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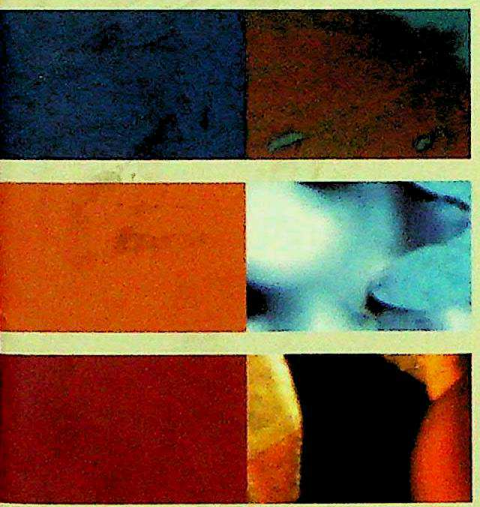
WHO/CSI/2002/WP6

REVIEW REPORT

WHO's interactions with Civil Society and Nongovernmental Organizations



CIVIL SOCIETY INITIATIVE

External Relations and Governing Bodies

World Health Organization

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The review process

Origins and purpose of the review

Governments and international institutions are having to take notice of an awakened and energised civil society mobilizing for greater inclusion in both local and global development processes. Reaching public health goals today requires the cooperation of a wide array of actors forming multiple partnerships and alliances. While national governments have the primary role in assuring the health of their citizens, the formulation and implementation of health policies and programmes are increasingly involving a wide range of civil society actors.

As the world's leading public health agency, the World Health Organization (WHO) works with 192 Member States in seeking new ways of strengthening these alliances. In recognition of the growing importance of civil society, Dr Gro Harlem Brundtland, Director-General of WHO, established the Civil Society Initiative (CSI) in 2001, to:

"Establish a programme of evidence collection, consultation with a broad range of actors and analysis – within and outside WHO – to identify and develop propositions for more effective and useful interfaces and relationships between civil society and the WHO. This work will be developed within the context of WHO's mandate, the expressed interests of the Executive Board and the World Health Assembly, and in response to interest shown by groups from civil society. (Civil society here includes social movements, voluntary organizations, nongovernmental organizations, grassroot organizations and other non-state and not-for-profit actors.) It is anticipated that within a year this initiative will be followed by concerted action at country, regional and Geneva levels."

Dr Gro Harlem Brundtland,
Message from Director-General,
11 May 2001

As part of its mandate to submit concrete proposals within a year, CSI conducted a review of WHO's current policy and practice regarding civil society and nongovernmental organizations (NGOs). This report contains the key findings of the review and will serve to renew WHO's policy on interactions with civil society. Key aspects of this review should also form the basis of a draft resolution for consideration by the Executive Board and possible forwarding to the 56th World Health Assembly in May 2003.

Methodology

The review process was carried out through a *desk review of documents* and a process of *consultations* during the period July 2001 – July 2002. Detailed results of the review are documented in CSI Working Documents.

CSI Working Documents include:

WHO's Interactions with Civil Society Organizations, Short Historical Background (CSI/2001/WP1)

Summary of Interviews with Executive Directors and selected Directors (CSI/2001/WP2)

Informal Consultation document (CSI/2001/WP3)

Strategic Alliances for Health: The role of civil society in achieving health goals. (CSI/2001/DP1)

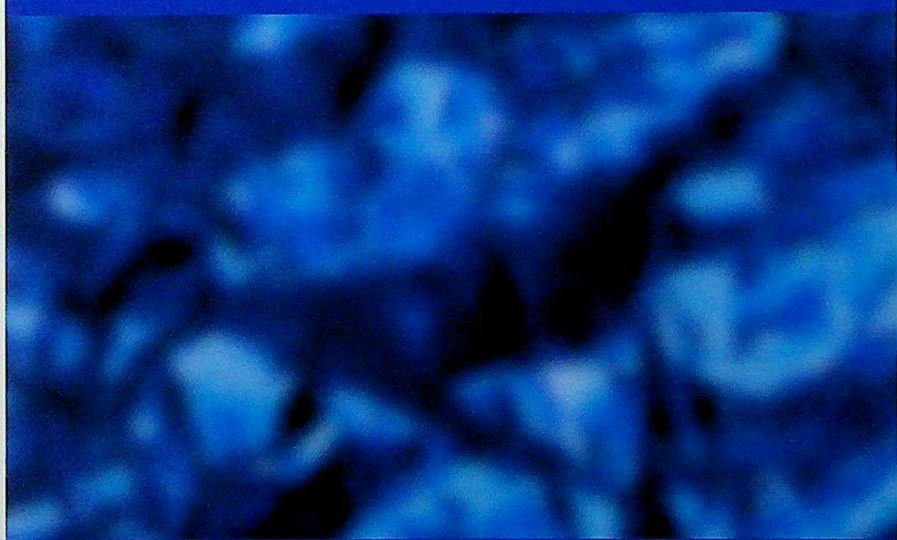
Inventory of WHO/HQ Relations with Civil Society Organizations (CSI/2002/WP1)

Summary of consultations with Civil Society Organizations (CSI/2002/WP2)

Analysis: NGO Participation in WHO Governing Bodies, 1998 to 2002 (CSI/2002/WP3)

A Study of the WHO Official Relation system with Non Governmental Organizations. June 2002 (CSI/2002/WP4)

Report of WHO Inter-Regional Meeting on Civil Society Involvement in Health and in the work of WHO (CSI/2002/WP5)



Desk Review

In order to explore current thinking, trends and challenges about the role of civil society organizations in health and their relations with WHO, the review drew on current literature, publications and WHO documents. The following analyses were made:

- Historic background of WHO's work with NGOs.
- Inventory of WHO/HQ department's collaboration with NGOs in 2001.
- Desk review of WHO Regional offices' relations with NGOs.
- Overview of policies and practices regarding NGOs and CSOs among UN and development partners.
- Legal assessment of the current principles governing WHO relations with NGOs.
- Analysis of NGO participation in WHO governing body meetings 1998-2002.
- Conceptual papers on what constitutes civil society and the role of civil society in achieving health goals.

Consultations

The above analyses were complemented and enriched by consultations that included:

- WHO staff at HQ, including Executive Directors, Directors, and focal points for NGOs.
- Staff of WHO regional and country offices including Regional Directors, and selected WHO representatives.
- Representatives of NGOS/CSOs through organized meetings and E-mail consultations.
- Staff of UN systems agencies, the World Bank ,EU, bilateral organizations and the UN Non Governmental Liaison Service (NGLS).

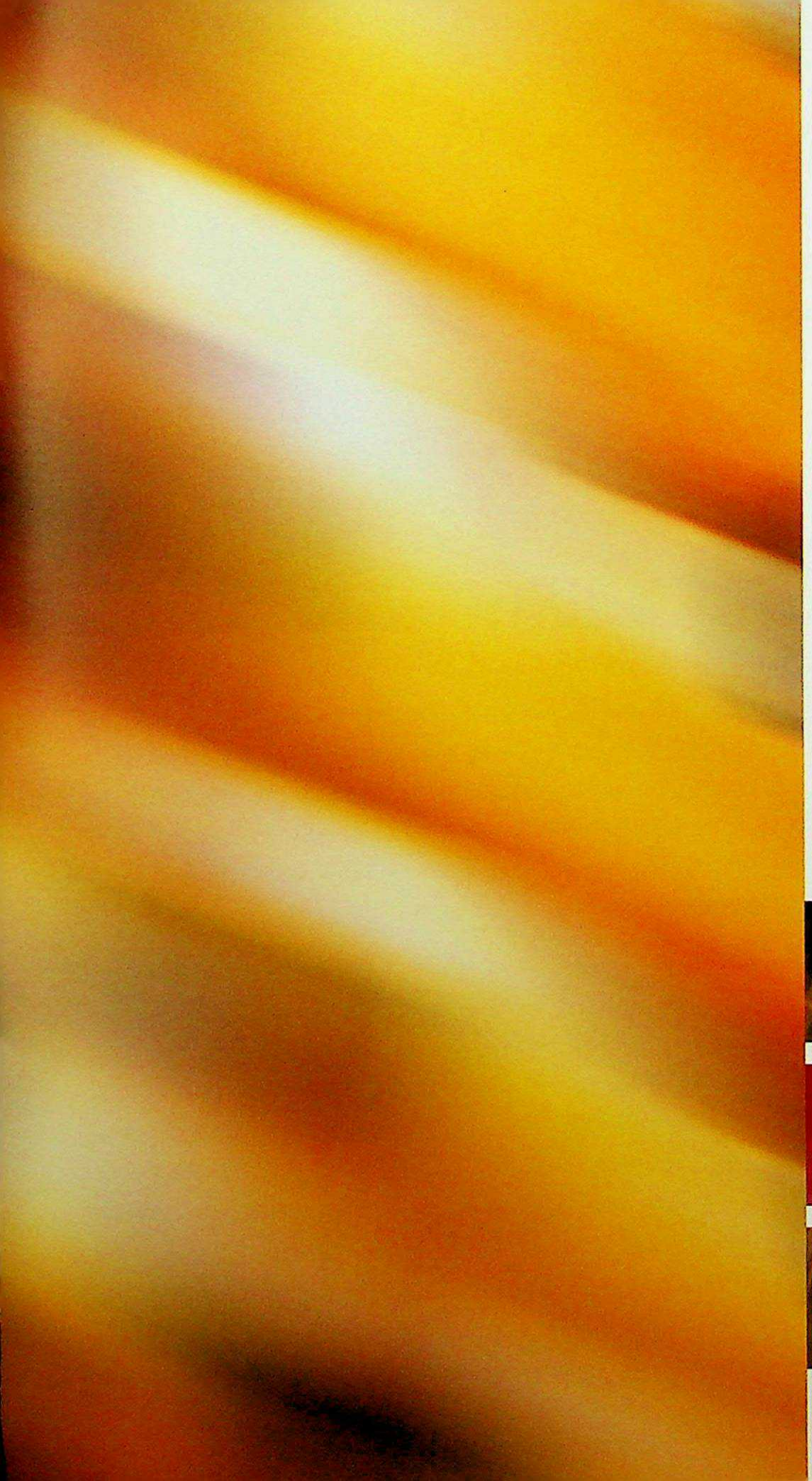
An "Informal Consultation document" was developed by CSI and used as a base for most of the above consultations.

Understanding the terminology

There is great variation between Member States and within the family of United Nations regarding the precise definition of the terms nongovernmental and civil society organizations (CSOs). Many use the term NGOs synonymously with CSOs.

Civil society is seen as a social sphere separate from both the state and market. The increasingly accepted understanding of the term "civil society organizations" is that of *non-state, not-for-profit, voluntary organizations* formed by people within the social sphere of civil society. These organizations draw from community, neighbourhood, work, social and other connections. CSOs have become an increasingly common channel through which people seek to exercise citizenship and contribute to social and economic change. They cover a variety of organizational interests and forms, ranging from formal organizations registered with authorities to informal social movements coming together around a common cause.

The term NGO is also commonly used to describe non-state, not-for-profit, voluntary organizations. However, they usually have a formal structure, offer services to people other than their members and are, in most cases, registered with national authorities.



In practice, however, state involvement in the funding and establishment of CSOs/NGOs may blur the borders between state and non-state. The borderline between market and non-market may also be blurred by organizations that are non-profit but closely related to commercial enterprises. (WHO defines commercial enterprises as the for-profit part of the private sector, EB 107/20, annex). These include associations that are non-profit in nature but which represent business or commercial interests.

Reflecting the common usage of the time, the 1947 WHO Constitution refers to the word NGOs, a term that was used by subsequent World Health Assembly resolutions in setting up the current system of official relations. This review report, therefore, uses the word NGOs when referring to the official relations system. When referring to interaction with civil society in general, the wider term CSOs will be used.

International developments: civil society organizations in health

Trends and challenges at global level

In recent years there has been a dramatic growth of civil society actors and an increase in their political influence in all areas of health, development and human rights. This development has been triggered by sweeping political, economic and social changes that have had a profound influence on the role of the nation state, bringing national and international health agendas closer together.

In addition, increasing concern about the perceived weakening of the nation states' authority vis-à-vis transnational corporations has led to an increased involvement of civil society in public policy debates on globalization, trade, development co-operation and health. Organized into national and global networks and supported by expanded access to information, CSOs have become more prominent as demand has grown for improved public accountability and responsiveness to citizen inputs at local, national and global levels. This has had an impact on public health as well, widening the range of interests that WHO has to interact with in its mandate to improve global health.

At UN level

ECOSOC revised its policy on NGO/CSO relations in 1996 and called on the United Nations system to do the same.[1] In July 1998, a report to the Security Council by the Secretary General *(Renewing The United Nations: A Programme For Reform)* stressed the need to reach out to civil society. The Millennium Summit Declaration in September 2000 similarly reflected the need for the UN to work in different types of partnerships with civil society.

[1] The Resolution 1996/31 of the 49th Plenary meeting "Consultative relationship between the United Nations and non-governmental organizations" outlines the proposed changes.

This has lead to a general UN review of existing policies and strategies. New and improved forms of communication and collaboration are being introduced by many UN agencies. A number of UN entities have modified their accreditation system for attendance of CSOs to their governing bodies, "upgraded" and expanded headquarters units dealing with civil society issues and designated liaison officers at departmental level. Mechanisms are being established at senior management level for involvement of CSOs, with and without official status, in policy-making via "NGO Liaison Committees" and "Civil Society Advisory Committees". One agency, UNAIDS, has also included representation of CSOs within its governing body.

At national level

CSOs have become critical in the health domain at the national level. They contribute resources and skills to the provision of services, particularly in reaching poor and disadvantaged populations and in strengthening primary health care and community-based health care. In many places, CSOs also assume a watchdog role in the protection of public health interests. Their commitment, experience and mobilizing capacity provides governments and WHO with unique options that may not otherwise be available.

Developments and processes at national level are becoming increasingly complex. The implementation of development aid programmes are increasingly being channelled through CSOs. Global health initiatives and national development processes, such as poverty reduction strategies, are involving CSOs as major actors at country level. The contracting out of health services to these organizations is being debated in many places. These processes are challenging governments to strengthen their own role at the same time that they are under pressure to open up to new actors in health. In some cases the situation has increased tensions between governments and CSOs regarding the handling of external funds to the health sector. Member States are increasingly looking to WHO for guidance and support in handling these issues and interactions.

At development partners level

Among bilateral donors and regional development partners the emphasis on enhancing relations with CSOs is perhaps even stronger. Work with them is closely linked to the aim of poverty reduction and forms a dominant feature in many development cooperation programmes. Review analysis reveals that among WHO's most common donors an average of one-third of development aid is channelled through international CSOs.

All the donors studied have specific funding instruments for which northern CSOs can apply, some also fund southern organizations directly. Through northern and/or international CSOs, some donors are focusing more on building the capacity of national, southern CSOs to enable them to participate in and influence national policy formulation, programme development and implementation.

Most donors studied, however, see CSO support as a separate area in their programmes and not necessarily as part of an integrated CSO–health sector approach. This provides WHO with an opportunity to help integrate CSO support into health programmes as part of its general support to Member States.

WHO-NGO relations

Brief history

Interaction, consultation and co-operation with NGOs[2] is clearly encouraged by the WHO Constitution. In 1948, the first World Health Assembly (WHA) adopted a set of working principles governing admission of NGOs into Official Relations. These were amended and expanded by later WHAs[3], with the current *Principles governing relations between the World Health Organization and nongovernmental organizations* having been in place since 1987[4].

Collaboration with NGOs is a standing agenda item at both the Executive Board and WHA. It was the theme of Technical Discussions in 1985, and highlighted in the 1997 and 1998 Executive Board discussions and the consultations on the revised Health for All process in 1997[5]. WHO resolutions have called on NGOs and national governments to work in partnership with each other and WHO. The governing bodies of WHO have shown long-standing support and encouragement for strengthened WHO relations with NGOs.

WHO has also made a special commitment in the new *Corporate Strategy* approved by Governing Bodies in 2000.[6] It envisions broadening the scope of WHO's partnerships within new areas of work such as human rights and poverty reduction and to new actors spanning both the private sector and civil society.

[2] The word "NGOs" in this section refers to original usage found in the WHO Constitution and WHA resolutions.

[3] WHAs WHA 1.130, WHA3.113, WHA11.14 and WHA 21.28. The last amendment was made at the 1987 WHA (WHA 40.25).

[4] Principles Governing Relations between the World Health Organization and Nongovernmental Organizations, WHO, Basic Documents Geneva 2001.

[5] See in particular EB61.R38; EB79/1987/REC/1,Part1; A38/Technical Discussion/1; A51/5.

