Global Health Equity Foundation

research · advocacy · capacity building

Winter 2009

Dear Friend,

The greatest gains in overall health have been achieved by developed nations, with no concomitant gains in developing or under-developed countries. Despite the ambition of the United Nations and its establishment of the Millennium Development Goals, it is unlikely that we will see equitable gains in health outcomes across all countries by 2015.

"Global community" means every person on earth, and we ask that you consider your role as a member of the global community. In order to fulfill our potential for establishing equity, we must first accept that the state of global health affects all people and all states.

Gaps in health equity are commonly found in underserved and disadvantaged populations around the globe, whether those populations are defined by ethnicity, geopolitics, culture, environment, or displacement. This uneven distribution includes medicine, public health policy, humanitarian aid, education, shelter, and infrastructure.

With so many of us working towards improving global health outcomes, why will we fail to meet the Millennium Development Goals by 2015? To grapple with this question, we must identify our global strengths, such as advancements in technology, and we must not ignore our weaknesses, such as the failure to adapt technologies to serve the needs of diverse populations. Conventional channels of distribution are not working well for disadvantaged populations.

The concentration of knowledge in the minds of a relative few rather than the whole of the global population is an historical trend that must be changed. As specialists, scholars, leaders, and practitioners, we are responsible for applying and disseminating our knowledge. This is key to transforming underserved and disadvantage communities into contemporary civil societies, the precursor to developed states.

Traditional leadership, in the form of a hierarchical, top-down model, is increasingly inadequate to deal with the complexities of inequities across countries and cultures. Global Health Equity Foundation facilitates the distribution of leadership in the same way an organization may distribute healthcare and supplies.

Promoting a collaborative and distributive form of leadership is essential to capturing the expertise and skills of the global health community.

Successful interaction with organizations and individuals rests on our ability to think beyond conventional expectations, and beyond the comfort of our specialty. By engaging in open leadership we create an opportunity for transcending the boundaries of interest, of specialty, and of geography.

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Social responsibility is no longer the province of philanthropists and non-governmental organizations alone. It is integrated into the core structure of any organization. The matrix of for-profit organizations can and often does accommodate advocacy; and for-profit companies provide support for philanthropic organizations that can extend the reach and effectiveness of their humanitarian activities.

Balancing visionary goals with practical strategies will always be just that—a balancing act. The act improves with coaching and with time. Let's join together to refine and redefine our balancing act.

Tayeb Al-Hafez, MD, FACP

Founder and President

How to alter our outdated attitudes and plans?

Change how we achieve our collective goal of improving global health without fear or prejudice, and follow through on that choice.

In order to fulfill our potential for creating true change, we must first accept that the state of global health affects all people and all countries. "Global community" means every person on earth, and we ask that you consider your role as member of the global community today.

What are health inequities?
In terms of global health, disparities between developing nations and developed nations are increasing. These inequities are a direct result of inadequate distribution of both aid and knowledge.

Gaps in health equity are commonly found in underserved and disadvantaged populations around the globe. In fact, the descriptors "underserved" and "disadvantaged" speak directly to the disproportionate allocation of resources among different populations, whether they are defined by ethnicity, geopolitics, culture, environment, or displacement. This uneven distribution includes medicine, public health policy, humanitarian aid, education, shelter, and infrastructure.

This is not merely an accumulation over time of inadequate access to resources. Such conditions are a consequence of entrenched attitudes towards helping disadvantaged populations. These attitudes determine how health organizations are formed and how they provide help for these groups.

The greater the distance between a disadvantaged population and its nearest civil society, the greater the risk of despair for those populations. For the past three years, I have traveled around the world searching for both the root causes of our global challenge and for promising solutions. This search was both a personal and professional quest. I brought to it my history as a doctor practicing medicine in rural communities as well as my experience as an immigrant to the United States. In many different countries, on several continents, I witnessed the noble intentions of a variety of health organizations, government agencies, non-governmental organizations, and independent actors. I met with global health leaders, advocates, scholars, and practitioners who represent virtuous causes and high scholarship. I explored the expansive terrain of global health policies, initiatives, grassroots efforts and the politics inherent in globally coordinated programs. But I also witnessed the discontinuity built into the very fabric of our global and national efforts.

With so many of us working towards improving global health outcomes, why will we fail to meet the Millennium Development Goals by 2015? To grapple with this question, we must identify our global strengths, such as our advancement in technology, and we must not ignore our weaknesses, such as the failure to adapt

technologies to serve the needs of diverse populations. Conventional channels of distribution are not working well for disadvantaged populations. Methods, governance, teaching and volunteerism must adapt to a new model. There are three key determinants of success that have been frequently overlooked:

- People
- Time
- Global Knowledge Sharing

People

For many of us, whether as an individual or as a member of an organization, the idea that responsibility for improving global health outcomes lies with every member of the global community is a radical notion. The key to closing the gaps in health equity starts with people. Since everyone shares the same responsibility, there is no hierarchy of responsibility to guide us in choosing our role, whether we act as a member of a group or as an individual. Each individual must develop and accept a sense of responsibility. When we accept that this is our first step, the possibilities for adaptive change are boundless.

