.

“Primary care is a person’s first and main point of contact with the health system, and connects people with trusted health care providers who can meet most of their health needs throughout their lives.

“Recognising the importance of PHC, policy makers, donors, advocates and partners from around the world are coming together this week for the Global Conference on Primary Health Care,’’ the read in part.

It explained that the conference would sign and adopt a new declaration committing policy makers, donors, advocates and partners to strengthen primary health care as the foundation of health for all.

**Science Africa**

**Effective Primary Care Can Curb 8.6m Deaths**

**By: Sharon Atieno**

*30 October*

Half of the world’s people still lack access to essential health services, the majority of which can be delivered through strong primary care; this is according to a 2017 joint World Bank and World Health Organization (WHO) report. Statistics from a 2018 Lancet Global Health Commission on high quality health systems in Sustainable Development Goals (SDG) Era indicate that, 8.6 million people die yearly from conditions that are treatable by primary care and the rest of the health system.

Lack of data has resulted in less attention being given to primary health care (PHC) as there was no way to fully assess the performance of the sector. For this reason, Primary Health Care Performance Initiative (PHCPI) through partnership with 11 trailblazing countries has released the first set of Vital Signs Profiles (VSP). This is a measurement tool that provides essential data on various aspects of PHC thus making assessment of the sector possible for low and middle income countries.

“The profiles shine a light where systems are strong and where they are weak. They compile and analyze multiple quantitative and qualitative data sources helping to build a richer and more detailed picture of a country’s PHC system than what has been previously available,” said Beth Tritter, Executive Director, PHCPI. She was speaking at a media telephone briefing alongside other speakers in light of the new commitment by countries around the world to strengthen PHC systems in Astan, Kazakhstan.

Though PHC plays a vital role in ensuring that universal health care is reached, lack of or inadequate data has hindered countries from gauging the sector’s overall performance and knowing which areas need improvement thus, slowing the progress towards health care for all.

“There is significant data gap that makes it difficult to say where and why PHC falls short. Data that does exist is often old, of poor quality or generally difficult to understand and compare,” laments Asaf Bitton, Director, Ariadne Labs.

In addition, he pointed out that only a few countries globally have comparable data on the delivery of primary health care including information on whether patients see providers that are well trained, whether they get the right diagnosis and whether systems are working well and managed correctly.

“Data gap is a significant weakness in PHC and is making it difficult to increase investment and to really understand where and how health systems are falling short to drive targeted improvements,” stated Tritter.

The VSP focuses on four main areas: finance, capacity, performance and equity. In finance, it indicates the amount of money the government spends on PHC. For capacity, it provides information on policies that prioritize PHC as well as evaluating whether the system has enough drugs, supplies and health care providers. Moreover, it assesses performance on whether people are able to get the care they need without financial or geographic barriers and whether the care being given is of high quality. It also provides information on equity whether there is effective service to the most marginalized and disadvantaged groups.

The VSP is a measurement tool that multiple stakeholders can use to better understand and ultimately improve health care globally. Policy makers can use the profiles to drive deeper conversations and data gathering on PHC and set an agenda for concrete improvement as well as ensuring that health providers are accountable. Donors and development partners can use the VSP to drive resources where they are needed and to ensure investment for global health goal are achieving their intended effects. Citizens and civil society can use the profiles to hold policy makers accountable for global and national commitments, and to advocate for the types of policies and investments that make health accessibility for all a reality.

“The VSP is an important step to making information on PHC more accessible but it is as accurate as the underlying data that got into it. More investment has to be made to complement the data gap that we are seeing ,”Dr. Jeremy Veillard, Program Manager, PHCPI, World Bank

The VSP contains data from numerous national surveys such as the Service Delivery Indicators (SDI) from the World Bank Group, the Service Provision Assessment (SPA) and Demographic and Health Surveys (DHS) from USAID, the Service Availability and Readiness Assessment (SARA) from WHO, and the Multiple Indicator Cluster Surveys (MICS) from United Nations International Children’s Emergency Fund (UNICEF). Additional data was collected and reported by countries. Sources were chosen after several rounds of review with global experts on the monitoring and evaluation of PHC.

Globally, similar data sources were preferred, when available, in order to promote international comparability as a potential mechanism for enhancing accountability and cross-country learning. While indicators and globally comparable data sources were preferred to populate areas of the VSP, in many cases such data does not exist. In these cases, PHCPI has worked with countries to find alternative data sources for the profile that are consistent with the PHCPI framework, even when such sources are not globally comparable.

Improving PHC requires availability of more and better data on PHC that will be used to drive decisions that make people’s life better thus achieving universal health care and SDG 3 which advocates for good health and well-being. Measurement is key to accountability and improvement through capturing the essential processes and outcomes that matter to individuals.

**The Standard**

**Bold political choices best guarantee for good health care**

**By: Sicily Kariuki**

*8 November 2018*

Primary Health Care (PHC) plays a critical role in achieving health for all. It is an essential feature of health systems that secures accessible, affordable, cost-effective, quality, equitable, comprehensive, integrated and people centered services.

Existing evidence indicate health systems that are developed around strong PHC deliver better health outcomes because 90 per cent of all health needs can be met at the Primary Health Care level.

**Alma-Ata declaration**

It is in this regard that 40 years ago, 134 countries adopted the declaration of Alma-Ata, which set a target for the attainment of health for all. Progress in the uptake of PHC across the world has since contributed to raising global standards of health care, delivered important population health gains, including improved life expectancy and increased child survival.

Kenya has made tremendous strides in health care provision. Life expectancy has improved from an average of 48 years in 1978 to 65 years. Similarly, under-five mortality has reduced from 175 to 54 deaths per 1,000 live births and maternal mortality ratio from more than 800 deaths per 100,000 deliveries in 1978 to 362 deaths per 100,000 deliveries.

The use of modern contraceptives has increased from as low as 7 per cent in 1978 to 52 per cent in 2018 while fertility rate has reduced from 8.1 per cent to the current 3.8 per cent. Likewise, we have managed to increase the proportion of deliveries by skilled personnel to 62 per cent and the fully immunized children below one year to 80 per cent.

Malaria fatality cases and TB infections have been reduced while the prevalence of HIV has declined from 14 per cent to 5.6 per cent. Diseases like smallpox have been eradicated while guinea worm infections and maternal tetanus have reduced significantly.

While we cherish these tremendous achievements, the world is now grappling with emerging challenges. For example, close to six million children are lost around the world every year before their fifth birthday, mostly from preventable causes. Over 150 million children are stunted and many adults are still dying from non-communicable diseases.

The emerging challenges of non-communicable diseases including cancers and cardiovascular diseases, mental health, trauma and violence and the unattained goal of health for all has reignited a call for comprehensive PHC interventions.

At a recent global conference in Astana, Kazakhstan to revitalize PHC, Kenya renewed its commitment to develop people-centred PHC interventions, build on the principles of the Alma-Ata Declaration towards UHC and Sustainable Development Goals.

The adopted Astana Declaration pledges to make bold political choices for health across all sectors, build sustainable PHC interventions, empower individuals and communities and align stakeholder support to national policies, strategies and plans.

**What We’ll Do**

We share the common global goals. Consequently, we shall carry out the following:

Firstly, prioritise, promote and protect people’s health and well-being at both population and individual levels, through strong health systems.

Secondly, promote primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed.

And thirdly, create enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being and finally push for alignment of partners and stakeholders activities toward providing effective support to national health policies, strategies and plans.

The success of our health system depends on PHC-oriented interventions geared towards proactive care, prevention measures, and health promotion at the local population level.

We are investing in PHC through community-based care, first-level health facilities, and population-based interventions with a hinge on individual and social behaviour for healthy choices throughout the life cycle.

Mrs Kariuki is the Cabinet Secretary, Ministry of Health

**Taarifa**

**Bill Gates Says Rwanda’s Healthcare System Worth Emulating**

**By: Samson Iradukunda**

*28 October 2018*

Bill Gates has hailed Rwanda’s health system that has seen a ‘remarkable progress’ since 1994 and said it could become a model for other nations to emulate.

In a video posted on his official Twitter account following the Global Conference on Primary Health Care held in Astana, Kazakhstan on October 25-26 this year, it’s said that “the results in Rwanda show how a strong primary healthcare programme can reap to improve healthcare outcomes.”

The conference theme was “to renew a commitment to primary health care to achieve universal health coverage and the Sustainable Development Goals.’’

“Rwanda’s health system has become a model for other nations to follow. The country’s example should inspire all leaders to renew their commitments to primary health care,’’ Bill Gates said in a tweet.

According to Bill & Melinda Gates Foundation’s video reserved for the Global Conference on Primary Health Care, in 1994, there were only 96 doctors serving a population of six million, meaning one doctor for every 63,000 people.’’

As the country emerged from the genocide, the Rwandan Government prioritized rebuilding its health system and after two decades since, it made remarkable progress.

Between 1995 and 2005, the number of community health workers increased from 12,000 to 45,000 in 2015.

Official numbers as per 2017 show that between 2010 and 2017, there were 45,516 community health workers who can treat 80% of sicknesses and treated over 900,000 sick people from 2010 2017.

In 2018, three community health workers including one dedicated to maternal health provides medical in every Rwandan village.

These workers also provide database used at the national level to identify emerging problems, develop policies and ensure funds are used effectively.

Rwanda reduced its under 5 mortality rate from 195/1000 live births in 2000 to 39 /1000 in 2016 and 98% of children are receiving their basic vaccinations and every child is diagnosed and provided with vaccinations for pneumonia and malaria.

In 2015, Rwanda achieved the fifth among the Millennium Development Goals (MDG 5) which had two targets; to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and to achieve, by 2015, universal access to reproductive health.

Rwanda is one of only nine countries to have achieved this goal of reducing their maternal mortality rates by at least 75% by 2015.

Bill Gates supports different health services programmes in Rwanda through his Foundation ‘Bill & Melinda Gates Foundation’.

**Zimbabwe Broadcasting Association**

**Zim targets modernising health care services**

*4 November*

Health and Child Care Minister, Dr Obediah Moyo says the country targets to modernise health care services at primary health care level to ensure five-star and comprehensive quality service to all citizens.

Dr Moyo, who attended the 40th Global Conference on Primary Health Care in Astana, Kazakhstan recently, said the modernisation of primary health care services especially in rural areas should be a priority.

The conference saw representatives of various countries, declaring that governments, societies and partners should prioritize the provision of quality service to all citizens by setting up strong health systems.

Dr Moyo was among representatives of over 50 countries and high level officials from the global health community who adopted the Astana declaration, affirming their countries’ commitment to improving health care systems.

The declaration witnessed nations making commitments to make bold political choices for health across all sectors and build sustainable primary health care policies that will deliver comprehensive quality health care to the citizens.

## Asia

**Armenia Press**

**Armenia’s acting healthcare minister visits Astana to attend Global Conference on Primary Health Care**

*24 October 2018*

YEREVAN, OCTOBER 24, ARMENPRESS. Acting healthcare minister of Armenia Arsen Torosyan is in Astana, Kazakhstan on a working visit where he is taking part in the 2nd Global Conference on Primary Health Care, the ministry told Armenpress.

The event is organized under the auspices of the President of Kazakhstan in cooperation with the World Health Organization (WHO) and UNICEF. The conference is dedicated to the 40th anniversary of the Declaration of Alma-Ata.

The meeting is attended by healthcare, finance, education, social insurance ministries from dozens of countries, high-ranking officials from the UN member states, Ambassadors, as well as representatives of international organizations and NGOs.

During the visit the cooperation agreement between the healthcare ministries of Armenia and Kazakhstan, which was ready yet in 2015 and agreed with the Kazakh side through diplomatic channels, will be signed.

**Astana Times**

**Astana hosts global conference on primary healthcare**

**By: Malika Orazgaliyeva**

*26 October 2018*

This year marks the 40th anniversary of the Declaration of Alma-Ata, which was adopted at the International Conference of Primary Care in 1978 in what was then the capital of the Kazakh Soviet Socialist Republic. That conference gathered health experts and world leaders to commit to health for all. The Declaration of Alma-Ata formed the foundation for the last 40 years of global primary healthcare efforts.

Astana’s Global Conference on PHC adopted a new declaration emphasising the critical role of primary healthcare around the world. The declaration refocuses efforts on primary health care to ensure everyone everywhere achieves the highest possible attainable standard of health. The Astana Declaration will inform the UN General Assembly high-level meeting on United Healthcare (UHC) in 2019.

“Worldwide contribution to a better healthcare has become an important asset of the medical community. The Alma-Ata Declaration, a historical document, was included in textbooks of many universities outside of Kazakhstan. The document became a prime example of the effectiveness of international efforts. It outlined the basic principles of the development of primary healthcare, including public health education, maternal and child health, disease prevention, vaccination and drug provision. Since then, healthcare throughout the world has developed in accordance with these key areas,” he said, according to primeminister.kz.

Kazakh Prime Minister Bakytzhan Sagintayev also addressed the opening ceremony.

“Since Kazakhstan’s independence in 1991, we achieved a total coverage of our citizens with medical services. We have created an extensive infrastructure of PHC facilities, which include 1,808 polyclinics, medical centres and dispensaries. The priority area of our national healthcare policy is primary healthcare,” he noted.

“During the last 10 years, we were focused on disease prevention. Each year, two million adults are undergoing screening. The programme of vaccination against 21 infectious diseases covers five million people annually,” he said.

On the margins of the conference, Sagintayev discussed the protection of children’s rights with UNICEF Executive Director Henrietta Fore.

Sagintayev thanked UNICEF for supporting Kazakhstan’s efforts to protect children’s rights and the country’s international and regional initiatives.

Sagintayev noted that Nazarbayev declared the next year the “Year of Youth of Kazakhstan.” In this regard, the government has been tasked to support the efforts of international organisations, the non-governmental sector, research and academic circles and  human rights organisations to protect children’s rights with an emphasis on the rights of vulnerable groups.

The opening ceremony continued with meetings and sessions. In addition, the conference programme included discussion sessions and exhibitions. In general, the event was attended by 1,500 participants, including heads of state, ministers, non-governmental organisations, professional organisations, academics, young professionals and youth leaders, health practitioners and UN partners.

Sagintayev also met with Director General of the WHO Tedros Ghebreyesus. They discussed the development of common approaches to healthcare in the world, the improvement of the quality and accessibility of medical services and education, as well as the introduction of modern digital technologies to health infrastructure at the meeting.

According to [www.who.int](http://www.who.int/), PHC is about caring for people, rather than simply treating specific diseases or conditions. PHC is made up of three main areas: empowered people and communities; multisectoral policy and action; and primary care and essential public health functions as the core of integrated health services.

This includes a spectrum of services from prevention, including vaccinations and family planning, to management of chronic health conditions and palliative care.

**Astana Times**

**Kazakhstan, Russia agree to use telemedicine, work on digitising health care**

**By: Zhanna Shayakhmetova**

*30 October 2018*

ASTANA – The Kazakh and Russian Ministries of Healthcare agreed to develop joint systems to provide medical aid using telemedicine during the Global Conference on Primary Health Care held Oct. 25-26 in the capital, reported the Kazakh ministry press service.

The two countries will create a road map for cooperation. They approved collaboration to digitise health care and telemedicine and develop common standards for data exchange ensuring system interoperability to provide medical assistance using telemedicine technologies.

The agreement will improve peoples’ quality of life, noted Kazakh Minister of Healthcare Yelzhan Birtanov.

“The development of telemedicine is one of the main directions for the ministry. Recently, the head of state delivered a state-of-the-nation address focused on social issues including income of the population, social status, affordable quality education and healthcare. He emphasised the necessity to develop primary healthcare (PHC) and to increase salaries for health workers. There is a need to move to digital service and paperless medicine. We are currently working on this,” he said.

He noted Russian companies provide information systems in the medical services’ domestic market.

“We now want to expand traditional telemedicine outside hospitals with active public education, using technology to connect health workers and patients. We are confident that this memorandum will have a positive impetus. We also intend to cooperate in terms of training and exchange of experience. We want to cooperate in drug provision, to develop this area and to build a network of distributors. We are open for discussions,” he added.

Russian Minister of Healthcare Veronika Skvortsova confirmed their readiness to support all projects.

“We are convinced that digitisation is the basis for our further relations including infrastructure, personnel training and drug provision,” she said.

Earlier in the conference, she noted Russia’s medical organisations will be connected to the unified state medical system by the end of 2020.

“It will be integrated with central and regional medical information systems. The system will be linked to the procurement and drug tracking system. We will create 85 regional segments with a regional server. We will connect all medical organisations to the regional server. In total, 75,000 objects will be connected to the healthcare system,” she added.

Birtanov met with Iranian Health Minister Seyd Hassan Hashimi and participated in a Joint United Nations Programme on HIV/AIDS (UNAIDS) meeting.

The conference agenda included economic development and promoting equity through PHC. Discussions focused on building more resilient health systems to ensure emergency health response, a cross-sectorial approach to PHC and public health management, introducing PHC at the community level and access to vaccines, drugs and medical products.

**Azernews**

**Iran, Russia to expand medical coorperation**

*26 October 2018*

The health ministers of Iran and Russia in a meeting in Almaty, Kazakhstan discussed ways of promoting bilateral cooperation in the fields of health, treatment, education and supply of medicines,[IRNA](http://irna.ir/en) reports.

Iranian Minister of Health, Treatment and Medical Education Hassan Qazizadeh Hashemi met with his Russian counterpart Veronika Skvortsova on the sidelines of a conference marking the 40th anniversary of Declaration of Alma-Ata.  
  
Referring to the development of pharmaceutical sector in Iran, he underlined the need for Iran and Russia to expand cooperation in this sector with a view to increasing production capacity in this sector.  
  
The Russia health minister, for her part, said her country should make further use of Iran's successful experiences in the field of pharmaceutical industry and vaccine production.  
  
The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, Almaty, Kazakhstan, 6–12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people.

**BloombergQuint**

**Four Ways India Can Aim For Universal Primary Healthcare**

*8 November 2018*

India has to move from vertical to comprehensive programmes, improve quality and access, hire more mid-level health workers and increase funding to improve primary care for achieving universal health coverage, public health experts told IndiaSpend.

That health is not “merely the absence of disease or infirmity,” but “is a fundamental human right” was proclaimed 40 years ago in the Alma-Ata declaration in Kazakhstan. On Oct. 25 and 26, the declaration was reiterated by 197 countries around the world as they signed the Declaration of Astana that vowed to strengthen primary healthcare as an essential step for achieving universal health coverage.

India, also a signatory to the Astana declaration, has to strengthen primary healthcare if it has to achieve health for all since it accounts for 17 percent global burden of maternal deaths, the highest number of tuberculosis cases and deaths in the world and the highest number of stunted children in the world. As many as 55 million Indians slipped into poverty in 2011-12 because of health catastrophes they could not afford.

The Declaration of Astana Makes Four Key Pledges:

* Make bold political choices for health across all sectors.
* Build sustainable primary health care.
* Empower individuals and communities.
* Align stakeholder support to national policies, strategies and plans.

“Astana declaration is very important for not just India but the world as a whole to be reminded of the importance of primary healthcare as the foundation of a health system and as the critical component for achieving universal healthcare. It’s a timely reminder,” said K Sujatha Rao, former union secretary of health, public health expert and author of Do We Care: India’s Health System.

**Shift from Vertical Programmes To Holistic Care**

Even though the Alma Ata declaration called for global commitment to comprehensive primary health care in 1978, donor-driven programmes steered the low and middle income countries towards ‘selective healthcare’ focusing on a few diseases and health needs, said K Srinath Reddy, president, Public Health Foundation of India, a think-tank and research institute.

Even the millennium development goals focused on select targets and fragmented the health system into vertical disease programmes and segmented health services for specific diseases and age groups.

For example, 55 percent of the ministry of health and family welfare budget in 2018-19 was for the National Health Mission, of which maternal and child health component accounted for 74 percent. This despite the fact that non-communicable diseases such as hypertension, cancer and diabetes killed 61 percent Indians in 2016.

“The lessons of the past 40 years have taught us that vertical programmes, however nobly intended and well designed, cannot be force fitted in to a weak health system,” said Reddy.

India has taken steps to address the gap and included comprehensive primary healthcare in National Health Policy 2017.

An important component of the Ayushman Bharat Yojana or Pradhan Mantri Jan Arogya Yojana (National Health Protection Scheme) is the health and wellness centres--sub-centres and primary health centres that will be converted to provide comprehensive care for communicable and non-communicable diseases.

“If implemented, this (health and wellness centres) can be a game changer,” said Rao. “I feel this should have been accorded high priority and sequenced to be achieved before launching the hospitalisation aspect of Ayushman Bharat.”

Health systems have to be built incrementally, and hospital insurance in India’s context is likely to be overwhelming and drain resources from primary healthcare, she added.

**Improve Quality Of Care And Reduce Barriers**

Indian healthcare killed more people due to its poor quality than due to lack of access. In 2016, 1.6 million Indians died due to poor quality of care, almost double than those killed due to non-utilisation of health services (838,000), IndiaSpend had reported in September.

The current standard of sub-centres and primary health centres is poor and ill-equipped to take care of the needs of India’s growing population.

Sub-centres are at the forefront in providing healthcare at the local level; however 73 percent sub-centres were more than 3 km from the remotest village, 28 percent were not accessible by public transport, and 17 percent were unhygienic, IndiaSpend reported in a two-part series (here & here) in August.

In 24 states, instances of non-availability of essential drugs were observed by an audit by Comptroller Auditor General. Further, there was a 24-38 percent shortfall in the availability of medical personnel at primary health centres, sub centres, and community health centres in 28 states and union territories of India, CAG found.

This makes a large number of citizens--58 percent in rural areas and 68 percent in urban areas--to seek care from the private sector though it may not be any better in quality.

Implementing the Clinical Establishments Registration and Regulation Act that is adopted by over 20 states) to set in standards and monitor the private sector may help in this aspect, Reddy had told IndiaSpend earlier. Also, having a composite health quality assessment system in place will bring in more transparency, he added.

Empowering and implementing Rogi Kalyan Samitis--the patient welfare committees that use community participation for improving facilities in public hospitals can also make a difference.

**Pay And Train Frontline Workers Better, Hire Mid-Level Health Workers**

India’s over one million Accredited Social Health Activists, who are the frontline health workers, are inadequately trained and are underpaid.

About 70-90 percent ASHAs said they needed better training, monetary support and timely replenishment of the drug kit to perform better. Only 22 percent ASHAs surveyed had some understanding of their role, IndiaSpend reported in May 2016.

ASHAs are now paid a honorarium of Rs 2,000 a month--equivalent to the cost of an up-market meal for two--up from Rs 1,000 from October.

Poor living and working conditions, irregular drug supply, weak infrastructure, professional isolation and the burden of administrative work make working in rural areas difficult for doctors. This explains why there are 1,974 primary health centres without doctors and why 39 percent medical providers in PHCs in 19 major states were counted “absent.”

One alternative to meet the healthcare needs of rural population is training and employment of mid-level healthcare staff, also known as community health workers.

In one such initiative, in Chhattisgarh, rural medical assistants, a special cadre of health providers trained for three-and-a-half years, were inducted into the state’s health workforce to fill the gaps created by vacancies for medical officers in PHCs.

It was found that RMAs performed the best in terms of prescribing drugs, and the perceived quality scores were the highest for RMAs (85 percent), followed by medical officers (84 percent), AYUSH medical officers (80 percent) and paramedicals (73 percent), IndiaSpend reported in October.

“We need to increase the numbers, skills, salaries and social status of community health workers, auxiliary nurse midwives, nurse practitioners and community health officers trained in a three-year programme,” said Reddy.

“We should equip and train them in easy-to-use technologies adapted to point of care diagnostics, decision support systems and tele-consultation,” he added. “They should become part of village and block level health planning and monitoring process and be enabled to become the trusted community connects of the health system.”

