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Annexure

GLOBAL HEALTH WATCH

As part of the Indian dialogueue on the Global Health Watch, Community Health Cell, Bangalore hosted a meeting on behalf of the NGO forum. Prior to the meeting, with a view to generate some pre-dialogue discussion and also as a means of focussing on the questions of what, how and who, a questionnaire was sent out. The meeting itself had presentations by various 'watches' already working and sharing of a few campaigns. There were also group discussions where the participants were divided into smaller groups and asked to discuss the questions in details. This paper is compilation of the responses from the questionnaire as well as the ideas that were generated during the discussions. The attempt would be to not only highlight the more commonly felt views but also to reflect the whole range of views that were received and discussed.

During the meeeting after the group discussions question wise range of responses were presented and the groups discussed and added any points they had specifically discussed. In the paper we present both the range of views and a sense of the discussion that followed.

1 What are the inequalities and inequities in Health in your country ?

- Regional differences, including differences in access to services and spending on services, inequalities arising due to areas being isolated and interior, rural and urban differences and North / south diferences.
- Class - economic status, systems of graded services, different levels of monetisation of economies
- terrorism and insurgency affected states
- urban slums
- nomadic / immigrant labour / unorganised sector of labour.
- inequal budgetary allocation against PHC and towards tertiary care
- historical processes that states go through
- inequalities arising out of inequtable distribution of information / awareness / education
- employment status
- inequality in access to quality of care
- gender -(esp as sex of doctor available is most often male)
- caste
- life expectancy
- age - geriatrics / adolescent
- tribals
- religion

Recognising that the range of inequalities compiled from the questionairre was too wide, the group felt it was important ot focus on **class, caste, gender and regional differences.** It was important to realise that inequalities were not only present but were also on the

different
bring to bullets
point & changes
during the meeting

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increase. It was also highlighted that certain regions like the North East were being systematically neglected. Another point brought up was that there was also inequity in the access to quality care.

(b) Implementation of conventions, treaties, plans of action etc?

This was seen as a measure of commitment of the Government to the concept of Health For All.

- A majority of the respondents felt that the government had failed to implement the treaties
- A few felt that the government had partially fulfilled implementation and had failed to succed due to subtle changes being made over time, and the fact that the governments commitment to the convention was not reflected in the policies.
- There was one respondent who felt that the government had done its job.

It was brought out that it was important before asking the national government about its commitment, one should ask whether the WHO was really committed to the HFA goal. This was as important due to the complete distancing of WHO from its earlier stand in Alma Ata due to pressure from from the funding agencies, recognising that the national governments were also under similar pressures. However at the same time it was also felt that one should not use this to absolve the governments of all responsibilities. It was highlighted that though the govt. signs all conventions it had systematically avoided those that made it accountable in any way. The fact that the govt. was not seen to be implementing its commitment was also due to the fact that there were no efforts to translate these commitments into policy. It was also brought out that the public was not aware many times of the commitments made by the govt and if this had been there there would have been more pressure on the govt. Further the unstated agenda behind most of these Bretton Woods sponsored conventions needs to brought out in the open.

(c) Are there any specific examples where these inequalities are being compounded by other factors ?

This would highlight the compounding factors which the Watch should be aware and without tackling which no real progress can be made in achieving Health for All.

- SAPs , stratification of services due to ..
- corruption- misuse of public resources
- media explosion leading to changed values
- management structures not suiting Indian ethos
- environmentally unfriendly development projects
- inadequate / untimely release of funds
- lack of infrastructure.
- Influence and vested interests of drugs and pharmaceuticals industry
- external aid
- lack of private sector effort / involvement

- complete dependence on the f government
- lack of seense of participation
- lopsided priorities
- poor information base /illiteracy / unaware citizenry/ lack of sense of participation
- uncommitted professionals, lack of monitoring / supervising
- urban bias of NGOs
- insurgency / violence
- eco non-friendly tourism
- western based education / medical education.

There were numerous compounding factors that were identified. They could be succinctly put as **mismatch of health policy from epidemiology in the context of already existing socio-economic inequality.**

2 How would you measure health inequalities ?

(a) How would you show that these inequalities exist ?

- government data including - census /SRS / NFHS / - by disaggregating for different factors
- comparative perspectives
- qualitative and case studies , narratives
- per capita expenditure in various areas
- sale of drugs etc / utilisation of hospital services.
- pattern of unfilled posts./ idle time in PHCs / adequacy of equipment
- fees structure of various services available in a given region / financial burden
- data should be sensitive to determinants of health
- no need to demonstrate.

