Partnership in Health and Poverty: Towards a Common Agenda

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Partnership in Health and Poverty: Towards a Common Agenda

Report of an International Meeting
WHO headquarters, Geneva, 12-14 June 2000

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1. Introduction

The World Health Organization (WHO), in collaboration with the World Bank, the United Kingdom Department for International Development (DFID) and the European Commission, held a major meeting on *Partnership in Health and Poverty: Towards a common agenda* (WHO headquarters, Geneva,12–14 June 2000) with key development partners. The 130 participants included senior government officials from developing countries, experts from civil society organizations and academic institutions worldwide, and health and development officials from United Nations and bilateral agencies, the World Bank and regional development banks (see Annex 2 for list of participants).

The main objectives of the meeting were:

- To provide a **forum for exchanging** information on current thinking on health in development and on current practice related to health and poverty reduction
- To **identify critical gaps** and obstacles in knowledge for action
- To encourage participants (as key development actors) to discuss strategies on how to **strengthen partnerships and other efforts** to integrate health into national and international development planning
- To stimulate **joint action** on research, policies and actions
- To build **linkages** to forthcoming United Nation events and other international meetings.

Each of the eight sessions of the three-day meeting was structured so as take stock of current thinking and activities; to identify obstacles, opportunities and critical gaps in knowledge for action; and to identify ideas and recommendations to be carried forward and to specify the responsible actors (see Annex 1 for meeting agenda).

The first four sessions focused on **analysis of health and poverty**, covering:

1. Health as an asset: protecting and improving health as a core international development strategy.
2. "Voices of the Poor" - some lessons for health.
3. Ill-health and poverty, health and development: addressing the links.
4. Globalization and health consequences for the poor.

The remaining four sessions focused on **actions to protect and improve the health of the poor:**

5. Implications for health systems.
6. Implications for sectoral/development policies.
7. Implications at country level
8. Implications for action.

By holding a session on “Voices of the poor” on the first day, the meeting gave full recognition to the concept of good health as the greatest asset of the poor. It acknowledged that development policies focused predominantly on economic growth without a strong protective social environment had not achieved the best possible economic outcomes, and at the same time, had widened inequality in health. The meeting therefore aimed to find new strategic approaches to health and development through cooperation and partnership. Subjects covered ranged from how to understand the multidimensional needs of the poor to ways of negotiating at the international level for financial support to put a pro-poor health agenda into action.

The papers presented (see Annex 3), the discussions, and the recommendations that emerged from the meeting were very rich. This report cannot hope to capture fully the breadth of knowledge and vision displayed by the participants. It aims only to sketch some of the key messages, ideas and debates to which each session gave rise. As such it complements the March 2001 issue of *Development,* the quarterly journal of the Society for International Development, on “Partnership in Health and Poverty” which contains many of the papers (see Annex 4). It is a record of an important moment in the history of the WHO and its partners in their collaborative effort to put health where it belongs − at the centre of sustainable development.

2. Health and poverty: review and analysis

"The need for much closer integration of economic, social and environmental objectives … [where] … health policy is a core instrument for poverty eradication has been acknowledged. This is a real sea change. … We are challenged to take full advantage of this shift in thinking and to face up to the tough task of putting policy into practice. … A common strategic framework will be needed, to guide both health and broader development actors on the health content of anti-poverty policies and programmes." *David Nabarro*

Opening session

Setting the meeting's agenda

The opening session set the context of the meeting in terms of both the history of the emerging partnership between key health and development actors and the main messages that informed the programme. In her welcome to participants, *Poonam Khetrapal Singh* said that the meeting was an opportunity to exchange information, identify knowledge gaps and key partners, and design joint actions that will lead to a common agenda for pro-poor health systems.

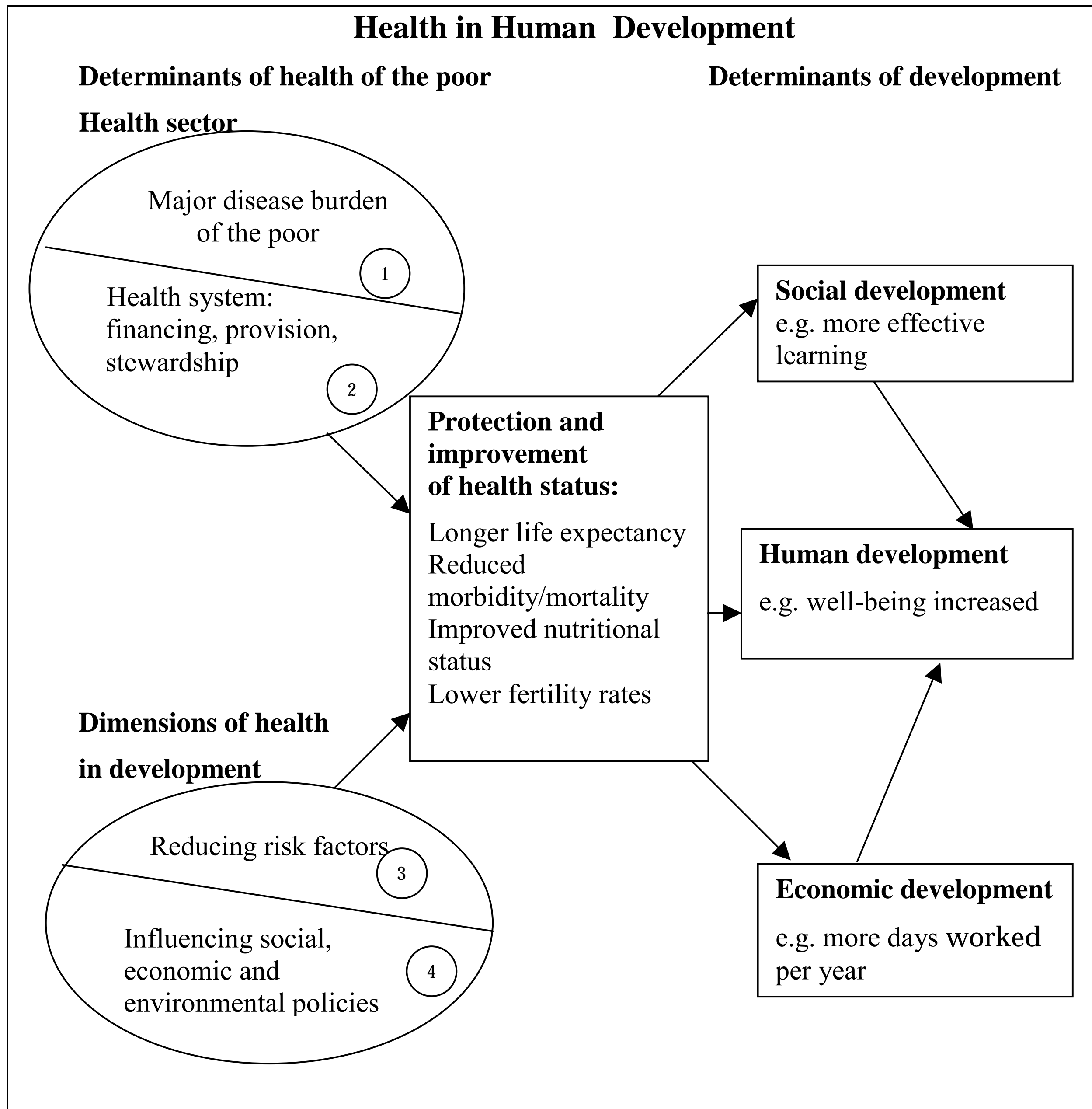
David Nabarro, in his opening remarks, put the meeting in its historical context as the follow-up to the ministerial meeting on "World Health Opportunity; Developing Health, Reducing Poverty" held in May 1999 in London and hosted by DFID. The ministerial meeting had framed a new agenda for international health based on an international partnership among WHO, the World Bank, DFID and the European Commission to ensure that the full benefits of investing in health were brought to bear on the livelihoods of poor people. That meeting had called for closer linkage and more coherence between international health policy and macroeconomic advice to countries. The main message had been that translating policies into practice would need a better understanding of the health needs and priorities of poor people.

