



Institute of Tropical Medicine
50th annual colloquium



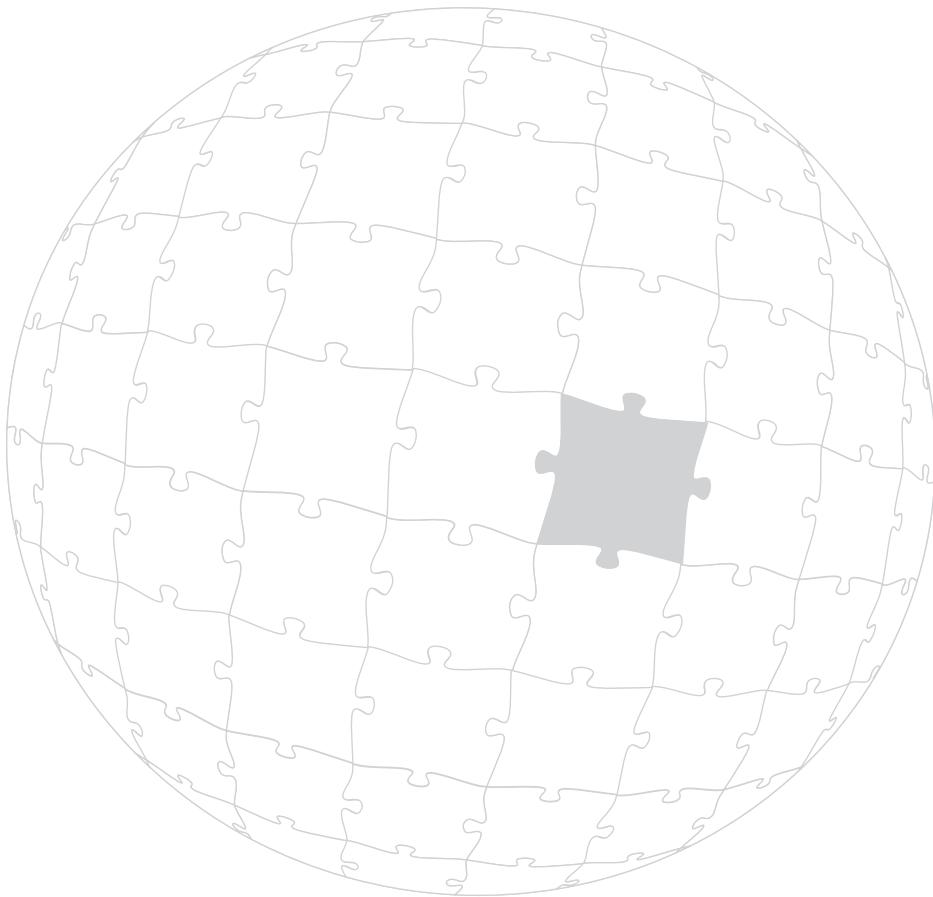
PRIMARY HEALTH CARE *in Times of Globalisation*

'Alma Ata, back to the future'

"In 2008, the world celebrates the 30th anniversary of the Declaration of Alma Ata. The commemoration provides an ideal opportunity to share experiences and evidence on Primary Health Care as a strategy to reach the declared goal of "Health for All", and to redefine its position in the global health arena of today."

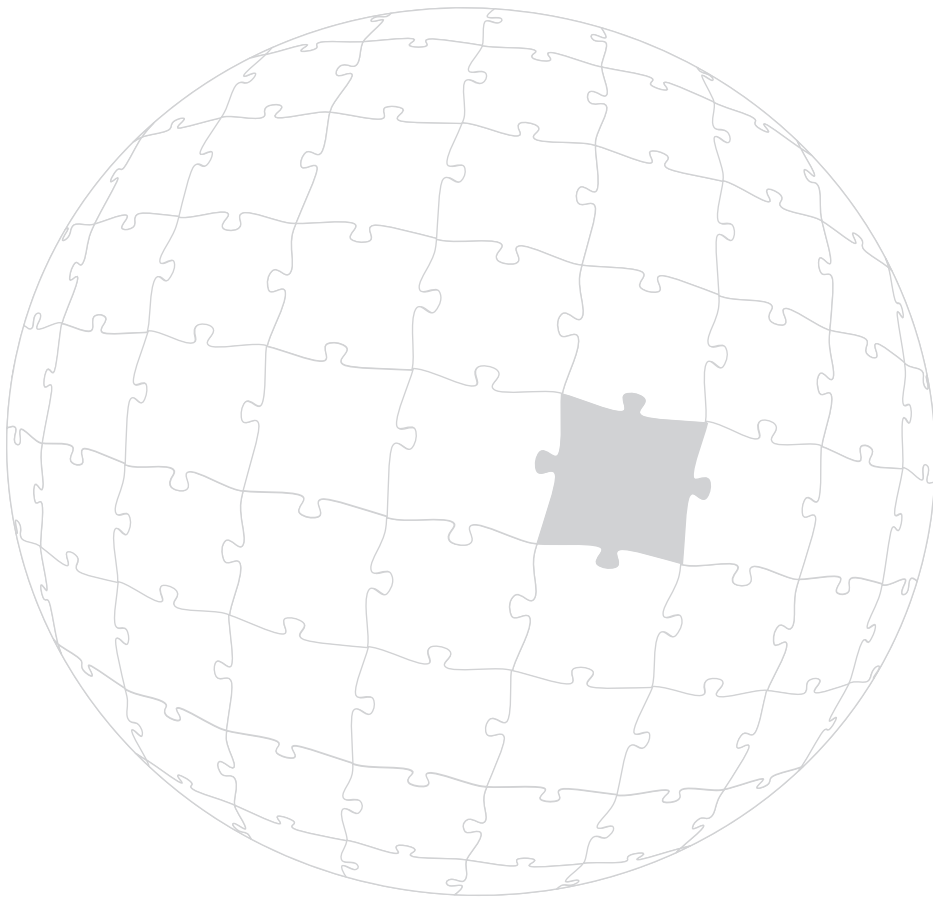
26th and 27th of November 2008

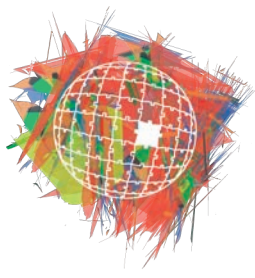
Aula P.G. Janssens, Campus "Rochus", Sint Rochusstraat, 2000 Antwerp, Belgium



Content

Background and objectives.....	3
Organising and scientific committee.....	4
Programme.....	5
Primary Health Care (PHC) now: setting the scene - Monique Van Dormael.....	9
Abstracts 26 November	13
One year of reflections on the future of Primary Health Care - Gerry Bloom.....	15
The ever changing international health landscape, a view from the South - Francisco Songane	17
The People's Health Movement in India - Thelma Narayan	19
La reconstruction d'un système de santé en post conflit, le cas de la RDCongo - Hyppolite Kalambay	21
Rural public health care in Latin America around the millennium switch - Edgar Rojas	25
Neighbourhood Health Centres in Belgium - Jan De Maeseneer	27
Thematic sessions	31
Theme 1: New ways to promote community participation - Pol De Vos.....	33
Theme 2: New models for Human Resources for Health at the first line - Monique Van Dormael.....	35
Theme 3: Changing Aid modalities to strengthen PHC - Bruno Dujardin.....	37
Abstracts 27 November	39
The World Health Report 2008: bringing Primary Health Care back to business - Denis Porignon	41
The Report on the WHO Commission on Social Determinants of Health - Lucy Gilson.....	43
The second Global Health Watch report - Hani Serag	45
PHC and Disease control: the case of AIDS programmes in Africa - Marianne Pirard	47
The Paris/Accra process and Global Health Initiatives: what's the impact on health systems? - Nejmuudin Kadir.....	49
Health services in Mexico City, lessons for the future of Primary Health Care - Asa Cristina Laurell	51
Annexes	53
List of Posters.....	54
Organisations present in the Market Place	56
The Alma Ata Declaration, 1978	57
DGDC Presentation	60
BTC Presentation.....	61
ITM Presentation.....	62
Be-cause health Presentation.....	63





PRIMARY HEALTH CARE in Times of Globalisation

'Alma Ata, back to the future'

26th and 27th November 2008, the Institute of Tropical Medicine, Antwerp

In 2008, the world celebrates the 30th anniversary of the Declaration of Alma Ata. This commemoration provides an ideal opportunity to share experiences and evidence on Primary Health Care as a strategy to reach the declared goal of "Health for All", and redefine its position in the global health arena of today. The colloquium is organised jointly by the Antwerp Institute of Tropical Medicine (ITM), the Directorate General for Development Cooperation (DGDC), the Belgian Development Cooperation Agency (BTC) and the Belgian Platform for International Health (Be-cause Health).

Background

In September 1978, the World Health Organization organised an historical international conference on "Primary Health Care" in Alma Ata (Kazakhstan, then the USSR). Representatives from almost all UN members gathered with main international organisations to define a framework for promoting "Health for all", with special emphasis on poor communities in developing countries. The conference resulted in the legendary Alma Ata Declaration, which called for *"a publicly funded, comprehensive system approach to ensure the right of health for all"*. The Primary Health Care referred to in the Declaration did not only include the public health sector, but *'all related sectors and aspects of national and community development, in particular agriculture, livestock, food, industry, education, housing, public works, communications and other sectors'*. As a result, 'Health for all' was generally accepted as a broad social objective and not just as a narrow medical goal.

During the Belgian presidency of the European Union in 2001, the Belgian Development Cooperation and the Institute of Tropical Medicine organised an international colloquium on 'Health Care for All', a translation of one of the most probing components of the Alma Ata message i.e. accessible quality health care as a fundamental human right.

In addition, the ensuing "Health Care for All Declaration" (www.itg.be/hca) pointed to the essential role of comprehensive health care systems for effective and sustainable disease control, at the very moment that the Global Fund to fight AIDS, Malaria and Tuberculosis was founded.

Fully in the spirit of the "Health Care for All" principles, the WHO recently reaffirmed the Alma Ata Declaration as a standing principle and driving force of global health development. The international community has found itself in the Paris Declaration (2005), calling for donor harmonisation and country leadership, with the fragmented health aid sector as a priority and tracer area for new financing mechanisms.

The 30th anniversary of the Alma Ata Declaration sets the scene for a number of international meetings, and reflects on updated primary health care concepts in the contemporary, globalised setting.

The Antwerp colloquium thus comes at the end of a year of celebration, reflection and reorientation. It is an ideal opportunity to take stock of the results of all these efforts, to summarise the state of the art and explore the road ahead for research, development and advocacy of Primary Health Care. The colloquium will link up specifically with similar events this year (Geneva, London, Basel, etc.)

Objectives

The main objectives of the colloquium are:

- to summarise and analyse the results of the international efforts to rethink the Alma Ata Declaration in 2008
- to review a wide variety of scientific evidence and experiences from the field on primary health care as a strategy to reach health for all
- to discuss the challenges ahead in a changing and dynamic global environment
- to reaffirm the commitment to the principles of Primary Health Care and Health Care for All by all stakeholders
- to raise awareness with Belgian and international policy makers and stakeholders
- to promote interaction between scientists, experts, advocates and organisations

Participants

250 participants, representing:

- public, private, academic and non-governmental stakeholders from across the globe
- students in Public Health and Disease control at Belgian universities and at ITM
- European and international networks

international, European and Belgian authorities and policy makers

Organising Committee

Peter Decat
(International Centre for Reproductive Health, Ghent, Belgium)

Wim De Ceukelaire (International Action for Liberation,
Brussels, Belgium)

Maaïke Flinkenflogel (Ghent University, Ghent, Belgium)

Karel Gyselinck (Belgian Technical Cooperation, Brussels, Belgium)

Bruno Marchal (Institute of Tropical Medicine, Antwerp, Belgium)

Francis Monet
(Directorate General for Development Cooperation, Brussels, Belgium)

Carole Schirvel (Cemubac, Brussels, Belgium)

Martine Vandermeulen (Health Research for Action, Reet, Belgium)

Dirk Van der Roost (Institute of Tropical Medicine, Antwerp,
Belgium)

Ann Verlinden (Institute of Tropical Medicine, Antwerp, Belgium)

Scientific Committee

Mariano Bonnet
(Instituto Nacional de Higiene, Epidemiología y Microbiología,
La Habana, Cuba)

Luk Cannoodt (Katholieke Universiteit Leuven, Leuven, Belgium)

Jan De Maeseneer (Ghent University, Ghent, Belgium)

Narayanan Devadasan (Institute of Public Health, Bangalore, India)

Bruno Dujardin (Université Libre de Bruxelles, Brussels, Belgium)

Bruno Gryseels (Institute of Tropical Medicine, Antwerp, Belgium)

Guy Kegels (Institute of Tropical Medicine, Antwerp, Belgium)

Jean Macq (Université Libre de Bruxelles, Brussels, Belgium)

André Meheus (University of Antwerp, Antwerp, Belgium)

Edgar Paryio (Makerere University, Kampala, Uganda)

Francisco Songane
(Partnership for Maternal, Newborn and Child Health, WHO,
Geneva, Switzerland)

Marleen Temmerman (Ghent University, Ghent, Belgium)

Colloquium Secretariat

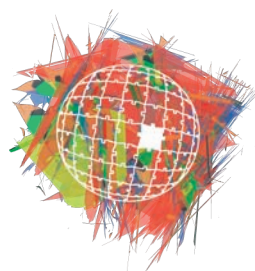
Institute of Tropical Medicine - Nationalestraat 155, B-2000 Antwerp, Belgium

Tel: +32 3 247 08 01 - Fax: +32 3 247 62 13

E-mail: colloq2008@itg.be

Website: <http://www.itg.be/colloq2008>

Programme



PRIMARY HEALTH CARE in Times of Globalisation

Alma Ata, back to the future

26 November

8:15 Registration

9:00 Welcome address

Peter Moors, Director General, Directorate General for Development Cooperation (DGDC), Brussels, Belgium

9:15 Objectives of the colloquium

Bruno Gryseels, Director, Institute of Tropical Medicine (ITM), Antwerp, Belgium

Theme: 30 years of Alma Ata

Chair: Paul Verlé, Belgian Technical Cooperation (BTC), Brussels, Belgium

9:20 Primary Health Care (PHC) now: setting the scene

Monique Van Dormael, ITM, Antwerp, Belgium

9:50 One year of reflection on the future of Primary Health Care

Gerry Bloom, Institute of Development Studies (IDS), Brighton, UK

10:10 The ever-changing international health landscape, a view from the South

Francisco Songane, Partnership for Maternal, Neonatal and Child Health (PMNCH), Geneva, Switzerland

10:30 Discussion

10:50 Coffee break

Theme: Evidence from the field in 4 continents

Chair: Paul Verlé, Belgian Technical Cooperation (BTC), Brussels, Belgium

11:10 The People's Health Movement in India

Thelma Narayan, People's Health Movement (PHM), Bangalore, India

11:30 La reconstruction d'un système de santé en post conflit, le cas de la RDCongo

Hyppolite Kalambay, Ministry of Health, Kinshasa, DR Congo

11:50 Rural public health care in Latin-America around the millennium switch

Edgar Rojas, Pontificia Universidad Católica del Ecuador (PUCE), Quito, Ecuador

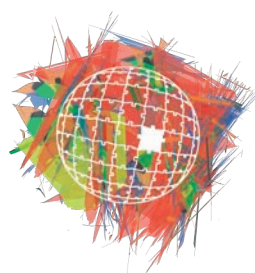
12:10 Neighbourhood Health Centres in Belgium

Jan De Maeseneer, Ghent University (UGent), Ghent, Belgium

12:30 Discussion

13:00 Lunch

Programme



PRIMARY HEALTH CARE in Times of Globalisation

Alma Ata, back to the future

26 November

14:00 Parallel sessions - Coffee break at 3.30 p.m.

until **Theme 1: New ways to promote community participation**

17:30 *Chair: Pol De Vos, ITM, Antwerp, Belgium - Location: Auditorium*

Mariano Bonet, Instituto Nacional de Higiene, Epidemiología y Microbiología (INHEM), La Habana, Cuba

Wim De Ceukeleire, International Action for Liberation (INTAL), Brussels, Belgium

Leen Deroo, Neighbourhood Health Centre, UGent, Ghent, Belgium

Thelma Narayan, PHM, Bangalore, India

Pedro Villasana, Public Health Network Latin America, Venezuela

Jonathan Wangisi, Taso, Kampala, Uganda

Theme 2: New models for human resources for health at the first line

Chair: Monique Van Dormael, ITM, Antwerp, Belgium - Location: Aula Janssens (translation available)

Narayanan Devadasan, Institute of Public Health (IPH), Bangalore, India

Lucy Gilson, University of Cape Town (UCT), Cape Town, South-Africa and London School for Hygiene and Tropical Medicine (LSHTM), London, UK

Hlengiwe Hlophe, University of Bloemfonteyn, Bloemfonteyn, South-Africa

Abderrahmane Maaroufi, Institut National d'Administration Sanitaire, Rabat, Morocco (to be confirmed)

Mit Philips, Médecins Sans Frontières, Brussels, Belgium

Salif Samaké, Ministry of Health, Bamako, Mali

Theme 3: Changing aid modalities to strengthen PHC

Chair: Bruno Dujardin, Université Libre de Bruxelles (ULB), Brussels, Belgium

Location: Room C (Campus Nationalestraat, second floor)

Paul Bossyns, BTC, Brussels, Belgium

Luc De Backer, DGDC, Brussels, Belgium

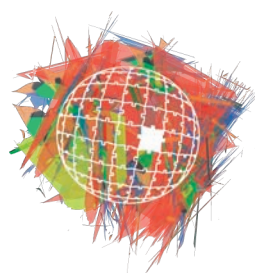
Leo Devillé, Health Research for Action (HERA), Reet, Belgium

Elisabeth Paul, University of Liège, Liège, Belgium

Francisco Songane, PMNCH, Geneva, Switzerland

19:00 *Evening Dinner at Antwerp Cruise Terminal, City Centre, River Schelde, next to Flandria embarkation point*

Programme



PRIMARY HEALTH CARE in Times of Globalisation

Alma Ata, back to the future

27 November

Theme: A look into the near future

Chair: Martine Vandermeulen, chair of Be-cause health and HERA, Belgium

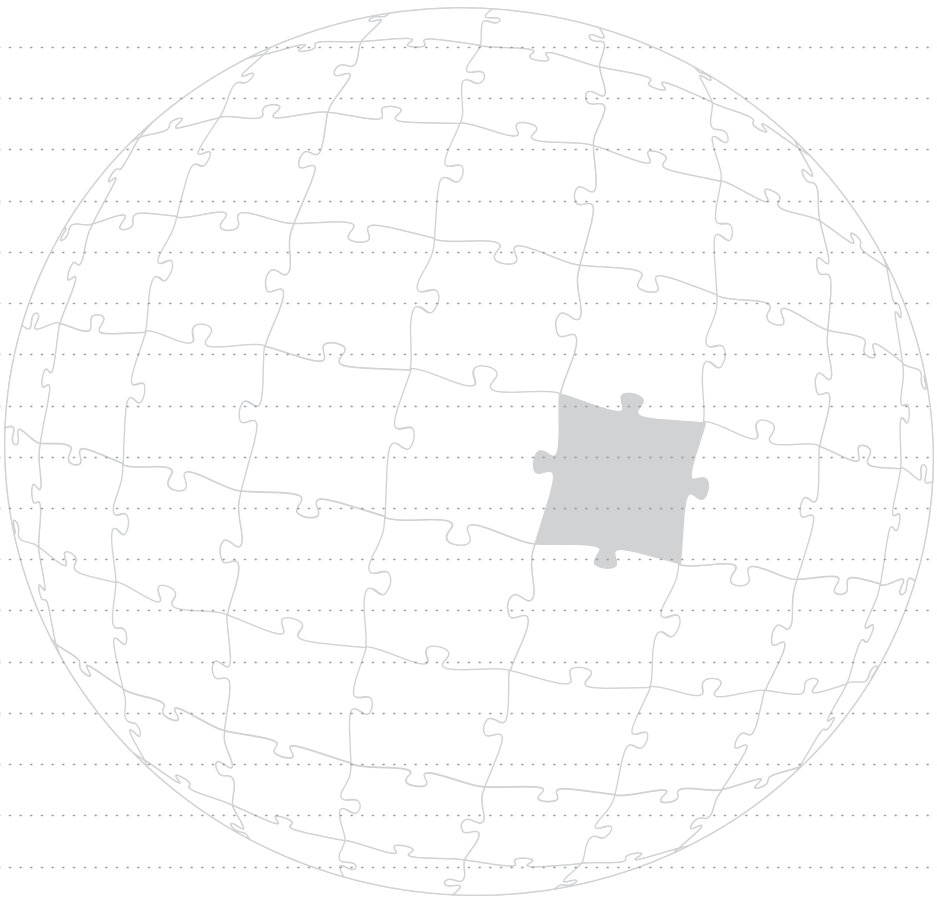
- 9:30 The WHO Report and the role of WHO in Primary Health Care
Denis Porignon, World Health Organization (WHO), Geneva, Switzerland
- 9:50 The WHO Report on Social Determinants of Health
Lucy Gilson, UCT, Cape Town, South Africa and LSHTM, London, UK
- 10:10 The second Global Health Watch report
Hani Serag, PHM, Cairo, Egypt
- 10:30 Discussion
- 10:50 *Coffee break*
- 11:20 PHC and Disease control: the case of AIDS programmes in Africa
Marianne Pirard, ITM, Antwerp, Belgium
- 11:50 The Paris/Accra process and Global Health Initiatives: what's the impact on health systems?
Nejimudine Kedir, Ministry of Health, Addis Ababa, Ethiopia
- 12:10 Health services in Mexico City, lessons for the future of Primary Health Care
Asa Cristina Laurell, Centre for Social Security Studies and Analysis, Mexico City, Mexico
- 12:35 Discussion
- 13:00 *Lunch*

Theme: Closing session

Chair: Dirk Barrez, journalist

- 14:10 Feedback from the ITM workshop 'PHC in the 21st century: new challenges and opportunities for the first line (November 24/25)
- 14:25 Summary and conclusions from parallel sessions
- 15:00 Debate: "How to ensure the right to health and health care in times of globalisation?"
Christopher Knauth, AidCo, Brussels, European Commission; Hyppolite Kalambay, Ministry of Health, Kinshasa, DR Congo; Representative of the Minister of Development Cooperation, Brussels, Belgium; Thelma Narayan, PHM, Bangalore, India; Francisco Songane, PMNCH, Geneva, Switzerland; Marleen Temmerman, UGent and Belgian Parliament, Belgium
- 16:15 *Coffee break*
- 16:40 Conclusions, recommendations and discussion
Colloquium Reporters (Karel Gyselinck, BTC, Brussels, Belgium and Guy Kegels, ITM, Antwerp, Belgium)
- 17:15 Closure
Martine Vandermeulen, chair of Be-cause health and HERA, Belgium;
Bruno Gryseels, Director, ITM, Antwerp, Belgium
- 17:30 *Reception - Fair Trade Drink*

Notes



Primary Health Care now: Setting the scene

Prof. Monique Van Dormael, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium

Email: mvdormael@itg.be

Primary Health Care (PHC) and the Health for All movement resulted from new outlooks on health emerging from field experiences in the 1960s and were very much in line with the spirit of the times. While technical and scientific progress remained promising, they did not affect the unacceptable health inequalities among countries and within countries. Even more, faith in technology had led to eradication-inspired programmes and hospital-centred health care systems, giving rise to fears of dehumanisation of health care, undue medicalisation and iatrogenesis. It was increasingly acknowledged that improved health would not be achieved by medical care alone, and that new avenues had to be explored with people and communities.

