Alma-Ata: Rebirth and Revision 4

30 years after Alma-Ata: has primary health care worked in countries?

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We assessed progress for primary health care in countries since Alma-Ata. First we analysed life expectancy relative to national income and HIV prevalence to identify overachieving and underachieving countries. Then we focused on the 30 low-income and middle-income countries with the highest average yearly reduction of mortality among children less than 5 years of age, describing coverage and equity of primary health care as well as non-health sector actions. These 30 countries have scaled up selective primary health care (eg, immunisation, family planning), and 14 have progressed to comprehensive primary health care, marked by high coverage of skilled attendance at birth. Good governance and progress in non-health sectors are seen in almost all of the 14 countries identified with a comprehensive primary health care system. However, these 30 countries include those that are making progress despite very low income per person, political instability, and high HIV/AIDS prevalence. Thailand has the highest average yearly reduction in mortality among children less than 5 years of age (8·5%) and has achieved universal coverage of immunisation and skilled birth attendance, with low inequity. Lessons learned from all these countries include the need for a nationally agreed package of prioritised and phased primary health care that all stakeholders are committed to implementing, attention to district management systems, and consistent investment in primary health-care extension workers linked to the health system. More detailed analysis and evaluation within and across countries would be invaluable in guiding investments for primary health care, and expediting progress towards the Millennium Development Goals and "health for all".

Alma-Ata—worldwide rhetoric and country reality

Although an understanding of worldwide trends and policy shifts is important, improvements in health depend on what happens at national, subnational, and district levels and, ultimately, in the communities in which families live and die. In the past three decades, great progress has been made.[1] For a girl born in Alma-Ata in 1978, the risk of dying before her fifth birthday was 7·3%. This risk for a baby born in 2008 in what is now Almaty, Kazakhstan is less than half at 2·9%. This reduction is similar to the worldwide average reduction during the past 30 years, with mortality for children less than 5 years of age decreasing from 145 per 1000 before the Alma-Ata Declaration to 72 per 1000 live births now (a 50% reduction). However, the reduction has been less in the least developed countries (42%) than in the richest countries (77%). Similar patterns exist for maternal mortality and life expectancy.

National data are important to track regional and worldwide trends but, most importantly, should be used for appropriate action within countries and to ensure governments are accountable for provision of services to the poorest citizens. James Grant, Director of UNICEF at the time of the first-child survival revolution, placed great emphasis on objective measures of progress, using national data as an important impetus for action, notably through yearly reports ranking countries' progress such as Progress of Nations and State of the World's Children.[1] Countdown to 2015[2] represents a further iteration in the measurement of country progress, returning to some of the core Alma-Ata principles, including tracking equity and progress in other sectors (such as education, water, and sanitation). Although few of the 68 Countdown priority countries are on track for Millennium Development Goals (MDGs) 4 and 5,[3] a substantial number of low-income countries, some not included in the Countdown list, have made major progress in the past 30 years in delivery of primary health-care services at high coverage, and reduced maternal and child deaths. Some of these countries provide examples of sustained success in the presence of poverty, political instability, or high HIV/AIDS prevalence. An improved understanding of the factors associated with such progress could help to expedite progress in other countries. For some large countries, such as India, where each state can be larger than some countries and between-state variation is enormous, well-achieving states, such as Kerala, contrast with those where child mortality is at least five-fold higher.[4]

Analyses across countries with data at the national level have many caveats. A central tenet of the Alma-Ata Declaration is that progress in health depends on many factors—ie, economics, education, nutrition, health system, and culture—and is closely linked to governance, social justice, and changes in other sectors.[1] Attribution of cause and effect over time at national level is particularly difficult with the wide range of factors that might have changed. Changes and possible associations could also be masked by shifts in definitions and data quality with time. Country-level analysis masks intra-country variation. Despite these caveats, we set out to

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