International Journal of Multidisciplinary Research and Modern Education (IJMRME)
ISSN (Online): 2454 - 6119
(www.rdmodernresearch.org) Volume II, Issue I, 2016

EVOLUTION OF INTERNATIONAL ACTION ON HEALTH FROM 5000 BC TO DATE: AN ESSAY

Rafia Rahman
Lecturer, Institute of Health Economics, University of Dhaka, Bangladesh

Abstract:

Presently worldwide health is fundamental human right. Ancient to modern age every individual wish to lead a healthy life. Ancient time there was no idea about health or maintains health, quality of life, level of living, standard of living and wellbeing also. When people become sick they were seeking help from supernatural power. They have faith in that sickness and cure were absolutely come from supernatural wisdoms. When sick person become well people have confidence in supernatural power cure the person but the fact was the natural defence mechanism work actively and properly. After that role of environment (air, water, soil) for people sickness come in concern. Then germ theory of disease discover. Gradually importance of sanitation and demand for clean water rise. Following this the definition and importance of public health was determine. That was the great revolution in health sector. Then UN organizations including WHO establish. Over the decades they work for ensure better health for every citizen of the world to prevent, promotion and rehabilitation. So that everyone could able to enjoy quality of life, standard of living and finally socially and economically productive life. In this paper I try to notice the rigorous sequential activities of the international action for doing best from one phase to another, another to another then next.

Primitive Concept of Disease and rise of Health Care Concept:

About 5000 BC disease was considered as the wrath of god or sign of demon possession or influence of stars and planate. Then (5000 BC) Indian medicine like Ayurveda & siddha system, Unani, Tibb, Chinese medicine (2700BC) like principles of Yang & Yin, system of bare-foot doctor acupuncture, Egyptian medicine (2500-BC)etc were derive. Actually up to 800AD it was Dark Age of medicine after that Arabian medicine, the Unani system of medicine (800-1300 AD) stem. Beyond 1500AD revival of medicine occurs. Then Fracastorious, Andreas did lot of dissection, Harvey's discovery of blood circulation in 1628, Leeuwemhoek's microscope in 1670, Jenner's vaccine against small pox in 1796 discover. Disease due to sanitary was rise. During 1800 AD great sanitary a wakening happens. At 1840 AD concepts of public health come. The Epidemiological study of cholera in London from 1848 to 1854 by an English epidemiologist John snow established the role of polluted drinking water in spread of cholera tocreate a demand for clean water. Till 1920 AD demarcated as disease control phase as this time discovery of gonococci, typhoid bacilli, pneumococcus, tubercle bacilli etc.

Rise of Public Health:

Then professor Winslow (1920) Provide the public health definition 'the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of the medical & nursing services for early diagnosis and preventive treatment of disease and the development of social machinery to ensure for every individual a standard of living adequate for maintenance of health. From 1920 to 1960 AD demarcated as health promotional phase. The important discovery during this time

were the birth of preventing medicine, establishment multifactor causation of disease (1900 AD), discover of penicillin by Alexander Fleming (1927 AD).

Enhance Social Equity:

Beginning in the 1930's international organizations, some governments and NGOs sought methods to enhance social equity to improve the health of populations and reduce health disparities due to poverty. Small scale attempts to provide community based comprehensive care emerged in sites such as China, India, Cuba, Costa Rica, Mexico, Nigeria, Tanzania & in faith- based programs. A number of pilot and longitudinal research program were established in low income countries to test the cost effectiveness different ways of providing health care to all the people of country.China provided the first broad experiences beginning in the 1930's. This was expanded into the concept of the "barefoot doctor" on a rational scale.

Proposal of Health Education and Health Care Facility Establishment by Bhore Committee:

When the number of solsures was dying due to typhus, plegra and other diseases, the governments of Brithish India have felt the need to improve the health services of the country, appointed in 1943. A commission which was designated as Health survey and Development Committee headed by Sir Joseph Bhore. The committee included administrators, physician's surgeons, public health experts, engineers & lawyers.

Bhore Committee Recommendation:

- ✓ Integration of preventive and curative services at all administrative level.
- ✓ Development of primary health centers in two stages. (a) A short term measure for establishment of one primary health center of one primary center in rural areas to covers 40,000 population with a secondary health center to serve as a supervisory, coordinating referral institution. (b) A long-term program of setting up primary health units with 75 beds hospitals for each 10,000 to 20,000 population secondary units.
- ✓ A major change in medical education with includes 3 moth's training in preventive & social medicine.

Establishment of UN Organizations and WHO:

Charter of UN established as a consequences of UNA conference on international organization held at san Francisco USA on 26th June 1945. It was activated from 24thOctober 1945 till 2011 there were 19 member countries, WHO, UNICEF, UNESCO, UNDP, and UNFPO. All are organizations with United Nations except WHO.It (WHO) is a specialized non-political health agencies for UN with headquarter at Geneva. The constitution of WHO was approved on 22nd July 1946 but it came into force on 7th April, 1978 with the objective of: (i) To promote the highest possible level of health and the least differences in health status among population. (ii) To establish standards, adopt conventions, promote regulations and monitor health status. (iii) To work in partnership with member status non-government organization & others.

WHO and Health:

At 1948 WHO provided definition of Health as" Health is a state of complete physical mental & social well-being and not merely an absence of disease or infirmity, so that each citizen can lead a socially & economically productive life. According to WHO definition of health it is a multi-sectoral approach as it address physical, mental, social, spiritual well-being with which an individual is in optional equilibrium. After that concept of Right to health derive like-

- ✓ Right to medical care

- ✓ Right to responsibility for health
- ✓ Right to a healthy environment
- ✓ Right to food
- ✓ Right to procreate or not to procreate
- ✓ Right to die

EURO Symposium and Community Health:

According to universal declaration in 1948- "Everyone has the right to standard of living adequate for the health and wellbeing of himself and his family. In 1966 EURO symposium give community health as "All the personal health and environmental services in any human community, irrespective whether such services were public or private ones". The existing gross inequality on the health status of the people particularly between developed and developing countries as well as with in countries is politically, socially and economically unacceptable and is therefore of common concern to all countries.

Bottom- Up Community Based Approach:

The WHO Director General Halfdan Mahler (1973-88) studied alternative methods to improve health like Bottom- up community based approaches in Chinese experience and favorable health outcomes, priories national programs focused on prevention & local involvement world Health Assembly conduct in year 1976.

UN Declare Human Rights in 1968, that is:

"Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity".The realization of the right to health may be pursued through numerous, complementary approaches such as the formulation of health policies or the implementation of health programs developed by the World Health Organization (WHO) or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. The international conversation economic, social & cultural right 1966.Enjoy complete physical, mental &a social well being is a fundamental right. The attainment of the highest possible level of health is a most important world-wide social goal. The promotion and protection of the health of the people is essential to sustained economic & social development & contributes to a better quality of life & to world peace. Governments have a responsibility for the health of their people. The intergovernmental conference was attended by delegators from 134 governments and by representatives of 67 United Nations Organizations specialized agencies and nongovernmental organizations in official relations with WHO and UNICEF. The conference declared that the health status of hundreds of millions of people in the world today is unacceptable, particularly in developing countries. More than half the population of the world does not have the benefit of proper health care.