The Antwerp Institute of Tropical Medicine (ITM) participated in and was influenced by this turmoil of challenging ideas. The founders of the nascent Department of Public Health, Pierre Mercenier and Harrie Van Balen, had been involved in field work in India and Central Africa. The Kasongo project, started in Congo in 1971, became a field experiment of what would later be called a district health system based on primary care. Convinced that principles underlying primary care were applicable also to the North, Pierre Mercenier and Harrie Van Balen actively contributed to innovative ideas about health in Belgium within the *Groupe d'Etude pour une Réforme de la Médecine* (GERM). In 1971, this NGO published a pamphlet, the overall message of which was that health care organisation should contribute to the global emancipation of human beings, and not replace disease dependency by health care dependency. Primary Health Care has been over the years the backbone of health systems research and teaching at ITM. The 30th anniversary of the Alma Ata Declaration is an opportunity to reflect together on its spirit, the relevance of its principles and values in today's changing world, and the challenges lying ahead to revitalise PHC.

The Alma Ata Declaration is based on essential humanist values and principles: health as a fundamental human right, social justice and dignity for all people, participation as a right and an obligation, self-reliance and self-determination, social responsibility, a spirit of partnership and service...

The Alma Ata Declaration certainly did not reject science and technology, necessary to identify effective and efficient methods to achieve improved health and well-being. However, science and technology needed to be balanced with people's aspirations in a participatory approach: communities and individuals should be entitled to decide whether benefits of health interventions outweigh costs, on the basis of objective information as well as on the basis of social or individual values and aspirations. This went contrary to the traditional views on the role of health workers and their relations with people. Health workers had to be suitably trained technically but also socially. The authoritarian or paternalistic relations prevailing in medicine had to be replaced by partnership relations in PHC.

While PHC was more than just medicine, improved health would not result from health care alone: other social and economic sectors had to be mobilised. This was not only a question of effective multisectoral collaboration to improve health and fight health inequality. It was also a matter of political commitment. The Alma Ata Declaration called for a New International Economic Order, and for world peace: resources spent on military conflicts needed to be reoriented to foster social and economic development and equity.

What is left of this today ? While the 30th anniversary of Alma Ata has been throughout 2008 the occasion to reaffirm the relevance of PHC's values and principles for today's world, some of the spirit of Alma Ata seems to have gotten lost over the past decades.

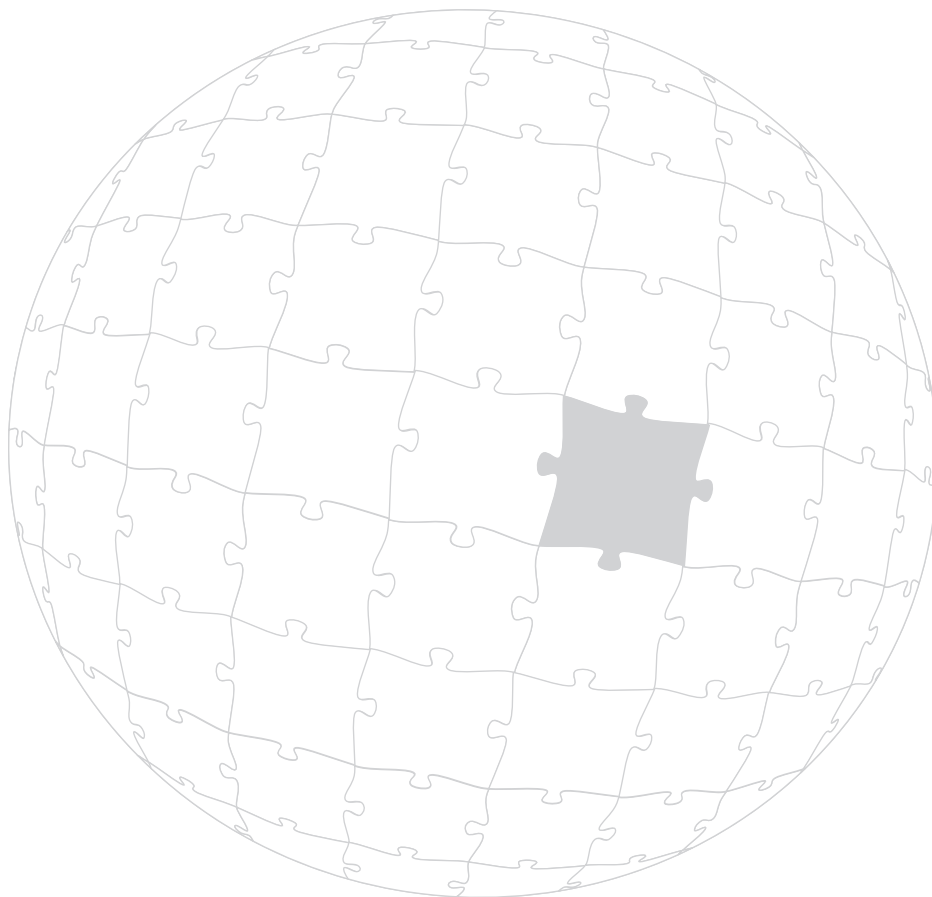
A major distortion of the spirit of Alma Ata was that the socio-political dimension of PHC was quickly dropped and replaced by technocratic approaches. Central to the spirit of Alma Ata is the tension between rationalisation on one hand, participation on the other and the need to combine them in ever-changing balances. Very soon, however, PHC was said to be too ambitious and naïve, and was replaced by selective PHC, giving priority to effectiveness and efficiency as defined by experts, at the expense of listening to people's expectations. Today global initiatives invest large shares of resources into programmes addressing a few priority diseases, while health care systems remain too weak to respond to communities' felt needs, and there is growing concern about adverse effects on the functioning of health systems as a whole. We obviously witnessed considerable progress in improving rational decision making, with the development of evidence-based guidelines and the generalisation of evaluation as an integral part of professional and managerial practice; but there is a real danger that evidence and efficiency become the exclusive and ultimate values guiding decisions, leaving aside social aspirations, reducing participation to an obligation of compliance with expert advice, and viewing patients and communities as passive recipients of interventions designed without them.

Another – and somehow paradoxical – distortion of the spirit of PHC was the limited role often given to qualified health workers and health services in PHC development. The declaration calls for promoting maximum community and individual self reliance and lists community health workers (CHW) among the health workforce. A quite prevailing interpretation rests on CHWs as cornerstones for PHC – an interpretation linked to distrust of the vested interests of the health professions. However, when the declaration stresses the role of health workers, it includes highly qualified staff. The declaration also states that PHC should be sustained by referral systems, leading to the progressive improvement of comprehensive care for all (cfr. the Harare declaration on district health systems in 1987). PHC visions omitting to integrate formal health services failed to change organisational culture in health services. Still today, many health professionals (especially physicians) feel little concerned with PHC and low clinical qualification of health centre staff is not seen as a major problem. We witnessed some attempts to introduce a PHC approach in the training of health professionals, for instance in community-oriented family medicine programmes, and here and there primary care providers have achieved recognition and contribute to an increasing PHC orientation of their health care system. Generally speaking, however, health care systems remain strongly disease-, hospital- and technology-oriented, and the notion of health as physical, mental and social well-being seems difficult to internalise for a majority of health care providers. The best possible balance between biomedical and social logic remains but rarely attained.

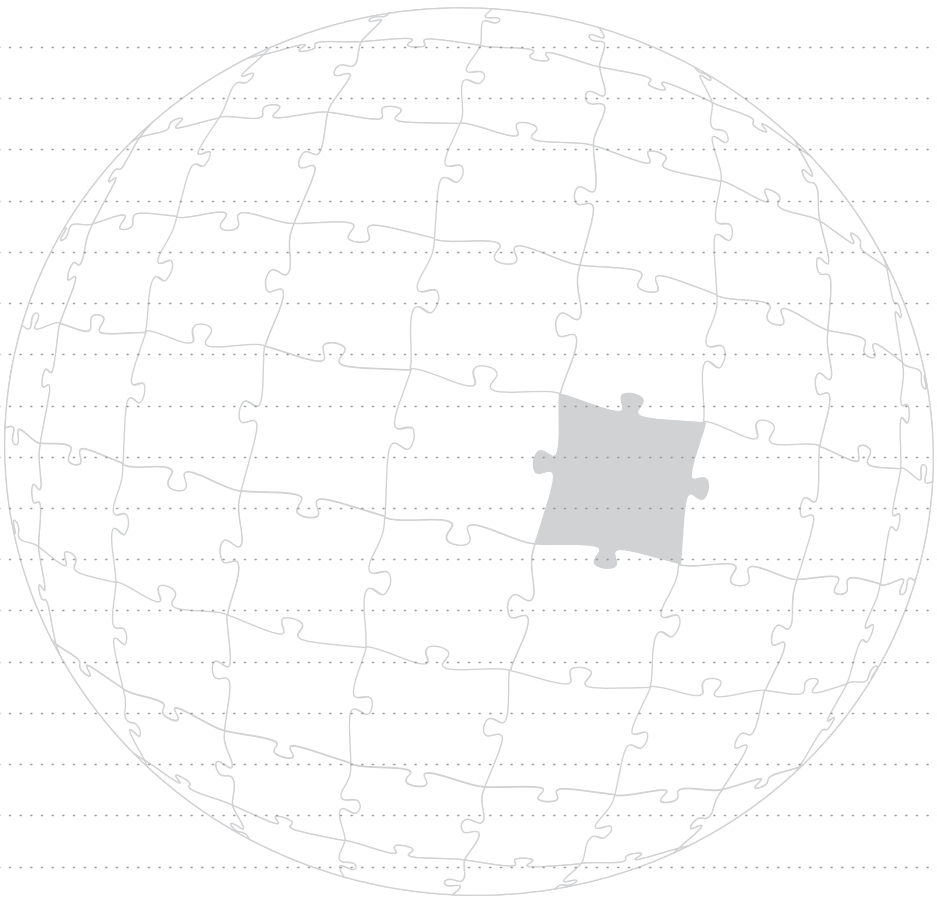
Social justice did not become a true priority at international level. While the Alma Ata Declaration stressed the need to combine economic and social development, dominant trends in international policy prioritised economic development, assuming trickle-down effects for the poor – which did only partially occur and virtually always resulted in increased inequalities. We gained increased knowledge about social determinants of health and health inequalities compared to 30 years ago, but the gap between rich and poor widened in most countries in the world. Underinvestment in health care systems as a consequence of structural adjustment led to uncontrolled privatisation of curative care, accessible to only part of the population, and underfinanced public services for the poor focusing on disease control and minor curative care. The gap between rich and poor, between and within countries, remains huge. International aid flows for health, although increased, also generated distortions in the functioning of health systems in developing countries through poor donor harmonisation and donor dependency, affecting priority setting at national level.

The enormous hopes expressed in 1978 were soon defeated by “realistic” visions guided by short-term feasibility. The result was that PHC principles were only partly implemented, with limited consideration for people empowerment and social justice, and many people in the world still have no access to health care services responsive to their needs. But there were also successful experiences. During this colloquium, we will discuss such experiences and successes in PHC, and we will also attempt to clarify some of the challenges to be addressed to revitalise PHC, in a context that has changed dramatically over the past 30 years. There may be today a new momentum for breakthroughs. Three recent and important reports call for major shifts in strategies and increased social accountability: the report of the WHO Commission on Social Determinants of Health, the 2008 WHO Health Report, and the second Global Health Watch Report.

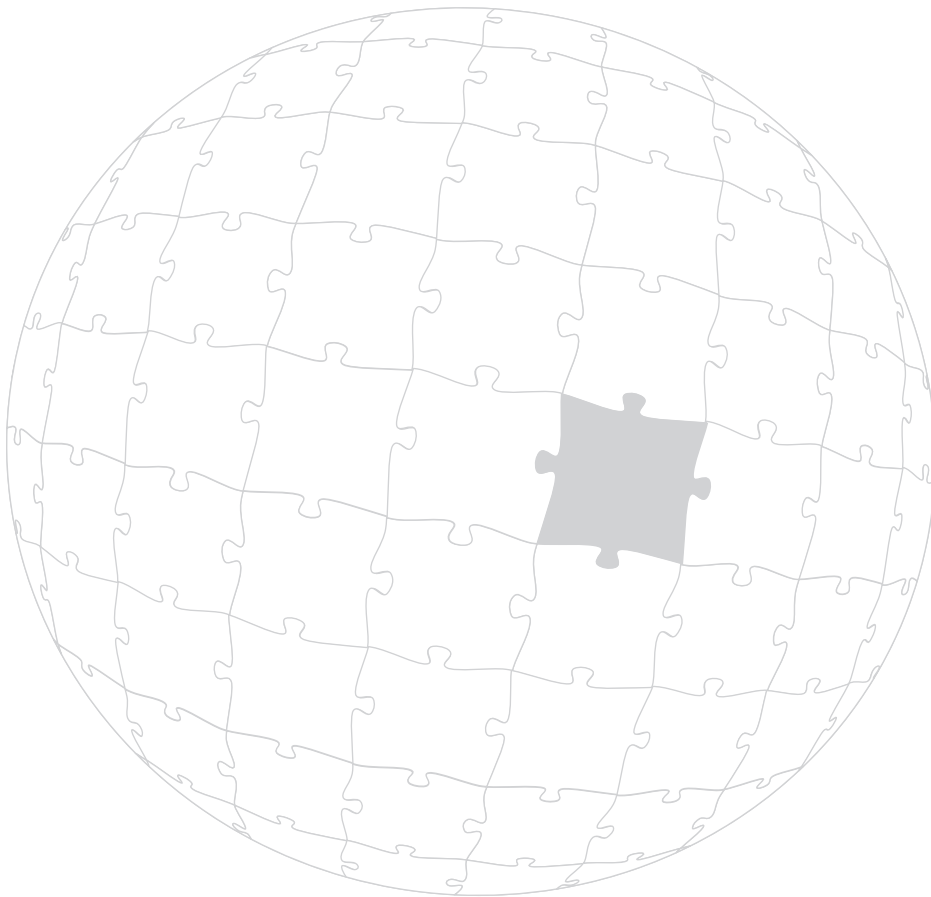
The Alma Ata Declaration was undoubtedly a political statement. Its message probably needs to be reformulated with the language of present times: nostalgia for the old words will get us nowhere. The underlying meaning is that PHC strengthening is simultaneously an issue of putting evidence into practice, and of actual participation of all citizens in decisions affecting their daily life, including equitable access to comprehensive health care.



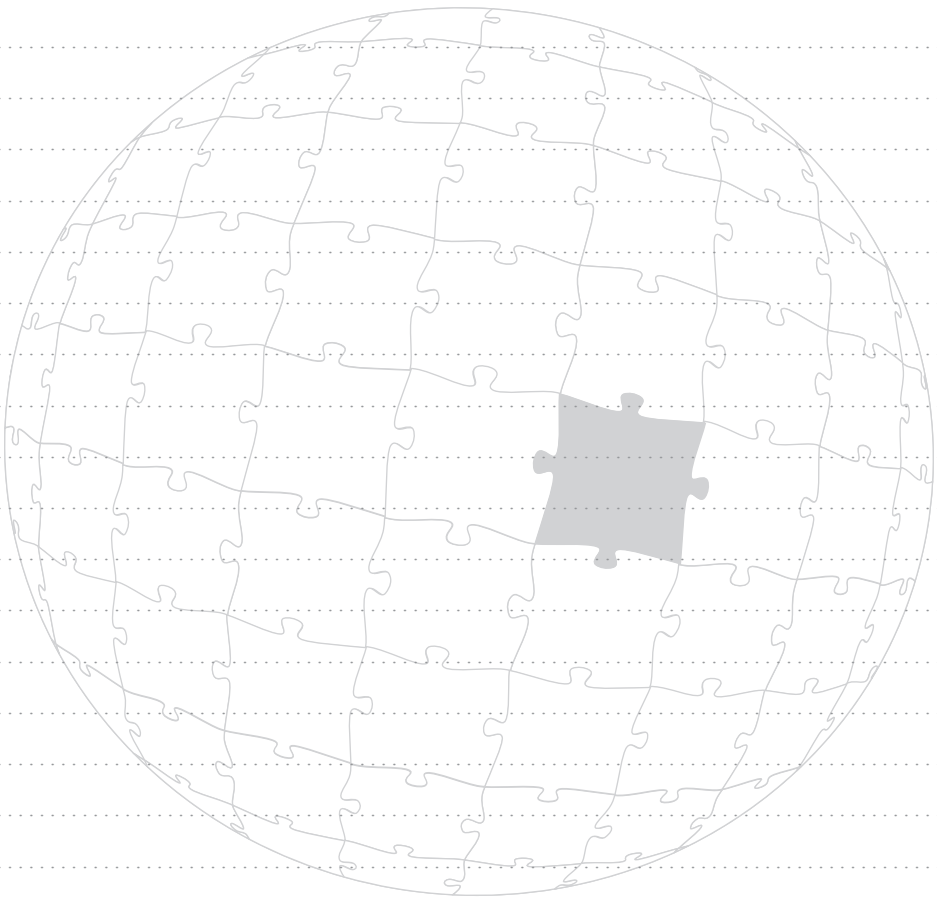
Notes



Abstracts 26 November



Notes



One year of reflections on the future of Primary Health Care

Prof. Gerald Bloom, Institute of Development Studies, University of Sussex, Brighton, UK

Email: G.Bloom@ids.ac.uk

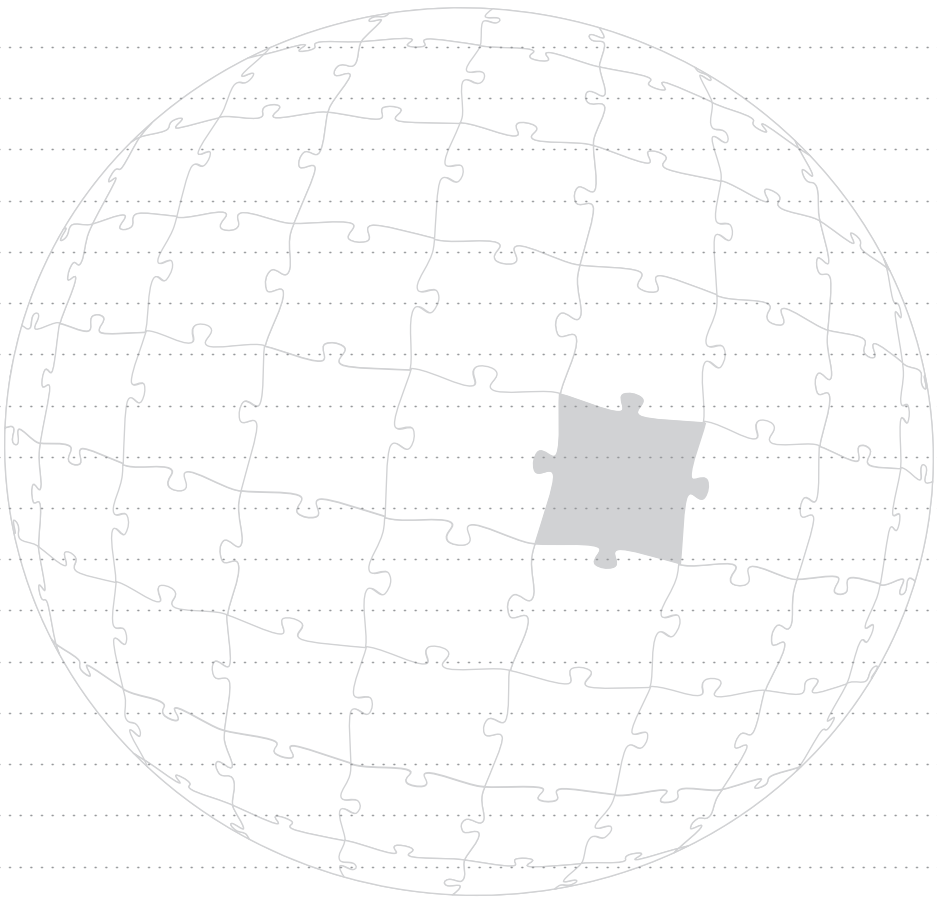
The Alma Ata Declaration summarised an international consensus built on successful experiences of health system development by post-colonial and post-revolutionary regimes. It emphasised government's responsibility for constructing, financing and managing health services, consistent with the prevailing understanding of development.

