

Background document

Making Health Care Work for the Poor

Efficiency in Health Delivery Systems

“Best of” in Primary Health Care

**Review of the NGO experiences
in selected Asian countries.**

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Introduction

Purpose and approach of this paper

Our purpose has been to conduct a review of NGOs' contributions to health care in Asia.

Taking into consideration the World Health report and the recommendations of the national consultations on macroeconomics and health, we have focussed on these NGOs which have Primary Health Care as a stated goal.

While we have reviewed the accomplishments of about 50 NGOs, Asia is so vast that this can only be a small sampling. We selected large NGOs which have a proven record of efficiency, competence and field action, such as BRAC. On specific issues such as mobile medicine, we focused on those selected by the United Nations in organizing the World Summit on Information Society, while on microcredit, we took a sample from the recently held Summit on Microcredit organized by NGOs in New York.

It is with these limitations in mind that we have selected those NGOs which represent vast network of organisations sharing a common objective and a common advocacy platform such as the People's Health Movement internationally which brings together several thousand NGOs in Asia.

Outline of this document

The first section presents the contribution of NGOs to poverty alleviation and their broad comprehensive approach to health. Mechanisms such as microcredit to improve health and experiments in community-based microinsurance schemes are discussed.

The second section considers the role of international advocacy by NGOs on macroeconomic and national aspects of health care, discussing public versus private health care, highlighting successful public health systems from an NGO standpoint.

The third section defines Primary Health Care Systems and indicates successful NGO experiments that are being expanded. Innovative and efficient PHC systems are the way to the future.

The fourth section describes innovations to improve access to health services through mobile medicine and the use of modern technologies (telemedicine, the internet).

What NGOs can contribute

The World Health Report 2003¹ that has just been published strongly advocates for strengthening integrated primary health care systems, and rebuilding efficient ones where they are very weak or inexistent. Clearly, national macroeconomic mechanisms, which bring together responsibility for health and for finance, have a responsibility. The task is bringing health back on top of the agenda, nationally and globally.

Rebuilding health systems today could not just be State responsibility and NGOs have an increasingly important role to play in partnership with States.

NGOs cannot replace State funded and State backed public health systems. However, NGOs can show the way in building experimental health systems starting with people's needs, no matter how poor. States can then cooperate and assimilate NGO's health systems.

Health is an integrated state of well-being and requires the fulfilment of basic needs - such as water and nutrition - and therefore, the ideal set up of a health system would be funded and staffed by the State and be linked to a large array of community based organized groups and NGOs. This situation will mean: democratic participation in the elaboration and functioning of health care systems for the poor - who should become less poor as a result.

*"One of the key roles of civil society organizations is to hold health care providers as well as governments accountable for what they do and how they do it. Where civil society is active, organizations can monitor government policy choices and practice advocacy ... without mechanisms enabling people to hold officials accountable, stewardship may falter"*²

For example, the problems of high quality affordable health care for all in the highly populous countries of Asia, is also being handled by large NGOs. While this paper could not pretend to offer a comprehensive view of all NGO work in Asia, we have selected telling examples of best off in NGO delivery of integrated health care to the poor and NGOs' expert reviews of the best achievements in public health systems for the poor.

Concept of Integrated Health Care Systems

An integrated health system includes preventative, curative, promotive, and rehabilitative structures to be put into place.

To combat infectious diseases which are the major cause of illness and death among the poor, optimising determining factors on health such as schooling – especially for women, nutrition, water and sanitary installations have to accompany the expansion of preventive and curative health services.

The French scientist who contributed so much to modern disease treatment by proving the germ origin of diseases and who invented the first vaccine, Louis Pasteur, stated, “I did not strive to cure, my objective has always been to prevent diseases^{3 4}.”

For Louis Pasteur’s immediate collaborators and followers in Asia and Africa like Alexandre Yersin, who lived and worked in Viet Nam, “to prevent disease” meant understanding the ecology of diseases and acting on the chain of transmission: water management, husbandry, plant growth and their parasites, and human disease and health, were approached together as the environment defining health.⁵ The science of development in practice, empowering the poor to become less so, is what health is all about. Ill health breeds poverty and poverty is the main cause of ill health. That statement, at the heart of the Millenium Development Goals is universally acknowledged but needs to be substantiated by good practice.

Within this framework, what may be the determinants of an “integrated strengthened health care system based on Primary health care” as the World Health Report 2003 has just called for?⁶

Fact is, it may not be as difficult as it seemed to put in place a performing system. Community groups and non-governmental organizations that sprang from innovative leaders in people’s health have often enough realized what may be best health care for the poor in a nutshell.

Perhaps, the evidence is already there. We will try to highlight important “experiments” in social health, organically grown among the people concerned, the rural often very deprived masses and the urban slum dwellers. We will also argue that a Health System for the poor need not be and should not be “poor health system for the poor⁷” but, rather, can and must be inscribed into the national and international effort of “better health for all”, in the Alma-Ata tradition.⁸ We draw from the “Global Consultation on Increasing Investments in Health Outcomes for the Poor” which took place from 28-30 October 2003 at the World Health Organization Headquarters in Geneva⁹, which included Ministers and high-level officials from Finance, Health, and Planning from 40 developing countries, as well as senior representatives from a number of development agencies, foundations, regional organizations, research institutions, and international banks. A selection of national Macroeconomics and Health Reports in Asia and actual or potential NGO collaboration frameworks are added to the overview¹⁰.

Box 1 – Components of an Integrated Health System

	Rehabilitative	Curative	Preventive	Promotive
Diarrhoea	Nutrition rehabilitation	Oral rehydration; Nutrition support	Education for personal and food hygiene; Breastfeeding; Measles immunisation	
Pneumonia	Nutrition rehabilitation	Chemotherapy	Immunisation	Water; Sanitation; Household food security; Improved child care
Tuberculosis	Nutrition rehabilitation; Social rehabilitation	Chemotherapy; Nutrition support	Immunisation; Contact tracing	Nutrition; Dry, ventilated housing and workplaces
Cardio-vascular Disease	Weight loss; Graded exercise; Stress control	Drug treatment; Supportive therapy	Nutrition education; Increased exercise; Treatment of hypertension; Smoking cessation	Nutrition policy; Tobacco control; Recreational facilities

David Sanders, Director School of public health - University of Western Cape, South Africa¹¹.

1. From poverty alleviation to better health

The Millenium Development Goals to improve the well being of the poor masses propose an integrated and combined approach to poverty and health¹². In fact, improving health and reducing poverty can be seen as the same objective. The adoption of the Alma-Ata principles of primary health care understood that approach, as we are reminded in the World Health Report 2003¹³.

An effective approach to improving health of poor populations therefore entails an effort to improve living conditions, insure that people have adequate means of sustenance and have access to clean drinking water and proper waste disposal.

There is an abundant literature on this relationship. We all know that the decline in mortality in Europe during the 19 and early 20 century was linked with the provision of fresh water and also the improvement in housing, the increase in agricultural production leading to better nutrition. Early followers of Louis Pasteur who migrated to Africa and Asia, such as Yersin in Vietnam, sought a comprehensive grasp of the environment when they went about discovering pathogens and their relationships with humans and animals.

The interconnectedness between the health status of the individual and his/her living conditions and environment has been demonstrated time and again. For example, a very recent study in Sri Lanka found a distinct correlation between types of housing and risk for malaria: the risk of malaria was 2.5-fold higher for people living in poorly constructed houses than for those living in houses of good construction¹⁴.

On the whole, a comprehensive approach to individual health demands a collective approach to the broader determinants of health¹⁵. Traditionally, the region, or State assumes responsibility for the well being of the community, and invest a proportion of collective income, or labour, towards necessities for all – infrastructures needed for development.

This has historically been the case independently of the form of governments – it is essential for successful capitalistic forms of economic development, as economics Nobel Prize Joseph Stiglitz¹⁶ reminds us, and is also an important issue in communist or socialist regimes.

Amartya Sen¹⁷, reputed internationally for his ground breaking work in economics to understand determinants of poverty, has also located health and illness within a broader economic framework of well-being.

1.1 NGOs' broad approach to health

Leaving aside government-collective investments, a cursory examination of the activities of not for profit non-governmental organizations – NGOs – and community based organizations generally, indicates that highly successful actors for health are also actors for other non-health aspects in the lives of poor people.

In fact the characteristic feature of NGOs' action in health, from advocacy to direct care delivery, is that it is comprehensive: health is one domain for action, along with agriculture, water, gender, human rights, independent living, and so forth.

As such NGOs have a long tradition of acting for Primary Health care systems “*fully integrated with the services of the other sectors involved in community development*”, to use the definition of PHC when it was first recommended by the WHO Executive Board in 1975¹⁸.

There are NGOs which started with provision of health care, then moved on to the creation of a bank, elaboration of an educational system, such as GK¹⁹ in Bangladesh, and other NGOs which started with agricultural development and then moved on to health care, such as BRAC²⁰.

This paper provides many examples of NGOs in Asia which have programs in health AND other services essential for development. Some countries which have strong central governments that may not be too receptive to registration of “NGOs” as such, often have important social organizations which fulfil the same role as NGOs, leaving aside criticism of the government. Furthermore, large NGOs often need State support and financing to operate, unless they receive funding and financing from other State governments.

1.2 The role of microcredit in development

Since the field of actions against poverty is very vast, focusing on the role of microcredit in NGO's approach to improving the living conditions of populations is an interesting angle.