Towards a common framework

In responding to that call, the second partnership meeting in Geneva took up the challenge of how to turn policy commitments into action that would protect and improve health of the poor not only as an end in itself, but as a means of advancing economic and social well-being. The meeting recognized the need to develop a common strategic framework to guide actors in both health and broader spheres of development on the health content of anti-poverty policies and programmes. Ideas on the contents of such a framework were voiced in both the plenary and group work sessions. The WHO framework for a pro-poor health strategy was offered as a starting point for further discussion. It focuses on four strategic directions:

- Influencing economic, social and environmental development policy;
- Reducing health risks through a broader approach to protecting and improving the health of populations;
- Reducing the excess mortality of poor and vulnerable populations;
- Ensuring that health systems serve the poor effectively.

The meeting was asked to consider ways of establishing equitable health financing systems that would allow partnerships to carry out programmes in accordance with those four strategic courses of action.



Source: WHO/HSD

1 Reducing the burden of excess mortality and disability, especially in poor and marginalized populations.

2 Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair.

3 Reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.

4 Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

Moving from words to action

Eva Wallstam, introducing the programme for the meeting, explained how WHO understood the links between health and poverty in diagrammatic form.

Participants were asked to take up the following core tasks for the meeting:

- To ensure that the outcome of the meeting was focused on actions that would benefit poor people directly as well as indirectly;
- To enable health actors to take a more comprehensive approach to health and development so that alongside health equity goals they considered the impact of health on social and economic development.

Participants were also asked to use the opportunity of the "sea change" in policy opinion about the links between health, social and economic development in order to draw up practical ways, using their tools and knowledge, to protect and improve the health status of the poor.

The links to international agendas

John Martin pointed to the crucial linkages that are were being made between poverty and health at the international level: in the five-year review of the World Summit for Social Development; in negotiations at the World Trade Organization (WTO); at the G8 meetings; at World Bank and International Monetary Fund (IMF) meetings; and in plans for future international summits such as the conferences on Finance for Development and the Least Developed Countries and the 10-year review of the United Nations Conference on Environment and Development in 2001. In those meetings it was important to put health on the agenda not as a service, but as an asset.

Alex Preker joined in tracing the changes during the five years since the World Summit for Social Development, with uneven but significant shifts in priority to support social aspects of development. The challenge was to link social development to economic development at the country level. Understanding social services was a key component of development that included a poverty focus, but that was not enough: it was necessary to look at development as a whole. The World Bank's Comprehensive Development Framework (CDF) was an effort to put a more comprehensive development agenda at the centre of the financial assistance provided by the Bank and IMF. Through mechanisms such as CDF, the World Bank was working to change the way it understood poverty and social development. Indicators on which it based its policies were now aimed at covering the full life cycle and full range of conditions that affected the poor. In addition to the enhancement of human capacity, efforts should be well grounded in social services, safety nets and linking the social infrastructure development to the social development agenda.

Looking anew at poverty reduction

Jean-Claude Faure explained that the partnership needed to work on three main strategies to achieve pro-poor growth: to put equity alongside economic growth as the goal of development; to provide the resources to ensure human security founded on basic needs; and to empower people to act in their own development process, especially women. In taking a fresh view of poverty, health had to be integrated into all three areas through an honest partnership with civil society including capacity- and institution-building. Harmonious and effective coordination with a renewed sense of responsibility

on the part of donors was needed to ensure that financial resources were linked to poverty reduction and social policy.

In the general discussion following the presentations, participants raised several recurrent issues: what form the common agenda should take; the need for a clear definition of poverty; and ways of ensuring the openness of the partnership.

Session 2: Voices of the poor - some lessons for health

"Poverty is pain; it feels like a disease. It attacks a person not only materially but also morally. It eats away at one's dignity and drives one into total despair." A poor woman, Moldova. Quoted in *Voices of the Poor- Can Anyone Hear us?* World Bank

"We have to try to look at health with the perspective and through the eyes of the poor. In this way we would come to different conclusions." *Deepa Narayan*

Health as an asset of the poor

The session set the tone of the meeting by beginning with an in-depth examination by the World Bank of what poor people were saying about poverty, well-being and health and by exploring what a sustainable livelihoods approach brought to health and development.

Deepa Narayan put forward the new perspective for development and health "through the eyes of the poor". She based her presentation on material gathered for the *Voices of the Poor*, a study conducted by the World Bank to inform the *World Development Report 2000/2001: Attacking Poverty* and poverty reduction strategies. The study findings were based on discussions using participatory research methods with over 60000 poor men and women from 60 countries. She highlighted four key findings from the study:

- Poverty is multidimensional, and powerlessness and voicelessness emerge as trapping poor people in an interlocking web of poverty.
- The body is sometimes poor people's only asset and is a major source of insecurity.
- Gender inequity and domestic violence against women remain widespread.
- State institutions, including health care institutions, are experienced as corrupt and ineffective. NGOs are appreciated where they exist but are not perceived as empowering or accountable to the poor. As a result, poor people end up depending primarily on their own informal networks of family, kin and friends.

The implications of the findings for action by the health community, she suggested, are critical for the partnership to consider:

- Affordable health protection services, curative services and innovative health insurance programmes for poor men and women are vital. Health care providers must give *caring* health care to poor people and not treat them in ways that violate basic norms of humanity.

- The body has to be seen as an asset and an energy system that is constantly expending more than is available to it. More emphasis therefore needs to be given to developing energy-saving devices that improve health and ultimately contribute to development. These include: reducing the distance to water and firewood; improving transportation and roads; and reducing harassment and waiting times when poor people attempt to meet their daily survival needs.

- New partnerships between public authorities, the private sector and community groups must be formed in order to provide clean water and basic sanitation as the foundation for good health.

- Violence against women must be seen as a public health threat and addressed by health care professionals who also need to care for the mental health of individuals. Social spaces and counselling services need to be developed to help both men and women better cope with changing social roles and economic conditions.

- The issue of HIV/AIDS needs to be addressed as a social, emotional, medical and health care problem, in both prevention and care.

Focusing on poverty – implications for health actors

In explaining the links between sustainable livelihoods, health and poverty, *Jeremy Holland* and *Eleanor Fisher* underlined the need for health specialists and others to recognize the complex strategic decisions made by the poor with respect to a range of material and non-material assets. In order to put in place a pro-poor strategy, there was a need to facilitate change from a managerial, top-down approach to health sector interventions, in which external actors determined necessary health actions, to an inclusive approach that encompassed poor people's own health-promoting understandings and actions.

They outlined examples of models that could be helpful in this process. These include the asset vulnerability framework, which is based on the idea that vulnerability is linked to asset ownership: the more assets people have, the less vulnerable they are; the greater erosion of assets, the greater the level of insecurity; and the Sustainable Livelihoods Approach, which is a dynamic and process-oriented approach to understanding the nature of poverty, and to implementing and assessing poverty reduction interventions. It links the asset of good health to the macro structures and processes that affect individual livelihoods.

The role of the poor in building a common agenda on health

In their comments, *Dan Kaseje* and *Shobha Raghuram* drew on their own experience of working with the poor in Africa and India respectively. They underlined the need to give the poor the possibility of assessing their situation and projecting their points of view into the mainstream. People needed to be respected and treated with dignity. That meant ensuring that people were given the opportunities to make connections and to build networks based on knowledge and access to services and resources. Donors needed to engage in a self-critique that would include an audit to determine if the money spent had really reached the poor, and to look at ways to bridge the gaps between the realities of the poor and the donor institutions.

