To Our Health

No. 4
21 May 1999

The Newsletter of the World Health Organization

Unified call to fight poverty

Good health is a question of priorities, not income – Dr Sen

"Financial conservatism should be the nightmare of the militarist, not the doctor, or the school teacher, or the hospital nurse," Nobel Laureate Amartya Sen told the World Health Assembly Tuesday.

Professor Sen, a scholar from India whose work produced a new understanding of the catastrophes that plague society's poorest people, won the Nobel Economics Prize last year for his contributions to welfare economics, which help explain the economic mechanisms underlying famines and poverty. Sen "restored an ethical dimension to the discussion of vital economic problems," the 1998 Nobel citation said.

Dr Sen speaking to delegates Tuesday

The 65 year-old economist, Master of Britain's Trinity College in Cambridge (UK) and former Lamont University Professor Emeritus at Harvard University, said that fast economic growth has helped improve health in some countries where the growth is wide-based and income is used to expand health care education and social security. However, other countries have used "support-led processes that work through a programme of skilful social support of health care, education and other relevant social arrangements" to enhance living conditions and reduce mortality rates, even without much economic growth", he noted.

Because of this support-led process, he said, "Despite their very low levels of income, the people of Kerala (India), or China, or Sri Lanka enjoy enormously higher levels of life expectancy than do the much richer populations of Brazil, South Africa and Namibia, not to mention Gabon."

"And yet, when it comes to health and survival, perhaps nothing is as immediately important in many poor countries in the world today as the lack of medical services and provisions of health care," Professor Sen said. Citing a recent study called "Infections and Inequalities: The modern plagues," by Paul Farmer, he said "a major difference can be brought about by a public determination to do something about" pervasive deprivation of biomedical services, both for easily treatable diseases like cholera and malaria and more challenging ailment like AIDS and drug-resistant Tuberculosis.

The issues of social allocation of economic resources "cannot be separated from the role of participatory politics and the reach of informed public discussion," he said.

"The public has to see itself not merely as a patient, but also as an agent of change. The penalty of inaction and apathy can be illness and death," Professor Sen concluded.

"Health is a fundamental human right," Dr Brundtland said. "We need public voices to speak out for all those who are denied their human rights to health. "You can count WHO as one (of these voices)."

Closer cooperation the way to better health – Dr Brundtland

The World Health Organization will work closely with Member States and other UN organizations to substantially improve the health conditions of the world's poorest.

"We are not aiming at modest gains," WHO Director-General Gro Harlem Brundtland told delegates at the 52nd World Health Assembly – the Organization's annual "shareholders' meeting". "In East Asia, life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history. Repeat these gains – and we could be launching a new leap forward for human progress and development."

In addition to the formal resolutions adopted at every Assembly, this one will also contain round-table discussions on key health questions, a lecture by Nobel Laureate Amartya Sen on health's role in development, and a large number of associated activities – ranging from a World Bank report on the economics of tobacco to briefings on WHO's role in relief work in the Balkans.

In her speech to the Assembly, Dr Brundtland spelt out the role WHO will play in the years to come to ensure that the one billion who have so far been excluded from the health "revolution" of the second half of the twentieth century will see drastic improvements in their health in the coming decade. Having restructured Headquarters and brought about a realignment to ensure that regional offices and Headquarters share priorities and work effectively, WHO is now ready to focus on the challenges ahead, Dr Brundtland said.

She said WHO is working more closely with Member States, both through increased day-to-day cooperation with the missions in Geneva, by establishing a closer and more strategic work with WHO's Executive Board, and through clearer political leadership of the World Health Assembly.

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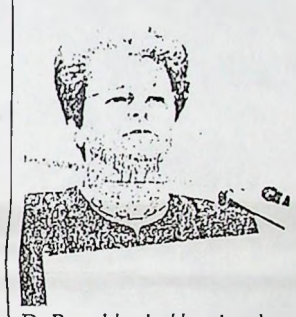

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She added that the dialogue initiated with the World Bank and the International Monetary Fund over the past months had been fruitful and would be intensified.

A key factor in WHO's new priority-setting is to emphasize the economic benefits from improved health and the need for cost-effective, equitable health systems.

"A five year difference in life expectancy may yield an extra annual growth of 0.5 per cent. It is a powerful boost to economic growth," Dr Brundtland said, reaffirming conclusions of the World Health Report, which she presented to Assembly.

South African anti-smoking laws to stay

South Africa's health minister, Dr Nkozasana Zuma, has reiterated her country's determination not to bow to pressure from the powerful South African tobacco lobby smarting under the country's tough new anti-smoking laws.

The legislation, recently signed by President Nelson Mandela, bans the advertising of tobacco products. It also bans sports and arts sponsorship by tobacco interests, the use of tobacco trade marks on other products, and smoking in public places, including the workplace.

"They (the tobacco industry) are putting a lot of pressure on us through the media, sometimes attacking me personally and trying to mobilize the trade unions against us ...but our position is that everybody must comply (with the anti-smoking laws)," Dr Zuma told reporters.

Addressing charges by the tobacco lobby that the new laws violate the constitutional principle of freedom of expression, she replied: " Freedom of speech is not an unlimited right; there are limitations to every right and we strongly feel that this is an area where the limitation has to be applied."

The Minister said government would work with players in the tobacco industry to help them diversify into other equally profitable ventures. Tobacco is a multi-billion Rand industry in South Africa, employing some 200,000 people. "We did a study on the economic implications of doing something or doing nothing about tobacco use in our country, and came to the conclusion that the economic consequences of doing nothing are much more dire," she said.

With the introduction of tobacco advertising bans, South Africa joins more than 22 others with complete or near-complete advertising bans, in line with a May 1990 WHO resolution.

South African Health Minister Dr Nkozasana Zuma Monday was honoured by the World Health Organization for her efforts to rein in the tobacco industry and control the tobacco epidemic in South Africa.

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Interview

Amartya Sen on development and health

By Adrea Mach

In her address to the World Health Assembly, Dr Brundtland lauded keynote speaker Professor Amartya Sen, 1998 Nobel Laureate in economics, as "having placed poverty and development at the core of economic theory and, linking the social and economic dimensions of human development". The interview below is a TO OUR HEALTH exclusive interview with Professor Sen.

Development economics focuses on "the world's most enduring problem", persistent, widespread poverty. Where does health fit into the poverty picture?

If one thinks of poverty only as low income, then the health link is indirect: it is easier to earn a living and alleviate poverty when one is in good health. On the other hand, if we think of poverty as basic deprivation of the quality of life and of elementary freedoms, then ill health is an aspect of poverty. Bad health is *constitutive* of poverty. Premature mortality, escapable morbidity, undernourishment are all manifestations of poverty. I believe that *health deprivation is really the most central aspect of poverty.*

You are keen to reduce poverty, especially through better education and improved health coverage, so that entire societies may benefit. But if we do a reality check, what about countries like India? Is universal health coverage really feasible over the short to medium term? Or is this an idealistic illusion?

Indeed, it would be quite difficult to provide sophisticated medicine for every person in India. But basic medical care can be guaranteed to every human being, even in a poor country like India.

Some areas of India are much better provided in terms of health care than others. For example, Kerala has very wide health care. Now Kerala is not any richer than the rest of India; it's in fact slightly poorer on average. If Kerala can do it, the rest of India also can. In fact, in terms of survival to mature ages, the African American population in the United States, though many times richer than the population of Kerala, actually has a lower chance of survival to mature ages. Low per capita income is not really such a barrier. That's the first thing.

Secondly, basic medical care is very labour-intensive. In a low wage economy, the state has less money to spend on health care, but it also *needs* less money to spend on the same amount of health care because the cost of medical services is lower. That is a very important economic consideration. So if you do a reality check, you should consider how much the state must spend but also what the expenses are and by how much good economic organization can reduce them, building on the low wages that make health care that much cheaper. Universal health coverage is no Utopian illusion at all, even for very poor economies.

What is the relative importance of public vs. private sector funding, especially for really impoverished countries?

The importance of the public sector in fields like health care is very well established. There is no way the private sector can do as much. Those who think privately financed medicine could do it all are mistaken. Private insurers don't have the incentive to cover the most vulnerable people because it's always against the interests of an insurance company to cover someone who is more likely to become ill.

However, I quite agree that we have to consider how to improve the quality of public sector health care delivery. The market gets its incentives from the profit motive, but it is rather neglectful in the field of health care. When it comes to the public sector, you have to provide the same incentive in other ways. That requires active public discussion on health care provision; it requires constant vigilance about the quality of hospital, medical, nursing services, etc. This incentive has to be provided through the medium of public discussion and criticism.

In the past, health has often been both isolated and isolationist. How can health now be mainstreamed into the broader development agenda?

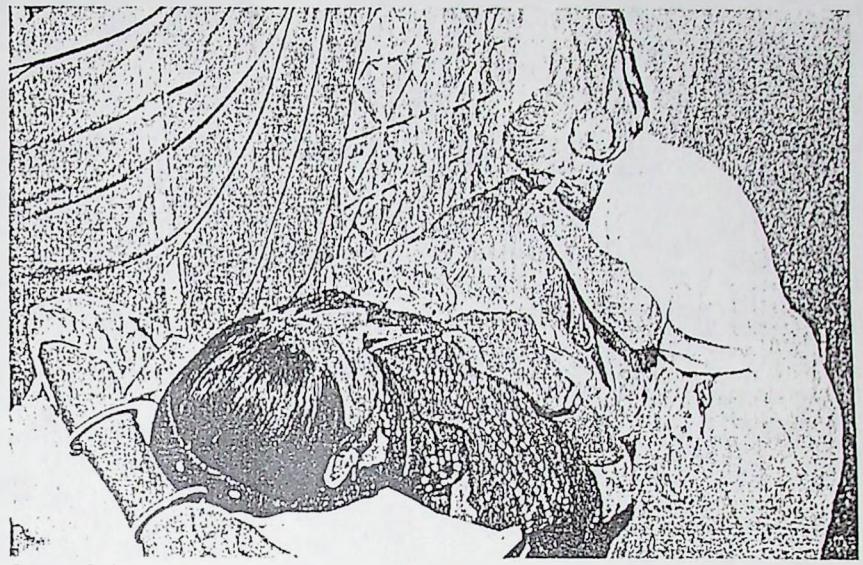
Health should be seen as an integral part of the development agenda. There is, first of all, the basic recognition that deprivation of health is an aspect of underdevelopment. Just as for the individual, not having medical treatment for curable ailments constitutes poverty, similarly, for a country, not having adequate health arrangements is a part of underdevelopment. So you have to place the issue of health care right at the centre of the development agenda.