Alma-Ata Declaration and Health for All by the Year 2000AD:

Review of 1975's WHO assembly led to 1978 WHO conference in Alma Ata kazakhstan (former USSR). In May 1977 The WHO at the 30th world health assembly announced the "Attainment by all the peoples of the world by the year 2000 AD of a level of health that will permit them to lead a socially and economically productive life." The basis of the Health for All policy can be found in the WHO constitution. It is mentioned that the objective of WHO is the attainment by all people of the highest possible level of health. The goal of Health for All by the year 2000 embodies this objective and emphasizes the highest possible level of health. At the minimum, all people in the country should have at least such a level of health that they are capable of

working productively and participating actively in social life and community activities. This is popularly known as "Health for All' by the year 2000". Health for All as a movement, articulated in the Alma-Ata Declaration, does not mean that in the year 2000 health professionals would provide health care for everybody or that nobody would fall sick or disabled. Health for All is a process leading to progressive improvement in the health of the people. Health for All means:

- ✓ People use better approaches for preventing disease and alleviating unavoidable disease and disability and have better ways of growing up, growing old and dying gracefully.
- ✓ There is an even distribution among the population of whatever resources for health are available.
- ✓ Essential health care is accessible to all individuals and families in an acceptable and affordable manner and with their full involvement.
- ✓ People realize that they themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of disease and aware that ill-health is not inevitable.

Primary Health Care Following Alma-Ata Declaration:

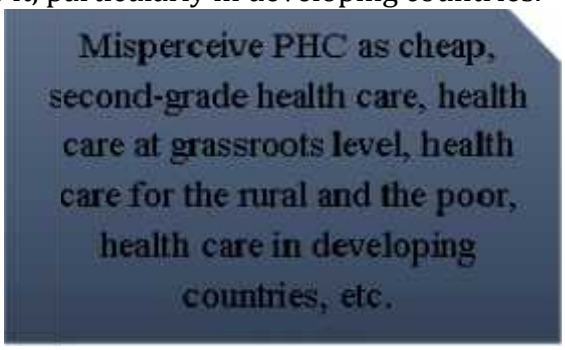
The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

- ✓ The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health.
- ✓ The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and therefore common concern to all countries.
- ✓ Economic and social development, based on a New InternationalEconomic Order, is basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries.
- ✓ The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.
- ✓ Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, internationalorganizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000.
- ✓ Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-alliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community. With the national health system bringing

health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

- ✓ Primary health care.
- ✓ All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country.
- ✓ An acceptable level of health for all the people of the world by the year 2000 can be attained through a further and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmentalorganizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries.



The ultimate goal of primary health care is better health for all. WHO has identified five key elements to achieving that goal:

- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people's needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.
- As a concept PHC offers a comprehensive guide on equity, what to prioritize, technology to be applied, sociocultural aspects, target groups, full involvement of the community, cost-effectiveness and efficiency. Perhaps due to its rich and comprehensiveness nature, PHC is oftentimes misperceived. These misperceptions to some extent are understandable considering that PHC has a multiplicity of meanings depending on which perspective we look into:

- ✓ A package or a set of activities
- ✓ A Level of care
- ✓ An approach, which has been termed interchangeably PHC principle, PHC pillar andPHC strategy. These are describing below:

From a "Package" Perspective, PHC was defined in Alma-Ata to consist of at least eight activities or elements, namely:

- ✓ 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 health care, including family planning.
- ✓ Immunization against the major infectious diseases.
- ✓ Prevention and control of locally endemic diseases.
- ✓ Appropriate treatment of common diseases and injuries.
- ✓ Provision of essential drugs.

Later on this package was labeled as essential health care package, basic health package, essential health services, etc. The content of the package largely depends on the main health problems prevailing in each country. Thus it is not meant to be a rigid package for worldwide implementation. In general, public health problems do not constitute major health problems in most high-income or developed countries. Furthermore, usually there are public institutions that are responsible to carry out public health programs. For this reason, Primary Health Care in several developed countries focuses more on medical services where family (primary) physicians usually become the main backbone of the health system.

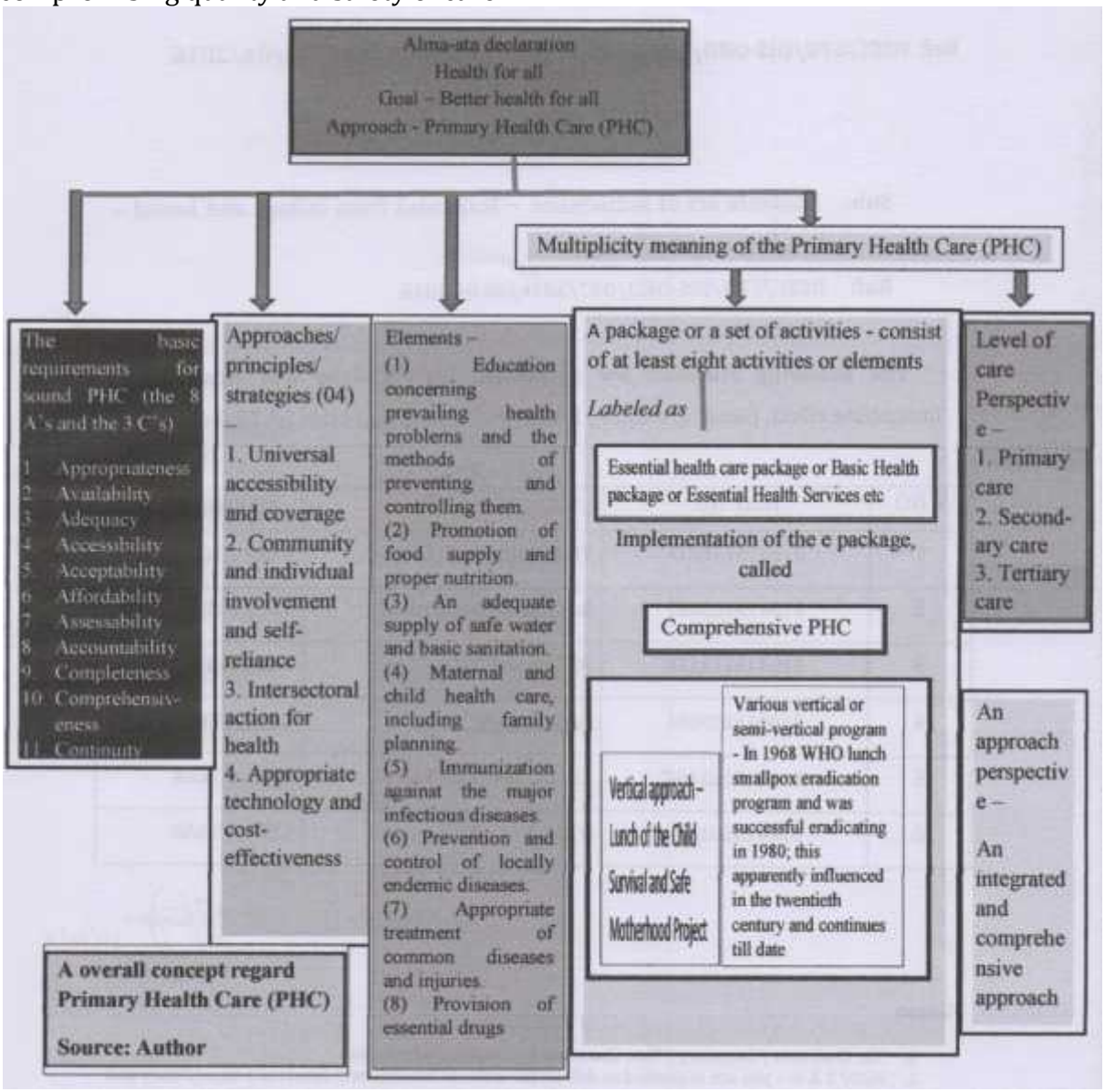
Implementation of the above package, known as *comprehensive PHC*, requires strong health systems which most low-income countries do not possess. The oil boom in the 1970s brought temporary relief to some countries. Some bilateral and multilateral donors, interested in tackling the unacceptably high child and maternal mortality, were quick in realizing the shortcomings. They are of the opinion that to deal with high mortality conditions, selectivePHC, better known as the *verticalapproach*, is preferable; hence, the launch of the Child Survival and Safe Motherhood Project. The smallpox eradication programme was launched by WHO in 1968 and was successful in eradicating it in 1980; this apparently influenced various vertical or semi-vertical programs in the twentieth century and continues till date.

