

The Addis Ababa Declaration on Global Health Equity: A call to action

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Abstract

Background: Health inequalities occur through differences in health status or in the distribution of health determinants between different population groups. Access to basic health services was affirmed as a fundamental human right by the declaration of Alma-Ata in 1978. The reality is that, in 2012, more than 40 years later, many people in resource-poor settings still do not have equitable access to even basic health services. In many places this gap is widening.

Rationale: In order to tackle the different global health inequities there is still a need for a concerted effort by different public health experts and institutions. As a multidisciplinary professional association, the World Federation of Public Health Associations (WFPHA) which has a mission of promoting and protecting global public health is one of the institutions which stand for such causes. One of the WFPHA platforms for such kind of initiatives is its triennial World Congress on Public Health, a scientific conference for public health professionals from around the world.

The WFPHA Congress: The 13th World Congress on Public Health with the theme of “*Moving towards Global Health Equity: Opportunities and Threats*”, was held in *Addis Ababa, Ethiopia from April 23-27, 2012*. The congress brought together over 3000 public health experts from more than 100 countries to discuss different health issues including its major theme global health equity. Participants of the congress touched several public health issues that include: major health threats, health inequity, migration, fair trade, revised MDGs, development aid and health workforce which were used to forward recommendation for action.

Call for action: Based on the different interaction, at the conclusion of the 13th World Congress on Public Health, the WFPHA issued the Addis Ababa Declaration, a call to action on Global Health Equity. [*Ethiop. J. Health Dev.* 2012;26 Special Issue 1:233-237]

Introduction

The Alma-Ata conference, 6-12 September 1978, in the former Soviet Union, provided two major foci - one was the principle (and slogan) of Health For All 2000, with the obvious inference in respect of equality and equity, whilst the other was the primacy given to the primary care setting. It also incorporated a commitment to community participation and inter-sectoral action. At the culmination of the conference one of the declaration stated that “ 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 is, therefore, of common concern to all countries” (1).

Health inequalities occur through differences in health status or in the distribution of health determinants between different population groups. Tackling health inequities is very complex phenomena and it requires widening our lens to bring into view the ways in which social determinants such as employment and working conditions, education, appropriate housing, affordable energy, economic and social relationships, access to care and resources, and even political power influence individual and community health. When societal resources are distributed unequally by the different social determinants, population health will be distributed unequally along those lines as well (2).

In order to tackle the different global health inequities there is a need for a concerted effort by different public

health experts and institutions. As a multidisciplinary professional association, the World Federation of Public Health Associations (WFPHA) which has a mission of promoting and protecting global public health is one of the institutions which stand for such causes. One of the WFPHA platforms for such kind of initiatives is its triennial World Congress on Public Health which has been held since 1975. The International Congress, which takes place every three years, is a scientific conference for public health professionals from around the world. The 13th World Congress on Public Health with the theme of “*Moving Towards Global Health Equity: Opportunities and Threats*”, was held in *Addis Ababa, Ethiopia from April 23-27, 2012* (3). The congress brought together over 3000 public health experts from more than 100 countries to discuss different health issues including its major theme global health equity and at the conclusion of the 13th World Congress on Public Health, the WFPHA issued the [Addis Ababa Declaration](#), a call to action on Global Health Equity (4).

In order to come up with the final paper on the Addis Ababa Declaration a drafting group composed of members from different national public health associations and the executive board of WFPHA reviewed several background papers including the WFPHA Istanbul declaration on Health, the First Human Right of 2009 (5) as well as the Rio Declaration on Social Determinants of Health of 2011 (6).

Background Papers

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Major Health Threats

In addition to the multitude of health problems traditionally faced, health is today at increased risk due to man-made threats which are global warming, economic imbalance, governance and global insecurity. All of these are closely interconnected. For example global warming constitutes a key cause of natural and man-made disasters, floods, water shortages, and desertification, in turn, contributing to wars, demographic and economic divides, all of which all too often result in poverty and hunger therefore impeding the health of entire populations. This chain of consequences extends in both directions; as noted by the Commission on Macroeconomics and Health, where it is noted that an acceptable health status is a precondition for economic development, which can reduce the risk of violent conflicts for scarce resources and risk of environmental damage (7). Although health is widely understood to be both a central goal and an important outcome of development, the importance of investing in health to promote economic development and poverty reduction has been much less appreciated. Ten years after the establishment of the Commission on Macroeconomics and Health, the evidence showed that extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security (8).

