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CUAMM

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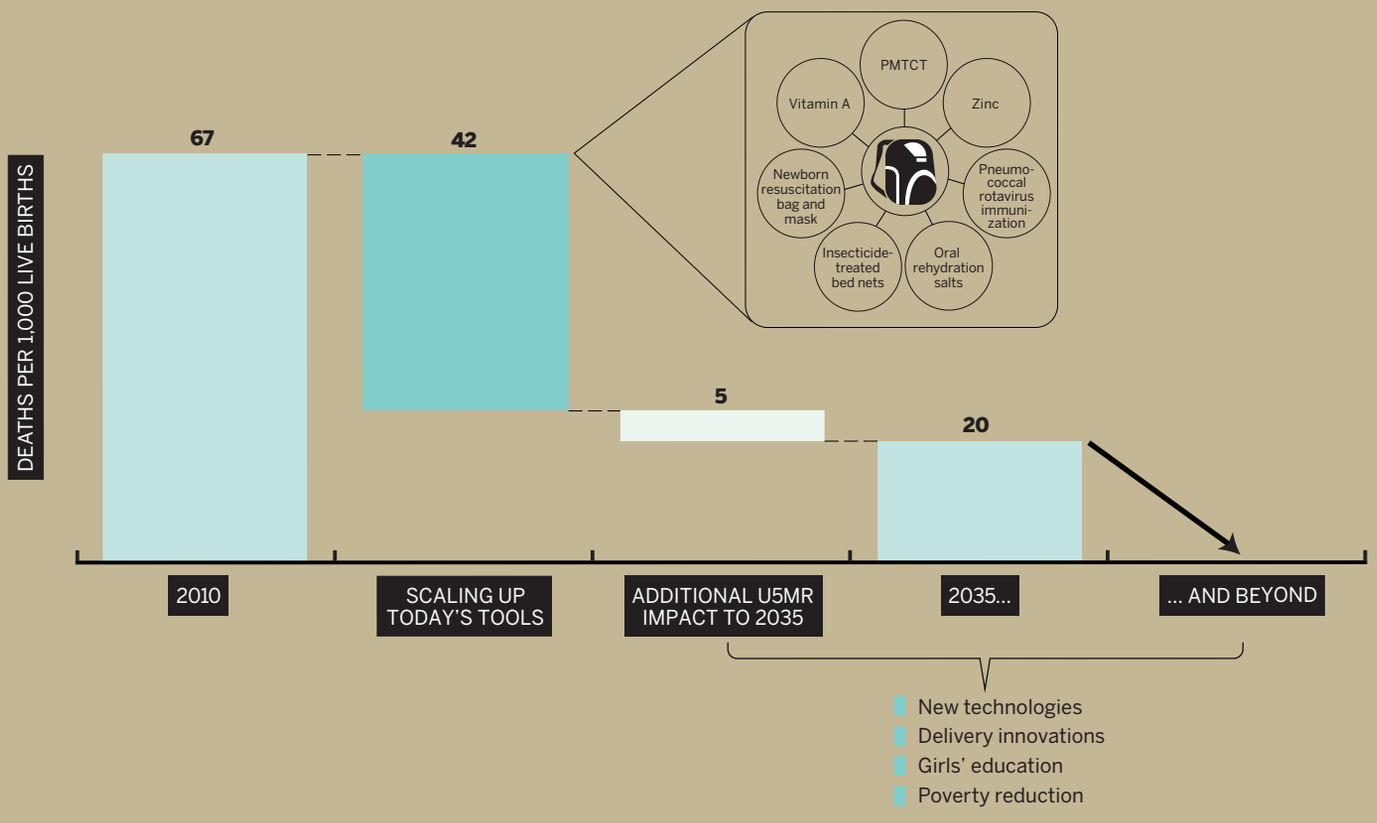
NEWS

A new programme to combat child mortality in the poorest countries. Old wine in new casks...

After shelving a series of time-bound objectives – including "health for all by 2000", "MDGs by 2015" – solving the intolerable excess mortality of children in the poorest countries has been postponed to 2035, through a new programme entitled *Child Survival Call to Action: Ending Preventable Child Deaths*, promoted by WHO, UNICEF and various governments (USA, UK, Australia, Norway, etc.). The Figure describes the roadmap, starting from the 2010 under-5 mortality rate (67 per 1,000 live births) and reaching the goal of 20 per 1,000 in 2035. The requirements for achieving this goal form the contents of the rucksack: vitamin A, drugs to reduce vertical transmission of AIDS, zinc, vaccines against pneumococcus and rotavirus, oral rehydrating salts, insecticide-treated bed nets and a newborn resuscitation bag and mask. Followed by innovation, technologies, education, fight against poverty. Technically there is nothing new. All that is missing is political will.

FIGURE / THE ROADMAP OF UNDER-5 MORTALITY RATE



Source: Based on Lives Saved Tool modeling by Johns Hopkins Bloomberg School of Public Health 2012

EDITOR

Gavino Maciocco

EDITORIAL STAFF

Maria Rosaria Acquaro, Andrea Atzori, Dante Carraro, Adriano Cattaneo, Silvio Donà, Fabio Manenti, Luigi Mazzucato, Giovanni Putoto, Angelo Stefanini, Anna Talami

EDITOR-IN-CHIEF

Anna Talami

OWNERSHIP

Medici con l'Africa Cuamm

ADMINISTRATION

Via S. Francesco, 126 - 35121 Padova
t 049 8751279-8751649
f 049 8754738
e-mail cuamm@cuamm.org

EDITORIAL COORDINATION

Chiara Di Benedetto

EDITORIAL SECRETARIES

Elisa Bissacco

CREATIVE IDEA AND COVER ILLUSTRATION

Ramon Pezzarini

LAYOUT AND PRINTING

Publistampa, Via Dolomiti, 36 - 38057 Pergine Valsugana (Trento)

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Joanne Fleming

Cover illustration by Ramon Pezzarini.
Africa rising, is the title of one of this issue's editorials, recalling the fitting expression used by the *Economist* just a few months ago. Africa's profile is changing. It has opened up dialogue with different countries and players; new networks of non-governmental organizations, public institutions and private partners are taking shape. Cooperation and synergies among the involved parties are the route to constructive change, benefitting the continent and its relations with the rest of the world.

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DIALOGUE

AFRICA RISING

Ten years ago, the *Economist* carried the title, "Africa, the hopeless continent". A few months ago the same magazine described Africa in quite the opposite way: *The hopeful continent. Africa rising*. But this optimism about Africa – warns the *Economist* – should be taken in small doses.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

Sub-saharan Africa is growing at an impressive rate. Over the last ten years, six of the ten countries in the world with the fastest growth rates were African. The subcontinent's GDP increased by 6% in 2011 and the same percentage is expected for 2012, on a par with growth in Asia. Growth is largely, but not entirely, due to the export of raw materials, as oil and gold, whose prices have risen. In Ethiopia – which does not have either oil or gold – GDP rose this year by 7.5%, by becoming one of the world's leading producers of livestock. Africa is developing its infrastructures and paving the way for the manufacturing industry, which was almost non-existent until now, by attracting foreign investment chiefly from China, but also from Brazil, Turkey, Malaysia and India. Workforce productivity is growing by 2.7% per year. Trade has risen by 200% since 2000. Inflation has fallen from 22% in the 1990s to 8% in the last decade. Foreign debt has dropped by a quarter and public debt by two thirds. Another impressive phenomenon is the spread of technologies (in dramatic contrast with the poverty of rural dwellings, which are without electricity and running water almost everywhere). In Africa there are over 600 million users of mobile phones (a higher number than in Europe and America), which are compensating for the poor road communications with the enormous boom in "*mobile banking*" and "*telephonic agro-info*." About one tenth of the continent's surface is covered by internet services, with a higher percentage than in India. A middle class is developing with a respectable economic standing able to propel the solid domestic market: currently some 60 million Africans have an annual income of 3,000 dollars. This number is expected to rise to 100 million in 2015. The chapter of good news from the African sub-continent rounds off with a picture of greater political stability and less conflicts. But this optimism about Africa – warns the *Economist* – should be taken in small doses, because the situation is still pretty bleak in most of the continent. The majority of Africans live on less than two dollars per day. Per capita food production has returned to 1960s, pre-independence levels. Hunger and famine persist. The climate is worsening with deforestation and advancing desertification. Average life expectancy in various countries is below 50 years. The Millennium Development Goals for mother and child health are far from being achieved and most African governments invest in health much less than they should, as revealed by a Report drawn up by the African Child Policy Forum. To make an overall assessment of the political will of African governments with respect to their commitment to child welfare, the authors of the report have developed an index (the Budget Commitment Index) which consists of a measure formed by the following indicators: 1. Public health spending as a percentage of total public spending; 2. Total public spending for education as a percentage of GDP; 3. The percentage of the budget invested in EPI (*Enhanced Programme for Immunization*); 4. Military spending as a percentage of GDP; 5. The percentage variation in Government health spending since 2004.The first three countries in the *Budget Commitment Index* were Tanzania, Mozambique and Niger, which showed the best utilization of available resources for child welfare purposes. The other governments in the top ten were those of Gabon, Senegal, Tunisia, Seychelles, Algeria, Cape Verde and South Africa.