In Asia, several hundred million people are involved in small scale farming and related activities, and many millions of those are head of “micro-enterprises”, many of whom are women.

While this activity is central to securing means of livelihood (and therefore a basis for health), and a very important determinant in the status of women, one of the most persistent challenges is the lack of credit.

Writing and singing the peasant's woe in 16th century France, a musician took over a saying by the poet and satirist Rabelais to make a very

popular song of the time. The song is a listing all the terrible ailments and diseases affecting poor people: *There is small pox, gale, rheumatisms, bone aches...stomach aches but*, said the refrain, *Faute d'argent, c'est douleur non pareille!*-Lack of money.. is pain like no other!"

The condition of the average peasant or slum dweller in the developing world today is often not far from Europe's at that time. A major problem for development is the availability of credit, or lack thereof.

In the best seller *Ebène*, prize winning journalist Ryszard Kapuscinski²¹ provides an illustration of the problem: he reports sleeping in an extremely poor neighbourhood in Africa and being awakened by a terrifying wailing and crying in the middle of the night: it was an old lady returning to her hut to find that her sole possession: a cooking pot, had been stolen. Without the pot, she could not cook her beans, and go sell them on the market for a living. Without the pot, she became a beggar among beggars, condemned to die rapidly. Access to a microcredit structure, means that even the most abysmally poor individual such as that lady – can get credit, one dollar or even less, - to get that single pot which can mean the difference between life and death!

If billions can change hands daily in speculative flows, main formal lending institutions do not lend to the poor people, as explained by the Asian Development bank, road blocks include: *perceived high risk, high costs involved in small transactions, perceived low profitability and inability of the poor to provide collateral usually required of banking institutions*²².

This fact is worsened by the economic recession and financial crisis affecting Asia, which has constricted credit to industry, small and large enterprises, or farms, while many bankruptcies enlarge the flow of the unemployed which swells the masses of desperate poor individuals.

Large changes in economic and political structures can also "destabilize" traditional forms of living and lead to large internal migrations in Asian countries where economic growth and desperate masses are side by side. The Asia Development bank reported a tripling of unemployment in many areas, along with a 50% decline in hospital bed occupancies as people lost their insurance and access to care²³.

Yet, credit is nothing but a bet on the increased wealth that comes from tomorrow's labour. Credit is a means of exchanging labour to create wealth. Use of money – as distinct from usury and speculation- is an instrument for credit purposes.

When Grameen Bank²⁴ founder Muhammad Yunus launched what is now known as microcredit, no one believed this was sound econom-

ics, yet today, the founder this new form of banking is universally known and praised.

The NGOs microcredit summit recently held in New York City reported some astounding figures:

As of December 31, 2002, 2,500 microcredit institutions have reported reaching nearly 70 million people, with approximately 60% among the poorest when they took out their first loan. Of these, about 37 million were women. It is estimated that these loans reached by the end of 2002 some 208 million family members²⁵.

The United Nations General Assembly has launched a program whereby 2005 will be the "International Year of Microcredit."

1.2.1 Yunus distinguishes several types of Microcredits

The Asian Development Bank's Microfinance Development Strategy explains how microfinancing is critical for the mobilization of funds in resource poor settings. It describes how microfinance is a critical element for poverty reduction as it improves the accessibility and provision of savings and credit services, as well as insurance schemes. Microfinancing allows for the poor to develop microenterprises, enhances their economic capacity and helps to manage risks.²⁶

Grameen founder Muhamad Yunus distinguishes between different types of microcredit:

- Traditional informal microcredit (moneylenders, pawn shop, loans from friends and family, consumer credit in informal markets, etc.)
- Microcredit based on informal groups (tontie, ROSCA.)
- Activity-based microcredit through conventional or specialized banks (agricultural, livestock, fisheries, or handloom credit, etc.)
- Rural credit through specialized banks
- Cooperative microcredit (cooperative credit, credit union, savings and loan associations, savings banks.)
- Consumer Microcredit
- Bank-NGO partnership based microcredit
- Grameen type microcredit or Grameencredit
- Other types of NGO credit
- Other types of non-NGO non-collateralised microcredi

1.2.2 Expansion and Limitations of Microcredit

“In some countries, such as the Philippines, Pakistan, Nepal, laws for microcredit have been created...Microcredit has come a long way. Leading NGOs running microcredit programmes have now reached a stage of development where they may seriously consider the pros and cons of converting themselves into formal financial institutions, if conducive laws are available to them. Grameen Bank became a formal bank back in 1983 under a special law passed by the parliament...Pakistan has passed a law to create Microfinance Banks (MFB). The First Microfinance Bank has already been created in Pakistan under this law. This would be a good case to study before drafting a new legislation for creating a MFB.” - Muhammad Yunus²⁷

Studies have shown that small loans (10 to 200 USD) help people to get out of poverty. Savings and credit experiences involving groups of women are nearly always successful, with credit repayments reaching or exceeding 98% of the loans made.²⁸ About 21 percent of the Grameen Bank borrowers and 11 percent of the borrowers of the Bangladesh Rural Advancement Committee (BRAC) have managed to lift their families out of poverty within about four years of participation.

“Lending, with micro-credit for basic production, is the additional engine for development. BRAC promotes income generation for mostly landless rural people of Bangladesh, through micro-credit, health, education and training programmes, in over 60,000 villages in the country”, says

BRAC's Executive director²⁹.

However, there have been major obstacles to the expansion of microcredit. Microcredit for development is constrained when the state budget is shrunk and when unemployment rises. This has meant that C, D, E (See Yunus's Classification of Microcredit) types of microcredits – have been severely curtailed, or have disappeared, in a number of poor and middle developing countries as part of balancing the budget mechanisms. Simultaneously, the opening to the global market and joining of the World Trade Organization have forced State governments to cut subsidized credit to domestic small to medium-size enterprises, often resulting in bankruptcies and unemployment.

NGOs, as providers of microcredit, are limited by the lack of availability of funds. If the Grameen Bank overcame this problem, by creating the national fund PKSF which provided about US \$ 262 million to nearly 200 NGOs to carry out microcredit programmes, it was because it was financially supported by the Government and the World Bank. We see therefore that NGOs can only expend with state support, and NGOs that are large are, often enough, parastatal in some way. Under some circumstances, large NGOs, such as Bangladesh's Rural Advancement Committee (BRAC), PROSHIKA - Bangladesh or Self-Employed Women's Association (SEWA) – India, provide a parallel public service. Smaller NGOs, such as those found in the squatter settlements in Karachi, Pakistan (Orangi Pilot Project, Orangi Welfare Project) cooperate with the government to ensure marginalized populations get essential services, such as sanitation, electricity or proper housing.

The overall figures are telling: tens of millions are in demand for microcredit, even though in and of itself it is a condition necessary but not sufficient to lift people out of poverty. This type of lending is primarily efficient to improve the lives of the most destitute part of society, allowing some of the extreme poor to move up into the average poor.

1.3 Health microinsurance and financial protection

1.3.1 Community-Based Mechanisms in health insurance

When health service provision is linked with income generation, community-based health insurance and microcredit for health expenses tend to be sustainable. Trade unions, credit unions and people's banks provide microcredit

Examples of :

Microcredit formal institutions:

Grameen Bank (Bangladesh)

ASHI, Dugganong, CARD, (Philippines)

SHARE, ASA (India)

Nirdhan and SBP, (Nepal)

Bank Dagang (Indonesia)

Women World Bank (India, other Asian countries)

Small Farmers' Development Program (Nepal)

NGO-Banking schemes:

BRAC, GK (Bangladesh)

SEWA, The Mahila Milan Crisis Credit Scheme in Bombay – (India)

loans (small loans of money or materials), promote microenterprise development and provide appropriate insurance packages. They also provide local populations with emergency low or no interest loans in order to allow people to cover relatively important expenses (e.g. health problems, death, marriage).

When rural populations are at subsistence level, PHC work at a low cost with maximal efficiency, and can be accompanied by health insurance. GK (Bangladesh) runs a very efficient low cost insurance, and BRAC runs successful tuberculosis control and care programs. Both NGOs provide cheap care AND cheap insurance.

Micro-level household data analysis indicates that community financing improves access by rural and informal sector workers to health care and provides them with financial protection against cost of illness^{30,31}

Social protection for the socially excluded or marginal is a lot more difficult to achieve and is a typical undertaking of the NGOs and (CBHOs).

1.3.2 User fees as barriers to health access

Financial protection means that no family or household should contribute any more than a reasonable proportion of their income to finance a system of social protection in health and/or specific health services.

In this sense, the definition of financial protection implies the necessity of protecting a household's income in order to prevent it from falling into or remaining in poverty, as a result of excessive contributions to the financing of their social protection in health.

One of the problems identified by the NGO WEMOS in PRSPs is that they include user fees for access to health: "There is widespread international consensus on the need to avoid user charges at the point of service delivery, because of the adverse impacts on the poor. It is therefore remarkable that most PRSP continue to promote user fees for health, including for basic services....Exemption schemes are difficult to implement and in general fail to protect many poor people from being charged. The most equitable and feasible option for low-income countries are tax-based health financing systems."

Tax based health financing system are found more "equitable" by the vast majority of NGOs, because of simple arithmetic: the larger the base to share the costs, the more chances for the insurance scheme to work.

Adversely, the poorer the population, the more unsustainable will be the community insurance. The very poor have a "hand to mouth" existence which prevents the notion of savings.

