

Foreword

Formed in 2004, the Belgian platform for international health Be-cause Health, didn't wait for the Paris Declaration to put its principles into practice.

In its essence, Be-cause Health could be considered as "a sector wide approach" (SWAp), since this pluralistic movement offers itself as an excellent playground to gain experience in working in a complex environment and to engage in a continuous learning process. Learning to move beyond individual organisations, learning to balance between respect for diversity and coherent collaboration, learning to overcome apparent oppositions towards a deeper shared understanding, and learning from field experience.

Be-cause Health yields concrete results, such as the annual international seminar, the outputs of eight technical working groups, the preparation of a Belgian health policy note, the contributions towards (inter)national policies, the circulation of information and capitalisation of research, and the networking at EU level. The EU request to Be-cause Health to co-organise the EU health experts seminar isn't therefore surprising.

All this is only possible thanks to a great deal of voluntarism, the driving force of the movement. Its latest fruit is this first edition of a newsletter. Our newsletter will concentrate on reporting events. This first issue reports on the sixth annual seminar on Universal Health Coverage. For both seminar and newsletter we collaborated with Masmut, the platform on community health insurance.

Enjoy its reading and be(come) an active member of Be-cause Health. It's fun.
May this haiku poem inspire you:

*Dialogue is on
The cause of health is at stake
Spirits are moving (x2)*

Karel Gyselincx, Belgian Technical Cooperation, Chairman Be-cause Health

Be-cause health is a pluralistic network of both individual and institutional members such as NGOs, academia and public services, who consider health and health care as fundamental human rights. Current themes and working groups: human resources for health, access to quality medicines, sexual and reproductive health, people-centered care, social protection and universal coverage, HIV/AIDS, social determinants of health and cooperation in RD Congo.
www.be-causehealth.be



Images by Monique Van Dormael, Pieter Stragier & Tine Verdonck

Editorial Universal Coverage – Be-cause Health matters, aftermath events

The 6th Be-cause Health seminar was held in Antwerp on 10 November 2010 as part of the annual colloquium of the Institute of Tropical Medicine, Antwerp, Belgium, and was once more a highly successful event to say the least. This year the colloquium was preceded by a two-day Emerging Voices event where forty-eight Emerging Voices from the South presented their views on Universal Health Coverage in innovative presentation formats and fish bowl discussions.

Indeed after our Be-cause Health Seminar of 2009 that went beyond the numbers of Universal Coverage, the joint ITM/Be-cause Health/DGD colloquium focused again on the hot topic of universal coverage with the bottom-billion at the centre stage.

The idea of Universal Coverage in itself is not new: health and universal coverage were already discussed as a legal right in the 1948 UN Universal Declaration of Human Rights. In 60 years we saw numerous efforts, scientific breakthroughs, unprecedented global funding and targeting of the most vulnerable groups. Millions of lives have been saved.

Despite all attempts we are not yet there: 72% of the world population still has no access to comprehensive social security systems and one third has no access to any health services at all. Our joint colloquium aimed at mapping universal coverage and addressing the blind spots in existing efforts with a special focus on social health protection, health inequalities, maternal and child care and family planning.

Our colloquium was a prelude of several international events. In Montreux WHO brought together researchers, policy-makers, funders and ITM's 40 Emerging Voices from the South in the First Global Symposium on Health System Research – Science to accelerate Universal Health Coverage. The main objective was to share evidence and to reflect on the needs of low and middle income countries. Political will came out as a very important driver and research as an important player in providing evidence on best practices and on how to best influence the political agenda. The World Social Security fora in Brazil and Capetown in December 2010 and the IV World Social forum on Health and Social Security in Dakar in February 2011 show the growing public demand and the powerful voice and role of civil society in the debate.

One thing is sure: it is time for action to move towards universal coverage from all sides.

*An Appelmans and Dirk Van der Roost, ITM
Valérie Van Belle, National Alliance of Christian Mutualities, Masmut*



Be-cause Health Seminar 2010 Networking during the break

Plenary session

The hosting partners Be-cause Health (Martin Vandermeulen), The Belgian Technical Cooperation (François Bontemps) and ITM (Bruno Gryseels) welcomed the more than 200 participants. Their central message was built around a Switching the Poles approach: the classical north/south relations are over and Switching the Poles is the only way forward: the south is in the driver's seat and there is mutual exchange and learning between north and south. David Evans gave a preview on the World Health Report about Universal Coverage (see summary above). Gorik Ooms highlighted the international political economy of Universal Health Coverage. He pleads for pooling bilateral aid and for merging the best elements of existing programmes to create global social contract. Liliana Marcos of the Spanish Family planning Federation gave an NGO view on the EC Global Health Communication followed by comments from Jason Lane from DGDevelopment (EC).