Secondly, there are enormous interdependencies between different kinds of deprivations. For example, the deprivation of health is bad even for the economy because people's productivity depends on their level of nutrition and health. The functioning of the economy suffers from illness-related absenteeism.

One of the Director General's priorities is *Roll Back Malaria*. As someone who did suffer from malaria very early in my life, I can tell you that it's extremely debilitating. It is important to see the interconnection and the impact of health and health development, not just on the lives that human beings directly lead, but also what they can do as productive agents in the economy and as agents of social and political change. These are all part of the development agenda.

Today's world is characterized by increasing privatization of medical care. For example, consider the US model where costs are going up, quality is going down and more and more people are being left out. Today 16% of America's GDP is consumed by health related expenditures and even this doesn't do the job – there are still 44 million Americans without health insurance. If this type of model spreads, where will it lead in terms of the goal of Health for All?

That aspect of American medical arrangements is not one of glory. There are others which are quite glorious: the statistics of survival after the diagnosis of cancer, for example, show almost twice as many years in America as in, say, Britain. That is something that Americans do right. That is a characteristic of the efficiency of the system for those who can afford it.



In some Indian states, good public health care has ensured health indicators that are on par with those of much richer countries

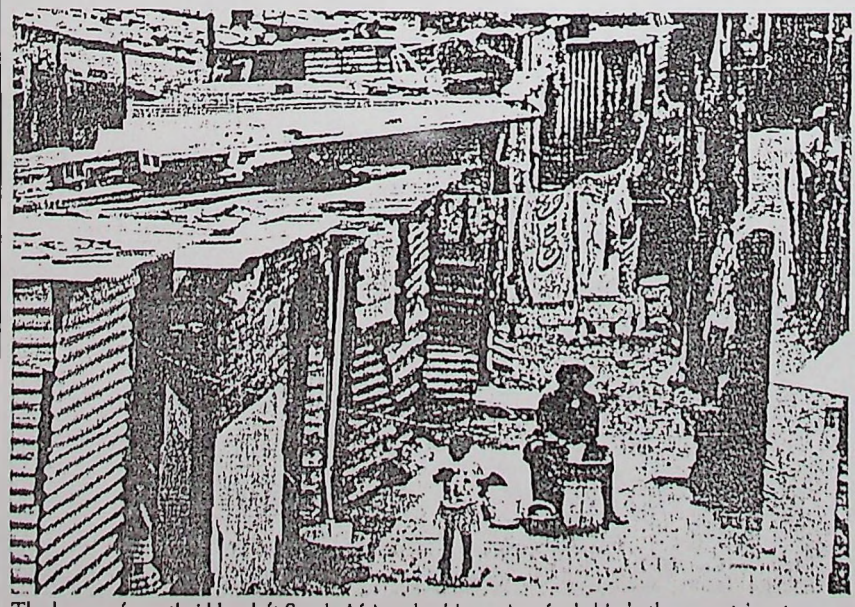
But the glaring defect of the American system is that it neglects lots of people who simply cannot afford it, like those who don't have medical insurance. You mentioned the number 44 million without medical insurance – that figure seems to be going up relentlessly. It is not just specialized medicine; people may be deprived of even the most elementary health care.

One has to recognize that the nature of the market economy makes it very efficient for certain types of production, like standard types of industries. But it's not very good for other kinds of economic activity, particularly medicine.

There are two reasons: one is that many of the results of medical care have the feature of being what economists call *public good* which affects not only the well-being of that person but also of others, for example with infectious diseases which are contagious to others. *In dealing with public goods, markets are notoriously defective.*

Second, the pattern of risk in medicine makes the market less efficient because, as I discussed before, it's always in the interest of private insurance to try to get out of covering those who are most likely to need medical care. But these are people for whom medical care is most important.

It's a question of trying to tain the efficiencies that American medical systems have – one should not deny those; they are radically important. If you have a serious illness, you have a very good reason to go to America for treatment – *if* you can afford it. And yet it's not very benign in terms of its coverage of the poorest. So we have lessons to learn. The way you put it, in terms of the limits of the market economy, is a very good way of understanding it. We must pay adequate attention to the role of public policy in dealing with medical care.



The legacy of apartheid has left South African health services far behind other countries at a similar economic level

You have emphasized "the abiding role of values as central to growth and development," saying that "development is a measure of human freedom" and that "health is crucial to freedom".

Yes, I have a book coming out in September which is called *Development as Freedom*. It's an attempt to see development as *enhancement* of human freedom. I argue that freedom is the primary end of development. Development isn't about raising GNP. No one wants money for its own sake. One wants money for something else, including good health. To be free to lead a good life, not to be cut off prematurely, not to have to suffer escapable ailments. Freedom of different kinds is constitutive of development.

Freedom is not only the primary end of development, it is also its principal means. Freedoms are of different kinds – *social opportunities (which include health care), market and economic opportunities, and political freedom in the form of participation in society and decision-making.* In different ways, freedoms affect our lives, from different ends. But as it happens, they are highly complementary.

For example, you do not have famines in a democratic country because the government could not face the polls or the criticism of opposition parties if it had a famine. There are other complementarities like social opportunities in the form of health care and education which make it easier for people to participate in a market economy, especially in a rapidly globalizing world. Freedoms of different kinds feed each other, support each other, consolidate each other.

I would like to argue that freedom is very central to development, both as ends and as means. It's the complementarity of different kinds of freedom which makes the analysis of "development as freedom" a particularly fruitful thing to pursue. Consolidating freedom of one kind helps consolidate freedom of other kinds. This is a very central issue in facing the challenges of the 21st century. The different aspects of freedom must influence the agenda of the coming century.

Professor Amartya Sen is Master of Trinity College, Cambridge and is former President of the International Economic Association, the American Economic Association, the Indian Economic Association, and the Econometric Society. The Royal Swedish Academy awarded him the Nobel Prize in economics in 1998 by citing his work in welfare economics and, in particular, on social choice theory, poverty and inequality.

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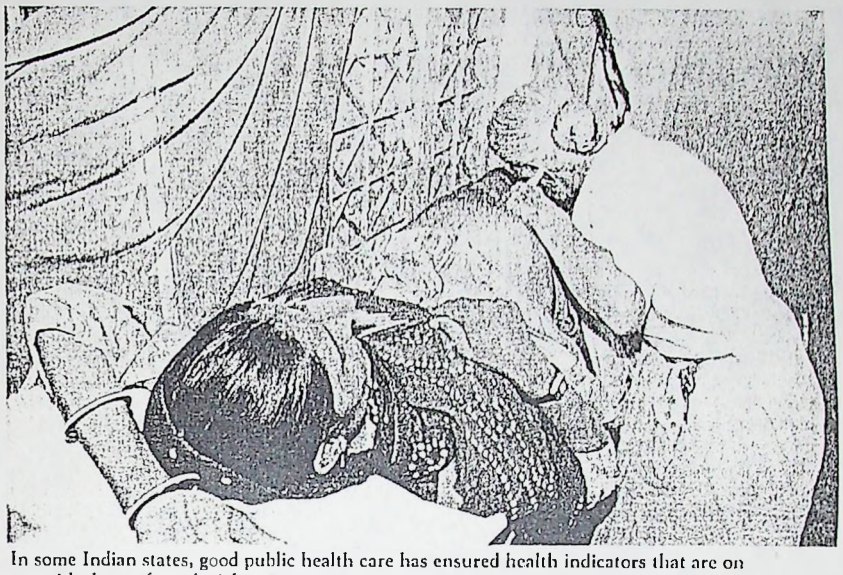

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FACSIMILE Message No. ..... Page 1 of 5 pages

From: J. Jameson, ICO

To: Dr R. Narayan, Coordinator, Society for Community Health and Awareness, Bangalore, India

Your ref.:

Fax No.: (91 80) 55 333 58 Date: 9 December 1997

Our ref.: P9/370/22

Subject: BACKGROUND TO MEETINGS IN LONDON, 15-16 AND 17 DECEMBER 1997

Dear Dr Narayan,

Please find attached copies of the Baltimore Charter and the London Declaration, which John Martin aksed me to fax to you.

With best wishes,

Yours sincerely,

Julia Jameson
Division of Intensified Cooperation with Countries (ICO)

ACTION IN INTERNATIONAL MEDICINE

CONFERENCE ON HEALTH AND POVERTY

Co-sponsored by the Division of Intensified Cooperation with Countries and Peoples in Greatest Need (ICO) of the World Health Organization

3-4 November 1995

The Conference on Health and Poverty held in London, 3 - 4 November 1995, was sponsored and organized by Action in International Medicine (AIM) and the Division of Intensified Cooperation with Countries and peoples in Greatest Need (ICO) of the World Health Organization. It was attended by 85 eminent members of major health and development professions, representing some 50 Institutions ad Associations in 209 countries, in official membership with AIM, as well as invited guests.

THE LONDON DECLARATION

The Conference on Health and Poverty meeting in London on this fourth day of November, nineteen hundred and ninety-five, expressing the need for urgent action by all relevant international organizations governments health, social and educational nongovernmental organizations, and all health and development workers to address the issue of gross and increasing inequities between countries and the widening gap between rich and poor within countries, hereby makes the following Declaration:

The Conference believes that the effects of political insecurity and the huge debt burden of many countries are seriously undermining the global health achievements of the past three decades. WHO has declared that worldwide action is required if a health catastrophe is to be prevented. Although there has been some improvement in health statistics in some countries, others are shameful and a disgrace to the 20th century (See attached Fact Sheet). The rich are getting richer and the poor are getting sicker.

Poverty is both a cause and an effect of ill-health. Economic and social development is of basic importance to the attainment of health for all. The promotion and protection of the health of all people are essential o sustained economic ad social development of a country.