The group agreed on the fact that to truly reflect the inequalities as they are, one required **disaggregated, sensitive and autonomously collected data.** Other points that were brought out were that the data really needed to be of the village or district level to truly reflect the inequalities. It was also felt that using rates instead of percentages would be more representative of reality. 'numbers'

(b) Which sources of data and information in yor country can be used for monitoring?

- Govt. reports - SRS / census / NFHS / NSS / expert comittee reports
- reports from other agencies - NGOs / NCAER
- cause of death survey
- HMIS
- media and media archives
- internet
- rural health bulletin

- full extent of inequalities can be appreciated only through micro studies
- large primary surveys

It was recognised that by far the most consistently available data and data from the widest area was the government data. However the data had inherent weaknesses especially the lack of sensitivity to determinants of health. The fact that disaggregation could not be done below state level and also not for all variables was a definite draw back. It was also important to recognise that the NGOs themselves had large amounts of data and these should be made available.

(c) What about accuracy and transparency of government data ?

- every body felt that it was inaccurate and not transparent but is was the only regular source of large scale data.
- It was felt that the quality of data correlates with the quality of health services / admin.
- SRS / NFHS - have been found reliable

There was a general agreement that government was neither wholly accurate nor transparent and more importantly was not truly reflective either. The fact that the govt. is resorting to large scale fudging of data is disturbing. It was also pointed out that senior officials in the govt. themselves were unaware of data or were fed with false data. There was also a systematic suppression of data that is deemed 'political' and this was a major stumbling block. It is also true that many National Units whose function it is to collect these data are neglecting their function.

(d) Is there a need for primary collection or would it be possible to analyse existing data?

- There was a general consensus that there was a necessity for primary collection of data - however these data should be collected from strictly supervised and monitored studies and these could be small sample studies.
- A few felt that the existing data was enough to work with and a innovative analysis of the available data would do.

It was felt that there should be a regular **system of collecting data** in place and this would be a autonomous body and would provide necessary data.

(e) How is it possible to gain access to the data ?

- right to information law
- trust building
- partnership with the government.
- funding agencies making loan availability conditional to provision of data

- govt data more easily available than NGO data

(f) How to verify if the data is reliable and accurate ?

- internal consistency checks
- following time trends
- cross - checking representative samples
- small sample surveys
- regular monitoring
- focussing on one or two important areas

(g) Is there a need to protect sources, and if so, how?

- most responses -no (as it would decrease the credibility of data)
- two responses -yes; for fear of data being withheld in the future
- classify data into common and classified sources of data classified as common need not be protected.

(h)Who would monitor the data and how?

- academics / researchers
- policy makers
- programme planners
- NGOs / activists
- government-NGO partnerships
- selected sensitive government officials
- parallel monitoring groups / special research teams
- individuals / groups outside the government
- press / media

(ii)how?
undertaking cross-check studies internal auditing

(j)What are the cost implications?

- Most people felt that the cost implications would not be large.
- A couple felt that it would be substantial
- depends on design
- it is cheaper in the long run to have a system in place

3. Advocacy

(a) Where can issues of inequality in health be take up?

- public fora including caste panchayats etc.
- media
- govt -NGO interactions
- take matters to court
- academic -govt interactions
- focussed conferences
- raising matters in the legislature
- professional associations
- local govt. level PRI
- community to be made aware of issues at all levels

It was felt that to decide on the where the issues of inequality should be raised was of strategic importance and therefore there needs to be a separate sitting of a core group once the structure and organisation etc of the 'watch' and its mandate were decided. It was felt that **involving the people was crucial** and merely advocacy by NGOs without popular support would never be effective.

(b)How can these issues be taken up?

- publications, lay and scientific
- public announcements / media releases
- NGO-community groups meetings
- general awareness/sensitising campaigns like *jan adalats / jan jatthas/* public inquests
- making issues part of political agenda
- by framing issues in a non-threatening manner
- participate in policy making bodies , state and national planning bodies
- school and college competitions
- fellowships for journalists / meetings with editors
- websites and e-mail campaign
- regional language / regional language press

(c)With whom should they be taken up?

- as in 3(a)
- corporate sector
- members of parliament

(d)What is the likely impact?