**Spend More On Health**

India spent 1.02 percent of its gross domestic product in 2015--a figure that remained almost unchanged in six years since 2009. Also, India’s public health expenditure is among the lowest in the world, lower than most low-income countries which spend 1.4 percent of their GDP on health, IndiaSpend reported in June.

The money India spends on public health per capita every year is Rs 1,112, less than the cost of a single consultation at the country’s top private hospitals or roughly the cost of a pizza at many hotels and about Rs 93 per month or Rs 3 per day.

This increases the share of out-of-pocket expenses for Indians, and have made Indians the sixth biggest out-of-pocket health spenders in the low-middle income group of 50 nations.

The National Health Policy 2017 talked about increasing public health spending to 2.5 percent of GDP by 2025, but India hasn’t yet met the 2010 target of spending 2 percent of GDP.

Despite greater investment in health with Ayushman Bharat Scheme, it may not necessarily lead to greater improvement in primary care if stacked against expensive hospital insurance model, said Rao. “India has never spent more than 1.2 percent of GDP for health,” Rao said. “Primary healthcare alone needs 1 percent of GDP to bring it up to some standards. So unless there is a significant increase in health budgets, choices will always favour hospital insurance.”

*Yadavar is a principal correspondent with IndiaSpend. This copy was published in a special arrangement with IndiaSpend.*

**The Daily Star**

**Improving primary health care, starting with better data**

*28 October 2018*

On the sidelines of the Global Conference on Primary Health Care, countries from around the world joined the Primary Health Care Performance Initiative to launch the Vital Signs Profiles, which provide a snapshot of the strength of primary health care in low- and middle-income countries.

The Vital Signs Profiles offer a more complete picture of the state of primary health care in different countries than ever before, providing insights into where systems are strong and where they can be improved. The Vital Signs Profile helps answer several key questions on primary health care systems:

**Financing**: How much money does the country spend on primary health care?

**Capacity**: Does the country have policies that prioritise primary health care? Does the system have enough drugs, supplies and health care providers?

**Performance**: Are people able to get the care they need, without financial or geographic barriers standing in the way? Is the care people receive of high quality?

**Equity**: Does the system reach the most marginalised people in society?

PHCPI — a partnership between the Bill & Melinda Gates Foundation, World Bank Group, and World Health Organisation, in collaboration with Ariadne Labs and Results for Development — developed the Vital Signs Profiles to help policymakers, donors, advocates and citizens better understand and ultimately improve primary health care.

Governments and donors can use each Vital Signs Profile to identify priority areas for improvement, track and trend progress over time, and ultimately improve primary health care. Advocates and citizens can use the Vital Signs Profile to hold leaders accountable and call for specific financing or policy reforms.

Half the world’s population still lacks access to essential health services, the majority of which can be delivered through strong primary health care. Primary care is a person’s first and main point of contact with the health system and connects people with trusted health care providers who can meet most of their health needs throughout their lives.

By partnering with PHCPI to develop and launch Vital Signs Profiles, countries are making a public commitment to collect more and better data on primary health care and use it to improve the health of their citizens.

**Daily Times**

**Health for All – a badly misunderstood initiative**

**By: Azhar Ali**

*24 October 2018*

It was 12 September 1978, when the world’s leading health specialists, organizations and ministers from 134 countries agreed on a very specific goal, ‘Health for All’ (by 2000). This was a decisive point in the history of Primary Health Care (PHC), thanks to some legendary specialists like John B Grant (father of Primary Health Care) who started his work in 1930’s in China, Jim Grant and John Gordon who mentored one of the most important PHC experts of the second half of the 20th century Carl Taylor.

The idea was simple and applicable; however, few were skeptical about its practical application. Later during 1980, the approach was forgotten and selective primary health care option was preferred. This approach emphasized on dealing with specific ailments rather than promoting the overall comprehensive health of the community. This approach gave immediate results in fields like immunization and iron supplements. However, soon most of the experts observed that this approach might have left people dealing with a range of other illnesses that also needed equal attention. World Health Organization (WHO) observed 30th year of Alma Ata Declaration in 2008 giving a clear message i.e. (Time to) ‘Return to Alma Ata’.

Alma Ata Declaration proposed a socio-medical approach to deal with illnesses. Therefore, its focus was more on health rather than illness. Alma Ata also declared that provision and caring for health couldn’t be restricted to the use of medical doctors and hospitals alone. It allows for an integration of conventional practitioners as well as ordinary people from different walks of life, trained in basic health care issues. This was the approach that produced great results in China’s Barefoot Doctors and in Turkey between 1923-33, to fight malaria. In these approaches common people like schoolteachers, farmers, community leaders and even religious clerics were trained to handle common illnesses and to give awareness to people about activities to promote health. With the passing of time, this approach was almost totally forgotten, some people started calling WHO as World Disease Organization around 2000, as WHO mainly focused on illness and disease eradication rather than focusing on promoting health.

Alma Ata suggested comprehensive approach to sustain and improve health of the community. It mainly emphasized on preventive measures, information sharing and community involvement to create a healthy community. Two prominent NGOs from India and Bangladesh and the Government of Brazil, followed Alma Ata. In India Jamkhed Comprehensive Health Project and BRAC (world’s largest NGO) in Bangladesh created a self-sustainable system to maintain community health. Brazil on the other hand, decided to emphasize on primary health and allocated a reasonable budget for this segment of health care system. In Brazil, Primary Health Care is provided by local authorities that can make it more suitable and appropriate for specific needs. All these three approaches have two things in common, first, they all aim to achieve ‘health for all’ and second, they reduced the pressure on higher tiers of the health system. Higher tiers of health system like specialist doctors and dedicated health facilities need large investments, though they bring big returns also. Most of the multinational pharmaceutical companies and investors choose to invest in such projects. This has left Alma Ata approach as a path not only to be followed but an approach that might really make a difference to attain health for all.

In Pakistan, Dr. Adeebul Hasan Rizvi established Sindh Institute of Urology and Transplantation (SIUT) in 1972, that provides free and quality treatment to kidney patients. This is a good example of selective free health service; however, Alma Ata Declaration also included the idea of informing people about ways to avoid kidney diseases. Since most of the health sector is now concentrating on the provision of selective treatment for specific illnesses, focus on health is almost lost in the debate. The soul of Alma Ata Declaration can only be understood if issues involving health, education and employment are well integrated within a community. Health should be the focus of new approaches rather than illnesses. This, however, does not mean that focused treatments of illnesses should be stopped, what this means is to help the community to avoid common diseases which may lead to chronic ones, which further consume a lot of resources in the future. To summarize, it is very hard to provide consistent and comprehensive information about health management to people because the information campaigns are short-lived, are mostly restricted to photo sessions, which are irrelevant and sometimes boring too.

However, the issue is important and needs a much broader intervention. Therefore, I suggest that primary health care in general should be made a compulsory subject for grade 9-10 preferably along with some practical work. Students studying different subjects should also be provided an opportunity to specialize in PHC in grades 11 and 12.

The Indian government has recently announced the world’s largest publicly funded health care scheme, Ayushman Baharat in February 2018. It aims to cover 500 million people. Main emphasis is on secondary and tertiary treatment with a little focus on primary. Similar initiatives have failed to achieve their objectives and have resulted in increased expenditures. Turkey on the other hand managed its health care transition successfully, as its main pillar was strengthening of family health care system implemented at primary level.

**Down to Earth**

**Child health programme failed to deliver in 100 countries: WHO**

*25 October 2018*

A poll conducted at the global conference on primary healthcare, organised to mark 40 years of the historic Alma Ata declaration revealed that 59 per cent of countries in the world spend 19 per cent of their national health budget on sexual, reproductive, maternal, newborn, child and adolescent healthcare (SRMNCAH). Also, it showed that 20-39 per cent of the budget of 26 per cent countries in the world is spent on SRMNCAH.

A World Health Organization (WHO) paper presented at the conference came down heavily on countries over how they have treated and used the health workers stationed at the periphery. “About 100 countries implemented a childhood illness programme that did not fully deliver on its promise due to fragmentation in technical and financial support and limited investment in integrated management capacity at all levels,” the paper said. It also highlighted the fact that the governments are suffering from management deficiencies, inadequate staff remuneration and resource gaps (equipment, transport, supervision) in dealing with the health workers stationed in rural areas.

The paper added that less than half of the women in the world get four mandatory ante-natal check-ups done. The only good statistic, which is a result of a poll, was that 29 per cent countries have 60-69 per cent of their women opting for institutional deliveries.

The WHO paper added that though the maternal and child mortalities have reduced considerably in the last few years, but survival did not necessarily mean thriving in a healthy manner. “An estimated 250 million children are at the risk of not developing to their full potential because of stunting and extreme poverty. An estimated 214 million women in low- and middle-income courtiers, who do not want to bear another child, are not using a modern contraceptive method. Half of all mental disorders start in adolescence, and most go undetected and untreated.” Said the paper presented at the conference.

It also points out that the packages designed for SRMNCAH services are narrow and present stand-alone approach towards pregnant women only. And, as a result, anyone who is not a woman of reproductive age, including, adolescents, men of all ages and women past their reproductive years remain bereft of these services.

The paper said that weak national and subnational civil registration systems and other data has lead to poorly informed decisions on investments in SRMNCAH and called countries to create such models of PHC which are people-centred and leverage technology to make it available to one and all.

In another session at the conference, it was revealed that antibiotic consumption has increased 65 per cent between 2000 and 2015 in the world and doubled in low- and middle-income countries, India is one of these.

The huge increase has obviously resulted in increased drug resistance. On the other hand, people are also facing lack of access to antibiotics. This presents a conundrum of sorts. “More people still die because of lack of access to antibiotics than from resistant infections, but unrestricted and inappropriate use of antibiotics will result in more infections that are untreatable, or most costly or difficult to treat,” the WHO paper presented in the session on antimircobials said.

A poll was conducted at the conference and 82 per cent of the participants said the major issue concerning the antibiotics was not inadequate access but their inappropriate use.  In such a scenario, the primary healthcare services assume great significance. But, it was highlighted at the session that many primary healthcare centres in low- and middle-income countries lack adequate access to water and sanitation infra, and waste management systems—all of which facilitate the spread of resistant infections. It was also said that drug shortages lead to use to inappropriate antimicrobials in primary care settings.

Since the food and agricultural sectors use antibiotics extensively, the study suggested that a national-level policy be framed and implemented locally by taking communities into confidence.

**Down to Earth**

**Astana Declaration: Not just health, but affordable health for all**

**By: Banjot Kaur**

*25 October 2018*

In an event that marked 40 years of the historic Alma Ata Declaration, which declared health a human right for all, all the 192 member countries of the United Nations, including India, signed the Astana Declaration. This declaration is meant to take the earlier agreement forward, strengthen the primary healthcare (PHC) systems and realise the idea of universal healthcare (UHC).

Taking a critical note of the developments after first such declaration was signed, Dr Tedros Adhanom Ghebreyesus, director-general of the World Health Organization (WHO), said, “Today, instead of health for all, we have health for some.” But, the Alma Ata declaration had precisely envisaged making health available for all.  He added, therefore, the declaration was signed on the first day of the two-day global conference on primary healthcare.

While the Alma Ata declaration talked about availability of healthcare for one and all, the Astana declaration goes a step ahead and expresses concern about growing cost of healthcare machinery.  “We must save millions from poverty, particularly extreme poverty, caused by disproportionate out-of-pocket expenses on health. We can no longer underemphasise the crucial importance of health promotion and disease prevention, nor tolerate fragmented, unsafe or poor-quality care. We must address the shortage and uneven distribution of health workers and act on the growing costs of medicines and vaccines. We cannot afford any waste in healthcare spending due to inefficiency,” reads the declaration.

The declaration also touches upon the crucial aspect that PHC should not function in vacuum and there has to be a cohesion between all tiers of healthcare so that the services given to patients are not limited. “We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care,” the document reads.  The declaration also takes into cognizance the growing threat of lifestyle and non-communicable diseases. The declaration asks all member states to make “bold political choices” for health across sectors.

The WHO, UNICEF and health ministry of Kazakhstan said that while the 1978 declaration did lay a foundation for strong primary healthcare, half the world’s population still lacks access to essential health services, including care for non communicable diseases, maternal and child health, mental health and sexual and reproductive health.

“Although, the world is a healthier place for children today than ever before, close to 6 million children die every year before their fifth birthday mostly from preventable causes, and more than 150 million are stunted,” said Henrietta Fore, UNICEF’s executive director.

“The new declaration will renew political commitment to primary health care from governments, non-governmental organisations, professional organisations, academia and global health and development organisations. It will be used to inform the UN General Assembly high-level meeting on UHC in 2019,” reads a WHO note.

**Economic Times**

**All-India electronic database system for healthcare by 2020: Union Health Minister J.P. Nadda**

*25 October 2018*

Union Health Minister J.P. Nadda on Thursday said the government is aiming to establish an electronic database system across all the districts in India.   
  
"We are aiming at establishing an electronic database in all its districts by the year 2020, to reduce the burden of paper-based data collection, recording, and storage," Nadda stated while speaking at '2nd International Conference on Primary Health Care (PHC) towards UHC (United Health Care) and SDGs (Sustainable Development Goals),' organised at Astana in Kazakhstan. 

Currently, the Health Ministry have three common applications in use across the country at Health and Wellness Centers -- for Reproductive Child Health (RCH), Non Communicable Diseases (NCD) and TB. 

"Over time we will progress towards an interoperable Comprehensive Primary Health care application," he mentioned.   
  
The minister said that other digital Health IT initiatives include an Inter-operable Electronic Health Records (EHR) System, Patient Feedback System (MeraAspatal), Personal Health Record Management System (PHRMS), National Identification Number (NIN) for both public and private health facilities (it is an unique identification number for health facilities). 

Hospital Information System (HIS) is also being implemented for computerized registration and capturing EHR (Electronic Health Record)/ EMR (Electronic Medical Record) of patients in public health facilities up to PHC level. 

"Online Registration System (ORS) is a framework to link various hospitals for online registration and appointments, online diagnostic reports and enquiring availability of blood online," he added.

The Health Minister also spoke on the theme 'The Future of Primary Health Care' further adding that the govt in making improvements in maternal, child health and communicable diseases.

"India has focused on improved and outreach and primary health care services and established referral linkages including transport and strengthened secondary care services, that has largely focused on maternal, new-born, nutrition, child health and communicable disease," Nadda noted. 

**Egeman Qzzaqstan**

**A new Declaration on Primary Health Care adopted at the Global Conference in Astana**

*25 October 2018*

Representatives of 140 WHO member states, international organizations and the world academic elite gathered in Astana. In total there are about 1,500 participants. The event was organized by the Government of Kazakhstan, the World Health Organization and UNICEF.

The main goal of the conference participants is to discuss the further development of primary health care, the adoption of the Astana Declaration on Primary Health Care.

The conference was opened by the President of Kazakhstan Nursultan Nazarbayev, addressing the participants of the event through a video message.

“Contributing to better healthcare worldwide has become an important asset of the medical community. That historical document (the Alma-Ata Declaration) was included in textbooks of many universities in other countries. The signing of the WHO Declaration in 1978 was a prime example of the effectiveness of international efforts. It outlined the basic principles of the development of primary health care. These include public health education, maternal and child health, disease prevention, including vaccination, as well as drug provision. Since then, health care throughout the world has developed in accordance with these key areas,” said the President of Kazakhstan.

According to the Head of State, today humanity is facing new challenges — environmental degradation, sedentary lifestyle, unhealthy diet, which led to an increase in chronic diseases.

“In turn, the issue of morbidity of the population increases the burden on social security systems. Of particular importance and relevance at the present stages are the issues of financing health care and universal coverage of medical services. These topics will be tabled at the UN General Assembly in 2019,” said the President.

Elbasy also noted that the current trends in the development of the technological revolution open up new prospects for humanity.

“Today in Kazakhstan, as in the whole world, digital transformation processes are being actively carried out, including in the field of healthcare. Providing support to the health of the population is the basis of sustainable development and growth of the nation’s welfare. I urge all leaders of countries to define this as a top priority of state policy. The adoption of the new Astana Declaration on Primary Health Care will be an important milestone in improving health systems around the world. I believe that this program document will contribute to the improvement of the quality of life and the health of people on a global scale. I thank everyone for their active participation in the conference, I wish you success and fruitful work,” said the President of Kazakhstan.

The UN Secretary General Antonio Guterres also made a video call to the participants of the Global

Conference.

“Health is both an outcome and the driver of sustainable development. Our health protection system is primarily aimed at prevention. Forty years ago, the Declaration of Alma-Ata recognized the importance of primary health care, yet too many people still have no access (to primary health care). The imperative is clear — to protect and promote the physical and mental well-being. Thank you for your commitment to this goal,” said the UN Secretary-General.

Prime Minister of Kazakhstan Bakytzhan Sagintayev in his speech noted the importance of the Global Conference in Astana. Forty years ago, the Alma-Ata Declaration was adopted on the Kazakh land. Its uniqueness is that for the first time in the history of mankind, all states officially recognize the equal right of people to health. At the same time, given that the world is changing, technological progress requires updating views and finding answers to new challenges.

“As a result of the joint efforts of the WHO member states, international organizations, the academic community, a new Declaration on primary health care has been prepared. Its adoption will set the direction for the development of primary health care as the basis of the health system of any country. The new declaration reflects the commitments of states, people and communities, health systems and partners in achieving health for all through sustainable primary care,” said Sagintayev, expressing confidence that the Global Conference in Astana will provide answers to a wide range of issues. Kazakhstan is open to dialogue and ready to interact.

Later in the course of the plenary session, a representative of the Archbishop Francis Chullikat made a speech with the Appeal of His Holiness Pope Francis; Deputy Prime Minister, Minister of Health of Nepal Upendra Yadav; WHO Director-General Tedros Adhanom Ghebreyesus; UNICEF Executive Director Henrietta Fore; European Commissioner for Health and Food Security Vytenis Andriukaitis and others addressed the meeting.

Following the delegates' speeches, the ceremony of adopting the Astana Declaration “An All-Governmental Approach to Promoting Primary Health Care Towards Universal Health Care Coverage” took place.

The adoption of the Astana Declaration will make it possible to determine the development of the primary health care system in the twenty-first century around the world as the basis of the health system of any country through which universal health coverage and health for all can be achieved. The new Declaration will reflect the commitments of states, people and communities, health systems and partners in achieving health for all through sustainable primary health care.

Further, the issue of primary health care and universal coverage is planned to be put forward for a high-level meeting at the UN General Assembly at the level of heads of state in September 2019.

The event continued with planar meetings and sessions with the participation of ministers of health, finance, economics, education, the environment and heads of international organizations. In addition, the conference program includes such events as side events, discussion sessions and exhibitions.

It should be noted that a number of additional events were organized within the framework of the conference. These are the summit of mayors of the WHO European Network of Healthy Cities in Almaty, a youth forum at the Nazarbayev University, Walk the Talk, the hackathon and the IT in Healthcare exhibition at the National Museum in Astana.

**EurasiaNet**

**As Kazakhstan’s economy regains vigor, concerns shift to healthcare**

**Joanna Lillis**

*6 November*

When one-month-old Bakytzhan Omarov developed a fever and a rasping wheeze last year, his anxious parents called the family doctor.

Unwilling to venture into the shocking winter cold of Astana, Kazakhstan’s capital, with their poorly newborn, they requested a home visit.

The doctor was reluctant to come, even though home visits in such cases are deemed a basic right in Kazakhstan’s health system, which provides free-of-charge care to all mothers and babies. It was only after the boy’s father, Asylbek, went to the clinic and insisted that the doctor relented.

“The doctor was incompetent,” Bakytzhan’s mother, Aigerim, told Eurasianet.

The doctor dismissed the illness as a case of flu and wrote out a prescription. Then Bakytzhan’s condition deteriorated. His frantic parents rushed him to the hospital, where medics diagnosed him with pneumonia and placed him in intensive care.

“He was on the brink,” said Asylbek. “We nearly lost him.”

The Omarovs, whose real names have been withheld at the family’s request to preserve their privacy, said their on-call doctor has never seen their child. Under Health Ministry standards, though, she should have visited him at home within three days of his discharge from the maternity ward.

This very kind of predicament was at the heart of discussions last month in Bakytzhan’s hometown, Astana, where hundreds of delegates gathered for a major international conference to commit to new global standards for primary healthcare.

The selection of Astana as the venue for the Global Conference on Primary Health Care was symbolic. The first global agreement on primary care, which the World Health Organization describes as the provision of lifelong medical attention, prioritizing prevention as well as cure – “caring for people, rather than simply treating specific diseases or conditions” – was signed in 1978 in Alma-Ata, then the capital of Soviet Kazakhstan. On October 25, delegates updated that 40-year-old document with their commitment to the Astana Declaration.

While Kazakhstan has made impressive strides in recent years, officials freely admit it has some catching up to do.

A report published this year by the Organization for Economic Cooperation and Development (OECD) praised Astana for pushing healthcare up its policy agenda and enacting reforms to improve “accessibility, equity and efficiency.”

Many of the headline figures are impressive. According to UNICEF, infant mortality in Kazakhstan has fallen from 18.8 per 1,000 live births in 2000 to 8.07 in 2017. Maternal mortality has plunged from 60.9 deaths per 100,000 live births to 12.

And yet, more than 4,000 children under the age of five still die every year. Forty percent of maternal mortalities occur in rural hospitals because of a lack of access to essential medical aid which leaves patients vulnerable to chronic diseases. Kazakhstan has boosted life expectancy, from 65 in 2000 to 72 today. But this is below the OECD average of 80.

This is where primary healthcare plays a crucial role.

After years of neglecting primary healthcare, the government is retuning its priorities, Almaz Sharman, president of the Academy of Preventive Medicine of Kazakhstan, told Eurasianet. The aim is to make primary healthcare the backbone of the system, Sharman said.

As the OECD report notes, it is hospitals that now serve as the cornerstone of healthcare delivery in Kazakhstan. This suggests an obvious problem – too many people are seeing a doctor too late.

In Kazakhstan, in-patient care absorbs 45 percent of the public-health budget, against an OECD average of 30 percent. The number of primary-care physicians, an estimated 7-16 percent of the total, is lower than the OECD average of 32 percent. The number of general practitioners is only 0.28 per 1,000 people, against an OECD average of 0.72.

This array of figures presents a landscape that goes against current conventional thinking.

“It is the family doctor who should have the […] overview of your health,” Juan Tello, head of the WHO’s Almaty-based European Center for Primary Health, told Eurasianet.

At the very least, family physicians are able, as advised in the OECD study, to help prevent or mitigate chronic conditions caused by poor lifestyle choices. Alcohol-related liver disease is one such problem in Kazakhstan.

Health Minister Yelzhan Birtanov says Kazakhstan is “on the same page as the Astana Declaration” when it comes to shifting the focus to primary care.

Outlining the government’s “new vision,” Birtanov spoke to reporters last month about the recruitment of more frontline medics and the localization of services to run smaller facilities in greater numbers.

That will be welcome news to a public wearied by doctor’s appointments that never seem to arrive.

“I wish there were more specialists and shorter lines,” Arna, an Astana accountant who declined to give her surname, told Eurasianet. “It’s a burden on the doctor, and we wait ages.”

The government is partly addressing the problem by throwing money at it.

Astana has pledged to ratchet up public-health outlays from the current 3 percent of gross domestic product – far below the OECD average of 8.9 percent – to 10 percent within five years.

One imminent outcome of this heightened attention to healthcare is the 20 percent pay raise promised to primary-care medics starting from 2019.

Salaries will remain low by Western standards, however. Frontline staff like nurses and junior doctors earn 50,000-70,000 tenge ($135-$190) per month, a medic working in western Kazakhstan told Eurasianet on condition of anonymity.

Several professionals who spoke to Eurasianet see the improvement of resource-management as an even more pressing goal.

“The most important thing is to use the financing correctly, not to fight fires and plug holes,” said Kanat Sukhanberdiyev, UNICEF’s health and nutrition officer in Kazakhstan.

