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REGIONAL COMMITTEE DOCUMENT

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON HEALTH OF THE UNDERPRIVILEGED

1. INTRODUCTION

Technical Discussions were held on "Health of the Underprivileged" on 20 September 1990 under the Chairmanship of Dr U Tin U, Director-General, Department of Health, Myanmar. Dr Widyastuti Wibisana, Chief, Directorate of Community Participation, Ministry of Health, Indonesia, was elected Rapporteur. The agenda and annotated agenda, as approved by the Regional Committee (SEA/RC43/5, and Add.1) and the working paper for the technical discussions (SEA/RC43/10) formed the basis for the discussions.

1.1 Opening remarks by the Chairman

The Chairman, in his opening remarks, pointed out that the subject of health of the underprivileged was crucial to the attainment of the goal of Health For All by the year 2000. While Member Countries in the South-East Asia Region had made significant progress towards attaining this goal, large segments of the population in many of the Member Countries remained underprivileged from the point of view of health. This situation was of particular significance to the least developed countries in this region whose population constituted almost 40 per cent of the population of such countries in the world. Human progress could have meaning only if the lowest percentile of the population, judged by whatever means considered appropriate, was enabled to attain a better quality of life and thus increase their own potential and contribute to further development of the nation. It was the duty of health administrators to see to what extent the health of the underprivileged population could be improved by appropriately redirecting the available resources. The Chairman further stated that during the discussions, the emphasis should be on identifying measures which could be meaningfully adopted by the health sector in each of the Member Countries so that within the next ten years there would be a marked improvement in the status of the underprivileged. He was glad that the call given by WHO for achieving the social goal of Health For All by the Year 2000 followed by the Alma-Ata declaration, had brought about an increasing consciousness in the world to redirect efforts towards amelioration of the poorer and other underprivileged sections of the population.

1.2 Remarks by Director, Health Systems Infrastructure

Dr Uton M. Rafei, Director, Health Systems Infrastructure, welcomed the participants and said that while efforts were being made to improve the economic and health status of all sections of people, adequate attention was not being paid to the health aspects of society as a whole. Health administrators who recognized the need to improve the health of the underprivileged should evolve a common understanding and devise approaches to cope with the problem. He called upon the Member Countries to provide critical inputs in this regard by way of organizing national consultations on the subject of health of the underprivileged.

1.3 Introductory Remarks by Health For All Officer

Introducing the subject, Mr C.R. Krishnamurthi, Health For All Officer, referred to the sweeping political changes occurring all over the world, epitomizing the triumph of the human spirit. In the years since the end of the Second World War, there had been an overemphasis on economic growth as a panacea for all ills. The underlying assumption was that if economic growth took place, the benefits would percolate to the non-rich and poorer sections of the society and that it would result in overall development. Experience had shown that this was indeed not true and that such equidistribution of benefits did not occur unless it was backed up by a strong political process. In all societies, there were always some sections who, due to various reasons, viz. social, cultural, educational and economical, had less opportunities to strive for a better life, leading to their inability to realize their full potential to contribute in any significant manner to the growth of the nation. Human development could not be said to have taken place unless such sections of the population were also enabled to improve their quality of life. Conscientious health administrators should help reduce the inequities in health.

Speaking on the subject of human development, he drew the attention of the group to the Human Development Report-1990, brought out by UNDP. According to this report, human development was a process of enlarging the choices of people, such as to live a long and healthy life, to be educated and to have access to resources needed for a decent standard of living. The choices could be broadened to include political freedom, human right, personal self-respect etc. The process of development should create a conducive environment for people individually and collectively to develop their full potential and to have a reasonable chance of living a productive and creative life in accordance with their needs and interests. In this context, he recalled the World Health Assembly resolution, adopted in 1977, on the social goal of Health For All by the Year 2000.

He stressed the need to develop a definition of the term "underprivileged" and to design and develop a methodology which could be applied to the underprivileged groups in order to assess their health status and needs. The incremental approach adopted by Member Countries to extend health services to cover large areas and greater sections of the population would involve consumption of considerable resources. Actions could definitely be taken within the health sector with slight changes in the resource allocation pattern to improve the health of the underprivileged. He underlined the importance of the health sector interacting with other sectors so that measures taken therein enhanced the efforts of the health sector. He further stated that actions had to be taken by Member Countries to ensure that the vast human potential was fully tapped to improve the economic, social, cultural and physical quality of life and to bring about greater measures of social happiness.

1.4 Brief Analysis Report on the Situation in Countries

Dr M.J. Wysocki, Regional Adviser, Health Statistics, gave a brief overview of the country papers on the subject of health of the underprivileged and pointed out the widely varying approaches used by them. Thereafter, he presented the methodology for the identification of the underprivileged. To implement that methodology, it was necessary to have clear objectives so that the later evaluation of the effectiveness of health programmes could

rest on the ability to demonstrate changes in the health status of the targeted population. Noting that the health status depended not only on the availability of health care and health education but also on other factors such as socioeconomic status, level of education, household variables etc., he elaborated on the need in particular for data collection and analysis. Remarking that national census and the routine data collected by the health system might be useful in a general manner, he added that these tended to suffer from weaknesses since they were not directed towards the identification of specific groups of society. Consequently, the possibility of conducting household surveys using questionnaires and interviews needed to be considered seriously. Concluding his presentation, he emphasized the need for accurate demographic data so that the survey results could be interpreted appropriately.

Detailed discussions were held, based on the annotated agenda. The participants agreed that the working paper contained valuable information and suggestions and that the discussions during the meeting should be considered in conjunction with the working paper, particularly in relation to any additions or modifications suggested.

2. THE NATURE AND EXTENT OF THE PROBLEM - USE OF INDICATORS AND MEASURES

The Technical Discussions group (TDG) agreed on the need to develop country-specific definition of underprivileged populations. The aim should be to eliminate subjectivity and to attempt quantification to the extent possible. This would necessitate learning new techniques. Indicators and measures should be developed by each country so as to enable comparisons between different sections of people within the same country.

The group recognized that isolated communities living on hills, mountains and distant islands as also displaced persons could be categorized as underprivileged, particularly since their access to heath facilities was poor. The process of urbanization and the factors which led people to migrate to urban areas had led not only to the creation of urban slums, but also to the preponderance of underprivileged populations in such areas.

There was a definite need for leadership development so as to understand in a comprehensive manner the problems of the underprivileged and to obtain political commitment to be able to devote enough resources and technical attention to improve their health. While doing this one had to remember the temporal and historical perspectives which had led to deprivation and socioeconomic backwardness. Thus the efforts should be to change from the existing value system to a new multidimensional value system which implied that action had to be taken not only in the health sector but on a multisectoral basis. Political will and multisectoral activities were crucial issues for health development. The interrelationshiop between health and health-related sectors and the role of health in overall socioeconomic development was emphasized. The group underlined the fact that effective action to improve the health status of the underprivileged population could not lie solely within the health sector. Any adequate strategies and approaches for health development must contain measures beyond health such as nutrition, education, water and sanitation etc. which had a direct impact on the health status.

In general, the group agreed that each country should develop its own clear definition of 'underprivileged' using a limited set of indicators and measures and use it not only for comparison between different areas and groups but also to target specific health measures for such segments of the population who were below certain set standards. The possibility of developing a simple health status index (HSI) needed to be explored. Such an index, if developed, could be refined and improved in due course.

The indicators selected should be such as to have an impact on the policy makers. Thus, for example, in addition to infant mortality rate, malnutrition, water and sanitation coverage, and the physical growth of pre-school children were considered as possible indicators to be used.

3. DEVELOPMENT OF METHODOLOGY TO IDENTIFY UNPERPRIVILEGED GROUPS AND ASSESS THEIR HEALTH STATUS

The group emphasized the need to develop a practical, yet simple, methodology using the technical expertise available within the countries and in WHO. There was vast experience using an epidemiological approach already available within the health system. This needed to be applied through collection and analysis of disaggregated data and comparisons between the districts and groups of populations etc. Thus, once a set of indicators had been chosen, based on the experience of the countries, attempts should be made to identify the underprivileged by (a) using the existing reporting system, (b) using any ongoing census or similar surveys conducted by other departments with appropriate inputs and, (c) developing and promoting rapid assessment techniques.

Sample survey methodologies using the questionnaire and interview techniques could be developed and used with advantage, particularly in areas where routine data were not easily available and where the collection of data otherwise became a costly proposition.

4. OBJECTIVES AND TARGETS

4.1 Objectives

The objectives the efforts to improve the health of the underprivileged would vary from country to country depending on the stage of development, and the extent of political commitment and availability of resources. The Group felt that the specific objectives suitably adapted could be as follows:

(1) To ensure political commitment of leaders at all levels to make special efforts to improve the health of the underprivileged.

(2) To improve the health status of the underprivileged to certain pre-set standards.

(3) To upgrade the literacy/educational level, especially among women in the underprivileged group.

(4) To generate socioeconomic development programmes, especially those which benefit the underprivileged through intersectoral actions.

4.2 Targets

The group identified the following targets mentioned:

(1) Reduction in the percentage of newborns with a birth-weight of less than 2 500 g;

(2) Pre-school and primary education to be available to at least 25 per cent of the identified sections of the underprivileged;

(3) Income generation programmes based on self-reliance with collaboration to be introduced to cover the adults, including women, in the identified population;

(4) Primary health care service elements to be available to at least 50 per cent of the identified population, and

(5) Adult literacy education programmes to reach at least 10 per cent of the identified groups.

The group felt that these targets should be modified to become country specific. In particular, it was also mentioned that the possibility of including secondary education along with pre-school and primary education should be explored. The percentages mentioned in the above targets were considered to be suggestive in character, and, therefore, would need modification for each country. Since difficulty in communication was considered to be a fairly widespread phenomenon among the countries of the Region and constituted a geographical hindrance, the question of gaining access to the population living in such difficult terrains and far-flung areas should be included as one of the specific targets for ensuring improved health coverage.

5. APPROACHES AND ACTIONS WITHIN THE HEALTH SECTOR

5.1 Approaches

The group recognized that decentralization, democratization and delegation of power to local authorities and decision makers were factors which facilitated attempts to overcome the health problems of the underprivileged. Some concern was expressed on the impediments caused by cultural and traditional beliefs and habits. There was, therefore, a need to incorporate some of the good aspects of such beliefs and habits in the process of health development. There was general agreement that approaches on community participation, self-reliance, motivation and development of local leadership were essential in overcoming constraints.

Improvement in the management of the health system, in particular at district and local levels, reorientation of health service activities, allocation of new resources and reallocation of existing ones had to be taken up seriously. Furthermore, functional integration of health

interventions were required to avoid duplication of efforts. The health sector had been able to train a large number of community health workers in most countries. The proper deployment of such community health workers, adequate supervision, better training and development of general training modules for health workers, were considered essential not only to improve the health status as a whole but also in any effort to reach the underprivileged population.

The group recognized the valuable role played by the nongovernmental organizations and voluntary agencies and private groups. In general, they had noble objectives, particularly to improve the health of the deprived population in rural and urban areas. There was, therefore, a vital need to have greater involvement and closer collaboration with nongovernmental organizations to enhance the efforts of the health system.

5.2 Actions

In regard to the actions which could be taken within the health sector, the group agreed with the following:

(1) A rapid appraisal to assess the health needs of the underprivileged. This can be done by a suitable modification of the methodology already available for a rapid appraisal to assess community needs. From the data gained by such a rapid appraisal, an information pyramid will have to be built. This rapid appraisal can be done in selected areas in about ten days.

(2) A sentinel surveillance of the underprivileged population and monitoring of their health status using a maximum of five selected indicators.

(3) Giving more attention to promotive and preventive activities, especially for the care of the underprivileged population.

(4) Adopting a holistic approach to the health of the population rather than focusing on individuals.

(5) Increasing awareness among decision-makers and planners in the health sector of the importance of living conditions and lifestyles of the underprivileged on their health status.

(6) Study of the relationship between poverty, malnutrition, education, and infectious and parasitic diseases on the general health of the underprivileged population.

(7) Earmarking of specific health resources for the underprivileged and developing well-defined programmes and activities in identified geographical areas giving special emphasis to water supply and sanitation programmes for the underprivileged population.

(8) Remodelling information and education for health towards the underprivileged. In this process, special attention to psychosocial behaviour and the use of habit-forming substances such as drugs, alcohol etc. needs to be provided.

(9) Undertaking surveys to determine noncommunicable disease problems of the underprivileged population.

(10) Taking steps to change the behaviour and attitude of health providers so as to give priority attention to the underprivileged from the time of planning through implementation up to the stage of monitoring and evaluation.

(11) Ensuring that decentralized planning and management with adequate community participation becomes a reality.

(12) Improving the potential in the realization of individuals, particularly of the underprivileged population, so that they can protect and promote their own health as well as the health of the community.

(13) Developing an outreach strategy through the health services and involving nongovernmental organizations and community organizations in the care of the underprivileged population.

While taking action, the following points need to be kept in mind:

(1) There was a need to recognize that work in rural areas was not always considered attractive and hence, if possible, an incentive system for health personnel should be introduced.

(2) Within the concept of primary health care, the technology applied in the rural areas should not be widely different and thus give a perception that better facilities were available in the urban areas.

(3) There was an urgent need to undertake health services research to determine the health problems of the underprivileged.

(4) There should be greater support to nongovernmental organizations to encourage them to develop innovative approaches for the health care of the underprivileged population.

(5) Suitable entry points, depending on the country situation, should be devised.

6. APPROACHES AND ACTIONS BEYOND THE HEALTH SECTOR

6.1 Approaches

The group recognized that the possibility of coordination among the sectors could be high at the implementation level and, therefore, this needed to be encouraged. However, this did not exclude the need for a coordinated approach to planning. It would be preferable to introduce a bottoms-up approach so that decision-making was based on the actual needs. Consequently, there was a need to improve the managerial skills and also the coordination ability of managers at the local level. Furthermore, in consonance with the ideas of decnetralization and democratization,

resources should be transferred so that they were applied at the local level in a most coordinated and useful manner. Reference was also made to the need for developing a healthy public policy at every level. This would require political will and commitment towards equity which could be enhanced by emphasizing HFA leadership development. The initiative should cover other sectors such as education, agriculture and industry.

6.2 Actions

In regard to actions, the group suggested the following:

(1) Undertaking studies to establish and portray the linkage between poverty and ill-health.

(2) Improving the availability of food to the underprivileged sections of the population.

(3) Supporting measures for improving the income of the underprivileged sections of the population.

(4) Studies to assess the impact of price policies on the health of the underprivileged and interceding with the concerned sectors to ensure that the consumption patterns do not become adverse.

(5) Working with the education sector to ensure adequate literacy and education for mothers and girls.

(6) Monitoring of environmental factors so that they do not adversely affect the underprivileged population.

(7) Giving greater attention to occupational health.

(8) Reviewing legislation, rules and regulations that can have an adverse effect on health.

The group also noted that the poverty alleviation programmes, food subsidies, price subsidies and direct financial aid directed towards the most vulnerable group might, if properly implemented, enable the upliftment of such groups.

The group also noted that environmental factors that were coming to the fore should be kept in mind so that maintenance of a clean environment is planned and managed with the close involvement of the local people. Industrialization had both positive and negative aspects. On the positive side, it provided increased incomes, goods and services but on the negative side it could create health hazards, accidents and disabilities and deaths. Therefore, action should be directed towards safety precautions and prevention of child labour etc.

7. CONCLUSIONS AND RECOMMENDATIONS

The group concluded that the time to launch efforts to improve the health of the underprivileged had come and that actions should be taken in each Member Country to ensure that the vast human potential was fully tapped to

improve the economic, social, cultural and physical quality of life and to bring about not only greater happiness but an improved standard of living.

The group, after carefully considering the recommendations contained in the working paper, held that these were very appropriate, and therefore, be considered favourably by Member Countries for implementation. In addition to formulating policies in close interaction with other sectors, it was felt that the health sector should also develop and initiate coordinated action to improve the health of the underprivileged.

The following recommendations were made:

(1) Member Countries should, in the context of the poverty line, attempt to develop an understanding of the term "underprivileged" in so far as it relates to the health sector. "Underprivileged" does not refer to individuals as such but to a congregation of individuals - be they families, communities, clusters, villages or other recognizable groups of population.

(2) Using nationally-accepted parameters, information should be gathered on the social and geographical distribution of the underprivileged, their health problems and the like. This requires improvement of the health information system and the establishment of linkages between health status and socioeconomic variables.

(3) Each Member Country should develop appropriate indicators for measuring inequities in health. The idea of developing a Health Status Index (HSI) should be explored.

(4) The ongoing efforts for HFA leadership development should be extended to cover the underprivileged population.

(5) The existing health policies and strategies should be reviewed to ascertain the extent to which they address the problem of health of the underprivileged. Health policy analysis and research should also be undertaken. This implies the need to avoid any potential conflict between short-term needs and long-term requirements and also to overcome resistance to change.

(6) Targets for improving the health of the underprivileged should be formulated. Such targets need not be uniform but can be tailored to the needs of identified underprivileged populations in the country. Equity-oriented health targets, the organizational structure, financial resources and manpower needs, should be vigorously reviewed.

(7) Health status data should be disaggregated to the extent necessary, since too much disaggregated quantitative data can cause information overload on decision-makers. On the other hand, overly aggregated data could obscure vital information from decision-makers. There is, therefore, a need for judicious presentation of information geared to the health of the underprivileged.

(8) Close interaction with other sectors must be established to stimulate and assist in formulating policies and initiating coordinated action in order to improve the health of the underprivileged. For this purpose, health policy elements in related sectors should be identified and assessed from the equity point of view.

(9) The possibility of introducing legislation to secure, the health rights of the population including the underprivileged, should be explored.

(10) The present methods of increasing health services coverage, while providing for greater access, do not necessarily cover the entire population. The reorientation of the health system infrastructure, stressing the matching of needs of the underprivileged, would seem a prerequisite for reducing existing inequities in health. Till such reorientation becomes effective, the health system should seek to educate the underprivileged population in the advantages of utilizing the available health services and take steps to encourage them to do so. An important element would be the linkage to district health system development. The ongoing efforts on the district health system need to be strengthened managerially with a view to achieving the basic level of health for all major groups of the population within the existing financial constraints.

(11) Risk-oriented approach has been applied successfully to improve the health of population at risk such as mothers and children, workers in hazardous occupations, etc. The experiences gained in such a risk-oriented approach can be applied to identified underprivileged segments of the population.

(12) Noting that WHO had led the call for improving the health of the most deprived sections of the population, the group further urged that WHO should continue to play a supporting, collaborating and crusading role. In particular, it recommended that WHO should extend support to Member Countries in developing appropriate methodologies, including research/studies, for the identification of the underprivileged and in providing both technical and financial support for initiating catalytic programmes for improving the health of the underprivileged.