- keeping govt health information services on their toes
- watchdog on any policy having health implications
- sensitising policy makers
- achievement of equity
- impact immeasurable before major commitments of resources are made
- possible negative impacts like hostility or mistrust
- depends on the method of presentation to relevant authority
- public attention leading to pressurising policy makers

(e)Is there is a need for alternate reporting systems whereby NGOs can provide shadow reports to official government reports?

- A majority of the respondents felt that there should be alternating reporting systems however a few pointed out that need not be the prerogative of NGOs alone.
- A small minority felt that there was no need for a separate reporting system.

4. Partners.

(a) Which organisations or persons would be able to participate in this kind?

- independent academic institutions
- NGOs - recognised / reliable/ reputed / grass roots / research
- professionals outside government or political parties or health industry
- autonomous institutions financed by govt /industry
- training institutions - medical / social / nursing
- govt.
- IMA
- press
- anganwadi workers unions / other local bodies / consumer groups
- PRI and other stake holders at the district level
- sympathetic bureaucrats.

It was felt during the discussion that instead of defining who would or could be partners **those who are like -minded** should be encouraged to join the 'Watch,'

(b) What different roles could they play ?

- design and analysis of studies
- collection and provision of data
- think tank

- advocacy groups
- dissemination for wider debate
- watch dog for influences of other policies on health
- training government officials in data collection
- networking
- district level -collection and district level planning / different functions at different levels

5. Organisation

(a) How would a national watch be organised?

- Federal set up .- central secretariat with state branches including at levels SRS, govt and NGOs
- network of elected / selected / involved
- as a non-institutionalised platform of various actors working on the principles of shared responsibilities
- however it is organised it must reach the grassroots

It was generally felt that a rigid 'federal structure' was not necessary and loose network was enough. A few participants felt that the functioning of the 'Watch' should be divided into two. The data gathering and analysis should be looked after by organisation with a system and rigid structure, and the function of sharing information, advocacy, pressurising, awareness etc could be taken on by a more loosely defined network.

(b) What should be the structure ?

- international - national - NGO/ civil society / individuals
- to be coordinated by an NGO person ; Govt to participate as equal.
- Like SRS data to be collected from NGOs and collated upwards
- no need of new formal structure
- four levels - core group/ advisory group / consultative group / forum of participatory organisations.

Ideas that came up for the structure of the 'Watch' were generally that it should be a network of interdependent and exchanging units. It was felt that as this can be seen as a subeversive activity, it should not be seen to have a structure that can be co-opted by the Funding agencies. A more detailed four level structure was also proposed. It included a core group , an advisory group that helped and supported the core, a consultative group that came in on specific issues, and a general members forum that provided/ used / shared the data and undertook various activities. Another idea also shared was that instead of trying to develop a structure *a priori,* an organisation should start the 'watch', gradually gain credibility and a structure would automatically emerge.

(c) How should it relate to a global health watch ?

- global watch - global issues - global advocacy
- relationship with GHW to be part and parcel of NHW
- through multilateral bodies like WHO / UNDP
- using foriegn soil to make contentious observations, especially against non-democratic states
- if in India NICNET could link up with all available sources of data it would be helpful as a web site for the national watch
- affiliation with autonomy

It was generallly felt that in relation to a 'Global Watch' a 'National Watch' should be **autonomous, having a scope set nationally, not in any way constrained by a 'Global Watch,' and to have equal access to data from western countries if it was to provide data to them.** It should be a relationship based on equality.

(d) How should the capacity of national and local NGOs from the South be strengthened ?

capacity building for -

- research and ideas
- communication facilities
- data handling mechanisms
- reference libraries include web based information
- inculcating pro-advocacy role
- funding for training, interactions and for capacity building
- support of international agencies like WHO could enhance their capability for advocacy
- management information systems
- does not require any strengthening!
- by enhancing its credibility

(e) How can a wide, sustainable and independent funding base be maintained?

- independent fund-raising activity
- contributions rather than funding which always comes with a tag
- tie-up with UN organisations for fixed percentage of funds
- multilateral/govt/local funding - govt. especially supporting research
- userfees by data-users
- private funding

6.Do you have any suggestions for the national watch to feedback on global issues?