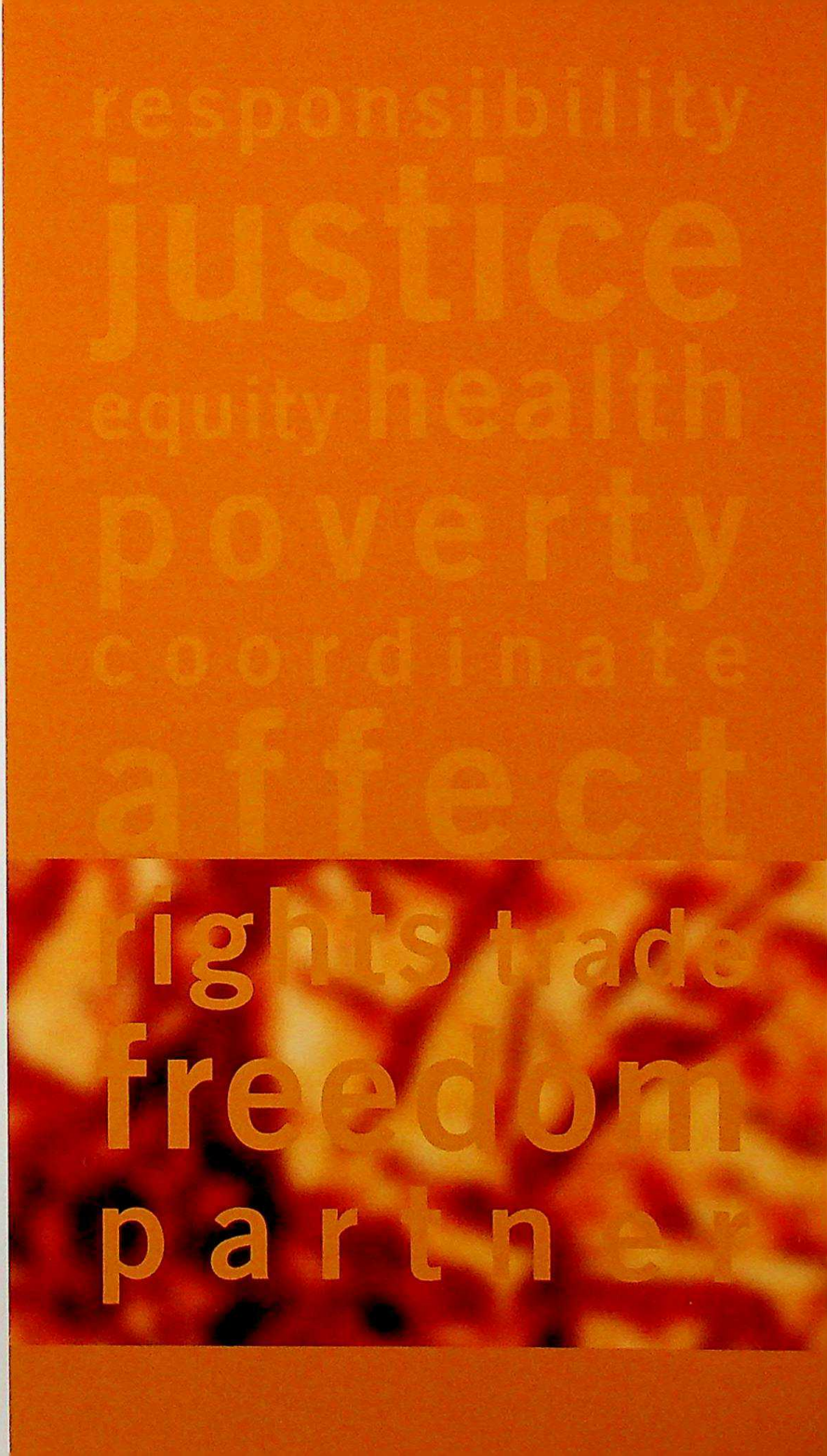
[6] WHO "A corporate strategy for the WHO secretariat". Report by the Director General to the Executive Board 105th session. EB105/3.

To deal with potential conflict of interest in relations with the private sector, *Guidelines for interaction with commercial enterprises to achieve health outcomes* have been developed by the Organization. These guidelines are directed in particular to commercial enterprises but "can also apply to a variety of other institutions including State run enterprises, associations representing commercial enterprises, foundations... and other not-for-profit organizations..."[7] These guidelines, therefore, have a hitherto untapped potential in guiding WHO interactions with NGOs linked to private (for-profit) sector interests as well.

Current WHO-NGO interactions

The 1987 *Principles* constitute the current legal basis for all aspects of the relations between WHO and NGOs. They declare WHO's objectives in working with NGOs to be the promotion of its policies, strategies and programmes, collaboration in the implementation of these, and the co-ordination or harmonization of intersectoral interests among the various sectoral bodies concerned in a country, regional or global setting. They define WHO interactions with NGOs to be formal (official relations) or informal.

[7] "Guidelines for interaction with commercial enterprises to achieve health outcomes "EB 107/20 Annex.



Formal or official relations

Only international NGOs can apply for official relations. As of July 2002, there are 189 NGOs in official relations. While they were originally drawn from the medical and public health fields, NGOs with broader mandates have increasingly been admitted. Both private sector NGOs (not-for-profit business associations) and public interest/citizen grouping NGOs have official relations status under the common title of "NGOs".

NGOs in official relations are conferred privileges such as participation in WHO meetings, committees and conferences including those of WHO governing bodies and the right to make a statement at these meetings.

As part of the requirement for official relations, NGOs need to establish a joint programme of work and a 3-year plan with a technical department of WHO. Designated Technical Officers are appointed as the focal points for such collaboration. Admittance into official relations is authorized by a formal decision of the WHO Executive Board. A review process of these relations is based on 3-year reports and the drawing up of new work plans.

Regional offices use the list of NGOs in official relations to invite participation at Regional Committee and other regional meetings.

Informal or working relations

All other relations with NGOs are considered informal. NGOs that have informal relations with WHO at HQ, regions and countries outnumber those in official relations. The inventory undertaken of WHO (HQ) relations with NGOs revealed that out of a total of 473 established relations, 45% were with NGOs in official relations and 55% were with NGOs not in official relations.

Informal relations include a wide range of interactions. Although the informal status does not prevent NGOs from attending technical meetings or working successfully with a technical programme in WHO, these NGOs are not given the privilege to participate in, or to deliver a statement to, WHO's governing bodies.

Range of organizations interacting with WHO

WHO interacts with a wide range of organizations. There is a great diversity in the structure, focus, mandate and funding sources of these organizations. The various structures can include, among others: memberships organisations, companies, foundations, federations and networks. Organizations can be financed by diverse funding sources such as governments, the commercial sector, foundations, individuals, churches or charities.

The basic focus of organizations vary. The examples below are illustrative:

- professional associations (such as those representing nurses);
- disease specific NGOs (such as those dealing with malaria);
- development NGOs (such as those working on poverty reduction);
- humanitarian NGOs (such as those dealing with emergency situations);
- patient group NGOs (such as those representing diabetic patients);
- public interest NGOs (such as those representing consumers);
- scientific or academic NGOs (such as those involved in medical research);
- health-related NGOs (such as those involved in occupational health, education, technology or safety and who have health as one of their objectives); and
- not-for-profit organizations that represent or are closely linked with commercial interests (such as those representing the pharmaceutical industry).

Spectrum of WHO interactions

WHO's interactions with these diverse organizations cover a wide spectrum of activities at HQ, regional and country level. They range from simple interactions of a very informal nature to more structured ones based on formal contracts or agreements. The range is illustrated in this table below:

Informative interactions

Passive/occasional exchange of information and ideas.

- Inclusion in address lists, e-mail list serves.
- Exchange of newsletters, reports, publications and other materials.
- Exchange visits.

Ad hoc relations

Active *ad hoc* participation in WHO meetings, events, campaigns and consultations.

- Promotion of WHO advocacy materials.
- Exchange and mutual support in campaigns and events such as World Health Day.
- Participation in WHO training events and consultations.

Systematic relations

Regular contributions to WHO policy and normative work.

- Participation in expert committees, policy discussion fora, development of guidelines, or standard setting.

Structured collaboration

Collaboration as defined by a formal contract, or written agreement on joint work plans.

- Collaboration and research on products, methods, development of tools and guidelines and service outreach in countries.

Assessment of WHO-CSO interactions

General benefits for WHO

Advocacy support

CSOs are instrumental in advocating issues of public health promoted by WHO and taking it to a broad audience. They perform a watchdog function in the protection of public health concerns. They are also able to bring up sensitive issues that WHO, as an intergovernmental organization, may not be in a position to address for political reasons. This is especially true for CSOs working with a rights-based approach.

Access to public opinion

By collaborating with CSOs, WHO can ascertain the direction and content of public opinion on various health matters. This can prove invaluable when formulating programmes and provides a reality check for WHO. CSO collaboration in policy development also strengthens the democratisation of international relations and cooperation. It makes the work of WHO more visible and transparent and contributes towards actively building public accountability within the context of the widening UN framework for governance in global policy.

Programme implementation

CSOs are often involved in the testing of methods and approaches at field level, in building up the national capacity of health systems and implementing WHO programmes at country level. National CSOs concerns for equity in health, closeness to local communities and capacity to respond to community needs are strengths that WHO can draw upon. Collaboration with some CSOs makes outreach to remote areas and disadvantaged populations possible for WHO. In emergency relief, WHO effectively benefits from the flexibility and rapid response of humanitarian NGOs/CSOs by channelling aid through them.

General benefits for CSOs

Capacity support

Interaction with WHO provides CSOs with enhanced access to expertise, skills and resources, especially on technical and policy issues. This access helps improve the work of CSOs in general.

Enhances public relations

Being associated with an international agency like WHO strengthens the status, credibility and recognition of CSOs and enhances their public relations and fund-raising opportunities.

Outreach and influence

Working with WHO enables CSOs to reach beyond their immediate audience and contribute their valuable expertise, experience and advocacy support to the technical and policy work of WHO and public health in general.

General constraints for WHO-CSO relations

Gaps in communication and information

The lack of access to and transparency about WHO processes at HQ, regional and country level was highlighted by many CSOs. Inadequacies were identified in the range of topics on which material was produced as well in the dissemination of this information and material. CSOs were also uncertain about how to approach WHO, including possible participation at meetings and activities of the Organization. Information needs range from understanding how WHO governance works to gaining updated knowledge on specific technical issues.

Lack of distinction between types of CSOs/NGOs

The current *Principles* offer no guidance in distinguishing between public interest NGOs and those linked to commercial interests. Voices from the CSO community therefore urged that business-linked organizations be classified as the private (for profit) sector and not fall within the CSO/NGO classification.

Insufficient safeguards on conflict of interest

While it was generally accepted that all opinions should be heard and interactions encouraged, concern was expressed that the very nature of some organizations may represent a potential conflict of interest. The closer the involvement of CSOs in the work of WHO and in the setting of policies, norms and standards, the more important it is for WHO to be aware of, make transparent and eliminate all risks of real or perceived conflict of interest. Review participants from both CSOs and the Secretariat pointed out that the *Principles* do not make provisions for such safeguards. Newly developed conflict of interest mechanisms have not been used very extensively and should be supplemented by additional measures.

Specific constraints of the official relations system

Lengthy, onerous and rigid procedures

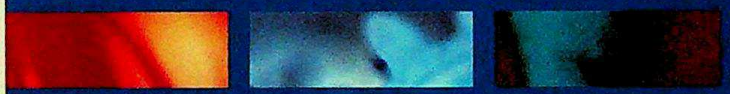
The detailed procedures contained in the *Principles* allow for little flexibility to meet new challenges and needs. This was amply demonstrated during the tobacco treaty sessions of the Intergovernmental Negotiating Body when NGOs not in official

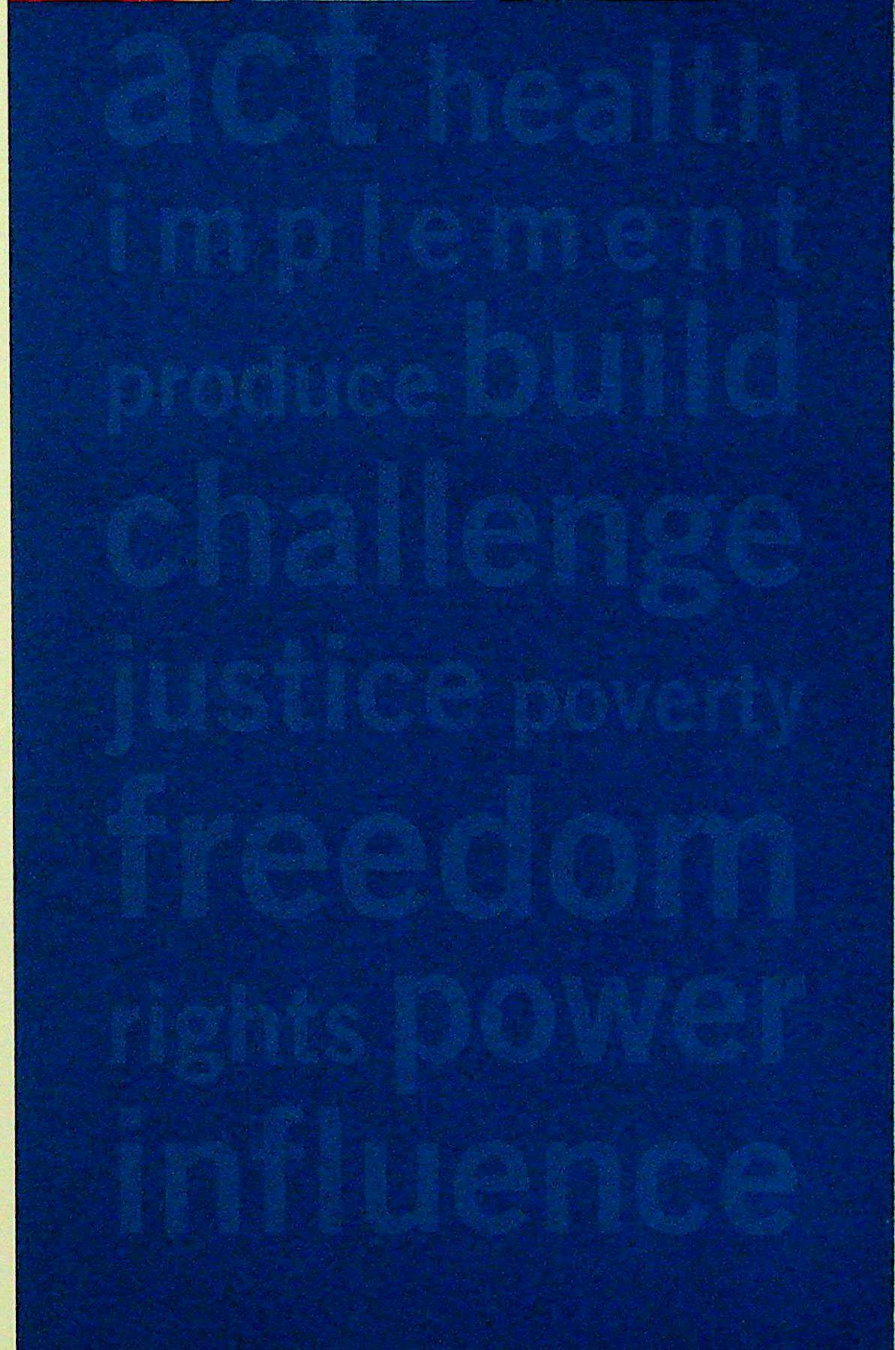
relations, but with strong working relations with WHO, sought ways of participating in the sessions. Special "fast-track" procedures were created (endorsed by the EB) to enable some NGOs to obtain the official status they needed to participate.

The process surrounding admittance of NGOs into official relation also demands drawn out procedures (different stages over 3-4 years) and a substantial amount of administrative work both for the Secretariat and for the concerned NGOs. The process is perceived as among the most complicated of UN agencies. The requirement of establishing joint work plans and reporting on these every third year was found to be overly bureaucratic, difficult to monitor and not always relevant especially since WHO has two-year work plans. The task of the NGO Standing Committee of the Executive Board to admit or to consider the continuation of official relations for 60 to 80 NGOs every year was also considered overly bureaucratic. More often than not, the work of the committee was limited to approving recommendations from the Secretariat.

Personalised linkages

The linkage between the NGOs in official relations and WHO is between two individuals – the focal point in the NGO and the WHO designated technical officer. Therefore, the quality and endurance of the relationship can sometimes boil down to the personal commitment and rapport between the two individuals. This individual link can be broken during a turnover of WHO and NGO staff, leading to difficulties in re-establishing the relationship when new people take over.





Insufficient information on NGOs

The *Principles* have no formal requirement to analyse and make public the information received on NGOs. Basic information on NGOs in official relations have not been sufficiently updated or highlighted. NGOs have been questioned on funding sources and mechanisms only at the time of applications but not in the triannual reviews. There is a lack of systematically accumulated knowledge about the sponsors and the interest groups behind individual NGOs. There is also a lack of information regarding those who govern NGOs or sit on NGO boards. This information can be important when board members have connections to certain industries whose goals are considered contrary to WHO's basic public health goals, such as the tobacco or arms industry.