The challenge for partnership in health and poverty

In the discussion, speakers stressed that though common visions and goals were needed, the how and the why might vary at the local level. Poverty was a multidimensional phenomenon. There was a need to focus on various aspects of poor people's experience and concerns such as: vulnerability, coping capacity, bargaining power, entitlements, dignity, capabilities, and deprivation.

Health for the poor was not only a matter of access to appropriate services and quality care, but also about providing an enabling environment for the poor that would protect health as a major asset for their livelihoods. Their body and their health were the prime and in some cases their only assets. Health for the poor therefore had to be approached from a rights and security perspective, in full awareness of differences of gender, ethnicity and place. That approach required strengthening the capacity, knowledge and skills of poor people. It also entailed their empowerment and, vitally, their "connectedness"' to political and social systems that could sustain their well-being. The poor had to be empowered to be heard, to be listened to, and to have access to basic services, including informal and formal health systems that were accountable to their expressed needs. They must be entitled to participate with dignity in the processes that determined their health and well-being.

To achieve those objectives, international, national and local actors needed to provide the means to build responsive health systems. In practice that meant, at the local level, to ensure greater accessibility of the poor to health care, and responsiveness to their livelihood needs; at the national level, to provide responsible and appropriate care; and at the global level, to develop the macro enabling environment for nations which would enable them to adequately finance and sustain the provision of these services. Partnership should mean learning from each other, breaking oppression, and talking *with* the target groups, not *at* them. That was essential for the poor, so that they could experience human rights and dignity.

The challenge for a partnership for health was that health was broader than simply the provision of health care. How could services be provided in ways that strengthened local capacity? How could cross-sectoral approaches be constructed taking into account issues of power and governance? How could the fragmentation of health actors be brought together and the knowledge already acquired be built on? How could a top-down approach be avoided? Should a pro-poor health approach be seen as essentially a political process?

Session 3: Ill-health and poverty, health and development: addressing the links

> "If we wish to establish benchmarks for improving health as a vital aspect of fostering development, the process must be driven by a conceptualization and a methodology that can really place health at the centre of the development agenda." *Edward Greene*

Links between poverty, health and development

The session explored the implications of seeing poverty and health as a measure of development.

Davidson Gwatkin presented the challenging approach to health and development of the World Bank. Country studies indicated that the very poor had not been reached by development and health policies and that current development policies had not worked. Development should mean better life conditions, not only economic growth.

Consequently, if development was to include social, economic and human development, health should be interpreted as a measure of the outcome of policies. The international community had to seriously consider and discuss the effect of macroeconomic choices on health. The challenge was how to improve private and public sector partnerships to reach the poor not only through health services but also through social policies implemented at the country level, the international community providing the core resources needed. The process must build on knowledge about the existing differential access to resources and health care between rich and poor and mobilize a change of political will from a pro-rich to a pro-poor bias.

In his presentation, *Christopher Murray* showed that ill-health *was* poverty. He introduced empirical evidence from direct measurement of the level of absolute poverty in 191 countries (not just people in poor countries). He outlined country research that assessed the fairness of the financing of health systems and the health problems of the poor, who too often were not reached by the official health system. The empirical data indicated that poverty and health had to be seen in quite different and innovative ways nationally and internationally. The mapping out of this by WHO allowed for a new framework for poverty and health programmes.

Binayak Sen complemented that picture with a discussion of health and sustainable development in Bangladesh. Underlining the strong impact of health on development, he pointed to the need for social policy that empowered women and for the state to work in partnership with civil society. He looked at the intrinsic, the associative and the causal significance of health. He suggested a rethinking of the view that economics was the main source of developmental knowledge. An alternative system of knowledge could then be constructed that allowed an interdisciplinary approach to development problems, and with proper focus on health as integral to poverty reduction.

Contextualized poverty

Commenting on the papers, *Else Oyen* and *Edward Greene* stressed the context of poverty. How did the poor cope in a non-poor world? Poverty was not absolute; it was about the distribution of resources, power and influence. In order to link health policy and poverty, it was important to use analytical tools of poverty research that had different goals and paradigms than the habitual medical and economic approaches in which the traditional measure of US $1 of income a day predominated. Which kind of poverty was the meeting referring to? Any discussion of public health involved advocating issues outside the health sector. In the general discussion participants pointed out that issues such as human rights, equity, education, gender policy, labour market policy, child labour and trade were integral to examination of the linkages

between poverty and health. There were choices to be made between macroeconomic growth goals and resources for the health needs of the poor. That would mean very different types of development intervention. Members of the health community had "to walk their talk", step out of the biomedical paradigm and become unashamed social activists if they were to achieve their vision.

Session 4: Globalization and health consequences for poor people

"We all share a responsibility to make sure that globalization is inclusive and that its benefits are distributed equitably." *Nick Drager*

Linkages, risks and opportunities

The session set out the implications of globalization for health and poverty reduction. *Debra Lipson, Robert Beaglehole* and *Nick Drager* made a joint presentation on the approaches of WHO to globalization and health. They argued that if properly managed, globalization offered great potential for improving health outcomes for the poor. The growth of cross-border flows of people, goods and services and finance, aided by new technologies for communication and information-sharing, could consolidate and build on the advances in global health over the previous 50 years. However, globalization had also been associated with growing gaps in health status, within and between countries. The issue of health, which should be regarded as a cornerstone of economic growth, was instead seen as a drain on resources that governments responded to by seeking to privatize, decentralize and reduce health budgets. Furthermore, epidemiological and economic evidence indicated that globalization had the potential to reinforce, exacerbate or create new inequities in health. The relation between poverty, health and globalization was complex; the health community needed more accurate knowledge and data to understand the impact of globalization on the health of the poor in clear and precise terms.

The speakers presented some of their findings to date related to globalization and health, in particular on the increase of coronary heart disease and the interconnection of the health of rich and poor people across countries. They concluded that there was a need for more information on the impact of globalization at country level and for improvements in the methodology used for health impact assessment.

Health as a global public good

Marc Stern presented a paper written by *Inge Kaul* for the United Nations Development Programme (UNDP) which argued that the present openness and connectedness of countries had expanded the reach of the public benefits/costs of people's health, from local and national to regional and global. People's health today constituted a global public good. Globalization demanded that national policy-makers viewed health as an international concern, while international cooperation should extend to ensuring global levels of health. Possible areas for that extension were discussed, in particular:

- Creating an intellectual property rights regime that would ensure more pro-poor research and development and thus help to improve people's health status, notably that of the poor;
- Helping to reduce poverty, not just for moral and ethical reasons but also for reasons of self-interest, for the benefit of global health;
- Providing appropriate financial mechanisms to help countries pursue certain policies jointly, irrespective of being rich or poor.

Stern concluded that today's health challenges were not signalling that globalization had gone too far. Rather, because global public policy partnerships were lacking and international public goods for health were underprovided, they had failed to keep pace with the globalization of private activities and cross-border externalities. He proposed the creation of a global health council, which could monitor trends, foster private and public health research and development initiatives, and improve international health surveillance and emergency response.

Globalization and equity: a contradiction in terms?

Commenting on the presentations, *Meri Koivusalo* and *Zafar Mirza* brought out some of the contradictions of globalization. Globalization had seen an increase in differences in health, insecurity and safety within countries and between developed and developing countries. It was important to fight the tendency to use globalization as an excuse for national governments not to provide services for the poor. National health policies could no longer ignore the influence of globalization on the health of the poor in developing countries; it offered both risks and opportunities for health in those countries. Moreover, for effective partnerships with a common agenda for health and poverty reduction, the conscious involvement of civil society organizations was crucial.