Time

Gaps in health equity take time to evolve. Closing gaps in health equity require foresight and commitment. The systemic nature of both problem and solution requires that our actions take hold over time, and effect lasting change. Too often, work done for an underserved population does not trigger a structural change in the existing conditions. Time is a resource and a condition for collecting, analyzing, and understanding data. The passage of time allows for transformation and helps foster relationships among the individuals and organizations that are working to build trust between them and the disadvantaged communities they serve.

Global Knowledge Sharing

Gaps within the established systems of knowledge that international and national organizations rely upon deserve our dedicated attention. These systems are integral to how many organizations function, yet they can stand in the way of effective and efficient support of underserved and disadvantaged communities. The concentration of knowledge in the minds of a relative few compared with the whole of the global population is an historical trend that must be changed. As specialists, scholars, leaders, and practitioners, we are responsible for applying and disseminating our knowledge. This is key to transforming underserved and disadvantage communities into contemporary civil societies, the precursor to a developed nation.

In order to be successful in achieving global health equity, we hold these concepts to be fundamental:

- Leadership
- Responsibility
- Knowledge
- Resources

- Innovation
- Leadership

Leadership

Traditional leadership, in the form of a hierarchical, top-down model, is increasingly inadequate to deal with the complexities of inequities across countries, communities, and cultures. Global Health Equity Foundation facilitates the distribution of leadership in the same way an organization may distribute health aid and supplies. Promoting a collaborative and distributive form of leadership is essential to capturing the expertise and skills of the global health community. Successful leadership begins with the personal, then evolves into collaborative leadership as empowered individuals come together to share their experience and contribute their skills for the betterment of others. This open, distributed leadership model relies on contributions of many individuals from diverse backgrounds and areas of expertise.

Responsibility

The right to health is implicit in the vision of achieving global health equity. To understand the significance of global health equity is to acknowledge the importance of empowerment and the ability to make change. Communities everywhere are unique and often have the natural ability to be their own leaders and to address their specific challenges with their unique perspective. Our institutions are well-equipped to provide new personnel, such as scholars, students, managers, and directors. We can fulfill our responsibility to those populations that are underserved and disadvantaged. Global health governance is a prime example of nations uplifting their neighbors to the level of civil society that fosters health equity. It is clear that health equity is achieved when all members of a community, and across communities, collaborate and cooperate with one another to make change. By taking responsibility for affecting health outcomes in a constructive way, we can assure that local health leaders are also local actors. Members of the community who live and work there will possess and share the necessary knowledge.

Knowledge

An individual's and community's knowledge is the key to their empowerment. The empowerment of communities arises, not simply from an outsider's generous gift of time, aid, and information. Knowledge is a life-sustaining resource that must emerge from experience. It develops over time as a result of residing in a community, understanding local customs, engaging in local culture. Part of our collective responsibility is to enable the practice of knowledge building within the local context where barriers to health equity are first raised.

Resources

Health inequities are at once global in their pattern and local for their place, people, and history. Just as knowledge must be distributed to balance the global health equity equation, so must natural and manmade resources be distributed. The macrocosm of global climate change is reflected in the micro levels of geopolitical climates, where

poor policy decisions and civil strife directly influence factors that promote inequities in global and communal health. As natural disasters affect larger populations than ever before, we are reminded how much more there is to be done to address not only the immediate physical needs of a displaced population, but also their mental and emotional needs. Displacement is a complex condition that affects large swaths of populations in every country of the world, in all spheres of citizenry and in migratory populations.

Innovation

Successful interaction with organizations and individuals rests on our ability to think beyond conventional expectations and beyond the comfort of our specialty. By engaging in open leadership, we create an opportunity for transcending the boundaries of interest, specialty, and geography. When we think freely, beyond our respective field of training and our cultural constraints, we open ourselves to possibility. Knowledge as a practice of discovery, concentration, and dissemination is inherent in the integration of research, advocacy, and capacity building. Integration enables groups and individuals to innovate through specific, contextual problem-solving.

For too long we have overlooked opportunities to find real solutions to the problems resulting from health inequities. Global health equity is the solution to resolving the disparity between the rise of health outcomes for developing nations and the stagnation of health outcomes for underdeveloped nations.

— **Tayeb Alhafez**, MD, Founder & President of Global Health Equity Foundation, a 501(c)(3) organizatio