From a "Level of Care"perspective, there are three levels of care with different characteristics for each level of care, in terms of personnel, problems encountered and available facilities, which are mention below:

- ✓ Primary care: personnel serving this level are called generalists. Health problems encountered, medical and non-medical facilities available are usually simple.
- ✓ Secondary care: personnel serving this level are called specialists; health problems encountered, medical and nonmedical facilities available are more complex.
- ✓ Tertiary care: personnel serving this level are called subspecialists; health problems encountered, medical and nonmedical facilities available are the most complex and sophisticated.

The emphasis put on primary level of care is justified from the point of view of cost-effectiveness and feasibility of implementation. Many ill-health conditions can actually be prevented at this level by implementing primary prevention and promotion measures before they manifest or progress to a higher degree of illness. This is also the focus of public health, where the emphasis of intervention is the community, as opposed to medical care, which deals more with curative and rehabilitative aspects of health care with the focus on individual and institutional care. Health promotion and disease control, either through immunization or case treatment, are best implemented at the primary level of care. For example, evidence is accumulating for treatment of pneumonia in children with antibiotics: the result achieved in treating them in hospital

is almost the same as treatment at home. Currently, more and more countries are examining the possibilities of lowering the level of care to reduce cost without compromising quality and safety of care.



From an "Approach" Perspective: Primary Health Care is an approach to health development. The Primary Health Care concept refers to implementation of a total health development strategy with emphasis on developing primary care as the first level of care of a continuum of care. The application of the Primary Health Care concept in total health development requires an integrated and comprehensive approach.

It implies the use of the four approaches described below in an integrated manner. While more resources and efforts should be focused on provision of essential or basic health care at the first point of contact with the health system, development of various sophisticated hospitals as referral facilities should also receive appropriate attention in program planning.

The Four Approaches/ Principles/ Strategies Arise from the Concept of Primary Health Care, Namely:

1). Universal Accessibility and Coverage: Primary Health Care strives to ensure universal accessibility and coverage. This translates into the task of fulfilling needs of

International actions following Health for All, Primary Health Care Approachflow chart:

the vulnerable and the marginalized such as women and children as well as those living in remote areas and the poor. This principle also implies that equity or social justice be upheld while trying to cover the whole population.

2). Community and Individual Involvement and Self-Reliance: Health should not be the sole responsibility of the government. Each individual and the community should be held responsible as well by involving them from the planning stage down to the implementation and monitoring and evaluation of health programmes. By so doing the sense of ownership will be promoted that eventually ensures sustainability of the health programme. Evidences are accumulating that community empowerment and advocating self-reliance will further sustain the health programmes

3). Intersect Oral Action for Health: The causes of ill-health are twofold, namely health risk and health determinants. Health risks emerge from people's lifestyles, such as use of tobacco, alcohol consumption, food consumption and physical exercise. The determinants of health cover a broad spectrum of factors that include social, educational, economic, gender, political, security and physical environment, such as water and sanitation. These determinants are certainly beyond the health domain to influence. The implication is that successful implementation of Primary Health Care requires intersect oral action, as well as ability to coordinate with other sectors.Mainstreaming health is the manifestation of intersect oral action for health. One way of mainstreaming health is to advocate the importance of having Healthy Public Policy or policies of other sectors that promote health. One such policy is making all development projects subject to health impact assessments besides enforcement of environmental impact assessment.

4). Appropriate Technology and Cost-Effectiveness: Right choice of technology (i.e. appropriate and cost effective technology) will ensure better efficiency of the health system. Appropriate technology does not automatically translate into cheap and simple technology like ORS (oral rehydration salts), ITN (insecticide-treated nets) and

"kangaroo care" for pre-term infants.By using the Primary Health Care approach as a health development strategy, many developed/high income countries in North America and Western Europe are able to provide effective and efficient health services to the community, through provision of accessible, affordable and quality family health services by family doctors as the first point of contact. At this point, services provided follow the basic principles of family practice, which include -

- ✓ Continuous, comprehensive and integrated health services
- ✓ Commitment to the person rather than to a particular body of knowledge, group of diseases or special techniques;
- ✓ Sees every contact with patients as an opportunity to provide prevention or health education;
- ✓ Emphasis on evidence-based medicine; and
- ✓ Sees him/herself as part of community-wide network of supportive and health-care agencies.

In developing/low- and middle-income countries in Asia and Africa, the use of the Primary Health Care approach as a health development strategy is manifest as the provision of basic health services to the community through the establishment of community health centers/health posts in every village.