Experiences reported in recent years have established that strategies designed to alleviate poverty, to relieve the suffering caused by unemployment, to generate employment and to foster social cohesion are most likely to succeed when a multi-faceted, multi-sectoral and integrated approach is pursued. The long-term aim should be the creation of self-help environments in which all human beings can solve their own problems and have opportunities to earn their own way out of poverty through health and increased productivity

Indignation leads to action

Underlying all action is the explicit recognition that to be effective, health must be addressed within the broader framework of peace, security, literacy, employment, nutrition, safe water supplies and sanitation.

The Conference participants recognize that the ethics of all health professions provide a moral imperative for addressing the health needs of all peoples without distinction and that the orientation of primary health care towards equity also establishes health as a vehicle of poverty alleviation.

In view of these facts, they wish to express their great indignation and to call for urgent action to change the present iniquitous situation.

AIM, working with, and through, its member organizations, resolves to define, coordinate, integrate, and support country-specific action programmes in order to respond to the challenge. This is consistent with its fundamental goals of promoting basic health care as a human right and actively working to support the district health systems in the poorer countries.

The Conference therefore calls upon all AIM Member Institutions and Associations to convene follow-up conferences on Health and Poverty in their own countries, bringing together representatives of all health and development workers, appropriate agencies and organizations in order to identify and initiate specific local and national activities. It also calls upon them to form a string world-wide network to influence public opinion and policy makers and act to:

- mobilize other health and development professionals to approach political leaders of their country to urge them to make public commitments to reduce poverty and improve the health status of their populations,
- exchange and disseminate information on trends in health and poverty and on successful and failed interventions directed at tackling their causes and effects;
- recognize, enhance and harness the potential energy resource of poor people themselves;
- work for the direction of more health resources to the District level of their health care system;
- foster and coordinate intersectoral and interagency collaboration, especially at District level;
- work to eliminate the marginalization of population groups such as lonely elders, disabled people and refugees;
- ensure that front-line health workers have appropriate training and also the ability to access and use relevant information,
- influence public opinion by liaising with members of the national and international media;
- lobby governments to reduce their economic dependence on harmful activities, e.g. the production and promotion of arms and substances such as narcotics, drugs, nicotine and alcohol.

Lastly, AIM recognises the enormity of the task it has set itself, and invites all other Institutions and Associations of health professionals to join it and its members in this vital endeavour.

Fact Sheet

- The number of the least developed countries (LDCs) (the poorest of the poor) rose from 27 in 1975 to 48 in 1994.
- Approximately 1.5 billion people throughout the world live in poverty and 700 million of these live in extreme poverty. Their life expectancy is 50 years.
- In richer nations, the average life expectancy is 74 years. In developing coutnries it is 62 years.
- Infant mrtality is 60 per cent higher in poor countries than in dveeloped nations.
- Mothers in poor countries are 150 times more likely to die of complications of pregnancy and childbirth then women in rich countries.
- More than a billion people in dveeloping countries lack safe drinking water.
- Nearly two billion people lack access to safe sanitation.
- In developing countries, 17 million people die each year from infectious and parasitic diseases. Most of these deaths are linked with poor nutrition and an unsafe environment.
- Some 240 million people (about 30% of the total population) are under-nourished.
- In Brazil more than 200,000 children spend their lives on the streets.
- Even conservative estimates put the combined number of child prostitutes in Thailand, Sri Lanka and the Philippines at 500,000.
- In developing countries there are nearly 20 million internally displaced people.
- Worldwide there are over 19 million refugees.
- Around 15 mission people are believed to be HIV-positive, some 80% of them in developing countries.
- In industrialised countries on average there is 1 doctor for every 400 people. In Sib-Saharan Africa the figure is 1 per 36,000.
- One-fifth of humankind, mostly in industrialized countries, has well over four-fifths of the global income.
- In the European Union countries, 44 million people (some 28% of the total workforce) receive less than have the average income of their country.
- Over the past 20 years, the narcotics industry has grown from a small cottage enterprise to a highly organized multinational business employing hundreds of thousands of people and generating billions of dollars in profit.
- In the USA, consumer spending on narcotics is believed to exceed the combined GDPs of 80 developing countries.
- Across the world, there are an estimated 150 million unexploded landmines buried in unmarked locations.
- In Angola alone more than 20,000 people have lost limbs due to landmine explosions.
- The top five exporting countries which sell 80% of the weapons exported to developing countries are all permanent members of the UN Security Council.

Source: The Human Development Report 1995. UNDP. Oxford University Press.

Baltimore Charter: Partnership for a Healthy Urban Future

We, participants of the International Congress on Investment Strategies for Healthy Urban Communities at Baltimore, 15 to 17 September 1997, call for new efforts in all countries to ensure a healthy future for the urban communities of the 21st century.

We are gravely concerned that the economic and social viability of cities will be unsustainable without determined action to eliminate the health gaps which exist among the communities who live in them. These gaps result from misdirecting the benefits of economic growth by the failure to give due attention to the elimination of poverty and the fostering of human development and social cohesion. In many countries the situation is getting worse. Poverty and growing inequality are the greatest threats to health for all.

We are concerned about the health status of individuals and families. We will focus on improving family health and well-being, increasing immunization, diminishing infant mortality, decreasing the transmission of communicable diseases, creating a better environment with less poverty, less environmental degradation and resource depletion, and more security. We also seek a greater sense of personal and collective responsibility.

Inspired by the experiences shared at this Congress, we commit ourselves to **mobilize others who share our concern**. These include **national, regional, city and neighborhood leaders**; the **business community**; **universities** and the **health professions**, and **non-governmental organizations**. Above all, we commit ourselves to **ensure the fullest involvement of the most needy groups of our populations**.

Poor people need opportunities. Above all, people need opportunities which enable them to draw on their own creativity, energy and enthusiasm.

To this end, we propose a course of action which will draw together personal commitment, solidarity and cooperation in a **Partnership for a Healthy Future**.

We call on our **national, regional, city, and neighborhood leaders, from both public and private sectors, to contribute the political support**, strategies, and solutions needed to ensure balanced economic development which reduces poverty and enhances living standards for all people.

We call on **members of the business community to practice business policies which target poverty and health gaps** as barriers to lasting stability and prosperity. We urge them to **share their energy and know-how in creating enterprises to reduce poverty and ill-health**.

We call on **government and members of the medical and other health professions to promote universal access to health services**. Such services should consider the adverse effects of the social conditions of the poor.

We call on our **universities to research solutions and monitor progress in reducing the health inequities** which afflict our communities, taking full account of all major economic, social, cultural, environmental and political factors.

We call on **national and regional government to develop public policy** to ensure a healthy future for urban communities and to commit the necessary resources to carry out these policies.

We call on **non-governmental organizations to mobilize community support and resources to build partnerships** with the public and private sectors to improve the health of all people.

Building on the contacts which we have made at this Congress, we commit ourselves to **exchange information and experiences by networking between the partnerships** for a healthy future.

Finally, we call on the **World Health Organization to provide its encouragement and expertise** for our endeavors.

IPHNnews
INTERNATIONAL POVERTY AND HEALTH NETWORK
A newsletter prepared and distributed by WHO - Issue 2, March 1999

Turning the Tables on Poverty and Ill Health

WHO's Director-General recently spoke at a seminar on Public Health for a New Era at the King's Fund in London on 14 January. In her speech to the assembled planners, economists and public health specialists, Dr Brundtland said:

"There is solid evidence to prove that investing wisely in health will help the world take a giant leap out of poverty. We can drastically reduce the global burden of disease. If we manage, hundred of millions of people will be better able to fulfil their potential, enjoy their legitimate human rights and be driving forces in development. People would benefit. The economy would benefit. The environment would benefit. It is a complex process – but it can be done."

Dr Brundtland added that, although the world has long known that poverty breeds ill health, it was now clear that ill health also perpetuates poverty:

"Turning that around we end up with a simple, but vastly significant assertion: improved health is a key factor for human development and again, for the development of nations and for their economic growth", she said. It is well-known that the poor are the most exposed to the risks of a hazardous environment, and the least informed about threats to health. It is the poor who bear the brunt of crude structural adjustment policies and unregulated globalization, of epidemics of HIV/AIDS, malaria and tuberculosis.

"In the fight against poverty, we need to approach rich and poor countries alike", stressed Dr Brundtland, who added *"From being an unproductive consumer of public budgets, health is now gradually seen as a central element of productivity itself"*.

Our lack of interest in health as an economic concept is due to complacency, she suggested. This is *"promoted by powerful interests in health care technology, including within the health professions themselves....Health systems have become dumping ground for the consequences of inadequate policy"*. Dr Brundtland emphasised the need for improved policies on health which must encompass economics, politics, the environment and social issues.

The seminar was also addressed by Amartya Sen, winner of the 1998 Nobel Prize for Economics, Clare Short, UK Secretary of State for International Development, Tessa Jowell, UK Minister of State for Public health and Sir Donald Acheson, author of the UK's Independent Inquiry into Inequalities in Health.

A list of all Dr Brundtland's speeches is available on the Internet by accessing the following address: http://www.who.int/inf-dg/index.html#speeches

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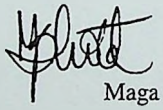
EDITORIAL

Bringing health to the core of development - the commitment made by Dr. Brundtland is close to the concerns of a small advisory group which met recently in Kenya to explore how the Network could highlight the role of health in poverty reduction and in sustainable human development. Ideas on this and on other issues related to poverty and health that were shared at the meeting are presented in this issue of our newsletter.

One of the strengths of the Network is the direct involvement of its members, at local or country level, in activities that promote health and contribute to reducing poverty. One of the aims of the Network is to build partnerships with communities. This means strengthening communities in their own efforts to address underlying causes of poverty, social exclusion and ill health. Such an approach to addressing poverty and ill-health focuses on *people* and in particular the poorest people in all countries.

In 1995, the World Summit for Social Development strongly endorsed this approach by calling for a people-centred sustainable development. Goals were developed from a peoples' perspective. Now, five years later we need to revisit the goals and assess how they have been implemented. We invite you to participate in that process and to share your experiences and insights so that the voices of those directly involved in efforts to reduce poverty and ill health are heard.



