WHEC UPDATE

Briefings of worldwide activity of Women's Health and Education Center (WHEC)

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Lessons From The Field

Globally, half of the population lives in rural areas but they are only served by less than a quarter of all doctors and less than a third of all nurses. Therefore, providing people in rural areas with access to well trained health workers is a global challenge. Relatively little research has been conducted on effective strategies to promote rural practice, particularly in low-income countries. Finance has always been the bone of contention in any practice, particularly in a rural area where the population is relatively poor. For a practice to be successful, the services provided must not only be accessible and acceptable but also affordable. The use of appropriate low-cost, but effective, technology significantly reduced the capital investment. One problem has been the difference in gross earnings between rural and urban professionals. However, the difference in the cost of living, which is in favor of the rural practitioners, probably neutralizes this. Another problem has been the lack of job opportunities for spouses of health workers in rural areas. Misdistribution is arguably the most critical workforce challenge, not only for achieving universal coverage but also for addressing inextricably linked workforce problems such as shortages and skill imbalances. In many countries, overall shortages are exacerbated, indeed even caused by server misdistribution. In many countries, ethnic and cultural minorities have been forced into remote mountains, arid lands and recently into urban slums – that are further handicapped by weak economies and infrastructures. In communities that never had trained health workers, the challenge may be less of retention but more of the training of workers indigenous to the local communities or incentivizing urban workers for rural service. Distribution within countries is mirrored by disparities between countries. Whereas high-income countries have more than 10 doctors/nurses per 1,000, some of the poorest countries with higher burdens of disease may not have even 1 doctor-nurse per 1,000.

Rotations through rural health institutions should be made compulsory during postgraduate training. Postgraduate medical training can be conducted in remote areas in a manner that ensures professional development, counteracts professional isolation, and allows trainees and their families to grow roots in rural communities. Rural practice can satisfy modern principles of adult learning (problem-based and attached to real-life situations) and can offer excellent training conditions. We also believe rural health institutions should be made functional using the appropriate technology. Community participation is crucial to the sustainability of rural medical practice. The community benefits not only from the availability of affordable health care at their doorsteps but also from the job opportunities provided in the clinic and the infrastructure (transportation, catering and so on) that support it. Ensuring universal access to skilled, motivated and supported health workers, especially in remote and rural communities, is a necessary condition for realizing the human right to health, a matter of social justice. It is also at the core of each and every global health goal – the United Nations' Millennium Development Goals, primary health care, immunization, and control of HIV/AIDS, malaria and tuberculosis. For none of these goals is attainable if significant population groups are denied access to health workers. Abundant experience and sufficient evidence exist to solve this problem. The challenge is implementing effective strategies in specific contexts. Understanding the preferences of health workers for working in rural areas is essential in developing appropriate strategies.

It is indeed a pleasure to report our educational initiative: ***WomensHealthSection.com*** is also serving in remote areas of 220 countries and territories and on 24th October 2010 celebrates its 8th birthday. Numerous challenges exist, but we are confident our efforts will make a difference.

Striking The Right Balance

Rita Luthra, MD

Your Questions, Our Reply:

What can countries do to encourage their health workers to work in rural areas?

Combined Incentive Work: Most of the countries currently face internal and external migration of health workforce and interventions are needed to attract professionals in rural areas. An equitable distribution of human resources is essential to improve health outcomes. Low- and middle-income countries are hit hardest by the dual burden of external migration of health professionals to high-income countries and internal migration to wealthy urban areas. Given the complex interplay of factors, interventions addressing a single determinant might not be sufficient to tackle this problem. Several systematic reviews, however, have unveiled the scarcity of well designed interventions in low- and middle-income countries. In many programs the main incentive is a paid residency in a university hospital plus attractive salaries and benefits proportional to the degree of isolation and clinical responsibility. Reforms in the medical education and health-care system in the 1980s and 1990s has introduced tuition fees, creating a direct route to residency programs through self-financing. In addition, increasing numbers of private medical schools and the promotion of private health care have enforced competition for certain medical specialties that ensure better financial prospects. Drawing on Dolea's framework, the bundled set of incentives of the Rural Practitioner Program are in four domains: (i) monetary compensation (direct or indirect financial incentives); (ii) education and regulatory interventions; (iii) management, environment and social support; and (iv) external incentives.

Better working conditions are strongly associated with the health workforce retention in remote and rural areas. Many national programs have successfully matched the interests of physicians in specialization with the country's need for doctors. However, a gap might be forming between the demand for certain specialties and what programs can offer. There is a need to conciliate both parties, which will require a more refined strategy than before. This should be grounded in robust knowledge based on program outcomes and evidence of the interests and motivations of health professionals. Interventions to retain doctors and other professionals in rural areas must balance organizational stability with flexibility to ensure the alignment of the incentives with national health policies and other challenges of the health workforce. Significant efforts are needed to implement evidence-based reforms of the program to effectively adapt its successful design to the changing needs of the country's population.