Prince Mahidol Award Conference:

The Prince Mahidol Award Conference in 2008 reviewed the past and defined the future of Primary Health Care, and revealed several obstacles and mistakes in implementing Primary Health Care as follows:

- ✓ Financial resources become scarcer, due to unexpected and unprepared for world-wide economic crises.
- ✓ Lack of community participation. Many countries fail to maximize and mobilize the energies and ambitions of locals, civil officers, NGOs and the private sectors.
- ✓ High expectation from people for better health care and quick results with various choices.
- ✓ Shortage of human resources especially trained and motivated health workers who are willing to work at primary care level.
- ✓ Emergence and re-emergence of infectious and preventable diseases and increased pace of spread of serious and unusual disease events. This has resulted in the implementation of more selective Primary Health Care that will not solve most of the health problems.
- ✓ Health services have become market- and profit-oriented. Moreover, corruption occurs at many levels of the health sector, making matters worse.
- ✓ The growing world population has made consumption of food, drugs and fundamental resources increase. People are moving more than ever, seeking greener pastures for survival, wealth or tourism, and giving us greater connectivity. The more interconnected world leads to the rapid spread of epidemic and pandemic diseases. Universalizing of certain food tastes could lead to greater breeding and slaughter of food animals which could lead to greater danger from animal related diseases. Public health events in one location/region may be a threat to others.
- ✓ Mental health problems, stress and dysfunctional families are all on the increase.
- ✓ Inequity due to differences in economic growth and geographical challenges. Two-thirds of the vision impaired people in the high-income countries who are not yet blind have cataract surgery whereas a much greater number of blind people in the developing world have no access to such basic remedies.

Most countries in South-East Asia were turning to community participation as a part of the action needed to reinvigorate the Primary Health Care strategy. In India, community participation was being encouraged for the procurement of medical equipment for hospitals, and cost-sharing schemes have been introduced for the maintenance of health facilities. In Indonesia, dominant community participations were lead by the women's welfare movement. For improving drug accessibility and affordability, community cost-sharing schemes were implemented in Indonesia, Myanmar, Nepal and Thailand.

Ottawa Chatter:

It has long been recognised that socially, economically and environmentally the maintenance of health has benefits over the correction of ill-health. However, within so-called "Western" approaches to medicine, these two activities have developed somewhat independently of each other - the former into socio-environmental "Public Health" and the latter into technocratic "medicine". Crudely, public health has concentrated on the "public good" aspects of health, and "medicine" has concentrated on the "private good" aspects of health. By the mid 1970's is was becoming increasingly recognised internationally that "medicine" had begun to reach the level of diminishing returns for both financial and technical reasons in technically advanced nations. A decade later the first UN WHO conference on health promotion was given the task of developing a framework which would be applicable internationally to the promotion of health as defined at Alma Ata, it drew on:

- ✓ The experience of public health and the role of government (in its broadest sense);
- ✓ The role of education and the development of personal skills;
- ✓ The "medical model" and the impact of appropriate services;
- ✓ Psychology and sociology in terms of the need for individuals and communities to feel supported in their endeavours;
- ✓ Community development in terms of the impact of energy released when individuals and communities feel that they have a degree of influence and control over their lives.

Philosophically the conference asserted that no single person or institution "owns" either the problem or the solution, rather it is own collectively. Similarly the responsibility for the problem and the solutions is shared throughout the community. It also took a behavioural systems approach - there is an interaction between the individual and the environment. The healthy behaviour of an individual is shaped by his or her environment, and whose behaviour in turn shapes a healthy environment.

The Ottawa Conference produced a framework which is useful both as a tool for analysis

and as a guide to action and evaluation. Crucially in this case it helps to categorise the kinds of initiatives necessary for individual behaviour change in those areas where the gain is neither immediate not necessarily apparent.The basic strategies for health promotion were prioritized as:

- **Advocate:** Health is a resource for social and developmental means, thus the dimensions that affect these factors must be changed to encourage health.
- **Enable:** Health equity must be reached where individuals must become empowered to control the determinants that affect their health, such that they are able to reach the highest attainable quality of life.
- **Mediate:** Health promotion cannot be achieved by the health sector alone; rather its success will depend on the collaboration of all sectors of government (social, economic, etc.) as well as independent organizations (media, industry, etc.).

The Framework: This is the framework as finalised by the WHO: - Five action areas for health promotion were identified in the charter

- ✓ **Building Healthy Public Policy:**Policy and legislation must be consistent in its promotion of health. Therefore policy makers and legislators at all levels should be aware of and accept their responsibilities towards promoting healthy behaviour. Policy making and legislative processes must identify the barriers to healthy behaviour and seek to reduce them. This requires co-ordination and joint action in the areas of legislation, fiscal measures, taxation, and organisation.
- ✓ **CreatingSupportive Environments:**There is a complex interaction between an individual and their social and physical environment. These social and physical environments must support healthy behaviour and the endeavours of individuals to adopt and maintain healthy behaviours. These social and physical environments include the built environment, the work social and physical environment, the non-work social and physical environment, economic factors, the support of peers and the support of those who are not peers.
- ✓ **StrengtheningCommunity Action:** At the heart of this state is the process by which communities (social and physical) gain ownership and control over their collective endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction of health matters be they setting priorities, making decisions, planning strategies and delivering services.
- ✓ **Developing Personal Skills:** Health is promoted by the development of appropriate skills for behaviour change and maintenance. The processes of skill development need to take into account the social and other factors which affect the development of skills and recognise that skill development occurs in a variety of different settings and institutions.
- ✓ **Re-Orienting Health Care Services Toward Prevention of Illness and Promotion of Health:** Appropriate health services are those which contribute to the pursuit of health. They include services which lie outside of those normally considered as being part of the health sector. "Appropriate" means that they respect the cultural, social, physical and economic experiences of individuals and groups of individuals. The responsibility for appropriate health services is shared between all those providing a service which can affect a person or a community's health.

Implementing the Framework:

There two interesting things about the framework:-

- ✓ Once the overall goal is set, then the co-ordination required to implement the framework is minimal. Once an organisation has bought into the overall goal and the framework, it is up to them what their particular contribution is and how they do it. It doesn't really matter that all organisations might do things differently, or that they do only one bit of it as long as they stick to the framework an overall pattern will emerge.
- ✓ It applies to whatever level of system you use it at. For instance, you can see things at a national level (eg policy = legislation); or a regional level. You can see things at an individual organisational level (eg an individual workplace will have policies and rules, it has a culture, it has particular services that it provides etc)

Jakarta Declaration in 1997:

The Jakarta Declaration on Leading Health Promotion into the 21st Century is the name of an international agreement that was signed at the World Health Organization's 1997 Fourth International Conference on Health Promotion held in Jakarta.[1] The declaration reiterated the importance of the agreements made in the Ottawa Charter for Health Promotion, and added emphasis to certain aspects of health promotion.The Jakarta Declaration included the following five "priorities for health promotion in the 21st century".