Maga Sköld
Editor

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The Social Summit - where are we?

The World Summit for Social Development, which took place in Copenhagen in 1995, was an important effort to focus world attention on social issues, particularly eradicating world poverty. It took place at a time when global and national politics were dominated by market liberalization and reducing the role of the state. Now, almost 5 years on, we must ask ourselves - Did it do any good? We think the short answer is Yes. But it will take time to undo the narrow preoccupation with economics, which had 15 years head start. The number of people living in extreme poverty continues to grow. Conflict, economic instability, and misgovernance, all continue to exact a heavy toll on health.

On the positive side, 107 countries now produce their own human development reports and many have initiated poverty eradication programmes. Financial commitment by international financing institutions and some governments is on the rise. The 20:20 initiative is gaining gradual commitment to its proposal that 20 % of external aid be used for basic social services, provided recipient countries spend 20% of their public budgets for the same purpose.

But we still have is a long way to go. Least developed countries, particularly in Sub Saharan Africa, are still marginalized. There is still a big gap between the international rhetoric and action on the ground; between the calls for sustainable development and poverty reduction to be integrated with policies for economic growth, and the reluctance to put the good intentions into practice.

In June 2000 a special 4 day session of the UN General Assembly will take place in Geneva to look at progress made since 1995, and to identify how to accelerate implementation of the commitments made at Copenhagen. Preparations for this are underway. The 37th Session of the Commission for Social Development was held in New York from 9-19 February 1999, focusing on Social Services for All. During this meeting, WHO called for a new initiative, which goes beyond social services, to put health at the centre of future development policy and practice. Yet we must admit that health professionals also contribute to the problem, with too many preoccupied by biomedical and technical approaches to disease, and not enough acknowledging their roles in fighting poverty. Until this changes, we risk being accused of hypocrisy in calling for others to do more for the health of the poor.

NGO Participation in Copenhagen+5

The Preparatory Committee (PrepCom), which will hold two substantive sessions, is making its work open to the participation of NGOs, including those in consultative or roster status with ECOSOC, those having already submitted an application to ECOSOC, as well as others accredited to the Social Summit or other major UN conferences and summits. Governments are being encouraged to include representatives of civil society in their national preparatory processes, as well as in their delegations to the PrepCom and the special session. Modalities and conditions for NGO participation in the special session will be considered at the meeting of the PrepCom in May 1999 (see enclosed NGLS Round-Up for further information).

Calendar of Follow-Up to Copenhagen +5

- 17-28 May 1999: 1st Preparatory Committee for Copenhagen +5 at UN/HQ New York
- February 2000: Commission for Social Development at UN/HQ New York
- 3-14 April 2000: Second Session of the PrepCom, at UN/HQ New York
- 26-30 June 2000: Special Session of the General Assembly on Copenhagen +5 at UN/Geneva

1995 World Summit for Social Development

In order to share information within the Network on activities being developed by members, we would like to hear from you on your involvement in the follow-up of the Social Summit.

1. Are you, or your institution, involved in any way in implementation of the Summit recommendations or in the follow-up activities to the Summit at local, national or international level?

2. At country level, what has been done so far to implement the recommendations of the Social Summit? How has health been used as an entry point to reach the broader goals of the Social Summit, such as poverty eradication and sustainable human development?

3. In your country, has the government included representatives from civil society in the national preparatory process or in the delegation to the Prep. Com and the Special Session?

4. Will your institution be represented at the Prep. Com which will take place from 17-28 May 1999? Have you prepared any position paper, statement, documents or reports for that meeting which you could share with the Network?

USEFUL CONTACTS

The **United Nations Nongovernmental Liaison Service (NGLS)** was created in 1975 with the aim of fostering and promoting greater understanding, dialogue and cooperation between the UN system and NGOs on development and related issues under review within the UN system. Initially, NGLS was seen as a system-wide initiative to strengthen cooperation with national and regional NGOs and NGO networks worldwide engaged in development information, education, and policy advocacy work. NGLS activities deal with the entire UN sustainable development agenda across all UN agencies, programmes, funds and departments concerned with economic social and humanitarian issues.

NGLS provides information, advice, guidance and support to NGOs wishing to be more involved in the UN system, and creates opportunities for dialogue, interaction and increased mutual understanding and cooperation. NGLS's mission statement says, "The Non-Governmental Liaison Service (NGLS) promotes dynamic partnership between the United Nations and non-governmental organisations. By providing information, advice, expertise and support services, NGLS is part of the UN's effort to strengthen dialogue and win public support for economic and social development". Other NGLS activities include:

- joint organization of meetings and other events with NGOs and UN offices;
- maintaining databases on the NGO and UN communities;
- publicizing important UN and NGO development activities, & publishing development information/ education materials, including the *Go Between* newsletter and *NGLS Roundup*, and information on UN events, conferences and other activities, e.g. follow-up to Copenhagen Social Summit;
- advice to NGOs on the work of the UN system and issues on the UN's agenda and how to engage in effective information and advocacy work;
- monitoring and participating in research, meetings and publications of various institutions on the changing roles of NGOs (both north and south), and their relations with governments and multilateral organizations.

NGLS publications and more information from:
Mr Tony Hill, Coordinator, UN-NGLS, Palais des Nations, CH-1211 Geneva 10, Switzerland
Tel: (41 22) 798 5850; Fax: (41 22) 788 736
Email: ngls@unctad.org

Meeting of the Advisory Group to the International Network on Poverty and Health

Since the idea of an International Network on Poverty and Health was discussed and agreed on at a meeting in London 1997, the Network has gradually gained momentum. During 1998 many new members joined the Network which today is made up of 200 individuals, organizations, business enterprises and community groups.

In order to consolidate the work of the Network, agree on key objectives and priorities, and strengthen participation in the network of people and organizations in the South, a meeting of a small advisory group was held in Nairobi and Kisumu, Kenya during November 23-26, 1998.

Statement of Purpose of the Network:

One of the important elements of the meeting and for the continuing development of the network was building consensus amongst the participants, of the Statement of Purpose of the Network. These were agreed on as follows:

- **What is the International Poverty and Health Network?**

  The IPHN is a world-wide network of people and organisations from health, business, NGOs, government and society-in-general who exchange experiences and share information on the most effective approaches and solutions for health in poverty eradication policies, strategies and actions.

- **Who is it for?**

  People and organisations that wish to influence policy and action to protect and improve the health of the world's poor, with particular emphasis on the poorest in all countries.

- **What is its aim?**

  To integrate health into poverty eradication policies and strategies, promoting community partnership and intersectoral action, as a means to achieve effective and sustainable results.

The meeting discussed the main links between poverty and health and explored some of the contributions health can make to poverty reduction.

Experiences presented at the meeting from both developed and developing countries pointed to the fact that poverty has many dimensions and cannot be viewed from an economic perspective alone. Stronger emphasis and consideration needs to be given to the reality of poor people as experienced and expressed by themselves, and to the analysis of root causes and factors that influence or determine poverty.

Discussions evolved around issues such as the geographic dimension to poverty which is reflected in variations in poverty rates across regions within the same country; the seasonal variations in poverty, a consequence of the inter-seasonal variations in the production of food crops leading to periods of want and "seasons of hunger"; the link between environmental degradation, ill-health and poverty; and the macro dimensions to poverty including economic and political governance.

The question of governance also led to discussions on forms of participation and on the importance of community involvement in political and economic developments and of strengthening the capabilities of civil society.

There was a broad consensus at the meeting that a participatory approach to poverty reduction and community development is desirable both on ethical and operational grounds. This means listening to how local people themselves identify the poorest members, and involving them in the development of strategies or policies to address poverty. Partnership building between government, civil society, the business community, the poor themselves, NGOs and health professionals was emphasised as the only way to ensure political commitment to poverty reduction at a local, national and international level.

The meeting emphasized the need for adopting a balanced approach to poverty reduction that addresses both the macro level issues of economic growth and poverty reduction, and the specific health needs of the poorest and most vulnerable people.

During the business session of the meeting, participants identified the stakeholders of the Network and explored its strengths, weaknesses, threats and opportunities. In light of these discussions and of the discussions related to poverty and ill health, the meeting decided on the following areas of priority for the Network:

1. Mobilising Stakeholders

The aim of mobilising all stakeholders is to ensure commitment by local, national and international sectors, business, health professionals, politicians and researchers etc to poverty reduction and improvement of health of the poorest populations; and to ensure co-operation between the different sectors to achieve results in priority areas. This would be done by:

- Developing a clear rationale for business involvement in poverty and health
- Involving new actors and identifying and involving stakeholders at local levels
- Developing country specific plans and mobilising key stakeholders
- Disseminating information and experiences.
- Writing a joint letter on behalf of the Network, to all the world's health professional associations (and medical journals) to join and share the mission.

2. Involvement in Copenhagen Plus 5 Summit Meeting

The aim of focusing on the Copenhagen plus 5 meeting is to engage the network in national and international events and to bring health to the agenda of poverty reduction strategies. This will be done by:

- Sharing information on what is already been undertaken by network members and on developments leading up to the Special Session at the UN Assembly
- Disseminating information on the main outcomes of the 7 Summits
- Consulting national governments on the implementation of Summit agreements
- Participating through the secretariat (WHO) at the Prep. Coms of the Copenhagen plus 5 process and keeping members informed about developments.
- Becoming involved and influencing the agenda at national level

3. Information, Research and Capacity-building

The meeting recognised the need and importance of collating, exchanging and disseminating information regarding heath in poverty reduction in order to strengthen local and national and international capacities. This would be done through:

- Promoting evidence based research and community involvement in research
- Collecting research results, experiences, methodologies and best practices relating to poverty and health
- Exchanging and disseminating information through newsletters, the Internet, existing networks, publications, national, regional and international summits and conferences, journals, political arenas, the media etc.
- Storing and retrieving information experiences by creating a data base and the publishing a catalogue
- Building capacity among health professionals and people of other disciplines working with communities in management and governance, research skills and advocacy methodologies
- Producing workable community based models of addressing poverty and health currently developed by Network members.