Uneven participation at governing bodies

Among the NGOs in official relations, only about 40% have attended WHA and only 25% have attended EB sessions during the last four years. The general profile of NGOs attending has remained almost unchanged from session to session. The right to speak has been also used to a relatively small extent: the number of NGO statements has been on average 16 during the WHA and 11 during the sessions of the EB.

Imbalance between North and South

There was a perceived imbalance between participation of organizations from the North/West and those from the South/East at meetings of WHO governing bodies (including Regional Committees).

Specific constraints in informal or working relations

Lack of participation of CSOs not in official relations

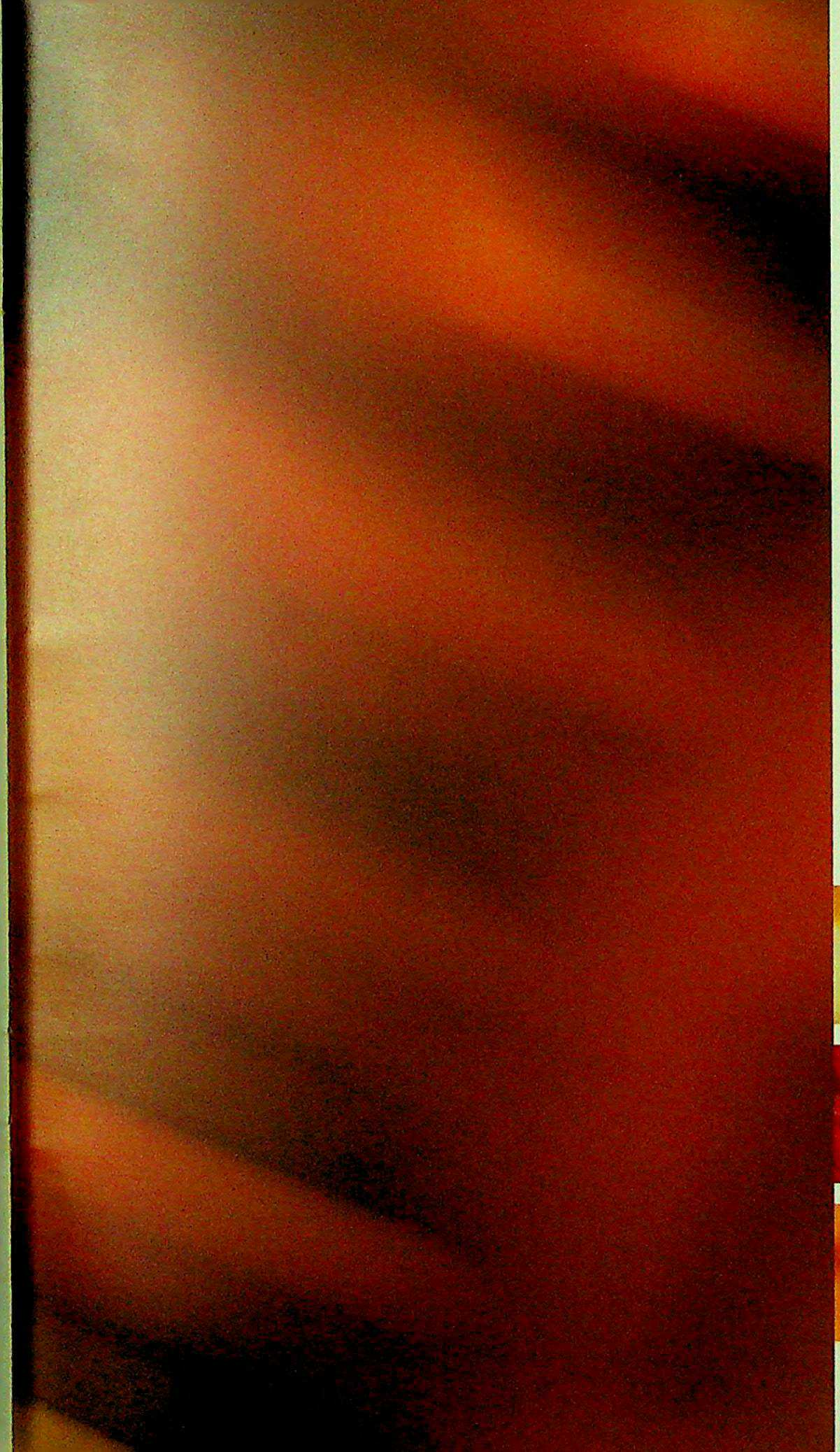
Many CSOs that are in not official relations, but working with WHO, would welcome the opportunity to attend meetings of the governing bodies regardless of whether they want to speak at them or not. Under current rules they can attend only as part of the public or as a member on the delegation of an NGO in official relations. This system of linking official relations to certain privileges has created a perception of two categories or classes of CSOs that bears little relation to the quality or importance of their collaboration with WHO.

Lack of relevant guidelines

The review found that the existing *Principles* do not offer the needed managerial and policy guidance for WHO staff interacting with CSOs at the HQ, regional and country office level. This contributed significantly to the lack of staff capacity and skills in relating effectively with CSOs. Some of the specific needs identified were: administrative advice on types of agreements; methods for assessment of suitable CSO partners including methods for identifying and addressing conflict of interest; and information on methods for civil society involvement in health promotion, health reforms and health systems.

Regional and country level concerns

Regional and country offices expressed a need for guidance on how to assist governments in strengthening partnerships with CSOs and in facilitating government dialogue with CSOs.



This was especially important in a context where development aid is increasingly being channelling through CSOs at the country level, with or without government consent. Country office staff were also uncertain about circumstances under which they were allowed to work with CSOs directly or whether government endorsement was needed for all WHO collaboration with a national CSO. These uncertainties may not only have prevented WHO from seeking valuable CSO inputs to their work but reduced WHO's ability to strengthen the capacity of CSOs as well.

Strengthening the profile of WHO at country level as a resource centre and support for all actors in health, including CSOs, is currently being explored by some country offices and merits further attention. Country offices also recommended that WHO's Country Cooperation Strategy include participation of CSOs.

New policy proposal

In summary, the review underscored an overall consensus that the current *Principles* are inadequate and less relevant to the realities of WHO and to the needs and aspirations of civil society.

New policy

Based on the review findings, CSI suggests that the *Principles* be replaced by a new policy. In keeping with the WHO Constitution and general UN practice, the policy would continue to use the term NGOs defined as non-state, not-for-profit, voluntary organizations. The policy would, however, establish principles to distinguish between different kinds of NGOs and their related interests. It is suggested that this new policy would consist of:

a. *An accreditation policy:* this would serve to guide the participation of NGOs to WHO governing body meetings. In contrast to the current "official relations" system, accreditation would not be conditional on working relations with the Secretariat.

b. *A collaboration policy:* this would enhance general interactions between the WHO Secretariat and NGOs, including clarity on differentiating between organizations and the role of WHO in supporting Member States work with civil society.

This two-fold policy shall be based on:

Basic agreement of aims and purposes

For both accreditation and collaboration, the basic interest of NGOs shall be consistent with the WHO Constitution and not in conflict with its public health mandate.

Clarity about nature of interests

Whether for accreditation or for collaboration, the interests of each party shall be clear and transparent. This would include NGOs readily disclosing information on structure, membership, activities, and source of financing.

An accreditation policy for governing bodies

A new accreditation system is needed to simplify the bureaucracy and procedures surrounding attendance of NGOs at WHO governing body meetings. NGOs will include organizations such as public interest NGOs, professional associations and business associations.

In addition to basic agreement with WHO's Constitution and disclosure of interest, the following shall be *criteria* for NGOs seeking accreditation:

Relevance

Competence in a field of activity related to the work of WHO, whether it is a technical issue related to public health or a social, economic and inter-sectorial issue related to the determinants of health.

Established structure

A constitutive act, accountability mechanisms and existence for not less than three years. Membership organizations shall have authority to speak for their members, a representative structure and accountability to their members.

International scope

International membership or activities.

Transparency

In addition to being asked for basic information on the application form, NGOs will be provided with categories representing different kinds of organizations and requested to place themselves in one or more categories. This information will be made publicly available in a database. The Secretariat can initiate a regular information collection procedure to periodically update the basic information.

In application of the accreditation policy, Regional Committees can decide to set up additional rules to invite sub-regional and national NGOs to Regional Committee meetings.

A collaboration policy with NGOs

This part of the revised policy framework would deal with the Secretariat's interactions with NGOs and would involve the development of guidelines for such interactions. Collaboration with NGOs representing commercial interests will be guided by the existing *Guidelines for interaction with commercial enterprises to achieve health outcomes.*

In addition to basic agreement with WHO's Constitution and disclosure of interest, a collaboration policy shall be based on the following *criteria*:

Reciprocity

Each party shall respect the autonomy, integrity, limits and differences of the other.

Responsibility

Collaboration shall be based on clearly agreed responsibilities by the parties involved when agreeing to common plan of action, identification of resources or strategies for implementation and monitoring.

Implementing both policies

Guidelines will need to be developed in order to implement both the accreditation and collaboration policy. Priority areas for work include:

Strengthening capacity for the Secretariat

Staff training and development of capacity support modules at all levels of the WHO system will be needed to implement both policies, backed by an adequate procurement of resources.

Assisting management

In order to implement the accreditation policy, guidelines on the application of the new procedures, mechanisms for admission, information and database design, methods for assessment and reporting to the EB, and transitional arrangements for a shift from the current "official relations" system to the accreditation system will have to be developed.

New guidelines for collaboration with NGOs will need to be developed to clarify the authority and the flexibility given to WHO staff in their interactions with NGOs. This would include types of contracts or agreements, funding arrangements, cosponsoring of meetings, methods for identifying and choosing NGOs, and contribution to and use of a NGO database.

Building a knowledge base

A data base with basic information on accredited NGOs needs to be developed, updated and made public. The building up of a knowledge base would assist collaboration by ensuring that experiences gained in WHO-NGO relations and civil society's contributions to global health policies are documented and accessible to a wide audience. This would include the role of civil society and NGOs in national health governance, health systems and services.

There is a clear need to merge civil society research with health systems research. The production of a series of documents providing "state of the art" and policy analyses would serve the WHO Secretariat and the Member States in their work.

Formulating a communication strategy

Communication and information sharing between WHO and civil society actors needs to be improved for both accredited NGOs and those in collaboration. NGOs need "lay" materials and information on WHO governance and decision-making processes, on WHO policies, programmes and priorities, and practical guidance on how they can participate in WHO's work. On the other hand, WHO Secretariat would benefit from information on how to best arrange consultations with NGOs or how to locate civil society issues within current health debates. New types of NGO consultations and dialogues are needed to contribute to WHO's advocacy, policy and technical work. A web site, practical tools and information documents need to inform the communication strategy.

Conclusion

A new policy guiding WHO's relations with civil society is clearly overdue given the importance of these relations to WHO in particular and public health in general. This review report contains the core elements that need to inform this policy. The main conclusion has been that the current *Principles* need to be replaced by a policy that looks at two aspects: accreditation and collaboration. More detailed work is now required to translate the needs identified by both WHO staff and civil society into relevant policy criteria and guidelines.

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Thailand's Health System Reform

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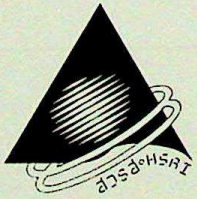

HEALTH SYSTEMS RESEARCH INSTITUTE

Thailand's Health System Reform

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Foreword

Health System Reform is an ambiguous term, which is usually spelled out as limited change within the context of some elements or functions of the health system such as health care, financing, or decentralization. In the midst of a drastic evolutionary shift in political, societal, economic and technological circumstances in the last decade, Thais are confronting a challenge to reshape their health entity. A process to reform a comprehensive and holistic health system seems to be inescapable. Research and mutual learning endeavor has turns to be essential knowledge in uncovering a camouflaged crisis on the health of the nation as well as a premise of strategy for redesign health systems.

Thailand's political reform coincided with a country wide economic crisis in 1977. It raised a strong demand for extended societal restructuring, which finally triggered a paradigm shift in health. Political commitment in coordinating a wide range of civil society groups to work with academics was demonstrated as a crucial leverage to lead an envisioned and systematic reform. A triangular process - a symbiotic

interaction among academic activities, social movement, and political involvement - was employed as a key strategy to pursue the mission. Movements toward health system reform were enthusiastically welcomed so that it culminated into a stronger political commitment - legislation of the National Health Act. This has extended opportunities for research institutes to contribute their efforts and then serve to meet social demands.

Thailand's Health Systems Research Institute (HSRI) was entrusted to perform the function of stewardship in support of the reform. Researchers and the academia worked arm in arm to provide wisdom resulting in creative change that was gained and learnt through their mandated endeavors. Clear and critical illustrations to demand a holistic health system reform were profiled through a series of academic analyses. Concerned with threatening circumstances, the Thai Government committed to lead civic movements so that Thai society would be empowered to redesign its health system.

At this moment Thai society has redefined health and the health system, which leads to a capability in envisioning a holistic scope of the health system. The process of drafting the national health act is ongoing as a firm foundation of the reform. This initiated the utilization of sound knowledge to arm public policy towards health concern. Thus, a learning society inspired with an aim for healthy lifestyle is in itself a means and an end for health system reform.

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Thailand's Health System Reform

1. Introduction

Thailand has economically evolved from an agrarian society four decades ago to a newly industrialized country with a great leap in societal and people's lifestyle. Health is among the most rapidly growing sectors reflected in both the expanded health care infrastructure throughout the country and improvements in the health status of the Thai people. However, the immense health gains in the last few decades have decelerated and unprecedented catastrophic social anomie has resulted in increased death and suffering in the last few years. This has been caused by the unexpected emergence of new health determinants. At the end of 1990s', the economic crisis has had a broadly negative impact on the country. It has also driven Thai society to rethink the holistic structuring of its societal paradigm and infrastructure.

Betterment of health status and the illusion of admired successful health programmes without sound evaluation in the last two

"The first research initiative was a quest for the shifting health paradigm as well as to inspire a willingness to reform."

decades had camouflaged the failures of the country's health system performance. To raise the awareness of the public on the critical facts of the health system, a series of analyses on health policies and health ideologies that had emerged in Thai society was conducted and publicized. The first research initiative was a quest for the shifting health paradigm as well as to inspire a willingness to reform. Secondly, packages of academic review and synthesis were undertaken to provide a clear vision for all parties to trust so that they would join the process of reform. Thirdly, essential devices and mechanisms to reorient and sustain the health system had to be created and tried in order to confirm the possibility of innovative performances. And finally, research to delineate profiles and the competence of civic involvement in the health system had to be conducted in order to propel the reform synergistically.

Thailand's health system reform was raised as a national agenda in the midst of a drastic evolution in political, economic, and technological structures. However, the constraint of resources as a result of the economic crisis inevitably affected this reform so that policy implementation for transition had to be undertaken with a deliberative and insightful movement.

2. New Constitution: Reorientation for Thailand's Health Demand

The new constitution (1997) established enormous opportunities for further progress in restructuring the relationships between the state and civil society; for further democratizing the development process; and for creating new institutions and mechanisms that provide greater accountability, transparency, representation and participation. Initiatives in these areas are rooted in law and guided by far-reaching principles pertaining to basic human rights. It is of utmost importance that these opportunities be seized to the full and remain central issues in the policy and reform agenda. Their full and effective utilization will allow civil society organizations to further flourish and to serve as a positive force for change as well as enable them to serve more effectively as a countervailing force against the negative impacts of globalization.

"The new constitution has provided a crucial re-orientation for the health of Thais."

The new constitution has provided a crucial re-orientation for the health of Thais. Currently, health is stipulated as a human right, which must be protected by the state. An egalitarian standpoint is emphasized in the context of health for the first time in Thailand's political philosophy. An equal entitlement to health was introduced for a wide range of vulnerable people; i.e., the elderly, the disabled, abandoned children and so forth Consumer and environment protection, particularly for the sake of health, is another area that is mandated.

Under a section on the fundamental policy of the state, the government was responsible to efficiently provide public health services to all people at the same standard. Disease control is also a state obligation to be pursued free of charge. In order to comply with these missions, devolution of various services upon local governments must be conducted urgently. Health services under the new constitution must be under the state of equity, efficiency, quality, as well as transparency and accountability to the community.

Political reform, thus, calls for a re-examination of the health sector's role and approach, with concern for social capital as well as for financial capital. The health sector has to re-orient its own vision and mission to meet this new demand for health and health care so that the new constitutional mandate can be achieved. Leadership for collective movement through collaboration of all societal sectors is pivotal to meet these constitutional demands.