- ✓ "Promote social responsibility for health"
- ✓ "Increase investments for health development"
- ✓ "Consolidate and expand partnerships for health"
- ✓ "Increase community capacity and empower the individual"
- ✓ "Secure an infrastructure for health promotion"

The declaration recognizes that

- ✓ Participation is necessary for change.
- ✓ Health literacy is essential for participation - emphasizes the need for access to education and information and hence, the empowerment of individuals and communities.
- ✓ Combinations of five strategies for health promotion -- "build healthy public policy", "create supportive environments", "strengthen community action", "develop personal skills", and "reorient health services"—are more effective than "single-track approaches".

Health for allTargets in 1997:

Halfdan Mahler, Director General (1973-1983) of the WHO, defined Health For All in 1981, as Health For All means that health is to be brought within reach of everyone in a given country. And by "health" is meant a personal state of wellbeing, not just the availability of health services – a state of health that enables a person to lead a socially and economically productive life. Health For All implies the removal of the obstacles to health – that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines. It provides -

- ✓ Health for All means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it.
- ✓ Healthfor All demands, ultimately, literacy for all. Until this becomes reality it demands at least the beginning of an understanding of what health means for every individual.
- ✓ Health for All depends on continued progress in medical care and public health. The health services must be accessible to all through primary health care, in

which basic medical help is available in every village, backed up by referral services to more specialized care.

- ✓ Health for All is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health. Medical care alone cannot bring health to in hovels. Health for such people requires a whole new way of life and fresh opportunities to provide themselves with a higher standard of living.

The adoption of Health for All by government implies a commitment to promote the advancement of all citizens on a broad front of development and a resolution to encourage the individual citizen to achieve a higher quality of life. The rate of progress will depend on the political will. The World Health Assembly believes that, given a high degree of determination, Health for All could be attained by the year 2000. That target date is a challenge to all WHO's Member States. The basis of the Health for All strategy is primary health care.

Health 21 in 1999:

Health21 is the name given to the World Health Organization (WHO) European Region policy framework derived from the "health-for-all policy for the twenty-first century" passed by the World Health Assembly in 1998. The framework was called "Health 21" not only because it dealt with health in the 21st century, but also because it laid out 21 "targets" for improving the health of Europeans.The Health 21 targets were:
"Solidarity for health in the European Region," or "closing the health gap between countries"

- ✓ "Equity in health," or "closing the health gap within countries"
- ✓ "Healthy start in life," for example "policies should... create a supportive family, with wanted children and good parenthood capacity"
- ✓ "Health of young people," that is, "young people in the region should be healthier and better able to fulfil their roles in society"
- ✓ "Healthy aging" as reflected in increases in life expectancy, disability-free life expectancy, and the proportion of older people who are healthy and at home
- ✓ "Improving mental health"
- ✓ "Reducing communicable diseases"
- ✓ "Reducing non-communicable diseases"
- ✓ "Reducing injury from violence and accidents"
- ✓ "A healthy and safe physical environment"
- ✓ "Healthier living" such as "healthier behavior in such fields as nutrition, physical activity and sexuality" and "increase in the availability, affordability and accessibility of safe and healthy food"
- ✓ "Reducing harm from alcohol, drugs and tobacco"
- ✓ "Settings for health," specifically, "people in the region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community"
- ✓ "Multi-sectoral responsibility for health"
- ✓ "An integrated health sector" with "better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system"
- ✓ "Managing for quality of care" by focusing on outcomes
- ✓ "Funding health services and allocating resources," calling for "sustainable financing and resource allocation mechanisms for health care systems based on

the principles of equal access, cost–effectiveness, solidarity, and optimum quality"

- ✓ "Developing human resources for health" to ensure that health professional and others "have acquired appropriate knowledge, attitudes and skills to protect and promote health"
- ✓ "Research and knowledge for health": "health research, information and communication systems" should "better support the acquisition, effective utilization, and dissemination of knowledge"
- ✓ "Mobilizing partners for health," including governments, professionals, nongovernmental organizations, the private sector, and individual citizens
- ✓ "Policies and strategies for health for all" at "country, regional and local levels"

Bangkok Charter in 2005:

The Bangkok Charter for Health Promotion in a Globalized World is the name of an international agreement reached among participants of the 6th Global Conference on Health Promotion held in Bangkok, agreement reached among participants of the 6th Global Conference on Health Promotion held in Bangkok, Thailand in August 2005, convened by the World Health Organization. It identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion.The Bangkok Charter recognizes:

- ✓ The health inequality between developed and developing nations
- ✓ The changing trend of communication and consumption in a globalized world
- ✓ Urbanization
- ✓ Global environmental change
- ✓ Commercialization

Five key areas of action for a healthier world:

- ✓ **Partner and build alliances** with private, non-private, non-governmental or international organizations to create sustainable actions
- ✓ **Invest in sustainable policies**, actions and infrastructure to address the determinants of health
- ✓ **Build capacity for policy development**, health promotion practice and health literacy
- ✓ **Regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well being
- ✓ **Advocate health** based on human rights and solidarity

7th Global Conference on Health Promotion 2009:

7th Global Conference on Health Promotion organized by WHO and Kenya Ministry of Public Health will be held in Nairobi, 26-30 October 2009. Over the period from the Ottawa Conference through the six global conferences to Bangkok, a large body of evidence and experience has accumulated about the importance of health promotion as an integrative, cost-effective strategy, and as an essential component of health systems primed to respond adequately to emerging concerns. Thematic tracks at the conference were -

- ✓ Track 1: Community empowerment
- ✓ Track 2: Health literacy and health behavior
- ✓ Track 3: Strengthening health systems
- ✓ Track 4: Partnerships and intersectoral action
- ✓ Track 5: Building capacity for health promotion

The Nairobi Global Conference on Health Promotion, Kenya, October 2009, closed with the adoption and declaration of the Nairobi Call to Action which reflected the collective views of over 600 international participants from more than 100 countries.

8th Global Conference on Health Promotion 2013:

This conference was co-hosted by WHO and the Ministry of Social Affairs and Health, Finland. The main theme of the conference was "Health in All Policies" (HiAP) and its focus was on implementation, the "how-to". It was structured around six themes. Building on our heritage, looking to our future: The 8th Global Conference on Health Promotion was held in Helsinki, Finland from 10-14 June 2013. The meeting builds upon a rich heritage of ideas, actions and evidence originally inspired by the *Alma Ata Declaration on Primary Health Care* (1978) and the *Ottawa Charter for Health Promotion* (1986). These identified inter-sectoral action and healthy public policy as central elements for the promotion of health, the achievement of health equity, and the realization of health as a human right. Subsequent WHO global health promotion conferencescemented key principles for health promotion action. These principles have been reinforced in the 2011 Rio Political Declaration on Social Determinants of Health, the 2011 Political Declaration of the UN High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, and the 2012 Rio+20 outcome document (*the Future We Want*). They are also reflected in many other WHO frameworks, strategies and resolutions, and contribute to the formulation of the post-2015 development goals

Millennium Development Goals (MDG):

In 2000 world leaders reached a consensus on a new movement, termed Millennium Development Goals (MDG), to be achieved by 2015. Five out of eight goals are health-related. The World Health Organization sees the MDGs as milestones on the road to HFA since they set clear goals and distinct targets compared with HFA.As a vision, HFA does not need a concrete timeline as is the case of MDGs adopted by world leaders in 2000. We can consider health MDGs as the mission or objective of HFA till 2015, and simultaneously as proxy indicators to HFA.For health systems, commitment to reach the health-related Millennium Development Goals has two main implications. First, delivery systems must do a better job of reaching the poor, who tend to live in remote rural areas and urban shantytowns. Second,schemes for financial protection

must be in place to ensure that the costs of health care, especially catastrophic expenses do not themselves cause poverty.Despite much progress revealed by many countries in implementing PHC through their health systems, the following are some challenges that need to be addressed if we are to achieve health goals in general and health MDGs in particular.