Tanzania achieved the best score, partly for its allocation of a considerable percentage of domestic resources to health, having significantly increased its own direct contribution to national immunization programmes.

At the other end of the scale were, instead, the governments of the Central African Republic, Guinea, Angola, Sierra Leone, the Comoros, the Democratic Republic of the Congo, Burundi, Eritrea, Guinea Bissau and Sudan.

Sudan exhibited a particularly negative performance compared to the other countries, by allocating the lowest percentage of its GDP to education (0.3%) and failing to make any direct contribution to immunization programmes, despite the country's adverse health indicators.

NOTES

1 http://saluteinternazionale.info/2011/10/investire-nell'infanzia-in-africa-dalla-retorica-alla-responsabilita/

DIALOGUE

APPEAL FOR INTERNATIONAL COOPERATION

Doctors with Africa CUAMM is working towards the implementation of healthcare programmes in developing countries through staff engaged in cooperation projects who can get the right to leave of absence. The total lack of funding is having a particularly destructive effect on healthcare programmes. Here the appeal about this problem.

TEXT BY / DANTE CARRARO / DIRECTOR OF DOCTORS WITH AFRICA CUAMM

Funds allocated by the Ministry of Foreign Affairs for international cooperation slumped from approximately 700 million euros in 2008 to almost 90 million euros in 2011. This dramatic reduction is all the more striking when compared to the conduct of other countries – including Great Britain, Belgium, the Netherlands and Finland – which have remained faithful to commitments made at international fora by keeping their allocation above 0.5% of GDP. The recent Three-Year Economic and Financial Planning Document (April 2012) commits Italy to realign with agreed goals, but does not establish clear amounts or specific times. In the meantime, the forecasts for 2012 remain crucial: no u-turns are planned and the overall allocation is frozen at 0.13% of GDP. According to the European Commission, Italian PAD (Public Aid for Development) could reach a mere 0.16% in 2015.

Recent OECD-DAC statistics (www.oecd.org) do instead indicate an increase in Italy's PAD, which appears to rise from 0.15% in 2010 to 0.19% in 2011. Alas, only apparently so. In the sixth AidWatch Report (www.concordeurope.org), which photographs cooperation for development on a yearly basis in the European Union and in the individual member states, the evidence suggests otherwise. On removing bilateral aid relating to expenditure for refugees (approximately 30%) and for the remittal of now irrevocable debts (approximately 35%), PAD falls dramatically to a scandalous 0.13% of GDP, a percentage which has not been so low for many years. Italy seems ready to take its place at the tail end of Europe in aid for development.

The picture is worsened by the Government's additional drastic cut in the financial resources allocated to international cooperation, approved in the current year's budget. This serious decision has effectively cancelled projects promoted and implemented by non-governmental organizations in the framework of Italian law no. 49/1987.

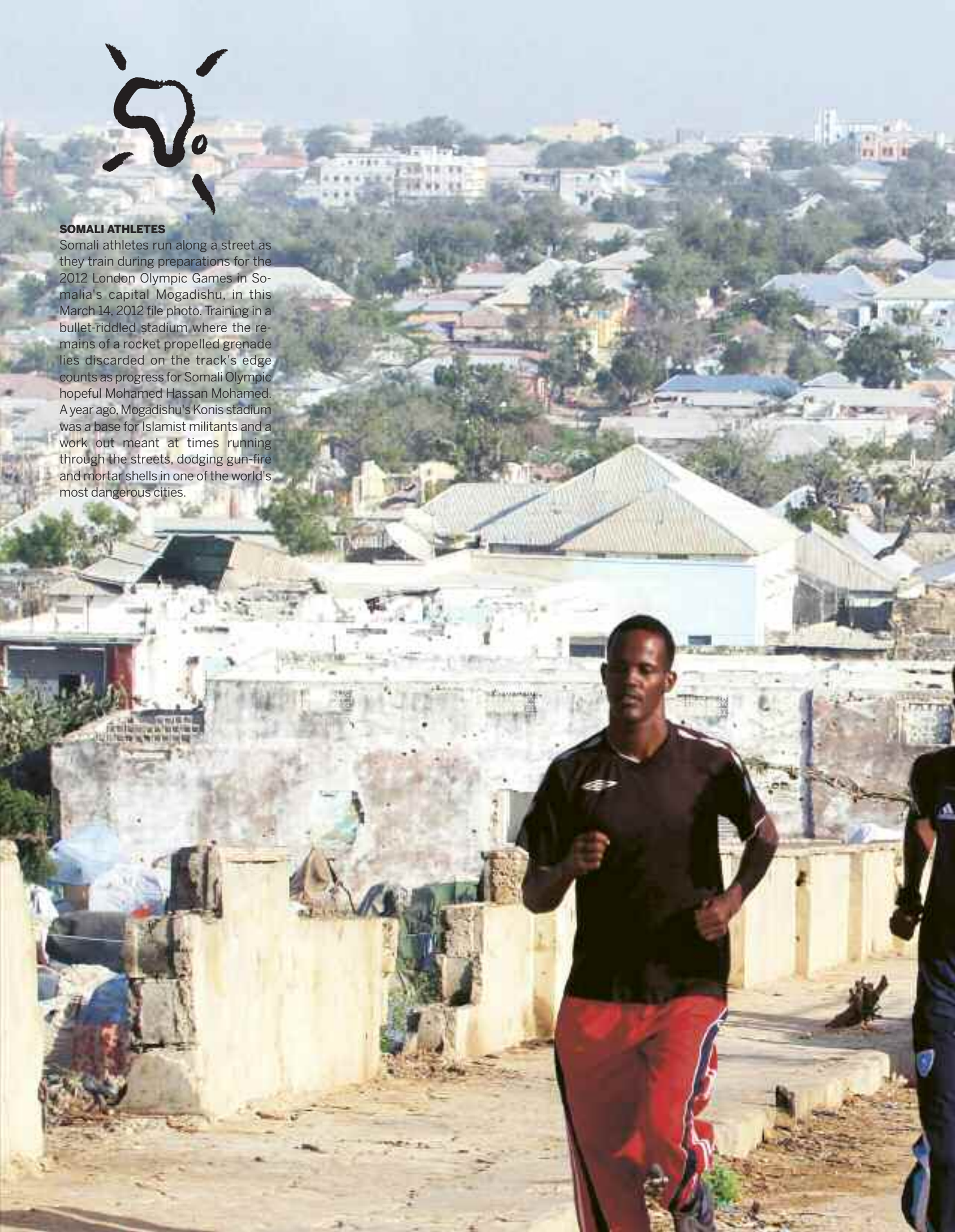
This total lack of funding is having a particularly destructive effect on healthcare programmes: there are no resources enabling voluntary workers, doctors and paramedics to take leave of absence from the public health facility where they work to engage in cooperation projects. Yet an average of just 20,000 euros per year is all that would be required to give a healthcare professional insurance and health and social security cover, without burdening the healthcare facility of affiliation.

As for our Association, which works for the growth of health systems in the poorest parts of Africa, through the development of long-term programmes backed by the intervention of doctors, nurses, midwives and health providers, these decisions jeopardize a sixty-year commitment which can only produce results in the presence of constant, continuous backing.

Which is why we are launching an urgent, pressing appeal to the Ministry of Foreign Affairs and the Ministry for International Cooperation, to immediately allocate at least 2 million euros to the Directorate General for Cooperation for Development to guarantee leave of absence (about one hundred applications) to engage in international health cooperation work carried out by NGOs.

Primarily, this is needed to make a commitment in favour of equity. It cannot be right to have a world with such marked differences between continents and countries, particularly in healthcare. Suffice it to consider the alarming data on maternal and child mortality in many Sub-Saharan countries. Neither can it be right that governments on the "powerful" side of the world fail to do their part in supporting the development and growth of poorer countries: something we consider an ethical duty in the name of justice and solidarity and for which we wish to fight.

Secondly, we feel it is short-sighted to abandon a policy of cooperation for development right now, in spite of the financial crisis affecting our country. It needs to be understood that cooperation is not an accessory that can be reduced or cancelled when times get hard. On the contrary, it is a great opportunity to promote the recovery of global growth and a far-sighted choice for our country, too. Helping Africa, the continent closest to us, come out of poverty, accompanying it in the creation of a more robust healthcare system, backing the hopes of revolutions in the Mediterranean, are ethical duties that are all part and parcel of human coexistence. Such policy also represents an opening towards future relations with a continent of one billion, mostly young people, which is rapidly developing as an economic community, with its own system of continental infrastructures and with the active lead role of governments, regional and local institutions and civil society.