We suggest any country facing a poor distribution of health professionals between rural and urban areas should consider adapting its training systems to rural areas, in the interest of improving rural recruitment and retention. Although working conditions vary widely around the world, health professionals share common features: they are highly educated and eager to continue their professional development throughout their working lives. Providing the opportunities for them to do so in rural areas, as elsewhere, is crucial for retaining them in remote rural areas.

About NGO Association with the UN:

UN Partner on Millennium Development Goals (MDGs)
A Gateway to the UN System's Work on MDGs

UNIFEM – United Nations Development Fund for Women
Gender Issues

UNIFEM is one of a number of United Nations agencies charged with supporting countries in moving forward on the Millennium Development Goals (MDGs). The eight goals, adopted by the international community in 2000, set targets for 2015 on eradicating poverty, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV and AIDS and other diseases, ensuring environmental

sustainability, and providing financing for development. All eight MDGs touch essential aspects of women's well-being, and in turn, women's empowerment is critical for achieving the goals. UNIFEM has engaged in advancing the MDGs through three entry points:

Operational programs: In all regions and through all its thematic areas, UNIFEM programs contribute to the MDGs. UNIFEM pilots innovative strategies and strengthen the capacity of other UN programs to support women's advancement.

Monitoring and analysis: UNIFEM works with governments and non-governmental organizations to evaluate progress on the MDGs, including through the use of sex-disaggregated data and indicators that fully account for gender gaps. UNIFEM also contributed to the UN Millennium Project, commissioned by the UN Secretary-General to develop an action plan to achieve the MDGs, by preparing background papers and sharing proven strategies.

Advocacy: Through various partnerships, UNIFEM has worked to raise awareness and encourage participation in MDG activities, including the national and international advocacy efforts led by the UN Millennium Campaign.
New Aid Agenda: Making Aid Effectiveness Work for Gender Equality

Collaboration with World Health Organization (WHO):

Launch of WHO program on increasing access to health workers in remote and rural areas through improved retention

On 2 February, WHO launched a new program to increase access to health workers in remote and rural areas through improved retention. The program is an integral part of the organization's renewed efforts to strengthen health systems through a primary healthcare approach. More than 30 international experts on health workforce rural retention met in Geneva to map out a plan of action to develop evidence-based recommendations, for publication in spring 2010. The recommendations constitute one of three interdependent pillars upon which the new rural retention program will be based. The other two pillars are to gather and share evidence and to support countries in implementing effective health workforce retention strategies in rural and remote areas.

Opening the meeting, WHO Assistant Director General Carissa Etienne emphasized the importance of developing recommendations that will have a real effect at country level: "This is why, from the very beginning of the process, we are integrating a focus on the eventual implementation of recommended strategies, and to ensure maximum impact where it is needed most."
Details: http://www.who.int/hrh/migration/background_paper.pdf

Bulletin of the World Health Organization; Volume 88, Number 10, October 2010, 717-796 Table of contents

Collaboration with UN University (UNU):

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

The Great Transformation 1989-2029: Could It Have Been Better? Will It Be Better?

Over 1.8 billion people, from Central Europe to East Asia, have been involved in the great systemic transformation to market economy, civic society and democracy. The process has brought mixed fruits. The diversification of the current situation is a result of both the legacy from the past and the different strategies and policies executed in particular countries over subsequent

periods. These polices have been based on different assumptions and followed the advice of alternative schools of economic thought. Consequently, theoretical lessons as well as policy implications can be learned from this vast experience.

Answering the questions: *Could it have been better? Will it be better?* It must be said that yes, it obviously could have been better—to various extents in various countries, in various fields for particular individuals and social groups. It could have been better if the objectives had been more accurately defined and the systemic transformation had not been perceived as a self-contained aim but rather as an instrument to achieve a more superior goal—fast socioeconomic development to enable the country to make up for its historical lags. *Will it be better?* In the absolute sense, of course yes. In the next two decades of transformations, the level of production and consumption will double and in some cases even triple. In twenty years, will GDP per head in the new post-socialist member countries of the EU be around 50,000 $PPP? This is not very probable with regard to all the 100 million people residing in this part of Europe, but it is possible that certain countries and regions (more and more often, one needs to think in terms of regions, not countries), will able to achieve economic success. Where success will occur, it will mean more than the GDP that at present accrues to the residents in the fifteen 'old' countries of the European Union. Even though these fifteen EU member states will grow, increasing their production and consumption at least by one-third, the gap between the countries of eastern Europe and of western Europe will diminish, but in many cases those differences even in twenty years will be substantial, still causing social tensions and political problems.

The conclusions derived from the preceding years, should help to reduce the gap between potential possibility and actual reality for the next two decades, 2010-29. However, even in 2029, just as in 1989 and in 2009, there will be people who will answer the question, *When at last will it be better?* With the sarcastic retort: *It's been already…*

Publisher: UNU - WIDER Working Paper; Author: Grzegorz W. Kolodko; Sponsor: UNU-WIDER acknowledges the financial contribution to the conference by the Finnish Ministry for Foreign Affairs and the continued support to the research program by the governments of Denmark (Royal Ministry of Foreign Affairs), Finland (Ministry for Foreign Affairs), Sweden (Swedish International Development Cooperation Agency—Sida) and the United Kingdom (Department for International Development).