- ✓ Misinterpretations of the concept of Primary Health Care
- ✓ Inequity in health
- ✓ Escalating health-care cost
- ✓ Trade agreements
- ✓ Interdependence of the world
- ✓ Inadequate performance or low efficiency of the health system
- ✓ Need for more research
- ✓ Financing the health system
- ✓ Need for integrated services
- ✓ Public—Private Partnership
- ✓ Climate change

Revised MDG monitoring framework including new targets and indicators, as noted by the 62ndGeneral Assembly, and new numbering, as recommended by the Inter-agency and Expert Group on MDG Indicators at its 12thmeeting, 14 November 2007. All indicators should be disaggregated by sex and urban/rural as far as possible. Health related MDGs are–

Goal 1: Eradicate Poverty and Hunger

Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Goal 4: Reduce Child Mortality

Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

Goal 5: Improve Maternal Health

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Target 5.B: Achieve, by 2015, universal access to reproductive health.

Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

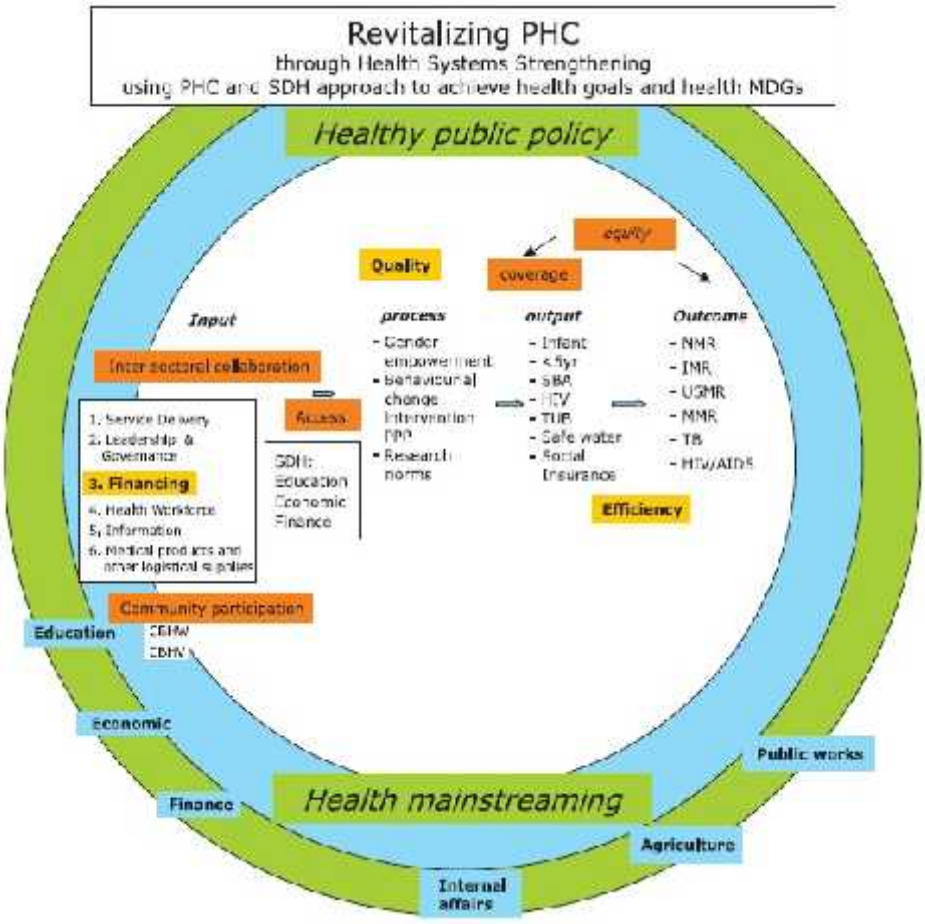
Goal 7: Ensure Environmental Sustainability

Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

Goal 8: Develop a Global Partnership for Development

Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

Revitalize PHC: The Health for All (HFA) movement was part of the Alma Ata Declaration on Primary Health Care (PHC) in 1978. Thirty years after PHC was adopted as an approach to operationalize health systems, we observe different perceptions of PHC that sometimes yield unfavorable health outcomes. Now it is very timely to revitalize PHC in light of the changing disease burden, globalization, trade agreements, social determinants of health, climate change, etc.



Since Health for All emphasizes the highest possible level of health, each country will have different health targets, which depend on the current status of health, their social and economic condition. Therefore, the Primary Health Care activities that need to be implemented in order to achieve the Health for All goals will vary from country to country. In the current context, HFA can be defined as:"a stage of health development whereby everyone has access to quality health care or practice self-care protected by financial security so that no individual or family is experiencing catastrophic expenditure that may bring about impoverishment".

Health Systems Using the PHC Approach:

A health system consists of all organizations, people and actionswhoseprimary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services.Health system of some sort have existed as long as people have tried to protect their health and treat disease, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions. Many reforms have taken place, shaped by national and international values and goals. PHC as articulated in the Alma-Ata Declaration of 1978 was a first attempt to unify thinking about health within a single policy framework.