The medical insurance scheme of GK, for example, with a tens of thousands enrolment is based on ability to pay, not as a cost recovery mechanism. It involves three categories, A- very poor families below food sufficiency do not pay membership but make only a symbolic contribution of one taka (a few cents) per consultation, B- food self sufficient families and C. farmers with a surplus pay membership fees dependant on income.

The NOVIB bank gave support for the deficit and then profits from the GK generics producing industry were invested into the insurance scheme.

However innovative, GK found it could not reach the extremely poor, even when fees were below costs and working primary health care system had reduced the costs of care to absolute minimums.

1.3.3 Social protection and the fight against social exclusion go hand in hand

Strategies and Techniques against social Exclusion and Poverty - STEP, a program of the International Labour Office, was set up on the premise that social protection and the fight against social exclusion go hand in hand. STEP is a comprehensive program to evaluate problems and potential solutions, motivated by the realization that *only one in five people in the world has adequate social security coverage!* In Asia, STEP combines community-based and national social protection schemes in Bangladesh, India, Mongolia, Nepal, Philippines, Sri Lanka, and Thailand³².

The ILO points to job instability as a growing phenomenon, while regular employment had historically been the chief mechanism to obtain health insurance. The higher the unemployment and instability, the more difficult it becomes to bring social security to masses of people with no stable economic base: "*Socioeconomic transformations around the world are challenging existing models of social protection in health: Although global in scope this phenomena is particularly pronounced in developing countries. While economic globalization has introduced new flows of capital and information sharing to many developing countries at the same time the international economic and financial environment is more instable than even before.*"

The ILO estimates that CBHO can "potentially be an instrument for organizing their members to

get better access and protection from the public health or other social security and/or private health insurance³³.”

1.3.4 Limitations To Microinsurance

But there are no cookie-cutter solutions, says the ILO, whose study on “Social Security”³⁴ has reviewed 80 cases from Bangladesh, China, Indonesia, Nepal, Philippines, Thailand, Viet Nam (as well as over a 100 from Latin America, the Middle Eastern and African regions). The ILO cautions against viewing the CBHO as capable of providing a comprehensive solution to the urgent question of community health insurance.

According to this comprehensive study microinsurance cannot be the basis of a comprehensive social security scheme, but it can be a *first response to people’s urgent need for improved access to healthcare*. It is estimated that microinsurance schemes reach about 25% of the target population and the only schemes which manage to reach 50 to 100% of those targeted are those in closely knit communities or groups for which participation in the scheme is mandatory (trade union, professional association, credit unions). The latter are able to reach a higher percentage of people than social insurance schemes open on a voluntary basis to self-employed because microinsurance contributions are lower and the schemes focus on people immediate needs³⁵.

Thailand introduced a low income card scheme in 1981. People eligible were those below a certain threshold in income. Ten years into the program, the LIC covered one fifth of the Thai population, but only 50% of those in extreme poverty and need were covered³⁶.

If and when the economic mechanisms of support for the health insurance scheme disappear, the system goes with it. The example of China: The rural cooperative medical system was reputed as a performing medical system with an insurance that was community based and administered on a national scale. The Rural Cooperative Medical System covered 90% of rural population programs in the 1980s, as it was based on the agricultural cooperatives which paid a share of the costs. The economic liberalizing reforms of the past ten years have led to the collapse of the insurance mechanisms³⁷.

1.3.5 Extension of National Programmes and Policies – Greater Social Protection

The role of people’s initiatives in improving coverage and working in a complementary way to nationally oriented financing systems needs to be emphasized (as explained in the WHO study on the issue)³⁸ But community based health insurance schemes have not been shown to work without a strong substratum where the State has a solid health care system.

The goal is to achieve universal coverage, and this can be accomplished, as demonstrated by the health system in a number of countries, only through State backed insurance schemes. People’s initiatives work with government subsidies and can help to extend government services to target populations. In Asian middle income countries, the population is divided between those who work in the government or formal sector and receive relatively well-financed health insurance schemes and those who rely on more poorly funded government services or have to pay for private care.

The Poverty Reduction Strategy Paper for Sri Lanka advocates the development of health insurance as a means to respond to health sector spending requirements. “*The report (on MH) questions the feasibility of expanding private insurance in a country where 40% of the population falls below the poverty line, the unorganized employment sector predominates and high unemployment and aging population prevail*”³⁹.

Examples of NGOs in health microinsurance:

Self-Employed Women’s Association (India)

Centre for Community Development and Research (CCODER-Nepal)

Women’s Working Forum (WWF)

Gonoshasthaya Kendra Health Center started in 1971 in Bangladesh.

2 From microeconomics to macroeconomics: Global advocacy capacities to set health policy making and implementation.

Analysis of the relationship between macroeconomic policy and public health is not the prime subject of this paper and would demand further research. However, the issue of private versus public care, as the object of macroeconomic strategy, has been investigated by the international NGOs, Save the Children, Medact, ETC Crystal and WEMOS, as well as by the WHO... There is little debate on the fact that the Structural Adjustments introduced by IMF and the World Bank damaged health systems. The book "Dying for Growth" edited by Jim Kim, formerly with Harvard University and now at WHO headquarters is among the best known advocacy document by NGO networks on the Right to Health in recent years⁴⁰.

Addressing the Macroeconomics and Health Consultation held in October 2003 in Geneva, the Indian economist and former Health Secretary Rajiv Misra thus began his intervention:

"The experience of health reforms in developing countries supported by international agencies has been mixed. In many cases, their benefits have not reached the really poor, and in some instances (e.g. indiscriminate privatisation and decentralisation, cost recovery etc.), they have been impacted adversely. Part of the problem has been the inadequate appreciation of the role of the state in health in general, and in respect of the poor in particular, in the wake of economic liberalisation and increasing reliance on the market." He added that he was hopeful that major macroeconomic institutions now understood that health systems could not go on being detrimental to the poorest part of Asia⁴¹.

Do PRSPs reflect a new understanding of the importance of health in the overall economy?

The health components of the PRSP (Poverty Reduction Strategies Papers) are located within a broader macro framework which calls for continued downsizing of the state and full privatization of secondary and tertiary care structures with safety nets for the poor. As a result "the poor" become the only recipient of Public State support. The question as to the appropriateness of privatization in countries where the majority are poor may be a determinant of success or failure in public health policies in general and NGO actions in particular⁴². Major development NGOs are sceptical as to whether the PRSPs

represent a major departure from the former Structural Adjustment Plans.

One of the main arguments for privatization is that secondary and tertiary health is perceived as too expensive from the standpoint of the State budget. PHC is sometimes neglected and public funds are invested in fancy health structures to which only the well to do have access. This results in the very wealthy small minority having expensive cardiac surgery while the poor masses may be dying of common preventable infectious diseases.

On the other hand, what would ensue if secondary and tertiary care are abandoned by public health altogether under the argument of cost-cutting, that is to reserve public spending only for PHC, which is perceived as most efficient? "A poor health system for the poor" answers Professor Bob Deacon in a comprehensive analysis of health systems reforms for the UK's DFID. *"There is a shift towards socially regulating the global economy... The model advocated (by macroeconomic institutions) who have developed socially oriented policy advocating unit, goes away from the European style 'welfare state' where middle class and the working or non working poor benefit alike from publicly financed and provided education and health services to a US style 'model' with proposed global regulation for States to provide services only for those deemed very poor while the middle class gets education and treatment from the privatized (and increasingly foreign owned and foreign run) sector."* Deacon warns about the "race to the welfare bottom... : *"the social services for the poor may be very poor services indeed..."*⁴³

Often hidden from the debate is that treating the poor could never be profitable, and, per chance, only care that could yield a high profit are to be privatized. Lack of public funding is often stated as the argument to privatize secondary and tertiary services. However if these sectors are public, this reduces costs, thus mobilizing funds. For example, a national drug plan based on essential drugs and use of generics can save an enormous amount of money, which can then be invested to make health service provision more equitable. This represents a tremendous saving for States, yet it is often resisted by private interest lobbying. A cursory comparison between continental Europe and the US-UK indicates where health care is both most equitable and cheaper for the individual.

NGOs involved in health care are broadly in agreement with the statement that: *"Specialised UN agencies like the WHO should provide independent support to governments for assessing the potential impact of economic and trade policies on health. Monitoring the implications of*

structural adjustment measures for health falls within the mandate of the WHO. (WHA 43.17)" says the MEDACT-WEMOS report⁴⁴.

2.1 PRSPs and the broad macroeconomic framework

MH national mechanisms are situated to function within the overall poverty reduction mechanisms already in place, such as the PRSPs.

Today PRSPs which have been fully developed in some countries and are in the process of elaboration in others, are required for countries to obtain loans from the IMF, or to benefit from World Bank programs, or, for the poorest countries, to be entitled to debt relief under the HIPC (Highly-Indebted Poor Countries) initiatives.

Health stakeholders could use the PRSP process to reassess existing health strategies from a poverty perspective.

Therefore, a review of how PRSPs work for health and the place of NGOs within that framework becomes imperative. Studies of PRSPs' content on poverty and health have been analyzed by both international advocacy NGOs and local health care NGOs. Experts from the Director General's Strategy Unit at the World Health Organization have also investigated the matter.

As the WHO analysis reports: A health strategy for poverty reduction – which is what most PRSPs propose, is different from a health strategy to meet the need of the poor, or poorest.⁴⁵

Since PRSPs are based on general assumptions of what may reach the poor rather than a systematic evaluation of needs in the local situation, they reflect a health strategy for poverty reduction, but in imposing prefabricated health strategies, PRSPs do not address the need of the poor for health.