3. Decentralization

The Decentralization Act became effective in November 1999. This Act defines the roles and responsibilities of the National Decentralization Committee (NDC). A primary responsibility of the NDC is to formulate a Decentralization Plan that will be executed by the government. This plan has defined the relationships and functional responsibilities between the central and local governments, as well as among local governments. It defines local revenue sources and

identifies the means to improve local tax and revenue mobilization. The plan outlines the stages and means to transfer functions from the central government to local governments. It recommends the means to coordinate the transfer of public officials from the central government to local governments and state enterprises that are related to the new assignments of functions and resources.

According to the Decentralization Act, the public health mission and hospital mandate must be devolved to local governments. Thus, a crucial re-orientation needs to be undertaken by both the central government's officers and local governments' authorities. The central authority has to shift its mission from the current function of logistic administration and policy control to that of policy guideline and quality assurance of health care in the future. At the same time, local government has to be empowered so that it will be capable of providing equitable and efficient health care, which will be accountable to the people in their own community.

4. Key Demands to Reform

The health status of Thais has immensely improved in the last decades of the millennium, but evidence indicating failures of the health system's performance has been tacitly demonstrated. A series of health policy research issues have been analyzed and have indicated that emerging crises could never be handled by the existing health infrastructure. Four major critical issues were depicted as key messages

that demanded structural reconstruction in health systems. These are: higher cost of health expenditure, unbalanced economic development, rapid technological evolution, and political and social reform.

1) Higher Cost of Health Expenditure: Paradigm toward Health Care

The majority of Thais are accustomed to the conventional health system where health care is the obligation of health care institutions. With the expansion of modern health care delivery systems in both the public and the private sector, the Thais are moving towards using more facility-based health services. National health spending in Thailand rose eleven times from $US 562.5 million in 1980 to $US 6,301.7 million in 1998. The per capita health expense rose nearly 9-fold from $US 12.1 to $US 103.6 during the same period. This is higher than the per capita average annual gross domestic product (GDP) growth of 7.0%. Thus, the share of GDP taken by health nearly doubled from 3.82% in 1980 to 6.21% in 1998.

"The Thais are moving towards using more facility-based health services."

Since the increasing burden of health expenditure has been masked by the sense that Thailand has a modern and efficient health system, a comparative study on the health outcomes of countries with less per capita health expense was publicized. This included China, Malaysia, and Sri Lanka, which have lower health spending related to their own GDP. On the other hand, they have improved their health situation at the same rate as, or better than, Thailand. This shocked the

policymakers who were concerned that Thailand was investing inefficiently.

2) Unbalanced Economic Development: Social Pathology

The incidence of poverty incidence fell from 33% in 1988 to about 11% in 1996. While Thailand can draw considerable satisfaction from its development over the past three decades, it has paid high costs in several areas: i) the unbalanced nature of much of the development has caused disparities among the marginalized population; ii) the disruption of social structures and relationships as well as the erosion of social and cultural capital; and iii) unsustainable levels of natural resource depletion and environmental pollution.

As a result of international recession, currency realignment, and capital mobility in the 1980's, the government shifted its economic strategy towards the promotion of exports in both service and manufacturing industries. Both natural increase and marked increase in rural to urban migration contributed to the manufacturing labor supply, the decline in agricultural growth, and the closing of the agrarian frontier.

Deterioration in its social ecology altered Thailand's health situation with the emergence of HIV/AIDS, traffic injuries, cancer, mental stress, and environmental hazard among the top-ten causes of mortality and morbidity. The mortality rate, which had declined from 20 in 1975 to 4.1 in 1986, rebounded to 5.0 in 1997 and 5.1 in 1998. This might signify that the existing health system was not well designed

to cope with the new societal challenges.

3) Rapid Technological Evolution: Reliance on Imported Technology

A wide spectrum of health technology has been researched and developed in industrialized countries then imported by developing countries at high cost. The HIV/AIDS epidemic exemplifies the widening gap of inequity with the accessibility of more efficacious drugs to wealthier people with HIV while leaving those who are financially disadvantaged to suffer on their own.

Cancer, the leading cause of death since 1980, is another example. Radiotherapy is expensive, requiring complicated medical equipment to effectively cure cancer patients. However, 54% of radiotherapy units are installed in Bangkok. While the other 46% are in provincial cities, they have a shortage of qualified manpower to provide the treatment.

"The policy proposing universal coverage of health care can never be achieved if the health system continues to rely on the importation of costly evolved technology."

The policy proposing universal coverage of health care can never be achieved if the health system continues to rely on the importation of costly evolved technology. Thailand needs to create and orientate a strong foundation on health research and development to enable it to transfer novel health knowledge and technology from industrialized to developing countries. Investment in government health research increased from 0.2% of the public health budget between 1992 - 1996 to 0.52% in 1999. Compared to research in

agriculture, industry, science and technology, which contribute directly to national economic growth, health research is not a top priority in Thailand.

4) Political and Social Reform: Demand for a Reoriented Public Sector

Civil society's movement has gained strength in the 1990's, when the need for political and social reforms became increasingly apparent. They have become a potent force for change and have played a decisive role in framing a reform agenda shaped by the principles of democracy, participation and respect for basic human rights. As both advocates and watchdogs, they are involved in activities that go beyond the traditional concepts of participation and even empowerment. They are spearheading the search for a new social paradigm based on a far-reaching process of political democratization.

"They are spearheading the search for a new social paradigm based on a far-reaching process of political democratization."

With the promulgation of the new constitution in 1997, the nation has built a more open and democratic society in which the basic rights of the population are safeguarded. Consequently, the Thais are provided with significant new opportunities to participate in all processes of development.

5. Public Sector Reform: Demand for Structural Adjustment

The new constitution set a framework for reforming public sector management and improving accountability, transparency, and mechanisms for combating corruption. It provided the National Counter Corruption Commission with more authority, established new organizations to monitor and improve transparency, and grants legal rights for civil society to participate in the policy formulation process. A new Official Information Act provided greater access to public information and created greater opportunities for people to be involved in public service.

"A new Official Information Act provided greater access to public information and created greater opportunities for people to be involved in public service."

Thailand's three - year Public Sector Reform Program that commenced in 1999 involved both central agencies and line ministries such as education and health. Both have embarked upon substantial reforms in these areas: i) expenditure management, ii) human resource management, iii) revenue management, iv) decentralization, and v) cross-government accountability and transparency.

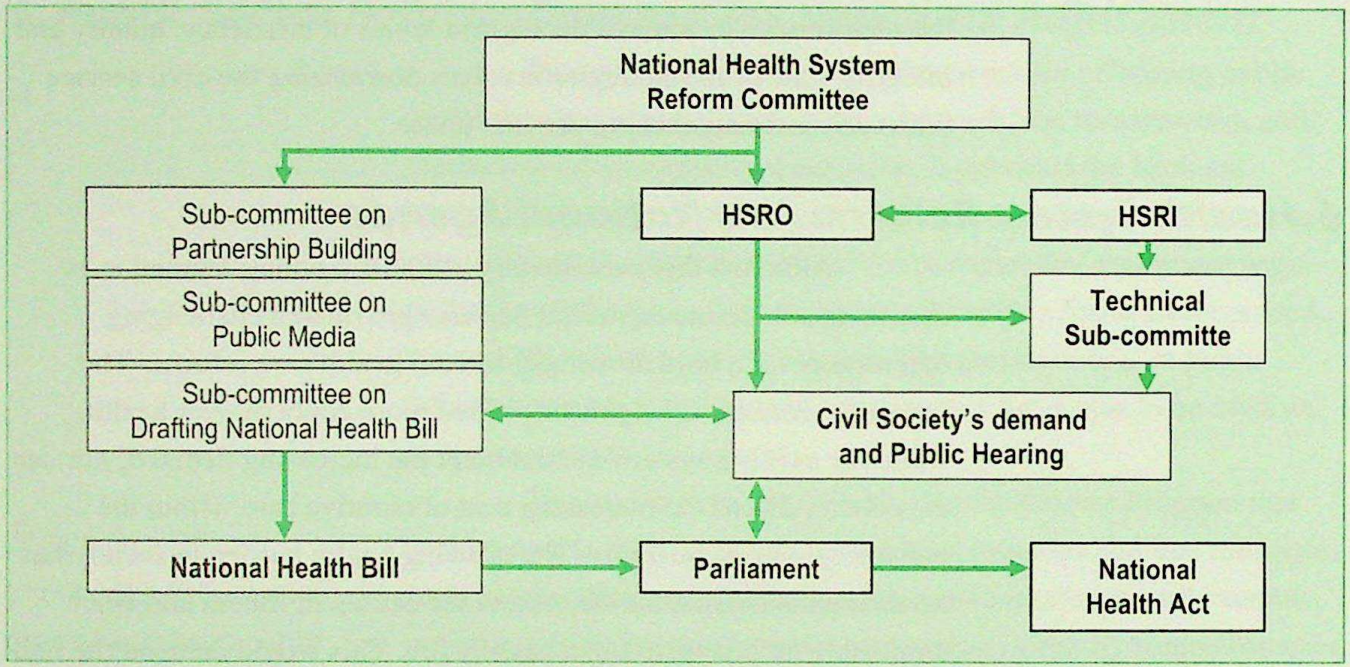
The Ministry of Public Health expects to reform its budget management for provincial health authorities and provincial hospitals. The Comptroller General's Office and the Fiscal Policy Office have begun analyzing the issue of fiscal transparency. A new accounting system is being developed which aims to acknowledge the cost of care.

The Office of the Civil Service Commission (OCSC) oversees the program on human resource management reform by encouraging

the civil service to achieve the highest levels of efficiency, quality and integrity. One of the strategies involves downsizing the civil service with early retirement being the first phase.

6. Health System Reform: As a National Agenda

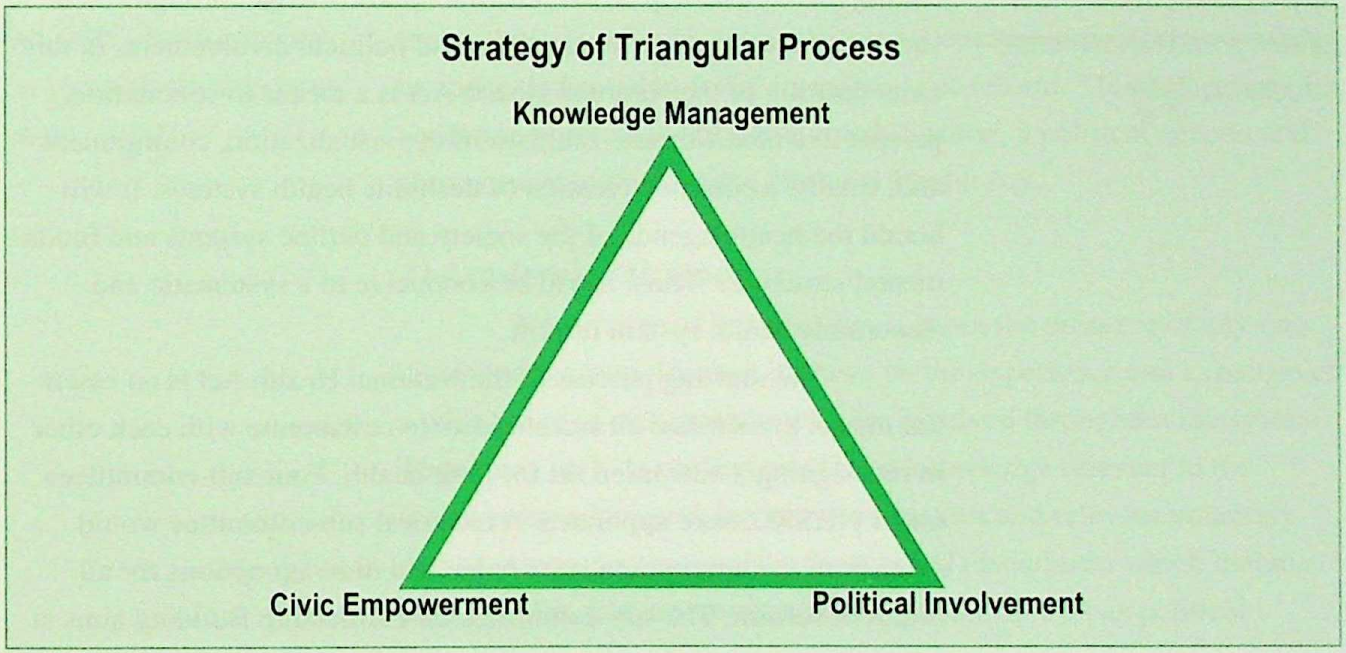
Although this evolutionary pluralistic policy seemed to be chaotic in coordinate control, it has also provided a challenging opportunity for a bold movement toward health care reform. The issue of constitutional rights has raised more concern over health, while the existing system can not meet the increasing demand, nor can the country afford the increasing cost of curative care within the prevailing state of infirmity. The growing health burden to society has become an inevitable hurdle, unless the causes of illness and death diminish with people living a healthy life. This would demand the real involvement of all stakeholders to cooperate in the health system. Then, societal accountability of the health authority would promote local and community self-governance of the health system as well as shift the central health function towards limited policy guidance and technical leadership. Local government would urge to be empowered with the redeployment of manpower and capacity building for administration and management. This also demands that the new health system be redressed within the evolving insights and ideology of health in Thai society.



In response, the Royal Thai Government has undertaken widespread health system reform. The cabinet approved a national agenda for Health Systems Reform on May 9th, 2000. It entrusted the HSRI to establish the National Health System Reform Office (HSRO) as Secretariat Office for the National Health System Reform Committee (NHSRC) under the chairmanship of the Prime Minister. A Prime Minister Office's Regulation on National Health System Reform was published in the Government Gazette on July 31st, 2000. This regulation ensures high level political support and continuity of the movement.

The regulation has two main aims. The first is the knowledge-based social movement to support health system reform. The second is to enact within three years, a National Health Act as the principal mechanism for future health system reform.

7. Triangular Process: Strategy to Reform



Health system reform is an intricate issue involving many factors including those of a cultural, social, environmental, and not least, political nature. Obstacles to reform are many, and often seem

insurmountable. An innovative "triangular process" approach to overcoming these difficulties has been applied in Thailand to the challenging task of restructuring and reforming the countries cumbersome health system.

"It will herald the health agenda of the society and outline systems and fundamental structures."

Analogous to the concept of **"the triangle that moves the mountain"**, this is based on establishing a symbiotic interaction among three basic objectives: creation of knowledge through research, social movement or social learning, and political involvement. In this case, drafting of the National Health Act is a means to solicitation, perspective modification, brainstorming, visualization, commitment and, finally, a common creation of desirable health systems. It will herald the health agenda of the society and outline systems and fundamental structures. Then, it will be conducive to a systematic and discernible health system reform.

The drafting process of the National Health Act is an essential means to mobilize all stakeholders to collaborate with each other in redesigning a new mind set for their health. Four sub-committees under NHSRC were appointed. A technical sub-committee would synthesize the appropriate knowledge and draw up options for all issues of reform. The sub-committee on Partnership Building aims at interacting with and involving all partners in order to seek their opinions and support. The sub-committee on Public Media is responsible for wider social advocacy and movement through public media. The last sub-committee will draft the National Health Bill. Health system

reform has been strongly endorsed with the advent of the current government in February 2001 so that it became the key health policy according to the Cabinet's policy declaration in the National Parliament.

"The official embarkation of the NHSRC was on August 9th, 2000. Its mission will be completed within three years..."

The official embarkation of the NHSRC was on August 9th, 2000. Its mission will be completed within three years; then, the Health Act will have been envisioned as a vivid gateway for furthering the evolution of health system reform. Concurrently, enormous work has been dedicated to fulfill its mandate of reform. This comprises of academic missions, civil society mobilization, a political agenda and commitment in drafting the National Health Act.

1) Academic Missions

Knowledge of health systems is not the preserve of any one disciplinary group. Instead, it draws on the experience and expertise of a wide range of stakeholders who are involved throughout the system. These may include professionals with knowledge relevant to the issues being addressed, key decision-makers and relevant voluntary organizations, and researchers from broad disciplines, which include public health, law, economics, social science as well as political science.

As a national agenda, it is legitimate for HSRI to facilitate the mobilization and strengthening of a wide range of related researchers and research institutes in support of evidence-based health system

"These research results should culminate into pivotal proposals and serve as a foundation to design a reform process."

reform. The main purpose is to support the synthesis of essential knowledge on a contextual basis for drafting the National Health Act. This entails an ongoing set of strategically planned and coordinated actions that involve a range of different actors who cut across a number of different disciplines and sectors. It is not a typical health research project or even limited to action in the public health domain.