4. Strengthening the Network Development

Efforts will be made to strengthen and expand the network through the following:

- Communication and exchange of information
- Creating a central web site for the Network with useful links
- Identifying and Mobilising the Network Resources
- Creating /linking up with networks at a national and international level

The full report of the Kisumu Meeting will be distributed to all Network members.

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Name the Network

The meeting in Kisumu was keen to come up with a catchy acronym for the International Poverty and Health Network - the general feeling was that "IPHN" didn't translate well into Spanish and French, and was therefore too clumsy to be catchy.

After many failed attempts, we were none the wiser, and decided to ask you, the members of the Network, to help! What do you suggest ?? Suggestions for both the name and the logo for the Network will be welcomed!

The next newsletter will present a selection of the proposals we receive and a small international group of members will be asked to make the final decision. So, it's over to you!

HSD News

We are delighted to inform you that our department, Health in Sustainable Development, has a new director. From Sweden, Mrs Eva Wallstam will be joining us on 6 April, and on behalf of the Network we would like to extend a warm welcome to her. During a short visit to Geneva last week, we asked her to write few lines to the Network:

"As new director of the Department of Health in Sustainable Development I am very pleased to convey my greetings to the IPHN members. Coming from Sida, the Swedish Development Cooperation Agency, where I have been the Head of the Health Division, and from a country, Sweden, where poverty alleviation and issues concerning economic and social equality figure high on the agenda, I have a strong personal commitment in these matters.

Clearly, poverty is at the root of ill-health and suffering. Our challenge at WHO will be to define our role in relation to governments, civil society and other organizations in order to maximize our contribution through global advocacy, intersectoral action, partnerships and involvement in work at the country level. I intend to try and contribute to raising WHO's profile in this area and I am looking forward to meeting and working together with you and your organizations as members of the IPHN."

Eva Wallstam

Further information on follow-up to the Copenhagen Social Summit can be obtained by accessing: http://www.un.org/esa/socdev/wssd.htm

EDUCATIONAL RESOURCES FROM THE WELLCOME TRUST/ CAB INTERNATIONAL

A new CD-ROM interactive training programme to tackle global diseases has been published by the Wellcome Trust and CAB International (CABI), entitled *Topics in International Health* (TIH). This innovative health training tool was launched in April 1998 and is aimed at medical students, healthcare professionals, researchers and academics in both developed and developing countries.

The package currently contains 8 CDs, each focusing on a disease or group of diseases - Leprosy, Malaria, Tuberculosis, Trachoma, Diarrhoeal Diseases, Sickle Cell Disease, Schistosomiasis and Sexually Transmitted Diseases. Discs on AIDS/HIV, Nutrition and Leishmaniasis will be published in 1999.

The CDs focus on training the user in the epidemiology, diagnosis and treatment of disease, and offer access to a vast amount of information through a series of interactive tutorials, an extensive collection of images and a comprehensive glossary of medical and scientific terms. The package is highly visual, fun to use, and extremely accessible, even to those with little experience of computers.

Each disc costs £95 for developed country institutions, (discounts on purchases of 4+ titles), and considerably lower prices for individuals and for those in developing countries.

Further information from Liz Woolley
Project Officer, Information for Development Programme, CAB International (CABI)
Wallingford, Oxon OX10 8DE, United Kingdom
Tel: 44 1491 832111 x2350; Fax: 44 1491 833508
mail:l.woolley@cabi.org; Website: http://www.cabi.org

I would like to become an active member of the International Poverty and Health Network

Name:.....My particular areas of interest:.....
Organization.....
Address:.....
.....
What I/my organization can contribute to the Network.....
.....
.....
Tel.....Fax.....Email.....

Please return the completed slip to the IPHN Secretariat at the address given on page 2 of this newsletter

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IPHNnews
INTERNATIONAL POVERTY AND HEALTH NETWORK
A newsletter prepared and distributed by WHO - Issue 3, July 1999

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New developments at WHO's Department of Health in Sustainable Development (HSD)

In the last issue of *IPHNnews* we were pleased to welcome our new Director, Eva Wallstam, to HSD. As many of you may already be aware, HSD is a new department in WHO, created as a result of the restructuring process at WHO that has taken place under the leadership of Dr. Gro Harlem Brundtland. As such, HSD also has a new mandate. As the title suggests, HSD believes that health cannot be considered solely as a health care issue, but must be seen as a significant part of a broader development agenda. In that perspective, health and development have a reciprocal effect - health is a determinant as well as a result of development. The mission of HSD is to catalyze action, globally and in countries, to integrate health into human development and poverty reduction policies and practices. In practice the work of HSD will be developed around three interlinked objectives :

- **Integrating health into development, involving other sectors and focusing on poor and marginalized populations.** For HSD this means identifying *how* best health contributes or could contribute to development, exploring and sharing best practices and experiences of intersectoral action, and contributing towards the development of integrated policies which benefit poor and vulnerable populations.

- **Focusing on international trade, finance and governance to address the effects of globalization equity and health.** The nature of globalization today is reinforcing familiar as well as creating new inequities within and across countries. HSD will focus on the economic (international trade and finance) and political (effective global governance) spheres of globalization and its impact on health. To support the development of WHO policy in this complex area, HSD co-ordinates a WHO- wide technical working group on Globalization, Trade and Health.

- **Promoting pro-poor health policies and practices.** Despite some development advances, the numbers of poor world-wide continue to increase; adequate access to health care and services are at risk. Although all WHO clusters contribute in varying ways to health sector development, HSD will play a catalytic role in developing and advocating pro-poor approaches within health. Learning from others will be an important part of this work, especially from the experiences of NGOs, local communities, indigenous populations and other groups in civil society.

Work is already underway and more is planned in the above areas including studies and research, an international consultation on health of indigenous populations, participation in the Copenhagen plus 5 process, national meetings to strengthen country networks, support of intersectoral initiatives at

country level such as health promotion and school health insurance in Vietnam, agriculture policy and human health, community based health development in Rwanda, and animal and human health in Mongolia.

In the next issue of *IPHNnews*, we hope to be able to share an update on exciting developments within WHO as a whole with regards to health, equity and poverty reduction. Having firmly committed itself to the *International Development Goal* of reducing poverty by half by the year 2015, WHO is in the process of conceptualizing and defining its own role in poverty reduction at all levels, global, regional and country.

Several important decisions have already been made within WHO which will support this process. One is that WHO will establish a high-level advisory committee on Health, Equity and Poverty Reduction, representative of the major development actors: governments of Least Developed Countries, civil society organizations, development assistance agencies, NGOs, and the private sector. Amongst other tasks, the committee will contribute towards the development of a WHO Policy and Strategy on Health, Equity and Poverty Reduction. HSD, in consultation with other clusters, is currently developing a proposal for the way forward for WHO in this new initiative. The process will involve broad consultation within and outside WHO and we look forward to involving IPHN Network members also in this development and to benefiting from your expertise and experience.

Contact us:

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Editorial

In a recent issue of "***To Our Health***" the internal newsletter of WHO, one of the main headlines was the following: **Health as Development: How do we do it**? What followed were more questions that have been spurred by recent commitments WHO has made to poverty reduction:

- How does a world-wide health agency fight poverty? Does it mean a total change in its purpose and actions, or merely a change of priorities?
- Will the Organization become more political?
- Will it mean the end of WHO as a technical agency?
- How can we influence country policies when we don't lend money?
- And who should be charting this new territory?

These challenging questions, a healthy reaction to the change process which is going on in WHO will, of course, need to be given consideration, by WHO, by Member States, and by partners with whom we collaborate. The process of searching for responses to these and other crucial questions related to health and poverty reduction has started through consultative processes and mechanisms.

For example, the department on Health in Sustainable Development has been created. It has a mandate to play a catalytic and collaborative role in developing pro-poor health policies and practices; a WHO Advisory Committee on Health, Equity and Poverty reduction will be set up shortly ; WHO will develop an overall policy on Health Equity and Poverty Reduction.

Many more activities will come. The most important and encouraging step has already been taken - the political commitment has been made to integrate poverty reduction as a major concern for the whole organization. We are delighted to be able to share some of the most recent developments with you in this issue of IPHN news, but we are also keen to receive *your* ideas, responses and input so please do keep us updated!

Margareta Sköld
Editor

Bangladesh Workshop:

How can we best meet the health needs of the poorest and most vulnerable?

This and other relevant questions were at the focus of attention of participants attending a workshop held recently 11-13 April, in Dhaka, Bangladesh. In an attempt to identify viable approaches and strategies for protecting the health of the poor, participants exchanged experiences, explored issues related to poverty and ill-health and agreed to continue to network after the meeting.

The meeting, jointly organized by WHO and the Bangladesh Institute of Development Studies (BIDS), was attended by representatives from national groups, civil society, institutions, ministries and nongovernmental organizations (NGOs) involved in activities aimed at improving health and well being of the poor and most vulnerable populations.

During the course of the meeting, many problems were identified but suggestions were also made of possible ways to address the problems. There was full agreement among participants that one of the conditions for reaching the poorest people is that concern for their health and well being is highlighted in national health policies. In Bangladesh, a five year health strategy includes a strong pro-poor agenda and discussions focused on successes and shortcomings in the implementation of this agenda.

The meeting recognized the important role of civil society and notably NGOs, in public monitoring and assessment of health policy implementation. In order to strengthen people's participation in health matters, NGOs could make sure they disseminate information and keep people and local communities aware of developments in national policy. This could also increase possibilities for poor people to become involved in national health policy making.

A pro-poor national health policy should respond to the needs of the poorest and it is at local, community level that these needs are most felt. The community itself is therefore best placed to identify these needs and to collaborate with local health authorities in developing appropriate responses.

The workshop stressed however, that improvement of health cannot be seen as a responsibility only of health services or the Health Ministry. Collaboration across sectors must be sought and promoted. Other issues elaborated by the workshop included the need for health professionals to develop a deeper understanding of the links between health and poverty reduction; the importance of recognizing and developing traditional or/and local ways of healing which include Unani, Homeopathy, Ayurveda; and the importance of working with the media, professional associations and other national and international networks to advocate the above issues and to sensitize health professionals, policy makers and planners to them.