PRSP's health strategy are not geared to fulfil the challenge of providing health care to poor people because, it is said:

Poverty is identified as a cause of ill-health... in some PRSPs, however only with a sentence or two. Ill-health is stated to cause poverty – also merely in a sentence or two.

*PRSP focus on goals and targets such as the MDG's but do not analyse **how**: how is infant mortality going to decrease, for example?*

PRSP do not provide evidence for the health strategies outlined.

PRSPs do not consider the need of poor people for hospital care.

PRSP do not offer poor people's representatives to participate in a monitoring process.

PRSP do not consider financial barriers to care for poor people (and most require user fees, as WEMOS indicated).

All the criticisms above are put forth in the WHO DGO's analysis of PRSPs – an analysis which substantiates strong reservations of large advocacy and health care NGOs such as Medact. Save the Children, Wemos, and others.

Several PRSPs include the demand to privatize water, without any linkage to the effect that limiting access to water may have on poor people's health. Alongside PRSPs there is the overriding assumption that privatizing advanced health centres is "pro-poor" presumably because it will free government resources for "health for the poor".

This assumes that the poor have no need for hospital treatment whatsoever,- say the WHO study in disbelief- or that communities will do it all without broad public services.⁴⁶

The most equitable and feasible option for low-income countries are tax-based health financing systems, says the WEMOS-Medact report.

Southern Asia is doing better than South East Asia, because of more state involvement in public health, according to a Malaysian economist and researcher for the UN's Research Institute for Social Development, author of a major study on the relationship between State implementation of macroeconomic policies and social indicators. "*The Republic of Korea and the RoC Taiwan which have had a strong policy of State support and investment in productive capacities also have better performing health and education infrastructure than those states who have adopted more liberal measures such as Malaysia, the Philippines or Thailand*"⁴⁷.

National mechanisms on Macroeconomics and Health could take advice from the WHO and NGOs in seeking to fill in the gap in PRSP. National health strategies need to be devised with a more detailed and participatory analysis of ways and means to strengthen health services for poor populations as well as insure that public health is not "credit starved"– at a time when the World Health Report 2003 has put forth the need for integrated Primary Health Care systems and a strengthening of public health.

2.2 International advocacy

2.2.1 Save the Children advocates for public health in Asia. Sri Lanka's public health system achieving the MDG

The international NGO Save the Children (StC) has carried out a comprehensive analysis of efforts to achieve the Millennium Development Goals 4 and 5, relating to child and maternal mortality respectively, including an in depth review of Sri Lanka's performance as a public health system⁴⁸.

Sri Lanka's infant mortality rate is currently 14 per 1,000 live births which is an achievement. The rate is today 76 for low income countries, 33 for lower middle income countries, 28 for upper middle income countries and 6 for high income countries.

StC's comprehensive analysis has praise for the Sri Lanka public health system. Its development over the past 50 years has been an example of achievement in providing health for a predominantly poor population:

- equity of access
- national distribution of Primary Health Care
- universal access to hospital care for the poor
- free care access - no user fees
- pro-poor redistribution (poorest income quintiles receive a larger share of the benefits of taxation-funded health expenditure than do the richest quintiles)
- equitable funding of the system through indirect taxation
- Public facilities offering a high quality standard of care, on par with private facilities.

The achievements of the MDG and good health outcome for the poor were facilitated by other crucial non-health investments of the government:

- education for all, free of access, achieving 77% literacy among (ever) married women
- subsidized distribution of rice

There is today a near public sector monopoly on inpatient care, while the private sector provides outpatient care.

"Pro-poor targeting is therefore implicit, but is much more effective than that achieved in most other developing countries. These characteristics indicate that equity of access and pro-poor redistribution are important elements in Sri Lanka's health care system success." However, notes the StC report, "insufficient recognition is given to them by international health policy advisers." Sri Lanka's public health care system has developed without mobilizing resources beyond what most other developing countries spend, and at significantly less cost than the World Bank's "minimum cost-effective package" of basic preventive and

curative health services. "This aspect of Sri Lanka's public health care system is important – says StC- because it illustrates that centrally-administered government systems can be inherently capable of continuous productivity improvements, and that this characteristic enables such systems to maintain universal access to health care. "

The report notes that the public health care system functions as an insurance mechanism against catastrophic illness and devotes an unusually high proportion of funds to providing freely available inpatient hospital care (estimates are 69%).

As in continental Western Europe, the high quality of public health care provision is supported by the non-poor population, and is plebiscited by the population at large.

The Sri Lankan experience therefore demonstrates that public health care systems can work well, and that when this is the case, there can be a mutually reinforcing relationship between this sector and private health providers.⁴⁹

Appropriate health system reform could enhance the already existing complementarity between the public and private systems, say both the StC analysis and the national MH report.

The Sri Lanka Macroeconomics and Health Report argues for more investments in health to sustain the achievements in public health achieved in the country. The report notes that Sri Lanka's 3.2 % health expenditures as a percentage of GDP is lower than other middle income level countries. To maintain quality of services, the report argues for the upper bracket of the CMH originally proposed 30-45 USD/capita, which would require a 5.3% ratio.⁵⁰

As economic growth is presently lower than expected, that ratio would have to be even greater to maintain the system.

The report estimates that the CMH would be ideally suited to develop a non partisan national health policy. "Tax revenue, which results in pooling as opposed to out of pocket spending, should take care of essential health services, particularly with regards to the poor (...) Community insurance and NGOs could be complementary to the State in taking care of other basic health care services (..) In the case of secondary and tertiary health care, the State must remain active to safeguard the poor". The report stresses that the PRSP "does not focus sufficiently on the needs of the poor, since it focuses on private provision without determining how the population will be encouraged to choose their source of care."

2.3 NGO advocacy on Trade and the brain drain

Almost all developing countries have a more or less serious shortage of health professionals, and in most low-income and least developed countries this represents a severe problem for public sector health services. While there are a number of causes, a major contributory factor is a dual (internal and external) "brain drain". The issue has come up on the agenda of most major NGOs, while it is also a major subject for consideration by the WHO, it has been mentioned in major speeches of the WHO Director General, in public statement of STOPTB, in the Joint Learning Initiative's research project, in the US Administration plan for Emergency Relief on AIDS, and other relevant international efforts and donors initiative to look at public health. The shortage of human resources and the reluctance of international financial institutions to fund recurrent costs for health is a frequent complaint of developing countries, and the question arose in the October Consultation on Macroeconomics and health.⁵¹

NGO advocacy in Asia has focussed on three related issues: 1- Courted by international institutions to step in and do the work of ever diminishing public health system, can they fulfil that role? The Save the Children' analysis of the Millenium development goals provides a good insight. The Sri Lanka example above provides the beginning of an answer. 2- The General Agreement on Trade and Services of the World Trade Organisation opens the door for increased migration of health workers from poor to rich countries; can there be limits to this fact?⁵² Advocacy on the issues have been carried out by the International Union for Health Education, as well as by large movements bringing together tens of thousands of grass root organisations such as the World Social Forum's People's Health Movement⁵³ 3- International issues such as treatment access and health system performance have put in the forefront the question of precedence between the WHO and the WTO in health matters.⁵⁴⁵⁵

In Mumbai, the World social forum included a week long debate on "health for all" for the first time ever.⁵⁶

WHO acknowledges the problems and impact of fluid labour markets on health systems. One of its reports suggests that "high turnover rates of staff dilute results". No programme can mitigate the effects of losing up to 50% of staff who have been trained. Simply training more staff is not an effective strategy. Attention must be directed at supporting and retaining the staff⁶⁷."

"We must return to basics: putting people first to spearhead health change. The workforce is the entry, lever, and focal point for sustainable health services -- the glue that binds all resources together. Without a workforce, money and drugs will be wasted. Dr. JW Lee of WHO deserves praise for recognizing the importance of 'human resources', reflecting undoubtedly his practical experience in the field. In Commission follow-ups led by Sergio Spinaci, Ghana and Ethiopia cited the workforce as their highest priority", said Lincoln Chen⁵⁸, October 2003 Consultation on Macroeconomics and Health.

In matters of health, trading in health services and access to drugs are matters in which the WHO may intervene more forcefully to limit potentially damaging effects of global rulings by the WTO. Such was the wish and commitment made by the WHO representatives who attended the World Social Forum in Mumbai this January in a meeting attended by 800 people representing several hundred NGOs.⁵⁹

Most international advocacy networks of NGOs are demanding a larger involvement of health experts into trade matters and macroeconomic policy making generally. Besides the World Social Forum, the International Union for Health Promotion and Education has developed expertise in this domain.⁶⁰

Examples of:

International Networks of NGOs active in health lobbying and macroeconomic issues

Based in Asia:

ActionAidAsia

ACHAN

People's Health Movement

OneWorldAction

Consumers Action International

Global:

International Union for Health Promotion and Education

Save The Children

Health Action International

Wemos

Medact

Physicians for Human Rights

NGOs of Unions based in Asia and active in health and macroeconomic issues lobbying:

Public Services International

3 Primary Health Care Systems and NGOs

3.1 Designing Primary Health Care Systems

... If the recommendations of the Commission on Macroeconomics and Health for large increases in global investment in health are followed by the international community, the coming years will offer a crucial opportunity for development of health systems that are led by primary health care. (WHR 2003- Dec 17 2003)⁶¹

This December, ending the 25th anniversary of the Alma Ata Declaration⁶², the WHO officially declared its commitment to a return to the principles of Primary Health for All.