Some other challenges are subtler and will require a change of culture. Medical staff in Kazakhstan are hogtied by the ever-present risk of being punished for incorrect decisions. Adjusting mindsets will help improve the process of learning through errors and ultimately deliver better results, Sukhanberdiyev said.

There is an inescapably political angle to all this. As the economy returns to expansion following a period of slower growth and sluggishness, the authorities are eager to be seen as spreading the fruits of prosperity.

The priority is to translate economic growth into changes that are tangible “in the real life of ordinary people – so quality education, affordable housing, quality healthcare,” Yerzhan Ashikbayev, deputy foreign minister, told Eurasianet at the conference.

“People may not care what the growth rate is, 3 or 5 percent, but they do care when they see real changes,” Ashikbayev said.

As for Bakytzhan Omarov, he is now a healthy toddler and his parents are grateful to the hospital that treated him. But they expect the government to live up to its promises.

“They saved his life,” his father said. “But even after we came back home, the [family] doctor was supposed to come to check [...] because she has to check on all the newborn babies in her area. But she didn’t come at all.”

Joanna Lillis is a journalist based in Almaty and author of Dark Shadows: Inside the Secret World of Kazakhstan (2018).

**Express Healthcare**

**Global conference on primary health care**

*24 October 2018*

*World Leaders to declare historic commitment to primary health care and health*

The World Health Organization, UNICEF and the Government of Kazakhstan will co-host the Global Conference on Primary Health Care. The World Leaders to declare historic commitment to primary health care and health for all at the Palace of Independence in Astana, Kazakhstan.  
The conference will mark the 40th anniversary of the historic Alma-Ata Declaration on primary health care, and will unite world leaders to affirm that strong primary health care is essential to achieve universal health coverage.

The Global Conference on Primary Health Care will help chart a course to ensure that everyone, everywhere can access quality, affordable primary health care in their community. Country representatives will sign and ratify a bold declaration to increase investments in primary health care to advance universal health coverage and the Sustainable Development Goals.

The Attendees will include heads of state; ministers of health, finance, education and social welfare; health workers and patients; youth delegates; and leaders representing global health institutions, civil society, academia, philanthropy, media and the private sector.

Investing in primary health care is one of the most effective, cost-effective and equitable strategies to improve health outcomes and advance universal health coverage. On every continent and at every income level, countries are pursuing some of their most ambitious health reforms to date to expand access to health care and transform health systems.

**Greater Kashmir**

**2 Kashmiri students attend global conference at Kazakhstan**

*27 October 2018*

Two Kashmiri students from Baramulla district took part in a conference at Kazakhstan.

The conference on “Digitalization of Primary Health Care”, was organised by UNICEF and Ministry of republic of Kazakhstan.

Two Kashmiri students Sheikh Abid Mushtaq of Pattan and Muzzafar Ahmad Bhat of Palhallan

presented their project “2 Life.”

Muzzafar Ahmad Bhat and Sheikh Aabid Mushtaq said: “This hackathon is a bridge between medical science and information technologies. Medical technology is a broad field where innovation plays a crucial role in sustaining health, areas like biotechnology, pharmaceutics, IT, as well as development of medical devices and equipment.”

Sheikh Abid said, “We are participating in the hackathon with the hope that we would be able to contribute to develop healthcare system.”

The global conference on primary health care was held at Astana, Kazakhstan and it was co-hosted by WHO, UNICEF and the Government of Kazakhstan. Participants from different parts of the globe attended the conference.

**The Hindu Business Line**

**WHO chief, Pope pitch**

*26 October 2018*

**Health is a right, not a privilege**

Director-General of the World Health Organisation, Dr Tedros Adhanom Ghebreyesus, recently met Pope Francis to discuss ways to ensure that all people can obtain the healthcare they need, whoever they are, wherever they live. Pope Francis and Dr Tedros both reiterated that health is a right, and should not be a privilege and share a commitment to improving the health and well-being of the most vulnerable and marginalised — in both rich and poor countries. Pope Francis and Dr Tedros met in Rome ahead of the Global Conference on Primary Health Care, to take place during October 25-26 in Astana, Kazakhstan. The conference marks the fortieth anniversary of the historic Alma-Ata Declaration and its commitment to achieve Health For All. Delegates in Kazakhstan will endorse a new declaration to revitalise primary healthcare around the world.

The goal is to ensure that healthcare focusses on care for people, rather than simply treatment for specific diseases or conditions — factoring in all aspects of people’s individual lives and situations.

**Fake medicines, devices unearthed**

A crackdown on fake medicines and medical devices by the UK’s Medicines and Healthcare products Regulatory Agency (MHRA) has netted a haul of more than 1 million doses worth in excess of £2 million. The seizures were part of Interpol’s globally coordinated Operation Pangea initiative involving 116 countries. During October 9-17, the MHRA and UK partners found falsified and unlicensed medicines and medical devices in the UK, including diazepam, modafinil and dermal fillers.

Using intelligence, MHRA enforcement officers raided a semi-detached property and a small lock-up unit in connection with the illegal supply online of potentially harmful medicines. This led to one arrest.

Raids on the properties in the north of England involved local police and forms part of an international response coordinated through Interpol to the growing illegal trading in online medicines and medical devices. Worldwide, Operation Pangea led to 859 arrests and yielded items worth in the region of £10.9 million.

Clinical breakthrough

**New investigational antibiotic to treat UTI**

Results from a phase 2 randomised trial suggest that a new investigational antibiotic is as effective as the current standard-of-care antibiotic for the treatment of complicated urinary tract infections (UTIs) caused by several multi-drug resistant Gram-negative bacteria. The findings, published in *The Lancet Infectious Diseases*, indicated that patients treated with the siderophore-based drug, cefiderocol, had a higher and more sustained level of pathogen eradication and similar clinical outcomes to those treated with the current standard of care, imipenem-cilastatin. “Cefiderocol acts as a trojan horse,” explains Dr Simon Portsmouth, Shionogi Inc, US, who led the research. “The drug uses a novel mechanism of cell entry that takes advantage of the bacteria’s need for iron to survive. During an acute infection, one of our innate immune responses is to create an iron-poor environment. In response, bacteria increase their iron intake. Cefiderocol binds to irons and is transported through the extra outer membrane by the bacterium’s own iron-transport system. These iron channels also enable the drug to bypass the bacteria’s porin channels and gain repeat entry even if the bacterium has evolved efflux pumps,” a note from the journal said.

**Hindustan Times**

**The community’s health can drive great economic and social progress**

**By: Sanchita Sharma**

*24 October 2018*

The Alma Alta Declaration put “health for all” centre stage as a fundamental right in 1978, with 134 countries committed to making primary health care the mainstay to achieve universal health coverage. In a tectonic shift from the existing disease-focused hospital-based treatment approach, it redefined health as physical and mental well-being of the community and essential for social and economic progress.

Over the next three decades, the declaration was dismissed as idealistic and unrealistic and the focus shifted to selective, targeted deliverables that offered low-cost and quantifiable solutions to the most common causes of death. Instead of strengthening primary healthcare, policies and public health budgets went almost exclusively to controlling communicable diseases and programmes on ‘GOBI’ (growth monitoring, oral rehydration, breastfeeding, and immunisation), and later, ‘GOBI-FFF’ (GOBI plus food supplementation, female literacy, and family planning). India, too, got on the targeted programmes bandwagon with the major chunk of its health budget going to reproductive and child health and family planning.

There is now a steady and growing support among public health experts to end this approach to health care. The Sustainable Development Goals on good health and well-being also call for making modern health care equitable and accessible to all by investing in community-based care, health centres, hospitals, and population-based interventions for prevention, early diagnosis, treatment and management.

Though people in most parts of the world enjoy better health than ever before, most countries still struggle to provide primary health care. Disease-specific policies, an unregulated private sector, overinvestment in specialised hospitals for curative treatment, and an acute workforce shortage has widened the gap in access to quality health care between the rich and the poor. Epidemics and outbreaks caused by new emerging infectious diseases, such as HIV, Ebola and influenza, further burdened the public health infrastructure in many countries already struggling to meet the growing load of non-communicable diseases, such as heart disease, diabetes, cancers and mental health diseases.

Half the world’s population still has no access to essential health services, even though 80-90% of their health needs across a lifetime can be provided by primary health care services, which range from maternity and child care, to disease prevention through vaccination, management of chronic diseases such as diabetes and hypertension, and supporting care of ageing populations, who live longer but often less healthy lives because they have more than one disease.

This week, 1,200 decision-makers and influencers, including heads of state, ministers of health, finance, education, and social welfare, not-for-profits and health professionals will meet at the Global Conference on Primary Health Care in Astana, Kazakhstan, which is co-hosting the meet with the World Health Organisation and Unicef. As in the rest of the world, much has changed in Kazakhstan since 1978. Kazakhstan is independent of the Soviet Union, Alma Ata has been renamed Almaty, and the country’s capital has shifted to Astana, best known for its glittering, sci-fi skyline that appears to have magically sprung up in Steppe wilderness. What is now being resurrected in this futuristic city is the need to rejuvenate and revitalise people-centric primary health care using newer tools, such as technology.

India, which was one of the participants in the Alma Ata conference, has made a start with the launch of health and wellness centres under Ayushman Bharat that offer health promotion, disease prevention and management, treatment of simple fever, infections and pain, and early diagnosis and timely referrals to hospitals at the community level. These will be staffed by a new cadre of technologically enabled community health officers (CHOs) trained as mid-level providers, who will work with support from auxiliary nurse midwives, community workers (Asha), and male health workers to ensure everybody in a population of around 5,000 people gets free basic medicine, diagnosis and treatment.

Around 80% of India’s 1.04 million registered doctors of modern medicine (allopathy) work is in cities, which is home to 31% of the country’s population. The rural population is heavily dependent on the public health sector, where the allopathic doctor-patient ratio is 1:11,082, against the WHO-recommended ratio of 1:1,000. These CHOs will help meet the shortfall of doctors in rural and underserved areas and strengthen health sub-centres at the village level to free up doctors for tertiary care and substantially reduce people’s out-of-pocket health spending.

Strong primary health care, rooted in community participation, builds resilience against new and existing diseases and helps governments to respond to evolving health needs, demographics, environmental challenges, and emergencies to improve outcomes and well-being at lower costs.

**Hindustan Times**

**WHO’s Astana Declaration stresses on moving from disease treatment to health promotion**

**By: Sanchita Sharma**

*25 October*

A multi-sectoral action that includes technology, scientific and traditional knowledge, along with well-trained and compensated health professionals, and people and community participation is needed to strengthen primary health care and provide quality “health for all”, the World Health Organisation said in its Astana Declaration on Primary Health Care released in the Kazakhstan capital on Thursday.

The Astana Declaration marks the 40th anniversary of the historical Alma Alta Declaration that declared health a human right for all and not just a privileged few, and urged the world to make primary health care the mainstay of universal health coverage in 1978, in what was then the Soviet Union.

Forty years on, almost half the world’s population lacks access to essential health services, and 100 million people are pushed into poverty because of catastrophic health expenditure each year. Primary health care can provide 80-90% of a person’s healthcare needs in their lifetime.

“We must acknowledge that we haven’t achieved that vision. Instead of health of all, we have achieved health for some. On the one hand, we have made enormous progress. Over the past 40 years, life expectancy has increased, maternal mortality and child mortality have halved, we have turned the tide on HIV, malaria deaths have halved... we can list many successes, but progress has been uneven and unfair between countries and within countries.,” said Dr Tedros Adhanom Ghebreyesus, director general, World Health Organisation.

“We have been too focused on fighting specific disease, too focussed on treatment at the expense of preventing diseases. We must recommit to making primary health care as the foundation of universal healthcare... Health is not a political toy, it must be used for advancing health, not impending it,” he said.

The declaration, which has all 194 WHO member states on board, including India, urges countries to use high-quality, safe, effective and affordable medicines, including “appropriate” traditional medicines, vaccines, diagnostics and other technologies to improve access to health while “protecting personal data”.

Primary health centres must provide a comprehensive range of services and care, “including but not limited to vaccination”, said the declaration, which marks a move away from targeted health programmes that work in silos to an integrated health approach.

It underlines the growing need for prevention, control and management of non-communicable diseases like diabetes and heart disease, among others, which now account for more years of ill health and deaths in most parts of the world, including in India.

For the first time, a health declaration acknowledged the need to “create decent work and appropriate compensation for health workers” working at the primary health care level and invest in the education, training, recruitment, development, motivation and retention of the workforce, with an appropriate skill mix.

It said countries must strive for the retention and availability of the PHC workforce in rural, remote and less developed areas and not allow international migration of health personnel to undermine developing countries’ ability to meet the health needs of their populations.

“We will prioritise disease prevention and health promotion and will aim to meet all people’s health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care,” said the statement, while asking countries to increase investments in human, technological, financial and information resources in primary health care to ensure health services and continuum of care reach the needy.

**The Kathmandu Post**

**Nepal vows to achieve universal health coverage as UN member**

*27 October 2018*

United Nations member states on Thursday unanimously agreed to the Declaration of Astana to achieve universal health coverage, 40 years since declaration on primary health care in Alma-Ata.

The declaration reaffirms the historic 1978 Declaration of Alma-Mata by world leaders to improve primary health care.

Addressing the Global Conference on Primary Health Care in Astana, Kazakhstan, Minister for Health and Population Upendra Yadav highlighted the improved health status of Nepalis despite various barriers, difficulties and political unrest in the last four decades, and spoke about the new Public Health Act.

“Nepal succeeded to make a drastic change in terms of maternal mortality ratio which was 850 maternal deaths per 100,000 live births in 1990 to 239 death per 100,000 live births in 2016, and this achievement became possible because of the global PHC campaign,” Yadav said.

“Our priority for strengthening primary health care network across the country with an integrated approach of comprehensive health care. Ante-natal care, post natal care, safe abortion services, delivery conducted by skilled birth attendants, institutional delivery have played significant role in reducing maternal deaths.”

The health minister said that a bill submitted to Parliament two months ago was approved and it was endorsed as Nepal Public Health Act 2018 with the aim of ensuring health as a fundamental human right. The Declaration of Alma-Mata was the first international declaration underlining the importance of primary health care and called for urgent action by all governments but progress has been slow.

It is estimated that at least half of the world’s population lacks access to essential health services-- maternal and child health, sexual and reproductive health, mental health and communicable and non-communicable diseases.

“We, as a global community, can change that by bringing quality health services close to those who need them. That’s what primary health care is about,” Henrietta Fore, UNICEF executive director, said in her address. UNICEF data estimates close to six million children deaths every year before the age of five and most of them due to preventable causes and more than 150 million are stunted.

The Declaration of Astana pledges to make bold political choices for health across all sectors, build sustainable primary health care, empower individuals and communities and align stakeholder support to national policies, strategies and plans.

“The new Declaration reflects obligations of countries, people, communities, health care systems and partners to achieve healthier lives through sustainable primary health care,” said Yelzhan Birtanov, minister of health of the Republic of Kazakhstan.

**Kazinform**

**Almaty hosting WHO Healthy Cities Summit of Mayors**

*24 October 2018*

ALMATY. KAZINFORM - The WHO European Healthy Cities Network is holding the Summit of Mayors in Almaty, Kazinform correspondent reports. The summit is taking place in the run-up to the adoption of the Astana Declaration, which will determine the prospects for the development of outpatient care, issues of prevention, health. In Almaty, summit participants are discussing the role of cities in preserving and enhancing the legacy of the Alma-Ata Declaration of 1978. In his address to the mayors of cities, Oleg Chestnov, Head of WHO Country Office in Kazakhstan, called for expanding the WHO European Healthy Cities Network all over the world. "For now, Almaty is Kazakhstan's only city that is in the movement of healthy cities. Other cities have not yet entered this movement. What reasons can prompt the mayors of Kazakhstan to follow the example of foreign friends? We intentionally invited to Almaty not only European cities but also other cities of Kazakhstan, and from other continents as well. It is necessary to cultivate the movement across the globe. Almaty is a green city," Chestnov said.

Mayor of Almaty Bauyrzhan Baibek in his speech recalled that the summit is held in one of the 600 megacities which make up 70% of the world economy. Life expectancy in Almaty is 76 years old, the highest in Central Asia. "According to experts, in 2035, the population of Almaty will exceed 3 million, which is 30% more than now. Within 15 years, according to our estimates, the number of people using public transport should quadruple, the number of pedestrians and cyclists should triple, the number of private vehicles should remain at the current level of 600,000. This is an ambitious goal, and we intend to meet the challenge. The share of recycled waste and renewable energy should increase tenfold by 2050. Creating an innovative environment, high-quality education, healthcare following the example of OECD countries is our priority. The goal is to provide the population with the necessary social infrastructure, high-quality jobs. We are developing a master plan for the development of Almaty for the next 30 years. We are interested in other cities' experience in creating high-quality healthcare," said the mayor.

Last year, Almaty became a member of the WHO European Healthy Cities Network. The global movement is mainly aimed at promoting in every way the development of a healthy lifestyle, quality of medicine, environmental improvement in cities, and the creation of a comfortable and healthy urban environment. The mayor reminded that Almaty is being turned into a city for people, not for cars. There is the 2020 Development Program of Almaty, which is compliant with the UN Sustainable Development Goals, and its main priority is caring for people. "60% of the historical center has been modernized. Walking and cycling prevent many serious diseases. That is why we actively support cycling. We are restricting the space for the main source of harmful emissions from cars, developing public transport, upgrading the bus fleet, switching over to more environmentally friendly fuels. 80% of all public transportation in the city is carried out by environmentally friendly public vehicles. The plant for the production of electric buses using advanced German technology has been opened," Bauyrzhan Baibek informed.

Kazakhstan hosts the WHO Healthy Cities Summit of Mayors for the first time. The event is held in advance of the 40th Anniversary of the signing of the Alma-Ata Declaration on Primary Health Care and the 30th Anniversary of the establishment of the European Healthy Cities Network of the World Health Organization. The Summit is attended by about 250 people from 24 countries.

**Kazinform**

**Kazakh FM, WHO Dir Gen met in Astana**

*27 October 2018*

ASTANA. KAZINFORM Minister of Foreign Affairs of Kazakhstan Kairat Abdrakhmanov had a meeting with Director General of the World Health Organization Tedros Ghebreyesus who had arrived in Astana for the Global Primary Health Care Conference.

The sides discussed the outcomes of the event, the press service of the Foreign Ministry says. According to Tedros Ghebreyesus, the international community is grateful to President of Kazakhstan Nursultan Nazarbayev for his personal attention to the organization of such global representative forum, for the support of the healthcare system and emphasized high level of the PHC Global Conference. The parties stressed the importance of the Astana Declaration adopted unanimously on October 25. The document reflects the countries' adherence to the fulfillment of the 1978 Alma-Ata Declaration requirements. The document adopted in Almaty 40 years ago laid the foundation for the development of healthcare systems around the world with a focus on primary health care. Tedros Ghebreyesus emphasized Kazakhstan's contribution to the development of primary health care at the global level.

The sides also touched upon the prospects of adoption of the World Health Assembly Resolution in Geneva in May 2019 which will be based on the Astana Declaration. Besides, it is planned to initiate the Resolution of the UN General Assembly High-Level Meeting regarding the Universal Health Service Coverage in September 2019 in New York.

**Kazinform**

**Kazakh Senate Speaker meets WHO Director General**

*26 October 2018*

ASTANA. KAZINFORM - Chairman of the Senate of the Parliament of Kazakhstan Qasym-Jomart Toqayev has received today Director-General of the World Health Organization Tedros Adhanom Ghebreyesus, Kazinform cites the Kazakh Senate's press service. At the meeting, Qasym-Jomart Toqayev thanked Tedros Adhanom Ghebreyesus for supporting the WHO Global Conference on the occasion of the 40th Anniversary of the Alma-Ata Declaration on Primary Health Care

"For Kazakhstan, it is a big step forward. You have reason to be proud of your work," said Toqayev. He said that Kazakhstan is absolutely committed to the UN Sustainable Development Goals outlined in the 2030 Development Agenda.

The Director-General noted the historic significance of the Conference, stressing that the Astana Declaration on Primary Health Care adopted at the end of the Conference will be of key importance in ensuring the accessibility of modern-technology medical services for the population.

Tedros Adhanom Ghebreyesus emphasized that Kazakhstan can and should be a leader in providing primary health care, adding that this may become a brand of Kazakhstan. In his opinion, Kazakhstan's health policy can set an example for developing countries. He also mentioned that WHO had already begun work on how to translate the language of the Declaration into the language of action.

The head of the Senate highlighted the WHO's success in coordinating international activities in the field of health within the UN, informed the interlocutor about the crucial aspects of the State-of-the-Nation Address by the President of Kazakhstan, in particular, about the goal to raise the expenditure for education, science and health to 10 percent of GDP. The Director of the WHO Regional Office for Europe, Zsuzsanna Jakab, expressed her satisfaction with the progressive development of health care in our country, the work to reduce infant and child mortality rates, and the fight against tobacco.

In her opinion, the opening of the UN House in Almaty is of great importance not only for Kazakhstan but also for the entire region. Ms. Jacab also expressed hope that the long-term cooperation will be strengthened. Qasym-Jomart Toqayev expressed the Senate's readiness to legislatively support the international efforts aimed at improving the health of Kazakhstanis.

**The Times of Central Asia**

**Kazakhstan: New global commitment to primary health care for all at Astana conference**

*26 October 2018*

ARTICLE UNDER PAYWALL

**Ukrainska Pravda**

**And they lived long and happy ... while they appreciated their family doctor**

**By: Iryna Reshniuk**

*(29 October)*

When did you last go for a preventive check? Not from coercion, but from one's own will.

Someone reminds you of this? Does anyone care that you keep track of blood sugar, eat well, do not smoke or abuse alcohol? Vaccinated themselves and children (if any)?

Breast cancer is the most common form of cancer among women in the world. And I have never deliberately gone to the mammal to check, although it should be.

I do not remember if I ever tested my blood sugar level.

Not revaccinated from diphtheria and tetanus, although this should be done every 10 years. Never checked if he had picked up sometime in a manicure salon hepatitis C.

He never returned to the doctor for a re-examination after he had prescribed a medicine for acute respiratory viral infections or another "mild sore" ...

The list can be continued.

Am I alone?

Disease prevention - this is what is now on the agenda in many countries around the world.

Over the diagnosis, prevention and treatment of "the simplest" recently agreed to work UN member states at the Almaty Medical Conference in Kazakhstan.

In order to reduce mortality, outbreak cancer and cardiovascular diseases, family doctors, pediatricians and therapists, and other professionals who help at the "first level" should focus on preventing maternal and newborn deaths .

This is the basis of health, the declaration of October 25 adopted by nearly 200 countries of the world has been confirmed.

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Let's look at a few digits.

The number of non-infectious diseases - such as cardiovascular, cancer, chronic respiratory diseases and diabetes - is rising around the world. They each year take 41 million lives, shows WHO statistics.

People with such ailments live and may not see any symptoms until it is too late. Therefore, timely diagnosis and disease detection is so important.

Primary care should create a platform where people will be screened for the presence of these ailments, will help them prevent them, work with people at risk and provide long-term care in chronic conditions.

Another figure - 36.9 million people in 2017 were HIV.A quarter of them did not know about their status, reports UNAIDS. The credibility and quality of the "primary" could help them to test, identify HIV, get treatment and live further.

The same applies to tuberculosis. In 2017, he took 1.6 million lives. It is the worst infectious disease in the world, WHO notes.

By estimates, around 3.6 million people in the world live with TB and do not know about it.That is, as in the case of HIV, they do not receive treatment and risk to infect others.

Expected, but no less notable figure: the Lancet study found that almost all of the world's reproductive age people, of whom 4.3 billion are in their lives , lack adequate access to sexual and reproductive health services.

Even in communities with access to it, stigma and discrimination are so strong that they discourage people from seeking support and assistance from professionals.