One proposal which gained support of many participants was to set up a *National Health and Poverty Network* that would interact with IPHN. BIDS, the local host of the workshop was asked to take the lead in setting up the Network. IPHN news welcomes this initiative and looks forward to hearing more about the Network activities from its members in Bangladesh.

For a copy of the full report please contact:

Department of Health in Sustainable Development
World Health Organization, 20 Avenue Appia
CH-1211 Geneva 27
Switzerland
Tel: (41 22) 7912903/2709 ; Fax: (41 22) 791 4153

Follow-up to Kisumu meeting

At the IPHN advisory group meeting held in Kisumu in November last year, it was agreed that a letter should be written on behalf of the Network, to major professional associations and medical journals around the world, inviting them to join network and to share its goals.

The letter is currently being drafted by members of the Intercollegiate Forum on Poverty and Health in the United Kingdom, and IPHN members will receive it shortly for comments and feedback. Please look out for it in the mail so that it really can become a Network initiative.

Name the Network

In the last issue of *IPHNnews*, we asked you to suggest a new, catchy acronym and a logo for the Network. So far, we have received only two proposals!

Please send your suggestions to us and we'll include them in the next issue for voting. We are counting on you!

NETWORK FACTFILE

1. Teaching-aids At Low-Cost (TALC)

Over the years, TALC has made a particular effort to supply material for those providing health care to the less well off in developing countries. TALC distributes copies of *Where There is No Doctor*, which is the most widely used book by community health workers. It also distributes the *Strategies for Hope* booklets concerned with those tackling AIDS, and *Child to Child* material, a programme which emphasizes how children can play a part in improving not only their own, but also family and community health.

TALC can be contacted at:

Teaching-aids At Low Cost (TALC)
P.O. Box 49
St Albans
Herts AL1 5TX
United Kingdom
Tel: (44 1727) 853 869; Fax: (44 1727) 846 852
Email: talcuk@btinternet.com

2. Community Health Cell, Bangalore

The Community Health Cell grew out of a study-reflection-action project begun in Bangalore in 1984, initially supported by the Centre for Non-Formal and Continuing Education, Bangalore. In June 1990, the Society for Community Health Awareness, Research and Action (SOCHARA) was established, with CHC as its functional unit.

Aims and Objectives

- To create awareness in the principles and practice of Community Health among those interested and/or involved in health and related sectors
- To research Community Health Policy issues, including:
  - community health care strategies
  - health human power training strategies
  - integration of medical/health systems
- To evolve educational strategies to enhance knowledge, skills and attitudes of people involved in community health and development
- To enable the formulation and implementation of community-oriented health policies through dialogue with health planners, decision-makers and administrators
- To promote/support community health action through voluntary/governmental initiatives
- To establish a library and documentation centre in Community Health

CHC has developed a diverse interaction among individuals; coordinating agencies; issue-raising health groups; development projects, networks and training centres; government agencies and ministries; national and international agencies. CHC seeks collaboration with anyone involved in Community Health.

CHC is the joint organizer of the November meeting "South East Asian Dialogue on Poverty and Health", which will take place in Bangalore from 15-18 November 1999.

Further information from:

Dr Ravi or Thelma Narayan, Coordinators
CHC Bangalore
No 367 "Srinivasa Nilaya"
Jakkasandra I Main, I Block
Koramangala, Bangalore 560 034, India

Tel: (91 80) 552 5372; Fax: (91 80) 553 3358
Email: sochara@vsnl.com

Forthcoming Events

1. African Community Action Network for Health (**Afri-CAN**) Think-Tank on **Mobilizing all for Health and Development**, Harare, Zimbabwe 18-22 October 1999

The 1999 Afri-CAN Think-Tank will facilitate:

- sharing models of best practices in health and development
- learning from each other through exchanging experiences and discussion on emerging issues faced by health workers
- a coordinated voice to influence policy at local, national and international levels
- pooling of ideas to engender collective action.

The Think-Tank is for all those who have an interest and an active involvement in health and development issues, and who want to influence health and development action in a positive way. Invited participants include health and development workers, managers from the public and private sectors and of church-related programmes, policy makers, academic institutions and community members.

The purpose is to bring together people actively engaged in health and development to share their experiences on related community-based health initiatives within the region. It also provides a forum to help those in strategic positions at community, local, national and global levels to shape and influence policy.

The Think-Tank will be organized around thematic sessions, chaired by two co-moderators (anglophone and francophone), which allows active participation by all. Working groups will also meet to discuss specific areas of interest, and these will be flexible so that individuals my join their preferred group.

Further information (including on cost) from:

Dr Dan Kaseje,
Chairman Afri-CAN
P.O. Box 30690, Nairobi, Kenya
Tel: (254 2) 441920/ 445020/445160
Fax: (254 2) 440306

2. The People's Health Assembly

The world is currently facing a global health crisis, characterized by growing inequities within and between countries. Despite medical advances and increasing average life expectancy, there is evidence of rising disparities in health status among people worldwide. The many facets of poverty, the HIV/AIDS epidemic, and other related problems are contributing to reversals in previous health gains, and this is associated with widening gaps in income and shrinking access to social services, as well as to persistent racial and gender imbalances.

The People's Health Assembly (PHA) is a new initiative which seeks to involve as many people as possible in their own health agenda and setting their own priorities. The initiative is being coordinated by several organizations, both within and external to the international agencies - the Asian Community Health Action Network, Consumers International, the Dag Hammarskjöld Foundation, Gonoshasthaya Kendra, Health Action International, International People's Health Council, and the Third World Network.

Despite an abundance of rhetoric, governments and international organizations have largely failed to achieve their oft-stated goal of health for all, and equitable access to health care. To try and improve the situation, the PHA will be organized in 2000 by a group of concerned organizations and networks to analyse and assess the knowledge and experiences from around the world, to identify the main problems, trends and challenges, and ultimately to develop strategies to combat these and bring us closer to achieving the goal of health for all.

The overall goal of the PHA is to re-establish health and equitable development as top priorities in local, national and international policy-making. It will strive to achieve this through:

- Hearing the Unheard
- Reinforcing the principle of health as a broad cross-cutting issue
- Developing cooperation between concerned actors in the health field
- Formulating a People's Health Charter
- Improving the communication between concerned groups and institutions
- Sharing and increasing knowledge, skills, motivation and advocacy for change

The People's Health Assembly event will be held from 4-8 December 2000, near Dhaka in Bangladesh. About 600 participants are expected, and activities will include keynote addresses, analytical presentations, sharing of experiences on health practices and concerns, workshops, debates, exhibitions, and cultural and audio-visual presentations. The event promises to be exciting, vibrant and inspiring, and follow-up will include the dissemination and promotion of the People's Health Charter; coordinated advocacy and lobbying at the local, national and international levels; and publication of materials related to the PHA.

For more information, contact:

Janet Maychin, PHA Secretariat
Consumers International Regional Office for Asia and the Pacific (CI ROAP)
250-A Jalan Air Itam
10460 Penang, Malaysia
Tel: (604) 229 1396; Fax: (604) 228 6506
email: phasec@pha2000.org

or visit PHA's website on: http://www.pha2000.org

GUEST SPOT

Copenhagen Plus Five: Health and Business

The three pillars of development are health, nutrition and education, and if one of these three is lacking, there is little hope of realising economic development and social progress. All three elements are pre-requisites for the creation of wealth and the business community is becoming more and more aware of the role it can play in the development of these domains.

Concerning health, three important elements are the prevention of illness, working conditions, and the quality of the products and services produced.

Business leaders must make sure that all possible measures are taken - vaccination, hygiene, housing, environment - to offer their employees and their families the best possible guarantee of good health: in a business, it is the human capital which is the most important. Modern working conditions must optimise the quality of light, air, and temperature, and reduce noise, to create the best possible environment for the workers. Measures of security related to equipment and procedures must be rigourously studied and applied. The considerable amount of pollution produced by certain factories must be reduced, even if this is not yet fully imposed by law.

Business has a considerable responsibility in assuring the quality of its products, not only in the food and pharmaceutical industries which have experienced several disasters, but also for the numerous products produced for mass consumption. This is becoming more and more apparent to large companies, and existing regulations are being standardized on an international level The task of sensitizing smaller businesses, and those in countries which do not yet have these laws to this responsibility is immense and international cooperation can help in accomplishing it. Exchanges of experience and know-how can considerably reduce time and costs.

At the UN Social Summit in Copenhagen in 1995, specific commitments were made by national and international public authorities, as well as by industry. These, in particular, concern the promotion of codes of good conduct, which fortunately are becoming the norm, despite ignorance, neglect and irresponsible behaviour.

Maximizing profit in the short-term is too narrow an objective to respond to the legitimate social aspirations of our time. On the other hand, economic activities have more of a chance of being sustainable when the inherent problems are understood and dealt with in a spirit of cooperation - from the factory floor right up to company management level.

The same values deserve to be expressed and underlined once again when we look at the evolution of thinking and action over the past five years at the meeting of the Forum Geneva 2000, and at the United Nations General Assembly Special Session on the Copenhagen Social Summit which is scheduled for the end of June 2000.

by Olivier Giscard d'Estaing, Chairman,
Business Council for the UN Social Summit
(BUSCO)

Gender, Health and Poverty

Fifty years after the WHO Constitution was first formulated, we now know that factors determining health are not the same for men and women, who play different roles in differing social contexts. These roles are valued differently, and usually more highly for men. This affects the degree to which women and men have access to, and control over, the resources and decision-making needed to protect their health. It also results in inequitable patterns of health status and use of health services.

There has been a growing recognition world-wide, including within the United Nations system, that equality between women and men is necessary for health and sustainable development.

This recognition has been demonstrated through the agreements reached at all the major international development conferences of this decade. The method chosen by the international community for working towards this goal of greater equality is gender mainstreaming.

In 1997, the Secretary-General of the United Nations formally requested the UN organizations and specialized agencies to incorporate gender mainstreaming into all their policies and programmes.

To be successful, any mandate focusing on poor and marginalized populations, and pro-poor health policies and practices, must include a gender perspective. HSD has therefore committed itself to adopting gender perspectives and gender analysis in all its work. What does this mean in practice?