3.1.1 What is a comprehensive Primary Health Care system,

Primary health care systems have been developed traditionally by communities themselves, whether in China's old communal system, in Gandhi's India, or other experiences with rural cooperatives, or community based organizations rooted in village life, or other NGO experiments. All such PHC systems share common features that have been well defined by the WHO, and such principles were central in the adoption of the Alma Ata declaration of 1978.

3.1.2 From comprehensive to selective PHC.

"Selective PHC" represents a substantial distortion of the initial principles, according to the World Health Report itself.

Subsequent to the Alma Ata conference of 1978 and the adoption of PHC, the notion of PHC as a SYSTEM of delivering care to the whole population was replaced with a very narrow and cost-cutting concept of a "Primary Health Care Center", staffed with low paid and low trained staff "waiting" for the client to come in, while having often enough precious little to offer in the manner of diagnostic capacities, clinical care or medicines. This shift became known as the adoption of "selective PHC".

Twenty years of 'selective' PHC Centers have given rise to abundant literature and documentation on their inefficiency. No amount of talk about the need for referral convinced the people concerned, when ill, to go check into the PHC center first before trying to go to the hospital miles away. The situation only worsened over the years as budget crisis hit, reducing the pay of the health care centres and their supplies to next to nothing. The rural health post in Africa is but a health post in name only, and sometimes has become a collection agency for user-fees and "co-payments" says the World Health Report 2003 to illustrate the demise of "selective PHC".

This deteriorating situation led to the production of studies on how the poor masses had lost confidence in public health care systems and staff. It was used to further shrink State investments in national health. In a number of poor and developing countries, very expensive and very advanced medical care for pay sits alongside poor health for the poor. Lacking confidence in PHC, poor people continue to bypass first level health post and go directly to hospitals, but wait until very ill to check in. While insufficient investments in public health has been acknowledged as the first and initial cause of the crisis in health systems, the inequity of it all is the basis for arguments to cut further in public health spending.

Guiding principles in PHC

to shape PHC 'around the life pattern of the population' ;

for involvement of the local population;

for 'maximum reliance on the available community resources' , while remaining within cost limitations;

for an 'integrated approach to preventive, curative and promotive services for both community and for the individual' ;

for all interventions to be undertaken 'at the most peripheral practicable level of the health services by the worker most simply trained for this activity' ;

for other echelons of services to be designed in support of the needs of the peripheral level; and,

for PHC services to be 'fully integrated with the services of the other sectors involved in community development' ¹.

Meanwhile, cost recovery mechanisms continue to be proposed and even expanded. Those are traditionally fought by NGOs large and small. In a presentation in China, and a subsequent paper, World Bank's expert (C. Hansen) from the Nutrition, health and population department argued that tuberculosis should no longer be free. She argued that free TB treatment was not pro-poor as the non-poor will benefit from it, (by checking into public health facilities when ill) and, under cost recovery obligations, hospitals will prefer to shift to heart surgery than treat TB from predominantly poor patients. The argument that free treatment was not "pro-poor" was totally opposed by the largest world NGO involved in tuberculosis control, the International Union against Tuberculosis and Lung Disease which trains and manages TB control program in over 200 countries. In 2001, the IUATLD combated this view, in agreement with technical experts of the WHO TB department and blocked its advocacy in the StopTB newsletter and subsequent endorsement by the StopTB partnership.

3.1.3 Basics of PHC : start with the community not the individual

A PHC system does not see to "target" the poor, but to respond to the poor populations needs. It does not focus on the individual disease on the individual patient, but starts with the protection of the village, the community, from epidemics.

To do so, a PHC system does not "parachute" a health care staffer with some pills, rather, it starts with recruiting the local health person in the village/slum, like the midwife into an education mode. Then, building a system, organically, it trains community hands into basics such as dressing a wound, or oral re-hydration. Next, it trains and deploys paramedics and nurses who move, who go to the homes of villagers, to assist the others.

The local multi-villages health center is staffed with a doctor or doctors, which center is backed up by the district or regional hospital. In the People's Health Center (GK) system in Bangladesh, the doctors rotate from the regional hospital to the centers.

Home care is preferred to hospital care, and care is as close to the community as possible. That being stated, acute cases are brought by the medical chain to the regional hospital.

Another central aspect to the PHC system is that it must be firmly set on a national policy of Essential drugs. It is remarkable to note that when Bangladesh adopted an ED national policy, GK founder Dr Zafrullah Chowdhury and other experts on the national committee to draft the policy rejected 1700 drugs out of 2000! ED policy

means generics, basic drugs, and it represents a major savings for the state budget. Advocated in the 1993 World Bank report "Investing in Health", but in contradiction with the parallel recommendation to privatize drug sales and procurement, the policy of promoting generics became limited to individual States and not global policy.

PHC system has to fit the specific conditions of the country.

The principles of primary health care are *"evolved from the economic conditions and sociocultural and political characteristics of the country and its communities."*

From the Alma Ata declaration, PHC principles promote *"maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources."*

The best examples of working health care systems are those that have developed "bottom up" with participation of citizens and the State's strong sense of responsibility in health.

Principles of PHC are to address *"the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly"*⁶³.

3.1.4 Returning to Primary Health Care systems.

This year, the WHO has committed the organization to return to the Alma Ata principles that define a primary health care system. In the WHR2003, it is stated that health policy needs to be made on the basis of health expertise and not on the basis of other macroeconomic conditions:

*"Originally, primary health care and the health-for-all movement represented an effort to change practices and structures in the health sector based on population health criteria. Subsequent health sector reform efforts have often been steered by criteria largely extrinsic to health (for example, broad commitments to decentralization or civil service reform, or the need to reduce government spending). Reaffirmation of primary health care principles by global health stakeholders signals a recognition of the need to return to population health criteria as the basis for decisions affecting how health care services are organized, paid for and delivered"*⁶⁴.

3.1.5 Bangladesh's Gonoshasthaya Kendra or the People's Health Center

What makes GK special?

The NGO Gonoshasthaya Kendra –GK- which is Bengali for People (Gono) Health (Shasthaya) Center (Kendra) had elaborated a distinctive Primary Health Care system in a country, Bangladesh, that has only as few doctors per 100 000 inhabitants – as in the poorest parts of Africa. It is a comprehensive and innovative health care system, build over 30 years and providing a continuum of care, from the large primary health care network to the most advanced surgical care.

Concentrating on the poor rural communities north of Dhaka, GK began by providing preventive and primary health care for the villages where access to health was non existent in a wider and wider radius around its initial health center and hospital Savar, started at the time of national independence in 1971. Over the years, GK has grown into an integrated rural development project which includes education, nutrition, agriculture, environment, generic drugs manufacturing, vocational training, and medicinal plant research.

GK's 2500 employees work and operate in twelve locations besides Savar and Dhaka and will be expanding to more than 200 Union districts in 2004, covering 6 million people as per agreement with the government of Bangladesh.

GK organized the first People's Health Assembly in Dhaka in the year 2000 with over 1500 people from 96 countries and 120 NGOs, out of which came the "People's Health Movement", brainchild of GK. The PHM includes thousands of NGOs from all continents, with a global secretariat in India. It is a mass movement for health for the poor. It does not promulgate a one solution fits all, but rather seeks to promote local, regional and national initiatives in health for the poor, and brings together many NGO actors for health in global advocacy for the forgotten people.

This January, the World Social Forum in Mumbai, India included five days seminars on health organized by the People's Health Movement, with a delegation from the World Health Organization. Attended by 800 people from several hundreds NGOs, the forum addressed issues such as access to treatment for the poor, and for People Living with HIV.⁶⁵

Today GK includes a pharmaceutical company producing generic drugs, an urban and a rural system of PHC including a main hospital, and a new plastic surgery center entirely devoted to acid burn victims (GK is actively campaigning for women's rights in every domain and the struggle against the horrible acid attacks is but one aspect), a bank, schools and a university.

GK founder Dr Zafrullah Chowdhury has made national drug policy in Bangladesh, based on the Essential Drug concept, and has thought to make its successful health structure model become the State's and an international model as well.⁶⁶

GK's Human Resources development system: from education to advanced care.

The most elementary course is given to the dai (midwives), village women, usually illiterate, who have learned their craft as apprentices. Their instruction, lasting only one week, is designed to fill gaps in their knowledge. After covering basic hygiene such as hand washing they are expected to treat common ailments and introduce them to family planning techniques. They receive a monthly GK supplement of Tk. 50.

The second group, also illiterate, is trained by GK for the government. The women receive one month of instructions on the treatment of common ailments such as diarrhoea, skin diseases, intestinal parasites, burns, shock and poisoning, and they attend lectures where family planning is fully discussed. After they return to their villages they will be evaluated by a GK doctor or advanced paramedic and will come to Savar – the hospital- for further training twice within the next 18 months. The government gives them a stipend of Tk. 100 a month.

The third category consists of GK's own paramedics. With rare exception they are required to have five years of schooling and be literate. Their training lasts from six months to a year. Lectures stressing the relationship between poverty and disease "take a big chunk out of our curriculum," Chowdhury laments, about these things, they must understand. "They are taught to treat the most prevalent diseases (70 percent of the village caseload), how to do blood, urine, sputum and stool tests, and all aspects of family planning.