Health Inequity

The WHO global burden of disease (GBD) measures burden of disease using the disability-adjusted life year (DALY). This time-based measure combines Years of Life Lost (YLL) due to premature mortality and years of life lost due to time lived in states of less than full health. The Burden of Disease measured as years of life lost (YLL) is 4 times higher in Sub-Saharan Africa and other developing countries than in the high-income countries (9, 10). While accepting the overriding importance of policy and action, doubt still exists about political will, acknowledgement of responsibility and that progress may be too slow and prolonged. The cost of health inequity in the European Union is about 20 percent of total health care costs (11). Furthermore in most countries the population is made up of diverse cultural groups and this has been exacerbated in recent decades by the mass movement of people across borders. Health services therefore have to adopt cultural pluralism if universal access is to result in the reduction of health inequity (12).

Migration

The divide between poor and wealthy populations leads to previously unseen mass migration within and between countries, often aggravated by violent conflicts. There are now about 200 million international migrants or 3 percent of the world's population living outside of their country of origin for at least one year. Among them there are close to 26 million internally displaced persons (IDPs) and an estimated 16 million refugees. However,

on the other hand the up side of the mass economic migration is that remittances by emigrants to their home countries (these usually being developing) have risen dramatically and now stand at a total \$337 billion, with the down side being that this is over twice the level of Official Development Assistance (13, 14). This may contribute in an indirect way to improve the inequity by improving the economic status of the remittance beneficiaries.

Within countries a movement from rural to urban zones can be observed worldwide. In 2025 about two thirds of the world's population will live in cities. Urbanization certainly alleviates several problems, e.g. overpopulation or land shortage. On the other hand, there are negative consequences in terms of increased poverty, the rise of slum and squatter areas, extremely unequal distribution of resources, overburdening of the urban infrastructure and difficulties to supply mega-cities with the necessary resources such as clean air and water associated with it (15, 16). Indeed, the urban poor are the main group affected by an unequal distribution of resources, and they have to live in quarters characterized by the worst environmental conditions like overcrowded slums and squatter settlements close to polluting industries or congested roads. In terms of accessing social service they starve amidst the plenty of inaccessible services surrounding them.

Migration also affects qualified professionals, but in our case, particularly the health professionals, which is a major problem. For example, there are only 750,000 health workers in all of sub-Saharan Africa, a region that serves 682 million people and suffers from 25 percent of the world's burden of disease, whereas it has been estimated that Africa needs about 1 million more doctors, nurses and midwives (as well as pharmacists and other categories of health professionals) to achieve the Millennium Development Goals. There is of course the right to leave the country of origin under the 1948 Universal Declaration of Human Rights, on the other hand low-income countries should be compensated for the loss of health professionals as they have invested into the upbringing and schooling and higher education (17-20).

Fair Trade

In addition the General Agreement on Trade in Services (GATS) a treaty of the World Trade Organization (WTO) states that public services are only excluded if "provided in the exercise of government authority" and if they are "supplied neither on a commercial basis nor in competition with one or more private service suppliers" (21). Since some aspects of public services are frequently also provided by the private sector, or at least have commercial relationships with private suppliers, there is doubt that many services would actually be exempt under this definition. To be protected, vital human services must be specifically and permanently excluded from international trade agreements. Authority and

accountability for population health need to be shifted back to public health organizations. The principle of health before trade has to be applied to all trade negotiations.

Revised MDGs

The gap between rich and poor is growing at a dangerous and unprecedented rate, and the world's 225 richest people have achieved a combined wealth equal to the annual income of the poorest 47 per cent of the world's people (22). Poverty is the major determinant for achieving or not the MDGs and the UN Director General, Ban Ki-Moon writes 2009: "...world leaders set far-sighted goals to free a major portion of humanity from the shackles of extreme poverty, hunger, illiteracy and disease. They established targets for achieving gender equality and the empowerment of women, environmental sustainability and a global partnership for development...we have been moving too slowly to meet our goals" (23). For example, for Sub-Saharan Africa it will be hard to meet the challenge until 2015. Moreover, the MDGs are obviously lacking the achievement of peace as a fundamental development goal. Regional and local wars are waxing and waning in many parts of the world. Arms are cheaply and disastrously abundant and available in many countries where food is scarce and expensive. Thus people are suffering from hunger and under-nutrition, complicated by insecurity. Furthermore they lack the obligation of the donor countries and organizations on the Paris/Accra indicators and the demand for universal health coverage (24).

Development Aid

Aid to developing countries should therefore be perceived as a moral obligation, which however more often is declared in speeches and resolutions than in deeds. A target of 0.7 percent of the GDP of economically developed countries for Official Development Assistance (ODA) has been first pledged 35 years ago in paragraph 43 of the [1970 UN General Assembly Resolution](#) and since has been affirmed in many international agreements over the years, including the Monterrey Consensus in 2002, when world leaders reiterated their commitment, stating that "we urge developed countries that have not done so to make concrete efforts towards the target of 0.7 percent of gross national product (GNP) as ODA to developing countries". However as percent of their GDPs the US does not even reach 0.2 percent and the EU average lingers around 0.4 percent (25). Despite the large literature on aid and growth, the debate about aid effectiveness is one where little is settled. Composition of aid in favor of developmental aid or increasing its quantity can lead to sizable long term benefits (26).

