View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by AJOL - African Journals Online

EDITORIAL

Reflecting back on Alma Ata Declaration: Primary Health Care Implementation Models, Impacts, Challenges and Lessons Learned in Ethiopia

(Based on a presentation on a panel discussion of the 29th Annual Conference of EPHA)

Yayehyirad Kitaw

The Primary Health Care (PHC) idea might be traced back to 1920 although Alma-Ata Conference of 1978 put it firmly on the global agenda (1). The Alma-Ata Conference reaffirmed commitment to health as a fundamental human right and universally accessible and affordable comprehensive health care that does not neglect the poor through community participation and self-reliance (1-5).

The PHC approach was not conceived as a 'one-fits-all' approach. It is adaptable to contexts as long as the basic tenets of essential health care are based on practical, scientifically sound, and socially acceptable method and technology (2).

The Alma Ata PHC was premised on the key ideas of: *appropriate technology* – a medical technology relevant to the needs of the people, scientifically sound, and financially feasible; *opposition to medical elitism* - disapproval of the overspecialization of health personnel and of top-down/vertical health campaigns; and *health as a tool for socioeconomic development* - health work not as an isolated and short-lived intervention but as part of a process of improving living conditions.

It also advocated key reforms such as *universal coverage* that ensures health systems to contribute to health equity, social justice and the end of exclusion; *service delivery reforms* that re-organize health services around people's needs and expectations; *public policy reforms* that secure healthier communities; and *leadership reforms* that replace disproportionate reliance on command and control or laissez-faire disengagement of the state (2,7,8).

The (comprehensive) PHC approach faced challenges when UNICEF, one of its major promoters along with the WHO, rapidly retuned to selective PHC purportedly due to the costs of integrated strategy. The debt crises of the 1980s and the rise of structural adjustment policies that emphasized public sector restraint and market-driven reforms reinforced this shift by UNICEF. The surge in the 1990s and 2000s to disease-specific global health initiatives has also reinforced vertical interventions at the cost of PHC (6).

In addition, due to difficulty of circumscribing the various global, society, community, inter-personal and social and individual determinants*(2,5,7, 9,10),* PHC has not set specific targets beyond aspirations such as Health for All (HFA) by the year 2000 (2), Universal Health Coverage (UHC) of 1 billion more people or HFA by 2030 (11). Some attempts to set more precise goals such as devoting 5% of GDP to health; over 90% of newborn weighing 2500 g; infant mortality rate of less than50 per 1000 live births; life expectancy at birth of over 60 years; and local health care units with at least 20 essential drugs (8)-seemed to have had an inadequate following-up. It is in these contexts that PHC models in Ethiopia over the years should be examined.

Ethiopia is a large country (total area of 1.1 $x10^6$ km²) with a largely young (45% under 15 years and rural (84%) population of over 100 million. The country is highly diverse with over 80 cultural groups (12). It is characterized by rugged terrain, urban, pastoralist and agrarian economy. Ethiopian governments of the different times after Alma Ata are reputed for adopting a comprehensive, integrated and centrally coordinated approach to health care with reform programs and radical/paradigm shifts attributed to donors (12-14). Under such circumstances, several PHC models have evolved including various abrupt changes in PHC delivery facilities and human resources.

Private consultant of public health, e-mail:- yayehyiradk@yahoo.com

During the Basic Health Services period in Ethiopia (circa 1950- 1974) principles that foreshadowed the PHC approach were advocated. Emphasis was on expansion of generalized and decentralized health services through Health Stations, Health Centers, etc. staffed by health workers that worked in teams. The health workers were expected to educate the population, undertake mass treatment at community and family levels and coordinate their efforts with other social services, administrative services and services by spiritual leaders (15). However, vertical programs such as Malaria Eradication Service, Smallpox Eradication Program etc. vied for the limited resources of the health care sector (12,16).

Community involvement and coordinated endeavors in development activities for improved health service delivery and gradual integration of special programs and specialized institutions with the general health service system were promoted during the PHC period (1974-1991) (17). In addition, community health services were delivered with affordable costs in the same period. However, inter-sectoral collaboration and community mobilization remained to be among the major challenges (12,18).

Post-military regime Health Sector Development Program (1991-2015) proclaimed *Democratization and decentralization of the health service system*. The program focused on developing: integrated health services, preventive and promotive components of health care, and an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources. Such focus could be implemented within the rubric of Health Extension Program (HEP) (19). However, a large number of global programs such as GAFTAM, GAVI, PEI, etc. detracted, to some extent, from the PHC approach (12,20).

All these movements have clearly impacted on health in Ethiopia. Evidence shows that Heath Access and Quality Index has increased from 23 in 1990 to 44 in 2015 but this remains low compared to 91 for Norway and 48 for Kenya in 2015 (21). People are healthier, wealthier and live longer with the mortality rate of the under-five dropping from 205 per 1000 live births in 1990 to 59 in 2015 compared to 49 and 3 for Kenya and Norway respectively. Maternal Mortality Ratio dropped from 1250 per 1000 live births in 1990 to 353 compared to 570 and 5 for Kenya and Norway respectively in 2015 (22,23).Yet, there were major challenges related to unequal development between and within countries and an aging-population and ill-managed urbanization and globalization. This implies that what was envisioned through PHC remains unfulfilled still in much of the world and Ethiopia has a long way yet to go (24). The major lessons gained in the course of the last four decades in the implementation of PHC are that there is no 'one-fits-all' solution to health care. However, PHC that 'fits-for-purpose' could be guaranteed by 'health in all policies' and strengthening evidence-based consideration of internal and external pressures and technological changes.