The Abbé Pierre group of supporters of GK recently reported from a trip to Savar's hospital that the GK trained paramedics (over 4000 trained) are of very high quality and considered as having above average professional qualification and this has led to constant efforts by private health care organizations to "steal" the GK trained paramedics, offering them many times the income they would make in GK. It follows that GK must always expect to lose a portion of its trainees to the private sector.

The People's Health system central to GK provides health care at very low costs, with health staff that is highly motivated, and a training appropriate to the health needs of poor working populations. It is based on the communal or village level, its "user fees" are extremely low, adapted to the resources involved, and basically exonerate the poorest.

GK provides a continuum of care, with the understanding that if the main effort is to be placed on prevention that does not mean that poor people would not need hospital care.

However, for such an extremely efficient system to operate there has to be State collaboration and support. The expertise of GK and similar PHC NGOs should be brought into informing national macroeconomics and health structures.

3.1.6 Conclusions: towards PHC for ALL!

A health system based on primary health care will:

- build on the Alma-Ata principles of equity, universal access, community participation, and intersectoral approaches;
- take account of broader population health issues, reflecting and reinforcing public health functions;
- create the conditions for effective provision of services to poor and excluded groups;
- organize integrated and seamless care, linking prevention, acute care and chronic care across all components of the health system;
- continuously evaluate and strive to improve performance⁶⁷.

Community based organizations and NGOs have experience in original fully developed Primary health care systems that are operational, have proven their capacities to fulfil health needs of poor population, are equitable, promote participation and women's emancipation AND those full fledged PHC system utilize resources efficiently.

Working and efficient public health system will have to build on NGO's experience with PHC to strengthen health services and make them respond equitably to poor populations' needs.

A dialogue between NGOs with an accomplished record of sound Primary Health care system implementation could advise national Macroeconomics and Health mechanisms and strive to implement universal PHC system as demanded of the WHO. Simultaneously, feedback is important from CBOs and NGOs to make sure health programs are more than paper brochures.

3.1.7 NGOs' role in delivering health care and advocacy – The case of TB

BRAC's TB Control Programme is based on the enlisting of voluntary community health workers called Shastho Shebikas, local women, averaging 25-35 years of age, many without formal schooling. TB is part of the health curricula taught by BRAC.

The BRAC TB program with the National TB Control Program to cover a population of about 14 million people. Its work includes disseminating information on TB, identifying suspect cases and referring patients to a center where a sputum test can be done. If the patient is found to have active tuberculosis, he will be followed by the Shastho Shebika who will provide drugs and follow him/her until treatment is completed. BRAC asks the patient to pay a bond of agreement of 5 dollars (200 takas) which is returned to the patient once he or she has complied to the end and pay a small sum to the Shastho Shebika.

Interviewed for StopTB news in 2001, BRAC's Deputy Executive Director MD. Aminul Alam said:

"If tuberculosis is primarily a disease of poverty, it is because good nutrition, good housing, a decent job and living conditions give the advantage to the human being over the bacilli, as was demonstrated by history (...) The basic principle of BRAC is to seek to pool people's productive capacities, to share creative ideas on improvement in labour, and to organize 'exchanges' (the Market) that will fulfil each and every one's needs. Treatment and cure of tuberculosis is an obvious and basic requirement for people not to be poor. Today BRAC covers about 30 million population (23% of country population) through its tuberculosis control programme with a cure rate of 89.6%. Case detection rate in 2001 was about 45%. In BRAC, we are not trying to be 'pro-poor', rather, we believe in each and every human being as 'wealthy' because to be wealthy is to be capable, to be intelligent, it has both material and spiritual meaning.⁶⁸"

A review of the role of NGOs in tuberculosis control reports that NGO health services are often of high quality, and popular with patients, and they often achieve high cure rates. The problem arises in conjunction with long term sustainability essential for TB control. The conclusion of the report is that the role of NGOs needs to be understood and emphasised, and that their primary contribution will be one of international advocacy.⁶⁹

“The nature of many NGOs has changed in recent years. Many organizations have recognized that their primary role is to facilitate and support – to help build capacity of individuals, communities and governments. This is particularly important when it comes to TB control. TB will not be controlled in 5 years or even 10 years – it will probably take at least 20 or maybe even 50 years. Few NGOs can be committed to providing services for that period of time. NGOs now recognize that they must support and help communities and governments develop and maintain the services that are essential for TB control”. Ian Smith, advisor to the DG, WHO.⁷⁰

NGOs in Nepal have been pioneer in advocacy for tuberculosis, and started the first international meeting and e-forum for international NGOs to exchange ideas and commitment in advocacy for TB.

Today, a further step has been taken with the creation of a network for TB and HIV combined advocacy.

Examples of:

NGOs active in delivering and promoting PHC and TB care in Asia:

Gonoshasthaya Kendra (Bangladesh)

BRAC (Bangladesh)

Voluntary Health Association of India

Catholic Health Association of India

Society for Community Health Awareness, Research and Action (SOCHARA) India

ICEHA International Center for Equal Health Care Access (Vietnam)

Aga Khan Foundation

Britain-Nepal Medical Trust, Nepal

INF Tuberculosis Leprosy Project, Nepal

Save the Children in Bhutan and Nepal

Indonesian Association Against Tuberculosis (PPTI), Indonesia

4 Innovations to improve access to health services

4.1 Mobile medicine and the use of modern technologies

For many years, “horizontal - fixed” health care posts and systems have been opposed to “vertical - mobile” systems. However, recent successful public health strategies as well as NGO experiments in Asia, indicate that strengthening health systems for surveillance, prevention and care may combine both and provide a continuum of care from the PHC community health worker to the tertiary sophisticated urban based care.

There are several aspects of mobility in medicine which are surveyed here:

The “mobile medical team” and its use in rolling back large epidemics back in the 20s, and recent use of mobility to fight malaria in an efficient system that’s backing up PHC

Internet use for health care and development for the poor as experimented by NGOs in a innovative approach to PHC, examples include the Ratanakiri mailman

Telemedicine today can provide efficient links between primary health care and secondary-tertiary care. It makes each aspect of the chain more efficient.

Mobile teams can be advanced surgical teams-bringing secondary and even tertiary care to remote rural areas. Trucks, boats, special vehicles, even planes have been used by NGOs.

The idea of mobility itself can entail PHC nurses going on bicycles, rotating physicians when human resources are scarce.

Health care in the future could entail all of the above and entail all of the above for greater efficiency of the whole system, overcoming bottlenecks such as the dearth of human resources or the reluctance of physicians to go into deprived rural areas.

4.1.1 Mobile team approaches to back up primary health care

The importance of the mobile unit is that it provides the expertise, the know-how and the means for the volunteers and community people. The concept of mobile medicine is not new. At the turn of the century mobile medicine meant a team with a specialist physician field hands, drugs and microscopes, going from village to village. Since the French physician Jamot (1879-1937) coined the idea and crisscrossed all of Central Africa to roll

back the most devastating plague of the 20s, trypanosomiasis (one third of the population of Cameroon died of sleeping sickness)⁷¹, the idea was at the source of the OCEAC (Organization for the Coordination of the Struggle Against Endemic Diseases in Central Africa) and OCCGE (similar French organisation based in Burkina Faso for all of West Africa) epidemic surveillance and control institutions. At its apex in the 1960s, mobile medicine utilized 1100 vehicles in Africa.⁷² It is returning today with utilization of a technological continuum from space research and satellites to low tech use of communication in remote rural areas.

From Jamot’s era to today, the use of mobile teams can be a fitting response to the difficulty represented by the lack of qualified personnel in rural areas. In fact, the concept is not that different from the travelling rural doctor experience in Italy or France not so long ago: it is not the patient who came to the doctor, the distances being too great, the doctors too few, and the cost too important for the patient. Rather, it is the doctor, or the nurse, who travels, and the villagers who know when the doctor shall come so that the patients be ready to see him.

4.1.1.1 Going to the patients

Mobile medical team travelling from village to village provide backup to local community efforts in combating a specific disease or providing general health services.

In Bangladesh, it was the innovation of having nurses do rounds on bicycle brought about by Zafrullah Chowdhury in the people’s health center system –GK– which eventually brought the State – then President Zia – to have all health workers use bicycles in Bangladesh!

The WHR 2003 notes “In rural Senegal, providing nurses with motorcycles not only made it possible to increase immunization coverage but also improved their access to technical support and reduced their isolation.”⁷³ The spectacular success of Vietnam’s malaria control campaign of the past ten years included mobility as a key component of the strategy.

At the simplest level, mobility can make a radical difference in preventive medicine (malaria control, immunization) as well as primary health care (community health being backed up by paramedical and nurses round). At the next level, mobility can mean doctors doing the rounds to provide assistance to community health centres staffed by nurses, or it can be used to visit far off areas. Lastly, mobile teams can be made up of experts coming to give support to local doctors or paramedics.

The capacities of the mobile team depend on the travelling human resources (e.g. team composed

of a malaria expert entomologist, a leprosy specialist, a TB-HIV care trained doctor). Mobile team systems can be used to overcome shortages in qualified manpower, be used to reinforce and give backbone to community workers as well as represent a quick way to overcome skilled personnel's reluctance to go into undeserved rural area. It can be surgical or medical emergency mobile teams with one area of specialization: the case of the mobile eye surgery clinics by vehicles, boats or even planes, or, for example, the mobile heart clinic travelling in urban slums.