- dialogue with international organsiations
- active media lobbying through personnel dedicated for the same

7. Additional points

- emphasis on constructive criticism
- impartial conduct in analysing/reporting
- regular interaction with govt
- ghw shall not be constrained by official charters and shall not be accountable to any multilateral agency
- unhealthy competition and mutual suspicions are to be resolved
- It was felt crucial in all this 'Watching' not to forget the medical profession and the science of medicine itself which needs internal corrections as well.

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DAY ONE Bold Size 12

SESSION I ; Chair : Dr. V. Benjamin Bold size 11

Dr. V Benjamin, President of the Community Health Cell (CHC) was in the chair when the participants responded to his request to begin the meeting by observing a two minute silence for the poor and the marginalised sections of India. This was followed by a brief welcome address by Dr.Thelma Narayan, Coordinator of CHC, who outlined the purpose of the meeting and hoped that the two day workshop would be able to *conceptualize the idea of a global and national body that would be able to shift on the health inequalities which are increasing and making life worse for the poor and marginalised* – a section of India he termed as the **"social majority"**. This was followed by a self-introduction made by all the participants. In all there were about 40 participants for the two day workshop from varied backgrounds including Government representative, academics, physicians, NGOs with primarily research agendas, activist NGOs, individual activists, economists, lawyers, management experts etc.,

Next Dr. Ravi Narayan of CHC who had been involved in the Global Health Watch (GHW) initiative since its inception by the NGO forum of the WHO made a presentation explaining the idea of GHW.

Originating as an article published in The Lancet in 1994, GHW as an idea for keeping a watch on the environmental determinants of health was taken up by the NGO Forum for Health and transformed into a concept of monitoring inequalities in health and development, because it felt that the spirit of the Alma Ata declaration of 1978 had been progressively frittered away by pursuance of vertical and reductionist policies. Partly because of various vertical and disease oriented programs launched by WHO and other international donor agencies and partially because of the rapid globalization that was bringing about a new economic order, the poor marginalised sections of society were being neglected and they had been at the receiving end of a iniquitous health care system. The forum had realized the necessity of an independent ombudsman-like agency that could keep a watch not only on health status of people in various countries, but also on policies that had a direct or indirect effect on health.

Ravi told the meeting that an organization agreed to fund the entire initiative, but the forum had perceived the need to have a multisourced mechanism of funding to ensure credibility and autonomy both absolutely essential in fulfilling its functions. The conference in Geneva he had attended had dwelt on the problems that needed to be addressed by the proposed GHW and the issues that should be "watched". It had felt that the liberalization – privatization – globalization phase of the present world had necessitated that a watch is kept on the growing inequities on the national and international levels. Specific focuses for the proposed watch included the issue of inequity, health and development and other policies, conflicts and disasters and global market exploitation. Other specific issues included global environmental degradation and loss of biodiversity, downsizing of health systems and privatization, racial and ethnic conflicts, various United Nations summits and conventions and their implementation Various groups the world over could keep a watch. It was well recognized that there was

no shortage of data that the only problems were that they needed to be accessed and analyzed sensitively. He felt that NGOs, academic institutions and other organizations could collect credible information, and if the Health Watch group could act as a flexible and interactive network cooperating and combining a mix of research and advocacy, a meaningful surveillance on health could be kept. This would improve the status of the poor and marginalised in various parts of the world.

Ravi at the end of his presentation made the gathering aware of some of the issues that were still unresolved and hoped that the discussion could attempt to look into them.

- How will data that is collected or 'watched' reach the people or their groups?
- How could the GHW be a truly democratic or global process in that it was not North dominated, not funder directed or was not top-down or prescriptive?
- How could the initiative be
    - Objective?
    - Independent?
    - Credible?

SESSION II Learning from other Watches. Chair : Dr.CM Francis CHC.

The forenoon session and most of the afternoon sessions were spent learning from other groups in India who have been acting as a watch on various issues. Each presentation was followed by a period of discussion where the participants asked for clarifications or linked some ideas to the GHW campaign.

HEALTH WATCH.

Dr. Gita Sen of the group Health Watch started by explaining the origins of her group after the ICPD conference at Cairo in 1994. The group emerged as a group of concerned individuals who got together to monitor the commitments made by the Indian government while signing the Cairo declaration on reproductive health, and has been having regional consultations with various NGOs to collect information from field level workers in order to confront and dialogue with Central government about its commitment to the ICPD declaration. She felt that the post-ICPD phase had been important in changing the government's perspective on Reproductive and Child Health and population policies because of the positive change seen at the global level, thus attempting to highlight how something positive globally could be used push changes at the national level.