A solid "primary" should create a "safe space" for people where they can receive such services alongside other medical services.

According to the WHO, over the last 20 years, significant progress has been made in improving the health of women and children, but many of them still do not receive proper medical assistance.

Studies have shown that a strong "primary" can reduce maternal, infant and childbirth deaths and stillbirths to 77%.

Many people die prematurely through four non-infectious diseases: cardiovascular ailments, oncology, chronic respiratory diseases and diabetes.

To a large extent, these "killers" can be protected by public policy aimed at overcoming the four risk factors: smoking, unhealthy eating and drinking, and lack of physical activity, according to a WHO report on noncommunicable diseases prepared by an independent high-level commission.

Experts also stress that the need for prevention and treatment of mental disorders becomes more and more obvious. Now this is part of the necessary measures in the field of non-infectious diseases.

In addition, depression is increasing. Only 300 million people are suffering from it in the world. Every year 800,000 die because of suicide.

Dementia is among the 10 major global causes of death . Its prevention, early detection and basic treatment - the work is precisely "primary".

For several days at an international medical conference I listened to arguments and stories, why it is so important to develop the "primary".

The problems are similar to many of us. For example, in Kazakhstan, too, it is common practice to go straight to narrow specialists instead of a therapist, so there is overloaded "secondary" and the doctor can not comprehensively "see" the patient and his needs.

Many still have access to medicine. Conditional, when in the capital the advanced technologies, and a remote village without basic help.

If the first stage of our medreform will succeed and our family doctors, pediatricians and therapists will work, "as the book writes," and the state will be able to give them decent wages and conditions for development, I will be much more protected.

Because then my doctor, whom I will choose for our medreform, will follow my health and be able to detect the disease in the early stages, and in the case of cancer, diabetes or heart disease it is very important.

If the "primary" would work as UN members want and confirm in a declaration, perhaps my dad would not have survived a heart attack, because the doctor would timely identify the risks and help them if not overcome, at least to reduce.

A good "primary" should give people the majority of medical services and cover more than 80% of the different needs of people regarding their health.

At the moment, this goal is still far from real, since half of the world's people still lack adequate access to important medical services.

Therefore, the worldwide recognition of "primary" healthcare grounds should improve this situation.

If primary health care can work as nearly 200 states seek it, we will be able to save millions of lives.

And its also.

**Ukrainska Pravda**

**Ukraine and UN countries have signed a document on the "primary". What does it mean**

**By: Iryna Reshniuk**

*(25 October)*

40 years ago, in 1978, in Kazakhstan, for the first time, they signed an international declaration that identified primary health care as the main strategy for achieving global access to medical care.

On October 25, 2018 in Kazakhstan, representatives of the UN member states, including Ukraine, reaffirm the written statement in the then Almaty Declaration.

lso, new challenges have been added to the document, and countries have taken on top-down commitments, reports the journalist of the Ukrainian Truth. Life from Astana.

This document is known as "Health for All". Then, in 1978, the world first said and decided that primary health care is the basis for providing health care.

When medical services should meet the needs of people and their expectations, and be easily accessible in places where a person lives and works.

Primary care is one of the most effective models to provide all people with the necessary help , says WHO.

A good "primary" should give people the majority of medical services and cover more than 80% of the different needs of people regarding their health.

At the moment, this goal is still far from real, since half of the world's people still lack adequate access to important medical services.

Ukraine did not fully fulfill the declaration, which at the time of signing was still part of the USSR.

**THE COUNTRIES HAVE CONFIRMED THE FOLLOWING OBLIGATIONS**:

Take bold political decisions for health in all sectors.

Promote cross-sectoral activities and set the goal of covering all people with medication, attracting market players and strengthening local communities to improve the "primary".

Create a primary medical aid stand, change health systems by investing in the "primary".

Countries need to increase the potential and infrastructure of the "primary" - the place of the first contact with medical services.

Priority is also to prevent diseases, to provide human health services in accordance with its needs throughout life through comprehensive prevention, treatment and rehabilitation.

**Primary has to provide a full range of services and care, including, but not limited to:**

* Vaccination
* Screenshots
* Prevention
* Control and management of non-infectious diseases (cancer, cardiovascular diseases, diabetes, etc.)
* Care and services that promote, support and improve maternity, health status of newborns, children or adolescents
* Psychological health
* Sexual and Reproductive Health

Countries have also committed themselves to create decent work and appropriate compensation to health professionals and other nursing staff of the "primary" if they effectively respond to different needs of the individual.

Countries have confirmed that they will continue investing in education, training, development and motivation of health workers.

The signatories undertook to strive to preserve the existing workforce of "primary" in rural, remote and less developed areas.

Reaffirmed that the international migration of health personnel should not undermine the ability of countries, especially developing countries, to meet the health needs of their populations.

Countries have supported the expansion and expansion of access to medpulles through the use of high-quality, effective and affordable drugs, including, if necessary, traditional medicines, vaccines, diagnostics and other technologies.

States have decided that through advances in information systems, it will be better to collect high-quality data properly in order to improve and monitor the health system, to use technologies to improve access to health care, to enrich medical services and deliver them to humans, to improve service quality and safety patients, increase efficiency and coordinate medical assistance.

The signatories called on all countries to continue investing in "pernik" to improve the health of the population.

This movement is encouraged to support all people, countries and organizations.

**WHY THIS IS NECESSARY**

"We emphasize that coverage of health services is the basis of the whole system," said World Health Organization head Teodros Adan Hebresius Petros . " We have made great progress over the past 40 years: reduced maternal mortality by half and more than half mortality infants, turned the epidemic of HIV, but progress is uneven and unfair.

There is a difference between the countries with the shortest and the longest life expectancy.

Some people have access to advanced medical technology, and some do not even have basic health care. Head of the World Health Organization Tedros Adan Hebresius Petros

100 million people have to live in total poverty.

We began to focus more on the fight against certain diseases than focusing on basic concepts. We need to focus more on disease prevention.

The declaration says that people should be at the center of our efforts.

Primary health care is the basis for a better health system that focuses on disease prevention, treatment, so that people become active, not passive, participants in their health. "

The new document confirms the vision and intentions expressed in the Almaty Declaration of 1978, and also signs the 2030 Agenda for Sustainable Development (Agenda for Sustainable Development until 2030) to ensure the protection of all the inhabitants of the planet.

Governments recognize that the promotion and protection of health and well-being, both individually and collectively, is a priority.

Primary care and medical services should be high-quality, safe, integrated, comprehensive, affordable (including financially) for everyone and everywhere, they should be given with respect and dignity by health professionals who are well-trained, educated, motivated and ideologically.

Countries have also committed themselves to creating a healthy environment.

States have agreed that strengthening primary care is the most comprehensive, inclusive and effective approach to improving the physical and mental health of people and their social well-being.

Primary care is the cornerstone of a sustainable health system for the global coverage of health care and health-related goals of sustainable development.

The document recognizes that the growing burden of non-communicable diseases leads to poor health, premature death . This is due to tobacco smoke, harmful use of alcohol, unhealthy lifestyle and unhealthy behavior, lack of physical activity and unhealthy eating.

"If we do not act immediately, we will continue to lose people prematurely because of wars, violence, epidemics, natural disasters, health will be affected by climate change and other environmental factors," the declaration says.

It says that states can not lose the opportunity to stop outbreaks of disease and global health threats like antimicrobial resistance spread by countries.

Preventive, curative, rehabilitation and palliative care should be accessible to all.

"We must save millions of lives from poverty, which resulted in disproportionate use of health care, " the document said.

We can no longer underestimate the crucial importance of promoting health and disease prevention, not tolerating fragmentary, dangerous and low-quality care. "

The countries confirmed that the shortage and uneven distribution of health workers should be addressed.

**United News of India**

**Nadda addresses 2nd Int’l Conference on Primary Health Care**

*25 October 2018*

New Delhi, Oct 25 (UNI) Union Minister for Health and Family Welfare JP Nadda on Thursday said multi-sectoral action is a key to addressing social and environmental determinants and operational strategies have been developed to build a shared goal and vision between sectors such as nutrition, drinking water and sanitation, education, rural and urban development departments.

During his addresses at the ‘Second Plenary Session of ‘2nd International Conference on Primary Health Care towards Universal Health Coverage & Sustainable Development Goals’, at Astana, Kazakhstan, the Minister said, 'our progress in making improvements in maternal, child health and communicable diseases is largely due to our sustained focus on and investing in strengthening health systems for these services.”

**The Health Minister spoke on the theme: The Future of Primary Health Care.**

Reiterating the commitment of the government, the Union Health Minister said India has focused on improved and outreach and primary health care services and established referral linkages including transport and strengthened secondary care services, that has largely focused on maternal, new-born, nutrition, child health and communicable disease, an official statement said here.

Mr Nadda added that this focus has yielded results, not just in terms of positive health indicators, particularly for those that are primary health care sensitive, but in a robust health systems platform that now gives us the confidence to move from selective to comprehensive primary health care services.

The government has recently launched the Ayushman Bharat- an initiative that is ambitious in scale and scope. Ayushman Bharat has two components: establishing about 1,50,000 Health and Wellness centres for the delivery of Comprehensive Primary Health care and the Pradhan Mantri Jan Arogya Yojana which will address the needs of secondary and tertiary health care for nearly 40% of our population, he added.

Appreciating the front line functionaries, the Minister said Community Health workers and ASHAs continue to be vital to the success of Primary Health Care. With re-articulated and reclarified roles, empowered by skills and adequate payments, they are strengthening their embeddedness in the community, he added.

On new information and bio-technologies, Mr Nadda said the role of biotechnology in public health has been used to good effect, particularly in primary health care.

**United News of India**

**New global commitment to primary health care for all at Astana conference**

*25 October 2018*

Astana (Kazakhstan), Oct 25 (UNI) Countries around the world on Thursday agreed to the Declaration of Astana, vowing to strengthen their primary health care systems as an essential step towards achieving universal health coverage. The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care. “Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO).

“We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health.”

While the 1978 Declaration of Alma-Ata laid a foundation for primary health care, progress over the past four decades has been uneven. At least half the world’s population lacks access to essential health services – including care for noncommunicable and communicable diseases, maternal and child health, mental health, and sexual and reproductive health.

“Although the world is a healthier place for children today than ever before, close to 6 million children die every year before their fifth birthday mostly from preventable causes, and more than 150 million are stunted,” said Henrietta Fore, UNICEF Executive Director. “We as a global community can change that, by bringing quality health services close to those who need them. That’s what primary health care is about.”

The Declaration of Astana comes amid a growing global movement for greater investment in primary health care to achieve universal health coverage. Health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems – a gap highlighted by several health emergencies in recent years.

“Adoption of the Declaration at this global conference in Astana will set new directions for the development of primary health care as a basis of health care systems,” said Yelzhan Birtanov, Minister of Health of the Republic of Kazakhstan.

“The new Declaration reflects obligations of countries, people, communities, health care systems and partners to achieve healthier lives through sustainable primary health care.”

UNICEF and WHO will help governments and civil society to act on the Declaration of Astana and encourage them to back the movement. UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in cooperation with other partners. The Global Conference on Primary Health Care is taking place from October 25-26 October here, co-hosted by WHO, UNICEF and the Government of Kazakhstan. Participants include ministers of health, finance, education and social welfare; health workers and patient advocates; youth delegates and activists; and leaders representing bilateral and multilateral institutions, global health advocacy organizations, civil society, academia, philanthropy, media and the private sector.

The Declaration of Astana, unanimously endorsed by all WHO Member States, makes pledges in four key areas: (1) make bold political choices for health across all sectors; (2) build sustainable primary health care; (3) empower individuals and communities; and (4) align stakeholder support to national policies, strategies and plans.

## Europe

**Acta Sanitaria**

**The Astana Declaration launches a new global commitment to Primary Care**

*25 October 2018*

Countries around the world have accepted the Astana Declaration on Thursday, October 25th, so they are committed to strengthening their Primary Care systems as an essential step to achieve universal health coverage, reaffirming the historical Alma-Ata Declaration of 1978, the first one that involved a commitment on the part of world leaders with this health branch.

The Declaration of Astana was born in the midst of a growing international movement to achieve greater investment in Primary Care and thus allow Universal Health coverage. Although the Declaration of Alma-Ata of 1978 laid the foundations for this specialty, progress in the last four decades is uneven, according to the World Health Organization (WHO). "At least half of the world's population lacks access to essential health services, including care for noncommunicable and communicable diseases, Maternal and Child Health, Mental Health and Sexual and Reproductive Health," he says.

"Although the world is today a healthier place for children than ever, almost six million children die every year before they reach their fifth birthday, mainly due to preventable causes, and more than 150 million are atrophied," said the executive director of the Fund. of the United Nations for Children (UNICEF), Henrietta Fore. "We, as a global community, can change that by bringing quality health services to those who need them. That's what Primary Care is about, "he added.

According to the Minister of Health of the Republic of Kazakhstan, Yelzhan Birtanov, "the new Declaration reflects the obligations of countries, people, communities, health care systems and partners to achieve a healthier life through care. Sustainable primary ". Thus, UNICEF and [WHO](http://www.who.int/) will help governments to review the implementation of this Declaration.

**Business News**

**In Astana the Health Minister, A. Xanthos for the 40th Anniversary of the Alma-Ata Declaration**

*26 October 2018*

In **Astana**, **Kazakhstan , Health Minister Andreas Xanthos** was found on 25-26 / **10/2018,** accompanied by an **. General Secretary of the Ministry, Stamatis Vardaros** , to take part in the World Health Organization World Primary Health Care Conference on the 40th anniversary of the 1978 Alma Declaration, which for the first time set up the Center for Primary Health Care "Health for All" objective. The Health Minister participated as a rapporteur in a special panel on "Promoting Equality through Primary Health Care". In his speech Mr. Xanthos mentioned the following:

"40 years after the Alma-Ata Historical and Flagged Declaration, the" value imprint "and its strategic directions, ie the holistic approach of Health, Health as a fundamental human right, the crucial role of the PSA on Equality in Health, remain live, up-to-date and inspire reforms in Health Systems around the world.

This Declaration was not technocratic or socially "neutral". It was a deeply political project of equality of access for people to effective health care and justice in the allocation of public health resources. Universal health coverage is a "dividing line" between progressive and neoliberal health policy because it is a political option that involves commitment to the idea of ​​equality and the elimination of social and health inequalities.

In Greece, for the past three years, we have been implementing a policy of universal and equal access to health care for uninsured citizens (still over 20% of the population) through the strengthening of the Public Health System. The decoupling of the right to health from work, insurance, income and the origin / nationality of people is the major reform of the country's

health policy and social policy.

In a period of fiscal constraints, we have increased the human and material resources of the NHS, reducing patient financial burdens and inequalities in care, investing in PRM and prevention, organizing the evaluation and negotiation of innovative and expensive medicines, strengthening public mental health and rehabilitation services, as well as public dental care.

Our top priority is the reform of the CPA and the institution of the family doctor. We consider PRM "key" for a Health open to all and not a barrier to access to specialized care. Integrated, continuous, documented and free care, the reorganization of the Health System with emphasis on PHC, prevention and community care, modification of social determinants of illness and public health policies are the answer to the asymmetry of needs and resources and to the demand for universality, equality and efficiency in Health. Our scientific and technical cooperation with WHO Europe is a condition of credibility, credibility and social rewarding of the changes in the SPC.

Today's bet after the end of the fiscal discipline program is to gradually overcome the limitations of austerity and to guarantee that universal coverage will not be a formal but a substantive right of the citizens of our country. Already the steps towards the goal of equality in Health are measurable: we have the first signs of a significant reduction in unmet medical needs, mainly for economic reasons, which from 4.1% of the total population in 2009 reached 14.4% in 2016 and declined to 10.9% in 2017, after the uninsured law.

Strong political commitment to universal coverage and Equality in Health strengthens social solidarity, cohesion and dignity, contributes to sustainable development and social well-being, is a crucial precondition for the rule of law and democracy. "

**Diario Medico**

**There is no ‘right to health’**

*29 October 2018*

In a hearing prior to the [World Conference on Primary Health Care](https://www.paho.org/hq/index.php?option=com_content&view=article&id=14725:from-alma-ata-1978-to-astana-2018&Itemid=39594&lang=es) , which took place from October 25 to 26 in Astana, Kazakhstan, coinciding with the **fortieth anniversary of the historic Declaration of Alma-Ata** , which laid the organizational foundations of the Primary Care, the director general of the [World Health Organization](http://www.who.int/) , **Tedros Adhanom Ghebreyesus** , celebrated the "support" of **Pope Francis** to "extend access to health" to all people because "it is a right, not a privilege "

True, that "access" should be a right, but, perhaps due to ignorance or frivolity, or to **confuse 'health' with 'health',** various documents, politicians and associations often claim a **non-existent 'right to health'** .

In one of the worst definitions of the term "health", the WHO describes it as "a state of perfect (complete) physical, mental and social well-being, and not just the absence of disease." Less utopian, the [Dictionary of Medical Terms of the Royal Academy of Medicine](https://dtme.ranm.es/index.aspx) defines it as **"a state of physical, psychic and social well-being that allows the development of one's life project conceived realistically"**. And the dictionary of the RAE is satisfied with "a state in which the organic being normally exercises all its functions; set of physical conditions in which an organism is located at a given moment ". It does not appear as such in the Universal Declaration of Human Rights and, in the Spanish Constitution, Article 43 recognizes "the right to health protection", which is not the same as the "right to health".

**The exercise of a right implies freedom and capacity for maneuver** . There is the right to private property, to found a family, to freedom of expression, to free choice of work, etc. But no one can claim a right to an IQ of 120 or to own an island in the Pacific. Although they can be condemned by external impediments, **rights depend on the will** , and health, although it can be improved with scientific advances, is often not available to human beings for much effort and money that is invested. Even less that "state of perfect well-being" which surely no mortal has yet reached.

Raising that false right does nothing but frustrate and stigmatize those who strive to cope with syndromes, phobias, paralysis and ailments for which there is sometimes no remedy. It is like showing them a perfunctory good that they can never access.

**Granda Hoy**

**EASP participates in the global health future**

*27 October 2018*

Since last Thursday and until yesterday the Astana Conference was held in Kazakhstan, whose objective is to present formally the proposal of the Declaration of Astana of Primary Health Care, which will replace that of Alma Ata of 1978, and where the Andalusian School of Public Health (EASP), based in Granada, participated with a parallel session and experts in the central debate sessions on the declaration.

After this presentation, the countries will have until 2019 to send their proposals and modifications, so that finally the declaration can be approved in the World Health Assembly that will be in May 2019 in Geneva. The final endorsement of the Declaration will be given at the United Nations Assembly that will be held in New York in September.

The conference is attended by health policy makers from all countries, together with a invited group of non-governmental organizations, medical professionals, academia and research, who have been working on the draft of the Declaration and reflecting the suggestions of the different health organizations.

Parallel to the work of the Declaration, a limited number of sessions are being held, in which issues related to the Declaration are being debated. A total of 20 are carried out, one of them the proposal by the Andalusian School of Public Health, which took place on Thursday 25, focused on over-diagnosis and treatment as a challenge for universal coverage. In this session, we have worked on practical cases and pathologies that are the subject of this over-diagnosis. The session was led by the professor of the EASP Sergio Minué and the world president of family doctors (WONCA), Anna Stevdal.

**Imperial College London**

**The far reach of primary health care**

**By: Franca Davenport**

*25 October 2018*

**Imperial researchers have shown that more attention to primary health care could help to tackle some of the world’s biggest challenges.**

In 1978, the [World Health Organization](http://www.who.int/) set out a plan for improving health and well-being around the world.

Its proposal, the Alma Ata declaration, called on governments and international organisations to back primary health care as a platform to improve lives.

Now, forty years on, researchers have revisited the WHO’s proposal, considering how primary care could help to meet the [UN’s Sustainable Development Goals](https://www.un.org/sustainabledevelopment/sustainable-development-goals/) – a set of targets aimed at tackling global challenges linked to everything from healthcare and poverty, to climate change and food security.

In [a review](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31829-4/fulltext), published in a special edition of The Lancet this month, [Dr Thomas Hone](https://www.imperial.ac.uk/people/thomas.hone12), Research Fellow at Imperial’s School of Public Health, highlights how primary care can help to address much more than health issues.

Here he talks about the need to be clearer about the language we use when talking about health, what still needs to be done, and how putting primary health care at the forefront of global policy will help tackle the world’s biggest problems head-on.

## **Q - Primary health care is a term that we see commonly used, but what does it actually mean and why is it important?**

People often use the terms ‘primary care’ and ‘primary health care’ interchangeably, but they are not the same.

Primary care is one part of primary health care and focuses on the delivery of community-focused frontline healthcare services, such as family doctors or GPs.

However, primary health care embeds health in the bigger picture, including the wider context around improving health. This includes the environment, sanitation, education and other sectors of society, which help promote equity and improve health and empower communities.

When the World Health Organization originally set out its vision for primary health care 40 years ago with its Alma-Ata declaration, it aimed to move away from expensive high-tech solutions that benefit only a few individuals, and move towards broader and more equal approaches that empower people and communities to improve their health and well-being.

## **Q - You recently looked at what has changed in the last four decades and highlighted the need for putting primary health care first. Why is this particularly relevant now?**

We felt there was a need to draw sharper attention to these broader approaches and revisit why they are important within the current global agenda, which is driven by the United Nations’ Sustainable Development Goals – a collection of 17 goals aimed at addressing the global challenges we face today, including issues around poverty, climate and health.

I think the disappointing uptake of the WHO’s Alma Ata declaration was partly caused by confusion over what it actually means.

People assume primary health care is about healthcare services and, when the Alma-Ata declaration was proposed, many felt that GPs and primary care workers would be burdened with achieving these huge social goals.

However, this isn’t what was meant. Primary health care does aim to orientate health systems towards primary care services, but bigger changes need to be brought about through political, institutional and other channels as well.

We hoped some academic thought and clarity could help to clear up the confusion, so people could see the true value that a primary health care approach could bring and so international policy makers could once again embrace the concept.

## **Q - How does your recent work help to clarify things?**

Rather than focus on Alma-Ata we decided it would be better to see how primary health care fitted with a more recent and relevant concept – the UN’s [Sustainable Development Goals (SDGs),](https://www.un.org/sustainabledevelopment/sustainable-development-goals/) which were set out in 2015 and now steer the global health and development agendas.

In our recent paper in The Lancet we reviewed academic publications and major reports from organisations such as WHO, the UN, and the World Bank to analyse how a primary health care approach can help achieve each of the 17 SDGs.

Firstly, we looked at the possible contribution of developing stronger primary care services in health systems, for example increasing access to GPs, opening new clinics, or shifting care out of hospitals.  We then analysed how a more comprehensive ‘deeper’ primary health care approach could help achieve the SDGs.

As one of the goals is specifically focussed on health and wellbeing we analysed this in more depth, breaking it down into its component targets.

## **Q - And what does your research tell us?**

## We showed that a primary health care approach can make major contributions to achieving the targets associated with goals for health and wellbeing ([SDG3)](https://www.un.org/sustainabledevelopment/health/) and that this happened both at the level of primary care provision and at the level of a more broad primary health care approach.

For example, in terms of combatting infectious diseases such as HIV, tuberculosis and malaria, there are many primary care actions that can help to reduce their burden such as antiretroviral therapies, prophylactic medicines, treatment, and education about risks and protection.

However, a broader more comprehensive primary health care approach that includes action on the wider social elements of health and community participation can tackle the underlying determinants of these infectious diseases, such as housing quality, sanitation, and controlling how the diseases spread.

We also showed how a primary health care approach can contribute to achieving the other sustainable development goals. For example, a primary care level approach can contribute to achieving the goal of ‘zero hunger’ through nutrition interventions, education, and growth monitoring. However, a wider primary health care approach would contribute substantially more to reducing hunger by calling for action within agriculture and the food industry to produce sustainable food systems and more equitable distribution of production and consumption.