The fundamental cause of poverty and deprivation is the same - vulnerability through lack of control over assets and entitlements. To work within a sustainable development framework, it is essential to have a clear understanding of the forces which create, sustain, or reverse poverty for different population groups, how poverty (and relative poverty) is experienced in different ways according to class, gender, and ethnicity, and how these experiences are reflected, both directly and indirectly, in health status and outcomes.

Definitions of gender and gender analysis:

"Gender" is the term used to describe those characteristics of women and men which are socially constructed, in contrast to those which are biologically determined. People are born male or female but learn how to be girls and boys, men and women. This learned behaviour makes up gender identity and determines gender roles.

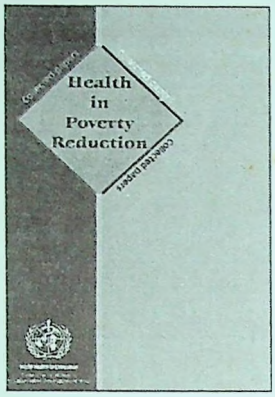
Gender analysis identifies, analyses and informs action to address inequalities that arise from the different roles of women and men or the unequal power relationships between them, and the consequences of these inequalities on their lives, their health, and their wellbeing. Power distribution in most societies leaves women with limited access to and control over resources to protect their health, and with less involvement in decision-making. Gender roles for men, on the other hand, may expose them more to risk-taking behaviour or may condition them not to seek medical help when sick. Gender analysis in health therefore highlights how inequalities of various kinds may be detrimental to the health of both women and men, examines the constraints involved, and identifies ways of addressing and overcoming these constraints.

It has been increasingly accepted in recent years that in many societies, being female is a particular precondition for deprivation and reduced access to resources or entitlements. In addition to issues of lesser education, status, and earning power, there are less obvious causes such as restrictive social norms or family responsibilities. In brief, among all categories of poor and disadvantaged, women tend to have fewer choices, options, and room for manoeuvre often due to restrictions imposed as a result of gendered perceptions of their capabilities/responsibilities - restrictions which are culturally derived but politically sanctioned through inadequate or inequitable policy and legislation.

HSD's gender approach, therefore, will recognize the particular disadvantages accruing to women while seeking a broader and more accurate knowledge-base about the social and economic determinants of health for both men and women. It will advocate, recommend and promote policies and strategies at international, national and local level to alleviate and adjust inequity or inequality for both sexes. *Jackie Sims*

New HSD Publications

HSD issues Poverty Compendium



The Department of Health in Sustainable Development, which houses the Secretariat of the Network, has just issued a compendium of documents entitled *"Health in Poverty Reduction: Collected papers"*. This compendium represents a wealth of information and research on poverty and poverty reduction, separated into three main sections:

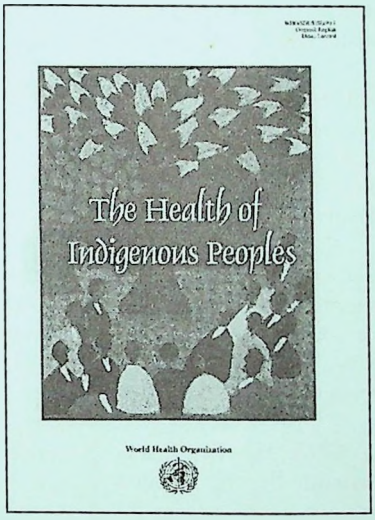
i) Links between poverty and health: analytical frameworks and empirical results
ii) Identifying and targeting the poor
iii) Policy perspectives

Included in this important document are papers by Binayak Sen, Godfrey Gunatilleke, Guy Carrin, Debra Lipson and Margareta Sköld.

The prevailing international climate, at the mid-point of the United Nations International Decade for Indigenous Peoples, is seen as an opportunity to capitalize, in favour of health, on such initiatives as the establishment of a permanent forum in the UN for indigenous peoples , as well as the adoption of a draft universal declaration.

As part of its contribution to the UN Decade, WHO has established an Indigenous Peoples focal unit in HSD, which has already brought about the publication of "Health of Indigenous Peoples", a document written by Ethel (Wara) Alderete, with contributions from WHO and AMRO/PAHO personnel, and the UN Working Group on Indigenous Affairs (IWGIA).

It is available free of charge from Paolo Hartmann at WHO/HSD. (reference WHO/SDE/HSD/99.1)



I would like to become an active member of the International Poverty and Health Network

Name:.....My particular areas of interest:.....
Organization.....
Address:.....
What I/my organization can contribute to the Network.....
.....
Tel.....Fax.....Email.....

Please return the completed slip to the IPHN Secretariat at the address given on page 2 of this newsletter

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IPHNnews

INTERNATIONAL POVERTY AND HEALTH NETWORK

A newsletter prepared and distributed by WHO

Message to members of the International Poverty and Health Network from Mrs Poonam Khetrapal Singh, Executive Director of the Cluster on Sustainable Development and Healthy Environments (SDE) at WHO Geneva.

It is with great pleasure that I write a few words in this first issue of IPHN news to share with you some of the recent developments at WHO. Above all, I am delighted to establish contact through the newsletter to such a broad group of committed individuals and organizations in many parts of the world engaged in improving the health and wellbeing of poor people.

As you may be aware, the World Health Organization has undertaken a major restructuring. It has involved grouping programmes into nine clusters to provide more focus and cohesion to the work of the organization. The cluster which I head, Sustainable Development and Healthy Environments, will work to ensure that health aspects of sustainable development and poverty reduction are properly addressed in formulating and implementing public policies, strategies and programmes at global, regional, national and local levels.

In her most recent speech to WHO staff, Dr Brundtland stressed that the cluster will place a special focus on "supporting countries in promoting policies which can address poverty as a major cause and consequence of ill-health".

You all know the immense challenges before us at global, national and local levels. The vicious circle of poverty, food insecurity, environmental degradation and ill-health can only be broken by concerted intersectoral initiatives aimed at placing health at the centre of sustainable development.

While the main responsibility for poverty reduction remains with each government, the role of civil society at a national and global level is becoming increasingly important. In recognizing the contribution which NGOs, community groups, health professional associations and the private sector make to poverty reduction, the Sustainable Development and Healthy Environment cluster will work in a variety of sectors with a wide range of partners. The expertise, experience and mobilizing force which you bring, as individuals and as members of the International Poverty and Health Network make the network a crucial partner in our work.

With the words of our Director General, Dr Brundtland I would like to stress the values which will underpin our work:

"When forging a vision for health and human development into a new century we need to apply a broad perspective. Democracy, peace and human rights create the conditions for renewed strategies towards human development and a lasting combat against poverty and ill-health. It is within this same framework that we must strive for the full utilization of our scientific advances."

I look forward to collaborating with the Network on issues of common concern and I assure you of my full support.

Poonam Khetrapal Singh

CONTENTS

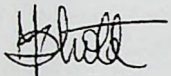
Editorial

We would like to welcome you to this, the first issue of our newsletter IPHN news.

The newsletter is intended to be a forum for the exchange of news and reports of activities related to the Network and its members. As such, we will need your input. Please share with other members what you are doing, experiences of sustainable initiatives to improve the health of people living in poverty, or strategies for dealing with poverty and health which have worked. Tell us about conferences or exciting events which will take place. Challenge us all with new ideas, shake us up with proposals for action and let us have your views - let's get a debate going!

The format and content of the newsletter will evolve as we go along and you let us know what may be useful to include. We want to give members a chance to present themselves. Each issue of the IPHN news will therefore contain our "Network Factfile" - giving information on a member institution to enable us to get to know each other better. A "country focus " or a specific experience from a country will give information on activities in the world's poorest countries, and letters from members will stimulate our thinking!

Welcome to YOUR Newsletter!



Margareta Skold
Editor

IPHN Advisory Group to meet in Kisumu, Kenya, from 23-26 November 1998

Background
With Dr Brundtland's arrival, it is clear that poverty reduction will be given stronger emphasis in the development of future activities of the WHO.

Her commitment is well expressed in the speech she made to the World Health Assembly in May where she stressed that "*We must speak out for health in development, bringing health to the core of the development agenda. That is where it belongs, as the key to poverty reduction and development underpinned by the values of equity, human dignity and human rights*".

The network is well placed to respond to this challenge and ICO is organizing a meeting of an advisory group made up of a few members from all regions, to explore possible concrete contributions of the Network to the process. The meeting will take place from 23-26 November in Kisumu, Kenya.

The aims of the meeting are:

1. to see, hear and learn from people living in deprived situations, and in particular to understand their ways of coping with poverty;
2. to agree of key goals, strategies and an action plan for 1999;
3. to explore the developing relationship of the Network with the restructured WHO; and
4. to see how the IPHN can increase the participation of members from the South and be more responsive to the issues that concern the South.

* *

The report of the meeting, which will also be the basis for future Network activities, will be distributed to all Network members.

* *

What is the IPHN ?

The International Network on Poverty and Health (IPHN) was created at a meeting on Poverty and Health in London in December 1997. The *broad objective of the Network* is **to advocate for health as a force for reducing poverty and improving human development**, through a wide coalition of health and educational NGOs, international organizations, governments, and health and developments workers. It aims to do this by addressing the issues of increasing inequities between countries and the widening gap between rich and poor within countries.

The *aims* of the network are: to contribute to the public debate on poverty and health and to provide collective support to political commitments to reduce poverty and improve the health status of populations; to recognize, enhance and facilitate the realization of poor peoples' potentials, enabling them to address the causes of the problems of poverty and to transform situations which prevent the attainment of health in its fullness; and through its members, to enable health professionals and the health sector to play an effective role in poverty reduction.

Current activities by members include: participatory analyses on the socio economic determinants of ill health in several African countries and in India, with community strategies being developed in response to the situation; a contribution to the Independent Inquiry on inequalities in health by the Intercollegiate Forum on Poverty and Health in the U.K: Conferences are also being planned in the Philippines on the role of health professionals in poverty reduction, and in the U.K. on health of adolescents living in poverty. We are pleased to inform you that an increasing number of people are expressing interest in, and joining, the network.