The participants learnt from Gita that the Health Watch that had emerged as a network with organizations with similar agendas had decided to prioritize its activities and had focussed on two issues.

- Removal of targeted approach of family planning.
- Improving the quality of services.

She said that Health Watch had decided to concentrate on how to change for the better rather than be negative in its approach. Working through a network of organizations and

individuals, it had organized one national and eight regional consultations besides some quick field research that formed the basis of the national level meeting.

At the end of her presentation she shared her learnings from the entire process that has been in place for five years.

- It was as difficult to maintain and run a network of people / NGOs for a long time, as to hang onto and continue grappling with the government.
- The relationships between larger and small groups need to be kept open and it is important to be accountable and democratic in its functioning for it to continue.
- Government is very suspicious about Health Watch.
- Government cooperation is based on the individual personality of the concerned bureaucrat and there is a need to institutionalize a mechanism by which a 'watch' could get continuous access to the government data and implementation machinery.
- As the health activities of the governments are being funded by the WB, it may be necessary for the 'watch' to be part of WB's appraisal group to get leverage / position so as to effect change in policy.

Replying to questions, she explained that Health Watch was being funded by a number of funders including the UNFPA, Ford Foundation, Mc Arthurs Foundation and that the network had not got to a stage where it had to decide on a common minimum program, rather the Health Watch remained a network of organizations with the ultimate goals alluded to above. Gita Sen replied to Sabu that although Health Watch was seized of the problem of 'son preference' almost in all parts of India, it had not focussed on it as an issue.

Thelma wondered if the population lobby was behind the RCH program, Gita ended her presentation by expressing her fears that the Cairo goals may not be achieved easily because both the politicians and the bureaucrats come from the conservative middle class and because of the politicians returning to the field, the RCH goals were being seen as too radical and there was reluctance to pursue the objectives.

The chair summarized the learning points of Dr. Sen's presentation as follows:

- The importance of taking an opportunity when one arises – here the ICPD and using it to bring about appropriate changes.
- The importance of involvement of bureaucrats and politicians.
- Networking with openness leading to relationship building and achievement of agreed upon goals.

SOCIAL WATCH.

As Jagadananda was unable to represent Social Watch, Dr. Sunil Kaul presented the paper prepared by the Center for Youth and Social Development (CYSD) Bhubaneshwar and Voluntary Association Network of India (VANI) New Delhi on their behalf.

Social Watch arose as an NGO watch dog system aimed at monitoring the commitments made by the government at the world summit for Social Development at Copenhagen and

analyses social development policies and actions by state / non-state actors to achieve the goals of the Copenhagen summit while bringing about equity. In India, CYSD and VANI have been preparing a report annually to circulate it among government departments, individuals and NGOs for public education and opinion building. Taking pro-poor / marginalised positions on social or governance related inequities, it examines government actions down to fundamental policy assumptions and now proposes to foster a mutually supportive and synergistic relationship between state & non-state actors involved.

Sunil explained that Social Watch had chosen to analyze three major themes of social development, which it termed as Basic Entitlements which included learning, health and housing etc., Sustainable livelihood including access to natural resources, strengthening skill base and promotion of local enterprises, and participation in governance. Social Watch picks up indicators to measure the progress in literacy and basic education, keeping specific linguistic and cultural contexts in mind and looks at issues of access to educational opportunities and food, hygienic housing, sanitation and water and primary health care especially for the children, mothers and the elderly. It measures the progress toward achievement of goals regarding access to productive natural resources, promotion of local enterprises, right to wages, maternity benefits etc., and examines the impact of modern production systems on livelihood opportunities. It also analyses the role that Panchayati Raj Institutions (PRI), dalits, tribals, and women play in governance, and the evolving legal or operational space for participation of civil society organizations in collaborating with the state in formulation of programs and policies.

Based on these, Social Watch has chosen indicators, which will help it to develop a Social Development Index and an Adequacy of Action Taken Index.

Gita wondered if advocacy can be focussed for issues of social development, because the responsibility lies with a large disparate set of ministries and the society at large, unlike health where there is the health ministry to pressurize. Anil Choudry felt it was not necessary to focus on all commitments made at the world summits because many of them were positively harmful for developing countries but had been signed under global pressure. Lawrence felt that development of indices are yet another attempt at meaningless reductionism, but Manjunath felt that it was a good mechanism to highlight issues and carrying out advocacy. Pankaj stressed the importance of indicators though he too felt that having indices might often hide realities. Ravi said that instead of focussing on different levels of watching, we should watch and see how we can use the experience/ data gained at different levels.