The 30th anniversary has stimulated reflections on the successes and failures of the international effort to achieve health for all and the implications for the future. Some have focused on the failure of many health systems to provide effective support, particularly for the poor. A large body of work has reiterated the strong relationship between illness, poverty, certain aspects of rapid economic and social change and large structural inequalities. Others have called for a rerun of the health system development strategies of the early 1980s backed by sufficient international funds to "scale up" and "roll out" appropriate interventions. A number of writings have focused on the impact of international health financing arrangements on national health systems. Still others have emphasised the need to take into account the impact on health development strategies of past investments in health systems and the many social, demographic, epidemiological, economic, technological and political changes that have taken place over the past thirty years.

The present economic crisis will create great challenges for health systems, but it will also open opportunities for serious reform. Many questions remain about how countries and the international community can live up to the objectives of the Alma Ata Declaration while adapting the expected roles of international organisations, governments, private providers, civil society organisations, households and individuals to the realities of the early 21st Century.



Notes



The ever-changing international health landscape, a view from the South

Dr. Francisco Songane, Director, Partnership of Maternal, Newborn and Child Health, Geneva, Switzerland

Email: SonganeF@who.int

We will review the implications of the international health arena by taking stock of the current situation for maternal, newborn and child health in developing countries. While progress has been made on improving the health of mothers and their children, much remains to be done; particularly, while coverage of interventions that are mainly implemented through campaigns, such as immunisation is high, coverage of interventions that require a well-functioning and sustainable health system is much too low.

The presentation argues that investments in health systems have historically fallen far short of the need, and traces the history of this neglect, from the effects of Structural Adjustment Programs (SAPs) in the 1980s to today's disease-focused funding mechanisms that provide a significant share of health funding in developing countries. SAPs were heavily promoted by the World Bank and the International Monetary Fund in the 1980s and 1990s. SAPs provided loans to countries conditional on the adoption of policies such as removing "excess" government controls and promoting market competition, and often insisted on cuts in health spending. Studies have shown that SAPs policies have slowed down improvements in, or worsened, the health status of people in countries implementing them; this includes worse nutritional status of children, increased incidence of infectious diseases, and higher infant and maternal mortality rates.

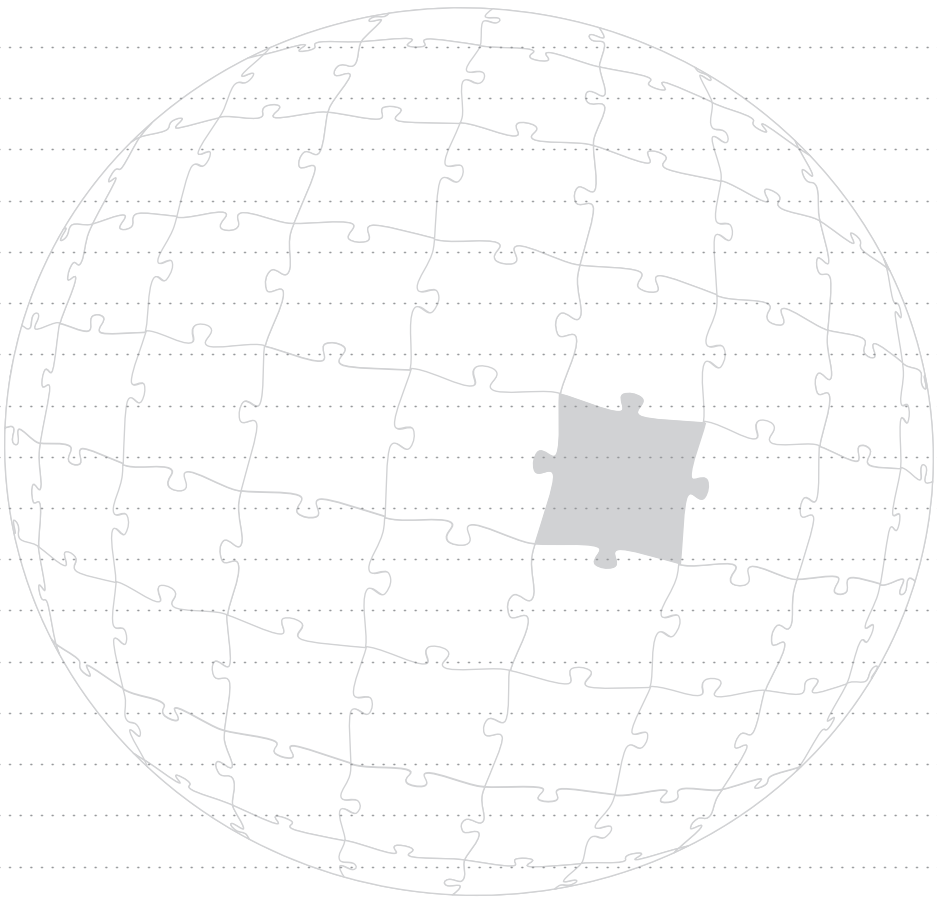
A 1987 UNICEF report detailing the negative impact of SAPs on health and education entitled "Adjustment with a human face" focused on policy recommendations for protecting public expenditure on the social sectors, such as health and education. However, the policy recommendations did not adequately address investment in health systems. SAPs have now largely been replaced by the Poverty Reduction Strategy Paper process. Also, World Bank operational guidelines now require analysis of the impact of adjustment programs on the poor and, in many countries, compensatory measures have been introduced. Critics argue that this is a "social safety net approach" in which social services are not regarded as a part of the normal primary functions of the modern state, but rather as institutions that respond to market failure.

The last decade has seen the creation of large, disease-focused funding initiatives, such as the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR). Although these initiatives have started to provide funding for health systems strengthening, the bulk of funding has focused on funding disease-specific interventions and activities and did not initially provide funding for health systems, leading to fragmentation and to increased verticalisation of the health sector.

This history of neglect of health systems has had severe implications. Many developing countries can not adequately respond to major epidemics such as avian flu, SARS and Ebola, nor provide adequate treatment of common childhood illnesses such as diarrhea and acute respiratory infections, which together account for more than a third of under-five mortality.

Thirty years after the Alma Ata Declaration, a refocus on primary health care and health systems is long overdue. Increased funding for health systems needs to be accompanied by renewed commitment and implementation of the principles in the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action: developing genuine partnerships and ensuring that developing countries are in the lead in setting their agenda for development.

Notes



People's Health Movement (PHM) in India

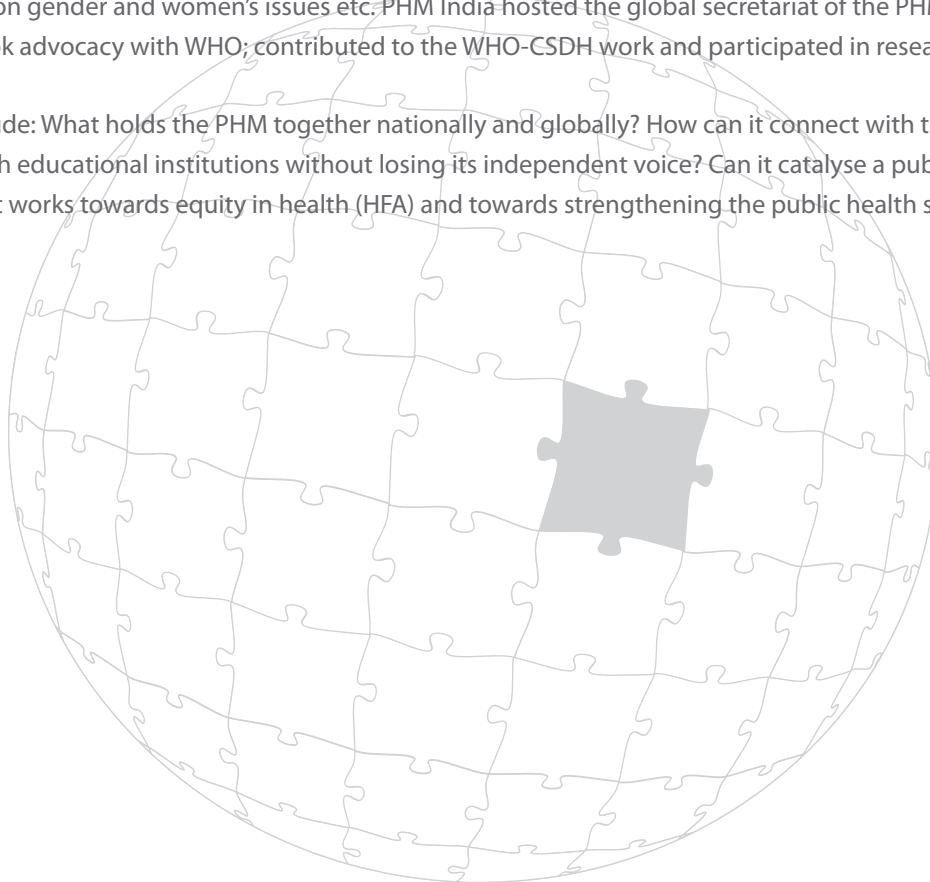
Dr. Thelma Narayan, Society for Community Health Awareness, Research and Action (SOCHARA), People's Health Movement, Bangalore, India

Email: thelma@sochara.org

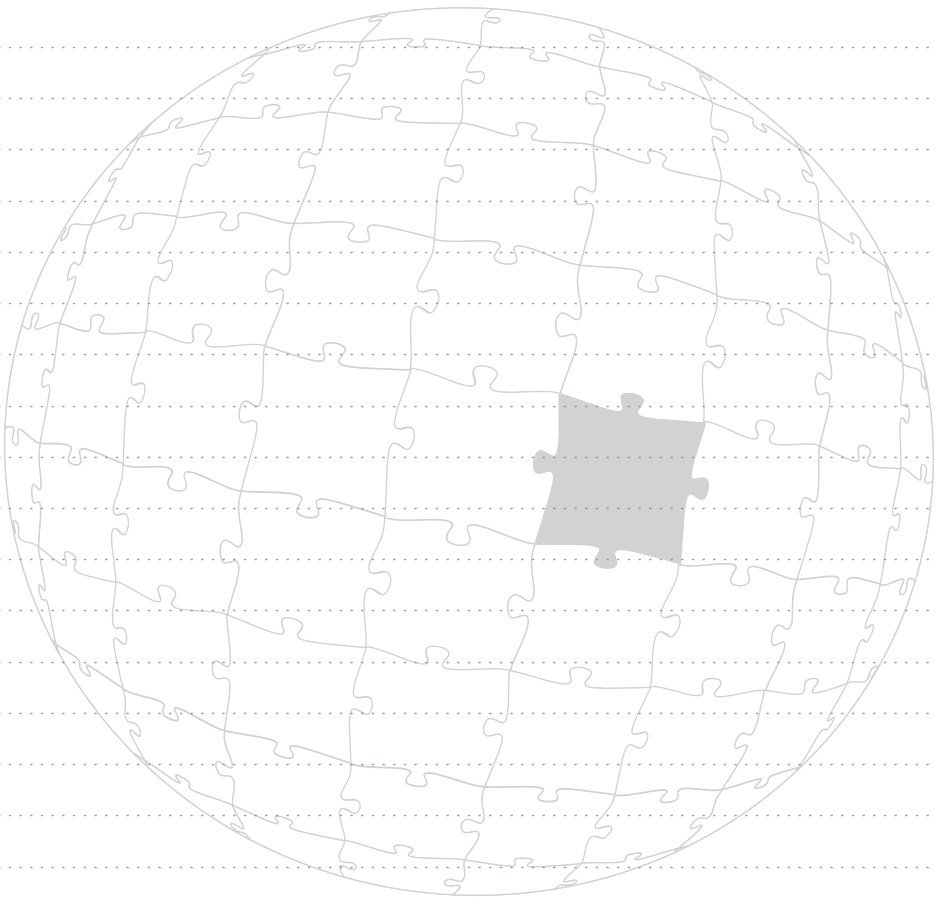
Key Messages: The PHM India (*Jan Swasthya Abhiyan* - JSA) emerged as a movement in 2000. It has played a critical role in revitalising Health for All using comprehensive primary health care as a strategy, and in addressing the underlying determinants of health over the past nine years. This is in the context of embedded social hierarchies and conditions and of globalisation.

Content: The coming together of 22 diverse national networks to form the JSA/PHM India in 2000 created a larger counter-veiling force that advocated and acted for HFA. Core components of its collective action included: community/social mobilisation; working with social movements; health policy advocacy at national and state levels; engagement with the public health system; a right to health and health care campaign; introduction of community monitoring of health systems; participation in the right to food campaign and in the campaign against privatisation of water, work on gender and women's issues etc. PHM India hosted the global secretariat of the PHM from 2003-2006; undertook advocacy with WHO; contributed to the WHO-CSDH work and participated in research for health.

Questions include: What holds the PHM together nationally and globally? How can it connect with the health system and with educational institutions without losing its independent voice? Can it catalyse a public health movement that works towards equity in health (HFA) and towards strengthening the public health system?



Notes



La reconstruction d'un système de santé en post conflit, le cas de la RDCongo

Hyppolite Kalambay, Director, Department of Investigation and Planning, Ministry of Health, Kinshasa, DR Congo

Email: hkalambay@yahoo.fr

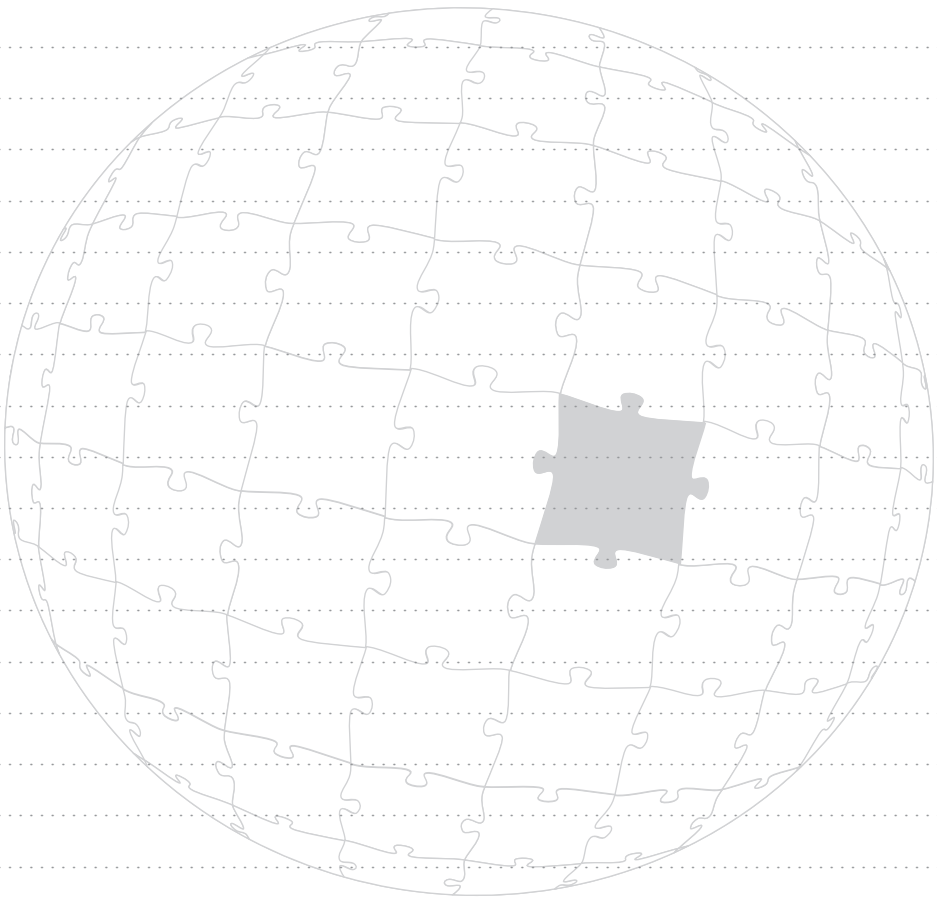
La République Démocratique du Congo est un pays d'environ 70.000.000 d'habitants. Il est entrain de sortir difficilement d'un conflit qui a duré près de 7 ans. Ce conflit a eu pour conséquence entre autre la tendance à la disparution de l'Etat et donc de son leadership sur l'ensemble des secteurs. Dans le secteur de la santé, on a assisté à détérioration de l'offre et de la qualité des soins de santé. L'organisation du système de santé qui était essentiellement basé sur les districts sanitaires et qui était parmi les meilleurs du continent a cédé la place à des services de santé de qualité douteuse. En 2001, le budget de l'Etat consacré à la santé était de moins d'un dollar américain par habitant, le taux d'utilisation des services de santé était de 0. 20 consultations par habitant et par an. Le taux de mortalité infanto juvénile était de 220 décès pour 1000 naissances vivantes et 1289 femmes décédaient pour 100.000 naissances vivantes.

La mise en place des Global Health Initiative (GHI) a permis au pays d'augmenter de façon substantielle le financement de la santé entre 2001 et 2006. L'aide publique au développement dans le secteur de la santé a atteint jusqu'à 300.000.000 USD par an, soit environ 4 à 5 USD par habitant et par an. Cependant, en absence d'un leadership fort dans le secteur, le financement international qui provient des GHI (vertical dans la majorité des cas), a conduit à une véritable atomisation du système de santé dans le pays. Celle-ci se caractérise par la présence d'un nombre sans cesse croissant d'ONGs qui travaillent dans le secteur de santé (environ 300 enregistrés), l'inflation institutionnelle (13 directions et 52 programmes) et le développement des stratégies de survie tant sur le plan institutionnelle qu'individuelle, la multiplication d'institution de formation du personnel de santé, la multiplication d'instance de coordination et des procédures de gestion rendant ainsi aléatoire l'efficacité du système.

En 2006, le Ministère de la Santé Publique (MSP) et des partenaires du secteur ont décidé de travailler ensemble en vue d'améliorer l'offre et la qualité des services de santé. Cette nouvelle vision est décrite dans le document de 'Stratégie de Renforcement du Système de Santé' SRSS en sigle, adopté lors d'une revue annuelle du secteur. La SRSS s'articule autour de six axes qui sont : (i) le développement des districts sanitaires, (ii) la redéfinition du rôle du niveau central et intermédiaire du système de santé en prenant en compte le contexte de la décentralisation, (iii) la rationalisation du financement de la santé, (iv) le développement des ressources humaines pour la santé, (v) le renforcement de la collaboration intra et inter sectorielle, et (vi) le renforcement de la recherche sur le système de santé. Le coût estimatif de la mise en œuvre de cette stratégie est évalué à 21 USD au niveau du district sanitaire (y compris le coût relatif à la lutte contre le VIH à ce niveau).

La mise en œuvre de la SRSS a déclenché le processus de mise en œuvre de la Déclaration de Paris dans le secteur de la santé. En ce qui concerne l'appropriation, la SRSS à travers le Plan d'Actions du Gouvernement permet l'amélioration de la pertinence de l'affectation du budget de l'Etat consacré à la santé. Concernant l'alignement, deux résultats sont actuellement enregistrés, il s'agit de l'inversion des tendances en terme de proportion entre le financement vertical et horizontal en faveur de ce dernier et d'une meilleure orientation du financement provenant des GHI.

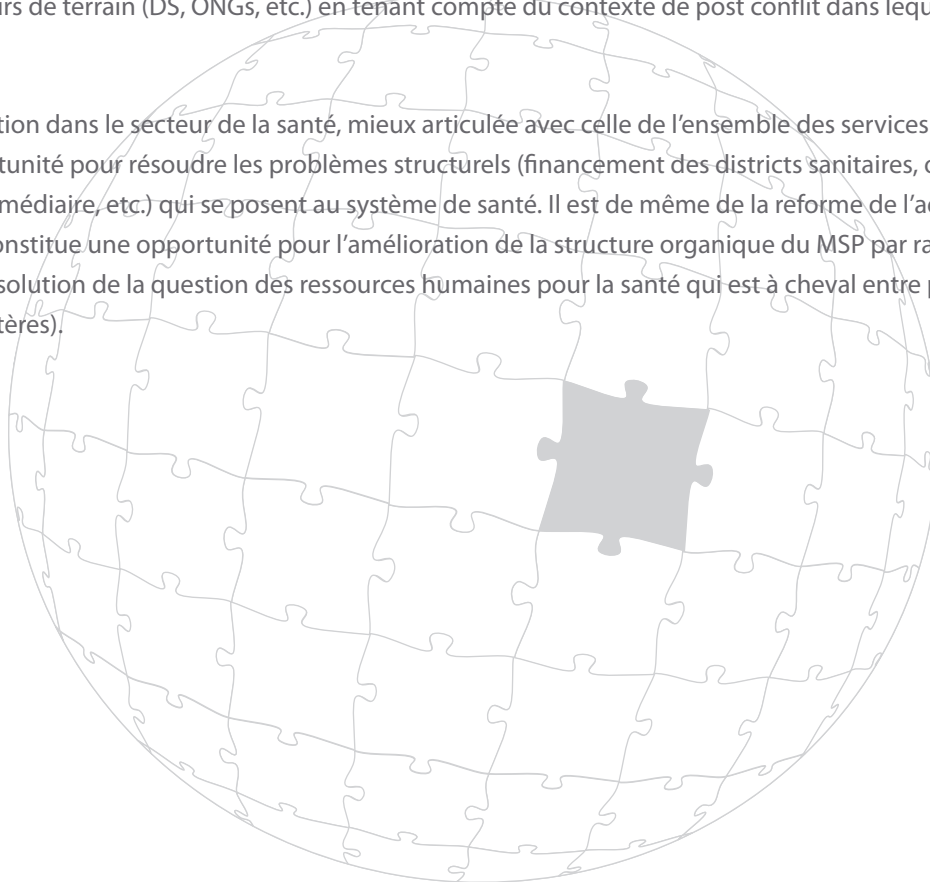
Notes



L'expérience de la RDC montre que l'alignement sur la stratégie nationale sans harmonisation des procédures a un effet très limité sur l'efficacité services de santé. On constate par exemple que sans harmonisation, un financement destiné à être complémentaire à un autre, commence quand celui auquel il devrait être complémentaire est terminé. Ainsi, le MSP et ses partenaires travaillent actuellement à la mise en place des procédures consensuelles dans le secteur. Le financement GAVI destiné au renforcement du système de santé en RDC sera utilisé comme un financement pilote dans la mise en œuvre de ces procédures. L'objectif à moyen terme est d'utiliser tout le financement de la santé (domestique et international) conformément à ces procédures consensuelles.