SOMALI ATHLETES

Somali athletes run along a street as they train during preparations for the 2012 London Olympic Games in Somalia's capital Mogadishu, in this March 14, 2012 file photo. Training in a bullet-riddled stadium where the remains of a rocket propelled grenade lies discarded on the track's edge counts as progress for Somali Olympic hopeful Mohamed Hassan Mohamed. A year ago, Mogadishu's Konis stadium was a base for Islamist militants and a work out meant at times running through the streets, dodging gun-fire and mortar shells in one of the world's most dangerous cities.

REUTERS / FEISAL OMAR

FORUM

CLANDESTINE VOLUNTARY WORK IN MILAN

The frenzied metropolis clashes with the need to defend those whose right to health is denied. Thanks to experience of volunteering with Naga, told by a young student passionate about justice, it is possible to fight for the right to health. In 2012, 25 students of SISM – Italian Secretaariat of Medical Students – took part in the project in Milan.

TEXT BY / CLARA BENEDETTA CONTI / SISM ITALIAN SECRETARIAT OF MEDICINE STUDENTS

In the mornings I look around me on the Milan underground packed with faces and stories, where five out of ten passengers have Latin-American, Egyptian and Indian features and produce multilanguage dialogue which did not exist twenty years ago. Immigration is part and parcel of big city life and clearly a growing phenomenon in Milan, some of it undoubtedly clandestine. Doctors, particularly trainees, cannot avoid contact with irregular immigrants living in the local area. In the Lombardy Region, as in the rest of Italy, the so-called STP (Temporarily Present Foreigner) code gives irregular, non-EU immigrants access to essential treatment, but not to a general practitioner. Over the years this situation has given rise to the establishment in the Milan area of independent voluntary associations belonging to SIMM (the Italian Society for Migrant Medical Care), which provides primary care for immigrants without a stay permit. One of these is NAGA (Voluntary Not-for-Profit Health and Social Care Association for the Rights of Foreign, Roma and Sinti Citizens), to which I was introduced as a member of the Milan branch of SISM (Italian Medical Students' Secretariat) during GrIS (Immigration and Health Groups) meetings, which we had been attending for a few years as a medical student association. Realization that the right to primary care was being denied prompted the need to organize, through SISM, internship work at the NAGA outpatient service in order to show medical students and promoters of the right to health, one clearly manifest, but hidden, aspect of Milanese life.

HOW DID THE PROJECT WORK?

The project started in January and ended in March 2011 when, in our capacity as members of the Milan branch of SISM, we met the heads of NAGA to propose setting up a clinical internship for students at their facility's general medicine outpatient service, run entirely by volunteer doctors. Initially, we had a vague idea about how things would work. We wanted to provide a new clinical experience for students, otherwise crammed with ultra-specialistic, tertiary level medicine, and make them aware that irregular immigrants were being denied the right to basic healthcare and that SISM felt a duty to provide self-training in this field, too. Fifth and Sixth year students were invited to take part in the project in order to work on a substrate of sufficient clinical knowledge and open students' eyes to the sharp contrast with daily work on the ward. All 25 students interested in the project became involved. After a mutual introductory meeting with an overview of the Association's work by the head of the outpatient service, Dr. Dalla Valle, the internship took the form of five days' attendance at the clinics. The student to volunteer doctor ratio was 1:1 and the students very enthusiastically took part in the Association's daily practice.

WHAT KIND OF WORK DOES NAGA DO? HOW IS THE OUTPATIENT SERVICE ORGANIZED?

NAGA is a secular, non-partisan Association founded on an apparent paradox, i.e. "established to disappear", where the founding principle is the desire to defend a denied right through activities designed to safeguard that right and remove the reasons for setting up the Association. The approach is not welfare- or charity-oriented but based on a political and human commitment.

It is formed by approximately 300 volunteers with legal and healthcare backgrounds, who inform, defend and protect so-called irregular citizens and socially excluded ethnic minorities in all situations where rights are denied. Besides the outpatient service, over 800 people living in rundown areas of the city are contacted by the "Street Medicine" service, involving hundreds of workers whose aim is to prevent and reduce health damage. The Association also offers free legal protection to many people. In addition, legal and social aid is provided to asylum seekers, refugees and victims of torture.

Our project was restricted to the Association's primary care outpatient service, where two doctors in the morning and two in the afternoon visit patients and guarantee a continuous voluntary service, each day. Over 15,000 people per year come to the service, without statistically significant differences between men and women, from North Africa, South America and Eastern Europe. Most of them are young workers, with common general pathologies similar to those affecting Italians: orthopaedic, gastrointestinal, respiratory, cardiological, gynaecological, infectious and influenza- related. They come to the service in trust and often bring simple problems made extremely difficult to solve by bureaucratic barriers and the ban on prescribing medicines and in-

vestigatory tests through standard national health service routes. Accordingly the Association is committed to ensuring that hospitals observe legislation in force, although this is not always the case, and has created a small internal "pharmacy," which receives donations of medicines. The students often perceived a sense of frustration and discouragement caused by the exasperating hurdles to overcome in providing a primary care service in a city like Milan, which can boast healthcare excellence and where national health service doctors can prescribe highly sophisticated services. In short: a real paradox.

WHICH GOALS HAVE YOU ACHIEVED?

Obviously the aim of the project was to develop a new awareness among students. We like to think we managed to dispel some preconceptions about irregular immigrants in those who, in turn, will become spokespeople and promoters of the right to health for all: a basic principle taken for granted but often denied. Since the experience was highly appreciated by the students, we decided to organize a new edition in 2012, now ongoing and involving thirty students.
We encourage all local branches of the SISM, all doctors and all association to ask NAGA to seek each other out locally in order to pursue the safeguard of the right to health, to raise awareness and heighten knowledge in those who will be on the front line in the complex job of caring for people.

TABLE 1 / THE LOCAL OFFICES THAT HAVE SET UP INTERNSHIPS AT OUTPATIENT CLINICS FOR MIGRANTS

LOCAL OFFICE	PARTNER ASSOCIATION	TYPE OF ACTIVITY
MILAN	NAGA AND OPERA SAN FRANCESCO OUTPATIENT SERVICE	5TH AND 6TH YEAR STUDENTS WORK ALONGSIDE VOLUNTEER DOCTORS IN PROVIDING BASIC MEDICAL CARE IN FOUR 4-HOUR MEETINGS
PALERMO	TRAVEL, TOURISM AND MIGRATION MEDICINE OUTPATIENT CLINIC AT PALERMO GENERAL HOSPITAL	STUDENTS ATTEND THE SERVICE INDIVIDUALLY OR 2 AT A TIME ON 2 MORNINGS A WEEK
PISA	SAN VINCENZO ASSOCIATION OUTPATIENT SERVICE	2 AFTERNOONS A WEEK OPEN TO 3RD YEAR STUDENTS ONWARDS
ROMA TOR VERGATA ROMA SANT'ANDREA ROMA LA SAPIENZA ROMA UCSC	CARITAS OUTPATIENT SERVICE	- EXPERIENCE AT THE CARITAS OUTPATIENT SERVICE. ENVISAGES 3 DAYS OF TRAINING AND 3 MONTHS OF INTERNSHIP - STREET PROJECT: INTERVENTION IN SUPPORT OF HOMELESS PEOPLE IN A NETWORK WITH LOCAL HEALTH AND SOCIAL SERVICES
TURIN	TURIN MIGRATION SERVICE (SERMIG) AND CAMMINARE INSIEME ASSOCIATION	OUTPATIENT PROJECT: 60 MEDICAL AND NURSING STUDENTS ATTEND SERMIG OUTPATIENT CLINICS, IN GROUPS OF 4 AT A TIME ON THURSDAY AFTERNOONS. STUDENTS CAN ALSO ATTEND THE CAMMINARE INSIEME CENTRE IN GROUPS OF 1 OR 2 FOR 1-2 CONSECUTIVE WEEKS EACH

INDIGNATION IS A MUST

The impact with an unknown and fascinating world: help the NAGA doctors in the care of the immigrants, here in Italy, for becoming a "responsible doctor".