Working groups of researchers were contracted to deliberate and synthesize on particular reform issues, which were hypothetically defined as strategic in direction. These research results should culminate into pivotal proposals and serve as a foundation to design a reform process. This yields not only recommendation reports to technically guide the NHSRC but also a creative network of researchers, policy-makers and civic activists who contribute their wills to forward the health system reform.

2) Civil Society Mobilization

Stakeholders in restructuring the health system might have their own varied interests. An emotional response to changing processes might vary in a broad range - from affirmative support through confusion or frustration to another extreme of a sense of rejection. Thus, reconciliation of the differences among stakeholders so that most of them can be allied as partners in the reform is a crucial initial strategy. To do this, basic knowledge on leadership and civil movement of the potential stakeholders has to be studied. In the first

few months, the stakeholders for national health systems reform were explored. Then, information on these stakeholders including responsibilities, contact persons, and addresses were collected and organized, then computerized as databases. Policy mapping and analysis of stakeholders within a framework of health related movements were verified in order to align their issues of interest. The alliances on health system reform were categorized into four functional groups, namely: public interest groups, health professional groups, profit-in-health related businesses, and community based civil society.

"Recommendations from civic alliances have been complemented by academic work, and then integrated into a draft of the National Health Act."

The HSRO mission is to encourage and empower all partners to express their interests and vision, and to be involved in the process of deliberating the National Health Act. Forums and seminars have been facilitated in every province to solicit those potential groups to join their own mutual learning process of the existing health systems. Mind Mapping and Focus Group Discussions were employed as powerful devices to explore the imaginary demands of people. In six months, broad and comprehensive views of the health system have been depicted and proposed. Recommendations from civic alliances have been complemented by academic work, and then integrated into a draft of the National Health Act.

3) Political Agenda and Commitment

From the start, HSRI has proposed a conceptual framework for health system reform to the government through parliament and

the cabinet. Consequently, in 2000, the senators' sub-commission on health recommended to the cabinet to reform the health system. Then HSRI formulated a plan and architecture for undertaking a process to draft the National Health Act as an essential device to mobilize the reform. This has been endorsed and approved by the Cabinet, which committed to launch the national agenda of health system reform.

"The cabinet has strongly endorsed the policy of health system reform, which emphasizes universal coverage."

The government's engagement is crucial to guarantee that legitimate, legislative, and cooperative device as well as financial, human, and public communication resources are provided to mobilize the reform. In the midst of a political rally in the first general election under the new constitution at the end of 2000, universal coverage of health care - a principal issue for reform - was raised by a newly established party. It turned out to be a popular policy. This party won a landslide victory in the election, then became the most powerful cabinet in the history of Thailand's democracy. The cabinet has strongly endorsed the policy of health system reform, which emphasizes universal coverage. However, difficulties lie ahead, since financing mechanisms as well as a wide range of health care infrastructures and referral systems are waiting to be constructed. A myriad of actors has had to be engaged to move the whole system. Implementation is underway with a serious demand for feedback information, in which HSRI has been entrusted to coordinate the monitoring and evaluation of the national universal coverage plan. Other items in the reform agenda, such as public sector reform, which demands restructuring of

"Until now, NHSRC has scrutinized and approved most of the essential issues related to new structures and functions..."

the health sector, decentralization, which aims at empowerment of local governments and civil societies and establishment of a national research structure, which strengthens and reorientates the function of science and technology in development, are addressed in its formulation and implementation.

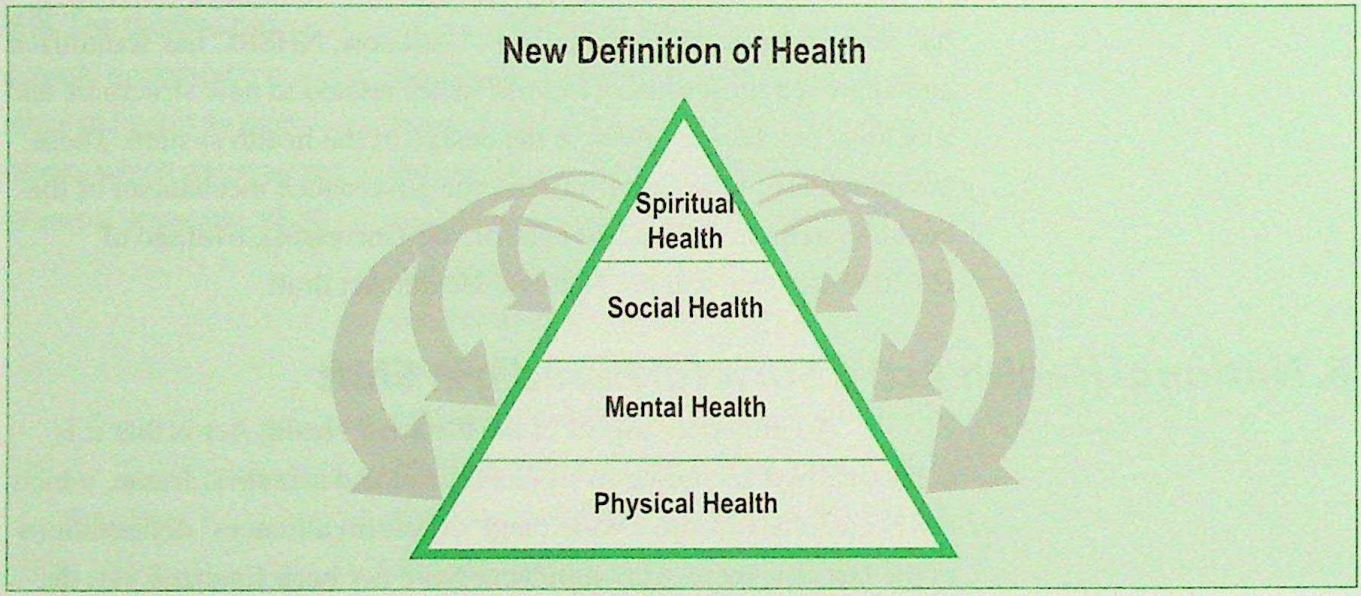
The National Health System Reform Committee (NHSRC) has been endorsed to further its task. Until now, NHSRC has scrutinized and approved most of the essential issues related to new structures and functions that have evolved in the design of the health system. These are principles of the health system, the governance mechanism of the health system, health hazard control, the Universal Coverage of Health Care plan, and the National Health Act draft.

8. National Health Act: a Societal Paradigm Shift

An important aspect of the National Health Act is that it is contextualised according to an ideological and scientific frame, which has been collated from a wide range of reform alliances' deliberations in the last two years. Although these have not been finalized yet, the core and essential structure of the expected health system has been vividly depicted in a draft of the National Health Act. The draft has been scrutinized and recommended by broad functioning alliances throughout the country. From it, a conclusion has been drawn up and modified by the Law Working Group to transform it into a legislative format.

The proposed health system reflects a shifting paradigm of the Thai people in many ways. The key issues are in terms of ideology, governance, and architecture.

1) Principles of Health and Health System



Health has been redefined as "a state of well-being that is physical, mental, social and spiritual", which has been modified from the conventional definition in WHO's constitution. The phrase "not merely the absence of disease and infirmity" has been deleted in order to be responsible for a broader dynamic of human well-being related

"...remarked term is "spiritual health", which is a strong sense developed into a crucial foundation for health at both individual and societal level."

to sex, age, genetics, and consequences of various health hazards. Since the constitution of 1997, the government has been obligated to be responsible for health as a right of the people, particularly those who are vulnerable.

Another remarked term is "spiritual health", which is a strong sense developed into a crucial foundation for health at both individual and societal level. At the individual level, it implies belief, faith, and sound commitment to a healthy life. This is verified and validated from the ultimate sense of various religious preachings through the pragmatic experience of scholars, then, to the realistic practice of broader civil society, which is exposed to sufferings such as those of people with HIV/AIDS, disabled groups, Poverty stricken groups, and so on.

At a broader societal level, it connotes a public will to equity, which entails strategy and actions to lead to real and sustained change in reducing unfair disparities in health and health care. This has been worked out by reviews of suffering from unhealthy public policy at broader terms of strategic, program and project level. The studies were conducted with the collaboration of academics, activists, and public authorities who are engaged with the policy as well as the involvement of community groups and stakeholders in policy formulation.

The health system's legitimate intervention according to this new definition is underway as various research projects. These range from individual and community health care to governance of healthy

"Civic policy will be constructive and powerful leverage in this reform."

public policy. Thus, the health system has been officially redefined as " all the systems which are holistically interconnected and which affect the health of the people throughout the country". It includes all factors related to health, namely, personal, environmental, economic, social, physical and biological factors as well as the health service systems.

This means that health system reform seems to be very broad, but all of these factors are mutually interrelated. Intervention on just a single well-focussed issue can not reshape the health system. In fact, it may cause a failed reform. Thus, holistic reform to redesign and integrate all of these issues will enable broader collaborations from all paces of life to clarify their destination. Civic policy will be constructive and powerful leverage in this reform.

2) Governance of the Health System

Culminating from deliberations towards health system reform, healthy public policy has been recognized as a strategic foundation to create a healthy pace for all life. Evidence from the experiences of civic movements from grass roots level, through local level, and up to national level has demonstrated a more effective and knowledgeable involvement with public policy. Most of the civic interventions have engaged with health based on a broad definition of ongoing reform. However, chaotic alignment within the existing public authority has prevailed since a centralised command structure still dominates the scene. In order to facilitate the change to a self-reliant health system,

a new model of governance has to be designed.

A review of various countries' health policy formulation and administration as well as governance of other sectors' of policy in Thailand were studied. This was concluded and synthesized to form a recommendation for a National Health Council to oversee all the health impacts affected by any sector's policy. Alternative drafts of architecture of the health system's governance were studied and scrutinized by civic activists as the basis of a real struggle for practical actions in their own fields.

3) Health System Elements

"Causal relationship of factors influencing holistic health has been realized... external factors, currently consisting of the ecological and social environment."

Based on a structural study of whole elements comprising of health systems, a holistic approach of interrelated elements has been identified. Not all of these have been synthesized to a final real architecture or organization, but mutually related functions have been depicted in order to articulate with broader related actors and expand the mission so that furthering the redesign of the system can be undertaken.

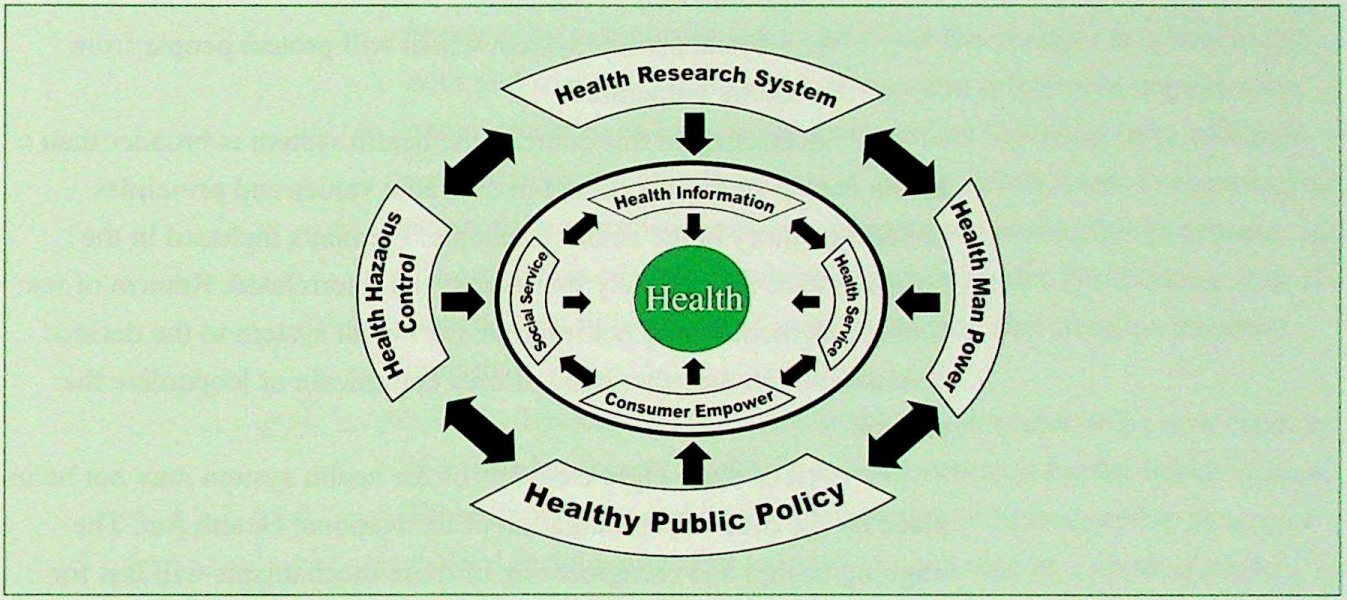
A schematic causal relationship of factors influencing holistic health has been realized. These are composed of external factors, currently consisting of the ecological and social environment. These factors are dominated by anthropogenic determinants with some natural impact. Intermediate factors are social determinants, which may play a prominent role in shaping human behavior. The inner

factors are genetic and biogenic factors that interact with human conduct and reflect the well-being of individuals and society.

With this conceptual framework of healthy a individual and society, a new interrelated set of elements comprising a health system was depicted. To support a healthy environment for society, the external roles are:

1. to guarantee healthy public policy - health impact, assessment, structure, and function;
2. to be the brain of the health system - health research system and technology development;

3. to prevent and control health hazards - surveillance and technical capability for protection;
4. to provide health related human resources - a network for manpower capacity building and policy.



The inner circumstance of elements would be the architecture for empowering the individual and society so that they can cope with the situation in a healthy manner. These are:

1. a health information system where new information technology would be employed to enrich individual and society knowledge;

2. a consumer empowerment mechanism, which would include the participation of civil society and a network of academics;
3. a health service system which supports a wide range of care as well as self care;
4. a social service system which will protect people from being vulnerable.

According to this context, the health system is broader than a health care system. It is rooted in desirable values and principles, including equity in the health of people. Elements included in the health system are mutually interactive and interrelated. Reform of just a single element would not improve the health system to the defined destination. On the other hand, it may complicate or jeopardize the reform.

All of these eight elements of the health system may not be in place by the time of promulgation of the National Health Act. The ongoing design and reengineering of these mechanisms will last for decades after that. Reorienting the architecture and function of the health system is a surmountable obligation, which demands clear visions and committed political force. However, knowledge management throughout this process of reform has entailed efforts to create a common understanding between policy-makers and the public on each specific issue.

9. Conclusion

Health system reform needs a holistic approach at all levels of a country; thus, synergistic effort among all stakeholders coordinated by firm government leadership is an essential cooperation to manage the transition. Only a stable political circumstance can provide an opportunity to mutually learn and direct the changes in accordance with real societal demands. Health system reform encompasses the entire spectrum of knowledge management - ranging from research coordination and empowerment of all the stakeholders to encouraging actors from pluralistic policy to be involved in the change process, and dissemination of understandable research results. Networking with all stakeholders to be involved in the reform is, therefore, an essential initiative.

Lessons learnt in Thailand have demonstrated a new capacity of a learning society to clarify societal demands for the health system. These knowledge management strategies were designed to synergize societal imagination with scientific knowledge as a vivid strategic plan, which will ensure visionalized reform among all potential alliances.

Knowledge management in a reform situation could oblige multidisciplinary researchers and institutes to join a broad network in order to undertake an enlightened mission. Without a promising theme of policy, it is difficult to interweave various lines of academic work into a complex prospect of targeted policy and systems. This supports

the fact that most academics wish to contribute their creations to benefit broader society rather than just solely publishing manuscripts. Coordination of analysts and researchers from different disciplines requires patience to mutually understand the issues and collaboratively analyze the situation then synthesize alternative options to be tried.

Health system research also has its role in empowerment of all partners of the reform to be capable of innovation within the ideology of the health system as well as in redesigning a sound architecture to support its new functions. A broad range of civil activists and policy makers was involved throughout the research work so that they could contribute their experiences to enrich the study. Simultaneously, they also learnt and realized an array of knowledge to empower their future movement as an integral part of health systems. This might be crucial leverage to manage the transition as well as to sustain the challenging change.

However, the process of drafting the National Health Act is not an end of a romanticized story, but rather the beginning of a long ongoing reform, which may last for decades. Thai society has initiated and is now acquainted with the utilization of sound knowledge to arm its wisdom. Certainly, not all innovations attained by the reform process will achieve the same expectations or be sustainable, but failures will also serve as learning experiences and be corrected. Thus, a learning society inspired with an aim for a healthy lifestyle is in itself a means and an end for health system reform.

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WHO and Civil Society: Linking for better health

CIVIL SOCIETY INITIATIVE

External Relations and Governing Bodies

World Health Organization

Introduction

We live in a world of shrinking borders and burgeoning needs, where people faced by rapid social, economic and political change are seeking new ways of controlling their lives and the future of their communities. Armed with more access to information than ever before, and backed by new technologies, people are banding together to find new means of articulating their needs and promoting their interests. Civil society today is more visible, organised and vibrant than it has ever been before. People's demands to participate in the development of policies that affect every aspect of their lives can no longer be confined to local settings but spill over into international arenas as well.