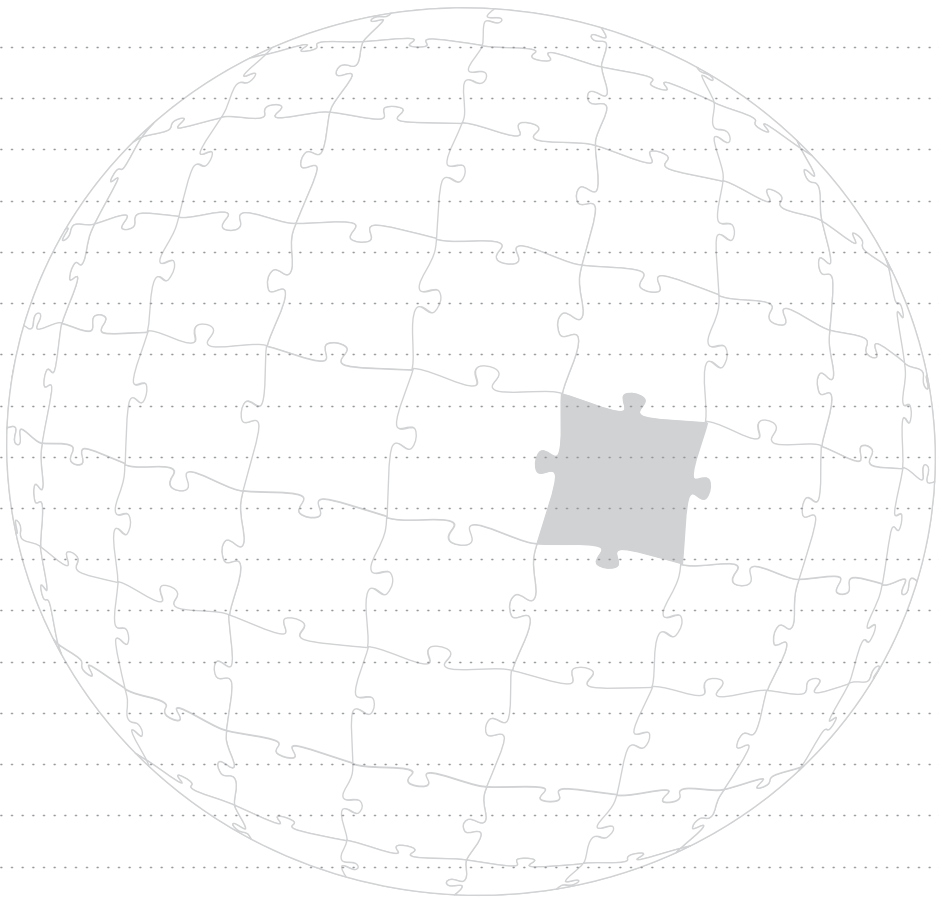
Au niveau périphérique, un recentrage des ressources disponibles (domestiques et internationales) pour la matérialisation des axes de la SRSS relatifs au développement des Districts sanitaires est en cours de réalisation. La revue des dépenses publiques réalisées en 2007 a démontré que plusieurs projets en cours ne disposent pas d'assez des ressources pour offrir les soins de santé qualité aux populations couvertes¹. Trois actions devront être entreprises à moyen terme à ce sujet. Il s'agit : (i) de mieux orienter le financement de la santé en fonction des besoins réels en vue de l'offre des soins de santé de qualité au niveau des DS, (ii) de mieux utiliser le financement communautaire qui, selon les estimations, constitue actuellement la source de financement la plus importante des services de santé en RDC (environ 7 USD par habitant et par an) et (iii) redéfinir le rôle et les responsabilités des différents acteurs de terrain (DS, ONGs, etc.) en tenant compte du contexte de post conflit dans lequel se trouve le pays.

La décentralisation dans le secteur de la santé, mieux articulée avec celle de l'ensemble des services publics devrait être une opportunité pour résoudre les problèmes structurels (financement des districts sanitaires, organisation du niveau intermédiaire, etc.) qui se posent au système de santé. Il est de même de la réforme de l'administration publique qui constitue une opportunité pour l'amélioration de la structure organique du MSP par rapport à sa mission et la résolution de la question des ressources humaines pour la santé qui est à cheval entre plusieurs secteurs (ministères).



¹ Les projets formulés avant la SRSS l'ont été sur base des estimations empiriques des coûts (1, 2 ou 3 USD par habitant et par an. Ces coûts s'avèrent largement inférieurs à ceux évalués moyen du iHTP (résultats préliminaires) pour l'offre des soins de santé de qualité au niveau des districts sanitaires.

Notes



Rural public health care in Latin America around the millennium switch

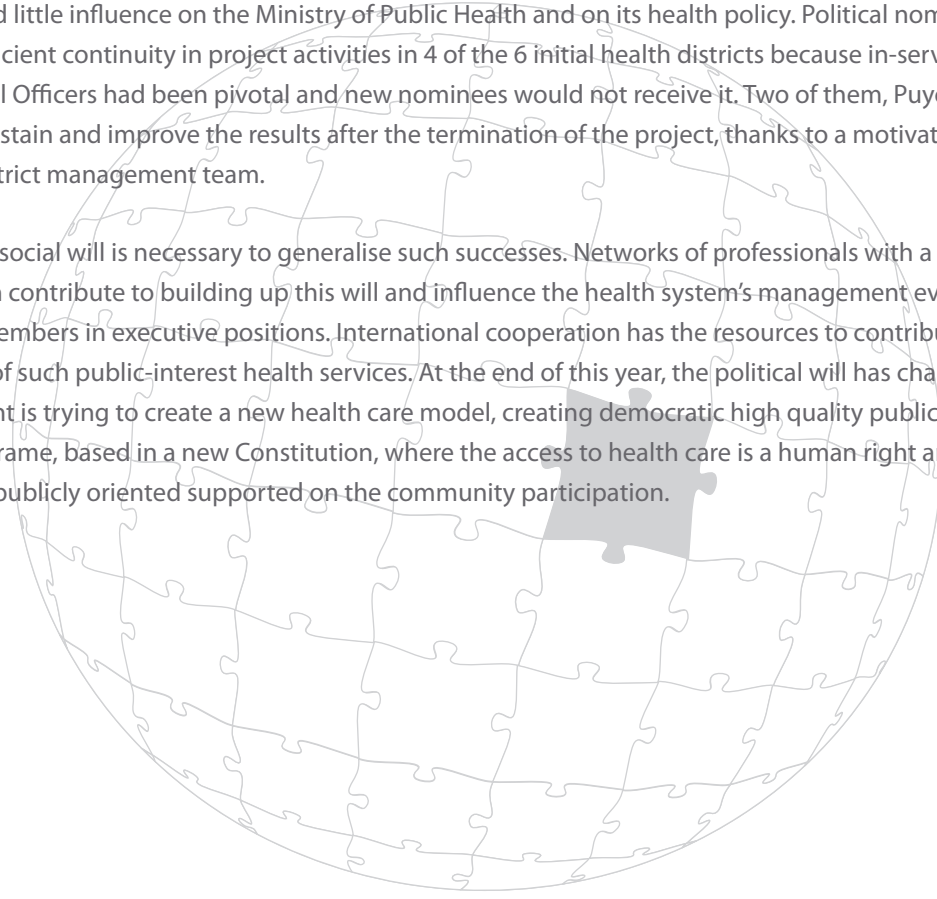
Dr. Edgar Rojas Gonzalez, Public Health Department, Pontifica Universidad Católica del Ecuador (PUCE), Quito, Ecuador

Email: EROJAS@puce.edu.ec

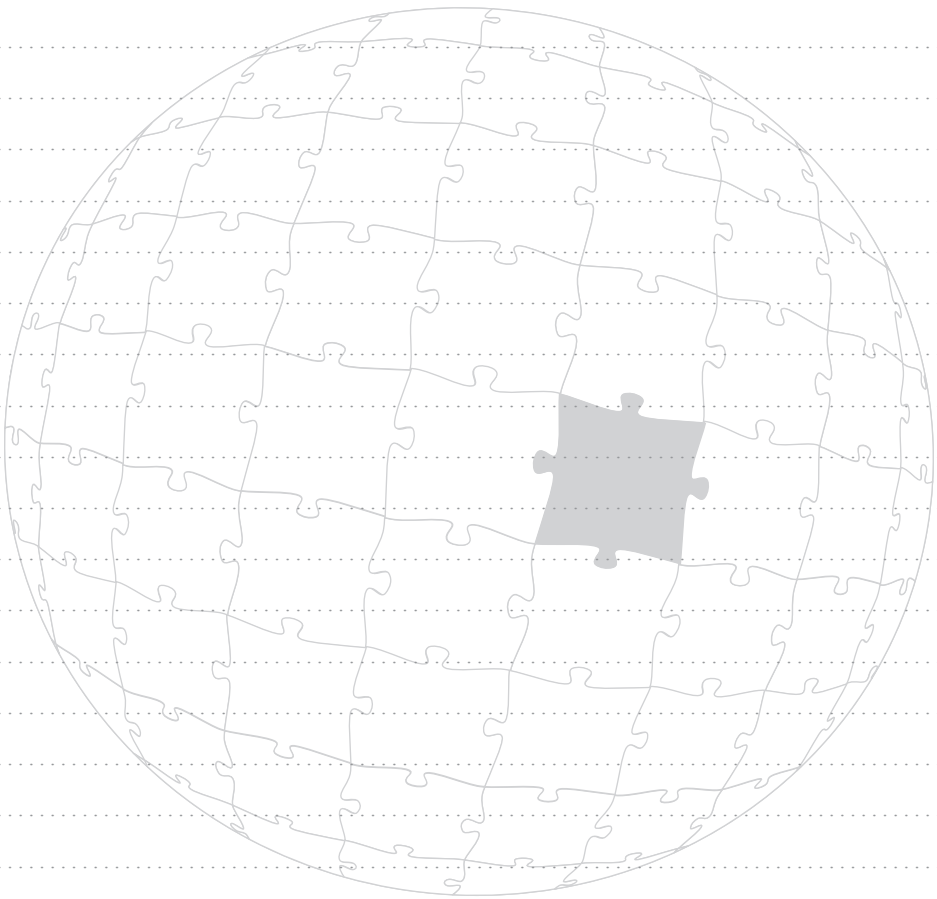
The Primary Health Care (PHC) Project, a bilateral agreement between Ecuador and Belgium (1993-2003), had the goal to make first line health services on good quality curative care, maintaining satisfactory levels of preventive and promotional care, because it is an answer to its principal health demands and allows for community participation and support in developing these services. Its primary objective is to improve access to quality curative (and preventive) care. Based on the former experience, we tried to conceptualise participatory strategies for the development of comprehensive curative care in publicly-oriented health services and to analyse the operational links between curative care, disease control, co-management and community participation.

Ecuador, during the past decade, hasn't defined yet a clear health policy; furthermore, it has reduced significantly its public health budget in the nineties and the beginning of this new century. The implication of communities in co-management proved mandatory to democratise public services and to develop health care. In the country, however, this project had little influence on the Ministry of Public Health and on its health policy. Political nominations prevented sufficient continuity in project activities in 4 of the 6 initial health districts because in-service training of District Medical Officers had been pivotal and new nominees would not receive it. Two of them, Puyo and Azogues, managed to sustain and improve the results after the termination of the project, thanks to a motivated and permanent district management team.

A political and social will is necessary to generalise such successes. Networks of professionals with a social conscience can contribute to building up this will and influence the health system's management even without having their members in executive positions. International cooperation has the resources to contribute to the development of such public-interest health services. At the end of this year, the political will has changed and now the government is trying to create a new health care model, creating democratic high quality public services. There is a new legal frame, based in a new Constitution, where the access to health care is a human right and the health care system is publicly oriented supported on the community participation.



Notes



Neighbourhood Health Centres in Belgium

Prof. Jan De Maeseneer, Department of Family Medicine and Primary Health Care, Ghent University, Secretary General The Network Towards Unity for Health, Chairman European Forum for Primary Care

Email: Jan.DeMaeseneer@UGent.be

In the aftermath of May '68, medical students were looking for a new orientation of their professional careers. This orientation was characterised by 2 elements: on the one hand a clear social commitment (as opposed to the traditional elitist attitude of medical students) and an orientation towards primary health care and public health.

In the 70s, the first community health centres started in Belgium. Most of the centres were initiated by health care providers, although some were started through civil society initiatives. Typically, health centres were located in underserved and deprived areas, and that was a deliberate choice by the young providers. The underpinning principles of the health centres were: equity and access, especially for those most in need, utilisation of a bio-psycho-social model, interprofessional cooperation, development of quality health care and involvement of the community, patient empowerment and health promotion. The teams were most of the times composed of family physicians, nurses, physiotherapists, social workers, health promoters.

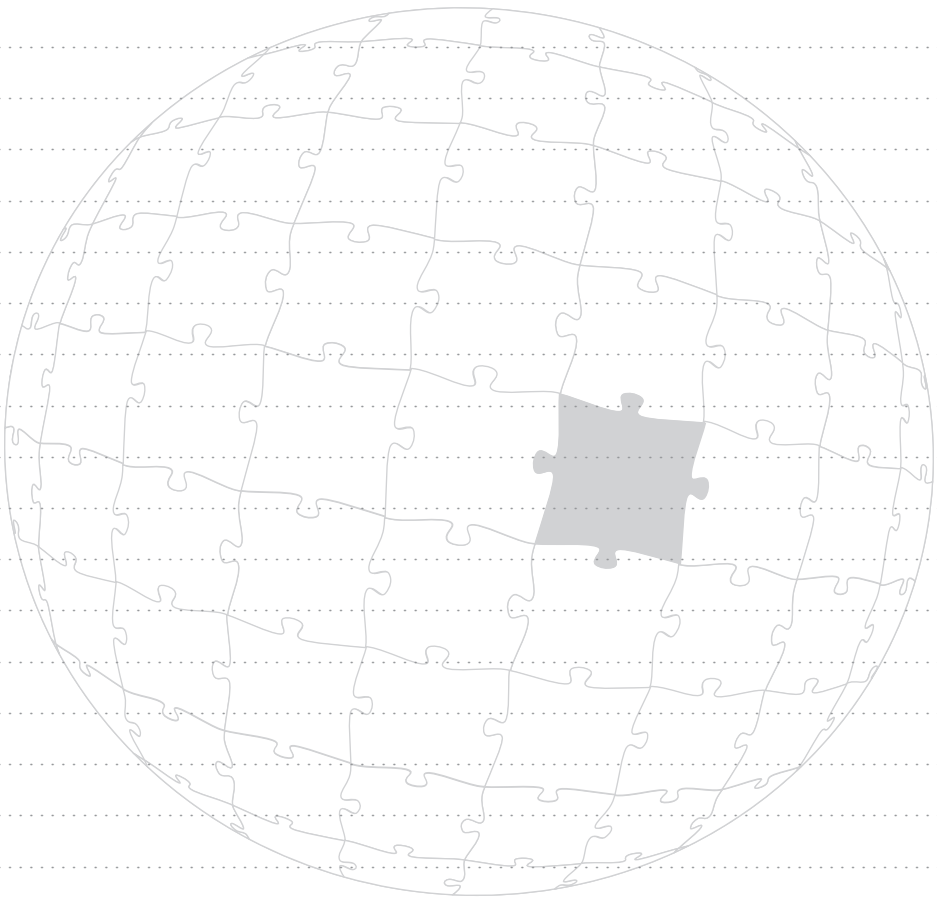
During the developments in the 80s, the teams encountered a lot of problems:

- Fee-for-service was inappropriate for the new way of practicing. Therefore in 1982, a capitation system was negotiated with the insurers, that fully developed in the 90s;
- There were a lot of negative reactions by the medical establishment (traditional trade unions, "Orde der Geneesheren/Ordre des Médecins");
- Health care professionals were ill-prepared to work in interprofessional teams;
- The health sector worked quite in isolation, what hampered the possibilities to act on the social determinants of health. Therefore comprehensive approaches like "community-oriented primary care" were developed;
- Community health centres were perceived as "care for the poor". This brought a risk of dualisation, that was totally in opposition to the universal approach that the centres were aiming at.

Despite the quite negative environment, the number of health centres increased continuously: in 2010 there will be almost 100 health centres in Belgium, taking care of 2% of the population. Most are located in cities, although some are also situated in rural areas.

In 2008 the Knowledge Centre for Health Care published a report on the comparison of performance of community health centres working in a capitation system with the care in fee-for-service. The first conclusion was that in terms of equity community health centres were very performant: the poorest group of the population has access to primary health care in the health centres (operating without financial threshold, as there are no co-payments). Moreover in terms of quality, for most indicators there was no difference between the 2 systems, and where differences occurred, community health centres did better (especially in prevention and screening). The economical analysis demonstrated that community health centres were more cost-effective than fee-for-service practices, as they reduced the use of specialist care, utilisation of laboratory and medical imaging, hospitalisation (except for psychiatric disorders), drug prescription (more appropriate antibiotic prescription and of anti-hypertensive drugs).

Notes



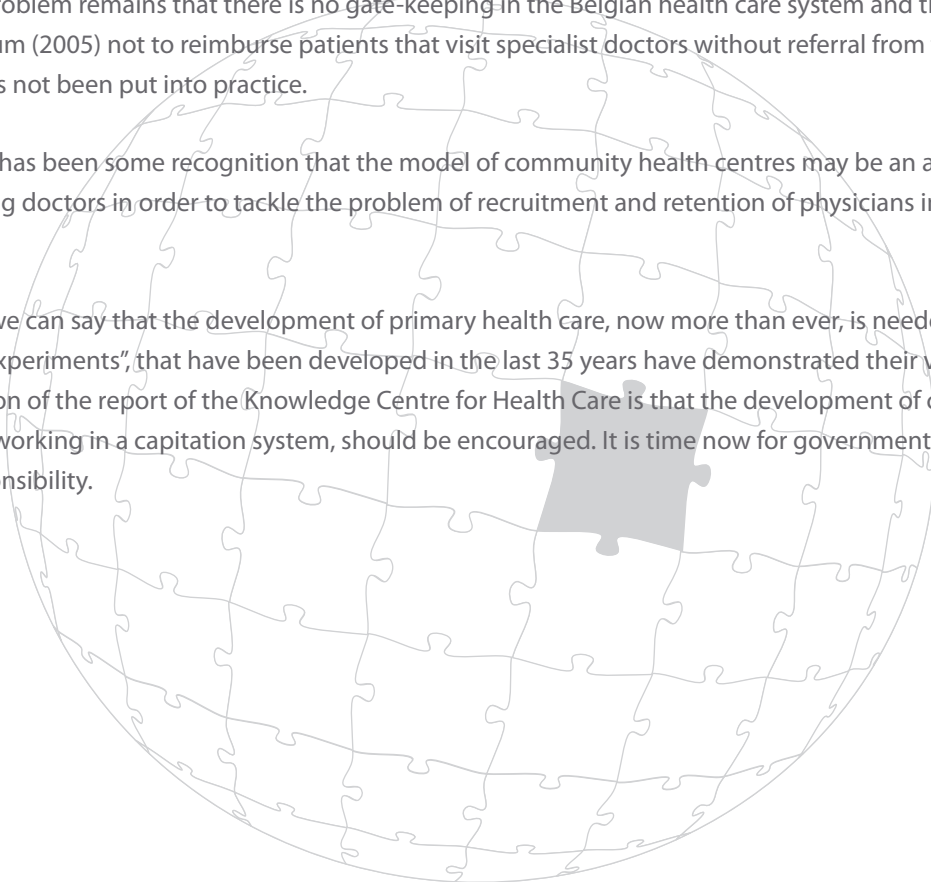
As far as the political impact of health centres is concerned, it was mainly at the local level (municipality), that links were created between community health centres and e.g. local social policy in Flanders. At the regional and federal level, there was only limited interest in the development of community health centres. The main reason for this is that, although the Belgian government endorsed the primary health care declaration of Alma Ata (1978), it has never had strong political support. The Belgian health care system is characterised by hospitalo-centrism, fragmentation, orientation towards specialist care. The health system lacks a clear health policy, the decisions are not related to clear set goals, but most of the time are reduced to “consecration” of the compromises that have been negotiated in bilateral committees between health insurers and providers.

The small changes that occurred have very often been influenced by developments in community health centres, but most of the time evolved very slowly. It took 12 years before the concept of a “global medical record” was formulated in a legal initiative, and today there is still not yet a “patient list” system in Belgium. Initiatives to stimulate recruitment and retention in family medicine (e.g. Impulseo I, Impulseo II), are just starting.

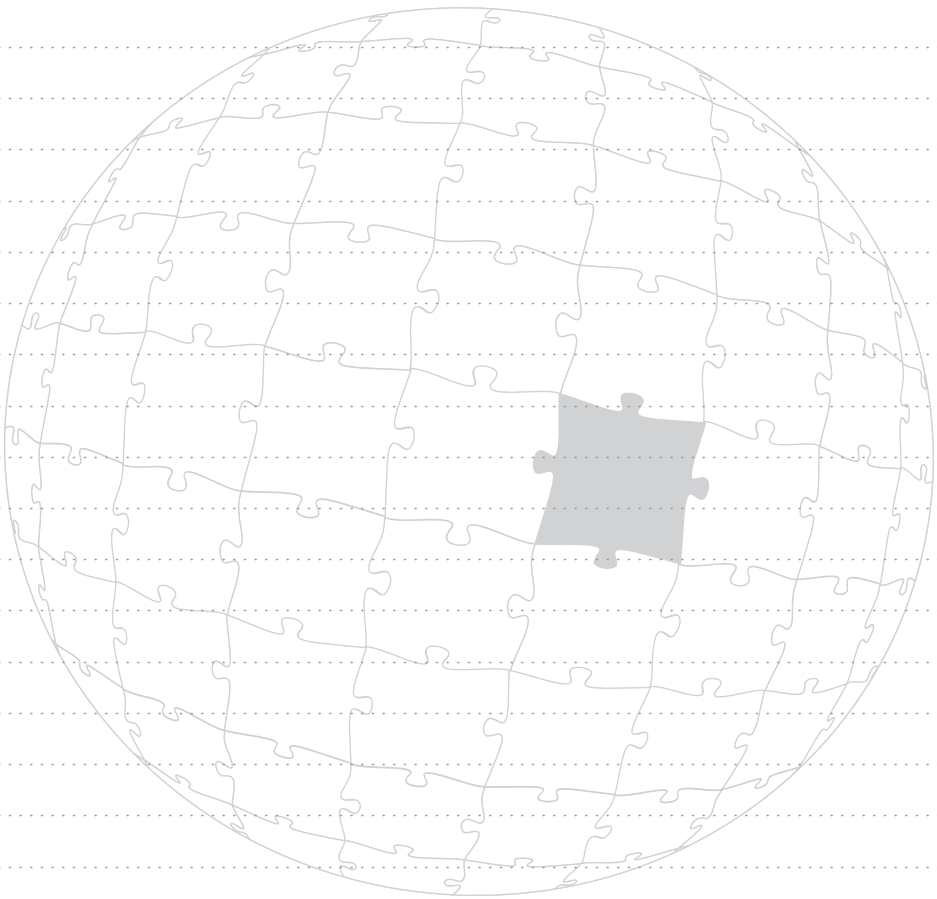
Community health centres have developed a lot of expertise in interprofessional cooperation and intersectoral action for health (those experiences are most of the time used by government for “export-purposes”). A fundamental problem remains that there is no gate-keeping in the Belgian health care system and that the OECD-advice to Belgium (2005) not to reimburse patients that visit specialist doctors without referral from their general practitioner, has not been put into practice.