Countries seeking to prescribe essential health care as prescribed by the Alma-Ata Declaration were faced with two difficult options:

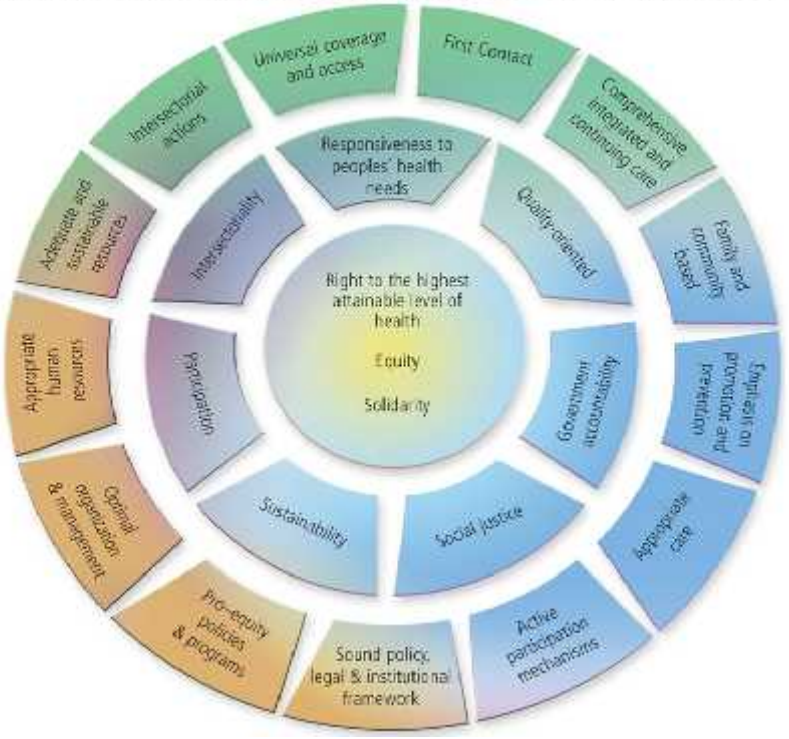
- ✓ Focus publicspending on interventions that are both cost-effective and possess public goods characteristics, and

- ✓ Boost financing through applying user's fees. While many governments started to levy fees, the poor were deterred from receiving treatment. Limited income yielded from user's fees has prompted many governments to focus on single disease programmes/selective PHC, which further exclude the poor from getting proper care.

As the crisis in many countries deepened in the 1990s, so many governments looked to the wider environment for new solutions. Infused with ideas from market-based reforms in Europe's public services and with new experiences emerging from transitional economies, health sector reform focused on improving efficiency.

Finally, they arrived at the conclusion that running the health system on $10 per capita or less is not viable. The Commission on Macroeconomics and Health in 2001 came up with a more acceptable proposition i.e. $34 for delivering only essential health care. Health systems are highly context-specific; there is no single set of best practices that can be put forward as a model for improved performance. The Pan American Health Organization (PAHO)/WHO Regional Office of the Americas defines Health System using PHC approaches as follows:

Figure 1: Core Values, Principles and Elements in a PHC-Based Health System



- ✓ A PHC-based health system is composed of a core set of functional and structural elements/building blocks that guarantee universal coverage and access to services that are acceptable to the population and that are equityenhancing.
- ✓ It provides integrated and appropriate care over time; emphasizes health promotion and prevention; and assures first contact care.
- ✓ Families and community are its basis for planning and action.
- ✓ It requires a sound legal, institutional and organizational foundation as well as adequate and sustainable human, financial and technological resources.
- ✓ It employs optimal organizational and management practices at all levels to achieve quality, efficiency and effectiveness and develops active mechanisms to maximize individual and collective participation in health.

- ✓ It develops intersect oral actions to address determinants of health and equity.
- ✓ In 2007, based on the functions defined in the World Health Report 2000, six building blocks of the health system were identified:
- ✓ Service delivery;
- ✓ Health workforce;
- ✓ Information;
- ✓ Medical products, vaccine and technologies;
- ✓ Financing; and
- ✓ Leadership and governance (stewardship).

PHC Now and More Than Ever:

Year2007 marks both the 60th birthday of WHO and the 30th anniversary of the Declaration of Alma-Ata on Primary Health Care. While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remain true. Yet, despite enormous progress in health globally, our collective failures to deliver in line with these values are painfully obvious and deserve our greatest attention. lie ahead, and identify major avenues for health systems to narrow the intolerable gaps between aspiration and implementation. These avenues are defined in the Report as four sets of reforms that reflect a convergence between the values of primary health care, the expectations of citizens and the common health performance challenges that cut across all contexts. They include:

- ✓ Universal coverage reforms that ensure health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection;
- ✓ Service delivery reforms that re-organize health services around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world, while producing better outcomes;
- ✓ Public policy reforms that secure healthier communities, by integrating public health actions with primary care, by pursuing healthy public policies across sectors and by strengthening national and transnational public health interventions; and
- ✓ Leadership reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership indicated by the complexity of contemporary health systems.

While universally applicable, these reforms do not constitute a blueprint or a manifesto for action. The details required to give them life in each country must be driven by specific conditions and contexts, drawing on the best available evidence. Nevertheless, there are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. As the last three decades have demonstrated, substantial progress is possible.

Doing better in the next 30 years means that we need to invest now in our ability to bring actual performance in line with our aspirations, expectations and the rapidly changing realities of our interdependent health world. United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all.

The Sustainable Development Goals (SDGs), officially known as transforming our world: the 2030 Agenda for Sustainable Development. On 19 July 2014, the UN General Assembly's Open Working Group on Sustainable Development Goals (SDGs) forwarded

a proposal for the SDGs to the Assembly. Agreed by the 193 Member States of the UN, the new agenda, Transforming Our World: 2030 Agenda for Sustainable Development, consists of a Declaration, 17 Sustainable Development Goals and 169 targets. The 2030 Agenda for Sustainable Development, are an intergovernmental set of aspiration Goals with 169 targets. The Goals are contained in paragraph 54 United Nations Resolution A/RES/70/1 of 25 September 2015.

Health-Related Sustainable Development Goals Targets:

Goal 1. End Poverty in all its Forms Everywhere:

- ✓ Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.
- ✓ By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters

Goal 2. End Hunger, Achieve Food Security and Improved Nutrition and Promote Sustainable Agriculture:

- ✓ Ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.
- ✓ By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

Goal 3. Ensure Healthy Lives and Promote Well-Being for all at all Ages:

- ✓ By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- ✓ By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per

1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

- ✓ By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

- ✓ By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
- ✓ Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- ✓ By 2020, halve the number of global deaths and injuries from road traffic accidents.
- ✓ By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- ✓ Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- ✓ By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
- ✓ Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.
- ✓ Support the research and development of vaccines and medicines for the communicable and no communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property

Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

- ✓ Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and Small Island developing States.
- ✓ Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Goal 4. Ensure Inclusive and Equitable Quality Education and Promote Lifelong Learning Opportunities for all:

- ✓ By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations.
- ✓ Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, nonviolent, inclusive and effective learning environments for all.

Goal 5. Achieve Gender Equality and Empower all Women and Girls:

- ✓ Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- ✓ Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
- ✓ Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Goal 6. Ensure Availability and Sustainable Management of Water and Sanitation for all:

- ✓ By 2030, achieve universal and equitable access to safe and affordable drinking water for all.
- ✓ By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

Goal 7. Ensure Access to Affordable, Reliable, Sustainable and Modern Energy for all:

- ✓ By 2030, ensure universal access to affordable, reliable and modern energy services.

Goal 8. Promote Sustained, Inclusive and Sustainable Economic Growth, Full and Productive Employment and Decent Work for all:

- ✓ By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.
- ✓ Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms.
- ✓ Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment.