The engagement with civil society profoundly affects the ways in which international organizations understand and respond to the needs of people all over the world. Concepts about poverty, equity, justice, security, rights and responsibilities take on new meaning. Exposure to the complexities of cultures and communities hone critical thinking and sensitivity. Assumptions are challenged, power is redefined, change is initiated.

The World Health Organization (WHO) has had a long and successful history of working with civil society and nongovernmental organizations (NGOs) to promote public health. Evolving concepts about health and the articulation of its links to poverty, equity and development have recently widened the range of WHO's partners. No longer the domain of medical specialists, health work now involves politicians, economists, lawyers, communicators, social scientists and ordinary people everywhere. These developments have given rise to a new emphasis on partnerships, communication and outreach within the Organization.

The Civil Society Initiative, created in 2001 to energise WHO's relations with civil society, recently concluded a review of WHO's relations with civil society and NGOs. The review showed that while WHO's interactions with NGOs were varied, dynamic and long-standing they could benefit from more recognition and systematic integration into the Organization's core priorities. This publication seeks to celebrate WHO's existing interactions with civil society. It does not represent a comprehensive evaluation nor a complete representation of all interactions but rather provides a quick glimpse, a kaleidoscope of different situations and interactions that suggest how partnerships with civil society can yield tangible public health benefits for all.

Pursuing human rights

The pursuit of human rights has been a central concern of civil society. Human rights groups and movements have provided both the impetus and inspiration for the formulation of international and national laws to protect the basic and fundamental rights of people. By monitoring situations and making their findings public, human rights groups have also proved invaluable in ensuring that these laws are implemented as widely as possible. In addition to civic, political and economic rights, the right to health forms an important aspect of human rights. The examples chosen in this section illustrate how various organizations have worked with WHO in ensuring that the human rights of women, adolescents and the disabled are adequately recognised in public health programmes and policies.

Empowering adolescents in Mongolia

The right of adolescents and young people to influence programmes that are targeted at them is now recognised as fundamental to the success of any youth-oriented programme. It is only when young people can express themselves, their needs and their priorities that programmes can begin to help young people achieve their right to health.

In Mongolia, WHO and various ministries including the Ministry of Health have formed a partnership with other UN agencies and several NGOs to "improve the outlook for adolescent girls and boys". With the help of two youth-based NGOs – the Mongolian Youth Development Centre and Scout Association – the project aimed to involve young people directly in the design and implementation of health services in order to improve youth access to health services and to make health educational messages more appropriate to adolescents.

Youth voices and the NGOs helped challenge the assumption that most young people are healthy. They showed that health problems related to lifestyle, risky behaviour, and adverse social circumstances are increasing among the youth. These include tobacco, alcohol and other drug use, oral health problems, accidents and injuries, violence and stress, mental health and sexual health problems.

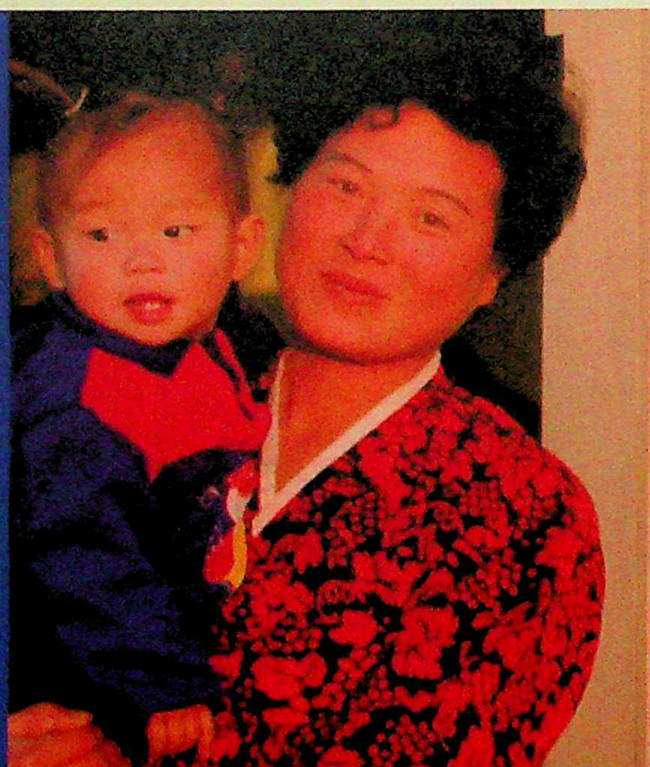
A review-team consisting of youth groups, parents, service providers, managers and policy-makers assessed the existing health services in the light of these health risks. In focus-group discussions, it became obvious that adolescents generally had little trust in service providers. They feared for their privacy and felt that their confidentiality would not be respected. When young people were asked evaluate the available educational material, it became obvious that they liked very little of it, and that it had been developed without their involvement. The project therefore conducted a six-day workshop to let the youth identify what kind of educational material they needed. They identified the need for simple and attractive posters on various issues including HIV/AIDS and reproductive health, material that was later developed by the project. Discussions with these young people have provided the basis for the development of a new Mongolian model for youth-friendly services.

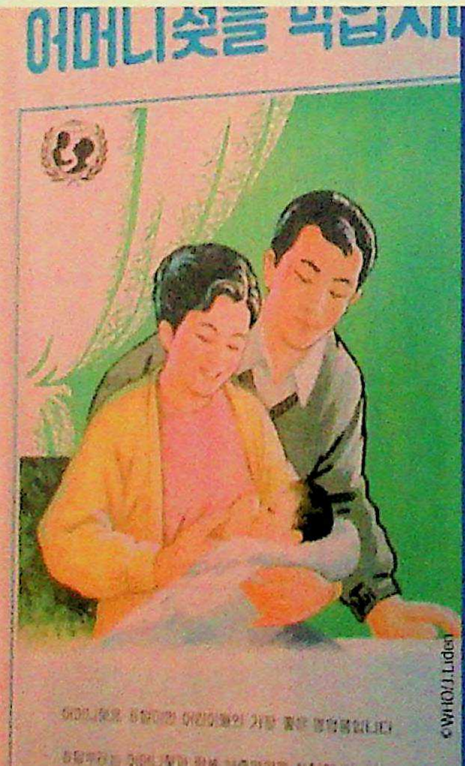
Based on project documents from "An Outlook of Adolescents in Mongolia".

Advocating reproductive rights

Women's rights advocates have pointed out the inadequacies of family planning programmes that focus only on fertility reduction to the exclusion of wider reproductive health issues for women. Women's concerns have ranged from the potential abuse of contraceptives to the lack of ethical standards in reproductive research. These and other concerns took centre stage during the 1994 UN Conference on Population in Cairo, and the adoption of the Cairo Declaration and Plan of Action is said to have been a breakthrough for the reproductive health and rights movement.

This development had implications for WHO's Programme for Human Reproduction (HRP) as well. The programme was set up to initiate and support the development of contraceptive methods. In response to





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Family planning programmes need to focus on the whole gamut of reproductive health needs and not just on fertility reduction.

the international demand for the inclusion of women's voices in reproductive health programmes, HRP initiated a series of dialogue meetings to ensure that the emerging views and approaches advocated by women's health advocates could be heard and reflected in its work. Policy-makers, scientists and providers of reproductive health services were offered an opportunity to listen to the experiences and needs of women who actually used these contraceptives and were potential recipients of new fertility regulation technologies. The dialogue meetings were conducted from 1992 to 1997, comprising of a total of six meetings, one in every region of WHO.

WHO pinpoints this dialogue process as having been a key factor in shifting HRP's contraceptive research agenda to increased emphasis on user controlled methods rather than only on hormonal methods such as injectables or implants, the delivery of which is dependent on the health system. A study in three countries on the acceptability, use-effectiveness and service delivery requirements of the diaphragm is one example of this shift. Research on the female condom was initiated in response to the need of women to be in more control of their reproductive options. Also as a result of the dialogue meetings, more attention is now devoted to training in ethical standards in research through a series of regional workshops on ethical issues in reproductive health research as well as a research initiative on the "informed consent process" to clarify what both research subjects and investigators understand by the concept of informed consent.

Based on documents concerning the project "Creating common ground" provided by HRP/WHO.

Preventing violence against women

Violence against women has been identified as a major public health and human rights problem in the world today. Women's rights activists and many others meeting at the UN Conference on Women held in Beijing in 1995 identified the lack of gender-sensitive health research and reliable data on the root causes, magnitude and consequences of violence against women as a major obstacle in the search for solutions to address this problem.

In order to collect such data, WHO started developing and co-ordinating a Multi-country Study on Women's Health and Domestic Violence in 1997. The study is being carried out in partnership with local research institutions and/or national ministries and women's organizations working on issues related to violence. The study has been implemented thus far in: Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Tanzania and Thailand.

Women's organizations have been important for challenging assumptions of the researchers and in shaping the questionnaire development for the collection of data. Research results have been used by women's organizations to mount information and advocacy campaigns in their communities. In Thailand, the study has provided the impetus for the formation of networks to address the issue,

in Peru has prompted women's health advocates to work on sensitizing local leaders to the problem of violence against women and gender inequality issues, and in Brazil has lead to integration of violence into medical and other health curricula. The study has also built local capacity by training the researchers and interviewers and building networks of people committed to working on violence against women.

The WHO staff involved in the study say the expertise of women's organizations has been invaluable in the development and implementation of the research. These organizations will also help WHO ensure that the findings are used for supporting policy change at both the national and international level.

Based on the report "WHO Multi-Study on Women's Health and Domestic Violence Against Women", June 2002.

By interviewing local women in their own surroundings, volunteers from women's organizations are critical in helping to gather data on violence against women.

Consulting the disabled about care

During the past two decades, beginning with the International Year of Disabled Persons in 1981, there have been significant changes in the concepts of disability and rehabilitation. The traditional medical model of disability has developed to incorporate social aspects such as participation in school, work and social activities as well.

Responding to these changing concepts, the Disability and Rehabilitation Team at WHO and the Ministry of Social Affairs in Norway organised the Rethinking Care Initiative and Conference bringing together disabled people and other stakeholders. The majority of the conference participants were composed of people with disabilities coming from all parts of the world, many of whom were represented by an NGO. The primary aim of the Rethinking Care Conference was to: "give disabled people requiring health and social support an opportunity to contribute to the process of Rethinking Care with respect to policy regarding the development of health and social services, and, in so doing, provide new insights and knowledge for the formulation of appropriate recommendations for WHO Member States".

Conference participants assisted WHO in formulating appropriate policy recommendations for governments. The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities provided the backdrop to the discussions, with participants focusing on awareness-raising, medical care, rehabilitation and support services in particular. The conference provided an opportunity for disabled people and the groups representing them to evaluate the care the disabled receive, and to suggest how services could be structured to suit their needs better. Among the recommendations made, governments were called upon to: ensure equal access to community-based services and facilities such as housing, schools and colleges, public buildings and transport systems; introduce comprehensive mandatory anti-discrimination laws; and secure the equal and effective treatment of all disabled people within mainstream medical services.

From the WHO conference report "Rethinking Care: from the Perspective of Disabled People", August 2001.

Promoting public health campaigns

By bringing in new perspectives, resources and outreach capabilities to supplement the government's and WHO's work, NGOs can make significant contributions to the implementation of public health programmes and campaigns. NGOs can be particularly effective in reaching marginalized populations and remote areas, ensuring community participation, and providing services and advocacy. The polio and epilepsy campaigns chosen for this section demonstrate that when WHO forms stable partnerships with NGOs, public health goals can be greatly enhanced.

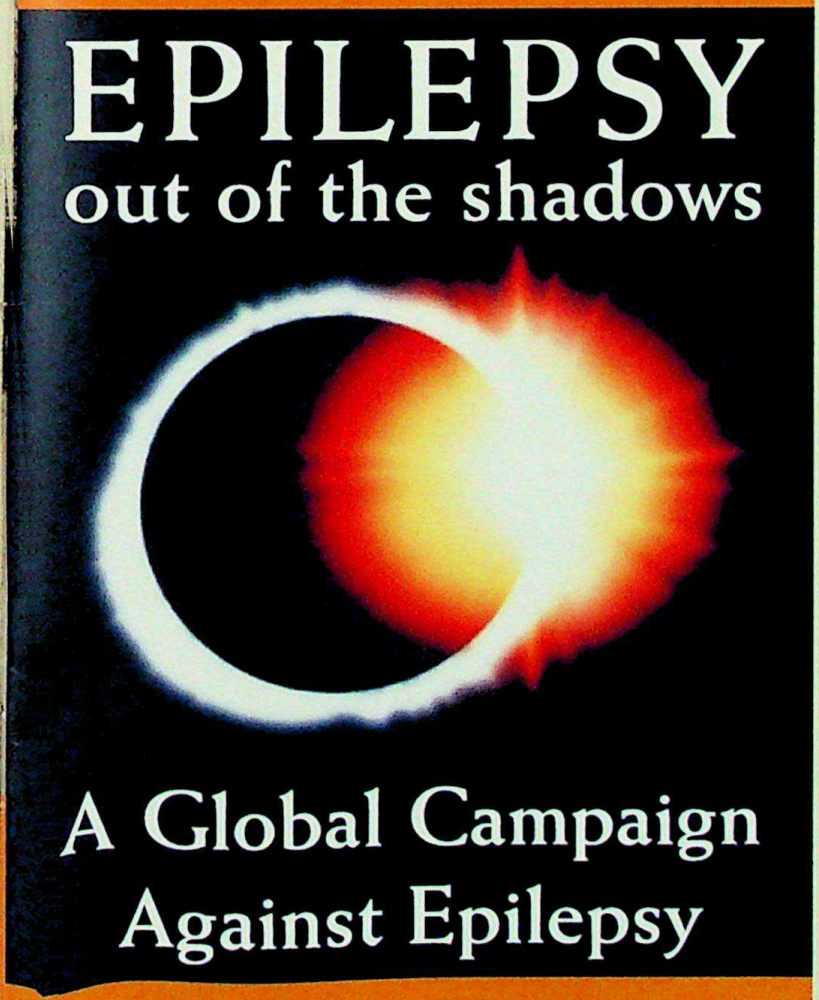
Fighting the stigma of epilepsy

Epilepsy affects 50 million people in the world today. With access to available treatments, the vast majority of them would be able to live normal lives instead of being subject to fear, stigma and discrimination. In order to raise awareness about epilepsy and its treatment, and to combat the stigma associated with it, WHO launched a global campaign in 1997 called "Out of the Shadows" along with two NGO partners. One is the International Bureau for Epilepsy representing patients and their families, and the other is International League against Epilepsy consisting of health professionals. Together, the three partners aim to raise the awareness about epilepsy to a level that has so far not been achieved, despite all efforts by each separate organization.

Together with the WHO Regional Offices, the national NGO-chapters in over 80 countries are the main actors in this campaign. The local chapters are in the best position to know the local problems, needs and solutions for people with epilepsy in their countries. The campaign activities vary from country to country. They include discussions to involve health ministers and health professionals in the campaign, translation of campaign material, poster competitions, and the initiation of advocacy efforts via the mass media such as radio, TV, and print press. Demonstration projects are set up to support Departments of Health with the aim of identifying and extending treatment to people with epilepsy as well as to promote prevention by educating health personnel. In addition to developing models for the integration of epilepsy care into existing health systems, the campaign partners also address the social and physical burden borne by patients and their families and work to dispel stigma. A newsletter, produced jointly by all three collaborating organizations, is regularly sent to over 600 addresses all over the world informing people about the progress and prospects of campaign activities. The NGOs also help raise funds from various public and private sectors to support campaign activities.

Adapted from a paper "ILAE/IBE/WHO collaboration", June 2002.

Out of the Shadows is an international campaign launched to raise awareness about epilepsy and its treatment and to fight the stigma and discrimination faced by people with epilepsy.



Eradicating polio

Rotary International is one of the partners on the Global Polio Eradication Initiative spearheaded by WHO, UNICEF, and the US Centers for Disease Control. Since the Initiative began in 1988, polio has been reduced by 99.8%. Polio still exists in a limited number of countries including India, Afghanistan, Pakistan, Nigeria, and Niger. Together, these countries account for 85 per cent of all polio cases, with the remaining cases found in the Horn of Africa, Angola and Egypt.