4.1.1.2 Rapid Diagnosis and Treatment

Mobility, as experimented so successfully in Viet Nam in the fight against malaria, means that one specialist physician can cover a very large population successfully. During the 1990s, Viet Nam was able to decrease the malaria death toll by 91% within five years through the combine use of trained mobile teams to supervise health workers in malaria endemic areas alongside the recruitment of volunteer health workers to work with communities⁷⁴ describes this remarkable massive, mobile and close to the poor program against malaria in Vietnam.

4.1.2 Applying Modern Technologies in Mobile Medicine

Mobile medicine using the internet and telemedicine is paramount for improving rapid diagnosis and treatment of diseases as well as for the surveillance of emerging new diseases (e.g. SARS epidemic), the re-emergence of more virulent forms of old diseases (e.g. TB) and the emergence of drug resistance (notably to drugs used against TB, HIV and Malaria).

The utilization of latest technologies to improve health for the poorest most deprived part of the world population, far from being antagonistic with community based civil society implementation in primary health care, can actually be complementary and a unique factor for efficiency in health care provision in poor settings.

As pointed out in the Report of Working Group 5 of the Commission on Macroeconomics and Health, "Improving Health for the Poor" the problem in delivering health to the poor is, often enough, not just the lack of know how or instruments, but the "How to", the issue of **access to the poor**. The key challenge is access to services, and specifically access for poor and marginalized groups⁷⁵ – as was also stated in the Working group one of the CMH. As Jeffrey Sachs stated at the October 2003 Consultation on Macroeconomics and Health, marketing in itself will mean the antimosquito bednets stay in

the warehouses and media blitz will not in and of itself solve the issue of access for the poor.

Indeed. But further to the point the question is, should the poor be close to services or health services go to the poor? As the past few years development in PHC indicates, ACCESS must mean both.

4.1.2.1 Telemedicine

Telemedicine is only at its beginning, but will be called upon to play a larger and larger role in providing qualified care to remote areas, as the technologies become available. Telemedicine provides the advantage of better use of technical equipment in a central manner. While it appears as a way to modernize secondary and tertiary care structures, it can also bring distant undeserved places into contact with latest most sophisticated medical centers. India's Space Research Agency is planning the launch of "Health Sat" a satellite solely devoted to health care and 40 medical institutions are linking up into the project for telemedicine.⁷⁶ The French Space agency is using its small telemedicine suitcase to bring the most advanced diagnostic tools to the remote tribal parts of Guyana.

NGOs that are technology conscious are also developing projects in India using telemedicine. For example JIVA is combining telemedicine with traditional Ayurvedic care.

4.1.2.2 Internet

Internet usage. Thousands of community based groups and NGOs are discovering the use of internet for poverty or health projects every month.

Some projects involve static internet focal centers (kiosks) in villages (such as Drishtee India), permitting exchange of information from center to center and from centers to the regional government (and health facilities), the national government, and even medical centers abroad.

Some projects combine mobility of a postman – on a motorcycle- with internet access, limiting the requirements in terms of internet access points. An innovative North-South NGO is linking villages to villages and villages to the Worldwide Web in Cambodia.

4.1.2.3 The internet facilitates communication of health news and health education.

Health services can "piggy back" on other money making or State funded internet services. Once the tool exists – in this case the Kiosk (in internet focal point center) - a large number of proximity services can be supplied. The Kiosk is extremely

The Ratanakiri Mailman

The American Assistance for Cambodia/Japan Relief for Cambodia, an American based NGO has developed a new method called the Ratanakiri Mailman, which bridges the health divide by linking villagers to central hospitals and to Harvard Medical School. The villages are located in Ratanakiri (border with Vietnam and Laos) and have no postal system or access to phones. The "Mailman" or the internet village motorman can go where there are no roads, thus accessing remote villages. He collects information from villages and then goes to the central satellite, empties all the information collected and stored in a few minutes by connecting to the internet through the antenna. Transfer is automatic once he is in the vicinity of the antenna.

In a village, the school is equipped with solar panels which provide electricity and power to run the donated computer. The village and the motorcycle have a short distance capacity antenna that uses little electricity. The teacher recruits a villager who receives training in computer usage and also works as a local health focal point. Through his/her connection with the mailman, he/she can send information about patients to the central hospital and even to Massachusetts's Harvard Medical School. This project is fast expanding to other communities in Cambodia starting with Preah Vihear and Siem Reap.

useful for health, although their first objective was not health per se. When government budgets are limited, it is intelligent to use and invest in services provided for other purposes and in other fields. For example, in rural zones, it is very important to know the weather forecast and the market price of different agricultural products and raw materials.

In India, entrepreneurship is flourishing around each local village internet kiosk which assists in permitting exchanges with the government as well as health news.

DakNet is an Indian project that focuses on bringing benefits of new technologies to more people and resulted from a partnership between the MIT Media Lab, the Government of India, and leading academic institutions. It uses a unique combination of physical and wireless transport to offer data connectivity to regions lacking communication infrastructure. The hybrid network architecture (patent pending) enables high-bandwidth intranet and Internet connectivity among kiosks and between kiosks and hubs. Internet often starts with schools, and the technologically open minded youth of Asia- over 60% of the population- can fast assimilate and disseminate such tools. In the words of a tuberculosis programme coordinator in the field in India: "without computers and the Internet, we are fighting 21st-century health problems with 19th-century tools".

4.1.3 Applying the concepts of mobility for the surveillance of diseases

Ever since the SARS epidemic, surveillance of the emergence of new diseases is of paramount importance, while the emergence of drug resistance (notably to drugs used against TB, HIV and malaria) is another. The CMH working group

5 proposes a "Massive Effort for Global Health Surveillance"⁷⁷ and calls for the establishment of a Global Health Surveillance Facility: "A sine qua non of any global program to improve the health of the poor would be routine, reliable, low cost, and long term reliable health surveillance systems. Currently no low-income country has adequate coverage of the four, often quite different surveillance function... The very fact of death is frequently not recorded in many poor countries"

This means that even the best statistics on health in the world, that of the WHO, is in part guess work, and that the international community is "blind" to the emergence of new diseases patterns.

4.1.3.1 Improving the quality of Data collection - Monitoring Vectors

As a World Bank report of 1998 reminds us: networked computers have played a vital role in controlling Onchocerciasis, or river blindness, in West Africa: "Data collected by sensors along 50,000 km of rivers were fed into computers by local inhabitants. From the computers the information was beamed to a network of entomologists by satellite radio, and used to calculate the optimum time to spray against disease-carrying black fly. River blindness has now been eliminated in seven countries, protecting 30 million rural people from the disease and opening up 25 million hectares of land to settlement and cultivation.

The CNES (National Center for Space Research) of France points out that satellites are of use for monitoring of disease vectors, and it has established a think-tank to consider the contributions of present and future space systems for telemedicine, focussing notably on teleconsultation for remote areas' primary health care (covering dermatology, maternal and child health, parasitology and emergency medicine). Having developed a telemedicine box, the CNES is presently using that most advanced technology to improve

health in the most deprived tribal parts of rural Guyana. This new system was presented at the recent world summit on the information society⁷⁸. (WSIS Dec 2003, Geneva).

4.2 Concepts of Mobile Medicine - Summary

The involvement of local communities in the health system could be efficiently assisted with mobile public health units to check for epidemics, bring know-how, register demands for assistance, and alleviate the shortage of human resources especially in rural areas. Equipped with the latest technologies in order to diagnose, treat and monitor epidemic diseases (especially those that are vector born such as Malaria), mobile medicine along with primary Health care might represent the medical system of the future and a sound approach to implement the Millennium Development Goals.

Most common is local pilot mobile acute care or surgical care unit. Local or regional examples of NGOs, mostly those involving a North-South collaboration using mobile vehicles, planes or boats mostly for acute care or surgery exists a bit everywhere. What is interesting about them is the fact that by being mobile, they go to underserved populations, they go to the patient instead of waiting for the patient to come into the hospital (or never come to any secondary or tertiary care unit for lack of access or financial means). The most interesting cases raise the question as to State investments in collaboration with NGOs into those type of care, as they can be very efficient (eye interventions for example), bypass the problem of incentives for physicians to go into underserved areas, and can also involve multidisciplinary teams.

Less common is State backed use of mobile units to control an epidemic in the tradition of the post war OCEAC and OCCGE. This is the case for the Vietnamese extraordinary successful roll back of malaria in recent years. In the new approaches to mobile medicine it is not imposed on populations as a vertical programs of the old days, rather it is supportive of primary health care system and community involvement and preventive care. It is also the basis for collaboration between State, community groups and NGOs. Considering the possibilities offered by internet and the technological advances made in mobile vehicles and mobile medical care (as in use for the military), there is ground for conceptualizing the health care model of the future.

Health use of satellites. Satellites have been used for controlling large epidemics, as epitomized by the highly successful WHO program on Oncocerciasis. Today, developing countries such as India

and preparing the deployment of health satellites imagining the use of telemedicine in the future. In French Guyana, pictures of blood slides are analysed thousands of kilometres away. In a sense, this means that the local health provider need not be equipped with ten years of medical school to know what to do. If he can send the picture over the internet, some far away lab can send back the diagnosis right away.

Information and Computer Technology for development: Even without telemedicine proper, the capacity of the local community focal person, for health, or education, for the local kiosk, to communicate with email to the regional hospital, to the weather forecast, to the central government, and even to far away centres of medical excellence, like Harvard, can mean a tremendous boost to community medicine and community development.