Recently, there has been some recognition that the model of community health centres may be an attractive career-option for young doctors in order to tackle the problem of recruitment and retention of physicians in primary health care.

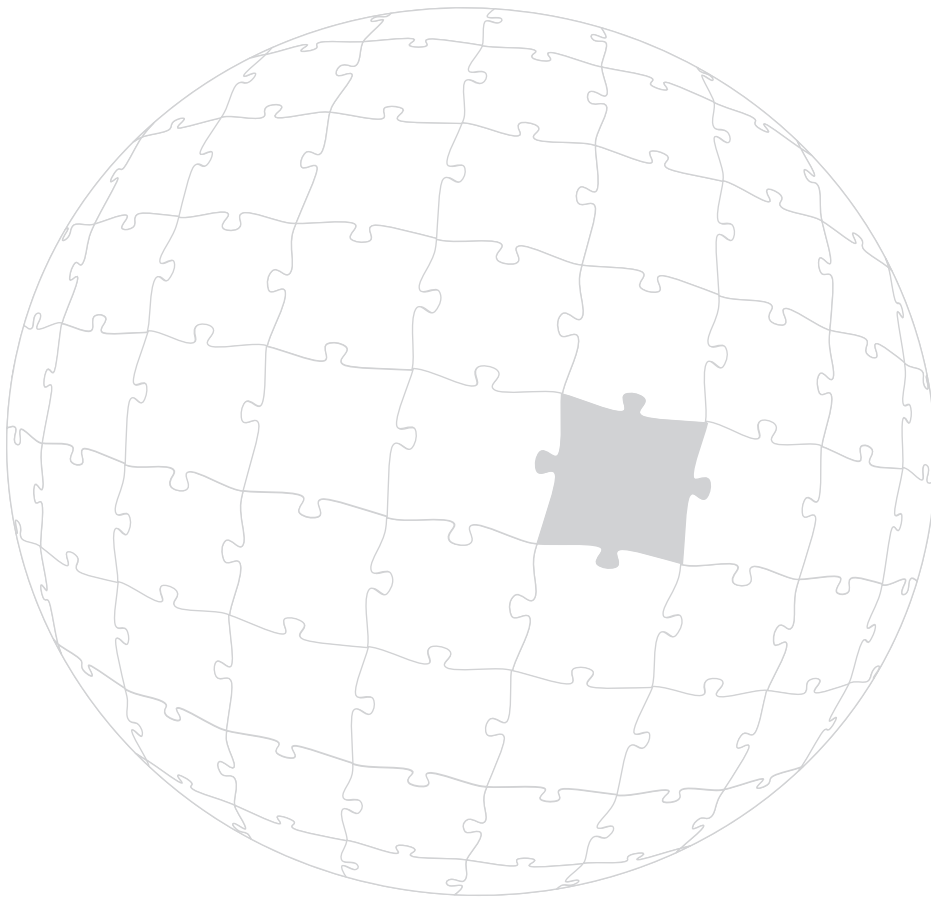
In conclusion, we can say that the development of primary health care, now more than ever, is needed in Belgium. The ongoing “experiments”, that have been developed in the last 35 years have demonstrated their value. The recommendation of the report of the Knowledge Centre for Health Care is that the development of community health centres working in a capitation system, should be encouraged. It is time now for governments in Belgium to take their responsibility.



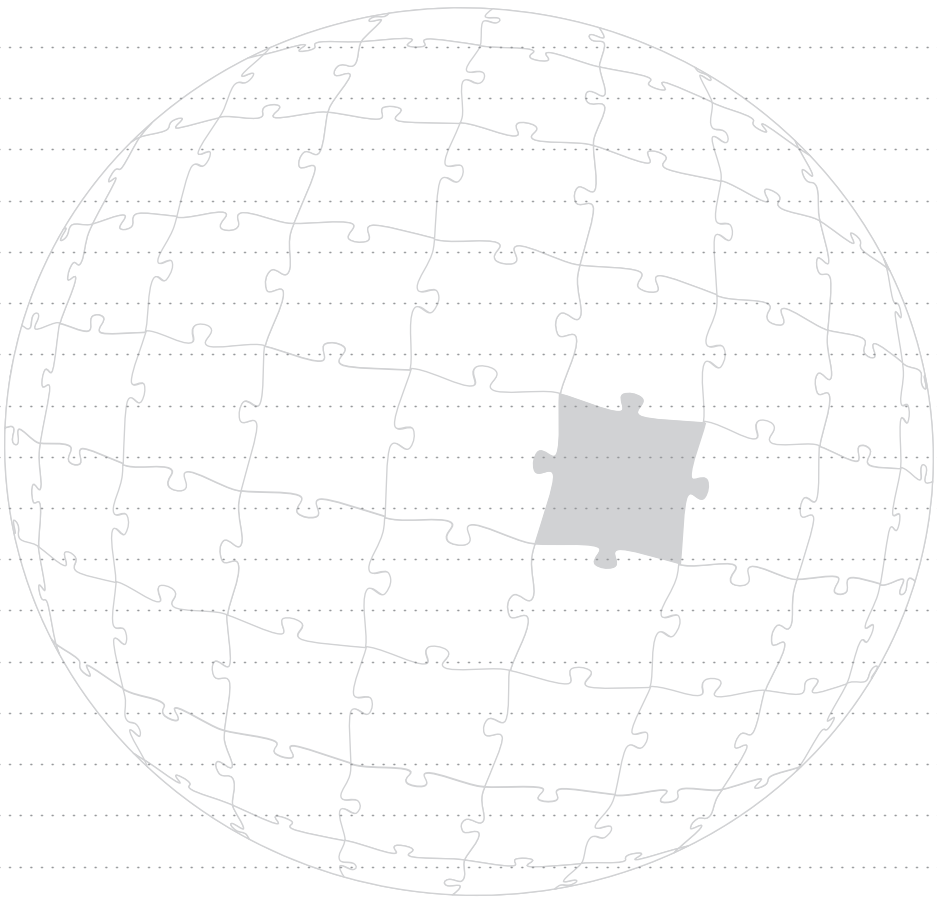
Notes



Thematic sessions



Notes



Parallel session 1:

New ways to promote community participation

Chair: Dr. Pol De Vos, ITM, Antwerp, Belgium

Email: pdevos@itg.be

Location: Auditorium

Background

The implementation of community participation and empowerment was a core element of the Alma Ata Declaration. Since then, rich local experiences developed in different directions based on the community organisation's capacities and on the local and national contexts.

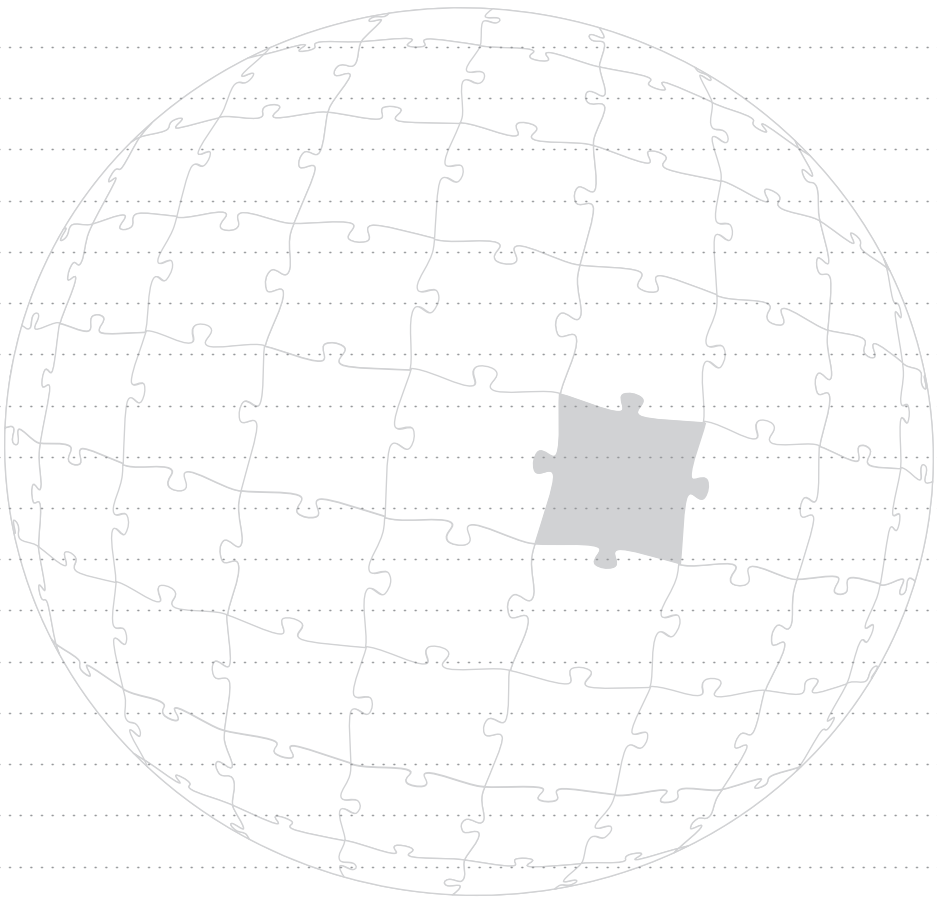
During the 1980s and 1990s, the evolution of the socio-economic and political context narrowed the possibilities of comprehensive primary health care. Nevertheless, communities looked for new and alternative ways to organise and to improve their living and health situation. Also, experiences evolved from the local level to a more national and even international level. During the 1990s, antiglobalisation movements saw the light and mobilised at national and international level to advocate for alternative policy proposals. Civil society organisations play a growing role in the formulation of national and international health policies. (See, for example, their recent reports for the Commission on Social Determinants for Health of the WHO).

In our discussion session, we hope to hear testimonies on novel ways of organisation, action and advocacy. A broad array of experiences will be analysed and discussed: What happened? Which elements are common? Which experiences have been different and why? Which lessons can be learned?

Invited panellists

- Thelma Narayan (People's Health Movement, Bangalore, India)
- Jonathan Wangisi (Taso, Kampala, Uganda)
- Pedro Villasana (Public Health Network Latin America, Venezuela)
- Mariano Bonet (Instituto Nacional de Higiene, Epidemiología y Microbiología, Havana, Cuba)
- Leen Deroo (Neighbourhood Health Centres Ghent / UGent)
- Wim De Ceukelaire (International Action for Liberation, Brussels, Belgium)

Notes



Parallel session 2:

New models for human resources for health at first line

Chair: Prof. Monique Van Dormael, ITM, Antwerp, Belgium

Email: mvdormael@itg.be

Location: Aula Janssens (translation available)

Background

The “human resources” crisis is often addressed in terms of shortage. But besides these quantitative aspects, it is increasingly acknowledged that human resources related aspects are crucial for health systems: roles and skill mix, attitudes and behaviour, management inducing commitment...

The red thread of this parallel session will be to scrutinise to what extent and how health professionals contribute to “empowering” patients and community to improve their own health – contrasting with a technocratic approach. This should be addressed through 2 major themes: Community Health Workers and human resource motivation (twice about 1 hour and 15 minutes).

Theme 1: Community Health Workers

In the context of the socio-political approach of the Alma Ata Declaration, Community Health Workers, viewed as emanating from the community, were seen as prompting social change by supporting communities to make decisions about their own health and increasing self-confidence in their own abilities to find solutions to their felt needs. Very soon however, the paradigm of selective PHC reoriented their role, emphasising its technical dimensions; their role was not so much to strengthen self-determination, but rather to “inculcate” them good health behaviors in a top-down rather than bottom-up approach. This operated a dramatic shift in the relations between CHW, communities and health staff. In practice, CHW programmes had variable successes. The present revival of CHW programmes is predominantly, but not exclusively, in line with the more “technocratic” approach, where CHW are mainly seen as “extension health workers”.

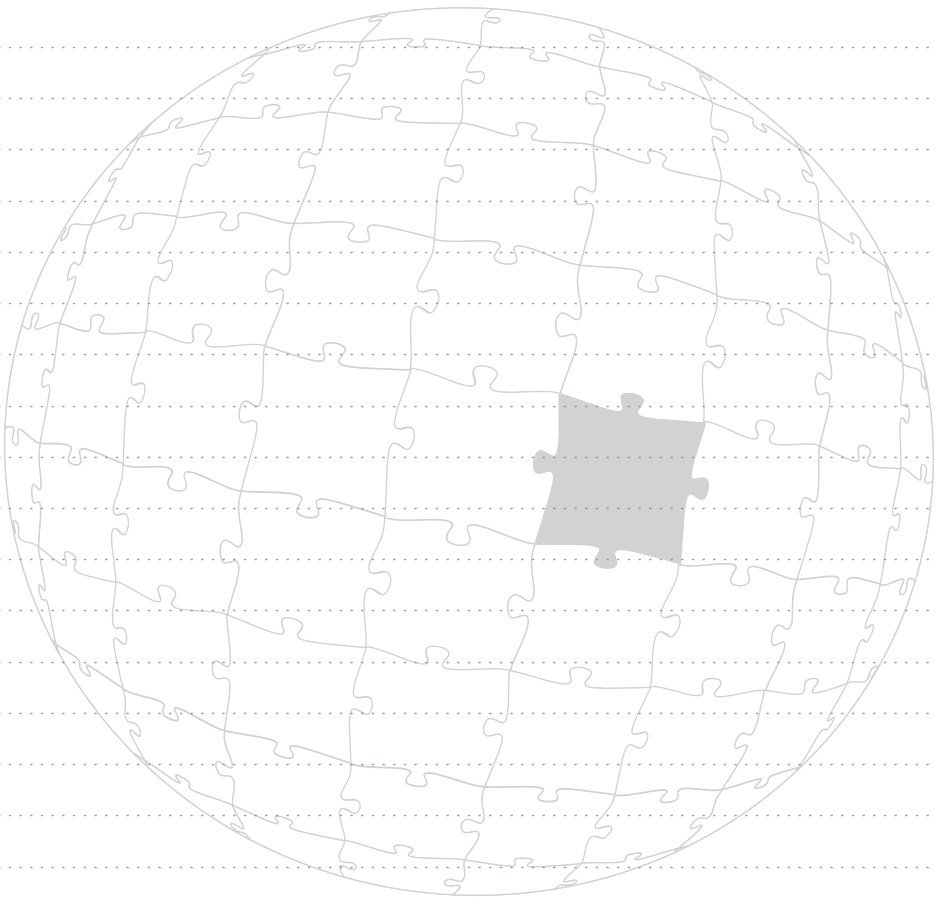
Theme 2: Staff motivation

Staff motivation is central for access to quality care. While many professionals do their best in delivering health care, low motivation is often the source of attitudes and behaviour opposed to acceptable care. Furthermore, it requires strong motivation and commitment to go and remain to work in deprived areas, such as rural areas or urban slums. There is a growing body of knowledge about effects of incentives – financial and non-financial – on health provider behaviour; it is also increasingly recognised that complex incentive packages are needed to promote health workers’ motivation. We want to explore different drivers of staff behaviour and reflect on strategies, on one hand to encourage attraction and retention of health workers in deprived areas, on the other to promote service orientation among health workers and decision making shared with patients and communities.

Invited panellists

- Narayanan Devadasan (Institute of Public Health, Bangalore, India)
- Lucy Gilson (University of Cape Town and London School of Hygiene and Tropical Medicine, London, UK)
- Hlengiwe Hlophe (University of Bloemfonteyn, Bloemfonteyn, South Africa)
- Maaroufi (or El Azzouni) (INAS, Rabat, Morocco)
- Mit Philips (MSF Belgium, Brussels, Belgium)
- Salif Samake (Ministère de la Santé, Bamako, Mali)

Notes



Parallel session 3:

Changing aid modalities to strengthen primary health care (PHC)

Chair: Prof. Bruno Dujardin, Université Libre de Bruxelles, coordinator GRAP-SWAP, Brussels, Belgium¹

Email: bruno.dujardin@ulb.ac.be

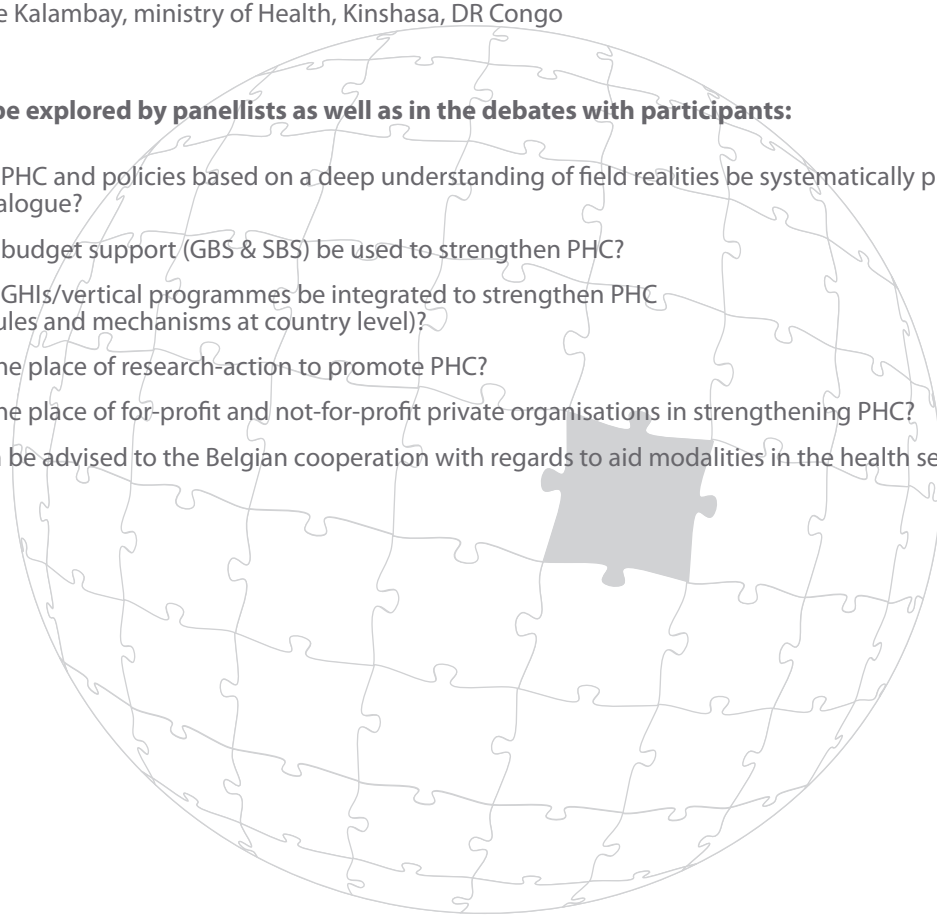
Location: Room C (Campus Nationalestraat, second floor)

Panellists:

- Elisabeth Paul (ULg – GRAP-SWAP, Liège, Belgium)
- Francisco Songane (Partnership for Maternal, Neonatal and Child Health, Geneva, Switzerland)
- Léo Devillé (HERA, Reet, Belgium)
- Paul Bossyns (BTC, Brussels, Belgium)
- Luc De Backer (DGDC, Brussels, Belgium)
- Hyppolite Kalambay, ministry of Health, Kinshasa, DR Congo

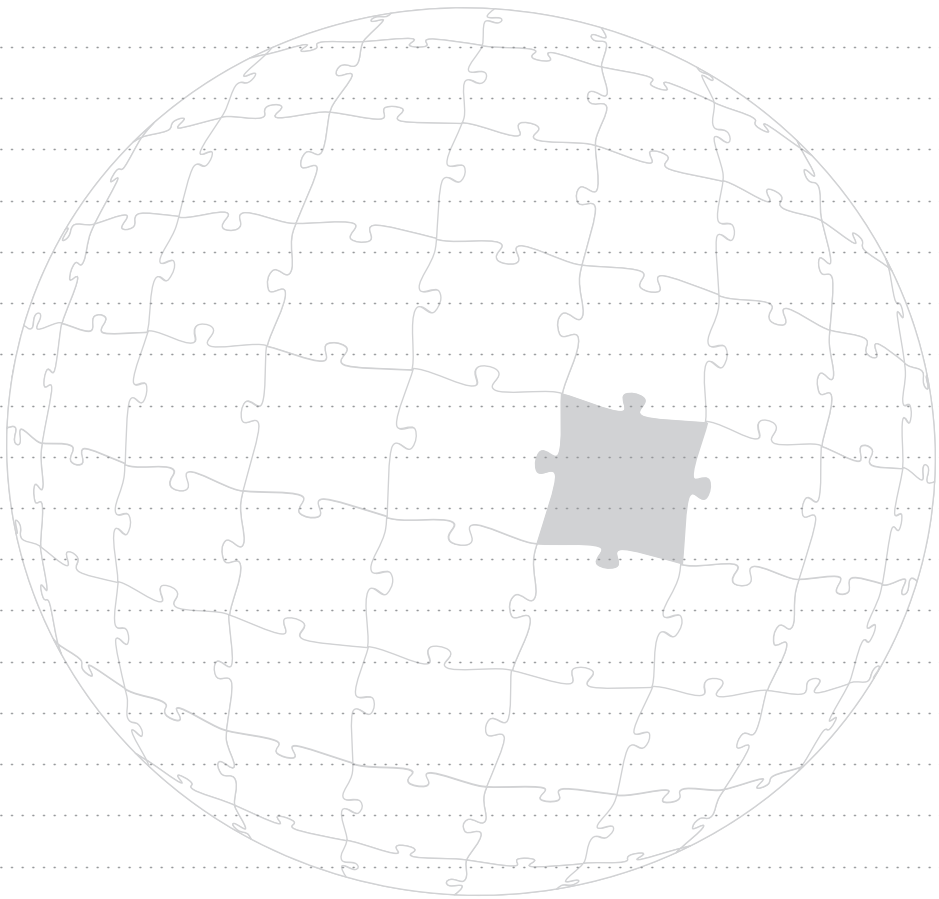
Questions to be explored by panellists as well as in the debates with participants:

- How can PHC and policies based on a deep understanding of field realities be systematically promoted in policy dialogue?
- How can budget support (GBS & SBS) be used to strengthen PHC?
- How can GHIs/vertical programmes be integrated to strengthen PHC (global rules and mechanisms at country level)?
- What is the place of research-action to promote PHC?
- What is the place of for-profit and not-for-profit private organisations in strengthening PHC?
- What can be advised to the Belgian cooperation with regards to aid modalities in the health sector?