TEXT BY / CLARA BENEDETTA CONTI / SISM ITALIAN SECRETARIAT OF MEDICINE STUDENTS

The main hall of the Naga Association[1] headquarters in Milan serves as a waiting room for the outpatient consulting rooms. The first time I arrived, there were about 30 people waiting their turn. Some were getting a coffee at the dispenser, others were chatting in Italian or other languages.
That afternoon the doctor I was working with received about 15 patients, many affected by apparently banal disorders, but which concerned them greatly. Others were back from seeing a specialist who had advised them to do tests that could not be prescribed by the Naga doctor, who sought alternatives, phoned colleagues and became quite stubbornly indignant about finding a solution. Some patients understood and took an active part, others smiled, others waited for the end of the visit to find out the final decision. Many asked me who I was and what I did; an eighteen-year-old boy asked me to go out with him that evening; another confessed his dislike of the doctor as soon as he left the consulting room to look for a suitable medicine in the little room used as a "pharmacy".
I enjoyed this time and I felt that this experience came closest to my idea of Medicine: protecting the health of everyone, regardless; a sort of "obstinate good" (Paolo Rumiz, *Il bene ostinato*), to quote a familiar concept. The more I worked there, the angrier I became about how the right to health was being denied, seeking little solutions through friends, my parents and those colleagues I most respected. I now feel that becoming a health promoter was a sort of awakening, instilling a sense of responsibility and a style of medical practice that should never stoop to compromise with social injustice.
I returned to that waiting room last week to attend a volunteer training course. On that occasion too, there were at least 30 people, who had at least one thing in common with the patients from the first day: the need to defend a fundamental human right.

NOTES

1 Naga – Voluntary Not-for-Profit Health and Social Care Association for the Rights of Foreign, Roma and Sinti Citizens

FORUM

WHO REFORM: THE CRISIS AND FUTURE PROSPECTS

WHO's lack of financial independence inevitably undermines its decision-making and operating autonomy, leaving it up to donors to set priorities and decide where to invest.
The future of WHO in fact depence on the charges that globalization is causing in our society: economical decisors are affecting also social and health interventors.

TEXT BY / CHIARA DI GIROLAMO, ALICE FABBRI / INTERNATIONAL AND INTERCULTURAL STUDY AND RESEARCH CENTRE, UNIVERSITY OF BOLOGNA

The World Health Organization (WHO), the United Nation's agency specializing in health, was founded in 1948 with the objective of ensuring attainment of the highest possible level of health by all the world's peoples[1].
The present round of reforms will undoubtedly lead to the biggest change since the Organization's creation. Everything officially began in 2011 with a document entitled, "*The future of financing for WHO,*"[2] in which the Director-General of WHO, Margaret Chan, presented a draft reform focusing on the problem of financing. The Agency is currently faced with a very critical but also highly sensitive financial situation and a budget inadequate to the task, increasingly subject to the will and priorities of donors.
In the financial planning for the two-year period 2012-2013, the member states allocated 3.96 billion dollars against the Organization's requested 4.8 billion, i.e., one billion short of the amount needed to cover planned activities.[3]
Another sensitive issue is type of funding, some compulsory (quotas paid by member states in proportion to their GDP and population size), other voluntary. At present, approximately 75% of WHO budget funds comes from voluntary contributions, i.e. money donated to WHO but, in most cases, earmarked for specific activities or programmes. WHO's resulting lack of financial independence, in terms of both available resources and ability to allocate them, inevitably undermines its decision-making and operating autonomy, leaving it up to donors to set priorities and decide which programmes to invest in.

THE TIP OF THE ICEBERG

While the financial squeeze remains a thorny issue demanding urgent attention, it is merely the tip of the iceberg of a much deeper structural crisis within an organization established at a time when multilateralism was a shared political strategy but is now left to survive in today's very different world. As Hawkes[4] commented, "Despite its past accomplishments, WHO fits increasingly uneasily into a world with a growing number of international players who seem fleeter of foot and deeper of pocket".
Up until the 1990s the WHO was the main player in the global health arena: an arena that has recently become a jungle populated by multiple different subjects, notably public-private partnerships as the *Global Fund to Fight AIDS, Tuberculosis and Malaria,* and foundations, as the one run by Bill and Melinda Gates. In this complex setting, global health leadership is fragmented and in the hands of a plurality of players, many of them private and accustomed to more rapid (but less democratic) decision-making procedures and greater financial resources. Moreover, given their business orientation, their interests are not entirely restricted to public health. The situation is further complicated by the fact that these entities have become part not only of the world scenario but also of the WHO itself. The Bill and Melinda Gates Foundation, for example, is the second donor to the WHO after the United States in absolute terms and the leading (and perhaps only) sponsor of the reform project. These dynamics inevitably implicate conflict of interest concerns. Besides, the fact that the Bill and Melinda Gates Foundation holds shares – more or less directly – in multinational food and drug companies begs the question whether global public health protection can compete with these corporations' business interests in the health field[5].

THE FUTURE OF WHO

From this angle, the WHO reform process is no longer merely a technical intervention to rehabilitate finances, but can be viewed as a political move designed to rethink the Organization's character and role.
Whether the WHO will assume a token rather than a leading role in the global health arena in the future will be closely bound up with ongoing globalization processes and current scenarios. Economic and financial crisis scenarios where global health-related decisions are made in settings such as the G20 (formed by the financial ministers and governors of the Central Banks of the world's 20 most powerful economies) or the World Economic Forum in Davos, and where democratic institutions, at both the national and international level, as the United Nations, are faced with a crisis of independent decision-making and legitimacy.
Nonetheless, these scenarios have also seen growing civil society engagement enliven the international reform debate, by reopening the question of governance and the strategic role that the WHO can and should play in promoting public health and protecting it from improper interests.

AN EXEMPLARY EXPERIENCE

Paradigmatic in this respect is the *Democratising Global Health Coalition* (DGH) experience, bringing together different social players, including the *People's Health Movement* (see **box**). Created to promote the right to health through a strong position on the reform process, shared by civil society, the DGH has managed to present its position at the negotiating table following intense advocacy efforts among member country delegates, leading to major successes.

It is still too early to assess how this will impact individual countries' health policies, but the southern hemisphere, which has always considered WHO to be a guide and an institution able to provide technical and political support, will be confronted with a new player whose limits are well known, but not its potential.

KEEP AND EYE ON THE WHO!

The international public opinion monitors the decisions and policies of major international players. The case of *People's Health Movement*, a network from over 80 countries

The *People's Health Movement* (PHM) is a global network, formed by civil society organizations and individuals from over 80 countries, established to promote the right to health for all. The founding principles of the PHM, summarized in the People's Charter for Health, are based on the values of social justice, equity and participation, and are inspired in particular by the WHO Constitution and the Declaration of Alma Ata. Under the umbrella of a wider initiative on global health governance, the PHM – alongside other non-governmental organizations and networks – has implemented the "*WHO watch*" project to observe and monitor WHO activities, with the following objectives:

- to promote active civil society participation in decision-making processes;
- to ensure that the WHO agenda is consistent with public interest;
- to make political decision-makers responsible towards the population.

Since January 2011, on the occasion of WHO and World Health Assembly Executive Board meetings, young activists from all continents, trained by international experts, have been meeting in Geneva to closely follow negotiations and conduct advocacy work among national delegations, with a view to influencing decisions on what civil society considers to be priority issues. The resulting documents, the positions of the member states and the critically commented resolutions are then posted on the Global Health Watch website (www.ghwatch.org), created ad hoc to inform public opinion and open a space for exchange on and discussion and monitoring of WHO decisions.

NOTES

1 World Health Organisation. Constitution of the World Health Organisation. http://www.who.int/governance/eb/constitution/en/index.html Accessd on 13.04.12

2 The future of Financing for WHO. A64/4, 5th May 2011. Sixty Fourth World Health Assembly. Geneva, May 2011

3 Butler D. Revamp for WHO. Nature 2011; 473: 430-431

4 Hawkes N. "Irrelevant" WHO outpaced by young rivals. BMJ 2011;343:d5012 doi: 10.1136/bmj.d5012

5 Stuckler D, Basu S, Mckee M. Global Health Philanthropy and Institutional Relationships: How Should Conflict of Interest Be Addressed? Plos Medicines 2011 doi:10.1371/journal.pmed.1001020

INTO THE FREE SOUTH SUDAN

On 9th July we celebrate the first anniversary of the independence of South Sudan, but still persisting tensions and clashes on the border with the North. In this photo rucks carrying refugees and their belongings travel to the Yusuf Batil refugee camp in South Sudan's Upper Nile. The emergence of displaced persons was very urgent in recent months, but has not yet been resolved. The volunteers from Doctors with Africa Cuamm have brought aid and basic care to the refugee camps near the hospital in Yirol, in Lakes State.

REUTERS / ADRIANE OHANESIAN

EXPERIENCES FROM THE FIELD

REDUCING MATERNAL MORTALITY. THE CASE OF RWANDA

When money is not everything and interventions from above must be supported by processes of grassroots participation to achieve significant results.
The case of Rwanda can teach a lot on the reduction of maternal mortality with few resources and good policy choices.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

The data speak for themselves: between 2000 and 2010, maternal mortality in Rwanda slumped from 1,0171 to 383 cases per 100,000 deliveries. Ninety-eight percent of women receive at least one antenatal visit. Sixty-nine percent of women give birth in healthcare facilities. Family planning has quadrupled. The comparison with Uganda, a country of similar healthcare and social status, is overwhelming[1].