During the different regimes in the country - Basic Health Services (the Imperial era), PHC (Military government) and Health Sector Development Program (the current government), PHC has suffered from heavy emphasis on central, top-down approaches. Such urban focused curative and technocratic health care systems failed to consider cultural diversity, specific disease ecology, the use of appropriate strategies, and genuine participation of communities (25).

In a nutshell, health in general and public health in particular is eminently 'politics' and political commitment is the key to achieving the goals of PHC. However, it is critical to guard against the tendency to depoliticize or to unduly use it to control lives of citizens (4, 51, 52). It therefore seems appropriate to conclude with words of Martin Luther King "Of all the forms of inequality, injustice in health care is the most shocking and inhumane" and the implicit promises of world leaders as stated by Prime Minister Hailemariam Dessalegn "An emerging consensus among global health leaders is that building stronger health delivery systems, with particular emphasis on community-based primary health care, will be required in the future." (26).

References

1. Frenk J. Reinventing primary health care: the need for systems integration. The Lancet 2009; 374 (9684): 170 - 173.
2. WHO/UNICEF, 1978, 'Primary health care: Alma Ata declaration', Geneva: WHO.
3. Smith RD and K Hanson (Eds). Health Systems in Low-and Middle-Income Countries: An Economic and Policy Perspective. Oxford University Press, 2012, Oxford.
4. Medcalf A et al (eds). Health for All: The Journey of Universal Health Coverage. Centre for Global Health Histories, The University of York, 2015, United Kingdom.
5. White F. Primary Health Care and Public Health: Foundations of Universal Health Systems. Med Princ Pract 2015; 24:103–116.
6. WHO. Health Equity Through Intersectoral Action: An Analysis of 18 Country Case Studies. 2008.
7. Cueto M. The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care. American Journal of Public Health 2004; 94(11): 1864-1874.
8. Labonte R et al. Is the Alma Ata vision of comprehensive primary health care viable? Findings from an international projectIs the Alma Ata vision of comprehensive primary health care viable? Findings from an international project. Glob Health Action 201.
9. Rawaf S et al. From Alma-Ata to Almaty: a new start for primary health care. The Lancet October 14, 2008 DOI:10.1016/S0140-6736(08)61524-X.
10. De Vos P et al. Participation and empowerment in Primary Health Care: from Alma Ata to the era of Globalization. Social Medicine2009; 4(2): 121-127.
11. Tokyo. Universal Health Coverage Forum 2017 "Tokyo Declaration on Universal Health Coverage: All Together to Accelerate Progress towards UHC", 2017, Tokyo.
12. Kitaw Y et al. Evolution of Public Health in Ethiopia 1941-2015. 3rd Revised Edition, EPHA, 2017, Addis Ababa.
13. Furtado, X. & Smith, WJ., 2007, 'Ethiopia: Aid, Ownership, and Sovereignty', GEG Working Paper 2007/28, Global Economic Governance (GEG) Programme, Oxford.
14. World Bank, 2013, 'Federal Democratic Republic of Ethiopia, Ethiopia Public Sector Reform Approach Building the Developmental State – A Review and Assessment of the Ethiopian Approach to Public Sector Reform', Report No. ACS3695, Washington DC, World B.
15. IEG, 1963, '2nd Five-Year Plan 1963-1967', Addis Ababa, Ethiopia.
16. Britanak, RA., Davis, JH. & Daly, JA., 1974, 'Syncrisis: the dynamics of health: Volume VIII, Ethiopia', Office of International Health, Division of Planning and Evaluation, U.S. Department of Health, Education, and Welfare, Washington, DC.
17. PMGE [Provisional Military Government of Ethiopia], 1984. Ten-year perspective plan (1984/85-1993/94). Addis Ababa. .
18. FMOH, 1985, 'Primary health care in Ethiopia: An assessment', Federal Ministry of Health (FMOH), Addis Ababa, Ethiopia.
19. TGE, 1995, 'Health sector strategy', Transitional Government of Ethiopia (TGE), Addis Ababa, Ethiopia, pp.21. .
20. MOFED & UN Country Team. Millenium Development Goals Report: Challenges and Prospects for Ethiopia. 2004, Addis Ababa.
21. GBD 2015 SDG Collaborators. Goals in 188 countries: a baseline analysis from the Global Burden of Disease Study 2015. The Lancet, September 21, 2016 http://dx.doi.org/10.1016/S0140-6736(16)31467-2 1.
22. UNICEF. ETHIOPIA Humanitarian Situation Report 2015.
23. WHO Ethiopia: WHO statistical profile. 2015, Geneva. 2015.
24. Rao M & E Pilot (2014) The missing link – the role of primary care in global health, Global Health Action, 7:1, 23693, DOI: 10.3402/gha.v7.23693.
25. Primary health care systems (PRIMASYS): case study from Ethiopia, abridged version. Geneva: World Health Organization; 2017.
26. Desssalegn H et al. Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations. 2015.