In the general discussion, participants agreed that the potential of globalization for equity and health could only be achieved if the underlying political reasons for growing gaps in equity and access to health care worldwide were challenged directly. The issue was how to promote social justice that included equity in health through global *and* national mechanisms. Therefore a discussion on health and poverty implied a critique of the institutions that were creating poverty and ill-health. The health sector was not independent; it relies on all other sectors. A critique of globalization's impact on health must look particularly at the vulnerability of the poor. Different people gained differently from globalization. With no adequate redistribution method of its benefits, globalization could mean increased risks rather than opportunities.

3. Health for poverty reduction: implications for action

"People are the means and the end of development but they have different amounts of power and resources. In nearly all societies the needs and preferences of the wealthy and powerful are well reflected in official policy goals and priorities. But this is rarely true for the poor and marginalized who struggle to get their voices heard in the corridor of power. As a result these and other less vocal groups tend to be ill served by public policies and services, even those who should most benefit from them. …. Reinvigorating public institutions must, thus, begin by bringing governments closer to the people. This means bringing popular voice into policy making: opening up ways for individual users, private sector organizations, and other groups in civil society to have their say. In the right setting it can also mean greater decentralization of government power and resources." (*World Development Report*, World Bank 1997, Chapter 7, "Bringing the State closer to people").

Session 5: Improving the health of the poor - implications for health systems

New approaches to poverty and health

The session explored ways for health systems to introduce new approaches to meet the multiple health and development needs of the poor. *Julio Frenk* presented the WHO framework for assessing health system performance which had been used to in a study that measured the health performance of 191 Member States. The study assessed how well society used resources to achieve health, taking into account values such as respect, dignity and equality of amenities and resources. The goal of such measurement was to encourage sound stewardship of resources and better financing and provision for health that would improve the health of the poor by reducing inequities and establishing better-quality services through equitable distribution of resources.

Sergio Spinaci described cost-effective interventions that would benefit the poor in the area of communicable disease. Government health systems were failing to respond to basic health needs of the poor because of a lack of political will and commitment; lack of financial resources to supply essential services of good quality; lack of human resources; weak managerial capacity to decentralize organization and management; and shortage of essential drugs and other commodities. There were no technical reasons for such low service coverage. Lessons should be learnt from successful stories in scaling up interventions as well as innovative research methods. However, what was needed most of all was political commitment on the part of those who had the power to shift resources to investment in health priorities for the poor.

Derek Yach reviewed the evidence on noncommunicable diseases and their impact on the poor. He examined the factors that drove the increase in chronic disease incidence, disability and death among the poor, which ranged from social and demographic changes and shifts in patterns of consumption to infectious disease, under nutrition, trauma, and the structure and focus of health services. Material deprivation and low levels of education exacerbated the burden of disease. Ways to respond to that double burden of disease and poverty included improved information, prioritization of resources, national and global actions and advocacy, transformation of health services,

and expanded partnerships. In particular, health services needed to be transformed to respond to chronic care needs of the poor and the importance of primary health care must be reinforced. Significant changes should be made in the organization of health services to develop a stronger approach to providing integrated care within a population-based management system. Explicit attention must be given to reducing barriers to full use of health services by the poorest in communities. He concluded by suggesting that there was a need to expand partnerships: NGOs must advocate for effective comprehensive prevention/promotion programmes that reached the poor in all countries; United Nations agencies had key roles to play in reducing the burden of chronic diseases; and coalitions with the private sector were needed in order to ensure that markets could work for better health.

The sociocultural context

The two commentators led a discussion on health systems' ability to tackle the problems of the poor. *Pieter Streefland* commented that any assessment of health systems should take into consideration their sociocultural and political context, as local social conditions and culture permeated health systems that were often purposely adapted to their context. Pro-poor health systems implied a need for a capacity to change; consequently, health systems should not be seen as static. He considered that the WHO assessment framework was static and closed, and that there was also a need to include health actions in the informal sector. He further suggested that chronic illness might set in motion and sustain a process of impoverishment. The relation between chronic ill-health and poverty should be examined in a comprehensive manner that included prevention and cure, care for the chronically ill, and the social and economic effects of illness of long duration.

Reviewing health systems

In her comments, *Hilary Standing* suggested that it was possible to think about the health system in two very different ways:

- As a rational, technical set of activities and processes geared to the production and distribution of health-related goods and services through formal (public or private) means with planning based on sound evidence and driven by governments;
- As a messy, dynamic political arena consisting of competing stakeholder interests, much of it not under the control of national governments.

Control was critical to the first concept. It echoed the biomedical discourse of controlled trials in ordered universes. It was that concept that predominated in most of health systems thinking. It lead to "should" and "ought" statements. That was necessary for goals, aims and visions. But it was the second concept that was the reality with which health professionals had to deal. The field of political players was now large and complex: households, communities, community-based organizations, service providers, different levels of government, private national operators, private international operators, donors, multilateral agencies, advocacy groups and philanthropic organizations. The analytical link in debates about poverty reduction and health systems

performance related to politics and agency. There was a need to start mapping what the opportunities and constraints were – what was being done and what could be done. She gave several examples of the type of political action required, including political astute questions to support the setting of international standards, such as a public health charter. Which actors would back the charter? What should it cover? Who should set and monitor standards? What inducements and disincentives could be put in place? How would default be held to account? What resources would need to flow to poor governments to make compliance realistic, and – most importantly – who would provide them?

In the general discussion participants reviewed ways of reshaping care and support systems to respond to the current shifts in health and social needs. It was clear that the innate conservatism of health professions and health systems thinking should be challenged and that the types of political action required must be taken into account.

Session 6: Protecting and improving the health of the poor - implications for development policies

"Poverty reduction must begin with ensuring children's well-being and good health, fully recognizing that it does not end there. It is not a question of charity, but of laying the foundation of a strong economy." *Jan Vandermoortele*

Investing in health for the poor

The session explored the effects of shifts in health policy in strengthening the growing acceptance of the focus on poverty in human development programmes. *David Bloom* and *David Canning* argued that there were three types of justification for improving health: as a human right; as a vital social goal; and as important to economic success. In each area health improvements relied on social choices and political priorities. Reforms to the health system and investment in health – especially when targeted at the poor – needed to be given more priority, along with implementation and management of change. They spoke of three different approaches to producing or protecting good health that needed to be specifically tailored for the poor: (1) *medical interventions*, such as vaccines and drugs, medical examinations, tests, and treatments; (2) *non-medical health interventions*, such as training of medical personnel, building of better health information systems, and strengthening of systems for procuring, storing, and developing pharmaceuticals and other medical equipment; and (3) *non-health interventions* to provide health benefits by, for example, providing clean water and improved sanitation, or offering better basic education, communications infrastructure, or governance. Relative investment in each of these areas – and interactions between them – must be decided strategically and developed specifically in each country. Some non-health interventions might offer cost-effective ways of tackling health problems, for example, investment in education for women. Provision of microfinance and economic policies that encouraged entrepreneurship and offered quick routes into the labour market were also likely to promote positive health outcomes. Above all, a focus on quality of life required an active engagement with the perceptions of poor people. It was only through a "customer focus" that those problems could be identified and tackled; otherwise a reform process might fail.