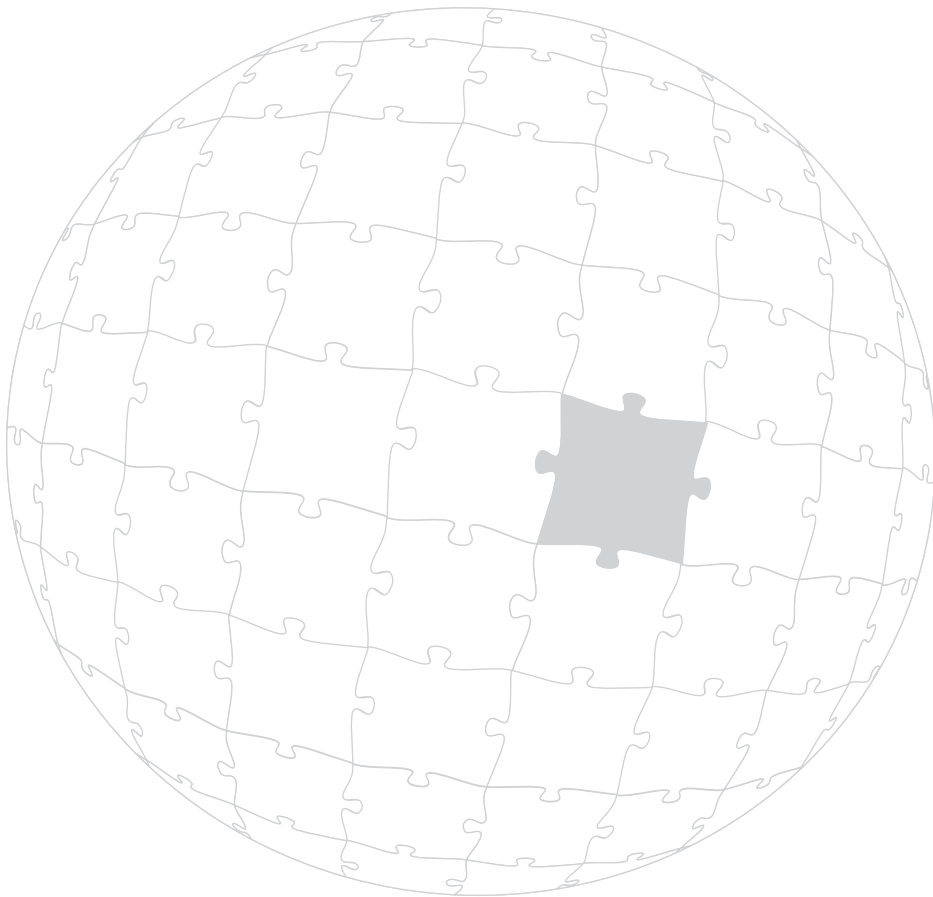


¹ GRAP-SWAP is the Research Group on Cooperation Modalities in Support of Sector Policies. It is a multidisciplinary group composed of teams from the universities of Brussels (ULB), Louvain (UCL) and Liège (ULg). It is financed by the francophone *Commission Universitaire pour le Développement* (CUD) to do research and support the Belgian cooperation policy.

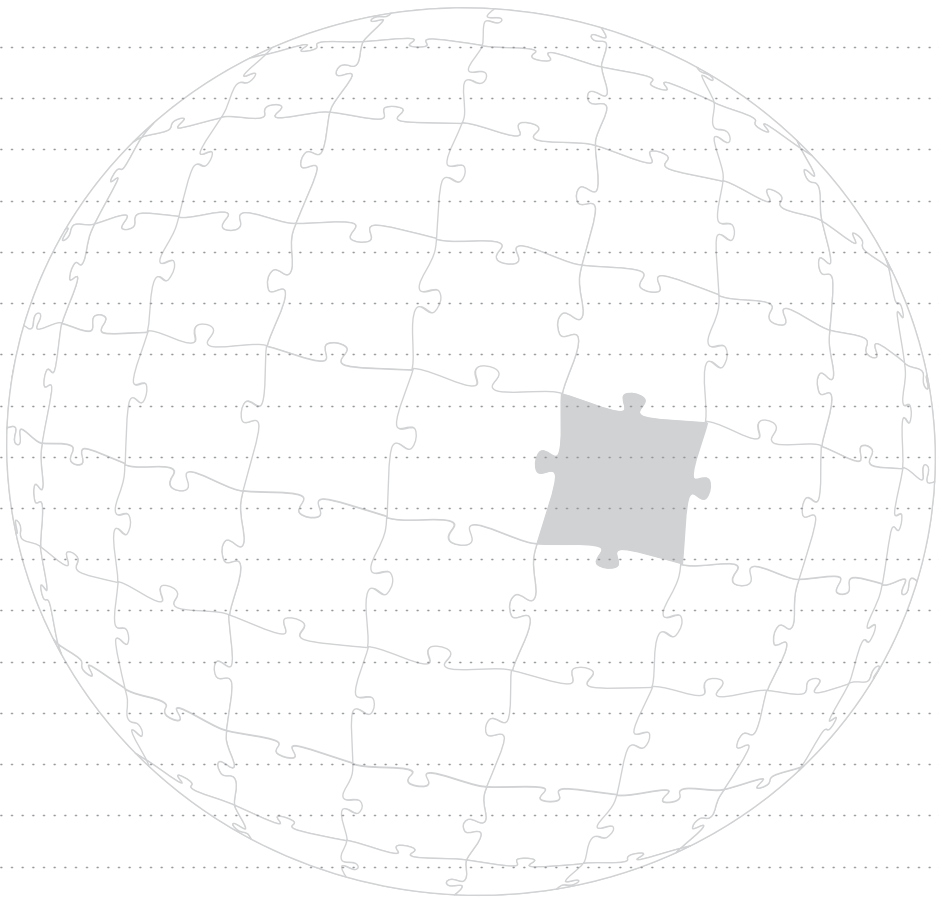
Notes



Abstracts 27 November



Notes



The World Health Report 2008: bringing Primary Health Care back to business

Prof. Denis Porignon, Department for Health System Governance and Service Delivery (HDS), World Health Organization, Geneva, Switzerland

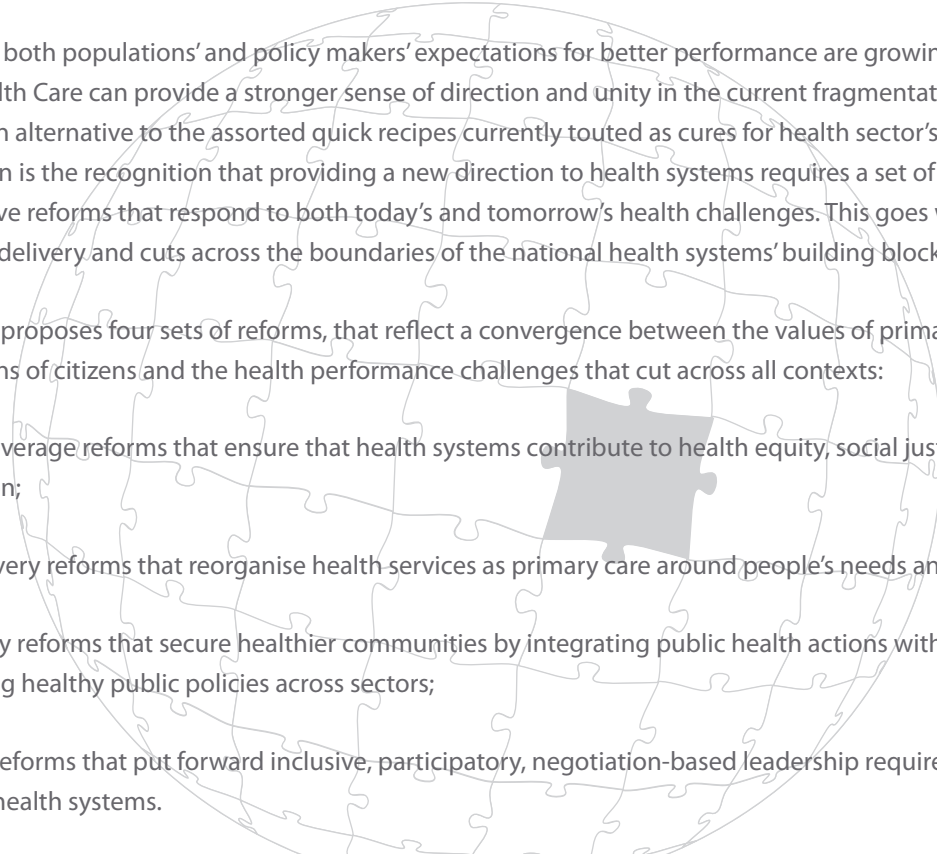
Email: porignond@who.int

After 30 years, there is today both a recognition that populations are left behind and a sense of lost opportunities since the 1978 Alma Ata's paradigm.

We can soundly argue that, on the whole, people are healthier, wealthier and live longer today than 30 years ago. This shows that progress is possible. However, the substantial improvement in health over recent decades has been deeply unequal, both between and within countries. In addition to that, the nature of problems is changing: ageing, urbanisation, globalisation, multimorbidity, climate change, together with food insecurity, social tensions are amongst those factors that are increasingly affecting world population's health. The responses of the health sector have been naïve and inadequate: disproportionate focus on narrow offer of specialised curative care, fragmented service delivery, unregulated commercialisation.

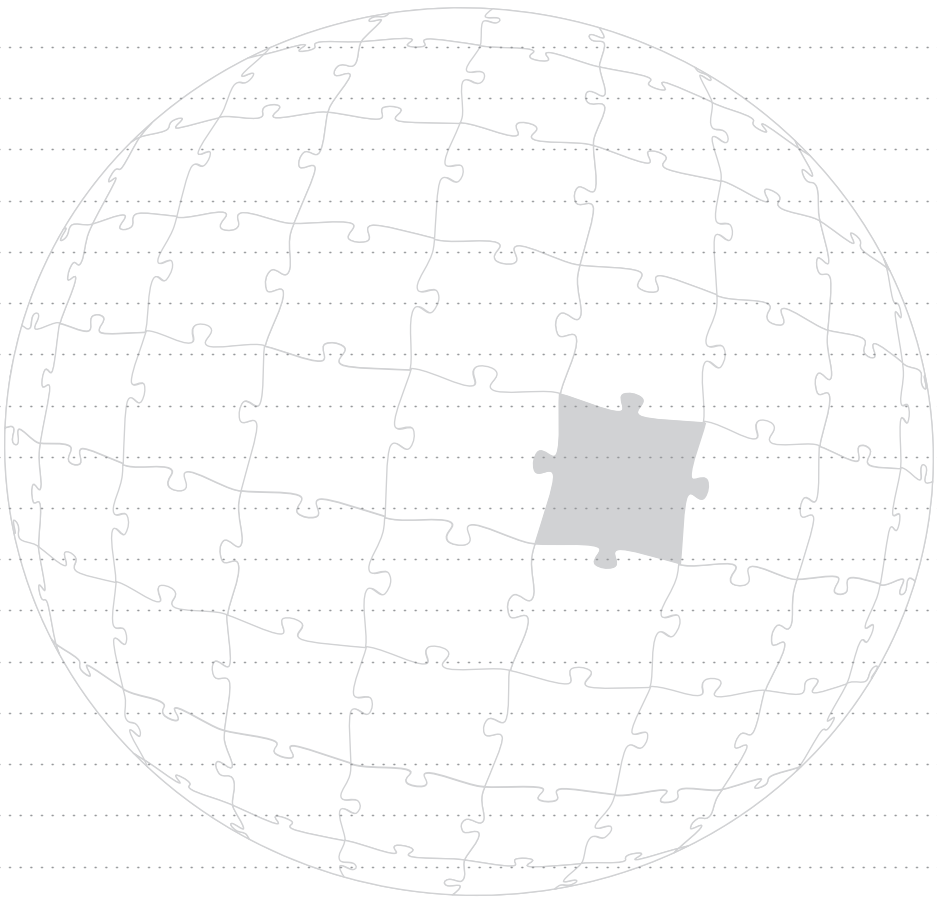
In this context, both populations' and policy makers' expectations for better performance are growing. The renewal of Primary Health Care can provide a stronger sense of direction and unity in the current fragmentation of health systems, and an alternative to the assorted quick recipes currently touted as cures for health sector's ills. Inherent in this evolution is the recognition that providing a new direction to health systems requires a set of specific and context sensitive reforms that respond to both today's and tomorrow's health challenges. This goes well beyond "basic" service delivery and cuts across the boundaries of the national health systems' building blocks.

The WHR 2008 proposes four sets of reforms, that reflect a convergence between the values of primary health care, the expectations of citizens and the health performance challenges that cut across all contexts:

- 
- (1) universal coverage reforms that ensure that health systems contribute to health equity, social justice, and the end of exclusion;
 - (2) service delivery reforms that reorganise health services as primary care around people's needs and expectations;
 - (3) public policy reforms that secure healthier communities by integrating public health actions with primary care and by pursuing healthy public policies across sectors;
 - (4) leadership reforms that put forward inclusive, participatory, negotiation-based leadership required by increasing complexity of health systems.

The operationalisation of these sets of reforms cannot be implemented as a blueprint or as standardised package. High income countries, but also fast growing health economies - where more than 3 billion people live - have or will have shortly the opportunities to develop health systems based on sound primary care and universal coverage principles, avoiding errors of the past. Fragile states and low-growth health economy countries, should rely on their potential to accelerate their growth through other means than counter-productive and inequitable out-of-pocket payments. Capitalising on this momentum implies to mobilise some drivers, i.e. knowledge production, workforce commitment and people participation. These are some of the essential steps to get to the "Health Care For All" goal in the 21st Century.

Notes



The Report of the WHO Commission on Social Determinants of Health (CSDH)

Prof. Lucy Gilson, Health Policy and Systems, University of Cape Town, South Africa and London School of Hygiene and Tropical Medicine, UK

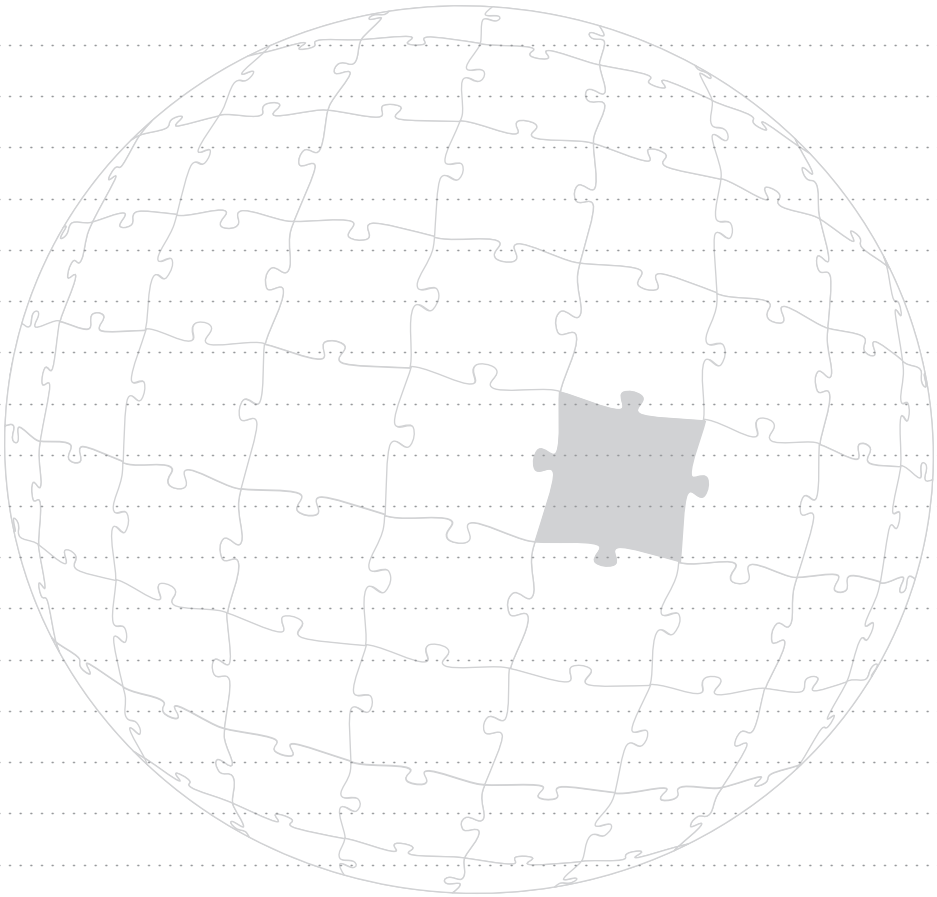
Email: Lucy.Gilson@uct.ac.za

The social environments in which people are born, live, grow, work and age generate health differences between population groups within and across countries. Although this fact is widely accepted, we continue to live in a world where there are huge and remediable differences in health between and within countries. But, as the Commission's report challenges, 'it does not have to be this way and it is not right that it should be like this'. The three-year process associated with the Commission sought not simply to identify the differences but, much more importantly, to champion and provoke the action needed to address them. This presentation will provide a brief overview of the processes underpinning the Commission's final report and present a synopsis of its agenda for action.

The report's three overarching principles of action are to: improve daily living conditions; tackle the inequitable distribution of power, money and resources globally, nationally and locally; measure the problem and assess the impact of action. Health care provision has some role in this agenda but much wider action is needed - political, economic and social action outside the health sector, as well as within it. Improving daily living conditions will require support for early childhood development, stronger urban governance, fair and decent employment and work conditions, and universal social protection policies including universal health care systems based on primary health care principles. However, taking these actions will also be possible through coherent government policy action based on fair international and national financing and national and international economic agreements that institutionalise health equity concerns. The gender biases in societal structures must also be addressed and, crucially, all groups in society must be empowered to participate in decision-making about health. Finally, health equity must become a global development goal, reinforced through global action.

Given the past decades' emphasis on economic growth as the engine for social development, the report's focus on addressing the inequitable distributions of power, money and resources is radical. So too is its recognition that governments, through public sector action, have the fundamental role in tackling health inequity. However, other actors must also be involved. Research institutions, for example, will play important roles in monitoring, research and training. Ultimately, the report's global agenda requires that all concerned with health inequity come together to close the health gap in the next generation.

Notes



Global Health Watch report

Dr. Hani Serag, Secretary general, People's Health Movement, Cairo, Egypt

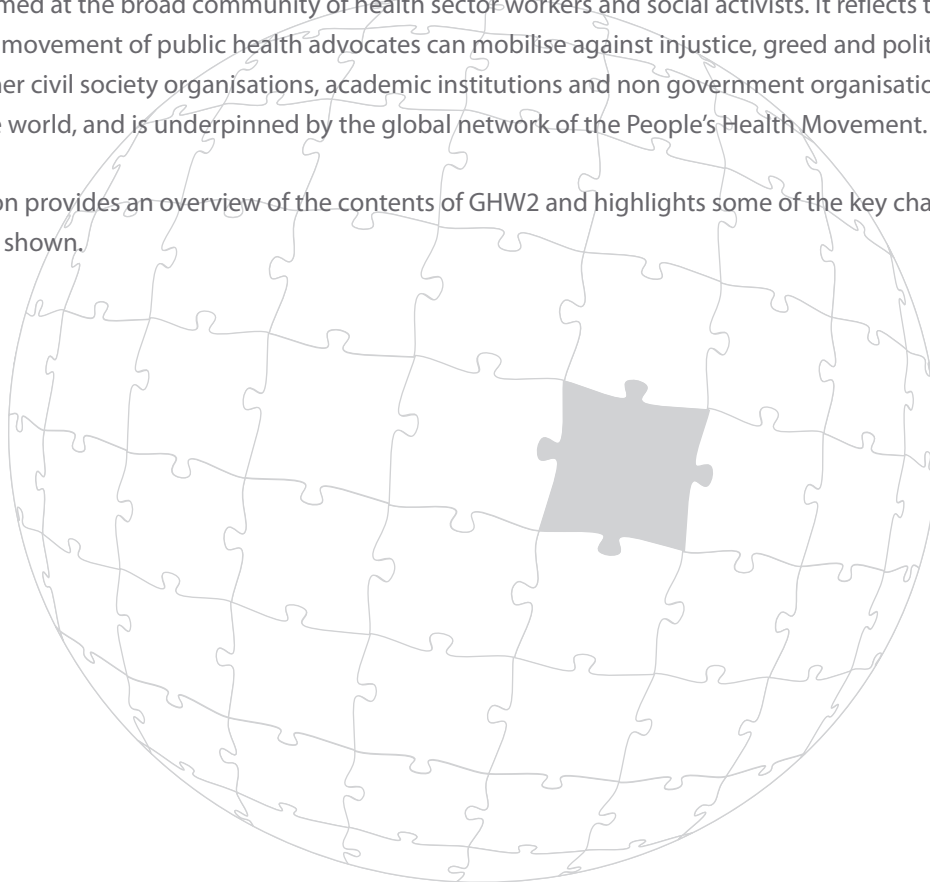
Email: secretariat@phmovement.org

Global Health Watch 1 was published in 2005. Global Health Watch 2 – like its predecessor - presents an alternative perspective on the state of global health in the 21st century. It places major health concerns in their political and economic context, highlighting the disparities in health between the rich and the poor and between the powerful and the marginalised. It emphasises the need to tackle the underlying determinants of ill-health and health inequalities.