TABLE 1 / OUTCOMES COMPARED

UGANDA	1995	2000/1	2005/6	2011	MDG
MM PER 100.000	506	505	435	?	131
% OF BIRTHS ATTENDED BY SKILLED PERSONNEL	38	39	42	?	100
RWANDA	**2000**	**2005**	**2008**	**2010**	**MDG**
MM PER 100.000	1.071	750	540	383*	268
% OF BIRTHS ATTENDED BY SKILLED PERSONNEL		39	52	69	100

Fonte: HMIS; otherwise DHS

WHAT ARE THE SOURCES OF SUCCESS?

Some institutional characteristics appear to have contributed to the reduction in maternal mortality in Rwanda, including: coherent policy interventions, health service funding, systems of incentives and sanctions in support of performance, facilitation of local involvement[2].

POLICY COHERENCE AND SHARED OBJECTIVES

Healthcare services in Rwanda operate within a complex, highly coherent political system. National development policies (*Vision* 2020) are translated into realistic goals. On the government's political agenda, the programme to reduce maternal, neonatal and under-five mortality occupies a central, cross-cutting position. By underwriting a contract *(Imihigo)*[3] signed directly by the President of the Republic and thirty district mayors, the country's leadership puts constant pressure on the bureaucratic machine and urges it to produce results[4]. The contract is accompanied by a series of performance indicators relating to several areas of economic and social development, including health. The central authorities undertake to provide the financial resources required to fulfil the contract and it is up to the districts to carry it out. On an annual basis a mixed commission, formed by government and civil society representatives (*Civil Society Forum*), analyses the results achieved, identifies best practices and ranks the districts by performance. The contract signing ceremony and the publication of the final evaluation document are widely broadcast at local and national level through the media and the internet[5].

REFORMING THE HEALTH SERVICE FUNDING SYSTEM. THE PRINCIPLE OF EQUITY

In 2009, per capita health spending in Rwanda stood at $102 (PPP), 44% of which was private and 56% public, over half of which is supported by international aid[6]. Public funding of health services is based on a national fund fed by an insurance system including: RAMA (Rwandaise d'Assurance Maladie) for public administration employees, MMI for the military, insurance policies for private sector employees and, lastly, since 2004, the *Community Based Health Insurance (CBHI)* scheme. The aim of CBHI is to ensure financial accessibility to communities through a solidarity and risk-sharing mechanism. A special law governs the collection of CBHI funds, premium management, definition of the envisaged package of services and reimbursement mechanisms[7]. The CBHI are chiefly managed at district and local health unit level. The premium stands at $2 per person per package of basic services and $5 for a caesarean section at the district hospital. The premium is stratified into three categories according to the *Ubudehe*, a traditional mechanism which ranks the population by income and vulnerability. The poorest people are exempt from payment of the premium and the cost of services are charged to the national risk fund. Despite inevitable management and staffing problems, insurance coverage increased from 7% in 2003 to 92% in 2008. All quintiles benefitted from increased access to and utilization of services, with a reduction in inequalities in the first four[8].

THE INCENTIVES SYSTEM IN SUPPORT OF SUPPLY AND DEMAND

Coherent policy orientations and the definition of new finance system architecture have led to the establishment of clear roles and responsibilities for the various players and agencies involved in government maternal health policy. This was the necessary underlying institutional and organizational framework on which the complex system of supply- and demand-related incentives and sanctions was based. Women are given incentives to attend antenatal visits, to give birth in health centres and to attend postnatal examinations in exchange for material goods, e.g. clothing, soap, bed linen, umbrellas. The community health workers (CHW), who are active in the villages and organized into cooperatives, are regularly trained, and receive monetary incentives from their reference health centres in order to increase antenatal visits and assisted deliveries, again using preset parameters (*Community Performance Based Financing)*.
In turn, the health centres are monitored on a three-monthly basis by the district hospital team. Their performance, on which the financial bonus depends, is subject to continuous quantitative and qualitative controls based on preset indicators. To reduce absenteeism, public sector health staff are strictly prohibited from carrying out private work. If performance is low, the district healthcare, political and administrative authorities risk losing their job. Incentives for mother and child services have had a remarkable effect[9,10].

POPULATION PARTICIPATION

Mechanisms for facilitating local involvement have been developed in support of the above-described reforms. At both district and sector level, health boards, which have ceased to exist or are subject to disdain elsewhere, check indicators, analyse health problems and coordinate the activities required to develop both technical or administrative solutions. Information, educational and communications activities, village meetings, and community work (*Umuganga*)[11] designed to modify entrenched cultural practices, such as child-birth at home, have also been very dynamic. At the socioeconomic level, schemes to reduce poverty (*ubudehe*), which identify the destitute members of the villages, and savings clubs through which to pay the insurance premium in instalments, are participatory approaches appreciated by the population. Local coordination and civil participation are important features of the Rwanda model.

CONCLUSIONS

Undoubtedly such overwhelming results are chiefly attributable to the specificity of the setting, making it difficult to transfer them to other African health systems.
Rwanda, and the country's healthcare reforms, have followed a distinct historic pathway with a prevailing reference culture based on the principle of command and control. The government's attitude to democratic political competition and its style of national policy implementation seem rather controversial. Both reflect a trade-off between political freedom and the development results that not everyone would accept or ascribe to.
Having said that, there are nonetheless lessons to be learned from this reduction in maternal mortality. The first is that focusing solely on the inadequacy of human and financial resources is deceptive. Some "institutional or governance resources" have to be activated to optimize existing material resources, without which additional resources would not necessarily produce effective results. The second lesson concerns health system financing: the establishment of a single health fund to which various forms of insurance and the donors themselves contribute has helped overcome, at least in part, the chronic shortage of financial resources. The third lesson concerns health policies based on supply and demand, the need for which has secured general agreement for some time now. Their achievement requires a system of incentives which are probably essential in public settings strongly characterized by major organizational inertia, whatever management problems they may create[12].
The fourth lesson is not new but just as important. While top-down interventions are decisive in implementing a process of change, they must be backed by decentralized, community participation spaces and mechanisms in a spirit of mutual responsibility.

NOTES

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EXPERIENCES FROM THE FIELD

"COST ANALYSIS": THREE HOSPITALS IN COMPARISON

In Ethiopia and Tanzania has been experienced a tool to improve the sustainability of services provided and to determine the real cost of health services in hospitals supported by Doctors with Africa CUAMM. A necessary starting point to provide equitable and efficient services to women who turn to these structures to give birth.

TEXT BY / DONATA DALLA RIVA / DOCTORS WITH AFRICA CUAMM / GIULIA FAEDO / HEALTH POLICY AND MANAGEMENT CENTRE - TRINITY COLLEGE, DUBLIN
STEFANO VICENTINI / DOCTORS WITH AFRICA CUAMM PROJECT LEADER AT MIKUMI HOSPITAL, TANZANIA

INTRODUCTION

Reducing child mortality and improving maternal health are respectively the fourth and fifth Millennium Development Goals[1], towards which Doctors with Africa CUAMM has been working both through healthcare support at hospital and local level and through analyses and operating research, at the scientific level[2]. Doctors with Africa CUAMM's goal is to strengthen health systems in order to increase accessibility to quality services and, specifically, to guarantee assisted child delivery.

There are still relatively few economic assessment studies on mother-child healthcare services despite general consensus on the need to have reliable data in order to be able to efficiently and sustainably contribute to services offered to the population. This need is further highlighted by the national health policies of many countries where Doctors with Africa CUAMM is present, where the emphasis is on improving service management and therefore on the availability of reliable healthcare data, including economic information.

The policy of administrative decentralization underway in many African states, assigns responsibility for health service management to the administrative unit closest to the population, generally the "district"[3]. District health authorities are therefore required to continually improve their management skills, implying knowledge of data on the health services provided and their costs. Moreover, in countries like Tanzania, the public-private based partnerships governing relations between private, not-for-profit healthcare facilities and local government, envisage support mechanisms based on reimbursement of the cost of healthcare services provided[4].

The tool used to improve health facility efficiency and sustainability is designed to analyse the cost of services, particularly child delivery, and to propose cost coverage scenarios. In this framework, the organization has developed the following analyses:

- Survey of child delivery costs at St. Luke's Hospital in Wolisso, Ethiopia;
- Survey of costs of all health services provided at St. Kizito hospital in Mikumi and St. John of the Cross Hospital in Tosamaganga, Tanzania[5].