Children first

Jan Vandermoortele argued that poverty reduction must begin with children, not only because they were hardest hit when poverty struck, but because childhood poverty caused life-long damage to their minds and bodies. They were then likely to pass poverty on to their own children, sowing the seeds of a perpetual cycle of poverty. He argued that the provision of an integrated package of basic social services of good quality to all children was one of the most direct and least expensive ways of reducing poverty. Millions of children were denied their social and economic rights, even though the resources, knowledge and techniques were available to give each and every child a good start in life. A massive, front-end investment in children was within the financial reach of all countries, even the poorest ones. That was not a question of charity, but of laying the foundation of a strong economy. The policy of targeting the poor did not work. The 1990s had seen a series of broken promises in the area of health because there had not been enough investment in health or a real attempt at eradicating poverty. Greater political will needed to be found, with greater solidarity and better governance structures. By giving voice and choice to poor children, societies could effect radical changes for health and development.

Social capital and health

Ichiro Kawachi argued that poverty was not just lack of income or resources but also lack of access to social networks and social connections. He defined social capital as the resources available within social structures – such as trust, norms of reciprocity, and mutual aid – that individuals could draw on to achieve collective action. It arose as a by-product of social relationships and civic engagement in informal and formal organizations. The concept of social capital could be usefully taken up in health policies. An active civil society could succeed in securing broad benefits such as health care, basic education, and social safety nets through the effective transmission of its preferences to politicians and governments. Building the "trust" element of social capital in the context of improving the health of the poor would be to:

- Strengthen social networks at the village/community level where lay health advisors could be trained to mobilize resources within existing social networks, as well as to bring resources into communities.
- Build social organizations where development workers could increase the access of poor people to sources of political and economic power.
- Strengthen community ties by bridging across institutions within communities. This could help to establish relationships between groups that were normally divided across the lines of class, race/ethnicity, caste, and religion.
- Strengthen civil society to help inform decision-makers about the social consequences of development policies – for example, the effects that growing income polarization, privatization of public assets, and urban planning decisions would have on the social fabric.

Opening the discussion, *Hans Rosling* said that donor communities needed to change their attitudes towards health. Often donor countries were pressured by their constituencies to show immediate results from aid with no allowance for long-term policies but pushing for target-based approaches. A shift in attitudes was needed towards a longer-term horizon that allowed for the specific needs of the poor in the South, bearing in mind that health and well-being were determined as much by economic, political and social factors outside the health system as by the technical capacity of the health system itself.

Mario Rovere advocated a conceptually sophisticated view of poverty. He argued that the poor could not be reduced to a homogeneous category: the elderly, the young, men and women experienced different realities of poverty. In that context, improving social capital was necessary but not sufficient. The poor were managers of complex asset bases, with social relations determined by constantly changing economic and political realities. There was a distorted concept of poor people's coping mechanisms, compounded by the pressure that was being placed on governments to knuckle under to international dictates and to perform well in economic terms, leading to major financial constraints for social development.

Session 7: Protecting and improving the health of the poor - implications at country level

"At the country level we moving from donorship to ownership … there is a need now to widen the circle and be inclusive." *Katja Janovsky*

The response at the country level

The session explored the different strategies in countries' programmes necessary for national ownership of the health and poverty agenda. *Jeni Klugman* presented an overview of the World Bank's current work on poverty in response to the past decades' slow progress in reducing poverty, especially in Africa. Disappointment with the results of conventional aid modalities, including structural adjustment, had led to a shift in policies towards country ownership and leadership. The World Bank's new Poverty Reduction Strategy Papers (PRSPs) gave priority to public actions for poverty reduction; participatory processes, including consultations with civil society; more transparent policy-making and budget procedures; setting targets; and systematic monitoring of trends and programme impact. The frameworks for health that were being developed started with the household and community at the centre and took a long-term perspective. In a major departure from past practice, sector strategies were drawn up with a focus on poverty reduction and through country-level teamwork. The country economist worked with colleagues from other sectors and IMF counterparts in a much more integrated approach to health and development.

In her presentation *Katja Janovsky* highlighted the key points of WHO's country-level approach to pro-poor health. She emphasized the need for political and strategic action to ensure that health and poverty "get a seat at the big table" to negotiate major increased spending on health. There was also a need to work with civil society in order to take into account the realities of fragile democracies and the wants, needs and

resources of all stakeholders. Health policy and spending must be made pro-poor through better services, resources and institutions that were more focused on reaching the poor. By placing governance and partnership with civil society high on the agenda, the processes with all stakeholders – public, private, rich and poor – would be intensely political. Looking to the future, she argued that the partnership of health and development actors which was being strengthened through the meeting must bring the health sector from "donorship to ownership", learning from the process that was under way in Bolivia, Mozambique and Uganda.

Commenting on the presentations, *Mark Wheeler* said that national health programmes should deal not only with traditional health concerns, including the provision of primary health care, but also with environmental control to enforce standards for water supply, excreta disposal and food hygiene; health and safety in workplaces; public information on risks to health, health promotion, and appropriate use of health services; regulation of health service providers; and food fortification programmes. The health outcomes of the poor derived as much from the wider determinants of health (incomes, education, fertility, nutrition, lifestyles) as from the provision of health services. However, since the health authorities did not have direct responsibility in those matters, the appropriate role for health policy was to define and advocate actions in the health interest. Those actions potentially covered a very wide range of concerns, from the discouragement of tobacco consumption to the prevention of road traffic accidents, or from supporting income protection to the encouragement of female education. The general argument in favour of such interventions was that they had the potential to enhance the health status of the whole population, but some among them were likely to be pro-poor by analogy with the argument that the poor were disproportionately affected by existing adverse conditions.

Rolando Morales commented on the difficulty of improving the situation of the poor given the macroeconomic context in such countries as Bolivia. The poverty and inadequate health systems of Bolivia had to be tackled not only at the local and national policy level but also at the international level, where donor countries had to be consistent in their policies. If health was to be seen as central to poverty reduction and sustainable development, poor countries must be supported in their attempts to build up the health sector and not have economic regimes imposed on them that diverted resources away from a pro-poor health policy.

In the general discussion, participants recognized that the PRSPs were a big step forward. However, there were tensions arising from problems in timing, conditionality and debt relief and a lack of commitment by decision-makers, in particular among those determining economic sector policies, to make provision for a pro-poor health strategy at the national level. There was a considerable gap between the realities of the poor and the policy instruments available, and between the stated intention to address poverty and the actual action that was taken. Participants pointed to the need for suitable financing mechanisms to give voice to the poor, and wondered what scope for action in the public sphere was available to the poor. Any "common agenda" would need to include community-level organizations and encourage an open and participatory process of decision-making at national and international levels, building on successful experiences and learning from past mistakes. Participants observed that if health and poverty were priorities on the development agenda, resources had to be allocated for skills training

and appropriate logistical support at the country level. It was not enough to give ministers policy briefings; the financial, political and technical capacity must be ensured to put the policies into action.

Session 8: Protecting and improving the health of the poor – implications for action: reports from working groups

"Politics is intrinsic not extrinsic to health systems." *Hilary Standing*

The working groups were designed as a forum for exchange of information on current thinking on health in development and on activities related to health and poverty reduction. Participants were divided into five working groups and asked to take stock of current thinking and activities; to identify current obstacles, opportunities and critical gaps for action; and to identify ideas and recommendations to be carried forward by specific actors on each of the two set themes. The following sections summarize the five groups' observations and recommendations on the themes.

Report on theme 1: Making health systems pro-poor

Current thinking

The working groups reviewed the possible characteristics of a pro-poor health system. They agreed that in order to make health systems pro-poor, the challenge was to balance economic criteria, health objectives and social values.

They concluded that a pro-poor health system should combine a formal, technical mechanism and an informal community- or family-based support structure. It would be: accessible in terms of location and information; affordable, with an equitable financing mechanism; comprehensive and without geographical, financial and cultural barriers to access; and the services would be of sustained good quality. The system would respond primarily to the needs of the poor, ensuring that subsidies benefited the very poor rather than those who were better off. The system would be built on solidarity between different social groups, allow for equal access and appropriate care of women and children, and aim to preserve or restore the dignity of those who used it. It would operate from a human rights perspective rather than an economic motivation, building links with and incorporating other sectors into its work.