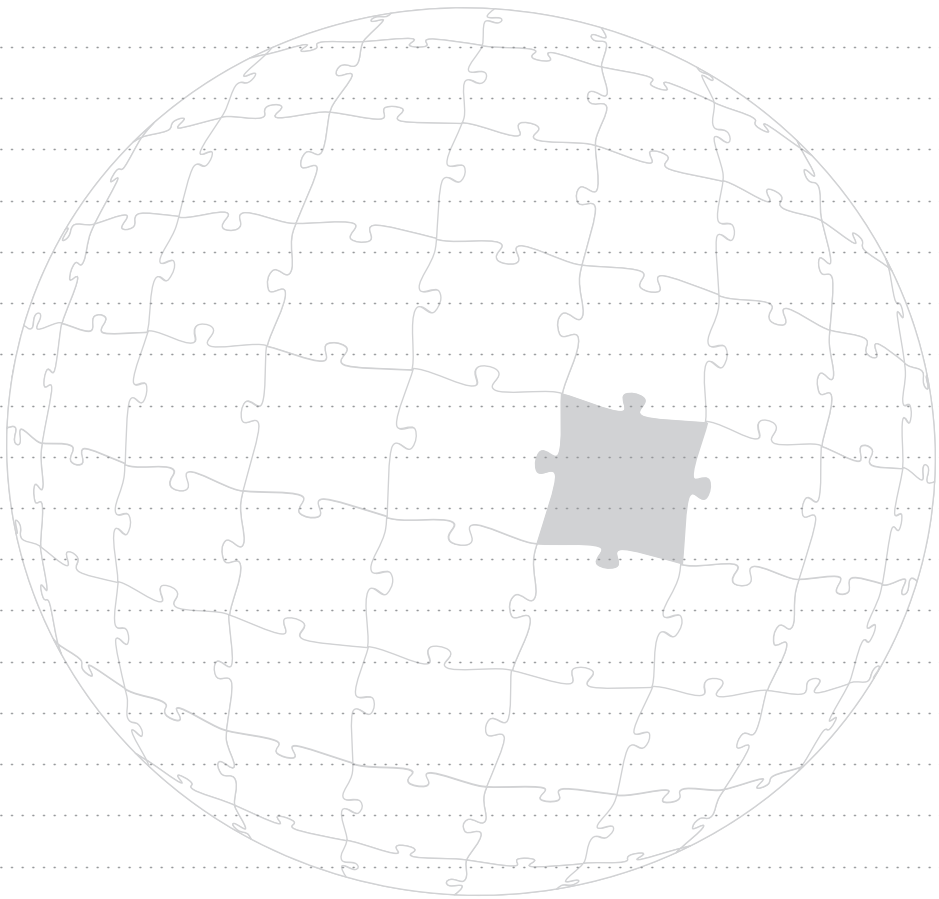
GHW2 calls on governments, international institutions and civil society to reassert the principles, moral values and rationale expressed in the Alma Ata Declaration on primary health care in 1978, a call that has become increasingly urgent given globalisation, the ascendancy of a harmful neo-liberal doctrine, and the threat of global warming. Crucially, it stresses that global health institutions must be honest and accountable.

The report is aimed at the broad community of health sector workers and social activists. It reflects the belief that a transnational movement of public health advocates can mobilise against injustice, greed and political apathy. It brings together civil society organisations, academic institutions and non government organisations (NGOs) throughout the world, and is underpinned by the global network of the People's Health Movement.

The presentation provides an overview of the contents of GHW2 and highlights some of the key chapters. A list of all chapter titles is shown.



Notes



PHC and Disease Control: the case of AIDS programmes in Africa

Dr. Marianne Pirard - Institute of Tropical Medicine, Antwerp, Belgium

Email: mpirard@itg.be

Primary Health Care (PHC) as defined in the Alma Ata Declaration includes “prevention and control of locally endemic diseases”. This initial comprehensive approach to achieve “health for all” was in many settings reduced to a set of interventions targeting a limited number of health problems. Disease control was placed in the camp of “selective PHC” and the divide between care-oriented “horizontalists” and disease-oriented “verticalists” dominated the public health debates in the 80s.

Structural adjustment policies in the 90s further hampered the implementation of PHC and the HIV epidemic put the health system in sub-Saharan Africa under severe stress. The emergency caused by AIDS called for exceptional measures from the international community but the global AIDS response also fuelled the debate between disease controllers and health systems managers. However, there is a growing consensus among all stakeholders about the need to strengthen health systems to increase access to PHC, including access to AIDS prevention and care.

System-wide effects of AIDS responses have been acknowledged as important but have been poorly documented so far. An ITM working group, including the authors, took the initiative to explore the effects of HIV/AIDS programmes on general health systems and services through the analysis of the extensive professional experience of MPH students from high HIV-burden African countries. This was further debated with a wider range of stakeholders during the “Antwerp in Geneva Workshop on the AIDS Response and Health Systems Strengthening in sub-Saharan Africa”.

The analysis revealed a mix of positive and negative effects on essential health system building blocks (human resources, infrastructure, M&E systems and service delivery) at all health system levels, including the primary care level.

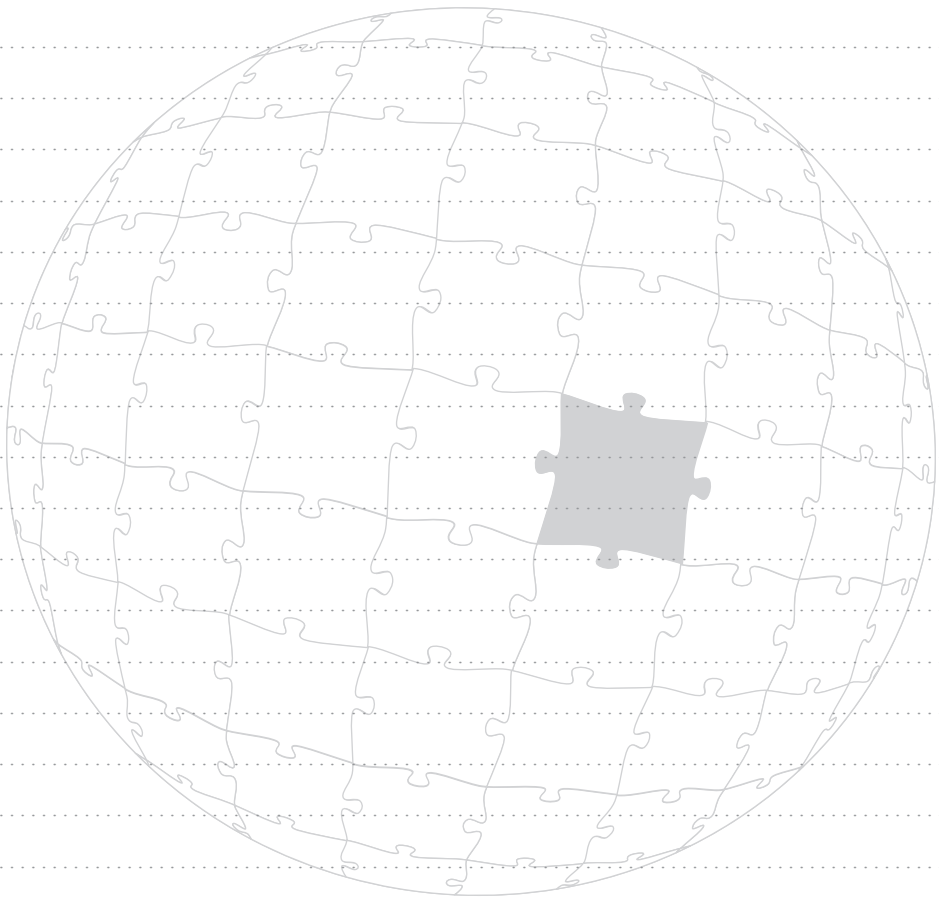
The most frequently mentioned problem was the internal brain drain of health workers from general health services to HIV/AIDS programmes due to more attractive employment conditions. This phenomenon could be partly prevented in countries with harmonised incentive and salary policies. Parallel drug distribution or M&E systems are often detrimental as they absorb resources and health worker time. The pressure to achieve selected AIDS-specific targets can reduce the scope of the efforts of health staff.

Investments in infrastructure, logistics, laboratory services and training by HIV/AIDS programmes contributed to strengthening of the general health services, especially where donors allow flexibility and/or countries opted for integration.

AIDS called for a comprehensive approach and boosted several dimensions of PHC: improved counselling skills strengthened patient centeredness; the development of models of care for AIDS patients proved to be helpful to respond to the new challenge of other chronic diseases such as diabetes and hypertension; and the involvement of people living with HIV in the design and roll out of ARV treatment programmes enhanced community participation in general.

All agreed PHC should be placed higher on the political and funding agendas, not in competition with AIDS but to increase funds for Comprehensive PHC including AIDS prevention and treatment.

Notes



The Paris/Accra process and Global Health Initiatives: what's the impact on health systems?

Dr. Nejmudin Kedir, Head of Planning and Programming, Ministry of Health, Addis Ababa, Ethiopia

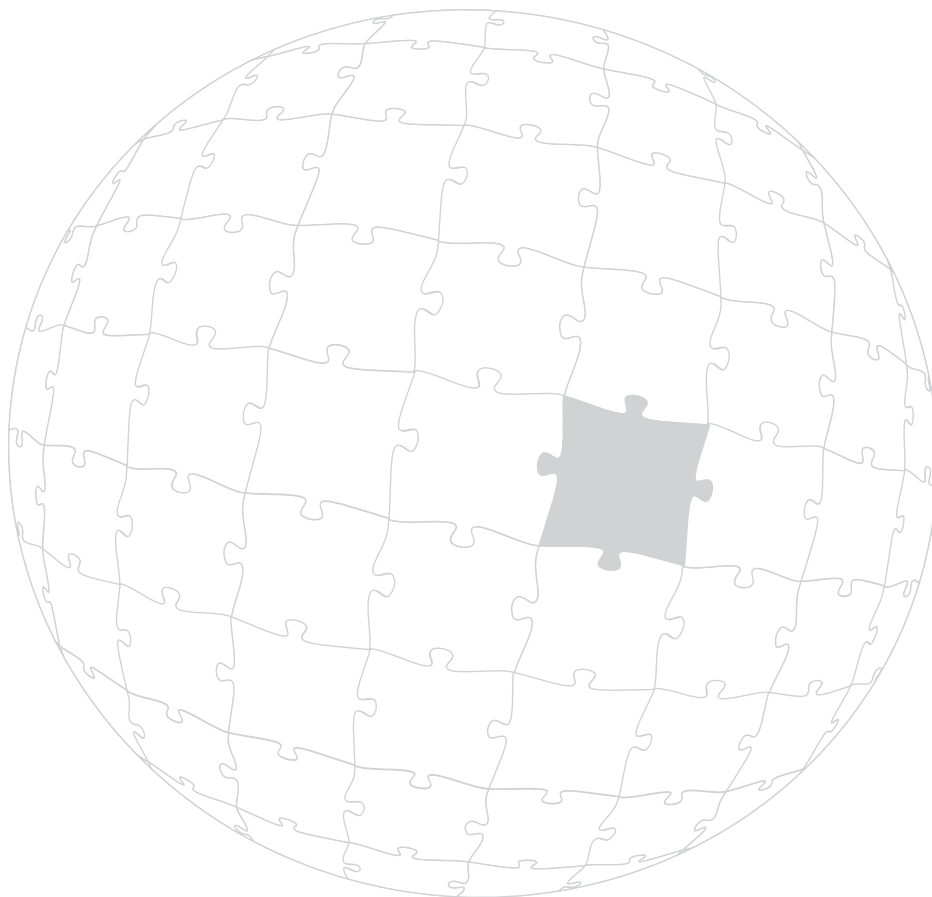
Email: moh@ethionet.et

In recent years, Ethiopia has demonstrated its strong political will to improve - in a context of severe resource constraints - the health situation of its citizens.

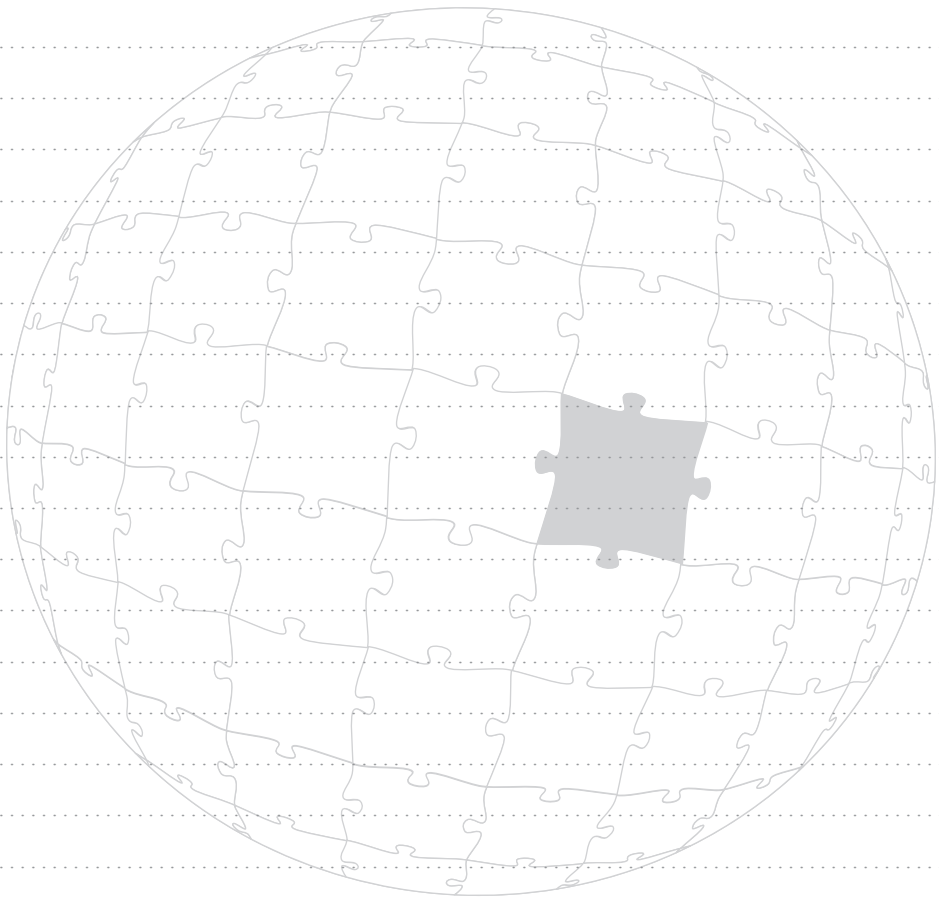
Coordination of efforts and the application of the Principles set out in the Paris Declaration have helped a lot to overcome a number of obstacles.

Ethiopia has been the first country to sign in August of this year a 'Compact' document in the framework of the International Health Partnership.

Global Health Initiatives have shaped our partnership landscape. Funding for health programmes has increased; at the same time the challenge has been to use the additional resources as efficacious as possible.



Notes



Health services in Mexico City, lessons for the future of Primary Health Care

Dr. Asa Cristina Laurell, Centre for Social Security Studies and Analysis, Mexico City, Mexico

Email: laurell9998@gmail.com

Key messages

It is possible to grant the right to health in a middle income country if it is a political and budget priority?

The PHC approach is favored by an integrated social policy and planning based on health needs but also depends on the strengthening and transformation of public health institutions.

Summary

The progressive Mexico City government (2000-2006) turned social policy into its first priority. It carried out an integrated and territory-based social programme that combined several components such as education, nutrition, housing, transportation, job creation, a universal pension, cash transfers to single mothers and to the disabled. In this framework its health policy established the goal to grant universally the right to health protection.

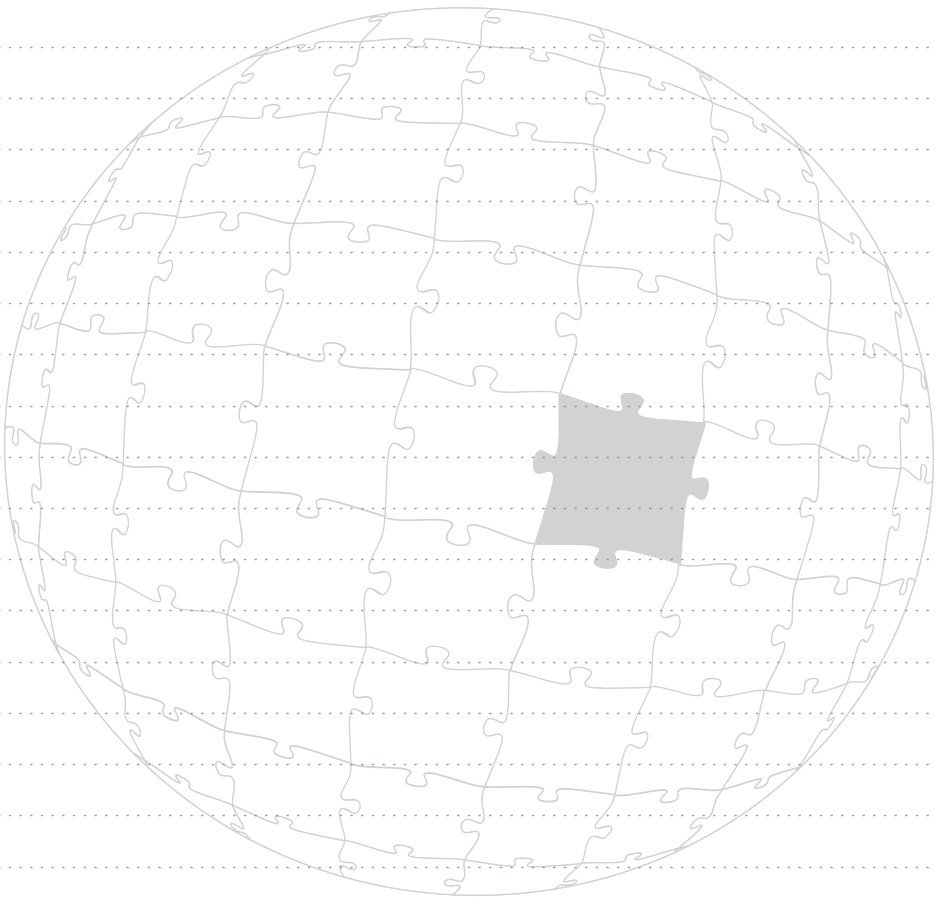
The policy approach to address the main social needs simultaneously and on a large scale implied that some important social determinants of health were dealt with as an overall government commitment and coordinated within the "social cabinet" and informed and discussed with the 1,348 territorial assemblies and their coordinating committees. This practice was very much in line with and supported a PHC practice.

The specific task of the Ministry of Health was to remove the barriers to access to needed health services and to strengthen and restructure public health institutions. To do so the economic obstacle was removed through the Programme of Free Health Services and Drugs (PFHSD) for the uninsured population (about 40%). This program was turned into a local law. At the end of the administration about 95% of the eligible families had enrolled. This measure was crucial to grant the right to health for all.

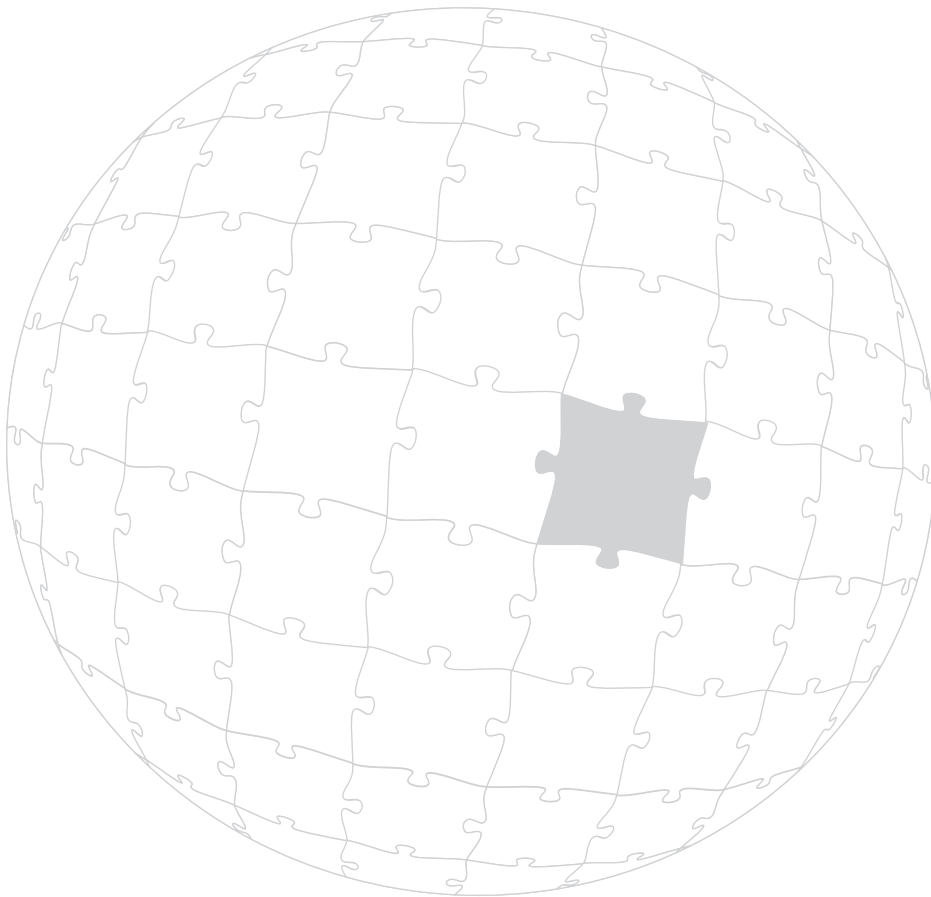
The PFHSD was sustained by a new model of integrated health care that focused on health education, promotion and prevention but also granted access to available hospital care to all in need. This approach departed from the federal health policy that is based on a contributory health insurance with a limited explicit health package and multiple providers and the separation between public health (public goods) and individual care (private goods).