## **Q - Are there any messages for policy makers to take away from the paper?**

Firstly, I think we need to stress that primary health care is not just about primary care services but is a much wider package that encompasses many other sectors of policy. This is related to the wider debate on Universal Health Coverage (UHC) and it is important to ensure the discussion does not purely focus on services and access as a way of improving health.

Secondly, we should engage with and resource these ‘deeper’ reforms around equity and the right to access good health that a primary health care approach would require.

And lastly, there is a real need to develop community engagement and involvement in order to make these approaches work and to do this we must foster accountability and trust in our political institutions.

**Info Salus (Europa Press)**

**The 193 countries of the UN sign the Declaration of Astana to achieve universal health coverage**

*25 October 2018*

MADRID, Oct. 25 (EUROPA PRESS) - The 193 member countries of the United Nations (UN) have unanimously signed on Thursday the Declaration of Astana, pledging to strengthen their primary health care systems as an essential step to achieve universal health coverage.

In this way, the Astana Declaration rearms the historic Alma-Ata Declaration of 1978, the first time that world leaders committed to primary care. "Today, instead of health for all, there is health for some, we have the solemn responsibility of guaranteeing that today's agreement allows all people, everywhere, to exercise their fundamental right to health", claims the general director of the World Health Organization (WHO), Tedros Adhanom Ghebreyesus.

While the Alma-Ata Declaration of 1978 laid the foundation, progress over the past four decades has been "uneven," according to the WHO. And, as they recall, at least half of the world's population lacks access to essential health services, including care for noncommunicable and communicable diseases, maternal and child health, mental health and sexual health and reproductive.

"Although the world is today a healthier place for children than ever, almost 6 million die each year before reaching the age of five, mainly from preventable causes, and more than 150 million are atrophied." We, as a global community, can change this by offering quality health services to those who need it, that's what primary health care is about, "says UNICEF executive director Henrietta Fore.

The Astana Declaration occurs in the midst of a growing global movement to achieve a greater guarantee of universal health coverage. UNICEF and WHO will help governments and civil society act on the Astana Declaration and encourage them to support the movement. In addition, they will also offer support to countries to review the implementation of this Declaration, in cooperation with other partners.

**Irish Medical Times**

**Ireland vows to strengthen primary healthcare system**

**By: Valerie Ryan**

*(31 October)*

The move is an essential step towards universal health coverage

Ireland has endorsed a new global declaration promising to strengthen the primary healthcare system as an essential step toward achieving universal health coverage.

The Declaration of Astana was signed by the World Health Organization (WHO) member states on the same day GP contract talks got under way in earnest last Wednesday, October 24, at the Department of Health headquarters at Miesian Plaza.

The WHO said the Declaration of Astana comes amid a growing global movement for greater investment in primary healthcare to achieve universal health coverage. Health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems — a gap highlighted by several health emergencies in recent years.

The new Declaration re-affirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary healthcare. The Declaration of Astana was signed by WHO member states during the Global Conference on Primary Health Care which took place last week in Astana, Kazakhstan, co-hosted by the WHO, United Nations International Children’s Emergency Fund and government of Kazakhstan.

Due to competing work commitments, officials from the Department of Health here were unable to attend the global conference. However, the Department had been actively involved in contributing to the formulation of the draft Astana Declaration, adopted at the Conference, the Department told IMT.

The new Declaration adopted by member states, makes pledges in four key areas: (1) make bold political choices for health across all sectors; (2) build sustainable primary healthcare; (3) empower individuals and communities; and (4) align stakeholder support to national policies, strategies and plans.

**Meditsiini Uudised**

**Estonia joined the WHO Declaration, which focuses on family care**

*26 October 2018*

**In order to ensure the sustainability of health systems and the provision of all necessary medical care to people, more primary health care is needed to be made, a statement adopted unanimously by all the WHO Member States was found at the Global Health Summit in Astana.**

ARTICLE UNDER PAYWALL

**News Bomb**

**Blond: Critical to the role of Primary Care for Equality in Health**

*26 October 2018*

The experience of the reform of [Primary Health Care](https://www.newsbomb.gr/tags/tag/91967/prwtovathmia-frontida-ygeias) in our country was transferred by Health Minister Andreas Xanthos and Deputy Secretary General of the Ministry, Stamatis Vardas , to the World Conference of WHO for the 40th Anniversary of the Alma- All.

The World Health Organization Conference took place in the capital of Kazakhstan, Astana, on 25 and 26 October 2018. The 1978 Alma-Ata Declaration set for the first time the "Health for All" objective, putting the PSH at the heart of the systems, prevention, interference with social (and environmental determinants of health.

Mr. [Xanthos](https://www.newsbomb.gr/tags/tag/60534/andreas-xanthos)participated as a rapporteur in a special panel on "Promoting Equality through Primary Health Care" . In his speech Mr. Xanthos said:"Forty years after Alma-Ata's historic and flagship Declaration, the" value imprint "and its strategic directions, namely the holistic approach of Health, Health as a fundamental human right, the crucial role of the PSA in Equality in Health, remain live, up-to-date and inspire reforms in Health Systems around the world. This Declaration was not technocratic or socially neutral. It was a deeply political project of equality of access for people to effective health care and justice in the allocation of public health resources. Universal health coverage is a "divisive cut" between progressive and neoliberal health policy,

In Greece, for the past three years, we have been implementing a policy of universal and equal access to health care for uninsured citizens (still over 20% of the population) through the strengthening of the Public Health System. The decoupling of the right to health from work, insurance, income and the origin / nationality of the people is the major reform of the country's health policy and social policy.

In a period of fiscal constraints, we have increased the human and material resources of the NHS, reducing patient financial burdens and inequalities in care, investing in PRM and prevention, organizing the evaluation and negotiation of innovative and expensive medicines, strengthening public mental health and rehabilitation services , as well as public dental care.

Our top priority is the reform of the CPA and the institution of the family doctor. We consider PRM to be a key to a Health that is open to all and not an obstacle to access to specialized care. Integrated, continuous, documented and free care, the reorganization of the Health System with emphasis on PHC, prevention and community care, modification of social determinants of illness and public health policies are the answer to the asymmetry of needs and resources and to the demand for universality, equality and efficiency in Health. Our scientific and technical cooperation with WHO Europe is a condition of credibility, credibility and social rewarding of the changes in the SPC.

Today's bet after the end of the fiscal discipline program is to gradually overcome the limitations of austerity and to guarantee that universal coverage will not be a formal but a substantive right of the citizens of our country. Already the steps towards the goal of equality in Health are measurable: we have the first signs of a significant reduction in unmet medical needs, mainly for economic reasons, which from 4.1% of the total population in 2009 reached 14.4% in 2016 and declined to 10.9% in 2017, after the uninsured law.

A strong political commitment to universal coverage and Equality in Health strengthens social solidarity, cohesion and dignity, contributes to sustainable development and social well-being, is a crucial precondition for the rule of law and democracy. "

**QuotidianoSanità**

**At 40 years from Alma Ata, health for all is a mirage. In Astana, a new WHO Declaration on primary care. But 3.5 billion people still without care**

*26 October 2018*

## The Astana Declaration reaffirms the 1978 Alma-Ata Declaration which saw the global commitment of all world leaders to achieve common health goals for all peoples of the world. But the progress made over the last four decades has not been uniform. At least half the world's population does not have access to essential health services. And the treatment of non-communicable and transmissible diseases, maternal and child health, mental health and sexual and reproductive health are still a privilege in many parts of the world. [*THE DECLARATION OF ASTANA.*](http://www.quotidianosanita.it/allegati/create_pdf.php?all=2231416.pdf)

**26 OCT** - WHO countries around the world signed the Astana Declaration (capital of Kazakhstan) during the Global Conference on Primary Care on 25 and 26 October, promising to strengthen their health care systems as an essential step towards achieving universal health coverage.   
  
**The Astana Declaration reaffirms the**[**1978 Alma-Ata Declaration**](http://www.who.int/publications/almaata_declaration_en.pdf)  in which for the first time world leaders have committed themselves to basic health care.   
  
"But today, instead of health for all, we have health for some", said **Tedros Adhanom Ghebreyesus, Director General of the WHO**. "We are all responsible for ensuring that Astana's declaration on basic health care allows every person, anywhere, to exercise their fundamental right to health".   
  
The 1978 Alma-Ata Declaration laid the foundation for primary care, but progress over the past four decades has not been uniform. At least half of the world's population has no access to essential health services, including treatment of non-communicable and transmissible diseases, maternal and child health, mental health and sexual and reproductive health.

**"Although the world is a healthier place for children today, almost 6 million of them die every year before their fifth birthday and mostly for preventable causes and over 150 million are stunted," said Henrietta Fore, Executive Director of UNICEF.** "We as a global community can change this situation by bringing quality health services close to those in need, this is basic health care."   
  
**The Astana Declaration is part of a growing global movement that provides for more investment in basic health care** to achieve universal health coverage. Health resources have focused predominantly on interventions for individual diseases rather than on solid and complete health systems, a gap highlighted by various health emergencies in recent years.   
  
"The adoption of the Declaration at this conference will establish new directions for the development of primary health care as a basis for health care systems in general," said **Yelzhan Birtanov, Health Minister of the Republic of Kazakhstan** . "The new Declaration reflects the obligations of countries, people, communities, health care systems and partners to achieve a healthier life through sustainable primary health care."  
  
**UNICEF and WHO will help governments and civil society act according to the Astana Declaration and encourage them to support the movement.** UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in collaboration with other partners.   
  
**The Astana Declaration, unanimously approved by all WHO member states, engages in four key areas:**  
  
**(1)** making courageous political choices for health in all sectors;   
  
**(2)** building sustainable primary health care;   
  
**(3)** empower individuals and communities in the defense of health;   
  
**(4)**align the support of stakeholders to the policies, strategies and national plans of individual governments.   
  
**The declaration begins by stating** "strongly the commitment to the fundamental right of every human being to enjoy the highest level of health achievable without distinction of any kind. On the fortieth anniversary of the Alma-Ata Declaration - the subscribers declare - we reaffirm our commitment in all its values ​​and principles, in particular justice and solidarity, and underline the importance of health for peace, security and development socio-economic ".   
  
**According to the declaration, the preventive, curative, rehabilitation and palliative care services** they must be accessible to everyone. Millions of people must be saved from poverty, in particular from extreme poverty, caused by disproportionate expenditure on health.   
  
We can no longer emphasize the importance of health promotion and disease prevention and then tolerate fragmented, unsafe or poor quality care: we must address the inhomogeneous shortage and distribution of health workers, and act on the rising costs of care health, medicine and vaccines.   
  
**We can not allow waste in health care costs due to inefficiency.**  
  
**To build sustainable primary health care, Primary healthcare (PHC) will be implemented in accordance with legislation,** the contexts and priorities of the nations. Health systems will be strengthened by investing in PHC, enhanced capacity and infrastructure for primary care - the first contact with health services - giving priority to essential public health functions.   
  
**The priority is towards disease prevention and health promotion** and we must aim to meet the health needs of all people throughout life through comprehensive prevention, treatment, rehabilitation and palliative care services.   
  
**PHC will provide a full range of services and assistance, including vaccinations,** prevention, control and management of non-communicable and transmissible diseases; cures and services that promote, maintain and improve the health of mothers, newborns, children and adolescents; mental health and sexual and reproductive health.   
  
**PHC will also be accessible, fair, secure, high quality,** complete, efficient, acceptable, available and affordable, and will provide integrated and continuous people-centered and gender-sensitive services. Fragmentation must be avoided and a functional reference system be established between the primary level and other levels of assistance.   
  
Sustainable PHC services improve the ability of health systems to prevent, detect and respond to infectious diseases and outbreaks, the statement said.  
  
**It will create decent work and adequate compensation for health workers and other health workers** working at the level of primary health care, to respond effectively to the health needs of people in a multidisciplinary context. It will invest in education, training, recruitment, development, motivation and conservation of the PHC workforce, with adequate and multi-professional skills.   
  
**There will be a commitment to the conservation and availability of the PHC workforce in rural areas**, in remote and less developed areas. The international migration of health personnel should not create difficulties for countries, in particular those in the developing world that must always have the ability to meet the health and needs of their populations.   
  
**The extension of access to a range of health services should be supported** through the use of high quality services, safe, effective and cost-effective medicines, including vaccines, diagnostics and other technologies. Their accessibility and their rational and secure use and the protection of personal data will be promoted.  
  
Through advances in information systems, disaggregated and high quality data will be gathered and information continuity, disease surveillance, transparency, accountability and health system monitoring will be improved.   
  
**Technologies will be used to improve access to health care and to** enrich the health service, to improve the quality of services and patient safety, and to increase the efficiency and coordination of care. Through digital and other technologies, individuals and communities will be able to identify their health needs, participate in service planning and play an active role in maintaining their health and well-being.  
  
**And on the funding side, the signatories of the declaration ask "all countries to continue investing in PHC to improve health outcomes.**We will face inefficiencies and injustices - they say - that expose people to financial difficulties resulting from the use of health services, ensuring better allocation of resources for health, adequate funding for basic health care and adequate reimbursement systems to improve the access and get better health results. We will work for the financial sustainability, efficiency and resilience of national health systems, allocating resources appropriately to the PHC based on the needs and peculiarities of the national context. We will not leave anyone behind, including the frail and those living in conflict areas, providing access to quality PHC services through continuity of care. "   
  
**"We ask all interested parties - concludes the declaration -,** health professionals, universities, patients, civil society, local and international partners, agencies and funds, private sector, religious organizations and more, to align with national policies, strategies and plans in all sectors, through approaches focused on the person and gender sensitive and undertake joint actions to build stronger and sustainable PHCs towards achieving UHC (universal health coverage). We will support the countries so that they can allocate sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices with full respect for national sovereignty and human rights ".

**SMTV San Marino**

**Healthcare segment – WHO Astana conference participation**

*25 October 2018*

On 25 and 26 October, the delegation of the Republic of San Marino, composed of the Health Secretary Saints and the Director of the Social Security Institute, together with representatives from over 120 countries from all over the world met in Astana (Kazakhstan) to celebrate the 40 years of the Declaration of Alma-Ata and affix a new piece in the project "health for all" promoted by the WHO. 

The conference, organized by WHO and UNICEF, was intended to commemorate the 1978 Alma-Ata Declaration on primary health care and reflect on the results achieved, on the mistakes made, but above all on the work that still needs to be done.

In 1978, a crucial conference was held in Almaty, Kazakhstan, bringing together health experts and world leaders with the commitment to promote the health of all, health as a fundamental right of humanity, creating the basis of principles and policies to activate global health care efforts carried out over the past 40 years. 

In the ten points of the Declaration, signed by 134 countries, an urgent and effective national and international action was required to develop and implement primary health care in every part of the world and in particular in the developing countries, according to a spirit of technical cooperation and in accordance with a new economic order international. The Conference urged governments, WHO, UNICEF and other international organizations, multilateral or bilateral agencies, non-governmental organizations, funding agencies, all health professionals and the entire global community to support the commitment national and international support for primary health care and to devote increasing technical and financial support, particularly in developing countries. 

The new challenge that is launched in these days is represented by the evidence that the strengthening of primary health care and putting the person at the center represents the best way to resolve the main critical issues of health and social care systems in a sustainable and effective manner. The PHC approach is critical to achieving our shared global Health Coverage and Sustainable Development Goals (SDGs) related health objectives, as set out in the  UN Agenda 2030. 

The new declaration, signed on October 25 at 12.30 in Astana, and symbolically handed over to the new generations of health professionals, will renew the political commitment to basic health care by governments, non-governmental organizations, professional organizations, universities is global organizations for health and development. With its presence at this important event, San Marino intends to underline once again the need to guarantee the right to health as a fundamental human right and how this can be achieved through equal access to primary quality care and through appropriate investments as well as indicated by the Sustainable Development Goals of the 2030 Agenda.

**Torin Oggo**

**Opi Torino shares Astana’s declaration: “Strengthen health care systems”**

*26 October 2018*

Forty years after Alma-Ata, the declaration that in 1978 laid the foundations for primary care, the road ahead is still long. Half of the world's population, in 2018, can not access essential health services.

Today, the WHO nations have signed a declaration in Astana, Kazakhstan, with the aim of strengthening their basic health care systems and thus being able to cover the entire planet from a health point of view. Trying to replace the health of all that reserved only for some subjects. A battle that Opi Torino, the Order of Nursing Professions, has been carrying out for some time. Suffice it to think of the need to invest more in basic health care by concentrating - just as indicated by the new Astana declaration - healthcare resources on solid and complete systems.

Hence the sharing of Opi of the four fundamental points underwritten: from the need to make courageous political choices for health in all sectors to the construction of sustainable primary health care; from the empowerment of individuals and communities in the defense of health to the need to align the support of the interested parties with the policies, strategies and national plans of the individual Governments.

Massimo Sciretti, president of Opi Torino: "The preventive, curative, rehabilitative and palliative care services must be accessible to everyone, and this is the only way to save people from extreme poverty, caused by disproportionate expenses for health. the objectives of the declaration are fully realized, with the awareness that it is necessary to take action on the ever-increasing costs of health care, vaccines and drugs: the priority is disease prevention and health promotion, starting from primary health care sustainable".

Family and community nurses are aware of this, gathered today in Ivrea - at the Officina H University Pole - for the third AIFEC National Congress. A meeting in which Nicola Draoli (president Opi Grosseto) and Monica Rolfo (vice president Opi Torino) participated in representing the professional associations. "In today's congress - explains Pasquale Giuliano, member of AIFEC and coordinator of the Master of Nursing of Families and Communities at the University of Turin - we reaffirmed how family nursing is at the service of citizens, for disadvantaged communities, for rural and mountain areas, we are in the experience of disadvantaged popular neighborhoods and in the metropolitan suburbs ".

"We are - to all effects - among the actors, together with educators and social workers, that work of development of generative practices that sees in Piossasco an interesting project of integrated community care.In this edition we stated that the nurses are ready to being in the new employment centers relaunched by the political proposal We are proposing to stay within this multidisciplinary team to build the support profiles for those entitled to the income of citizenship ".

**La Vanguardia (Europa Press)**

**The EASP attends the WHO Conference where the Astana Declaration of Primary Health Care will be approved**

*26 October 2018*

GRANADA, 26 (EUROPA PRESS)

This Thursday and Friday the Astana Conference is being held in Kazakhstan, whose objective is to present formally the proposal of the Declaration of Astana of Primary Health Care, which will replace that of Alma Ata of 1978, and where the Andalusian School of Public Health (EASP) participates with a parallel session and experts in the central debate sessions on the declaration.

After this presentation, the countries will have until 2019 to send their proposals and modifications, so that finally the declaration can be approved in the World Health Assembly that will be in May 2019 in Geneva. The final endorsement of the Declaration will be given at the United Nations Assembly that will be held in New York in September.

The conference is attended by health policy makers from all countries, together with a invited group of non-governmental organizations, medical professionals, academia and research, who have been working on the draft of the Declaration and reflecting the suggestions of the different health organizations.

Parallel to the work of the Declaration, a limited number of sessions are being held, in which issues related to the Declaration are being debated. A total of 20 are carried out, one of them the proposal by the Andalusian School of Public Health, which took place on Thursday 25, focused on over-diagnosis and treatment as a challenge for universal coverage.

In this session, we have worked on practical cases and pathologies that are the subject of this over-diagnosis. The session was directed by the professor of the EASP Sergio Minué and the world president of family doctors (WONCA), Anna Stevdal.

The professor of the EASP Sergio Minué is also among the group of experts invited to participate in the debate regarding the Astana Declaration.

On November 8, the first meeting in Spain will be held at the EASP after the Declaration with the participation of representatives of WHO and the panel of participants in the Astana Conference.

The objective is to bring the Andalusian Autonomous Community and the national health system closer to the reflections and contents of the Declaration and the implications for the Public Health System of Andalusia and the national health system, as well as the contributions they can make for the final version of the Declaration of Astana to be approved in September 2019.

## America & Caribbean

**AAFP News**

**The Never-ending Quest to Achieve Health for All**

**By: Cynthia Haq, M.D.**

*25 October 2018*

*"The attainment of the highest possible level of health is a most important worldwide social goal. … Primary health care is the key to attaining this target."   
-- Declaration of Alma Ata, 1978*

Commemorating the 40th anniversary of the signing of [the Declaration of Alma-Ata,(www.who.int)](http://www.who.int/publications/almaata_declaration_en.pdf) the United States and [193 other members of the United Nations gathered in Astana, Kazakhstan, this week(www.who.int)](http://www.who.int/primary-health/conference-phc) to review progress and challenges and renew their commitments to the never-ending quest to provide primary care for 7.5 billion people.

What led to this watershed declaration? What were the key elements? Why should this matter to U.S. family physicians and the patients and communities they serve?

### **The Evolution of Primary Care**

In 1978, a historic international meeting to define and promote primary care was held in Alma-Ata (known today as Almaty) in the former Soviet Union. The meeting, which was sponsored by the World Health Organization (WHO) and the United Nations Children's Fund, resulted in a declaration that was signed by 134 member nations.

International organizations and most world governments already had affirmed access to basic medical care as a fundamental human right as early as 1948. Subsequently, countries began experimenting with methods and components of services to improve the health of populations. Health was recognized as both a prerequisite for economic growth and an outcome of development. Small-scale pilot programs began to accumulate evidence about what worked and what might be considered essential health care services. [The Alma Ata Declaration was the culmination of decades of work.(www.who.int)](http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/)  
  
The Declaration defined primary care as both a level of service and a philosophy of care. Essential features included first-contact, personal, continuous, comprehensive, coordinated care for acute, chronic, preventive and community-oriented health issues. Primary care was considered the hub of the health system, with services to be equitably distributed according to the needs of the population in a manner that was scientifically sound, cost-effective, culturally acceptable, affordable and accountable.

Sound familiar? It should; these are also the key principles of family medicine.

### **My Journey**

The Declaration inspired nations, organizations and thousands of individuals -- including me -- to contribute to the goal of achieving health for all by the year 2000. This vision inspired me to pursue medical school and family medicine residency, as well as to work where I perceived the needs were greatest.

My husband, three children and I moved to rural Uganda for my first job in 1986. The country was recovering from a protracted civil war, the economy and infrastructure had collapsed, and one out of three children died before the age of 5, mostly from preventable causes. My job was to train village health workers to improve child survival. I was full of hope, loaded with tropical disease textbooks, and supported by a grant from the U.S. Agency for International Development. Within a few years, Uganda renewed its efforts to promote primary care services and reduced under-5 child mortality by more than 50 percent. The immense rewards of this work fueled my desire to develop family medicine training programs in rural and urban areas of the United States and low-income countries, and to work with the WHO and Wonca (the World Organization of Family Doctors) to promote primary care.

### Progress and Challenges

[Globally, average human life expectancy has more than doubled during the past century,(ourworldindata.org)](https://ourworldindata.org/life-expectancy#life-expectancy-increased-in-all-countries-of-the-world) more than in any other period in recorded history.

Additionally, the quality of human life has improved dramatically, with more people living better and longer. Improvements in living conditions, public health practices and primary care measures such as immunization and treatment of common conditions have saved millions of lives.

But this astounding progress in human health is unequally distributed, both within and between countries. For example, life expectancy is 56 years in Somalia, compared to 84 in Japan, because the conditions that promote health and prevent disease are unevenly distributed.

Most high-income countries, some middle-income countries and a few low-income countries have been able to implement primary care. Yet more than half of the world's population -- more than 3 billion people -- still lack access.  
  
In the United States, millions still lack access to primary care. More than half our counties and large populations within urban communities face [shortages of family physicians and other primary care professionals.(data.hrsa.gov)](https://data.hrsa.gov/tools/shortage-area/hpsa-find)Life expectancy and years of healthy life can differ drastically -- by as much as 35 years -- between the healthiest and wealthiest and the sickest and poorest neighborhoods in the United States. In many areas, the situation is worse than in some low-income nations.