The chair summarized the learning points from the presentation as follows:

- The need for any data collection to be action oriented.
- The dialectic on whether a 'watch' must be involved directly or indirectly with advocacy.
- The effort to develop sensitive indicators.

NADHI

Dr.Reuben Samuel described how North Arcot District Health Intelligence came to be set up as a Disease Surveillance system that was started initially to keep a tab on six of the immunization preventable diseases, but gradually has increased its range to many others like malaria, HIV hepatitis etc.,

Funded by the ICMR and a EC program he explained the system which was based on pre-printed post cards left with the field workers who were to fill out the details on it by observing an easily diagnosable disease and post it to the center where they were fed into computers and the data analyzed ~~to quickly set up a~~ methodology to prevent an outbreak in its vicinity.

He highlighted the way in which the system involved volunteers, private practitioners and how it cost only about 5 paise per head of the 50 lakh population involved. He ended his presentation by mentioning its limitations of being selective in its focus and that it was run by one private institution because of which replicability was not assured, ~~adding~~ however that an attempt was being made to replicate it in a few districts in Kerala.

Dr. Mohan Rao attempted to clarify that GHW concept went far beyond a disease surveillance system and was meant to include socio-economic and policy issues surveillance. RN hoped that GHW, unlike the NADHI system must incorporate a mechanism to report the data and analysis back to the people so that it becomes THEIR issue.

Sunderraman, who has also been involved with NADHI was doubtful if it could be replicated especially because he had seen the hostility and politics amongst the professionals because of the methodology of the surveillance system. He felt that as NADHI relied on Government and private practitioners, it missed a lot of 'community' perspective that may have been got by involving RMP's and compounders etc., He hoped GHW would involve the community in collecting information also.

Mohan Rao also felt the need of a system of information was highlighted by the successful approach of NADHI.

Gururaj wondered if the data was compared with government's data analysis and if the people collecting the data understood the importance of collecting it. Nandakumar wished that the disease surveillance system could include the issue of animal health as well. Sabu wanted to highlight the fact that that the possibility of making money out of the survey itself led to alteration in the quality of data.

The Chair summarized the learning points from this presentation as follows:

- Any source of data should be multiple and based on reliability / accessibility and validity.

- For data to be relevant in a 'watch' setting it must include some socioeconomic indicators.
- And the details of who was collecting data and how, are almost as important as the data itself.

PEOPLES WATCH

Mr. Britto told the audience that his NGO had two objectives;

- To ensure state accountability leading to a change in policing.
- Promotion of a culture of human rights through strategic interventions and education.

Peoples watch monitors human rights violations through fact finding missions whenever there is a report of custodial deaths or caste violence in Tamil Nadu . It also provides legal assistance to victims of HR violations as it did for the victims of torture by the Special Task Force set up to nab the sandalwood smuggler, Veerap9pan. It tries to intervene by providing information to national and international human rights agencies eg, the National Human Rights Commission and state HRCs. it also promotes solidarity amongst victims of HR abuses and agencies promoting HRs. In the past it had undertaken campaigns against Dalit atrocities and for repealing the controversial POTA act (prevention of terrorist activities act)

Britto also listed out the number of publications Peoples Watch has brought out so as to disseminate information about HR and on the performance of various national and international HR agencies. It has also published the Supreme Court judgement on sexual harassment in the workplace.

Peoples Watch also involves young lawyers and Law College students in HR orientation and in HR Campaigns. It also takes up activities to train and update the knowledge of HR activists and movement leaders. Recently, it has also undertaken a HR awareness program in 400 schools missionary and municipal schools.

Replying to questions, Britto explained how his NGO had carried out a public inquest into the causes of police attack in Tirunelvelli. He also talked about their linkages to the Dalit Movements and the activities regarding violence against women. When asked about the relations of Peoples Watch with the police, he said that PW had also been carrying out training programs for the police officers.

The Chair summarized the learning points form the presentation as follows:

- The two other methods of collecting data and building awareness ie. Fact finding teams and Public inquests.

PUCL KARNATAKA.