An Appelmans, ITM

Summary of the World Health Report 2010

The 2010 World Health report deals with 'HEALTH SYSTEMS FINANCING, the path to universal coverage'. In fact, it is a follow up report on the 2008 World Health Report, which proposed 4 major health reforms, one of them being 'universal coverage'. We had the honour to welcome David Evans, chief author of the report as key note speaker at the colloquium.

The reports states that every year 100 millions are pushed into poverty when they use health services, due to exclusion linked to factors outside the health system – inequalities in income, education and social exclusion -, because of weak health systems, and because of weak domestic health financing systems. The latter is the focus of the report. Direct payments of ill individuals need to be reduced.

Countries can raise revenue for health more efficiently by finding new or diversified sources of funds e.g. through 'sin' taxes (e.g. on tobacco) and other innovative taxes and through the development of health insurance of various forms. Community based insurance and micro-insurance can play a useful role in the early stages, but plans to merge them over time are important. In general, prepaid contributions, be it through taxes and/or insurance, will have to be made compulsory.

Furthermore countries can examine and reduce incentives that currently encourage inefficiency, e.g. in the area of medicine prices. Simultaneously they have to look at various mechanisms to eliminate or limit direct contributions paid by the poor and vulnerable everywhere.

Finally Evans made an appeal to the international community to keep current promises, to install innovative international financing such as a financial transaction taxes, and to stop continually introducing more global health initiatives, which are making the global health landscape more and more complex.

In conclusion:

The world is still a long way from ensuring that everyone can use required health services without the risk of financial ruin.

Even richer countries struggle to raise sufficient funds and to protect the poor and vulnerable in the face of ageing populations and increasing options for improving and maintaining health.

All countries can do something more to develop their financing systems to move closer to universal coverage or maintain it where it has been achieved

The global community can do more to raise needed funds in poorer countries to improve the efficiency of the global architecture, and to ensure that funds channelled to countries strengthened domestic financing institutions and capacities

The entire report can be downloaded at www.who.int

Dirk Van der Roost, ITM



Parallel sessions

Leveraging social protection

The objectives were to understand the links between the right to health, universal health coverage and social protection, and to allow contradictory debate. The session was opened by emerging voice Amal Shafik. Rachel Hammonds, researcher at the ITM of Antwerp, introduced the human right to health as a universal right enshrined in many international treaties and national constitutions. But the reality in many developing countries is that weak governments and inadequate accountability mechanisms undermine people's belief in their entitlement to health services and the government as an accountable duty bearer.

Maria Quispe, coordinator of the national movement 'women for life' in Ecuador, shared how her movement aims to recognize women as household workers and include them in the social protection scheme. Meeting this goal will mark an important step in achieving the right to universal insurance especially for women doing domestic work and unpaid care work at home. Jean-Claude Wema, GP advisor in the Mutual Health Association Support Unit in Bukavu (Congo) explained how users can improve the quality of health services and hold the health cost lower. Finally, Maria-Pia Waelkens presented an experience of community empowerment through the setting up of mutual health funds in Uganda. Empowering allows people at grassroots level to improve the way in which they express their needs, in deciding for themselves and in acting to obtain what they need.

In this session we heard from practitioners on the ground who argue they are helping communities to claim their right to health by participating in the development of community-based health insurance programmes. One key element of the rights-based approach to claiming rights is participation. In the absence of a political and social system that allows them to claim the right from the government, the community is helping to make the right to health a reality. The participants of the session discussed how health insurance should and can be leveraged to expand the debate to the national level. Werner Soors concluded by saying that the setting up of community-based health insurance schemes can be a mean to reach health for all, but not an aim for itself.

Valérie Van Belle, National Alliance of Christian Mutualities, Masmut

Family Planning, the way forward to improve MDG5?

3 presentations, from a demographic, a rights based and a health perspective clarified the answer to this question. Emerging voice Tamrat Assefa Nigatu shared the Ethiopian experience. Professor John Cleland stressed the importance of going back to the basics of population politics. His colleague Mrs Bibiane Mbaye went against him with her case for putting a rights based approach at the centre of the family planning discussion. Dr Aida Libombo contributed with her experience as gynecologist in Mozambique.

The different approaches and views on family planning gave way to a lively discussion. All agreed though that family planning deserves much more attention than it receives now. Family planning is to be taken more seriously. Sadly enough the small number of participants to this session already demonstrated literally how few people see it as a priority. There is an urgent need for more champions on family planning, for more political and financial leadership both in the North and in the South. We all have to work hard to get family planning at the top of the agenda.