METHODS

The Activity Based Costing (ABC) approach, combined with the Step-Down method[6,7], has been used to determine the cost of health services provided. The ABC cost accounting system is designed to reconstruct the healthcare service "productive" process, associating each activity with its related cost to give the sum of all the utilized productive factors. The Step-Down method is used to attribute indirect costs to the three types of child delivery (normal, complicated and caesarean). Part of the overheads (e.g. administrative costs, laundry and surveillance services) are attributed to the cost of child delivery, on the basis of various cost allocation "drivers"[8].

The first step in determining the cost of a health service, through the ABC, is therefore to map the patient's entire hospital-treatment pathway, from hospital admission to discharge. This pathway reconstructs all the activities performed by the various subjects (medical, nursing, administrative and support staff) in caring for the patient, into a logical-time sequence[9]. The following productive factors have been identified: 1.Staff; 2. Medicines; 3. Materials; 4. Equipment; 5. Diagnostic services (testing); 6. Hospital stay. The item "Medicines" refers to all medicines administered before, during and after child delivery; the item "Hospital stay" refers to the cost of healthcare staff who treat the patient (and her newborn) during her stay in the maternity ward (after the delivery), whereas the item "Staff" refers to the cost of delivery room staff.

A careful cost analysis has been carried out for each individual productive factor in order to quantify actual consumption using the following methods: direct observation; measurement of times and inventory of materials utilized; staff interviews; review of clinical records and pharmaceutical costs; comparisons with similar studies to determine the criteria for allocating overheads, using parameters that reflect resource utilization ratio as closely as possible[10].

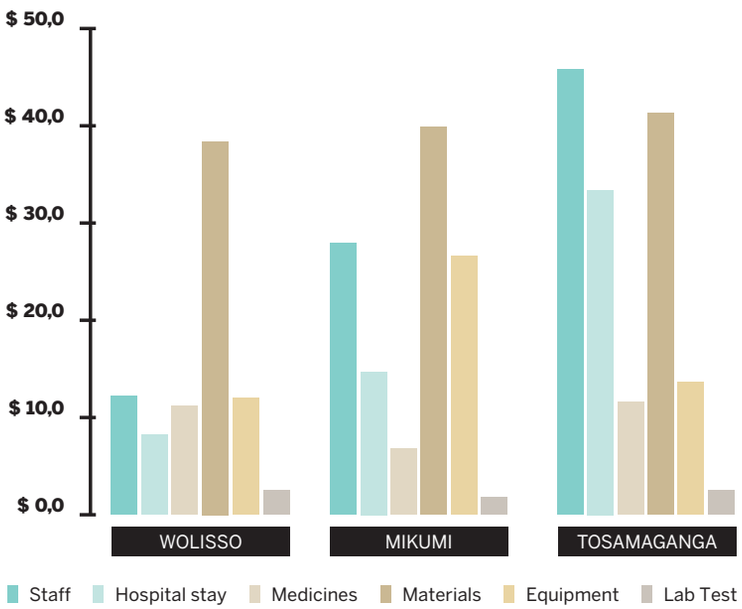
RESULTS

The aim of the analysis, conducted in 2010 in Wolisso and in 2011 in Tosamaganga and Mikumi, was to identify the unit costs of the various types of child delivery and, in Tosamaganga and Mikumi, the costs of all healthcare services provided. By way of comparison, the unit costs of the various child deliveries in the three hospitals are given below.

TABLE 1 / UNIT COSTS RELATING TO 3 TYPES OF CHILD DELIVERY AT THE 3 HOSPITALS. COST CALCULATIONS WERE IN US$. THE COST IN EUROS WAS CALCULATED AT A LATER DATE, ACCORDING TO MAIN ITALIAN EXCHANGE OFFICE RATES IN MAY 2012

HOSPITAL	NORMAL DELIVERY		COMPLICATED DELIVERY		CAESAREAN SECTION	
	US$	EURO	US$	EURO	US$	EURO
WOLISSO 2010	16,8	13,2	43,4	34,2	84,4	66,5
TOSAMAGANGA 2011	28,5	22,4	65,8	51,8	148,2	116,7
MIKUMI 2011	18,3	14,4	42,3	33,3	117,7	92,7

GRAPH 1 / COST ANALYSIS OF A CAESAREAN SECTION IN THE 3 HOSPITALS, BY PRODUCTIVE FACTORS



The main cost components for the three types of child delivery in the three hospitals refer to the items "staff" and "materials," whose combined cost on average constitutes 55% of total costs. This value increases where "staff" includes the item "hospital stay", which represents the cost of healthcare staff working at the maternity department. The weight of "materials" increases in the case of a caesarean section, due to use of the operating room.

The difference in unit costs for the three types of child delivery in the 3 hospitals is largely due to differences in type of facility:

- Wolisso hospital in Ethiopia is a reference facility for a catchment area of approximately 1,370,000 inhabitants and has 144 beds;
- in 2007, Tosamaganga hospital in Tanzania was designated as a district reference hospital for a catchment area of approximately 270,000 inhabitants and has 160 beds;
- Mikumi, which has recently been designated as a hospital, is smaller (65 beds) and has a catchment area of approximately 120,000 inhabitants.

What stands out on comparing the unit costs in the 3 hospitals is the high cost of all types of delivery at Tosamaganga. This is mainly due to differences in healthcare staff salaries. The average monthly salary for a midwife is $180 in Wolisso, $265 in Mikumi and $500 in Tosamaganga. There are also marked differences in staff pay within the same country, accounting for the difference in unit costs between Tosamaganga and Mikumi, which are both in Tanzania.
In Tosamaganga, staff is chiefly paid by the Tanzanian Government according to the national salary scale, by virtue of an agreement in 2007 between the Diocese of Iringa and the Government, which designated this private diocesan hospital as a district reference facility. In Mikumi, staff is instead mainly paid by the Hospital and therefore by the Diocese, with much lower salaries than those paid by the Government (between 40 and 50% less).
Similar results were achieved in Wolisso and Mikumi, despite the above-mentioned differences in setting and the lower cost of healthcare staff in Wolisso (approximately 50% lower). The lower cost of "staff" in Wolisso is instead compensated for and exceeded by the cost of "materials" (which account for 35% of the cost of a normal birth). This difference can be attributed to the presence of the nursing school, annexed to the hospital, which entails a higher consumption of materials for training purposes.
Unit costs for caesarean sections differ considerably between Wolisso and Mikumi, which are normally more aligned: a caesarean in Wolisso costs 66.5 euros compared to 92.7 in Mikumi. This undoubtedly depends on differences in healthcare staff costs. In addition, while hospital stay usually lasts 5 days at Mikumi and 8 at Wolisso, there is another determining factor: far less caesareans are performed per year at Mikumi than at Wolisso (50% fewer). Consequently, fixed operating room costs bear more heavily on the unit cost of caesareans in Mikumi, since they are distributed over a smaller number of cases.

CONCLUSIONS

Results are in keeping with those reported in similar studies in developing countries[11, 12, 13]. However, comparison of the costs charged to the hospital to provide the service (indicated in this study) and the user fees charged to patients for accessing services, deserves further investigation.
The three hospital facilities are private and belong to Dioceses in Tanzania and to the Ethiopian Episcopal Conference. In Tosamaganga, all healthcare services for pregnant women, children aged under 5 and the chronically ill are exempt from payment of any user fees, in accordance with national health policy and by virtue of the fact that the hospital is designated as a "district hospital". Conversely, in Wolisso and Mikumi, a normal delivery costs a pa-

tient 2.5 euros, a complicated delivery 3.5 euros and a caesarean 5.5 euros in Wolisso and 10 euros in Mikumi.
On comparing these values with the costs reported in the study, we see that the fees applied to patients in Wolisso and Mikumi do not cover even 20% of the actual cost of the service. In Wolisso the fee for a caesarean covers a mere 8% of the actual cost.
This does not mean that accessibility and equity are guaranteed because other considerations would need to be made about the socio-economic conditions of families in the hospital catchment area. However, keeping user fees as low as possible for patients means that a high percentage of the cost (over 80%) must be covered by the healthcare facility, in order to ensure the service.
One way of reducing the cost of hospital service provision is to try to optimize costs through improved organizational efficiency. However, this strategy would only have a marginal effect since the main component of child delivery expenditure is staff costs, which are subject to national wage policies and market and competition laws, and thus difficult to change.
Another way to improve sustainability could be to advocate greater support from governments through, for example, public-private partnerships, as implemented at Tosamaganga Hospital, or from other donors. In this respect, the study has permitted to define the real cost of healthcare services by providing a starting point for any negotiation about cost coverage. It would therefore be worthwhile to support healthcare facilities both in optimizing costs and in advocacy work with governments and donors with a view to promoting an increase in financial coverage. It will be essential to ensure systematic data collection in the 3 hospitals in order to keep the databases updated. Lastly, it will be important to spread the use of the tool to other health facilities supported by Doctors with Africa CUAMM.