Prof. Hassan Mansoor talked about PUCL and admitted that PUCL had not worked on health because traditionally the HR model used in India has been a western one, and has been more interested in police / state violence. He felt that the world perspective on HR

needed to include health as it is definitely a political topic. Prof. Mansoor stressed the need for everyone to join hands on the issue of societal violence, which included gender, caste and communal violence.

He talked about his work in 770 slums of Bangalore and cautioned everyone that violence is likely to increase. He opined that unless governments were held accountable the state might emerge as the 'big killer'.

Replying to a question he said that PUCL was different from PUDR but both worked together on occasions. Amar felt that HRs should not be confused with constitutional rights. A discussion emerged on the issue of Public Interest Litigation and Prof. Mansoor explained that the recent trend to dismiss PILs was an attempt by the Courts to curb PILs being filed on frivolous grounds, as it was being used by middle and upper middle class students to force changes in the failure percentage of universities rather than its intended purpose of protecting the rights of dalits and the marginalised.

Mohan Rao also shared his experience of being party to the PIL filed in Delhi to stop the practice of unbridled research on women under the guise of reproductive rights, and he felt that the courts had been silent on the main demands and instead picked the least controversial one i.e. To ban Quinacrine. Amar pointed out that Health Rights might also be seen as political rights and GHW may heed to be aware of this if it goes into advocacy issue. He also stressed the need for a broadening of understanding of Human Rights as an issue.

The Chair felt that to really have an impact, health has to be understood as political and as vital to the concept of human dignity.

SESSION III UNDERSTANDING EQUITY. Chair Dr. Sukant Singh.

As Dr. Abel had to leave, he shared his experiences of 'watch' in RUHSA at CMC Vellore, before the presentation on Equity. Abel shocked some of the audience by announcing his finding that female infanticide may be the leading cause of IMR, not just in the infamous districts of Salem and Madurai, but every where in Tamil Nadu. He said that in-depth studies carried out by his health workers had revealed this, although he admitted they had not been able to tackle the issue.

He also talked of how the meticulous record keeping and credible data base at RUHSA had helped in changing UNICEFs prescription of Growth Monitoring as an essential component of child health. He disclosed that his presentation in a UNICEF conference had been behind the evaluation of the Tamil Nadu Nutrition Program (TNIP) and its being closed because growth monitoring forms were found being fraudulently filled out to declare a success, when he had brought to light by an organized study the fact that mothers were invariably refusing to get their child weighed and it was not possible to monitor the growth of children because of the traditional belief systems.

Abel also talked of his latest study on HIV whereby he had found that only 1% of rural girls and 6-12% of rural boys were indulging in premarital sex. Based on this finding he had convinced his peers that promoting condoms to adolescent might not be useful at all.

In the discussion that followed, Thelma pointed out that though WB and IMF gave only marginal amounts of funds, they managed to get disproportionately large leverage in deciding the policy and we needed to look at ourselves before we endorse UNICEF/WHO/ or other agencies' policies. RN informed that he had attended a WB review meeting where he had received documents that admitted that no district has been helped by any WB loan given for any program.

EQUITY

Dr Pankaj Mehta from Manipal Hospital in a very organized presentation, tried to explain what equity meant. He said that in simple words it could be equated to fairness. Equity according to him meant those peoples needs rather than their social privileges guided the distribution of opportunities for social well being. In health care, equity had to be seen in resource allocation, services received and services that are purchased.

He felt that it was easier to define equity through its opposite, inequity, which had moral and ethical dimensions and referred to differences that are unnecessary, avoidable, unfair and unjust.

He reminded the participants that equity is socially destabilizing and that disregarding health equity is incompatible with long term productivity.

Pankaj displayed the various tiers at which inequity in health was apparent, starting at the Global Level where there is a divide between North and South, and rich and poor nations, and down to the family level where women and girl children were discriminated against. He also talked about the causes of inequity enshrined in sociocultural customs, and poverty, and the growing threat of globalization and liberalization increasing inequities. He laid special emphasis on inequities faced by women from the time they are conceived to the time they are cremated by listing out a long list of types of discrimination that affects their health.

Ravi Narayan thought it was important not to stereotype the terms we use because inequity is not associated with developing nations but that it is even more distressing in the so called developed nations.

In an effort to understand the feasibility of perceiving inequity in government data the next two presentations focussed on equity in government data and programs.