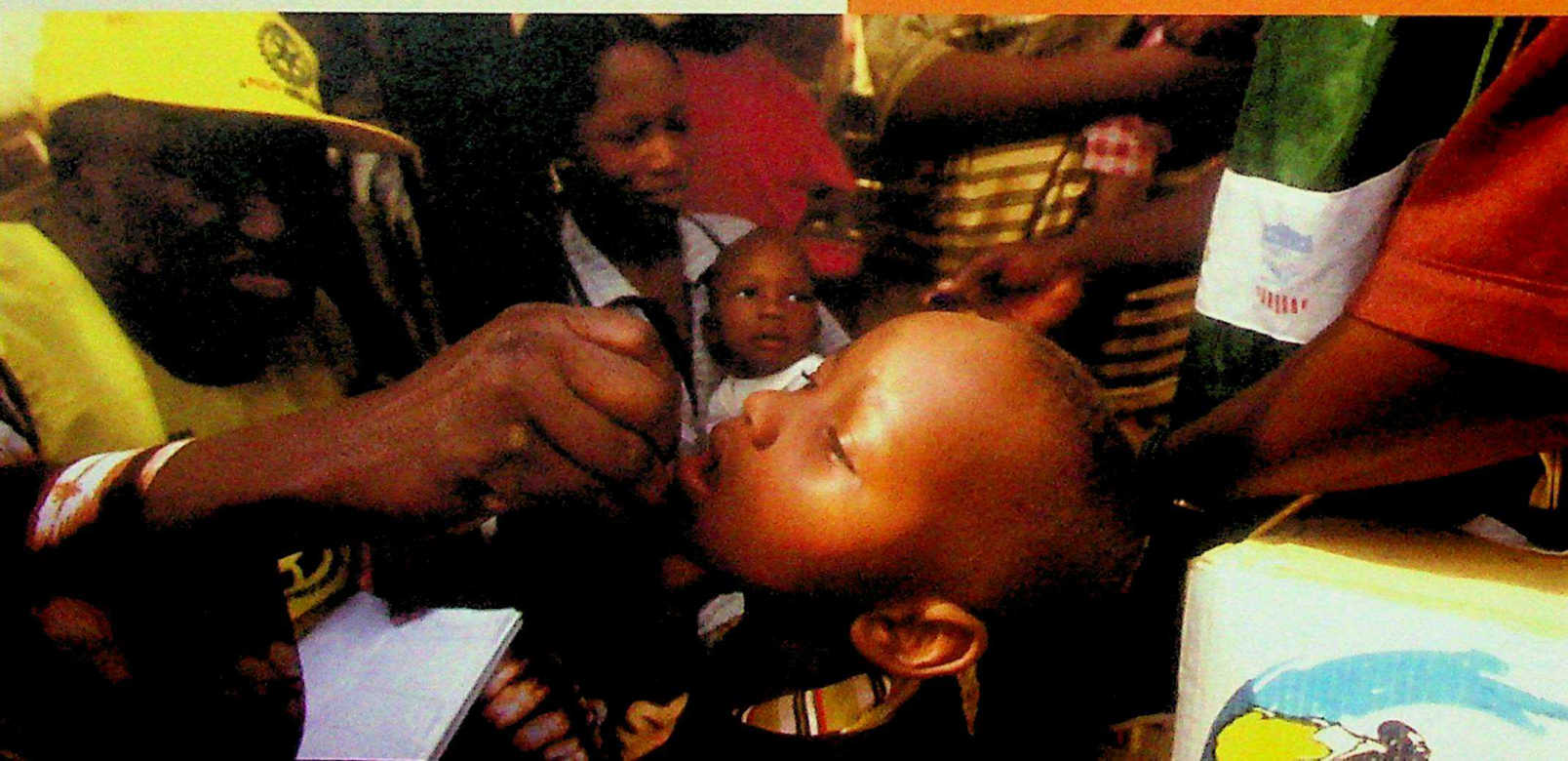
As a campaign partner and as an NGO, Rotary's role in the polio campaign has been manifold. Rotary members world wide have embarked on a major campaign to help meet the funding needs of the campaign and to raise US$ 80 million by the year 2003. To date, Rotary has committed US$ 510 million world wide, equivalent to 20% of costs. Indirectly, they have contributed even more by advocacy and pressure on their respective governments to contribute to the Polio Eradication Programme. In addition to raising funds, Rotary members donate their time and personal resources during National Immunisation Days. Rotary has also had an unprecedented role in mobilizing ordinary citizens, forming a highly motivated and trained volunteer base. In many countries, Rotarians have been active in preparing and distributing mass communication tools, assisting with vaccine delivery, administering the vaccine and providing other logistical support such as helping people get to the vaccination sites. In India, for example,

over 100 000 Rotarians and their families have joined the Indian government, health staff and volunteers to implement "immunisation days", reaching 152 million children in one day. Rotarians helped with social mobilisation, going from house to house to ensure that no child was missed.

"We couldn't accomplish what we have done without them," says a WHO officer when talking about Rotary International's commitment to the eradication of polio. The campaign's goal of eradicating polio is within reach, says WHO.

Based on Polio News Eradication, Polioplus by Rotary International, provided by WHO.

Donating time and resources, Rotary International has been active in organizing camps where children can get vaccinated against polio.



Reaching out in emergencies

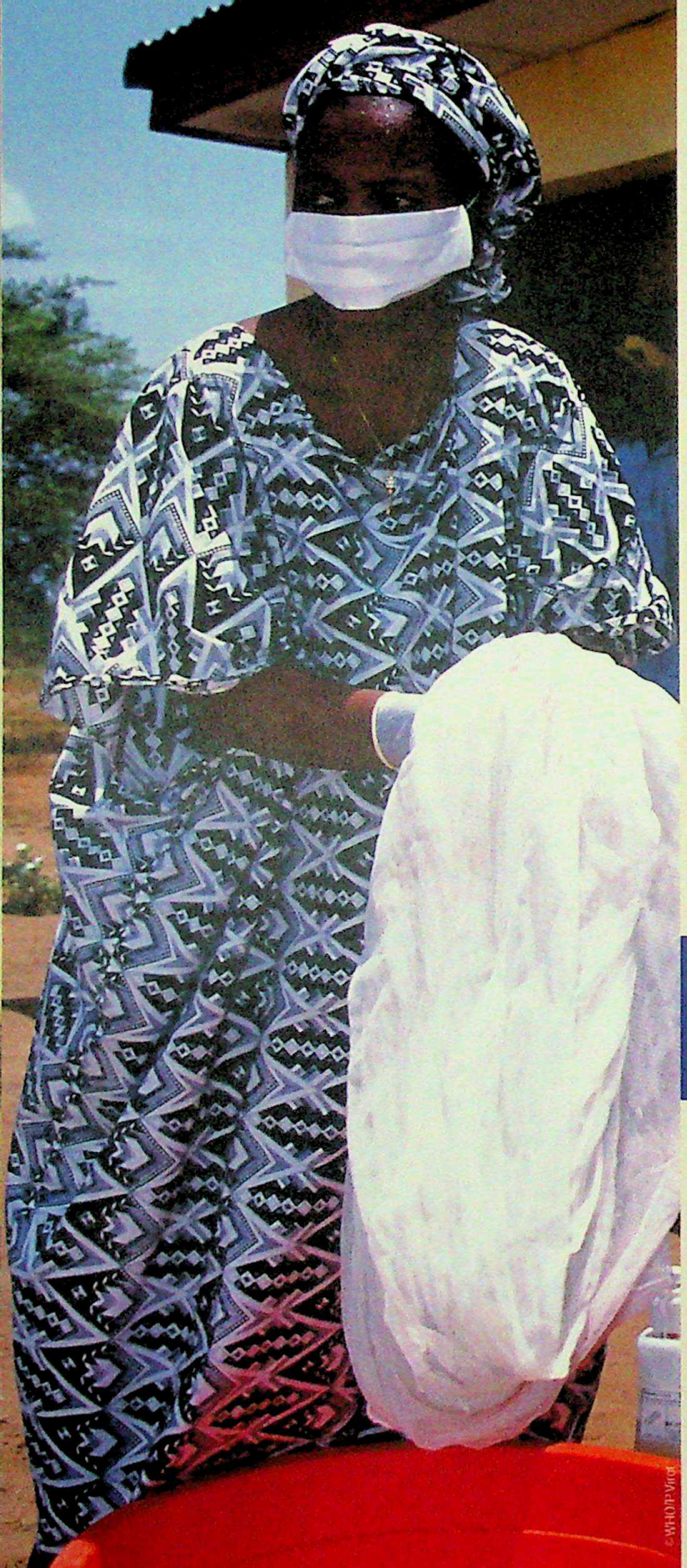
Emergency situations caused by armed conflict, civil unrest, drought, floods and other man-made and natural disasters effect people all over the world. In Africa alone 180 million people are affected. People suffer from fear and displacement, food and water shortage, and crowded and unsanitary living conditions in make-shift shelters and temporary camps. Basic health services collapse leading to rampant diseases that kill more people than the conflict or flood that created the emergency in the first place. Reaching these people in need can prove very difficult for international agencies such as WHO, making it necessary to turn to local and international NGOs operating in these areas. NGOs have a well-deserved reputation for setting up services and providing assistance to populations in emergency situations. Between 70 – 95% of health services are reported to be delivered by NGOs in emergency situations. The examples chosen in this section illustrate how NGOs have helped WHO treat and contain malaria, tuberculosis and guinea worm in countries where local systems have collapsed.

Rolling back malaria

Roll Back Malaria is a global partnership set up to have the world's malaria burden by 2010. At least a million deaths from malaria occur world wide each year – 90% of them in Africa, south of the Sahara. Up to 30% of Africa's malaria deaths are in countries undergoing complex emergency situations affecting large civilian populations.

In order to deal with these emergency situations, the partnership has set up a Technical Support Network on Complex Emergencies, housed in WHO, and consisting of UNICEF, UNHCR, the Malaria Consortium, Medicins Sans Fronti res, Medical Emergency Relief International and the US Centers for Disease Control and Prevention.

"Institutions are prone to slowness. We need NGOs to generate speed and action," says the Technical Support Network based at WHO. Besides mobilising NGOs and other emergency partners, the network trains and equips them and provides technical support to increase their capacity to respond quickly and effectively.



With the assistance of these emergency-NGOs, activities are ongoing in several Sub-Saharan African countries and in Afghanistan. Problems that have been addressed include the issuing of clear treatment guidelines in cases of drug-resistance, managing malaria effectively among malnourished people, and treating extremely poor people. Together, NGOs and WHO have developed standardized guidelines, a draft handbook on malaria control, and a training manual for health workers. NGOs have also helped develop and test new tools such as insecticide-treated emergency plastic-sheets for the construction of shelters.

From the Roll Back Malaria web site information provided by RBM/WHO.

Showing people how to treat sheets with insecticide is part of the malaria control work undertaken by health volunteers in Africa.

Treating tuberculosis in Somalia

Tuberculosis kills two million people every year. A lack of basic health services, poor nutrition and inadequate living conditions all contribute to the spread of TB and its impact upon the community – factors that are rife in emergency situations. Having seen great political and social upheaval in recent decades, Somalia has one of the highest TB incidences in the world, 375 per 100 000 population.

To respond to the fragmented situation in war torn Somalia, UN agencies, local and international NGOs, multilateral and bilateral donors organised themselves in 1993 into the Somalia Aid Coordination Body or SACB. A health sector committee and several ad hoc working-groups for diseases such as TB, malaria, and cholera were created. Seventeen international and local NGOs are the ones who actually provide out-reach services for people that cover the 18 regions of Somalia. In spite of considerable logistical and security problems, these NGOs have helped ensure that the overall treatment success rate has reached 79%, with several centres reaching the target of 85%.

The TB-working group in Somalia is also facing new challenges that will require even more synergy and understanding among partners. The increasing prevalence of HIV in TB patients, the threat of multidrug resistance, and the new opportunities like the Global Fund to Fight AIDS, TB and Malaria make it necessary that a broader approach to tuberculosis be undertaken. The role of NGOs in ensuring that these challenges are met will prove critical in the future.

From information provided by
WHO Country office, Somalia.

It is difficult to treat TB patients in countries undergoing great social and political upheaval.

Eradicating guinea worm in Southern Sudan

In the beginning of the 20th century, guinea worm disease or dracunculiasis was widespread. Due to public health campaigns mounted by WHO and its partners including Global 2000, UNICEF, NGOs and the endemic countries, 98% of guinea worm cases have now disappeared. The parasite, however, remains a problem in 13 Sub-Saharan African countries with the overwhelming majority of cases – about three-thirds – found in southern Sudan.

Working in this war-torn country has required WHO and its partners to find different strategies to combat this disease. The void created by the collapse of the health system has been filled by numerous international and local NGOs providing services to a scattered population. The only way WHO can fulfil its goal to eradicate guinea worm is by working with and through these nearly 40 NGOs.

WHO provides technical support to the NGOs in the form of training, supplies and transport. The NGOs in turn use the presence of their volunteers on the ground to raise awareness in villages about how the disease is transmitted. Volunteers teach villagers how to break the transmission cycle by filtering drinking water, digging wells and boreholes and chemically treating contaminated drinking water sources. NGOs also provide medical services by helping to detect cases early and by cleaning, treating and bandaging wounds caused by the worm. Since the health needs of the people are enormous and they face common risks, technical support from WHO has to embrace common health care needs and includes TB, malaria, leprosy and other diseases as well. Every year a coordination meeting is held in Nairobi with WHO and all the NGOs from the area, providing an opportunity to exchange information and experiences and to strengthen capacities for enhanced action. With the help of these NGOs, WHO hopes to make guinea worm disease the first parasitic disease to be eliminated.

Based on information provided by the Dracunculiasis Eradication Programme, WHO.

©WHO/Dr Ahmed T.Jayeh

Learning how to filter drinking water is a key aspect in controlling the spread of guinea worm in southern Sudan.

Enhancing local capacity

One of WHO's main functions is to work with Member States and civil society in strengthening national and local health systems. Health developments at these levels are often very complex, involving a range of different actors and issues. Governments and health systems have to balance competing health demands with limited resources. There are many situations when health functions can be effectively delegated or shared with grassroots and community level organizations, especially when financial or human resources are constrained. This can help reduce the burden on local and national administrations as well as enable governments to meet their social obligations more effectively. The examples chosen from India and Cambodia illustrate the various ways in which WHO can work with NGOs and the government to not only help improve the health of people but to also strengthen the internal capacity of both actors to sustain future public health efforts. The example chosen from Africa also illustrates the role WHO can play in building better understanding between governments and NGOs.

Improving sanitation in an Indian slum

The provision of water and sanitation services and the improvement of hygiene is a major problem in many parts of India. The rapid increase of the urban population has resulted in the formation of slums and squatters facing an acute shortage of basic amenities such as water supply and waste disposal systems. These unsanitary environments can lead to widespread infections and diseases caused by unsafe water, flies, mosquitoes, hookworms, or roundworms with a devastating impact on infant mortality and the general health of slum dwellers.

The South East Regional Office of WHO (SEARO) has established partnerships with NGOs and the local municipal government in a project to provide low-cost toilets and safe water for 150 000 people in 12 urban slums in Delhi, India. The Population Services International-INDIA (PSI) and Sulabh International Social Service Organization are the NGOs actually implementing the project in the slums.

The low-cost community toilets built, operated and maintained by Sulabh have vastly improved sanitation in the 12 slums. In addition to this, PSI and Sulabh have trained over 6000 residents of Delhi slums on hygiene and sanitation related issues and identified 1500 volunteers among the residents to

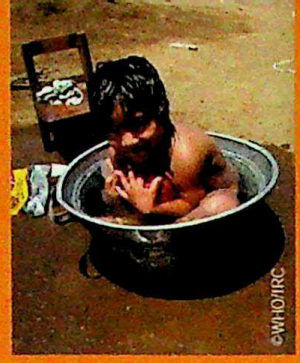
communicate health and environmental messages to the people. One of the key changes being promoted is the disinfecting of drinking water by people in their homes using a low-cost water disinfectant socially marketed by PSI. The perspectives and experiences of the volunteers have, in turn, shaped the nature and content of the training and the information material provided to them. As important as the toilets are in improving sanitation and hygiene in the slums, the education and advocacy efforts undertaken to change social attitudes and behaviours about hygiene and sanitation are considered vital to the long-term improvement of the health of the people.

Based on information provided by SEARO, Sulabh and PSI, India.

Reforming Cambodia's health sector

In the early 1990s, Cambodia had a new administration and the country was entering into a more stable phase after decades of unrest and conflict. The ushering in of a new era provided the WHO country office an ideal opportunity to work with the national authorities and other organizations in rebuilding and strengthening the health sector.

An initiative to improve the government's capacity to handle the health sector reform was undertaken along with WHO, UNICEF and NGOs active in health. There were about 80 international, emergency and development NGOs working on health in the country. WHO and NGO representatives were involved in monthly national Central Co-ordinating Committee meetings in charge of steering the health sector reforms. All NGOs at provincial levels attended similar coordinating meetings at the provincial level. These meetings served as peer



Children are particularly vulnerable to disease and infection caused by unsanitary conditions and unsafe water.

group reviews, allowing for discussion on the provision of care and the best ways for meeting the needs of the people. The Ministries of Finance and Health were able to get direct feed back from the field on various aspects of health policy reform such as the effect of user-fees on patient's health seeking behaviour. The NGOs helped to identify research areas that the Ministry of Health was able to subsequently take up. The NGOs also took an active part in developing national technical guidelines of care which were of particular use at the district level.