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A CLOSER LOOK

AFRICA AND DEMOGRAPHIC FORECASTS

By controlling births and looking for work far from home, millions of Africans will seek to build a better future for themselves and their few children along the route taken first by the Europeans and later by Asians and Latin Americans. Here the analysis by two professors of demography of the University of Padova.

TEXT BY / MARIA CASTIGLIONI AND GIANPIERO DALLA ZUANNA / PROFESSORS OF DEMOGRAPHY - DEPARTMENT OF STATISTICAL SCIENCES, UNIVERSITY OF PADOVA

According to new demographic forecasts released by the United Nations Population Division (UN-DP), population growth in two African regions should slow down. In the twenty-year period from 2010-30, the population is expected to increase by 31% in North Africa and by just 11% in South Africa. In another three regions, however, growth should continue at a brisk pace: +63% in East and West Africa, +58% in Central Africa. If the forecasts for these three regions are correct, global population growth from 1950 to 2030 would be formidable. One example. Kenya, whose population increased from 6 to 40 million between 1950 and 2010, could reach 66 million in 2030. The population has also increased in Europe but far less rapidly. In the first century of unity (1861-1961) the Italian population "only" doubled from 25 to 50 million.

What is behind this great demographic growth? As from the start of the 19th century and during very different times, all the world's countries experienced a rapid decline in child and youth mortality. In today's rich countries this decline was slow, because every advance in hygiene and medicine was followed up "in the field". This slow rate enabled couples to develop a new mind-set and to start birth control. In (today's) poor countries – however – child mortality has fallen more rapidly because medicines, vaccinations and hygiene have been imported and immediately adopted by the local populations. But mind-sets do not change that quickly and for many African couples, having lots of children is (still) perceived as an economic and social advantage.

However, there is something not quite right about these forecasts. Between 1980 and 2010, fertility in other parts of the poor world (Asia, North and South Africa, Central America) fell by 50% (from 5 to 2.5 children per woman). In 2010, 5 children were born per woman in West, East and Central Africa, but the UN-PD estimates that thirty years later more than three will continue to be born. There is no reason why fertility should not fall by half in the next thirty years in these three African areas – starting from the same levels.

Moreover, the UN-PD forecasts – again for the next thirty years – that the number of African emigrants will be much lower than in the last twenty years. This hypothesis does not take recent history into account either.

If – a generation later - fertility in West, Central and East Africa falls to the levels observed in the rest of the poor world and if the number of emigrants is the same as in the last twenty years, then the African population will continue to increase, but well below UN-PD's current estimates. Two hundred years of demographic history show that when mortality rates fall, sooner or later, attitude to one's own future and to the future of one's own children also changes. By controlling births and looking for work away from home, millions of Africans will seek to build a better future – for themselves and their few children – along the route taken first by the Europeans and later by Asians and Latin Americans.

REVIEW

THE HEALTHCARE SYSTEM IN POLAND

Access to health care is guaranteed for everyone by the Constitution but healthcare services are not equally accessible to all: long waiting lists, different forms of insurance, and even corruption overshadow the fundamental right to health.

TEXT BY / ALEKSANDRA MOTYKA, EWELINA WIERZEJSKA AND MATEUSZ COFTA / LABORATORY OF INTERNATIONAL HEALTH - DEPARTMENT OF PREVENTIVE MEDICINE POZNAN UNIVERSITY OF MEDICAL SCIENCES, POLAND

Poland is a republic with a population of 38.5 million people with a life expectancy of 71 years for men and 80 for women. The pediatric mortality rate stands at 6 children per 1000 live births. Total per capita health expenditure is $1,359. Between 1998 and 1999, the healthcare system in Poland transferred from Siemaszko's model to a decentralized, mandatory health insurance model (the Bismarck model).

FUNDING

In 2009, 7.4% of Poland's Gross Domestic Product (GDP) was spent on health. The healthcare system in Poland is funded by a mandatory insurance premium, paid by employees and covering 98% of the population. The core values of the health service are solidarity, free access to medical care, the right to choose own healthcare provider, self financing, targeted management and a state guarantee. Premiums, which account for 9% of personal income, are collected by the National Health Fund (NHF) and divided into 16 local bureaus (one for each province). Local NHF bureaus are responsible for funding health services and contracting public and nonpublic health service providers in their province. Some highly specialized procedures are financed directly by the Ministry of Health budget, which also finances medical care for certain groups of people (such as the unemployed), emergency health services and country-wide schemes. Overall, public funding accounts for 70% of health care expenditure, 83.5% of which is covered by mandatory insurance.

Private health insurance also exists in Poland and chiefly offers medical subscription packages to employees of large companies.

ACCESS TO HEALTH CARE

Primary health care doctors are at the centre of the national healthcare system and the gate to specialists. However, some groups of specialists, such as obstetricians, ophthalmologists, oncologists, dermatologists, psychiatrists and dentists, are directly accessible to patients, without referral. Likewise, some groups of patients have direct access to specialist services, including: tuberculosis patients, people with HIV-infection, war invalids, the depressed, and patients in need of drug and alcohol rehabilitation. Apart from family doctors, health insurance also comprises a primary nursing and midwifery service, including home visits to patients. The mandatory insurance system is funded on a per capita payment basis and no additional out-of-pocket payments are envisaged to see a doctor. Conversely, visits to specialists and outpatient diagnostic testing are financed on a fee-for-service basis. Patients are referred for hospital admission by their doctor, except in emergency cases, and these services are financed on a fee-for-service basis and according to type of problem.

CRITICAL POINTS AND PROSPECTS FOR CHANGE

The public health service in Poland is severely underfinanced and access to secondary care poses serious problems, thereby benefitting the private sector. Added to this is the problem of transparency: 36% of Poles admit having given bribes or gifts to healthcare providers, mostly to obtain better care. Doctors' salaries in Poland vary widely; in the public sector, during internship, physicians earn about 90% of the average monthly Polish salary (i.e. approximately €848). This rises to approximately €2,188 once they have finished training. In recent years, Poland has undergone many social and political changes, which have also had an effect on the healthcare service. Two new laws have been introduced, one relating to organization of therapeutic activities and the other to drug reimbursement. The transition phase is underway and needs to be constantly followed and monitored.

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GOOD HEALTH AT LOW COST

Can good health be achieved at low cost? A reserch presents four examples of good practices in different countries, including Ethiopia. Investing in health, sustainable funding, development of qualified human resources, strong political support are some of the factors that contribute to success.

TEXT BY / FABIO MANENTI / DIRECTOR OF DOCTORS WITH AFRICA CUAMM

The study "*Good health at low cost*"[1] published in November 2011 by the London School of Tropical Medicine and Hygiene, takes its cue from the famous first volume commissioned by the Rockefeller Foundation in 1985, to explain why some countries with limited resources are able to improve health more than others with the same or a similar level of per capita income. It analysed China, Costa Rica, the Indian state of Kerala and Sri Lanka to identify which factors successfully contributed to an increase in health. The term, "Good health at low cost," was used to define a significant improvement in health status utilizing relatively limited economic resources. Importance was attributed to community-oriented primary health care, deemed a key element of the health system, and light was shed on the broad range of social determinants of health and their complex interaction with social and economic policy choices.

Since 1985, access to health services and effective treatment has increased the world over and with it life expectancy, except in the countries most affected by the HIV epidemic and several ex-Soviet Union countries, such as Russia. The revision of strategies and the difficulties encountered in recent years have shown that the most effective approach to strengthening health systems is to address them in their entirety. Bangladesh, Ethiopia, Kyrgyzstan, the Indian state of Tamil Nadu and Thailand have now been analysed on account of the particularly high improvements achieved in health (notably mother and child care). The study findings suggest that to increase access to "low cost" services, a health system must: have long-term vision and strategies; recognise the limits imposed by previous choices and dynamics; build social consensus; guarantee flexibility and autonomy in decision-making processes; be resistant to crises; learn from experience by influencing new policies; be backed by solid governance (see transparency and the fight against corruption) and by the socioeconomic setting, which must reflect the population's culture and preferences; achieve synergies with other sectors and partners; be open to dialogue and public-private partnerships.

Ethiopia is quoted as a good example of improvement in mother and child health, owing to the efforts made and results achieved in this domain. What seems to underpin this success is the great effort to fight malaria and reduce its effects, the rapid expansion of AIDS prevention and treatment services, and the considerable increase in the coverage of drinking water and sanitation. Other determining factors appear to be the change in regime in 1993 and the launch of the country's wide-ranging health system reform, with its twenty-year programme and interventions based on the extension of primary care services and attention to equity.