In conclusion, globalisation can also mean that the poorest part of this planet have a right to the best technologies, much as backward Europe

Examples of:

NGOs experimenting in mobile medicine: Mobile surgery and tertiary care:

Gopio-Asian Heart Foundation

Project Orbis

Mary Stopes Int.

Internet and mobility:

The American Assistance for Cambodia/Japan relief for Cambodia (Cambodia)

Drishtee (India)

Jiva Institute (India)

Daknet

Telemedicine

Indian Space Research Organisation ISRO- national project for PHC- India.

CNES (Centre National d'Etudes Spatiales) – France. New partnership for telemedicine for remote areas.¹

benefited from the Arabic invention of numbers – noted Amartya Sen, who expressed otherwise support for the protesters against globalisation as they question “ *our world of extraordinary deprivation and of staggering inequality*”.⁷⁹

Physical mobility of health teams combined with the use of modern technologies make health care work for the poor by reaching out to people, rapidly diagnosing and treating diseases, linking primary-secondary-tertiary care and ensuring long-term sustainability by building health systems that are based on involving communities for their own care⁸⁰.

Conclusion

Strengthening the health system and its capacity to reach the poor will entail strong State involvement and strong NGO and community participation.

Asia has the largest mass of poor and extremely poor people in the world. In such instance, “targeting” may not be a useful concept – as the World Health Report 2003 noted.

Rather, to reach the poor, a health system will deploy its resources to the farthest corner of its rural population, to the most deprived of its urban slum, using advanced technology and above all, giving support to community people and community organizations.

The importance of strengthening the links between the different institutions and actors in the health field should not be underestimated. Such revived and/or new partnerships will be built on the principle of equity and accountability between the parties.

NGOs and CBOs have contributed important innovative systems to insure that poor populations have access to health.

What are the determinants of a functioning health system?

It must:

Have a sound foundation. Strengthening human resources in health and decreasing the brain drain are priorities at international and national level. NGOs accomplishments are dependant on functioning public health systems. In some limited instances, NGOs that are parastatal replace the State in health delivery, as is the case in Bangladesh. In some countries, or regions, FBOs are the main source of health care.

Have Speed: it must be able to act fast when epidemics strike. Good coordination, from communities to the international centre, in cases such as SARS, is key to efficiency. Global surveillance of diseases is necessary to protect people as a community, a nation, the concert of nations. Today, mobile medicine and use of internet can be combined with community based care for maximal response capacities.

Be Flexible: There is not one model of Primary Health care but several, and the concept is evolving. Populations move, and microbes as well. In practice, access to health care can take different forms: the health care giver can go to the patient or the patient go to the health centre. There may be the need to redefine the respective role of the physician, the nurse, the health care workers or community health focal point.

There has to be an articulation between the primary health care level and the secondary-tertiary levels, so the poor are not cut off from hospital care when in need.

Be Responsive: Urban health delivery in sprawling cities of Asia combine expensive health care – that is not always efficient (MDRTB spread by private practitioners in India) - while the poor are denied access altogether. Equitable system will work better and be cheaper in the long run.

Be Accurate: haphazard treatment of “diseases of mass destruction”, such as HIV or TB will spell international catastrophes. Vertical definition of drug combination for specific diseases is essential- as done by the WHO’s Essential Drug program. But simultaneously, fundamental and operational research into epidemiology, ecology and spread of diseases in countries and by country people is essential to avoid central headquarters’ assumptions on disease control.

Be User friendly: If the system ought to have verticality in support mechanisms – for TB, HIV, (such as defining best drugs combination) or in national procurement mechanisms- it should be horizontal “bottom up” in its fundamental workings. The WHO WHR 2003 speaks of an *integrated health system*. User fees have been internationally identified as a barrier to access– yet, cost recovery is still advocated today.

Be Equitable: Move away from a high concentration of medical personnel in richer segment of cities and none in the rest of the country. While strengthening of human resources is a priority, increased mobility of health personnel would be more equitable and would lead to better outcomes.

Be Lasting: develop the capacity to treat chronic diseases even and especially in poor settings, diseases such as HIV. NGOs need to lean on strong health systems not to fall into the “forever pilot” syndrome. Cutting off secondary and tertiary care from State funding – and privatise- to focus only on the poor, will damage the credibility of the health system and be unsustainable economically.

Be Fitting: NGO actions are of two types: international NGOs and ground based NGOs. It is important to have collaboration and sharing at the national level. Large disparities between pay of NGO personnel, or pay for donor funded projects and the pay of local health care people who will sustain the project in the long run - are ground for inefficiency and destabilization. Collaboration South-South should be encouraged.

Concluding Summary

NGOs contributions to present and future health systems for the poor

Health System for the poor need not be and should not be *poor health system for the poor*. but, can and must be inscribed into the national and international effort of "*better health for all*"

NGOs are on the record to favour "best of" in Primary Health Care

NGOs' assets:

- Know-how to deliver good health care to poor populations
- international powerful advocacy capacity for health as a human right

What are the specific contributions of NGOs to efficiency in health care delivery for poor populations?

We have looked at four aspects:

- 1- Apprehending health care within a broader socio-economic context.
- 2- Global advocacy capacities to set health policy making and implementation
- 3- Proven capacities to implement efficient comprehensive primary health care
- 4- Capacities to innovate and prepare health systems for the future.

I. Apprehending health care within a broader socio-economic context.

- Health care 'works' not as a specific commodity but as part of a broader socio-economic assistance and education project for poor communities
- BRAC provides agricultural support as well as:
 - health and Tuberculosis care
 - Microcredit
 - Health insurance....
- GK provides Primary Health Care and secondary and tertiary care as well as
 - health education,
 - training for women,
 - schooling
 - banking, microcredit and community health insurance ...

NGOs delivery Vs State delivery – or collaborative system?

NGOs involved in health care favour collaboration with strong public health system

- In Tuberculosis control, WHO study sees NGOs as complementary to public health systems

Credit mechanisms represent important levers out of poverty

The principles of credit are understood by main NGOs in the field of microcredit for health and poverty alleviation.

- Community financing for health care is a necessary but not sufficient conditions for access to health.

II. Global advocacy capacities to influence policy making and implementation

NGOs as the new partners in global health policy making:

- PRSPs - GFATM – 3by5
- Filling PRSPs on four Ws of health care to poor populations is among the role of NGOs

NGOs as international advocacy network play an increasingly important role in placing health on top of the international agenda.

- Save the Children and the Millenium Development Goals - The Mumbai declaration- World Social Forum. January 2004

III. Proven capacities to implement efficient comprehensive primary health care

NGOs have demonstrated that PHC Systems are:

- efficient in disease control
- equitable,
- promote community participation
- foster women's emancipation
- AND utilize resources efficiently

- The case of the People's Health Center in Bangladesh.

IV. Capacities to innovate and prepare health systems for the future.

Resource poor countries have used mobility with primary health care to achieve maximal efficiency - Vietnam Roll Back Malaria in the 1990s.

State backed "selective PHC" models have been based on fixed posts with poorly trained staff and no supplies, discrediting PHC among the poor.

NGOs have favoured flexibility and mobility of staff: going TO the patient

PHC brings a swift response when people need secondary or tertiary care.

PHC combined with use of latest technology internet- satellite links may be the health systems of the future, proving best combined assistance.

Notes

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"Health professionals from developing countries migrate to richer countries where they can earn more. While this may bring some benefits to source countries in terms of foreign exchange receipts from remittances, the difficulty of taxing such transfers means that the effect on public finances is unlikely to be sufficient to off-set the training costs of the migrant.

The General Agreement on Trade and Services (GATS) considers migration of professionals as a form of international trade in services ("Mode 4" trade). ...In the case of Mode 4, any commitments made by recruiting countries will represent an increase in demand, or at least a block on reducing demand from that country in the future. This is particularly problematic because of the "most favoured nation" principle – that an importing country cannot differentiate between other World Trade Organization (WTO) Member countries as suppliers. This would appear to make it illegal under the GATS for any country which recruits health professionals abroad to limit recruitment from countries where migration would exacerbate shortages.

The GATS Agreement encourages developing country Trade Ministries to make effectively irrevocable decisions with far-reaching consequences for the availability and distribution of health professionals, in the absence of the minimum data or analysis essential necessary for informed decision-making; and it encourages rich countries to increase their recruitment of health professionals from poorer countries, while removing from them the means to limit the effects on countries with acute shortages. This would appear to represent a strong case for removing health services from the ambit of the GATS"- Such is the analysis of David Woodward, People's Health Movement Europe, and recently named economist for Save the Children.

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⁷⁷ Report of Working Group 5, Commission on Macroeconomics and Health

⁷⁸ Space at the Planet’s Bedside, report from the CNES, National Center for Space Research, France, example of use of telemedicine for remote parts of Guyana, presented at the World Summit on the Information Society, Geneva 2003: http://www.cnes.fr/actualites/Les_Dossiers/durable_va.pdf

⁷⁹ Amartya Sen addressing the Seminar on globalization arranged by the Falcone Foundation, in memory of Antonio Falcone, on 23 May, 2001. By arrangement with: Yale Center for the Study of Globalization, published on PHA-Exchange. (reproduced in www.HTM-journal.info)

⁸⁰ Present day NGO experiments in mobile medicines were chosen from the « Best of » international prize winning experiences presented at the World Summit on Information Society, December 2003, Geneva. Examples of telemedicine-space are public-private partnerships.