On the other side Development Assistance for Health (DAH) has quadrupled since 1990 from 5.6 billion USD to 21.8 billion in 2007. Private foundations and NGOs shift the paradigm of global health aid away from governments and agencies like the World Bank and the

United Nations and make up by now a large piece of health assistance. But there are serious imbalances between DAH and the burden of disease. DAH for the last decade obviously has been given not according to the highest disease burdens but other criteria such as political and economic interests (27).

One of the obvious reasons for imbalances is the extreme fragmentation and therefore ineffectiveness of international aid. Globally: 280 agencies, 242 multilateral funds, 24 Development Banks, 40 UN Organizations, and thousands of NGOs can be identified. For under-resourced ministries in developing countries, the transaction costs can be unbearably high and reduce the value of the aid they receive to almost none. The sheer number of activities creates the need for greater harmonization between donors and alignment with partner country priorities according to the Paris Indicators, confirmed in Accra 2008 (28). Especially in the indispensable state sector knowledge and skills to secure coordination and collaboration in Public Health are limited. Against the recommendations bilateral aid increased its share over the years instead of multilateral integrated aid in the framework of a Sector Wide Approach (SWAp).

Health Workforce

Finally the public health workforce has to be enhanced in quality and quantity as the backbone of population health and the only professional "instrument" in the hands of the ministries of health. Governments therefore should promote a framework for the education and training of health-related professionals to include the acquisition of adequate competences for good governance and efficient management of health institutions and programs. They should ensure that a competent post-graduate training institution (School of Public Health) is available at national level, as well as in large regions, with links to both academic and health administrations. Such an institution should contribute to the dissemination of developments in public health and health-service research, as well as serving as a resource for the development, reform and evaluation of health systems (29). In this context a Pan-African Accreditation Agency for Public Health and an appropriate licensing system for public health professionals may be considered.

Conclusion

As we count the difficult situations facing global, national and community public health, we also ought to recognize and leverage the available opportunities available at all levels. All over the world there are enthusiastic and knowledgeable public health professionals who can be, and often are mobilized into national, sub-regional, regional and global public health associations or federations. These carry an eternal and inextinguishable torch in support of promoting the health of everyone, everywhere in the world. Everyone in the world desires to be guided to enjoy the highest level of positive health, and more often than not will be willing to

do what it takes to promote his or her health and the health of those dear to him or her. The power of individual and community will-power to promote health has too often not been tapped, but instead usurped by prescriptive, non-sustainable, expensive short-term health solutions. Yet, people all over the world are capable of adopting sustainable affordable health promotion and preventive health options if they are guided to do so. Equity would demand that pooling of public health human resource capacity in Public Health Associations and the positive involvement of all individuals and communities would go an extra mile making the world healthier.

Recommendations

Recognizing the ever-changing context within which all of us operate and the many acute challenges to the achievement of global health equity, the WFPHA calls on all governments and stakeholders to safeguard and promote the essential values of public health. These include, but are not restricted to: good governance, solidarity, equity and fairness, empowerment and participation, and social justice to achieve the highest possible standards of health for all.

In line with this at the conclusion of the 13th World Congress on Public Health the WFPHA recommends:

1. A code of conduct for NGOs including accountability and transparency is a first requirement.
2. The concept of sector wide approaches (SWAp) has to be further developed and made practical to put the receiving governments into the “drivers’ seat” on the condition of improved governance. To this end the achievement of the Paris/Accra criteria is essential.
3. Especially with regard to primary health care the dominating focus on vertical disease oriented programmes like the Global Fund can be disastrous as it often inhibits seriously the development of a sustainable infrastructure including training and human resource development. Therefore the linkage between governments and donors has to be strengthened with a priority for primary health care services instead of secondary and tertiary care
4. The migration towards Highly Developed Countries - especially of qualified professionals - cannot simply be stopped without violation of basic human rights. However, there should be an agreed mechanism to fully compensate the "sending" countries for basic investments into upbringing and education.
5. Governments should ensure competent post-graduate training institutions for qualifying public health professionals including adequate accreditation and licensing mechanisms
6. Governments and other stakeholders should actively support the pooled public health human resource capacity in PHAs and other health professional associations.

7. In the spirit of sustainable local action for equity in health, Governments and other stakeholders should actively support communities’ participation/involvement in positive health action and should actively follow-up on health equity through a “Social Determinants for Health” approach.

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