With growing national capacity, the joint meetings between the government, WHO and the NGOs have now become less frequent, although they still continue. The Ministry of Health is presently working on a Health Strategic Plan with active participation from NGOs as well.

Based on information provided by WHO Country office, Cambodia.

Mapping NGOs in Africa

In order to fill the gap in knowledge about civil society actors, and to provide governments and international agencies a sound basis for building new partnerships with NGOs, WHO's Regional Office for Africa decided to initiate a mapping of NGO resources in Africa. Forty-two of the 46 WHO country offices in Africa canvassed local NGOs and made inventories of NGOs active in the health sector, while the Regional Office produced an overall analysis based on these country reports.

The report noted that many of the national NGOs in operation in Africa are relatively young, having been formed in the 1990s, and tend to be largely concentrated in areas close to the capital cities. In general, national NGOs made up 50-75% of the total number of NGOs operating in the health sector, while the presence of international NGOs increased substantially in countries under emergencies.

Relations between NGOs and governments had improved substantially in recent years. However, there was a general lack of coordination of NGOs by governments and among NGOs themselves. Many countries lacked an NGO policy and NGO registration systems were unevenly spread out among countries. Where NGO policies did exist, few were drafted with the involvement of the NGO community. Not many countries had systematic structures or mechanisms established to facilitate the involvement of NGOs in policy-making and legislation. The report made many recommendations to improve this situation, including the setting up of new legal and administrative structures, improving information exchange, setting up of umbrella networks, and establishment of funding programmes.

The regional office report was presented to governments. So far, 14 African states have arranged special national NGO forums to discuss how to take the recommendations forward. The Regional Office hopes to work with more governments and NGOs in order to strengthen joint activities to improve health in Africa.

From the report "Tripartite Collaboration, an analysis of NGO country studies in the African region," Regional Office for Africa, Sept 2000.

Engaging professionals

One of WHO's main tasks is to produce guidelines on various public health issues that reflect the latest scientific knowledge and consensus on the issue. These guidelines not only set policy standards but also contain practical information on the application and implementation of public health programmes. WHO's technical guidelines involve and benefit professionals all over the world. Many of the guidelines are produced in collaboration with professional associations. Besides bringing the needed expertise and acting as local and cultural sounding boards for the application of these guidelines, professional associations can help WHO disseminate the information as well. The examples in this section illustrate WHO's collaboration with professionals in advancing knowledge on midwifery and sanitation.

Providing resources for water and sanitation experts

With the aim of accelerating health gains from safe water and hygiene, WHO collaborates with a wide range of organizations, including many from civil society. One example is the International Water Association (IWA) which has a history going back over fifty years, has long-standing official relations with WHO and provides access to an active network of around 7000 water professionals in over 130 countries. Its members includes university academics, government policy makers and regulators, both public and private water utilities as well as other private sector suppliers. The Association and its members cover the continuum between research and practice in all aspects of the water cycle.

These strengths have led to a multi-faceted relationship with WHO. The IWA provides access to a strong network of professionals, allowing WHO the benefits of working with the technical diversity and practical know-how of the Association's membership. The IWA's specialist groups provide scientific input to WHO publications on topics such as water quality guidelines. They collaborate to advance best practice such as the Sanitation Connection, a web-based resource on environmental sanitation.

WHO works with experts to promote safe drinking water standards.

©WHO/IRC

WHO and the IWA jointly publish material of particular relevance to IWA members such as new titles on microbial safety and chemical quality of drinking waters. WHO also has targeted access to expert audiences through participation in IWA conferences so as to disseminate new science to practitioners at both international and regional levels. While professionals get access to an international institution that works directly with governments and that sets standards, WHO benefits from the professional reach and technical expertise of the NGO.

Based on information provided by IWA and WHO.

Producing a best seller for midwives

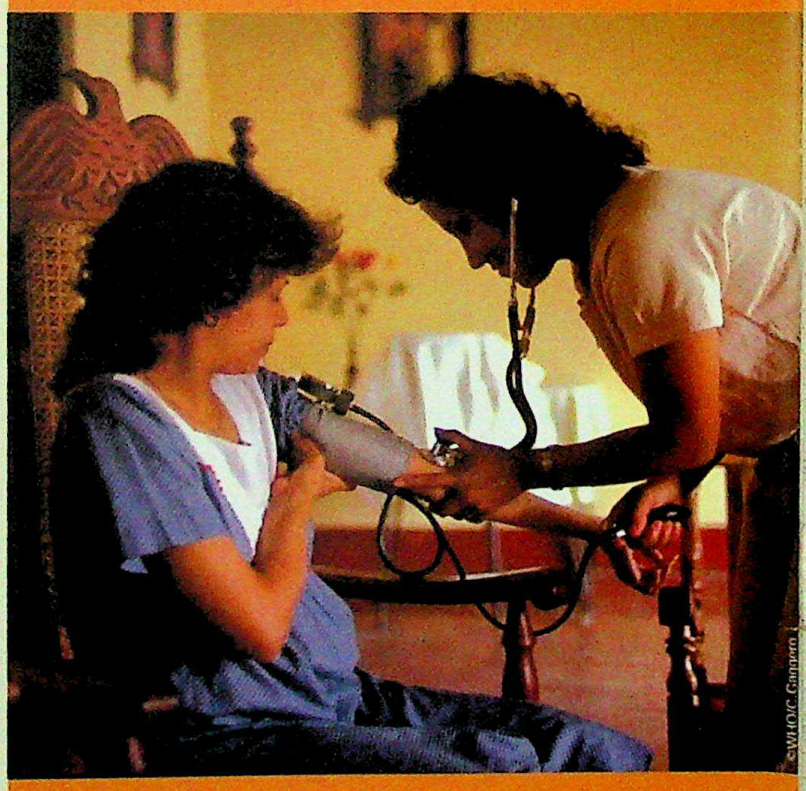
Midwives and nurses are critical in helping to reduce mortality, morbidity and disability among women and children and to promote healthy lifestyles. WHO works actively with two professional associations – the International Confederation of Midwives (ICM) and the International Council of Nurses (ICN) – to increase awareness about the importance of midwifery and nursing and to strengthen technical skills and leadership capacities of midwives and nurses in countries.

Towards this end, the production of midwifery training modules to upgrade midwifery skills and improve maternal and new born health care services deserves special mention. ICM and WHO's Department of Reproductive Health gathered together midwives and teachers of midwives from around the world to jointly identify needs for midwifery education for safe motherhood. Six training modules were subsequently developed based on needs identified by participants. WHO provided technical input, coordinated the project, and provided funds.

After intensive field-testing by WHO and the ICM, WHO printed the education material in 1996. Since then they have been updated, used all over the world and constitute a "best seller", according to WHO's publication distribution centre. An independent committee recently evaluated the updating of the six modules. The review process included UNICEF, UNFPA, the International Confederation of Midwives and the American College of Nurses and Midwifes. The review conclude that the modules were still in great demand and had advanced the cause of midwifery. It further recommended that the material should be used as basic text for training not just midwives but all other health professions requiring midwifery skills, including doctors. A new module is currently under way to complete the set, aimed at the management of the major causes of maternal death.

Based on information provided by RHR/WHO.

Midwifes play a critical role in helping to ensure safe pregnancies and in reducing maternal and infant mortality.



Balancing private sector interests

The pursuit of public health often brings WHO up against competing economic and political interests. Depending on the circumstances and the industry concerned, WHO may decide to work or not to work with certain industries. In either situation, NGOs play a critical role in helping WHO ensure that public needs are not drowned by private sector concerns.

The tobacco and pharmaceutical examples chosen in this section represent very different situations for WHO. The interests of the tobacco industry are totally contradictory to health. The tobacco industry's main objective is to sell more tobacco products, while WHO's goal is to reduce tobacco consumption to save lives. On the other hand, the interests of the pharmaceutical industry partially overlap with WHO's goals. Drugs and medicines are essential to protect health. The industry's policies can, however, sometimes run contrary to the public health goals of ensuring equitable, sustainable and integrated drug systems that are best suited to the country's needs.

Developing guidelines for drug donations

Countries perceived to have a shortage of medicines often receive donations of drugs provided directly or indirectly by pharmaceutical companies. These donations are not always needed, safe or appropriate raising great concern among public health officials. In order to set standards for drug donations that met public health needs, WHO initiated a global consultation in 1996. The Department of Essential Drugs and Medicines Policy consulted with over 100 individual experts, recipient countries, international organizations, donor agencies, industry representatives and NGOs. The result was a Guidelines for Drug Donations jointly issued by NGOs and international institutions – the World Council of Churches, ICRC, International Federation of Red Cross and Red Crescent Societies, M decins Sans Fronti res, OXFAM, UNHCR, UNICEF and WHO.

The Guidelines were translated into various languages and widely distributed by all the co-sponsoring agencies. They were published in scientific journals and used in training programs, academic courses and at international conferences. An evaluation 16 months after the introduction of the Guidelines showed that they had been adopted or adapted by either the governments or the organizations involved with donations in over 45 countries. Overall, the evaluation showed that the guidelines were making a difference.

Donations were meeting needs better and it had become easier for recipients to refuse a donation. The drugs received had longer shelf life, packaging and labelling had improved, and distribution-times had been reduced.

The Guidelines were revised and re-published in 1999, this time with 15 co-sponsoring organizations. In spite of not being an international regulation, the Guidelines have had a positive impact on drug donations internationally. According to the evaluators, "It is the awareness and the discussion that have actually led to better donation practice." The NGOs involved in the process played a major role in ensuring better standards, monitoring drug donations and in ensuring that the Guidelines have been adhered to by the industry.

Based on Guidelines for Drug Donations, 1999 and Five-year experiences with the Interagency Guidelines on Drug donations.

International guidelines try and ensure that drug donations are safe, are of the highest quality and meet the needs of the country.

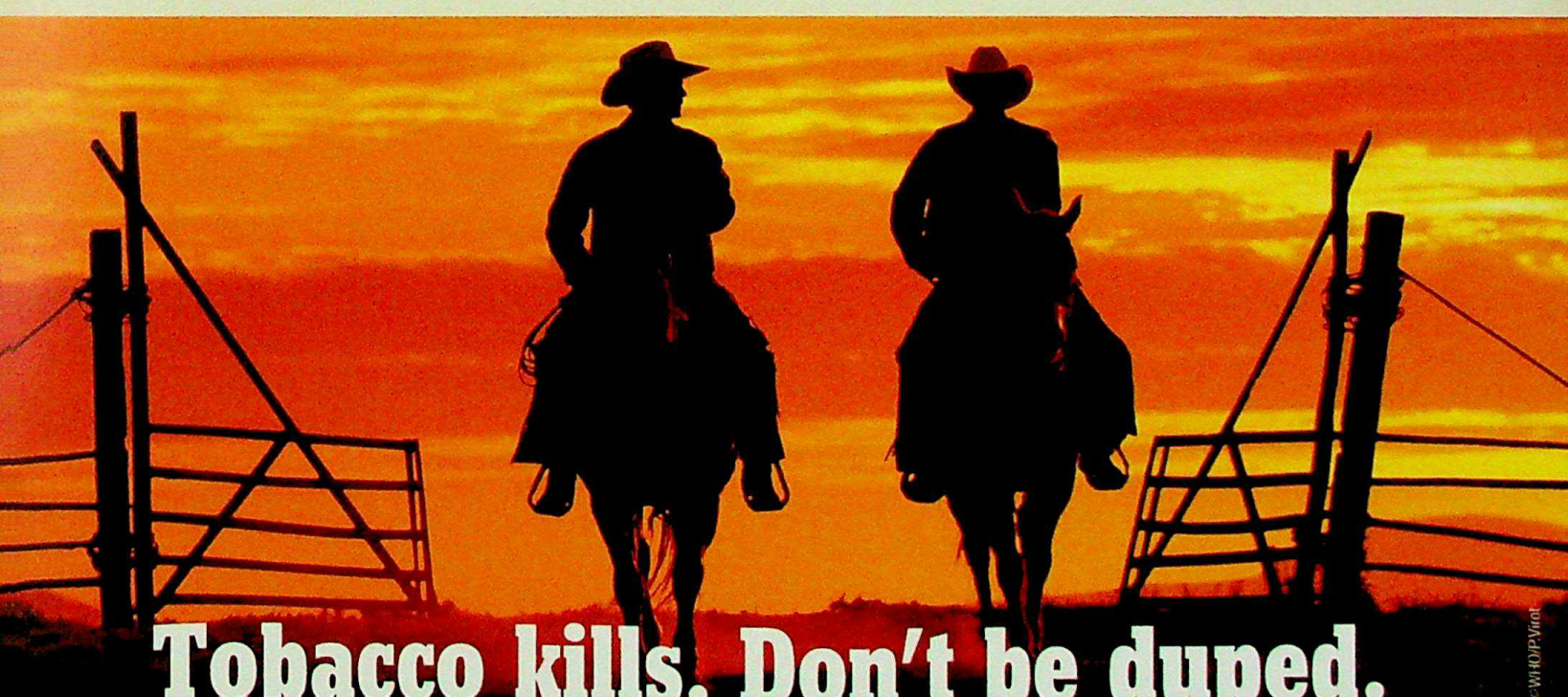
Countering the claims of tobacco companies

Tobacco kills nearly five million people every year, making it the single largest preventable cause of death today. Since the 1950s, the tobacco industry's own scientists have known that nicotine is addictive and that tobacco kills. Documentary evidence of the industry's own internal papers point to systematic and global efforts by the tobacco industry to undermine tobacco control policy and research in order to starve off legislation and regulation.

Countering the decades long campaign of tobacco companies and exposing the truth about tobacco is one of the main tasks facing WHO's Tobacco Free Initiative (TFI). This task took on an added urgency in 1999 when WHO's Member States began negotiating the world's first international treaty on tobacco, the Framework Convention on Tobacco Control. Tobacco companies, now faced by their first credible international threat, went into a high-gear public relations campaign to weaken the treaty.

As part of the advocacy efforts to support the treaty, WHO launched the "Tobacco Kills – Don't be Duped" global media and NGO advocacy campaign. The initiative aims to equip media and health communicators with appropriate information and tools to tell the story of tobacco, promote healthy choices and push for policy changes. Freedom of information issues, especially the public's right to know about the health consequences of tobacco use on the one hand, and the tobacco industry's practices on the other, are emphasised. As part of the project, NGOs in nearly 30 countries help WHO expose the truth about tobacco and tobacco company campaigns and strategies. Both within the project and outside, the NGO community's public scrutiny of the tobacco industry and continuous support for a strong treaty have provided WHO with effective allies in its fight against the tobacco epidemic. The success of Don't be Duped has led to the initiation of a new NGO project called "Channelling the Outrage" aimed at building up future support for the implementation of the tobacco treaty.

Based on information provided by TFI, WHO.



Conclusion

The examples included in this document represent a mere fraction of all the interaction and collaboration that takes place between WHO and civil society. Even this limited selection, however, shows us that public health is the winner when such collaboration is based on trust and respect.

- NGOs have played an important role in implementing human rights within public health. They have pushed for the formulation of policies as well as monitored the results of implementing these policies at local, national and international levels.
- Important public health programmes and campaigns in WHO have benefited from NGO contributions to fundraising, mobilization of volunteers and advocacy.
- In countries affected by emergencies, NGOs have ensured that people have access to health services and medicines. Very often, NGOs provide WHO's only access to local populations in need.
- NGOs help WHO and governments in building up local public health capabilities. The truth is that much of health services in many countries are delivered by NGOs.
- Working with professional organizations provides WHO with access to a varied pool of technical expertise as well as improves the professional's capacity to use data. Professional organizations also help WHO disseminate the information to an audience that can actually implement WHO's guidelines, providing an excellent source of practical feedback for the Organization.
- NGOs help WHO in balancing the political and commercial interests involved in public health. They can promote openness and transparency in the setting of public health standards and policy, and help ensure that private sector interests do not supercede public health priorities.

NGOs offer WHO unique avenues for action. They have engaged with WHO to implement health programmes at country level, made outreach to remote areas and populations possible, advocated public health issues to a broad audience, addressed sensitive issues and worked in alliance with WHO to raise funds more effectively. The increasing role of civil society in public health has not only placed new demands upon WHO but has also opened up fresh oppurtunities for expanding the mutual benefits involved in partnerships. Integrating civil society into its work will be vital to the Organization's future development and bring much needed vitality and energy to meet the public health challenges of the 21st century.

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