Letters from Network members

Drs. Ravi and Thelma Narayan, Society for Community Health Awareness, Research and Action, Bangalore, India have sent the following message to Network members:

"Dear friends of the IPHN,

Recently, all the members of the Poverty and Health Network received a letter from us via the IPHN secretariat informing them about the commitment made by Dr. Gro Harlem Brundtland, the new DG elect, in her recent speeches at WHO - "to fighting poverty as a key threat to people's health". The network members were invited to offer insights and suggestions on how WHO could tackle the global, national and local determinants of poverty. Three questions were asked in the letter to help focus the response of the members.

The responses that have come from Australia, Bangladesh, Belgium, Finland, France, Germany, Ireland, Philippines, USA and the UK have been very varied and thought provoking. They reflect the perspectives of people and organisations, who are concerned with the needs of the poor. We have integrated and summarised the responses so that a charter of ideas and action initiatives begins to emerge. Further responses will add to this so please let us have your ideas if you have not already answered. Please feel free to take any of the below ideas further or even disagree - in that way we will develop our ideas collectively.

Greetings from Ravi and Thelma"

Summary of responses from members

A. At Global Level

1. Core Agenda: WHO should make Poverty and Health interactions a core theme of their global health agenda - it subsumes not only health development but also the need to target poor and marginalized subgroups.
2. Articulate Key Concerns: WHO's role in efforts to reduce poverty can never be sufficient in terms of channelling of resources, but it has got has substantial capacities to be articulate and lobby globally with good evidence based arguments with respect to:
   - Health implications of economic policies
   - Resource allocations needed for health at national level
   - Implications of debt on health and health systems
   - Importance of social equity to health
   - Raising health issues in trade and investment negotiations
   - Raising the importance of capacities to stay healthy
   - Health, education and well-being of women and mothers
3. WHO should renew commitment to Health For All and Primary Health Care
4. WHO should develop country and policy analysis at national and international level
5. WHO should work with and/ or challenge other international institutions, NGOs and the private sector

Some specific suggestions include:

- A Peoples' Hearing on Poverty and Health at the Assembly
- Supporting innovative pilot/demonstrations project aimed at poverty reduction
- Exploring how to monitor the impact of transnational influences on countries

B. At National Level

WHO should provide an ethical challenge to people in government to address the conditions that contribute to poverty and help policy makers address the problems through intersectoral collaboration also involving grassroots.

C. WHO and Members of the Network

1. WHO and Network members should share information and sound advise on health promotion in poverty stricken countries including examples of successful initiatives and expertise on sustainable actions for health.
2. WHO should provide support for small scale pilot projects to alleviate poverty and improve health of the poor .
3. Network members who have field research capacities and universities should be commissioned to develop research projects suitable for inter-departmental/multi-disciplinary research (eg. Community Health, Economics, Development).
4. Network members should play an active role in developing the above ideas and suggestions

GUEST SPOT

Access to Health Care in the United States:

What is the Profession's Responsibility?

What is professional responsibility? This question is asked increasingly in the United States by physicians and medical organizations as we confront the unconscionable reality that 41 million Americans have no health insurance, and that an additional 30-35 million Americans are underinsured. The uninsured comprise urban and rural poor and an increasing number of working people. The maddening paradox is that the United States is experiencing one of its greatest periods of economic growth in history.

Since the end of the health care reform debate in 1994, almost 5 million more people have become uninsured. Indications are that those numbers will continue to grow at the rate of almost 1 million each year. If that trend continues, the number of people without health insurance will approach 47 million by the year 2005.

In September 1997, the American College of Physicians (ACP)-American Society of Internal Medicine (ASIM) and the American Board of Internal Medicine (ABIM) convened a 12-member task force to identify their collective concerns, and to advocate for activism in the debate to address the problems of the Nation's uninsured. One of the major concerns is the fact that the medical profession as a whole has been virtually silent on the subject of the uninsured.

Commitment to Change: Commitment to Access

The task force recognized the value of collaboration to promote physician advocacy to help America's growing number of uninsured, and established the following guiding principles:

- advocating for the health care of the uninsured
- promoting universal coverage and access to adequate health care for all
- providing an impetus and catalyst for involving members of the profession, professional organizations, and the public in advocating for the needs of the uninsured
- raising awareness of the profession's responsibility to participate in addressing the health care needs of all Americans
- affirming the profession's expectations that physicians will address unmet needs for health care by providing uncompensated services

The task force also crafted a set of tactical goals:

- to generate broader support for availability of health care to the uninsured
- to involve all health care organizations in contributing to the care of the uninsured
- to promote a spirit of volunteerism throughout the profession

Over the past 10 months, task force deliberations have identified a series of core activities for implementation and consciousness-raising, which focus on emphasizing the dilemma of the growing number of America's uninsured. The activities include advocacy for action and the development of an educational portfolio and position paper to ruffle the profession's conscience and enhance commitment to community service.

The task force makes the most of occasions such as annual sessions and meetings of professional Associations, to advocate and build awareness on issues related to access to health care, including the responsibility of professionals with regard to access. Furthermore, it has plans to release a position paper on the same theme at the end of the year which will be widely distributed among medical organizations and the public.

Finally, an educational portfolio on access is being developed to be used in residency and fellowship training programs for the purpose of raising awareness within the primary care specialties, as well as for use by the ACP-ASIM Board of Regents and Board of Governors at selected chapter meetings during the year ahead. The portfolio includes a Board of Governors at selected chapter meetings, dynamic facts sheet and compelling data, and recommendations for professional activism. To personalize the issue, a collection of patients' stories will be published concerning individuals with no current health insurance. Thus, the portfolio will stimulate both urgency and awareness of the crisis.

In summary, what is the profession's responsibility? The answer is clear. Because the lack of health insurance is an established risk factor for poor medical outcomes in the USA, the profession must lead the effort to achieve universal access to health care. It can do no less.

by Whitney Addington, MD, ACP-ASIM President-elect 1998-99 *and* Linda Blank, Vice-President, Clinical Competence and Communications, ABIM

NETWORK FACTFILE

One of our "regulars" - each issue of the newsletter will contain a short factfile - introducing the different members and institutions of the Network to each other.

1. **Healthlink Worldwide**

Healthlink Worldwide (formerly AHRTAG) aims to improve the health of poor and vulnerable communities by strengthening the provision, use and impact of information. It does this by:

- Communicating about health issues
- Promoting the development of good policy and practice
- Providing training in information management and dissemination
- Supporting partners in health information and publishing activities

Healthlink Worldwide works in collaboration with 30 partner organisations working in health in developing countries. Its resource centre holds the UK's largest collection of practical health materials from developing countries, with particular strengths in:

- HIV and sexual health
- AIDS & sexually transmitted infections care
- maternal health
- child health.

Specialist programmes include AIDS and sexual health, child health and disability and regional work in Africa, Asia, and the Middle East. The resource centre database is available on-line free to those working in developing countries.

Working with partners, Healthlink Worldwide publishes regular and practical bulletins, resource lists, manuals and publications on issues including child health and HIV, AIDS and sexual health. These publications reach an estimated audience of over 2 million in major languages. Some examples are **Child Health Dialogue, AIDS Action, CBR News, Health Action.**

Recent special briefing papers include:

- **Caring with Confidence - practical information for health workers who prevent and treat HIV infection in children**

- **Tuberculosis and children: the missing diagnosis.**

Healthlink Update is published every two months, giving information on new resources in primary health care and community based rehabilitation. It also provides technical support to partner organisations in, e.g. Tanzania, Namibia, India and Brazil, to establish and develop resource centres, information services, and learning and training resource materials.

During 1999, Healthlink Worldwide will be consolidating its work with health workers, especially on how changes in the practice of health or other development workers affect the health of poor and vulnerable people. More links will be developed with organisations that represent people from poor and vulnerable communities e.g. disabled people's organisations

More information on Healthlink International is available from:

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Department of Health Policy for Sustainable Development (HPD)
Sustainable Development and Health Environments Cluster (SDE)
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27

Tel: (41 22) 791 2564/2558
Fax: (41 22) 791 4153

Email: skoldm@who.ch/jamesonj@who.ch

Useful Websites

Each issue we will share information on some of the websites available, each dealing with some aspect of poverty, whether from a local, community, organizational or national perspective. We would be interested to hear which ones you have found most useful, what are their areas of interest and whether they might be of interest to other Network members.

The first two websites in this series are both based at the University of Sussex in Brighton, UK.

1. Institute of Development Studies (IDS)

IDS is a national centre for research and teaching on development. It was established in 1966 and is an international authority in the field. Research and teaching are combined with operational work, advising governments and aid agencies, and helping to turn theory on development into practice.

- IDS serves as a forum for debate, hosting conferences and workshops and producing a range of publications. It has an active programme of international collaboration, and welcomes visiting researchers and development specialists from all over the world.
- The British Library for Development Studies is housed at IDS. One of the world's foremost development libraries, it serves as both a national and international documentation centre.

http://www.ids.ac.uk/ids/aboutids/index.html

2. IDS also houses Eldis: the Electronic Development and Environment Information System

- ELDIS is a Gateway to Information Sources on Development and the Environment
- ELDIS offers an easy route to the latest information on development and environmental issues
- ELDIS is a directory and gateway to electronic information resources and is available free via the Internet
- ELDIS provides an ever increasing number of descriptions and links to a variety of information sources, including WWW and gopher sites, databases, library catalogues, bibliographies, and email discussion lists, research project information, map and newspaper collections. Where there is no Internet link available, other information on the availability of databases, CDRoms, etc. is given
- ELDIS offers a data and database hosting service

http://nt1.ids.ac.uk/eldis/eldis.htm

Other Internet sources of information include :

List of international organizations working in health and development:
http://www.digitalin.com/devpak/intlink.htm

Going Local Community Website:
http://www.dev-works.com/going.local.html

British Medical Journal: http://www.bmj.com/

I would like to become an active member of the International Poverty and Health Network

Name:.....My particular areas of interest:.....
Organization.....
Address:.....
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What I/my organization can contribute.....
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Tel.....
Fax.....
Email.....

Please return the completed slip to the IPHN Secretariat at the address given on page 5 of this newsletter

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