One particularly important aspect was government leadership which put health in first place on the development list, considering it essential in combating poverty. Central to achievements has been the programme to expand basic healthcare services through the so-called, *Health Extension Programme,* with over 30,000 *Health Extension Workers*[2] *(HEWs)* trained, paid and incorporated into the national health system. Together with the training of 5000 *Health Officers*[3] and the increase in the number of medical schools from 3 to 7, this programme has been the main response to the very serious lack of human resources in the health domain. Funding of the system is, however, insufficient, with 80% of costs being charged to patients and government contributions being amongst the lowest in East Africa.

In general, the study confirms the importance of investing in health, particularly primary care, sustainable funding, development of qualified human resources, strong political motivation to improve health, community involvement and measures to support equity and, lastly, policies to promote health that encompass other social sectors.

Five factors have proven to be closely associated with good health system performance: the capacity of the players involved, continuity with the past, the presence of catalysers, i.e. people able to seize the opportunity for change, the setting/context in which they take place and the role of governments.

NOTES

1 http://ghlc.lshtm.ac.uk/

2 The term *Health Extension Workers* (HEWs) refers to community health agents, preferably women, selected from the communities where they then work.

3 The term *Health Officer* refers to an intermediate figure between a doctor and a nurse, with diagnostic and treatment skills, who works in a Health Centre.

DOCTORS WITH AFRICA CUAMM

Established in 1950, Doctors with Africa CUAMM was the first NGO in the healthcare field to receive recognition in Italy (pursuant to the Cooperation law of 1972) and is the largest Italian organization for the promotion and safeguard of the health of the African populations.
It implements long-term development projects, intervening with the same approach in emergency situations, with a view to ensuring quality services that are accessible to all.

HISTORY

In its **60** years' history:
- **1,330** people have departed to work on projects: 367 of these departed on more than one occasion. The total number of departures was therefore 1,908;
- **4,330** years of service have been carried out, with a mean of 3 years per expatriate person;
- **950** students have been accommodated at the college: 640 Italians and 280 from 34 different countries;
- **279** doctors have departed from the Veneto region in almost 60 years;
- **211** hospitals have been served;
- **40** countries have benefited from intervention;
- **150** key programmes have been carried out in cooperation with the Italian Foreign Ministry and various international agencies.

IN AFRICA

Today we are in Angola, Ethiopia, Mozambique, Sierra Leone, Southern Sudan, Tanzania, Uganda with:
- **80 providers**: 47 doctors, 4 paramedics, 29 administrative and logistics staff
- **37 key** cooperation projects and about a hundred minor support interventions, through which the organization assists:
  - 15 hospitals
  - 25 districts (for public healthcare activities, mother-child care, training and in the fight against AIDS, tuberculosis and malaria)
  - 3 motor rehabilitation centres
  - 4 nursing schools
  - 3 universities (in Uganda, Mozambique and Ethiopia).

IN EUROPE

Doctors with Africa CUAMM has for years been actively implementing projects and building networks at European level, with the aim of building public awareness on the subject of equality of access to treatment and healthcare systems. Specifically, from 2011 to 2014 the organization has been coordinator of the European project, "Equal opportunities for health: action for development", on which it has been working with 18 other partner organizations from 7 European countries. Universities, student associations, non governmental associations in Italy, Poland, Latvia, Bulgaria, Romania, Malta and Hungary are working together to give room and voice to training in Global health and to promote greater awareness about the relationships between health and development, both individually and collectively.

NOTICE TO READERS

Support and take part in our commitment to Africa, in one of the following ways:
- **Post office current account** no. 17101353 under the name of Doctors with Africa CUAMM
- **Bank transfer** IBAN IT 91 H 05018 12101 000000107890 at the Banca Popolare Etica Padua
- **Credit card** call 0039.049.8751279
- **Online** www.mediciconlafrica.org

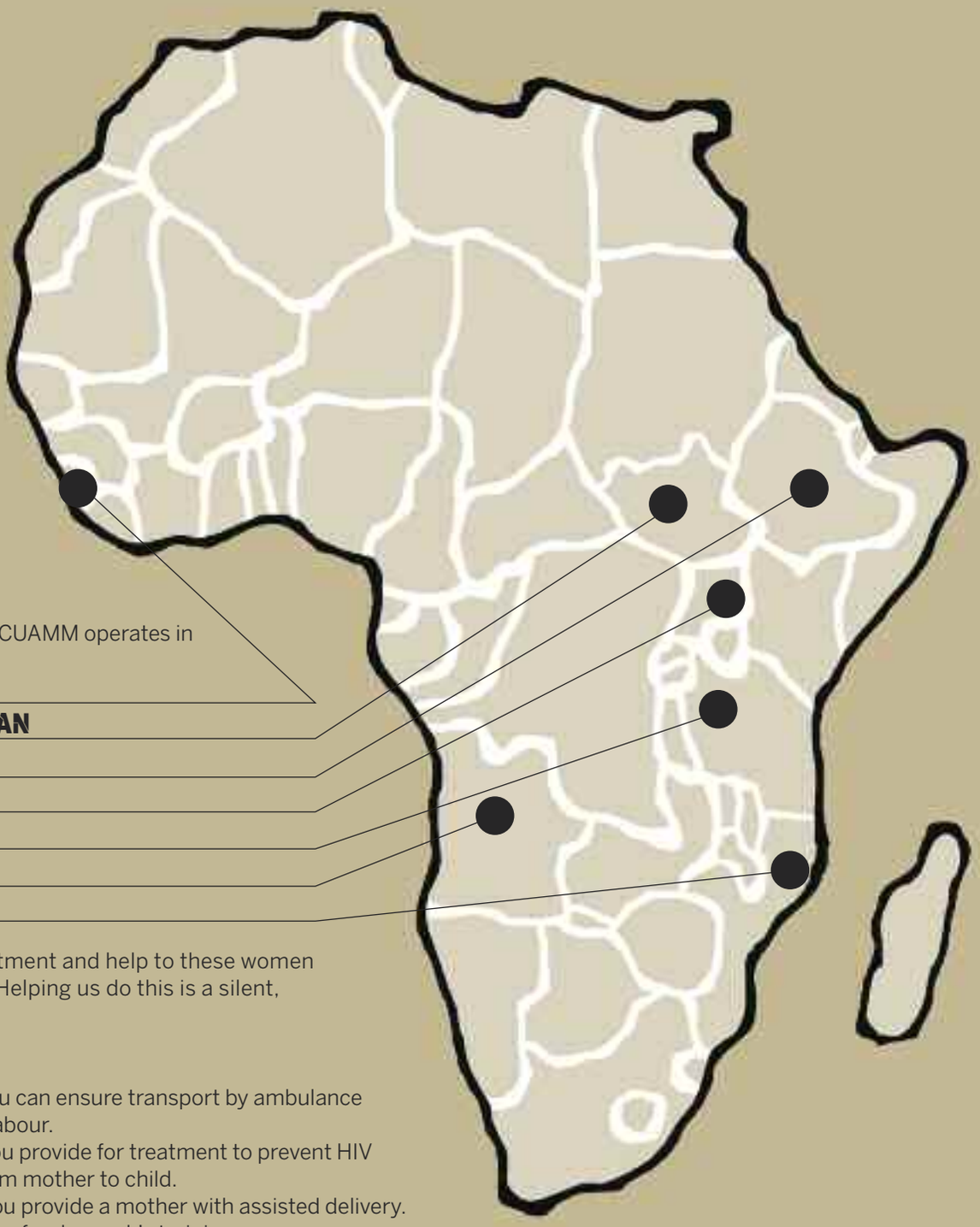
Doctors with Africa CUAMM is a not-for-profit NGO. All donations are therefore tax deductible. They can be indicated for this purpose in the annual tax return statement, attaching the receipt for the donation made.

HEALTH AND DEVELOPMENT offers studies, research work and documentation which are unique to the Italian editorial world. Our publication needs the support of all readers and friends of Doctors with Africa CUAMM.

NEEDY AFRICA

EVERY YEAR IN SUB-SAHARAN AFRICA:

- 4.5 million children die before reaching five years of age, for preventable diseases that can be treated at low cost;
- 1.2 million newborn children die in the first month of life through lack of treatment;
- 265 thousand women die from pregnancy- and delivery-related problems.



Doctors with Africa CUAMM operates in

SIERRA LEONE
SOUTHERN SUDAN
ETHIOPIA
UGANDA
TANZANIA
ANGOLA
MOZAMBIQUE

where it offers treatment and help to these women and their children. Helping us do this is a silent, forgotten war.

- With 15 euros you can ensure transport by ambulance for a woman in labour.
- With 25 euros you provide for treatment to prevent HIV transmission from mother to child.
- With 40 euros you provide a mother with assisted delivery.
- With 80 euros you fund a week's training course for a midwife.

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EQUAL OPPORTUNITIES FOR HEALTH ACTION FOR DEVELOPMENT

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