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page of WomensHealthSection.com)

International Fund for Agricultural Development (IFAD):

Chronic hunger and malnutrition almost always accompany extreme poverty, and 75% of the world's poorest people – almost 1 billion women, children and men – live in rural areas, depending on agricultural and related activities for their livelihoods. IFAD is an international financial institution and a specialized agency of the United Nations, dedicated to eradicating poverty in the rural areas of developing countries. IFAD mobilizes resources from its 165 member countries to provide low-interest loans and grants to middle- and lower-income members to finance poverty reduction programs and projects in the world's poorest communities. In 2007, IFAD adopted a debt sustainability framework based on a model developed by the International Development Association, to give grants instead of loans to countries with low debt sustainability. The framework is part of a unified effort by the world's largest multilateral financial institutions to ensure that essential financial assistance does not cause undue financial hardship for those countries most in need. Partnerships are fundamental to IFAD's work. From its inception, IFAD has worked in partnership with national governments and international organizations. It also has strong relationships with national partners, including farmers' organizations and NGOs. Its partners in the international development community include other UN agencies, international financial institutions, research institutions and the private sector.

IFAD is financed by voluntary contributions from governments, special contributions, loan repayments and investment income. Since 1978, it has invested more the $ 9.5 billion in 731 projects and programs that have reached more than 300 million poor rural people, and partners have contributed $ 16.1 billion in co-financing. At the end of 2006, it was financing 186 ongoing programs and projects worth $ 6.2 billion, of which IFAD had provided 2.9 billion and its partners about 3.3 billion. IFAD's Governing Council is made up of all 165 member states and meets annually. The Executive Board, which consists of 18 members and 18 alternates, oversees IFAD's operations and approves loans and grants. At the end of 2006, IFAD had 436 staff members.

President: Mr. Lennart Båge (Sweden); Headquarter: Rome, Italy

Constitution Of The World Health Organization:

(Continued)

CHAPTER VIII – COMMITTEES

Article 38
The Board shall establish such committees as the Health Assembly may direct and, on its own initiative or on the proposal of the Director-General, may establish any other committees considered desirable to serve any purpose within the competence of the Organization.

Article 39
The Board, from time to time and in any event annually, shall review the necessity for continuing each committee.

Article 40
The Board may provide for the creation of or the participation by the Organization in joint or mixed committees with other organizations and for the representation of the Organization in committees established by such other organizations.

To be continued……

Top Two-Articles Accessed in September 2010:

1. Health Literacy, e-Health and Sustainable Development;
   http://www.womenshealthsection.com/content/heal/heal017.php3
   WHEC Publications. Special thanks to WHO and UNESCO for the contributions.

2. Breast Cancer: Early Detection;
   http://www.womenshealthsection.com/content/gyno/gyno002.php3
   WHEC Publications. Special thanks to WHO, NIH and CDC for the contributions and editorial board for compiling the review.

From Editor's Desk:

New GA President opens 65th Session of the Assembly

The 65th Session of the UN General Assembly opened on 14 September 2010, with incoming President Joseph Deiss of Switzerland outlining the main priorities for the next year – including progress on the Millennium Development Goals (MDGs), reform of the United Nations and the promotion of environmentally sustainable development. In his opening statement , the new GA President stressed that the MDGs "are within our reach," despite the recent global economic crisis. "In particular, we must bridge the gaps in the fight against hunger, child mortality and

maternal health," he said. "This is possible. Our work in the coming week must result in a sincere commitment and a genuine plan of action to ensure that we reach the ambitious goal that the international community set for itself in 2000."

Mr. Deiss called for efforts to "reinstate" the UN and its 192-member General Assembly to the centre of global governance. "The challenges which we face today have acquired a global dimension and require global solutions. Our actions must have broad legitimacy and be the result of inclusive processes. We have to improve the mechanisms for information, consultation and cooperation between the United Nations and other actors and tools of global governance," Mr. Deiss said. He stressed that Assembly members must also ensure that there is decisive action towards the internal reform of the UN.

The 65th ordinary session of the General Assembly will feature several high-level events in the coming weeks, covering topics ranging from disarmament to biodiversity. Representatives of the United Nations Conference on Trade and Development (UNCTAD) and the Association of Southeast Asian Nations (ASEAN) also contributed their perspectives on how such efforts could reinforce South-South cooperation and benefit from deeper inter-regional collaboration.

Special Thanks:

To our friends and colleagues worldwide – without their support this initiative may not have succeeded.

Words *of* Wisdom:

Many, if God should make them kings,
Might not disgrace the throne He gave;
How few who could as well fulfill
The holier office of a slave.

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities