Statement by Dr. Nafis Sadik
Special Envoy of the Secretary-General
for HIV/AIDS in Asia and the Pacific

at the

Plenary Session - Reforms in Democratic Governance
and
Policy Decision Making

of the

18th World Conference on Health Promotion
and Health Education

Valuing Diversity, Reshaping Power: Exploring
Pathways for Health and Well-being

Melbourne, Australia
28 April 2004

Key question -- What is a vision for pro-health governance that recognises and respects diversity? What are the pathways forward?

Diversity and Effective Global Health Governance

Thank you for inviting me to be part of your discussion. I would like to contribute a few brief points on governance and health from an international standpoint.

- First, I think we should recognise that ***globalisation is social*** as much as economic; health care, education and gender issues are the human face of globalisation.
- Second, effective health care calls for an ***integrated approach***, across issues, and from international to national levels; support for local civil society at the same time as support for international organisations and government efforts.
- Third, the ***gender perspective*** is absolutely vital. I should not need to say this; but despite all the good rhetoric, in practice, the health concerns of the female half of the world still take second place.
- Finally, a ***global*** approach does not mean a ***uniform*** approach. Countries and the international community alike must be pragmatic, suiting the approach to the circumstances: in health care as elsewhere, ideology is the death of diversity.

Globalisation's Human Face

In the world of public health, "protecting diversity" usually means "protecting minorities"; but in the case of global health governance, we are all minorities in one way or another, so we need a rather different perspective. Public health workers protect the health interests of the whole community: and we represent and promote the interests of less privileged groups as part of that responsibility. In international terms, that means the great majority of the people in Asia, Africa and Latin America. It includes confronting global threats such as HIV/AIDS as well as addressing specific concerns, such as high rates of maternal mortality in the poorest countries and communities.

An effective approach calls for close attention to experience on the ground, from which some general principles can be derived. This is not a revolutionary thought; it is simply the scientific approach applied to conditions in developing countries. Just as with economic globalisation, health professionals in the developing world should beware of solutions imported wholesale from industrial countries: what works in one context may not work in another. At the same time, specific experience can be a useful guide: for example, developing countries today are moving towards making emergency obstetric care available to all pregnant women, rather than for high-risk pregnancies alone. They are

relying on experience in the US and Europe to suggest a solution which has eluded them until now.

Public health workers are advocates for the poor: and we should remember that poverty is relative as well as absolute. Rapid economic growth may actually widen gaps between rich and poor: it may exclude specific groups, driving them even further into poverty. Inequality can be as pernicious as absolute poverty.

Poor people are much more likely to fall ill from infectious and environmental diseases; and they are much more likely to use public-sector health care than the more affluent. Adequate and accessible public-sector health care is of paramount importance in the era of the global pandemic, of global urbanisation, and of global lifestyles. Today you can find Marlboros and Macdonald's from the high Andes to the Mekong delta—and you can see their effect on lungs and waistlines from Santiago to Ho Chi Minh City.

The poor, and especially poor women, are also exposed to a series of health risks that are only a folk memory for the more affluent. The most obvious of these are pregnancy-related mortality and morbidity, but malaria, typhus, TB, cholera and typhoid are all major threats to poor people's health.

HIV/AIDS disproportionately affects the poor. Women especially are ill-equipped to protect themselves from infection, and once infected, the poor cannot afford treatment. A series of health-related conditions which are not diseases also take their toll among the poor, among them unwanted pregnancy, unsafe abortion and obstetric fistula.

Poor health is the risk most feared by the poor themselves, and better health – including reproductive health – is the first requirement for helping the poor surmount their poverty.

An integrated approach

Global risks call for global responses – not just in the case of HIV/AIDS and the more obvious threats to health, but for traditional diseases of poverty, and the traditionally-ignored, including a range of concerns affecting women's health.

The international community has been slow to respond to the clear need for a global response to social issues. Governments, international organisations and aid agencies have worked for two generations to promote development; yet for most people in industrial countries, and even for some donor governments, health and education in developing countries are still in a category marked "charity", much as the Victorians used to collect small change for the poor on Sunday. We must move beyond this limited and parochial view.

An ***effective*** response to the health crisis in the poorer parts of the world will be an ***integrated*** response. It includes long-term, systemic co-operation by the international community with governments and civil society in developing countries. The purpose would be to remove the obstacles that prevent poor people participating in economic and social life, and to promote governance and policymaking for and by the poor. Such an approach recognises that health care, education and women's empowerment are aspects of a package that promotes inclusion and counters poverty in the long term.

We have done development piecemeal for two generations: it is time for a systemic, integrated approach. This sounds very ambitious, but it is the only practical way to approach development, including health care. Steps taken in the last decade foreshadow integration across issues and across borders—for example, the international consensus on population and development, which marks its tenth anniversary this year, and is having a profound effect on reproductive health in developing countries. The Millennium Development Goals adopted in 2000 assume such an approach to ending poverty. The top-line goals include cutting maternal mortality and morbidity by 75 per cent, and reducing the incidence of HIV/AIDS, malaria and other infectious diseases.

Governance requirements

I believe we must also integrate the mechanisms for transferring resources: rather than more international agencies and funds to combat HIV/AIDS, for example, the international community needs to agree on one mechanism, one channel, one set of reporting requirements. Donors should be able to commit to a steady, predictable flow of resources. This single step would remove a large burden from developing countries and guarantee more effective use of resources.

The international community is promoting a sector-wide approach to health care in developing countries: but, without a parallel movement on the part of donors, developing countries will still find themselves responsible for reporting on a wide variety of health care initiatives to a number of different donors. In this atmosphere, a sector-wide approach is just another burden. Removing these disparate obligations would increase countries' capacity to deliver health care, and would encourage them to focus on building their capacity still further. It would also have the effect of making externally-funded programmes an integral part of national health systems.

The system at the moment is too fragmented for such an ambitious step as overall integration; but that should be the aim, and co-ordination should be the means. The United Nations system offers a mechanism, involving donors, government and civil society, which is already in place in most countries. Governments welcome the inclusion of the United Nations as an honest broker.

For its part, the donor community should commit to a stronger, more effective United Nations system, and provide the necessary resources for it to work effectively.

Gender

Although women are a majority in most countries, they have a claim to be treated as a minority in nearly all countries. Discrimination against women starts even before birth: it is distressing to learn that sex-selective abortion is still widening the gap against women in many Asian countries, including India and China. Girls are still less likely to go to school than boys and they are much less likely to stay in school: for example, nearly half India's women are illiterate compared with only a quarter of men. Women are still subject to violence in the home, ill-treatment in the workplace and harassment in the street; and women in many parts of the world are still controlled as if they were children.

Discrimination extends to health care: pregnancy and childbirth are the biggest contributors to the burden of ill-health among women of reproductive age in developing countries; and family planning is available to less than half of the developing world's women, if China is excluded. Sex-selective abortion, high maternal mortality rates, low literacy, sexual harassment and coercion in family planning are all manifestations of lack of respect for women. Women are entitled not only to nominal equality, but to respect.

Conclusion – Human Rights

I believe that these practical approaches to health care embody the spirit of diversity. We know from experience that support for local values and cultures is a condition for successful social development. A commitment to human rights is perfectly compatible with a vibrant culture, because they share the same core value; respect for human life—and the same purpose: promoting the interests of the individual human being. All societies find themselves challenged by the impact of globalisation: it is the mark of a living culture that it can adapt to the pressures, and use them to stimulate positive growth. That said, there are some fragile cultures that deserve respect and protection as unique survivals. I hope respect for diversity can accommodate them too.

Over the last sixty years, the international community has carefully worked out a set of benchmarks for discussion and action, under the rubric of human rights. Human rights offers a framework which can accommodate national aspirations and cultural diversity, and a set of standards against which to measure practice and outcomes.

Finally, I would like to say that none of these proposals can succeed without firm and principled leadership. Political and community leaders, as much

as leaders in the health field, must give priority to health care, to protecting and promoting diversity, to gender equality, and to human rights. Sometimes exercising leadership will involve hard choices and difficult decisions. But good decisions now will earn the thanks of generations still to come.