What have we learned during the 40 years since Alma-Ata? It has been a wild, bumpy ride with uneven progress. Evidence from countries that have implemented primary care successfully point to several vital components: leadership; health in all public policies; community-based services; universal health insurance coverage; and adequate human, physical and financial resources.

### **Family Physicians as Champions of Primary Care**

Skilled health professionals who are trained to manage most common problems and distributed according to the needs of the population are essential for primary care delivery. Dozens of studies have confirmed that [family physicians and their teams improve the quality and lower the costs of health care.(www.healthaffairs.org)](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0020)

Family physicians serve as quarterbacks of primary care teams to prevent crises, manage complexity, improve the quality and expand the scope of teams. Family physician leaders know they need others, such as community health workers, nurses, therapists, pharmacists, oral and behavioral health specialists, and support staff to round out the skills of the care team. Family physicians are the only physicians who provide whole-person, first-contact, comprehensive continuity of care across the entire lifespan, coordinating services and referring patients to community and/or subspecialty and hospital-based resources as needed.

### Astana Declaration

Forty years after Alma-Ata, the nations of the world have gathered in Astana, Kazakhstan, for the Global Conference on Primary Health Care Oct. 25-26 to [renew their commitment to primary care(www.healthaffairs.org)](https://www.healthaffairs.org/do/10.1377/hblog20181024.24072/full/). What has changed? People are more engaged and have more information and higher expectations for health. An explosion of medical information and technology has broadened the range of available health services. We have more evidence, more stakeholders, more resources and more opportunities to achieve health for all.

Although we celebrate this remarkable progress, we know that uneven conditions contribute to persistent health inequities. People living in poverty and/or in rural areas are more likely to experience limited access to primary care. Therefore, we need to redouble our efforts to provide universal health coverage to ensure that all people, even those who are disadvantaged or vulnerable, have access to high-quality health services without financial hardship.

[The Astana Declaration(www.who.int)](http://www.who.int/primary-health/conference-phc/DRAFT_Declaration_on_Primary_Health_Care_28_June_2018.pdf) calls for nations to put public health and primary care at the center of universal health coverage. During the past 40 years, most countries have come to recognize the value of well-trained generalists and are now training family physicians. Although family physicians were not named in the original Declaration, the Astana document specifically identifies family physicians as vital members of the primary care workforce.

### AAFP Commitment to Health Care for All

AAFP members have been major contributors to the primary care movement. The AAFP has been a steadfast advocate of health care for all and recently renewed its commitment through [robust policy recommendations.](https://www.aafp.org/about/policies/all/health-care-for-all.html)

Through [The EveryONE Project,](https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html) the Academy has launched a national program to promote health equity. The AAFP [Center for Global Health Initiatives](https://www.aafp.org/about/initiatives/global-health-initiatives.html) is fostering global collaborations and recently celebrated a successful summit highlighting new partnerships, progress and innovations. The Robert Graham Center for Policy Studies in Family Medicine and Primary Care has developed [vital signs by which to measure a nation's primary care performance.(phcperformanceinitiative.org)](https://phcperformanceinitiative.org/about-us/our-indicators)

U.S. leaders of family medicine are calling for reinforcements to advocate for health care for all and to expand and reinvigorate our specialty. We need more students, residents and family physicians to bring fresh perspectives and new skills and tools and to become leaders of the next generation of champions of primary care. What will we accomplish in the next 40 years?

*"We envision*

* *societies and environments that prioritize and protect people's health;*
* *health care that is available and affordable for everyone, everywhere;*
* *health care of good quality that treats people with respect and dignity;*
* *people engaged in their own health."*

*-- Astana Declaration on Primary Health Care, 2018*

*Cynthia Haq, M.D., is professor and chair of the Department of Family Medicine at the University of California, Irvine. Her career is focused on health equity and preparing health professionals to serve patients and communities that are medically underserved and/or disadvantaged. She has provided full-scope family medicine and medical education for more than 30 years.*

**Agencia de Noticias da Aids**

**‘Health is a right and not a privilege’, says Pope Francisco and head of WHO**

*26 October 2018*

In a meeting on Tuesday (23) in Rome, Pope Francis and the Director-General of the World Health Organization (WHO), Tedros Ghebreyesus, reaffirmed that "health is a right and not a privilege." The head of the Holy See and the head of the UN agency also expressed their commitment to bringing quality care to the most vulnerable and marginalized individuals in both developed and developing countries.

"For many years, in our previous occupations and in our current jobs, we have worked to improve the lives of poor and vulnerable people. I am very happy to have the support of Pope Francis in our effort to extend the right to life and health to all people. I particularly welcome the Pope's emphasis on the well-being of children, "the WHO Director-General said after the meeting.

"I am encouraged to hear him say that he is on our side and that of those who work with us in an attempt to bring health to all, especially many people, including children, who live on the margins of society and suffer from health and hunger problems "Added Ghebreyesus.

The meeting in the Italian capital took place on the eve of the Global Conference on Primary Health Care, which starts tomorrow (25) in Astana, Kazakhstan. The event marks the 40th anniversary of the historic Alma Ata Declaration, which pointed to primary care as the motor of universal health. This week, countries must adopt a new milestone to reinvigorate the values ​​and goals of universal health.

According to WHO, the aim of the new text is to ensure that services focus on care for people throughout the life cycle and not simply focus on treating specific diseases or conditions. Primary care is at the heart of the global drive to achieve universal health coverage, one of the goals of the United Nations Sustainable Development Goals (ODS).

**Curacao Chronical**

**‘Health Is A Right Of The People And A Responsibility Of Government,’ Says PAHO Director**

*29 October 2018*

Health is a human right, and it is governments' responsibility to ensure that right, said the Director of the Pan American Health Organization (PAHO), Dr. Carissa F. Etienne, on October 26th, during the [closing session of the Global Conference on Primary Health Care](https://na01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.facebook.com%2F97320092545%2Fposts%2F10155864952442546%2F&data=02%7C01%7Coliels%40paho.org%7C295d8304f9bb44853b3208d63dcf6b4c%7Ce610e79c2ec04e0f8a141e4b101519f7%7C0%7C0%7C636764358410376023&sdata=nrySB6Kpb7kLeNTC%2F4j%2BBEY4PzpDkoP1Af6D1vG1ng8%3D&reserved=0) in Astana, Kazakhstan.

"Health is not a privilege, nor a commodity. It is a fundamental human right," said Etienne, adding that "national governments must lead and own national processes towards universal health, in coordination with partners."

The Global Conference on Primary Health Care, held October 25-26, was organized by the World Health Organization (WHO), UNICEF and the Government of Kazakhstan and was attended by representatives of governments, nongovernmental organizations, international agencies, academic institutions and youth organizations.

"We know what works and what we need to do," said Etienne, referring to what is known as the Primary Health Care (PHC) strategy. Based on the principles of equity and solidarity in health, the PHC strategy was first endorsed by global health leaders 40 years ago in the 1978 Declaration of Alma-Ata, signed in the city that served as Kazakhstan's capital until 1997.

During the Astana meeting, delegates from more than 120 countries—including many from the Americas—reaffirmed their countries' commitments to PHC and signed the Declaration of Astana, in which signatory countries pledge to strengthen their primary health care systems as an essential step toward achieving health for everyone, everywhere. Universal health is also called for in the United Nations' Sustainable Development Goals (SDGs).

PHC is a strategy for human health and well-being and social development that is centered on people, their families and communities. "It is not merely the first level of care, nor it is the provision of a limited package of services for the poor," said PAHO Director Etienne, who also serves as WHO's Regional Director for the Americas.

Primary Health Care envisions universal access to comprehensive and quality health care services that focus not just on curing diseases but also on prevention, rehabilitation, and treatment. The strategy also calls for addressing social determinants of health such as poverty, education and housing.

Etienne noted that PHC also requires breaking down barriers to access to health, including financial, geographic, and cultural and gender barriers. It also seeks to overcome the fragmentation and segmentation of health systems and services.

All this "requires State action," said Etienne. "Without State action, there is no right to health, especially for those living in situations of vulnerability." She urged governments to listen to the voices of those who have lacked equitable access to health, to better understand their needs and to strengthen their participation and commitment to be able to develop a model of care centered on people and communities.

**Toward a 'revolutionary first level of care'**

PHC should be central to countries' efforts to transform their health systems in order to advance towards universal access to health and universal health coverage. As a key step toward universal health, said Etienne, "we need a revolutionary first level of care" that offers comprehensive health services located where people live and work.

That first level of care should make rational and efficient use of technology and organizational innovation, including interdisciplinary health teams with a new cadre of personnel and skills mix. It should be supported by an integrated health services delivery network, including hospitals and specialized services, and should be able to respond to risk factors, violence, mental health issues, sexual and reproductive health, chronic noncommunicable diseases, and disasters, among others, said Etienne.

**Call to action toward universal health**

Everyone has a role to play in advancing universal health, said Etienne, including governments, young people, women, the private sector, academia, development partners, community leaders and people everywhere. She urged all these actors to accelerate their efforts going forward.

Etienne said governments should take the lead by adopting coherent policies and regulations and by investing in health. "Please do not reduce health to minimum sets of packages of essential services, when your peoples deserve so much more!" she told government representatives, adding, "Invest in your people and your systems; invest in health, not war."

PAHO's Director challenged young people to become more involved in health, saying, "You are our future, the energy that will drive change." She called on women to urge leaders to ensure that gender is central to decision-making in health. And she challenged academicians to invest in operational research that is context specific and focused on the needs of countries and the health systems, to provide evidence that will guide and support policymakers to take the right decisions.

Etienne also recognized the role of the private sector as health care providers and their importance in innovation and technological development. Emphasizing the principle of social responsibility, however, she urged that the private sector "Innovate, but based on health needs."

Addressing development partners, Etienne said that the Declaration of Astana and the SDGs offer a "golden moment" that must be seized. "We cannot leave here and repeat the mistakes of the past" by reducing primary health care to minimum sets of poor services for the poor.

"There is no other way" than PHC to achieve health for everyone, everywhere, said Etienne. "Primary Health Care is smart. Primary Health Care is right."

**Folha De S.Paulo**

**Celebrated worldwide, achievements of SUS are at risk**

**By: Cláudia Collucci**

*(27 October)*

While 194 countries in the world have just reaffirmed their commitment to upholding social justice, health for all and overcoming inequalities, Brazil is about to retreat even further on these issues depending on the results of Sunday's elections (28).

During the conference, the country was quoted three times on the first day in debates and presentations and at least five times in the second. All were commendable for what it has done in primary care despite the acknowledged underfunding.

The candidate Jair Bolsonaro (PSL), who is in first place in the polls, has said repeatedly, including in his government plan, that SUS has enough money and will not increase the resources for the system. For him, the problem is management. This is also true, but it does not eliminate the real lack of funding since its inception, which is extensively documented in international reports.

Returning to Astana, it was lovely to see even our neighbor Argentina tearing up in caresses of the Brazilian care model.

You must be thinking: it's because they do not know the SUS and this reporter lives in the world of the Moon.

And I say: it is because they know very well our experience in primary care, which has already been widely documented and studied by journals that are a reference in world health, such as the Lancet and the BMJ (British Medical Journal).

But look well. I'm talking about the entrance door of the SUS, which, although it still has many flaws, stands out in comparison to other countries of equal socioeconomic profile. It does not enter into this assessment, for example, the endless queues for specialized consultations and surgeries.

One of the main compliments is that Brazil has anchored its primary care in the Family Health Strategy (ESF) program and, together with the supply of medicines through programs such as the Popular Pharmacy, have achieved significant reductions in mortality rates and cardiovascular diseases, for example.

Immunization, HIV-AIDS and psychosocial care (Caps) programs have also been cited in Astana as examples to be followed by other countries in the world.

The most ironic was the Minister of Health, Gilberto Occhi, not to be present at the event to hear all this.

There was a Brazilian delegation, made up of researchers from Fiocruz, the national health council, among others, but by the conference rule only the minister of each country had the right to speak on the main panels.

As a result, the most cited country at the world's premier public health conference was virtually silent.

But absence is also symbolic. Achievements such as the reduction of infant mortality rates and premature deaths due to chronic diseases and the increase in vaccination coverage are beginning to recede, as this Folha revealed . And if the scenario of freezing of health resources persists (which Bolsonaro has also signaled to maintain) and cuts, future projections are catastrophic.

There is even a fear of the future of well-established HIV-AIDS programs. Behind the scenes, Bolsonaro has been giving signs that he can make changes (cuts - extinction? No one knows for sure, anyway, as everything pertains to his government plan).

The same happens with the family health program, which is slowly losing teams, as it happens in Rio de Janeiro and, consequently, suffering from the risk of dismantling.

In this moment of threats to the achievements of the SUS and flirtation with authoritarianism, it is worth reading an article published by Fiocruz on how (de) organized health in Brazil under the dictatorship: http://cee.fiocruz.br/ ? q = before-you

A few hours into the run-off election, these arguments will hardly resonate in the minds of those who have little attachment to public health or who do not mind giving a blank check to a candidate who has failed to debate the main Brazilian issues.

But I leave you with a question that has been asked me several times by incredulous members of delegations from other countries: Is Brazilian democracy in danger? Are not you afraid? Is the Brazilian democracy in danger? Are not you afraid?

The speech of former president of the STF Joaquim Barbosa this Saturday (27) seems to give the answer.

**Folha De S. Paulo**

**Half the world’s population does not have access to basic health care**

**By: Cláudia Collucci**

*23 October 2018*

Primary health care is in crisis in the world. It is still poorly developed in many countries, under-funded in others, and faces a serious challenge of recruiting and retaining the workforce.

This introduction of a recently published [editorial in The Lancet](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32478-4/fulltext?fbclid=IwAR07Y1O4uXEOh8jExs7Oi2U-08jVN_mvRiry5DibAWv0nlkVmmrrqsfSCCM) gives the tone of themes that will be on the agenda starting this Wednesday in Astana, capital of Kazakhstan, where the Global Conference on Primary Health Care will take place.

As a fellow at Global Health Strategies, I will be accompanying the event, co-organized by the government of Kazakhstan, WHO (World Health Organization) and Unicef, which is expected to bring together some 1,200 health leaders around the world among heads of state, health ministers , finance, education and social assistance, non-governmental organizations, researchers and health professionals.

The meeting comes 40 years after the signing of the epic Alma-Ata Declaration, which in 1978 drew the attention of world health leaders to the importance of primary health care as a key to better health for all, with social justice and equity. At the end of the meeting, there will be the Astana Declaration, where the pillars of Alma Ata should be strengthened, with new proposals.

The fact is that Alma-Ata's ideals are still far from being achieved. Half of the world's population does not have access to the most essential health services. The focus continues on individual diseases and there is no priority in prevention and health promotion.

There is a consistent scientific literature reporting that 80-90% of people's health needs can be provided within a basic health care framework. From prenatal care, disease prevention and vaccination, to management of chronic conditions and palliative care.

As populations age, multimorbity sets in and health costs are becoming unsustainable, prioritizing primary care and actually turning it into the organizer of health systems, it becomes ever more fundamental.

However, the workforce, an essential factor for the performance and sustainability of health systems, is still a challenge for strengthening primary health care.

According to the World Organization of Family Physicians (Wonca), despite efforts to train doctors in developing countries, there is insufficient investment in primary health care personnel. New curricula, multiprofessional environments, and more organizational support are needed. In most European countries, there is a shortage of general practitioners (GPs), especially in rural areas. The same thing happens in Brazil.   
   
General practice is often seen as low status, with little prestige for doctors, associated with a high administrative workload and lack of peer support. Despite some innovations, such as new roles for nurses and pharmacists in primary care, there is a need to offer more professional development and more support to infrastructure, including technological innovations.

According to the Lancet medical journal article, the recruitment and retention of community health workers, nurses and doctors need to improve in most regions of the world. And making primary health care a more attractive work environment is crucial to achieving this.

Other controversial discussions should take place during the conference, such as the growing pressure of private interests in public health systems, the economic and financial crisis, and the strong advance of neoliberalism and authoritarianism around the world.

In Brazil's contribution to the conference, approved by the National Health Council, it is advocated, for example, to exclude the term universal health coverage from the new text of the Astana Declaration.

In the Brazilian (and other developing countries) conception, universal coverage is a neoliberal proposal and antagonizes the right and universal access to health, provided for in the Constitution. As they say in my country, this will still give a lot of cloth for the manga. Wait.

**Folha De S. Paulo**

**Health is not a political toy, WHO director says**

**By: Cláudia Collucci**

*25 October 2018*

"Health is not a political toy, it must be used to promote well-being and quality of life, and this will happen only when we commit ourselves to making primary health care the basis of universal care." The statement was made by Tedros Adhanom Ghebreyesus, Director-General of WHO (World Health Organization), on Thursday when he signed an international agreement in Astana, capital of Kazakhstan, where 194 WHO member countries, including Brazil, pledged to strengthen primary care.

Called the " Astana Declaration, (https://www.who.int/docs/default-source/primaryhealth/declaration/gcphc-declaration.pdf) " the agreement also commemorates the 40th anniversary of the landmark Alma Alta Declaration, which called on the world to make primary health care (http://www.who.int/primary-health/conference-phc/declaration) the pillar of universal health coverage in 1978.

It turns out that although in the last 40 years life expectancy has increased and child mortality halved, for example, health progress has been uneven and unfair among countries and within countries. "We need to recognize that we have not achieved this goal [health for all]." Instead of health for all, we have achieved health for some, and we have been very focused on combating specific diseases that are very focused on treatment rather than disease prevention, "said Ghebreyesus.

Nearly half of the world's population does not have access to essential health services and, according to the WHO, 100 million people are pushed into poverty each year because of catastrophic health spending. Primary health care can provide 80-90% of a person's health needs during their lifetime. Asked by Folha whether the growth of authoritarian regimes and the threat to democracy could further worsen the universal health scenario, Ghebreyesus said he did not believe this hypothesis since the agreement between the countries is unanimous and supported by strong scientific evidence. It is not what researchers think of the Brazilian delegation present at the event.

"There is a real threat," said Ronald dos Santos, president of the National Health Council, which is part of the Brazilian delegation to the event. According to Ligia Giovanella, a professor at Fiocruz, if fiscal adjustment and health cuts were maintained, achievements in primary care in Brazil are in serious danger of regression. The Brazilian experience with primary care, which now serves 130 million people, was praised in three moments of the event, including the secretary of health of Argentina, Adolfo Rubinstein. "Brazil is our best example," he said.

For Paulo Buss, from Fiocruz and also a member of the Brazilian delegation, this was only possible because there was continuity of health policies, especially the family health program, since the government of Itamar Franco, "he said. International studies show that the Family Health Strategy (ESF) program has reduced rates of infant mortality and cardiovascular deaths.

For Buss, the immunization program and access to medicines in the SUS were fundamental to the success of these indicators. "You leave the appointment and already have the medication for diseases like diabetes, hypertension, asthma and verminosis."

According to the Astana Declaration, multisectoral action is needed that includes technology, scientific and traditional knowledge, together with welltrained and paid health professionals, and the participation of people and the community to achieve the much-desired health for all with quality.

It also reinforces the growing need for prevention, control and management of noncommunicable diseases, such as diabetes and heart disease, among others, which today are responsible for more years of illness and death in most of the world, including Brazil. It also recognizes the need for adequate remuneration for health workers and investment in education, training, recruitment, development, motivation and retention of the workforce.

According to WHO's Ghebreyesus, countries should strive to provide and maintain the workforce in rural, remote and less developed areas and not allow the international migration of health personnel, undermining the ability of developing countries to meet health needs of their populations.

**GGN**

**Fiocruz: Health is not a commodity**

*26 October 2018*

Forty years after the Declaration of Alma Ata, which guaranteed the universal human right to health, comes the Astana Declaration, which will result from the Global Conference on Primary Health Care held on October 25 and 26 in Kazakhstan. The Oswaldo Cruz Foundation (Fiocruz) and the National Health Council (CNS) reaffirm the commitment of the Alma Ata Declaration with the defense of social justice, health for all and overcoming inequalities between and within countries.

On the first day of the meeting the final declaration will be presented with the incorporation of suggestions from several countries. The contributions of Fiocruz and the National Health Council contrast some points defended by the World Health Organization (WHO), which, if approved, will serve as guidelines for all countries. The main concern is that the Astana Charter distorts Alma Ata: in draft charters already disclosed, "primary health care" has been treated as "universal health coverage", focused on financial coverage, which does not necessarily guarantee access services according to health needs.

In the first drafts of the Astana Charter statement, the reduction of Primary Health Care (PHC) to universal coverage is observed, which significantly restricts its scope; the absence of the call to governmental responsibility for guaranteeing the right to health; strong emphasis on private sector participation - and certainly there are huge private interests of insurance companies, pharmaceutical industry, equipment, among others, in the expansion of their markets by the proposal of universal coverage, yet no conflict of interest is mentioned; emphasis on individual responsibility for ensuring health and health care; there is no mention of the problem of social inequalities and the need to reduce them to guarantee the right to health, nor mention is made of social justice, among other issues.

To mark its position, Fiocruz composed a working group that elaborated a document of positioning in favor of the Primary Attention to the integral Health, the universal right of health and universal public systems of health - like SUS. The document was synthesized based on contributions from Fiocruz researchers on the topics mentioned in the first proposals of the Astana Charter and others included in the conference program in Astana already available on the Internet. Members of this group will attend the conference in Astana.

It is expected that pressure will be put on a statement by Astana reaffirming Alma Ata's comprehensive Primary Health Care proposal and the Alma Ata Charter principles of health for all and social justice. That the approved letter advances in relation to the first propositions and that there is a clearer defense of the universal human right to health to the access of health services according to needs and the primary responsibility of the governments in guaranteeing this right.

In the Americas region, Opas had to expand its understanding of universal coverage to include access to and guarantee of the human right to health, and recently, during the meeting of its board of directors, the Universal Health Commission, chaired by the former president of Chile Michelle Bachelet, presented a document with concerns like these.

**Social justice**

Already in the goals of the global conference of Astana includes Primary Health Care to *universal health coverage*  (UHC), universal health coverage (CUS). The CUS, as it is being disseminated by the World Bank, the Rockefeller Foundation and WHO, focuses on financial coverage, that is, that each individual has a private or public insurance plan, so that he does not incur excessive expenses in the act of use.

However, financial-only coverage does not necessarily guarantee access to health services according to health needs. Health services are not distributed according to health needs if the government does not plan and deploy a regionalized network system with integration among all levels of care that can be accessed as needed. Without a system design, regional inequalities are perpetuated and disadvantaged populations are not covered.

At the same time, insurance contracts imply in defining a basket of covered services that may be higher or lower depending on the possibility of payment of each. The experience of targeted insurance for people in extreme poverty encouraged by the World Bank in Latin America has produced more segmentation, more inequity. With health insurance differentiated by population group, inequalities are crystallized! No more is sought to reduce social inequalities or promote social justice! Very different from the proposal of universal public health system that has as principle that health is a right of all and duty of the State. Very different from what was proposed in Alma Ata.

**Declaration of Alma-Ata**

Adopted at the 1978 International Conference, the main legacy of the Alma-Ata Declaration was the comprehensive and comprehensive conception of primary health care. In the Alma Ata Declaration, PHC is understood as a strategy to organize health systems and guarantee the universal human right to health. It has three essential components: 1) it is the first point of contact and the basis of health systems of universal access and integral care; 2) recognizes the inseparability of the health of economic and social development, involving cooperation with other sectors to address social determinants and promote health; 3) promotes social participation for the empowerment of citizens in the defense and expansion of social rights. In a context distinct from the present, of independence of African colonies, democratization,

Although the Alma Rock conference, the Rockefeller Foundation, Unicef ​​and WHO have disseminated a selective approach to PHC, a minimum package of services for the maternal and child groups and populations in extreme poverty, this concept of integrated PHC has won hearts and minds around the world in the fight for human rights, and today guides local and global social movements such as the People Health Movement.

In a study carried out by the South American Institute of Health Governance on PHC in the 12 countries of South America, Alma Ata's statement was mentioned in almost all PHC policy documents as a strategy to reorient health systems and guarantee the right to health. Its legacy is the defense of the universal human right to health and that another form of more comprehensive health care is possible.

**El Medico Interactivo**

**The Declaration of Astana is signed to achieve Universal Health**

*26 October 2018*

The 193 member countries of the United Nations (UN) have unanimously signed the Declaration of Astana, committing themselves to reinforce their Primary Health Care as an essential step to achieve universal health coverage. This Declaration reaffirms the historic Alma-Ata Declaration of 1978, the first time that world leaders committed to Primary Care. "Today, instead of health for all, there is health for some. We have the solemn responsibility to ensure that today's agreement allows all people, everywhere, to exercise their fundamental right to health, "says the director general of the World Health Organization (WHO), Tedros Adhanom Ghebreyesus.

While the Alma-Ata Declaration laid the foundation, progress over the last four decades has been "uneven," according to the WHO. And, as they recall, at least half of the world's population lacks access to essential health services, including care for noncommunicable and communicable diseases, maternal and child health, mental health and sexual health and reproductive

The Astana Declaration comes amid a growing global movement to ensure universal health coverage. UNICEF and WHO will help governments and civil society act on the Astana Declaration and encourage them to support the movement.

**El Mundo Costa Rica**

**WHO: Towards universal health coverage, not for a few**

*25 October 2018*

Geneva, Oct 25 (elmundo.cr) - The Member States of the United Nations unanimously approved the Astana Declaration on Thursday, in which they pledge to strengthen their primary health care systems as the prelude to achieving universal coverage. Health.

The agreement was reached within the framework of the World Conference on Primary Health Care that takes place during two days in the city of Astana, in the Republic of Kazakhstan, and contributes to ratify the Declaration of Alma-Ata of 1978, the first in the world leaders committed to primary care services.

The Declaration commits the Member States in four areas: making bold political decisions for health in all sectors; build a primary health care sustainable; empower individuals and communities; and include stakeholder support with national policies, strategies and plans.

Similarly, it seeks to serve as an aid to achieve the Sustainable Development Goal 3, whose goal is "to guarantee a healthy life and promote well-being for all at all ages". The World Health Organization (WHO) and UNICEF will help governments and civil society to implement the agreement.

The Director General of the WHO, Tedros Adhanom Ghebreyesus, stressed that currently "instead of health for all, we have health for some" and held that the Declaration must assume a joint obligation that "allows all people, in all parties, exercise their fundamental right to health. "

**Disparity Progress**

According to WHO figures, at least half of the world's population lacks access to essential health services, which includes care for non-communicable and communicable diseases, maternal and child health, mental health and sexual health and reproductive This percentage demonstrates the uneven progress of the Alma-Ata Declaration during the last four decades.

Despite the great advances in children's health, UNICEF executive director Henrietta Fore said that "almost 6 million children die every year before they reach their fifth birthday, mainly due to preventable causes, and more than 150 million are stunted "

**Remove barriers**

Among those attending the Astana event are government delegations, civil society and academics from Argentina, Brazil, Canada, Chile, Cuba, Ecuador, El Salvador, the United States, Guatemala, Nicaragua, Paraguay, Peru and Suriname.

The Minister of Public Health of Ecuador, Veronica Espinosa, stressed the importance of access to health services by stating that "if we do not have sufficient access to health, coverage is simply a speech," he said.

He also urged to "eliminate the structural, economic, cultural, geographic, linguistic and gender barriers" that prevent people from using health services.

Among the regional efforts to achieve universal coverage, the Regional Universal Health Forum in the 21st century stands out: 40 years of Alma-Ata, held in Quito in December 2017, which sought to "identify obstacles and generate alliances" that would allow the countries of the region reach the goal of health for all by the year 2030.

In addition, the Pan American Health Organization stressed that the countries of the Americas were the pioneers worldwide in adopting a resolution on access and universal health coverage that outlined a regional road map to advance toward universal health.

**La Nación**

**Adolfo Rubinstein: “Primary care is the key to achieving healt for all”**

**By: Nora Bär**

*25 October 2018*

ASTANA, Kazakhstan.- Despite the long trip, the government secretary of Health and Social Action, Adolfo Rubinstein, is one of the officials who actively participates in the activities of the Global Conference on Primary Health Care organized by WHO, UNICEF and the government of the host country. It is not casual: Rubinstein, one of the pioneers of family medicine in Argentina, was for 20 years head of that service at the Italian Hospital before devoting himself to research as one of the founders of the Institute of Clinical and Healthcare Effectiveness. "For me, this has a special significance," he says. ­

**-You agree broadly with this vision of public health. How do you translate it in your management?**

-I have three axes. One is the implementation of universal health coverage, which has several components. The first is the development of the family and community health strategy. Together with the provinces, we are developing a territorial strategy for family and community health, creating family health teams (a family doctor or primary care physician, nurse, health agents with defined population in charge, in georeferenced areas that are expanding) provide primary care to the population, with quality and closeness. We try to avoid intermediation, to improve the scheduling of queries. We started in Mendoza and there we are scaling the experience, but we are also starting what we call "scalable provincial projects" in other places. They are a proof of concept: the province defines with us a population that has primary care centers and a referral hospital where we put all the components, especially to start adapting to the realities of each district. Finally, we are beginning to prioritize conditions for which the health disparities between rich and poor provinces in infant and maternal mortality, breast, colon and cervical cancer, heart attack ... are inadmissible ... ­

**-What kind of disparities?**

- For example, we have eight times more cervical cancer in the poorest provinces, four to five times more mortality from colon cancer, and differences of between six to eight hours, on average, between provinces and richer social works and more poor in the time between the onset of a heart attack and the revascularization procedure or thrombolytic treatment. That delay is critical: the more hours that pass, the greater the mortality or the consequences.

**-­How can those gaps be reduced?**

-The National State has to agree with the provinces and with social security, supporting strategies that are aimed at reducing them through a territorial structure, with family health teams, with primary care, with information, with electronic medical records and the consultation scheduled to improve the quality of care. And, also, giving incentives for better treatment of heart attack, cancer or maternal and child health problems. Without primary care, there is no universal health coverage.

­**-Alma­Ata was an inspiring milestone, but in fact it was not fulfilled. What is the difference between that statement and this one from Astana?**

-Alma-Ata was a manifestation of intentions: we wish that in the year 2000 there would be health for all, with affordable services, local, with participation of the community, integrated, but did not give the instruments. This occurs within the framework of a universal strategy, which are the objectives of sustainable development, which do give a much clearer North. Number 3, dedicated to health and well-being, refers basically to the implementation of universal health coverage. A way is outlined on how to secure the financing funds, with what axes to work, population, services, financial protection. And the framework clearly has to do with primary care; otherwise, it is not possible to achieve the objectives of sustainable development. We, in Argentina, will do it our way, without reinventing the wheel, ­

**-What is the role of the State in this transformation?**

-It has a leading role, especially to protect the most vulnerable population. This can not be left to the private sector, which does not mean that it can not collaborate. Universal health coverage relies, fundamentally, on the State. Note that in the more developed countries, except the United States, health is public. Both European countries, such as Canada or Australia, all those with systems oriented to primary care have a very strong public sector.

**La Nación**

**In a meeting of the WHO and UNICEF, unanimously agree a new course for health care**

**By: Nora Bär**

*25 October 2018*

ASTANA (Kazakhstan) .- After a colorful ceremony, traditional music, dancers dressed in brightly colored tunics and headdresses, a light show and speeches by the highest authorities of the World Health Organization, Unicef and the government of Kazakhstan, all the member countries of the United Nations today agreed to promote primary health care as a priority strategy to reach the goal of "health for all", slogan of the next General Assembly of this international organization in 2019.

40 years after the Declaration of Alma-Ata, which for the first time established the notion of health as a human right, and in light of the enormous social, economic, technological and epidemiological changes that have taken place in these four decades, more than 1200 political and academic leaders, NGOs and social organizations renewed the commitment to move forward in the reformulation of health systems to guide them towards this approach that puts human beings and not diseases at the center of the stage.

"The work of our predecessors was inspiring, but today we are here not to celebrate, but because we do not meet our objective," said Tedros Adhanom Ghebreyesus, Director General of WHO, "Instead of health for all, we have health for some. Progress was unequal not only between, but also within countries, there are 31 years of difference between those with more and less life expectancy, some are born with privileges and others with deprivation, some with great ambitions and others with the hope to reach the end of the day, but we all share the desire to enjoy good health We are here to recommit ourselves We allow Alma-Ata's vision to shrink, to be diluted We have the responsibility to ensure that the act of today give to each person, wherever he lives, the possibility of exercising their fundamental right to health ".

**Primary health care**

"Even though the world is today a much healthier place for children than ever before, still about six million die daily before their fifth birthday due to preventable causes and more than 150 million do not develop properly," said Henrietta Fore, executive director of Unicef-. We can change that by bringing services closer to those who need them. That's what primary health care is about. "

The Declaration of Astana, prepared by more than a thousand authors, comes when multiple studies support this vision to achieve universal health coverage. It proposes integrated interventions, which contribute to developing health systems focused on the individual and the family, instead of allocating huge sums of money to treat individual diseases separately.

"We achieved a lot, but we have to achieve much more," added Ted Chaiban, UNICEF's program director, "The world is waiting for solutions and we must meet, the challenges are substantial, but the opportunities are even greater health a movement and not just a moment. "

For his part, the government secretary of Health and Social Action of Argentina, Adolfo Rubinstein, who was one of the protagonists of the opening session of the event, underlined during his speech that "in 1978, the motto 'health for all' seemed Something very distant, aspirational rather than operative, at that moment, he emphasized, infectious diseases, problems of mother and child, and malnutrition were the dominant ones in underdeveloped countries Forty years later, considering the dramatic demographic changes and epidemiological, primary health care must be reconverted to address the growing burden of noncommunicable diseases, responsible for more than 70% of premature mortality and morbidity in the region. "

Rubinstein concluded with a provocative question: "More than ever," he said, "this must be the driving force that leads us to the goal of health for all." In the country, primary care is still nominal and implicit a lasting change To paraphrase the title of Primo Levi's famous novel, we could say: 'If not now, when?' "

**La Nación**

**In Kazakhstan, leaders from around the world call for the promotion of primary health care**

**By: Nora Bär**

*24 October 2018*

Astana, KAZAKHSTAN - "Sometimes we go house to house in the villages we visit, taking the blood pressure or simply talking to people, and in certain circumstances, a slap or a smile can be as important as a medicine. I love this work, "says Aizhan, a young Kazakh medical doctor who, along with eight colleagues, integrates the ambulatory hospital staff that combines ophthalmological, dental, gynecological, pediatric and clinical practice in a double-trailer truck parked in the land of the Polyclinic N ° 9 of this city, next to an ambulance of attention of urgencies, and another one for attention of childbirths.

Outside -4 degrees, but inside the health center, after crossing the traditional double doors in the buildings of this futuristic city, you have to circulate in a shirt. Created between 2014 and 2015 within the "100 schools and 100 hospitals" plan, this type of ambulatory care polyclinics represent a 180 degree turn in the health strategies of this continental country that borders Russia, China, Kirgiztan, Uzbekistan and Turkmenistan, is the ninth in the world by its size and the richest in Central Asia: thanks to its oil and gas industry, and its mineral resources, it generates 60% of the GDP of the region.

The clinics, which are public and free, focus not on treating the disease, but on preserving well-being. They practice what is known as "primary health care", a concept installed in 1978 in the historic Declaration of Alma-Ata (the then capital of Kazakhstan), when experts and world leaders committed themselves to achieving the goal of ensuring access to health for all. To 40 years of that date, from tomorrow and during two days more than 1200 ministers of health and political leaders from all over the world, NGOs, professional and academic associations, and international health organizations will gather in this city to renew the commitment and sign the Declaration of Astana.

**Welfare state**

"Four decades later, that vision did not materialize," the Lancet scientific journal, which participates actively in the meeting, says in an editorial , "Instead, the focus was on individual diseases with variable results of Sustainable Development inject new impetus to achieve universal health coverage through strengthened primary care "

It is estimated that half of the more than 7300 million people who inhabit the planet still lack access to essential health services and that every year around 100 million people fall into poverty due to the costs of medical treatment.

Primary care aims to offer services as close to the communities as possible, strategies to help them take care of themselves and stay healthy (such as vaccination, safety on routes and anti-smoking policies), or to be cured when their members are sick.

It is precisely in compliance with these principles that in Astana, the current capital of the host country, there are 27 outpatient polyclinics and each one has a population of around 80,000 people that it serves from eight in the morning until eight at night, plus an emergency service that works 24 hours a day. Each clinical doctor is assigned around 1900 patients.

"Here we do prevention and screening for early diagnosis and treatment through a multidisciplinary approach applied by teams of clinicians, social workers, nurses and psychologists." Nurses are responsible for calling patients by phone to invite them to take the exams that correspond to them and we have schools for family planning, young mothers, asthma and older adults, among others, "says Zhanar Kapshayeva, director of prevention at Policlínica N ° 10, the largest in the country. In the pharmacy of these centers, patients receive the prescription drugs completely free of charge and the medical records are digitized. In addition, they have an electronic application to request shifts or a doctor at home, and consult the results of laboratory studies. Once per year,

Despite this bet, progress is slow. "We have to keep moving forward," says Kamalzhan Nadyrov, director of the Astana Health Department, "yet most people only go to the doctor when they are sick."

"Primary health care is in crisis," the Lancet emphasizes, "it is underdeveloped in many countries, does not have the necessary budgets in others, and faces serious challenges in the recruitment and retention of human resources. and 90% of the health needs of a person throughout his life can be provided within this framework, from the management of pregnancy and the prevention of diseases through vaccination, to the management of chronic diseases or the Palliative Care As populations age and multimorbidity becomes the norm, the role of primary health care workers becomes increasingly important. "

**Results map**

"We see primary health care as a way of caring, but also as a more integrated approach that links public and private systems," explains Asaf Bitton, director of primary health care at Ariadne Labs. This modality of care saves lives and at a lower cost, besides being a promoter of equity and inclusion, and we believe that in the long term it offers the possibility of reaching the goal of health for all ".

“We have 40 years of accumulated knowledge: both successes and learning opportunities," says Bitton. "Now, donors and health agencies are aligned for the first time, not only in words but also in action how our systems work, make the invisible visible, understand what we lack ".

The problem is that the available data are of low quality or insufficient; among other things, because care is fragmented into innumerable specialties and vertical programs.

In practice, after defining the key conditions for developing the primary health care approach (such as access to care, quality, equity, governance, financing), the researchers translated it into a proof of concept: they developed the profile of eleven countries with respect to their exercise of primary health care. "All these data were missing," says Jeremy Veillard, program director for the World Bank, "We want to measure from the patient's perspective."

"In the case of Argentina (one of the included), Dr. Adolfo Rubinstein [current Secretary of Health] approached us because he was interested in monitoring the performance of the health system - explains Federica Secci, a World Bank specialist who is elaborating the national profile- Some of what we saw is that there are many inconsistencies or lack of data, partly due to the complexities of the federal structure that the country has, but beyond the obstacles, the important thing is that this Work has to be a promoter of dialogue between different providers, which allows to emphasize and develop this approach ".

**La Nación**

**Mental health: there are countries in Africa with 19 million people and a single psychiatrist**

**By: Nora Bär**

*28 October 2018*

ASTANA (Kazjistán) .- Considered a "giant" in the world of mental health, forty years ago the Indian psychiatrist Shekhar Saxena plays a leading role in removing mental disorders from the dark and place them in a priority of health systems . As a researcher at the World Health Organization (WHO), in 1998 he participated in a historical report on mental health in the world and, concerned about the lack of data on available resources, in 2001 he decided to publish the first Atlas of these diseases.

Director of the Department of Mental Health and Substance Abuse of the WHO until last June, he knows perfectly the deficiencies that exist throughout the planet. "As far as mental health is concerned, all countries are developing, none has services that work satisfactorily," he says in a recent issue of The Lancet magazine, "we have the knowledge and the necessary technical tools to offer care in larger scale, but we lack financing mechanisms, both national and international. " And later he adds: "Politicians should ask themselves not whether they can afford to invest in mental health, but whether they can afford not to, as they are playing with the human capital of their countries and communities."

Between session and session of the Global Conference on Primary Health Care that just ended in this city, Saxena gave us a few minutes. ­

**-What exactly does "primary mental health care" mean?**

-Primary health care varies from country to country. In some, it is managed by doctors and nurses. And in many others, by specially trained personnel and by volunteers. Everyone can help, but in different ways. In Argentina, where primary health care is mostly in the hands of doctors and nurses, they can be trained very well in the identification and treatment of at least the most common mental problems: depression, anxiety, alcoholism and drug use. , and also in developmental disorders in boys. If that is achieved and attention can be offered to between 60 and 70% of the people, it will be a huge step forward. Some will need special care and should go to a specialist. ­

**-There are those who think that this is an illusion rather than inclusion. What would you say?**

- That, indeed, for hundreds of millions of people, primary mental health care is still an illusion. We know that for 90% of the population in the countries of medium and low income, and up to 75% in the high income countries, they do not have access to even minimal effectiveness treatments. These are the numbers. So, for the great majority there is still no inclusion. However, meetings such as Astana [the Global Conference on Primary Health Care, which has just ended] are important for the political commitment that will lead us to renew efforts to make it a reality. And as we demonstrated in the Mental Health Commission of The Lancet, even for the poorest countries it is possible to cover the treatment of mental health in primary care. And it should be done now.

­**-What is the road?**

- We know that the number of specialists in most of the middle and low income countries is extremely small. There are some of Africa with 19 million people and a single psychiatrist. Even in Latin America, where the number of psychiatrists and psychologists is greater, it is totally insufficient. ­

**-Argentina could be considered an exception?**

-The Argentina has a significant number of mental health specialists, but if we pretend that they are the only ones that offer care, they would not be enough to meet the needs of all.

**-So, the system is inadequate?**

-Exactly! There is no alternative: it is essential to offer mental health services in primary care, supported and supervised by specialists.

**-­In Argentina there is a great controversy about the hospitalization of patients with mental disorders. What is your opinion? How should it be managed?**

-Some of the problems arise because good community care requires money and bad hospitalization can be cheap. The government has to establish community services dedicated to mental health, as Brazil did, a large number of family clinics where patients with mental disorders can be treated. This greatly diminishes the need for hospitalizations. That is the way for most diseases. We know that some people need to be admitted to a hospital, but that should be reserved only for a small number of patients, not for the majority. Community or family care is much better, both for patients and families and for long-term outcomes. When you hospitalize a person and they stay there for more than a year, they may never leave.

**-Are there short therapies, but also effective?**

-Absolutely. There are brief strategies for anxiety and depression that can be performed by people with less training than a postgraduate in psychology and psychiatry. If you have them, it's very good. But if not, you have to do what you can with the available resources. And people can be trained in a short time to perform treatment in four to eight sessions, instead of 80. The World Health Organization's guidelines are very clear: psychological interventions are as effective for depression as drugs. What is needed is to train those in charge of applying them, and help them to offer them systematically and effectively.

**-­Does this also apply to substance abuse?**

-That is a big problem in many countries and much of the effort should be in the health area. How can we reduce the need for these drugs? Working with young people through prevention. And if the person is already drug dependent, there are different methods oriented to the psychosocial sphere, especially cocaine, which help rehabilitation and recovery. Obviously, it is a long-term treatment. You can not expect results in a week, but in three months there can be results. ­

**-At present, new styles of relationship between the doctor and the patient are being explored, such as the group consultation. What opinion do you deserve?**

-The consultation and the treatment in a group context can be very effective. Taking drugs is a group phenomenon, so recovery can also be, depending on how the program is run. ­ Is there a difference in the quality of the treatments according to whether they are conducted by a psychiatrist, a psychologist or a primary care worker? -In primary care we do not talk about psychiatrists, but about a doctor or nurse. The time available for the person who deals with primary care is very small. A psychiatrist typically has about 40 minutes, however in the context of primary care does not exceed 15. Then, they have to be more efficient, and they have to recognize the most common disorders, make a treatment plan and provide it very quickly . But its effectiveness is very good and cost-effective. That is why the WHO warmly supports it. In fact, it recommends a pyramid of services: at the grassroots level, self-help and community care should be accessible to all; in the middle, primary care should be available to those who need it, and care by specialists should be reserved for a small number of cases. ­

**-How do public policies and other factors that are beyond the doctor's office affect mental health?**

-Mental health has a lot to do with things that are outside the clinic. Social policies, alleviating poverty, reducing violence, educating all children, reducing stress factors, such as armed conflicts, wars and disasters, are all actions aimed at the population that are very effective. Also, individual behaviors, such as doing physical activity or eating well, not consuming alcohol and drugs, are things that can definitely help reduce the prevalence of mental problems.

**Prensa Latina**

**Astana Declaration Approved in World Primary Care Event**

*25 October 2018*

Astana, Oct 25 (Prensa Latina) The Member States of the United Nations unanimously approved today the Declaration of Astana, in which they commit to strengthen their primary health care systems to achieve universal coverage of health care.

The agreement was reached in the context of the World Conference on Primary Health Care that is held between now and tomorrow here, which contributes to ratify the Alma-Ata Declaration of 1978, where nations committed to primary care services, says a UN statement.   
  
The Declaration commits Member States to make bold political decisions for health in all sectors; build sustainable primary care and empower individuals and communities, the text says.   
  
Also, he adds, include stakeholder support with national policies, strategies and plans.  
  
Likewise, it adds, it seeks to serve as an aid to achieve Sustainable Development Goal 3, whose goal is to guarantee a healthy life and promote well-being for all at all ages.   
  
According to the director general of the World Health Organization (WHO), Tedros Adhanom, today, instead of healing for all, we have healing for some.   
  
We have the firm responsibility to ensure that today's statement allows every person, anywhere, to exercise their fundamental right to health, he said.  
  
In spite of the great advances in infantile health, almost six million children die every year before turning 5 years, mainly by preventable causes, and more than 150 have growth retardation, reflected the executive director of the United Nations Fund for Children (Unicef), Henrietta Fore.   
  
As a global community we can change that, bringing quality healthcare services close to those who need them. That's what primary health care is about, Fore said.   
  
For his part, the Minister of Health of Kazakhstan, Yelzhan Birtanov, said that the adoption of this declaration at the global conference in Astana will establish new directions for the development of primary health care as the basis of health systems.  
  
UNICEF and WHO will help governments and civil society to comply with the Astana Declaration. In addition, they will support countries to review their implementation in coordination with other partners.

**St. Lucia News Online**

**Suriname among global countries signing Declaration of Astana**

*26 October 2018*

**(CMC) –** Suriname is the lone Caribbean Community (CARICOM) country to have signed the Declaration of Astana, vowing to strengthen its primary health care systems as an essential step toward achieving universal health coverage.

The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care.

The Declaration of Astana, adopted at the conference, makes pledges in four key areas, namely making bold political choices for health across all sectors; build sustainable primary health care; empower individuals and communities; and align stakeholder support to national policies, strategies and plans.

“We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health. Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO).

“We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health.”

The WHO noted that while the 1978 Declaration of Alma-Ata laid a foundation for primary health care, progress over the past four decades has been uneven.

At least half the world’s population lacks access to essential health services – including care for non-communicable and communicable diseases, maternal and child health, mental health, and sexual and reproductive health.

The Declaration of Astana comes amid a growing global movement for greater investment in primary health care to achieve universal health coverage.

Health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems – a gap highlighted by several health emergencies in recent years.

UNICEF and WHO will help governments and civil society to act on the Declaration of Astana and encourage them to back the movement. UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in cooperation with other partners.

Government, civil society and academic delegations from Argentina, Brazil, Canada, Chile, Cuba, Ecuador, El Salvador, United States, Guatemala, Nicaragua, Paraguay, Peru and Suriname, as well as from other countries all over the world, participated in the Conference in Astana, the WHO said.

**Surname Herald**

**Minister Elias participates in 'Declaration of Astana' at Global Conference on Primary Health Care**

(2 November)

A delegation led by Minister Antoine Elias of Public Health has represented Suriname at the Global Conference on Primary Health Care. The conference which was held in Astana, Kazakhstan, on 25 and 26 October 2018 was based on 'From Alma-Ata Towards Universal Health Coverage and the Sustainable Development Goals'. This reports Public Health via the NII.

The delegation also included director Rick Kromodihardjo of the Stichting Staatsziekenfonds (SZF) and deputy general director Herman Jintie of the Medical Mission Primary Health Care Suriname (MZ).

A total of 120 delegations sent out 1200 delegations, consisting of more than five thousand participants, to this large conference, which aimed to share experiences and approaches in the field of primary health care to come to action points. These action points should ensure universal coverage and the achievement of sustainable development goals.

The highlight of the conference was the signing of the Declaration of Astana. In this statement, the representatives of the participating countries reaffirmed the promises expressed in the Alma-Ata Declaration (1978) and the 2030 Agenda for Sustainable Development with a view to health for all.

According to Minister Elias, with the adoption of the Declaration of Astana, even more attention will have to be paid from the Surinamese government to the primary health care with a view to achieving sustainable health benefits for the country and its population. Primary health care deserves the high place it has on the current political agenda, partly because the largest group of people needing care can receive it through primary health care. Care must be taken to ensure that this concerns integrated care that puts the user at the center.

The minister indicates that this means that the government must make sufficient resources available for the primary health care, but must also make regulations so that communities are sufficiently involved in the design and direction of the care. Digital possibilities and resources should also be made available for care. "But above all, prevention and early detection of diseases and disorders must prevail in the policy. That is why the primary health care standard should be the first level of contact for the care recipient, "says Elias.

The CEO also points out that making the (primary) healthcare available and accessible requires an intersectoral approach, in order for Suriname to achieve universal coverage. "We will have to work on the most important factors that can influence health, such as clean drinking water, good hygiene, education and poverty reduction."

Elias emphasizes that the path leading to universal coverage and sustainable development goals is one of inclusiveness, innovation and investment, with a focus on health in everything and everything, leaving no one behind and going for a solidarity approach. "The backbone of the primary health care system is the human potential. The local health worker is the most important factor in this. This health worker must be part of a multi-sector team of workers, be well-trained, have defined tasks and responsibilities, but also gain the trust of the community.

Ideally, such a health worker should be 25 percent in the clinic and 75 percent in the community.

"The success of primary health care depends on the participation of the individual, the community, families and young people. For most countries it is difficult to convince their governments of the importance of primary health care. In the primary health care, not the doctor, but the multidisciplinary team is central. In addition, health budgets are increasing worldwide. For health ministers, the challenge is to get more out of what is already being spent on health. By investing in primary care, hospitals are helped to do better what they have to do. "

Elias speaks of a very successful working visit, because in addition to participation in the conference, bilateral talks were held with governments from countries such as Lebanon, Zimbabwe and Kazakhstan. The Ministry of Health, together with the SZF (State Sickness Fund) and MZ, will convert the acquired knowledge into concrete actions, which should result in the improvement of primary healthcare in Suriname. Knowledge will also be shared with the Regional Health Service, which is also included in the implementation of universal coverage.

**WIC News**

**PAHO director says health is a right of the people and responsibility of gov’t**

**By: Jen Schulz**

*30 October 2018*

Health is a human right, and it is governments’ responsibility to ensure that right, said the Director of the Pan American Health Organization (PAHO), Dr. Carissa F. Etienne, during the closing session of the Global Conference on Primary Health Care in Astana, Kazakhstan.

“Health is not a privilege, nor a commodity. It is a fundamental human right,” said Etienne, adding that “national governments must lead and own national processes towards universal health, in coordination with partners.”

The Global Conference on Primary Health Care was organized by the World Health Organization (WHO), UNICEF and the Government of Kazakhstan and was attended by representatives of governments, nongovernmental organizations, international agencies, academic institutions and youth organizations.

“We know what works and what we need to do,” said Etienne, referring to what is known as the Primary Health Care (PHC) strategy. Based on the principles of equity and solidarity in health, the PHC strategy was first endorsed by global health leaders 40 years ago in the 1978 Declaration of Alma-Ata, signed in the city that served as Kazakhstan’s capital until 1997.

During the Astana meeting, delegates from more than 120 countries—including many from the Americas—reaffirmed their countries’ commitments to PHC and signed the Declaration of Astana, in which signatory countries pledge to strengthen their primary health care systems as an essential step toward achieving health for everyone, everywhere. Universal health is also called for in the United Nations’ Sustainable Development Goals (SDGs).

PHC is a strategy for human health and well-being and social development that is centered on people, their families and communities. “It is not merely the first level of care, nor it is the provision of a limited package of services for the poor,” said PAHO Director Etienne, who also serves as WHO’s Regional Director for the Americas.

PAHO’s Director challenged young people to become more involved in health, saying, “You are our future, the energy that will drive change.” She called on women to urge leaders to ensure that gender is central to decision-making in health. And she challenged academicians to invest in operational research that is context specific and focused on the needs of countries and the health systems, to provide evidence that will guide and support policymakers to take the right decisions.

Etienne also recognized the role of the private sector as health care providers and their importance in innovation and technological development. Emphasizing the principle of social responsibility, however, she urged that the private sector “Innovate, but based on health needs.”

Addressing development partners, Etienne said that the Declaration of Astana and the SDGs offer a “golden moment” that must be seized. “We cannot leave here and repeat the mistakes of the past” by reducing primary health care to minimum sets of poor services for the poor.

“There is no other way” than PHC to achieve health for everyone, everywhere, said Etienne. “Primary Health Care is smart. Primary Health Care is right.”

## Middle East

**The Financial Tribune**

**Iran, Indonesia Sign MoU to Boost Health Cooperation**

*27 October 2018*

Iranian Minister of Health and Medical Education Seyyed Hassan Qazizadeh Hashemi has briefed the Global Conference on Primary Health Care in Astana on the Islamic Republic’s achievements in health and medicine.

Addressing the conference, the Iranian minister said the Islamic Republic has established over 18,700 health centres across the country over the past four decades, and at least 29,000 people are working in the centres offering services to the public.

As the new head of the conference’s panel on economic impact of primary healthcare, Hashemi said Iran began to establish its first health networks in the remote villages but spread them later step by step covering urban areas and big cities.

“The networks played a key role in preparing the ground for decreasing death tolls from diseases as well as infant and pregnant women mortality. They also provide most people with a direct access to healthcare like vaccination and prenatal care,” he noted.

The Iranian minister underlined that the healthcare networks significantly reduced health costs across Iran.

Irregular expansion of urbanization, lack of active systems for offering healthcare services, growing number of patients with non-communicable diseases, rapid advance in new technologies, expensive drugs and aging populations all and all led the country towards a dire situation which required the Iranian government to adopt appropriate measures and develop deliberate plans particularly in the urban areas, he added.

He also referred to the Health Development Plan which is being implemented in Iran and said over 21,000 people have been recruited in urban areas within the plan to fight non-communicable diseases which are deemed as the main reason for most fatalities in Iran and the world.

“From 3 to 5 people recruited in the plan are working under the supervision of family doctors. We have already begun to outsource our medical services by further involving private sector in this area. Private sector can contribute significantly to the health section.”

The Iranian minister underlined that all plans are developed in a way to offer cheaper services with higher quality and efficiency.

“Iran believes primary healthcare can have many positive economic results. The care not only meets the public’s needs but also prepares the ground for further participation of the public in the health area. Meanwhile it strengthens the health system and creates a balance between the society’s needs on the one hand and the specialists on the other, promoting the health services across the country.”

**Gidahatti**

**World states have promised “bold” policies in health!**

*26 October 2018*

The Ministers of Health and senior officials participating in the Global Conference on Primary Health Care Services, held in Astana, Kazakhstan, issued a declaration in which they undertook to make bold political decisions for health in all sectors and committed to creating a sustainable primary health care service.

The 40th Anniversary of Alma-Ata Declaration, which focuses on public health services to the world states and focuses on primary health care services, was held in Kazakhstan, this time at the Global Health Services Global Conference in Baskent Astana.

The World Health Organization (World Health Organization - WHO) and UNICEF, Kazakhstan hosted by the Ministry of Health, the country's health ministers and senior officials at the conference held in the participation of 25-26 October 2018 date for Turkey Deputy Minister of Health, Prof. Dr. Emine Alp Oak.

**Health insurance for everyone with a sustainable health system!**

On the first day of the conference, which emphasized that the main way to have sustainable health systems is to provide universal health coverage to everyone, and that this way is well-organized through primary health care services. The call was made.

Conference in the last 40 years the distance that the six health systems being drawn, were particularly praised Turkey's achievements in the field of maternal and child health.

## **Declaration published**

At the end of the first day of the Global Conference on Primary Health Care, a declaration was published.

States in the declaration;

* + governments and societies that prioritize and protect people's health through strong health systems;
  + high-quality, well-accessible, accessible through skilled and motivated healthcare professionals, primary health care services that are comprehensive and integrated with other steps of healthcare systems, accessible to and everywhere;
  + the environment supporting the health and well-being of individuals and communities;
  + stakeholders providing effective support to national health policies and plans.

## **Kabul Health inequalities are unacceptable**

Despite the remarkable developments in the last 40 years, there are still many people in the world who cannot meet their health needs and it is very difficult to stay healthy especially in the poor and vulnerable groups.

The declaration that the use of tobacco, excessive alcohol use, unhealthy lifestyle and behaviors, insufficient physical activity, and unhealthy nutrition caused by unhealthy nutrition is emphasized. was given.

In the final part of the declaration, governments have committed themselves to creating courageous political decisions for health in all sectors and to establish a sustainable primary health care service.

**Iran Front Page**

**Iran Briefs Astana Health Conference on Its Achievements**

*28 October 2018*

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**Mena FN**

**Iran to work with Indonesia on healthcare, medicine**

*27 October 2018*

(MENAFN - Trend News Agency ) Iranian and Indonesian ministers of health have signed a document for healthcare and medical cooperation, IRNA reports.

Under the Memorandum of Understanding (MoU), signed by Indonesian Minister of Health Nila

Moeloek and her Iranian counterpart Hassan Qazizadeh-Hashemi in Almaty, Kazakhstana, the two sides will cooperate in joint production of pharmaceutical products and medical equipment, undertake the R&D projects, launch joint efforts to prevent Contagious and Non-Contagious diseases, have studies and organize courses on traditional medicine, offer emergency services and focus on disaster management.   
  
The Iranian minister also had a meeting with his Indian counterpart J P Nadda, where they agreed on sharing information and experience in medicine, pharmaceutics, and vaccine production.   
  
Yet in another meeting, Qazizadeh-Hashemi and his Russian counterpart Veronika Skvortsova vowed to enhance cooperation on healthcare, medication and pharmaceutics.   
  
The meetings were held on the sidelines of a conference, marking the 40th anniversary of Declaration of Alma-Ata.

**Mehr News Agency**

**Iran, Kazakhstan sign MoU on healthcare coop**

*26 October 2018*

According to the [public relations department of Iran's Ministry of Health](http://www.behdasht.gov.ir/index.jsp?siteid=1&fkeyid=&siteid=1&pageid=55373&newsview=182792), Iranian Health Minister Hassan Ghazizadeh Hashemi held talks with his Kazakh counterpart Yelzhan Birtanov on Friday in Astana, on the sidelines of the Global Conference on Primary Health Care, which marks the 40th anniversary of the Declaration of Alma-Ata. The Declaration of Alma-Ata formed the foundation for the last 40 years of global primary healthcare efforts, according to Astanatimes.

During the meeting, the two sides signed an MoU on healthcare cooperation, including primary healthcare, research and education in the field of medical sciences, non-communicable diseases, strengthening human resources, as well as medicines and medical equipment.

The Kazakh minister welcomed the proposals of the Iranian side for making long-term plans in the field of healthcare, promising to visit Iran at the first opportunity.

At the end of the meeting, the Kazakh minister awarded the Iranian minister with two medals, one in commemoration of the 40th anniversary of the Declaration of Alma-Ata, and the other, a medal of honor from the government of Kazakhstan.

Minister Birtanov said that the medal of honor is bestowed on a selected few, adding that the medal is granted to the Iranian minister of health due to his effective contributions to global healthcare.

**Mehr News Agency**

**WHO head hails Iran’s contributions to health sector**

*27 October 2018*

Head of the World Health Organization (WHO) Tedros Adhanom Ghebreyesus met and held talks with Iranian Health Minister Hassan Ghazizadeh Hashemi on Saturday in Astana, on the sidelines of the Global Conference on Primary Health Care, which marks the 40th anniversary of the Declaration of Alma-Ata. The Declaration of Alma-Ata formed the foundation for the last 40 years of global primary healthcare efforts, according to Astanatimes.

During the meeting, the WHO director-general maintained that regional and domestic challenges have always prevented people from gaining access to healthcare, especially in countries such as Afghanistan, Pakistan, Yemen and Syria.

He voiced concern over the outbreak of cholera in Yemen, saying about one million people in the war-torn country have been infected by cholera.

He said necessary coordination will be made to better organize the upcoming regional ministerial meeting of health ministers in Tehran, thanking Iran for its efforts and the good progress it has made in the health sector.

For his part, the Iranian minister invited the WHO director-general to visit Iran and take a look at how the country's healthcare system operates.

Other issues such as communicable diseases in the region and Iran's cooperation with regional countries to tackle them were also discussed at the meeting.

**Sol**

**Almaty to Astana**

**By Akif Akalin**

*25 October 2018*

Today (25 October) In Astana, the capital city of Kazakhstan, an international conference, jointly hosted by the World Health Organization (WHO), UNICEF and the Ministry of Health of Kazakhstan, begins. The Global Primary Health Care Conference will once again ı renew sigort its commitment to ”primary health care kalkınma 40 years ago to achieve üd universal health insurance coverage“ and önceki sustainable development goals Küresel.

**WHAT IS THE PRIMARY HEALTH CARE?**

While the WHO was established, the health was accepted as a “human right bir, the, medical model tam, which was dominant in medicine and health, was rejected and the“ social model, was adopted in which health was not only the absence of sickness and disability, but also in terms of physical, mental and social well-being. . However, in the determination of WHO policies, the United States, which provided the largest financial support to the organization, was mentioned and the US was imposing a mali disease-based esinde approach to the organization, addressing the needs of the medical-industrial complex.

Since the early 1960s, a number of countries have succeeded in getting rid of the imperialist yoke and began to organize their health systems in a socialist way, not according to the needs of capital, but to the needs of society. Many countries, including China, India, Cuba, Iran, Tanzania and Vietnam, have established “horizontal” organizations (for example, barefoot doctors in China) instead of the mel vertical ”organization concept, providing clean drinking water, sanitation and nutrition. by adopting policies that address the social determinants of health, they have achieved great success in a very short time.

WHO, who could not remain indifferent to these developments, took this new approach, which would later be described as, primary health care ist despite the United States. organized a “Primary Health Care Conference” attended by representatives from 134 countries. At the end of the conference, the Alma Ata Declaration was published.

**PRIMARY HEALTH CARE CARS TO CAPITAL WALL**

The Declaration of Alma Ata said that in order for everyone to live economically and socially productive lives, the way to achieve the “health for all in 2000 tarafından targets set by WHO was ken in terms of primary health Alma. The share allocated to preventive and preventive services in health should be increased, cooperation should be made with other sectors in order to address the social determinants of health, and the material life and working conditions of people should be improved.

This approach, in particular the medical konferans industrial complex li, mobilized sectors that benefit from health problems, and in 1979 in Bellagio (Italy), hosted by the Rockefeller Foundation, in collaboration with UNICEF, organized an kesim alternative Bu conference. At the conference, instead of the ve comprehensive ındaki approach adopted in Alma Ata, the whole community was offered a sen selective da approach towards children under the age of five and women of reproductive age.

In the selective approach, the inin vertical lent organizations towards the problem would provide a rapid reduction of the infant mortality rate and increased life expectancy with cheap technological interventions (vaccines, contraception methods, ORT, etc.). According to the comprehensive approach, much faster improvements could be achieved in health indicators.

As a result, the majority of the signatories to the Alma Ata Declaration adopted a selective approach rather than a comprehensive approach, and organized various mainstream child health campaigns with the help of international organizations, while only Cuba, Vietnam, Sri Lanka and Nepal remained loyal to the declaration, and in 2000 imza Yalnızca only Cuba was able to reach its goals.

**SOCIALIST RECEIVING ATA MI, CAPITALIST ASTANA?**

Today, WHO and UNICEF will say, “In 2000, we could not provide health care to everyone in 2030,” he said at a meeting of Bugün capitalist ese Kazakhstan's Astana. Probably, at the end of the Conference, a'n Astana Declaration. Will be published in order to reach the Sustainable Goals announced when the Millennium Goals are revealed.

We will consider what is going on in the declaration in a few weeks, but it is already a declaration by the World Bank in the 1990s that has become a simple tool of the global neoliberal attack and has turned its annuals even to deny the catastrophe in the health field. we can say that you can not write.

Today, more than half of the world's population is unable to access health services, 2 billion 300 million people cannot find a toilet, but WHO and UNICEF are dreaming of ine health insurance coverage for everyone Bugün.

In 2014 it was calculated that the world spent 8 trillion 982 billion dollars on health. Of this expenditure, 8 trillion 103 billion dollars were for 3 billion 56 million people living in countries with a national income of over 12 thousand 475 dollars, and 879 billion dollars for 3 billion 66 million people living in low- and middle-income countries. Will Astana be on the agenda of this injustice?

Hard Out-of-pocket expenditures usal in health expenditures in middle and low-income countries are almost approaching public spending. More than 800 million people are forced to spend ”at least“ 10 percent of their income for their health. Of these, 180 million spend more than 25 percent of their income for their health. Moreover, every year, 100 million people fall into the grip of extreme poverty because of their health expenditures, in other words, bankrupt Dah. Are they going to be spoken in Astana?

**Tehran Times**

**Health minister highlights Iran’s achievements at Global Conference on Primary Health Care**

*26 October 2018*

TEHRAN — The Iranian health minister put a spotlight on the country’s achievements in the health sector at the Global Conference on Primary Health Care held in Astana, Kazakhstan, on October 25-26.

Hassan Qazizadeh Hashemi pointed up Iran’s accomplishment in primary health care over the past 40 years, specifically during the 8-year Iran-Iraq war in 1980s, IRNA news agency reported on Thursday.

He went on to explain that despite the hardships caused by the war some 20,000 healthcare centers were set up nationwide to provide everyone with healthcare services.

The minister also mentioned healthcare reform plan, as a governmental scheme to increase healthcare coverage for everyone.

The healthcare reform plan, aiming at decreasing the out-of-pocket expenses for the patients, promoting natural birth, and supporting underprivileged patients suffering from rare or incurable diseases, was launched in the country in May 2014.

He underscored the importance of the healthcare reform plan as a way to deliver all the promises made by the government regarding healthcare services saying that “if it wasn’t for the healthcare reform plan we would have nothing to say at this conference.”

Qazizadeh Hashemi also met Veronika Skvortsova, Minister of Health of the Russian Federation, on the sidelines of the event.

He explained that by drawing on Russia’s experience in reducing death caused by strokes Iran has notched up success in this regard which is a good example of a successful cooperation between Tehran and Moscow.

The Minster and his counterpart also stressed the improvement of pharmaceutical cooperation by exchanging knowledge and expertise as well as capacity-building to increase production.

Minister Skvortsova, for her part, explained that as per a decree issued by President of Russia Vladimir Putin on reducing medicine import to Russia since 2019, Iran can help Russia in empowering its pharmaceutical industry and vaccine production.

Iranian Minister was also scheduled to visit with his Kazakh and Indonesian counterparts and sign agreements in related fields.

The Global Conference on Primary Health Care “From Alma-Ata toward Universal Health Coverage and Sustainable Development Goals,” is held October 25-26 in Astana on the occasion of the 40th anniversary of the Alma-Ata Declaration.

Representatives of 140 WHO member states, international organizations and the world academic elite gathered in Astana. In total there are about 1,500 participants. The event was organized by the Government of Kazakhstan, the World Health Organization and UNICEF.

The main goal of the conference participants is to discuss the further development of primary health care, the adoption of the Astana Declaration on Primary Health Care.

The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly known as Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), September 6 to 12, 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people.

According to the World Health Organization at its heart, primary health care is about caring for people, rather than simply treating specific diseases or conditions. Primary health care is usually the first point of contact people have with the health care system. It provides comprehensive, accessible, community-based care that meets the health needs of individuals throughout their life.

**Tehran Times**

**WHO recognizes Iran as ‘good example’ of healthcare services**

*29 October 2018*

TEHRAN — The World Health Organization (WHO) director general has appreciated Iran’s efforts in primary healthcare and healthcare reform plan, recognizing Iran as a good example of carrying out proper primary healthcare projects, ISNA reported.

Dr. Tedros Adhanom Ghebreyesus made the remarks in his meeting with Iranian Health Minister, Hassan Qazizadeh Hashemi on the sidelines of The Global Conference on Primary Health Care.

The conference was held on October 25-26 in Astana, Kazakhstan, to commemorate the 40th anniversary of Alma-Ata Declaration.

Contagious diseases in the region and collaboration of Iran with its neighboring countries to fight them were the key topics discussed in the meeting.

Over the meeting, Ghebreyesus said that necessary arrangements will be made to better organize the next regional Health Ministerial Meeting in Tehran, thanking Iran for its significant achievements so far.

He noted that local and regional problems usually prevent people from maintaining their health especially in countries such as Afghanistan, Pakistan, Yemen, and Syria.

Qazizadeh Hashemi, for his part, invited Ghebreyesus to travel to Iran to visit the country’s health care system.

On the sidelines of the event, Iranian Health Minister also visited his Russian, Kazakh and

Indonesian counterparts and signed agreements in related fields.

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**St. Lucia News Online**

**Suriname among global countries signing Declaration of Astana**

*26 October 2018*

**(CMC) –** Suriname is the lone Caribbean Community (CARICOM) country to have signed the Declaration of Astana, vowing to strengthen its primary health care systems as an essential step toward achieving universal health coverage.

The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care.

The Declaration of Astana, adopted at the conference, makes pledges in four key areas, namely making bold political choices for health across all sectors; build sustainable primary health care; empower individuals and communities; and align stakeholder support to national policies, strategies and plans.

“We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health. Today, instead of health for all, we have health for some,” said Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO).

“We all have a solemn responsibility to ensure that today’s declaration on primary health care enables every person, everywhere to exercise their fundamental right to health.”

The WHO noted that while the 1978 Declaration of Alma-Ata laid a foundation for primary health care, progress over the past four decades has been uneven.

At least half the world’s population lacks access to essential health services – including care for non-communicable and communicable diseases, maternal and child health, mental health, and sexual and reproductive health.

The Declaration of Astana comes amid a growing global movement for greater investment in primary health care to achieve universal health coverage.

Health resources have been overwhelmingly focused on single disease interventions rather than strong, comprehensive health systems – a gap highlighted by several health emergencies in recent years.

UNICEF and WHO will help governments and civil society to act on the Declaration of Astana and encourage them to back the movement. UNICEF and WHO will also support countries in reviewing the implementation of this Declaration, in cooperation with other partners.

Government, civil society and academic delegations from Argentina, Brazil, Canada, Chile, Cuba, Ecuador, El Salvador, United States, Guatemala, Nicaragua, Paraguay, Peru and Suriname, as well as from other countries all over the world, participated in the Conference in Astana, the WHO said.