Obstacles and opportunities

The working groups found mainly obstacles to the establishment of pro-poor health systems. Investment in health care for the poor had decreased, with a tendency for resources to shift towards the more powerful, and for service provision for the poorest to be dumped on national and international NGOs. There was considerable difficulty in reaching the poorest of the poor. The lack of involvement of the private sector in the support of overall health policies, the conservative attitude of health care professionals, and the desire of all actors to retain or increase their own budgets and area of control and interest combined to make collective action for the poor difficult. Social and

cultural norms and context tended to be ignored. In view of the market failures in health, the increasing availability of unhealthy consumer products and services, and the short supply of health care in the public sector, poor consumers required protection through effective regulation of the health market. At present that lack of protection posed a major risk to poor people, especially to those who were also ill.

General recommendations to the meeting and to the emerging partnership in health and poverty

- Recognize that the poor have the right to health services;
- Support pro-poor advocacy groups;
- Take up opportunities to give "voice" to the poor concerning health issues, particularly when dealing with governments;
- Assess and monitor the capacity of health systems to reach the poor and meet their health needs;
- Identify successful practices through which communities have been enabled to demand health services responsive to their needs;
- Monitor local participation of the poor in health systems to determine needs and quality of services;
- Disseminate knowledge about health systems including efficiency and equity issues related to distribution of resources;
- Train health workers to deal with the problems of the poor (incentives);
- Apply lessons learnt from outside the health sector - including distributing and targeting resources - to critical pro-poor strategies;
- Take into account women's roles in informal care mechanisms within the family and the community;
- Increase partnership with the private sector and other stakeholders in sponsoring and implementing pro-poor health strategies.

Recommendations for national action

- Create an incentive structure to link various interest groups to help them recognize that it is in their best interest to help the poor;
- Ensure that social objectives are set, with corresponding benchmarks;
- Retain pro-poor orientation through policies for solidarity and reform of state services;
- Train health care personnel to improve their attitude towards the poor;
- Support civil society to monitor comprehensively the development of pro-poor health activities.

Recommendations to WHO

- Define WHO responsibilities as a proactive broker for pro-poor health systems;
- Define health targets;
- Determine minimum level of annual investment in health;
- Produce more evidence on appropriate pro-poor decision-making for health systems;
- Coordinate donor policy to avoid contradictory policies (consider Sector-wide Approaches);
- Ensure transparency in partnerships;
- Promote stewardship at top government level;
- Empower WHO country representatives to act.

Report on theme 2: Health in development/sectoral policies

Current thinking on how to improve the health of the poor and vulnerable populations.

The working groups identified several concerns in current thinking on health and development policy, in particular how to achieve equity and efficiency and how to integrate the health and other sectors. There was a series of debates around:

- Whether to have policy that "targets" particular groups or ensures universal "health for all";
- Whether to achieve redistribution through charity or global responsibility;
- How to introduce participation of the poor and decentralization of health systems based on partnership of organizations and programmes at a sustainable level, locally and nationally.

Obstacles and opportunities

Again obstacles were the central focus of the working group discussions. At the national level, groups pointed to a marked lack of commitment to poverty reduction strategies, the conservatism of the health sector, corruption, and poor governance. These factors were compounded at the international level by international trade barriers, competition between multilateral agencies over the leading role, the effects of policy prescriptions by global institutions such as Structural Adjustment Programmes (SAPs), and a narrow view of the health system. There were also the very real problems of how to deal with the growing pandemics of TB, malaria, HIV/AIDS, violence and drugs; the question of "who pays" too often came ahead of the needs of the poor people affected. The isolation of health should be avoided and links and partnership should be formed among health and other sectors (e.g. education, business, water, transport and communication) to achieve an equitable and effective health system that provided a gender- and poverty-specific response.

General recommendations to the meeting and to the emerging partnership in health and poverty

- Promote political processes that enable poor people to have more control over decision-making and use of resources;
- Build up a positive approach within the health sector towards assuming the leadership role in the health and development strategy.
- Establish a new approach to partnerships which ensures that sector priority targets are developed, overlaps among sectors are identified, and formulas are found to resolve conflicts and design trade-offs.
- Work to change the present culture in order to integrate health into the social agenda and gain acceptance from other sectors for such an approach, involving other stakeholders in a participatory process, e.g. local authorities, parliamentarians and unions;
- Strengthen the civil society approach to health and social development and to the development of skills in order to create opportunities to increase the social capital of the poor.

Recommendations for national action

- Focus on health outcomes;
- Open national health policy to scrutiny;
- Establish governmental monitoring mechanisms to influence the distributional effects of social policy (including participatory culture and viable civil society networks);
- Develop a fiscal framework to mobilize resources for health;
- Identify and remove inappropriate public subsidies in health;
- Promote civil service reform to improve public health service delivery, e.g. enhancement of human resource systems;
- Train health professionals – before and in service – to go beyond a biomedical perspective and engage with other sectors;
- Arm ministries of health with tools, information and skills to analyse issues and negotiate with counterparts outside the health sector;
- Support social capital formation;
- Involve a broad range of development actors in health and poverty reduction;
- Encourage strategic alliances at the local level between actors working in different sectors, e.g. water, sanitation and education;
- Promote policies in non-health areas that support health objectives, such as taxing tobacco and minimizing the effects of harmful products.

Recommendations to WHO

- Strengthen advocacy on health issues to other sectors;
- Take a high - profile role in publishing health indicators that reveal the effects of socioeconomic and other kinds of inequalities;
- Take the lead on linking to other sectors;
- Form alliances with civil society and the private sector;
- Explore how to regulate the private sector, by setting rules and providing information to the public on activities and impact of that sector (e.g. pharmaceutical companies, private health care providers);
- Evaluate macroeconomic and sectoral policies within countries to anticipate their impact on alleviating poverty and on health.

4. Main messages emerging from the meeting

Health in poverty reduction and development: a political process

- ♦ Clear evidence was presented at the meeting that demonstrated the centrality of health to reducing poverty and other deprivations (such as gender-related disadvantages) and to promoting overall social and economic development. But there was broad disappointment and frustration amongst the participants that this mounting evidence has still to lead to major changes in the mind-set and actions of both health and other development actors.
- ♦ The health community is still not doing enough to ensure that health is accorded high priority in development planning; nor do actors in other sectors give sufficiently high priority to health. The net result is that health is typically absent or of low priority on national poverty-reduction and development agendas, and not as high as it could be on the international development agenda.
- ♦ To redress this, health actors need to recognize and meet their responsibility to advocate that health is a critically important means of reducing poverty and promoting human development. Similarly, the development community as a whole needs to back the case both for making greater investments in health and for protecting and promoting health in every sector, whether it be planning, industry, agriculture or trade. There was strong agreement that these goals can be achieved only if health actors engage in the politics of development at the national level; simultaneously, international agencies, in particular WHO, must continue the push to place health at the forefront of the international development agenda.
- ♦ Health actors need to recognize that health – like all sectors – is embedded in *politics*. If health actors are to rise to the challenge of being effective political players, they will need to move beyond the narrow biomedical paradigm, equip themselves with requisite advocacy skills and tools, and participate vigorously in the politics of development.

- Achievements in health are critical to the fulfilment of the International Development Targets to which the international community has committed itself. Opportunities for gaining greater political prominence for health include such key forums as the five-year review of the World Summit for Social Development, the World Trade Organization negotiations, G8 meetings, World Bank and IMF meetings, and country-level poverty-reduction and debt-relief processes. In many of them, the voice of health has only recently begun to be heard.
- Despite the criticism of the inadequate pace of change, overall there was agreement that health was far higher on the international development agenda than at any recent time, and that opportunities flowing from this must be seized. The participation of such a broad range of development actors at the meeting was itself proof of the high stature of health and the growing consensus within the international development community that it must act to promote health.