Lut Joris, Sensoa

Equity

We define 'inequities' as inequalities that are socially unjust because they affect people and are avoidable. In its report 'Closing the gap in one generation' (2008), the WHO Commission of Social Determinants of Health included 'power' in the list of things that are unequally distributed: 'Health inequalities are due to unequal distribution of power, income, goods and services - globally and nationally -, to the consequent unfairness in the immediate, visible circumstances of people's lives (...) and their chances of leading a flourishing life.'

The session at the colloquium aimed to come up with arguments on how the health sector and health systems can contribute to empowerment and reduce the inequities, and on how to monitor and steer this.

Linda Mashingaidze, a young researcher from People's Health Movement, made the link between living conditions and health and advocated for a greater involvement of the health sector in tackling social determinants. Matthew Geddes from the Institute of Development Studies, Sussex, argued that by giving a different weight to quintiles, health indicators can better highlight improvements for the poorest quintiles. The indicators proposed report on progress, but don't reward the current situation. Most probably several indicators are needed to express well equity. This illustrates the difficulty to deal with complexity and to dispose of clear and understandable data at the same time.

A full room attended this session, with a lot of lively interaction. Clearly, equity was close to the mind and hearts of the participants from South and North. Be-cause health will come back to this subject and to the social determinants during the Annual Seminar end of 2011.

Guy Kegels and Dirk Van der Roost, ITM

Maternal Health

Linking MDG 5 to Health System Strengthening and Universal Coverage is quite a challenge, though more than needed if we aim at improving the access to quality maternal and reproductive health services for the most vulnerable people.

An emerging voice, Manassé Nimpagaritse set the scene with his Pecha Kucha (6m 40 sec!) on the free maternal care policy in Burundi. Abigail Kyei, International Midwife Adviser for the International Confederation of Midwives (ICM)/UNFPA program addressed the contribution of midwives in reducing maternal mortality in developing countries: Ghana succeeded to have skilled attendants available in remote areas. Fabienne Richard, ITM Antwerp, presented lessons learnt from 8 different schemes aiming at reducing financial barriers (vouchers, cash transfers, national health insurance, free selective care, community based insurance,...).

As an example of putting strategic visions into action, Dr Saloua Abouchadi, Direction des Hôpitaux, Morocco, highlighted the stepwise implementation of the maternal mortality reduction policy in Morocco. Dr Mean Chhi Vun, Director of the National Center for HIV/AIDS, Dermatology and STD (NCHADS), Phnom Penh, Cambodia shared how the Linked Response approach works increase the coverage of prevention of mother-to-child transmission of HIV (PMTCT) and reproductive health services at national level.

Although there is evidence in terms of what should be done in the field of maternal health, further research is needed on how interventions could be formulated, implemented and sustained at national scale in low-income countries, particularly in a way that builds the capacity of country systems to carry on with these interventions overtime. This area of research and technical support is the priority if we want evidence based policies to be effective and sustainable.

Fabienne Richard, ITM



François Bontemps opens the Be-cause Health seminar



Fabienne Richard introduces the session on Improving maternal health and health system strengthening

Food for thought

We must continue to spread the word about what works and what doesn't in health, no progress will be achieved by being timid, refusing to face unpleasant facts, or prejudging our fellow human beings. Spread the word as silence may mean death

(Koffi Anan)

An Emerging Voice from the South: NS Prashanth from India

More contributions can be found on the blog of our colleagues:

http://internationalhealthpolicies.blogspot.com/2010_11_01_archive.html

Research in health today is dominated by researchers from the richer countries. While research institutions in the South grapple with poor research budgets, poor teaching and skills and the lack of a 'culture' of research, most Northern institutions have had the benefit of long years of colonisation and Western science and greater budget allocations. Even when global research grants are given, the agenda is often dominated by the richer countries. In ITM, many of us emerging voices saw a genuine commitment to shift gears.

(NS Prashant, India)

Call for participation, reflections

In that spirit we ask you to participate in the Be-cause health Newsletter. We welcome you to ventilate your thoughts, ideas and critical comments to make it a lively exchange. You are kindly invited to contribute to our next newsletter that will focus on People-Centred Care. Do not hesitate to contact us (becausehealth@itg.be) if you have suggestions or ideas for improvement. We really hope we can involve as many of you as possible to make this newsletter a forum with useful and stimulating food for thought.

Save the date (upcoming events)

Seventh annual seminar on Social Determinants of Health: 15-16/12/2011