Goal 10. Reduce Inequality Within and Among Countries:

- ✓ By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.
- ✓ Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies.

Goal 11. Make Cities and Human Settlements Inclusive, Safe, Resilient and Sustainable:

- ✓ By 2030, ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums.
- ✓ By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons.
- ✓ By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations.
- ✓ By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities.
- ✓ By 2020, substantially increase the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change, resilience to disasters, and develop and implement, in line with the Sendai Framework for Disaster Risk Reduction 2015-2030, holistic disaster risk management at all levels.

Goal 12. Ensure Sustainable Consumption and Production Patterns:

- ✓ By 2020, achieve the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimize their adverse impacts on human health and the environment.

Goal 13. Take Urgent Action to Combat Climate Change and its Impacts:

- ✓ Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning.

Goal 16. Promote Peaceful and Inclusive Societies for Sustainable Development, Provide Access to Justice for all and Build Effective, Accountable and Inclusive Institutions at all Levels:

- ✓ End abuse, exploitation, trafficking and all forms of violence against and torture of children.
- ✓ By 2030, provide legal identity for all, including birth registration.

Goal 17. Strengthen the Means of Implementation and Revitalize the Global Partnership for Sustainable Development:

- ✓ By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.

Economists' Declaration on Universal Health Coverage:

Ahead of the September 2015 UN General Assembly, economists from 44 countries issued a joint declaration calling on world leaders to prioritize investments in health. Led by Lawrence Summers, this Economists' Declaration on Universal Health Coverage was published in The Lancet, with 267 signatories, including five Nobel Laureates and a diverse group of renowned economic thinkers.

Global Health *2035* at the United Nations:

CIH Commissioners have presented the findings of the Global Health 2035 report in various forums at the United Nations. In Jan 2014, a full panel of Commissioners participated in a high-level briefing at UN Headquarters titled, Towards a Grand Convergence in Global Health: What Convergence Means for Health after 2015. In September 2014, Kenyan President Uhuru Kenyatta hosted the "Domestic Financing for Health: Invest to Save" event at the United Nations General Assembly in New York. Commissioners Lawrence Summers and Agnes Binagwaho presented evidence from Global Health 2035 and made the case that increased domestic financing of health will not only lead to better health outcomes, but also economic gains. In February 2015, Commissioner Gavin Yamey presented at UN World Women's Health and Development Forumon Global Health 2035 and global policy-making for women's health.

As the world reviews healthcare services beyond 2000, work continues on reducing health inequities for poor people. Concern is being expressed that people living in absolute poverty still do not have access to basic services or a healthy environment. As economic development improves the incomes and standards of living in many developing countries, an increasing gap is opening up between the rich and the poor and this is associated with inequitable access to healthcare services. There are now calls to give "voice" to the poor so they have a greater say in how healthcare services are delivered. But, then, isn't this PHC?

Further, as we reflect on recent world events, surely we must address the underlying causes. If funds were expended on the provision of an equitable and comprehensive PHC system and the relief of the massive debt burden, this would be a major step in addressing the prevailing sense of frustration in resource-poor countries.
It is time to put political and economic ideology aside and determine the methodology that will yield the greatest gains and provide access to even the most basic of services for All People beyond the Year 2015 and or 2030.

Conclusion:

Health is a major concern for each people of the world. We invest on our health every day like taken balance food, life style modification so on. After implementations of so many initiative worldwide health status is improving but out of so many success till some under developed, developing countries and hard to reach areas are left behind. So this is the high time to work rigorously for work on it, decries inequality, increase work area, make a strong link from Centre to root level, increasers capacity and skill. Following this sequentially every life, every citizen will become as asset for their country not a burden.

References:

1. http://www.un.org/aboutun/sanfrancisco/history.html
2. "History of the United Nations 1941 - 1950"
3. Constitution of the World Health Organization (PDF). Geneva: World Health Organization. 1948.
4. Grad, Frank P. (Jan 2002). "The Preamble of the Constitution of the World Health Organization" (PDF). Bulletin of the World Health Organization 80 (12): 981.

5. Universal Declaration of Human Rights, United Nations, 1948
6. Pillai, Navanethem (Dec 2008). "Right to Health and the Universal Declaration of Human Rights" (PDF). The Lancet 372 (9655): 2005–2006. doi:10.1016/S0140-6736(08)61783-3. Retrieved 14 Oct 2013.
7. Gruskin, Sofia; Edward J. Mills; Daniel Tarantola (August 2007). "History, Principles, and Practice of Health and Human Rights". The Lancet 370 (9585): 449–455. doi:10.1016/S0140-6736(07)61200-8.
8. WHO. Declaration from the website of the World Health Organization.
9. WHO Publications :Primary health care – now more than ever
10. World health report 2008
11. WHO. The Declaration of Alma-Ata pdf, 26kb
12. "1941: The Declaration of St. James' Palace". United Nations. Retrieved 28 March 2016.
13. World Health Organization. Overview of the World Health Report 2003: Shaping the future Geneva, 2003
14. World Health Organization. The Ottawa Charter for Health Promotion. Adopted on 21
15. Mahler, Halfdan (1981) "The meaning of Health For All by the year 2000", World Health Forum, Vol. 2, No. 1
16. World Health Organization. Jakarta Declaration on Leading Health Promotion into the 21st Century. Accessed 2009 Jan 20
17. World Health Assembly. Resolution WHA51.7. Health for all policy for the twenty-first century. Geneva: World Health Organization, 1998. Accessed 2013 Apr 9.
18. Health21: an introduction to the health for all policy framework for the WHO European Region. (European Health for All series; no. 5.) Copenhagen: World Health Organization, Regional Office for Europe, 1998. ISBN 92-890-1348-6. Accessed 2013 Apr 9.
19. Health21: the health for all policy framework for the WHO European Region. (European Health for All series; no. 6.) Copenhagen: World Health Organization, Regional Office for Europe, 1999. ISBN 92-890-1349-4. Accessed 2013 Apr 9.
20. World Health Organization. The Bangkok Charter for Health Promotion in a Globalized World (11 August 2005). Geneva
21. Institute for Health Metrics and Evaluation. Financing global health 2011: continued growth as MDG deadline approaches. IHME, 2011.
22. Murray CJ, Ortblad KF, Guinovart C, Lim SS, Wolock TM, Roberts DA, et al. Global, regional, and national incidence and mortality for HIV, tuberculosis, and malaria during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet 2014 Jul 21
23. www.who.int/topics/sustainable-development-goals/en/
24. World Health Organization
25. News & Views article: 267 Economists Worldwide Agree: Universal Health Coverage Makes Economic Sense
26. www.who.int/gho/mdg/goals_targets/en/
27. Google –images of different framework
28. Diagram – a overall concept regard Primary Health Care and International action following PHC flow chart prepare by author.