Health of the poor: the need for strong commitment and a broader approach

- There was widespread recognition at the meeting that for poor people their bodies are critically important assets – often their only asset – for sustaining their survival and livelihood. Consequently, good health is of vital importance to them and ill-health a calamity.
- Promoting health for the poor requires raising access to affordable, appropriate, good-quality health services as well as creating an enabling environment to protect their health. This can only be achieved by developing collaboration between all sectors to address determinants outside the health sector that influence the health of poor people.
- Strategies to promote the health of the poor must take a rights approach, factoring for disadvantages engendered by gender, social exclusion, locale and other factors. They must also build on and strengthen poor people's capacity, skills and knowledge; assure them dignity and respect; and reinforce their connections to political and social systems that promote their well-being. These are essential elements for the poor to be able to ensure that informal and formal health systems respond to their felt needs and are accountable to them.
- There was also strong consensus about the need for greater participatory research involving poor people themselves in the process. Much more needs to be known about their circumstances, needs and views. This knowledge is crucial both to design health systems that are responsive to them and to clearly understand what actions outside the health sector will positively influence the broader determinants of their health.
- On a different front, participants cautioned that strategies to promote the health of the poor must build on past policies and efforts that have been effective in promoting their health, such as primary health care and the Health for All initiative. While efforts to promote the health of the poor are urgently needed, they should be enlightened by both the best practices and the cautionary lessons of the past.

- The meeting emphasized the need to ensure that societies and their governments are truly committed to the effort of improving the health of the poor. Otherwise, this effort will remain an initiative led by development agencies and donor governments, jeopardizing the chances of success.

5. Strategic action for making health central to development

To realize the goals of promoting the health of the poor and making investments for health a central part of the development agenda, the following key strategic actions were recommended by the meeting, relating to health systems, development policies, country-level processes, and development partners.

- To make health systems more effective in addressing the needs of poor people requires: establishing more affordable and equitable payment systems (with pre-payment/insurance instead of user charges); ensuring that health-sector actors respect the poor; developing mechanisms to involve poor people meaningfully in analysis and decisions; and implementing explicit strategies to tackle causes of particular disadvantages or deprivation, such as gender, social exclusion or geographical isolation.
- Health data need to be disaggregated by income, age, sex and locality in order to build a clearer understanding of poverty and who and where the poor are. This is especially important with data used in health planning and monitoring, so that actions can be geared to the real and local causes and consequences of poverty, and the impact of investments measured. These disaggregated data must be part of a larger "knowledge creation" effort to rapidly analyse, document and disseminate what does and does not work for the poor. This knowledge base will need to be informed by both quantitative and qualitative studies, and by research that documents the expressed health needs of the poor.
- The health threats and disadvantages that are primarily responsible for creating and perpetuating poverty need to be tackled urgently. These include major infectious diseases, maternal illness and mortality, poor environmental health, violence and accidents, and major emergent threats such as tobacco and other unhealthy consumer and food products. The particular health risks facing a community need to be assessed at a local level rather than on the basis of aggregated national or international data. These assessments must also highlight the different needs and risks faced by men, women and children.
- More effective resource mobilization is needed to multiply the financial and human resources available for health systems. These resources can be secured by strengthening the commitment of existing partners and by establishing partnerships with new allies.
- At the same time, the underlying determinants of health must be addressed and made more pro-health. For significant and sustainable gains in health outcomes, beyond action on the immediate manifestations of disease, action is needed to address the underlying determinants of health. For instance, there is little point in building clinics if people cannot reach nor afford them, or are turned away because of discrimination.

- To bring health to the centre of poverty-reduction and development strategies requires building public-private partnerships between governments, civil society organizations, the private sector and international agencies at both the country and international levels. These partnerships must link the health community to other development actors. Within government, health ministries must become equal partners of ministries of finance, planning and trade.
- Action at the country level must be accompanied by action at the global level to stimulate the development of global public goods in health and to ensure that health is protected and promoted in the globalization process.

6. Conclusions

The strong consensus of the participants was that this meeting was an important step forward in developing a common agenda on promoting both the health of the poor and the role of health in development. As the first meeting within the United Nations system on these issues, it had laid the foundations for several essential elements: a common, holistic knowledge base; a working consensus on key actions and strategies; and a partnership for action. To make further rapid and real progress in achieving this common agenda, participants said that three things must be ensured. First, that WHO – as the lead health agency - and all other institutions present had to continue to place top priority on these issues. Second, that all participants needed to sustain this partnership with their firm individual and organizational commitment. Third, that they needed to advocate within their own organizations for action on these fronts.

Partnership in Health and Poverty: towards a common agenda

World Health Organization, Geneva, Switzerland

Executive Board Room

12 -14 June 2000

Agenda and Programme

Monday 12 June I Health and Poverty: review and analysis

08.30 - 09.00 Registration

09.00 - 10.30 **Opening session**

- Welcome address
  Poonam Khetrapal Singh, EXD/SDE/WHO
- Opening address: Health as an asset: protecting and improving health as a core international development strategy
  David Nabarro, DGO/WHO
- Presentation of programme
  Eva Wallstam, HSD/WHO
- World Summit for Social Development
  John Martin, HSD/WHO, *Alex Preker,* HNP/WB
- Presentation of DAC position on poverty reduction
  Jean-Claude Faure, DAC/OECD
- Plenary discussion

10.30 - 11.00 Break

11.00 - 12.30 **Session 2**: **Voices of the poor - some lessons for health**

Moderator: *Chris Lovelace*, HNP/WB

- Analysis of "Consultations with the Poor" from a health perspective
  Deepa Narayan, PREM/WB
- Becoming poverty focused : implications for health actors
  Jeremy Holland/ Eleanor Fisher, CDS/DFID

Commentators**:**

Dan Kaseje, TICH, Kenya

Shobha Raghuram, HIVOS, India

- Plenary discussion

12.30 - 14.00 Break

14.00 - 15.30 **Session 3: Ill-health and poverty, health and development: addressing the links**

Moderator: *Lieve Fransen*, EC

- Ill-health as a *consequence* of poverty - health conditions of the poor
  Davidson Gwatkin, HNP/WB
- Inequalities in health and ill-health as a *cause* of poverty
  Christopher Murray, GPE/WHO
- Health as a *contributor* to development
  Binayak Sen, BIDS, Bangladesh

Commentators:

Else Oyen, CROP, Norway

Edward Greene, CARICOM, Guyana

- Plenary discussion

16.00 - 17.30 **Session 4**: **Globalization and health consequences for the poor**

Moderator: *Nick Drager*, HSD/WHO

- Linkages, risks and opportunities
  Debra Lipson, Robert Beaglehole, Nick Drager, HSD/WHO
- Global public goods and the poor
  Inge Kaul, UNDP

Commentators:

Meri Koivusalo, STAKES, Finland

Zafar Mirza, The Network for Consumer Protection, Pakistan

- Plenary discussion

Tuesday 13 June II Health for Poverty Reduction: implications for action

09.00- 10.30 **Session 5**: **Improving the health of the poor - implications for health systems**

Moderator: *Mehtab Currey*, DFID

- WHO Framework for assessing health system performance
  Julio Frenk, EIP/WHO
- Targeting the communicable diseases of the poor and vulnerable populations
  Sergio Spinaci, CDS/WHO
- Chronic disease and disability of the poor - tackling the challenge
  Derek Yach, NMH/WHO

Commentators:

Pieter Streefland, Royal Tropical Institute, Netherlands

Hilary Standing, IDS, UK

- Plenary discussion

10.30 - 11.00 Break

11.00- 12.30 **Working groups theme 1:** *Making health systems pro-poor*

12.30 - 14.00 Break

14.00 - 15.30 **Session 6: Protecting and improving the health of the poor**

- implications for sectoral/ development policies

Moderator: *Antonio Casas,* PAHO/WHO

- The health and poverty of nations: from theory to practice

  David Bloom, Harvard School of Public Health, USA

  David Canning, Queen's University, Belfast, UK
- Social policies and investment in health
  Jan Vandemoortele, UNICEF
- Social capital for health and human development
  Ichiro Kawachi, Harvard School of Public Health, USA

Commentators :

Hans Rosling, Karolinska Institute, Sweden

Mario Rovere, Ministry of Social Development and Environment, Argentina

15.30 - 16.00 Break

16.00 - 17.30 **Working groups theme 2:** *Health in development/sectoral policies*

Wednesday 14 June

09.00 - 10.30 **Session 7: Protecting and improving the health of the poor**
- implications at country level

Moderator: *Andrew Cassels,* DGO/WHO

- Poverty Reduction Strategy Papers : an overview
  Jeni Klugman, PREM/WB
- Health in poverty reduction: bringing it all together at country level
  Katja Janovsky, SCP/WHO

Commentators:

Rolando Morales, Universidad Mayor de San Andrés, Bolivia

Mark Wheeler, HSD/WHO

- Plenary discussion

10.30 - 11.00 Break

11.00 - 13.00 **Session 8**: **Protecting and improving health of the poor -**
implications for action

Moderator: *David Nabarro, DGO/WHO*

- Summary reports from working groups:
  1. Making health systems pro-poor
  2. Health in development/sectoral policies
- Summary report from overall meeting rapporteurs
- Conclusions and recommendations

Closure of meeting

Working group moderators: *Rolf Korte*/GTZ*, Andrew Haines/* RFUCSM, *David Peters /*World Bank*, Anna Ritsatakis/*WHO European Centre for Health Policy, Brussels, *Emilienne Anikpo N'Tame/*WHO Regional Office for Africa

Working group rapporteurs: *Kari Lankinen/*Consultant, *William Pick/*University of Witwatersrand, *Stéphaine Baile/*OECD*, Abbas Bhuiya/*ICDDR, *Eli Nangawi*/Christian Social Science Services Commission, *Pascale Brudon/* WHO, *Jean Llorin/* Bicol Habitat Foundation*, Edward Greene/* CARICOM, *Roger Drew/* Health Link, *Meri Koivusalo*/ STAKES.

General rapporteurs: *Wendy Harcourt/* Society for International Development, *Meg Wirth* Rockefeller Foundation*, Siddharth Dube,* HSD/WHO*, Meri Koivusalo*/ STAKES.

Report: *Wendy Harcourt, Margareta Sköld, David Thompson, Manique Abayasekara*

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Mr Matthew HODGE	Health in Sustainable Development
Ms Shasa HU	Health in Sustainable Development
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Dr Srinavasa MURTHY	Mental Health and Substance Dependence
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Mr Steven OLEJAS	Health in Sustainable Development
Dr Bruce PFLEGER	Management of Noncommunicable Diseases
Ms Lisa REGIS	Health in Sustainable Development
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Dr Eugenio VILLAR	Health in Sustainable Development
Mrs Eva WALLSTAM	Health in Sustainable Development
Mr Mark WHEELER	Health in Sustainable Development
Mr David WOODWARD	Health in Sustainable Development
Dr Derek YACH	Noncommunicable Diseases and Mental Health

List of papers distributed at the meeting [1]

1. The health and poverty of nations: from theory to practice
   David E. Bloom & David Canning

2. Becoming poverty-focused: implications for health actors
   A working paper prepared for the United Kingdom Department for International Development
   Eleanor Fisher & Jeremy Holland

3. A WHO framework for health system performance assessment
   Christopher JL Murray & Julio Frenk

4. Social capital for health and human development
   Ichiro Kawachi

5. Global public goods perspective on health
   Inge Kaul

6. The body as an asset: Voices of the Poor
   Deepa Narayan[2]

7. Protecting and improving the health of the poor : implications at country level
   Hatib Njie

8. The life and death question: health as a contributor to development
   Binayak Sen

9. Targeting the communicable diseases of the poor and vulnerable populations
   Sergio Spinaci & David Heymann

10. Economic dynamics and health implication: lessons learnt from Thailand
    Suwit Wibulpolprasert & Paichit Pengpaiboon

11. Reaching global goals by maximizing synergies among basic social services
    Jan Vandemoortele

12. Chronic disease and disability of the poor: tackling the challenges
    Derek Yach

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[1] Available on request from WHO's Department of Health in Sustainable Development. Please contact Hazel Pinder (e-mail: pinderh@who.int).

[2] This paper is based on two volumes of Voices of the Poor studies. *Can Anyone Hear Us? Voices of the Poor*, by Deepa Narayan with Raj Patel, Kai Schaff, Anne Rademacher & Sarah Koch-Schulte, World Bank and Oxford University Press, 2000; and *Crying Out for Change: Voices of the Poor* by Deepa Narayan, Robert Chambers, Meera K. Shah & Patti Petesch, World Bank and Oxford University Press, 2000. All quotations are from these two volumes.

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Development: The Journal of the Society for International Development
Aims and Scope

Development, the Journal of the society for International Development, aims to be a point of reference for the dialogue between activists and intellectuals committed to the search for alternative paths of social transformation towards a more sustainable and just world.

Development tackles the hard-hitting issues of today, listening to the oppositional voices and bringing in local and innovative perspectives from the margins of the global development discourse.

Development explores collective initiatives at local, regional and international levels which promote sustainable livelihoods and aims to bring accountability, equity and democracy to development.

Upfront
Editorial Note

Guest Editorial: Partnership in health and poverty/ *David Nabarro*

A Common Agenda for Partnership on Poverty and Health/ World Health Organization, World Bank, UK Department for International Development and the European Commission

Thematic Section: Health and poverty in a social context
'Consultations with the Poor' from a Health Perspective/ *Deepa Narayan*

Becoming Poverty Focused: Implications for health actors/ *Eleanor Fisher, Jeremy Holland & Sarah James*

Social Capital for Health and Human Development/ *Ichiro Kawachi*

A New Health Opportunity/ *David E. Bloom* & *David Canning*

Social Policies and Investment in Health/ *Jan Vandemoortele*

Health, Poverty and Dignified Living/ *Charles Omondi Oyaya* & *Dan C.O. Kaseje*

SID On-line Dialogue: Globalization, health and poverty

Chronic Disease and Disability of the Poor: Tackling the challenge/ *Derek Yach*

Communicable Diseases and Disability of the Poor/ *Sergio Spinaci & David Heymann*

Globalization and the Health of the Poor/ *Robert Beaglehole, Nick Drager*, *Debra Lipson & David Woodward.*

Global Public Goods and the Poor/ *Inge Kaul*

Women's Health, Poverty and Globalization/ *Wendy Harcourt*

Globalization, Health and Poverty: The role for civil society/ *Zafar Mirza*

Local Global Encounters: Health and poverty in national processes

Poverty and Ill Health: The Uganda national response/*Hatib Njie*

Economic Dynamics and Health: Lessons from Thailand/ *Suwit Wibulpolprasert* & *Paichit Pengpaiboon*

Decentralization and Public Health in the Philippines/ *Xavier Furtado*
The People's Health Assembly/ *Mike Rowson*

Window on the World

Partners in Health and Poverty

Who's Who

Last Word
International Conference on Health Research for Development/ *Lenore Manderson*