The strengthening and restructuring of the existing public health services was relatively easy as far as renewing and expanding infrastructure because the health budget was increased with about 80%. The creation of a new institutional culture was quite difficult after two decades of institutional demoralization, corruption and devalorisation of workers. To reverse the dominance of particular interests and make the general interest prevail is a very complex task; a task that has to be solved to make PHC a reality.

Notes



Annexes



Poster session ITM Annual Colloquium 2008

Strengthening public health systems: operational research in Cuban first line health services

Pol De Vos

Unit of Epidemiology and Disease Control, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

Insecticide treated curtains to prevent dengue: comparison of 2 distribution models, Thailand

Veerle Vanlerberghe

Unit of Epidemiology and Disease Control, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

Cost-effectiveness of engaging private practitioners for referring tuberculosis suspects to DOTS services: the patient's and public provider's perspective

Y. Mahendradhata^{Y1,2,3}, A. Probandari^{2,4,5}, R.A. Ahmad¹, A. Utarini^{1,2}, L. Trisnantoro^{1,2}, L. Lindholm⁵, M.J. Van der Werf^{6,7}, M.E. Kimerling⁸, M. Boelaert³, B. Johns⁹, P. Van der Stuyft³

¹ Department of Public Health, Faculty of Medicine, Gadjah Mada University, Jogjakarta, Indonesia.

² Centre for Health Service Management, Faculty of Medicine, Gadjah Mada University, Jogjakarta, Indonesia.

³ Unit of Epidemiology and Disease Control, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

⁴ Department of Public Health, Faculty of Medicine, Sebelas Maret University, Surakarta, Indonesia.

⁵ Epidemiology & Public Health Sciences, Public Health and Clinical Medicine, Umeå University, Umeå, Sweden.

⁶ KNCV Tuberculosis Foundation, The Hague, The Netherlands.

⁷ Department of Infectious Diseases, Tropical Medicine & AIDS, Center for Infection and Immunity Amsterdam, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands.

⁸ Gorgas TB Initiative, Division of Infectious Diseases, School of Medicine, University of Alabama, Birmingham (Alabama), USA.

⁹ WHO Country Office for Indonesia, Jakarta, Indonesia.

The impact of human resource management on hospital workers at Central Regional Hospital (Ghana): linking management, organisational culture and commitment

Bruno Marchal

Quality and Human Resources Unit, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

Effectiveness of a patient-centeredness approach on management of child nutrition in primary health care: a randomised controlled trial in rural Burkina Faso

Laetitia Nikiema¹, Dominique Roberfroid², Blaise Sondo¹, Patrick Kolsteren²

¹ Institut de Recherche en Sciences de la Santé, Ouagadougou, Burkina Faso.

² Nutrition and Child Health Unit, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

Evaluation of a community-based holistic model of HIV service delivery for the urban poor

Alamo Stella Talisuna

Unit of HIV/STD Epidemiology and Control, Department of Microbiology, Institute of Tropical Medicine, Antwerp, Belgium.

Can the implementation of a PMTCT programme improve quality of antenatal and delivery care services? Results from a study in Côte d'Ivoire

Thérèse Delvaux¹, Jean Paul Diby Konan², Odile Aké-Tano², Carine Ronsmans³, Anne Buvé¹, Patrick Van der Stuyft⁴

¹ Unit of HIV/STD Epidemiology and Control, Department of Microbiology, Institute of Tropical Medicine, Antwerp, Belgium.

² National Institute of Public Health, Abidjan, Côte d'Ivoire.

³ London School of Hygiene and Tropical Medicine, London, UK.

⁴ Unit of Epidemiology and Disease Control, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

Biomedical and psychosocial care to tuberculosis patients in Burkina Faso - What strategies to adopt?

K.M. Drabo¹, R. Zerbo¹, B. Kafando², S. Konfe², E. Mugisho³, B. Dujardin³, J. Macq⁴

¹ Institut de Recherche en Sciences de la Santé Burkina Faso.

² Direction Régionale de la Santé du Plateau central, Burkina Faso.

³ Ecole de Santé Publique, Université Libre de Bruxelles, Brussels, Belgium.

⁴ IRSS- Ecole de Santé Publique, Université catholique de Louvain, Brussels, Belgium.

The dead also count – Implications of different AIDS mortality models for estimating HIV incidence based on HIV prevalence

Wim Delva¹, Stijn Vansteelandt², Carel Pretorius³, John Hargrove³, Brian Williams⁴, Lieven Annemans⁵, Marleen Temmerman¹

¹ International Centre for Reproductive Health, Ghent University, Ghent, Belgium.

² Department of Applied Mathematics and Computer Science, Ghent University, Ghent, Belgium.

³ South African Centre for Epidemiological Modelling and Analysis, Stellenbosch University, Stellenbosch, South Africa.

⁴ Stop TB Department, World Health Organization, Geneva, Switzerland.

⁵ Department of Public Health, Ghent University, Ghent, Belgium.

Improving the follow-up of children born to mothers living with HIV through integrated reproductive and child health services: a case study from Mozambique

Yves Lafort¹, Diederike Geelhoed¹, Milagrosa Jossias Sitoie², Bertur Chombe Alfa², Marleen Temmerman¹

¹ International Centre for Reproductive Health, Ghent University, Ghent, Belgium.

² Tete Provincial Health Directorate, Ministry of Health, Mozambique.

Impact of post-abortion family planning services on contraceptive use and abortion rate among young women in three cities of China: a cluster randomised trial-PAFP study

Jin Liang Zhu¹, Wei-Hong Zhang², Yimin Cheng³, Juncai Xu⁴, Xiao Xu⁵, Diana Gibson⁶, Henrik Støvrin⁷, Patricia Claeys², Marleen Temmerman²

¹ The Danish Epidemiology Science Centre, University of Aarhus, Aarhus, Denmark.

² International Centre for Reproductive Health, Ghent University, Ghent, Belgium.

³ The National Research Institute for Family Planning, Beijing, China.

⁴ Shanghai Da Cheng Institute of Health, Shanghai, China.

⁵ The Henan Provincial Research Institute for Family Planning, Zhengzhou, China.

⁶ The Amsterdam School for Social Research, University of Amsterdam, Amsterdam, The Netherlands.

⁷ Research Unit for General Practice, University of Southern Denmark, Odense, Denmark

Hidden violence is a silent rape: a participatory assessment of sexual and gender-based violence determinants in female and male refugees, asylum seekers and undocumented migrants in Belgium and The Netherlands

Ines Keygnaert¹, Nicole Vettenburg², Marleen Temmerman¹

¹ International Centre for Reproductive Health, Ghent University, Ghent, Belgium.

² Department of Social welfare, Faculty of Psychology and Educational Sciences, Ghent University, Ghent, Belgium.

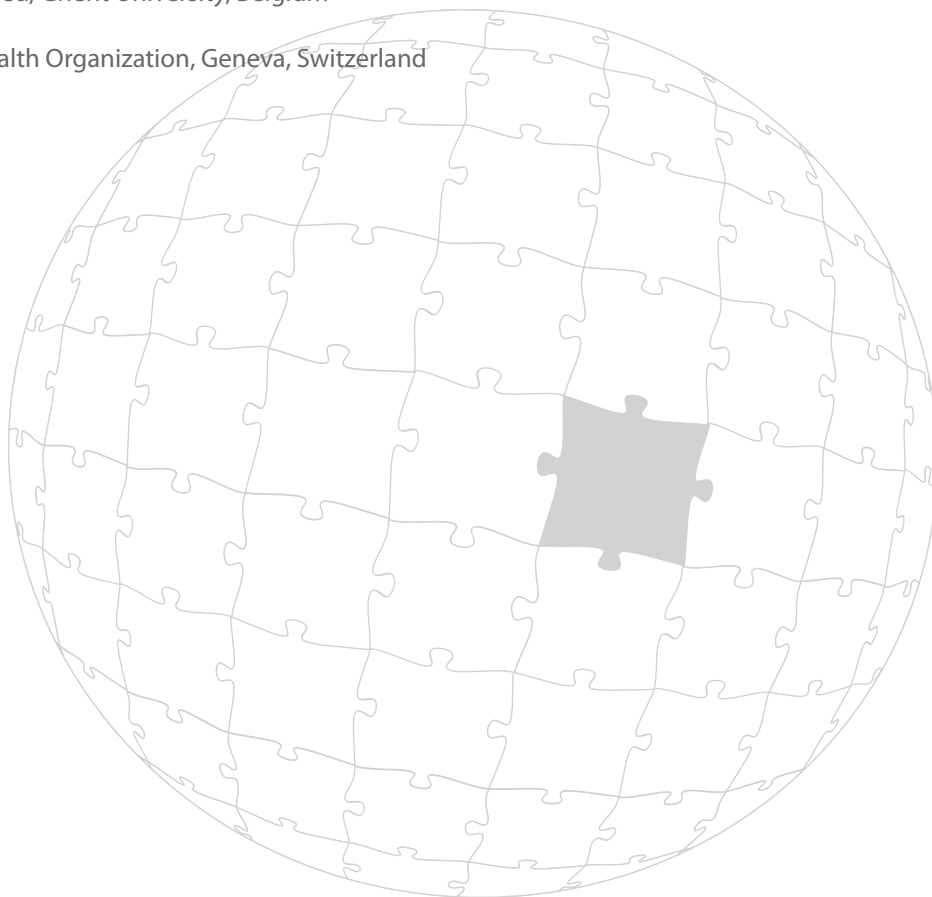
HIV risk reduction interventions for youth in sub-Saharan Africa in a theoretical perspective: gaps in theory and the 'relational-situational factor'

Kristien Michiels¹, Marleen Temmerman¹

¹ International Centre for Reproductive, Ghent University, Ghent, Belgium.

Organisations present in the Market Place

- Area santé, Brussels, Belgium
- Institute for Development Studies, University of Sussex, UK
- Institute of Tropical Medicine, Antwerp, Belgium
- International Action for Liberation, Intal, Brussels, Belgium
- International Centre for Reproductive Health, Ghent University, Belgium
- Médecins sans Frontières, Brussels, Belgium
- Memisa, Itterbeek, Belgium
- People's Health Movement (see Intal), Cairo, Egypt
- Primafamed, Ghent University, Belgium
- World Health Organization, Geneva, Switzerland



Declaration of Alma Ata

International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

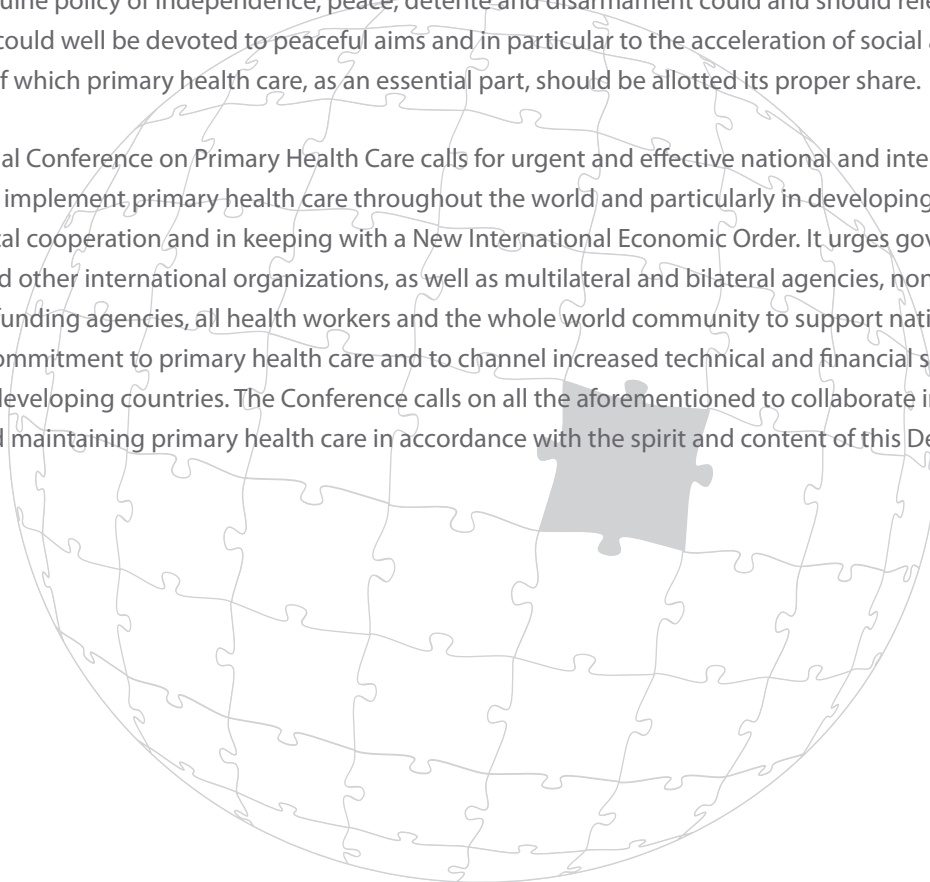
All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.



Federal Public Service - DGDC

Foreign Affairs, Foreign Trade and Development Cooperation Belgium

Directorate-General for Development Cooperation (DGDC)

The Directorate-General for Development Cooperation (DGDC) is the Belgian federal administrative body for development aid. The DGDC is a DG of the Federal Public Service Foreign Affairs, Foreign Trade and Development Cooperation and resorts directly under the Minister of Development Cooperation.

The DGDC is responsible for managing 55 to 65% of Belgian official development assistance.

- Headlines of the current Belgian policy framework:
- Focus on results
- Focus on Millennium Development Goals
- Evaluation for better results
- Belgian action plan for effective donor aid
- Reform of the Belgian NGO-sector

Three of the eight millennium goals are aimed at healthcare. Because Belgian policy is also targeted at improving basic healthcare for the entire population, we have grouped Belgian contributions towards these three millennium goals.

New policy framework for healthcare

In 2007 the platform of Belgian partners in healthcare 'Because Health' drew up a new policy framework for the improvement of public healthcare in our partner countries. The evaluation of Belgian assistance in the healthcare sector showed that we had definitely helped to make basic healthcare accessible to the whole population with our local approach in the sanitary districts. To guarantee sustainable improvements, however, we need to offer structural support for national health policy and the health system, in addition to the local project approach. This could be done via budgetary support for the national public health budget, for example, or by institutional capacity strengthening of the healthcare services. In future, then, healthcare projects in all of the Belgian development partner countries will be oriented mainly towards achieving structural and sustainable qualitative improvements in the healthcare systems, especially in the field of reproductive health. That means providing good education and training for personnel, working towards preventive healthcare with vaccination campaigns, sexual education for young people, etc. Combating deadly and "neglected" tropical diseases continues to be one of Belgium's priorities.

Website: www.dgdc.be

Belgian Development Cooperation agency (BTC)

BTC is the Belgian development cooperation agency. As a public service provider, and on behalf of the Federal Public Service of Foreign Affairs, Foreign Trade and Development Cooperation, BTC supports developing countries in their fight against poverty. Thanks to its field expertise, BTC also provides services on behalf of other national and international organisations contributing to sustainable human development.

BTC is managing more than 200 programmes in 25 countries in Africa, Asia and Latin America. With a turnover in 2007 of 213 million euro, BTC is employing 420 staff, 160 of them at its headquarters in Brussels and 260 in countries where projects and programmes are being implemented. BTC has 21 representations abroad.

The Belgian Technical Cooperation also manages the scholarships and the traineeships granted by the Directorate-general for Development Cooperation (1000 per year), the General Information Cycle of Belgian development cooperation (900 participants per year), and two sensitisation campaigns aimed at young people: Kleur Bekennen and Annoncer la Couleur. The BTC also implements the Fair Trade Centre programme for the promotion of fair trade in Belgium, and since 2006 the programme of the Voluntary Service for Development Cooperation (VSDC).

The Belgian Technical Cooperation was established in 1998 as a public-law company with social goals. Its relations with the Belgian State are set down in a management contract.

BTC undertakes assignments, amongst others, for or through joint financing with the European Union, the World Bank, the International Atomic Energy Agency (IAEA), the Directorate-General International Cooperation (Netherlands), the Department for International Development (DFID – UK), Lux-Development, the Inter-American Development Bank (IDB), Finexpo (Foreign Trade - Belgium), the King Baudouin Foundation, the Belgian federal government services, regions and communities.

Since 2002, BTC has been the proud owner of the 'ecolabel', issued by the Brussels Institute for Environmental Management.

Website: www.btcctb.org



Institute of Tropical Medicine - Antwerp

History and statute

The 'School of Tropical Medicine' was founded in Brussels in 1906 to train doctors and nurses for the Belgian colonies. In 1933 the school was transferred to Antwerp, close to the Congo Docks, and became the 'Prince Leopold Institute of Tropical Medicine' (ITM). After the decolonisation in 1960, the ITM became part of the Belgian, and later (in 1988), of the Flemish higher education system. In 1999 a decree formally confirmed the ITM as an 'Institution of Public Utility for postgraduate Education, Research and Services'.

The ITM today

The ITM employs about 400 scientists, technicians and other staff in five scientific departments, support services, a specialised polyclinic and a ward in the Antwerp University Hospital. Their main assignments are on the one hand the improvement of health in developing countries through education, research and public services, and on the other hand the provision of specialised medical services in tropical medicine in Belgium. Scientifically, the ITM belongs to the top in the fields of tropical diseases, AIDS and international public health. It's main mission is to tackle the grinding inequality in the world together with its many partners in the South and the North.

Education

Every year, about 250 medics and paramedics attend a specialized course in tropical medicine or animal health and about 80 specialists take the international Master Course in Public Health, Disease Control or Tropical Animal Health. About 80 PhD students perform their research at or in collaboration with the ITM. The ITM also organizes specialized courses on AIDS, fungous diseases and other topics. It also houses dozens of graduate students and trainees from Belgian and foreign universities and institutions.

Research

The ITM carries out fundamental and applied research on the main tropical and other infectious diseases of humans and animals. Another important field of expertise is the organisation of medical and veterinary health services. The research is carried out in our laboratories as well as in the field, mostly in close collaboration with other Belgian and foreign research institutions. The ITM plays a key role in a number of networks in which North and South, laboratory and the field, researchers and health workers meet.

Medical services

The medical services of the ITM take care of tropical infections and import pathologies, including HIV/AIDS and Sexually Transmitted Diseases (STD). They carry out over 20,000 preventive and curative consultations annually and give travel advice by phone or through the website. The in-patient ward is integrated in the Antwerp University Hospital (UZA). The ITM is recognised and funded by the Belgian Ministries of Public Health and Social Affairs for its medical reference tasks. The ITM also conducts preventive programmes under agreements with the Flemish Ministry of Welfare and Agriculture, and houses several national and international reference laboratories.

Development Cooperation

With support from the Belgian Ministry and the DGDC, the ITM conducts an elaborate programme of education, research, capacity building and policy support in the South. The ITM works together with 22 partner institutions in 19 countries in Africa, Asia and Latin America. The ITM also conducts many research and support projects with the World Health Organisation (WHO), UNAIDS, FAO, the EU, other foreign and international governments and non-governmental organisations. The ITM represents or supports the government in many international organisations and coordinates the Belgian platform for international health care and tropical (animal) health.

Website: www.itg.be

Be-cause Health: Belgian platform for International Health

In 2004 the Institute of Tropical Medicine of Antwerp explored the willingness of the broader audience to create a non-hierarchic forum on international health. We found widespread interest and commitment, and on June 4th 2004 all stakeholders met and decided to create a Belgian Platform for International Health, later called “Be-cause health”. The main objective of the network is to strengthen the role and effectiveness of Belgian stakeholders in favouring access to quality health care worldwide, through policy dialogue, coordination of efforts and exchange of information and knowledge. The platform unites almost all relevant public, non-governmental and academic organisations in Belgium as well as committed individuals. The envisaged results are a more effective Belgian contribution to international health policies; a better exchange of technical and scientific knowledge; more synergy at field level; better feedback from and collaboration with partners from the South. An active steering committee takes care of planning and management. ITM provides secretarial support. The common charter is the “Health CARE for All” declaration of 2001 (www.itg.be/hca).

In 2005 the platform took shape. The steering committee consists of 11 members, representative for the main public and private constituencies of the platform.

The website was launched in May 2005 (www.be-causehealth.be). Mid 2008 there were about 120,000 hits on the site.

The platform formulates policy advice to the DGDC and the Ministry of Health, particularly on topics debated at international forums, such as social health insurance, medicines policy, human resources for health, HIV/AIDS and health research.

Annually a Be-cause health seminar is organised in the prestigious Egmont Palace in Brussels and topics so far include:

Human ‘Resources’ for Health, breaking the deadlock, November 2005

Switch to SWAP?, December 2006

Drugs, cure or curse, December 2007

180 participants, half of them Masters students from the South at the Université Libre de Bruxelles and at the ITM, attended these seminars. A dozen of Be-cause health members contributed actively in the preparation and the organisation of the events. There has been a follow-up, both in terms of advocacy and of internal policies and practices of the stakeholders. As an example, we mention the ‘charter on the quality of drugs’, which is meant to be an advocacy tool at international level.

In Belgium other networking initiatives exist linked to global health issues: on HIV/AIDS, on population and development, on community health insurance (MASMUT) and on tropical animal health and production (Be-troplive). These initiatives encompass non-health sectors (such as demography and social economy). Be-cause health invests in keeping an overview in order to promote coherence and synergy between the various initiatives.

Website: www.be-causehealth.be

Notes