Dr Ravi Kumar talked briefly about equity in National Health Programs and showed statistics about Karnataka whereby it was apparent that inequities persist in health care. For instance, he said that only 25% of posts for lab/ technicians in Karnataka have been filled up. He also showed how cross analysis in data reveals that although all CHCs in

Please go to Edit. Then click Replace.
against Find, Type focuss*
against Replace with — focus*
Check result before closing!

Karnataka have been given Ultrasound Machines, most CHC doctors are not trained to use the machines or interpret their results.

He also highlighted the fact that the urban health centers had no health workers at all, as if everyone in urban centers was capable of paying for private health care.

He said that Karnataka was spending 30% of its GDP on the social sector, which is close to the desirable level of 40%.

Mr. Mohammed in the last presentation of the day Mr .Mohammed of St. Johns Medical College, explained the various types of data available with government and equity in government health information.

He explained that Census was the only data that could supply data right upto the village level, but it was carried out only once in ten years and the analysis was available too late. Listing out the various data the responsible departments and the levels at which they were carried out, Mohammed clarified the differences between Central registration System (CRS) and the Sample Registration System (SRS) and the Model registration System (MRS). He stressed the need for a demand to release the data of Health Management Information System which he informed was collated from district level upwards and because of its regularity and continuity, he felt could be of immense use to NGOs and the idea of GHW. He also felt that as socio-economic information is not available in any of the systems except the decadal census, it might be impossible to desegregate data to check socio-economic equity from available government data.

It was felt that GHW will need to demand the inclusion of Socio-economic and caste status data.

DAY 2 OF THE GHW MEET

SESSION IV

The first session of the day was spent discussing the types of irregularities seen in India, ways to measure them, the spheres of advocacy, roles that partners can play in a GHW framework, organizational structure, and the relation of a National Watch with a Global Watch. The three sub groups were given some common issues and some individual themes for detailed discussion. The themes were based on the questionnaire that was circulated among the participants before the meeting. ~~The outcomes of each discussion were presented in the plenary in Session~~ ??

SESSION V

The session after the tea break was devoted to some case studies of advocacy or campaigns carried out by leading groups related.

The outcomes of each discussion were used by the subgroups to modify/~~add to~~/prioritise the list of issues that had been culled out from the responses to the questionnaire circulated before the meet and presented in Session VI

CEHAT

Amar Jesani shared the experience of 2 campaigns launched by CEHAT, one against medical malpractice, and the other to promote medical ethics. He said that CEHAT had identified that the private sector was more popular and was providing the major chunk of health care because it was better than the others in understanding people's beliefs and cultures.

He stressed the importance of 'negative information' to launch a campaign, something that he has learnt from his successful experiences. Amar said that focussing on the ills of society by advertising or writing letters to the editor and asking people to send information about malpractice brought a flood of letters, highlighting and filing cases of malpractice of doctors and hospitals in the High Court also encouraged the media to take up such cases and very soon the whole city had woken up to the cause. He said that challenging the Government was important and one should be ready to face isolation from medical peer groups. Amar also cautioned that it was necessary to keep good relations with socially conscious journalists as media may often try to prevent the cases of some hospitals catching spotlight.

Regarding the medical ethics campaign, he said the CEHAT had started the Journal Of Medical Ethics and it was continuing for five years on subscription, which should be considered success. CEHAT had managed to get together a lobby of ethics-minded doctors who have been regularly contesting elections for the Medical Council but every time the elections have been rigged, and this has been brought out by an inquiry as well. The participation in these various processes was in a spirit of mainstreaming these ideas.

Amar felt that that any data churned out had to be focussed on those who were going to use it and understand it.

Answering questions, he informed that in one of the malpractice cases filed by CEHAT's campaign, Mumbai High Court has decreed that patients have a right to their medical record. During the discussions the Chair felt that the uniqueness of CEHAT's campaigning had been the coupling of education and awareness building (both among the victims and perpetrators), with negative campaigning and confrontation.

PEACE

Anil Choudry of Popular Education and Action Center listed out the activities of his NGO, which works through field, based organizations in the Hindi belt.

- Facilitating learning
- Supplying material continuously
- Networking to distribute information
- Counseling within/with groups
- Linking people / grassroots organizations with other specialist organizations.

To do this, PEACE has a Public Interest Research Group, which simplifies data, makes its relevant for the reader, distributes it and helps in advocacy for policy changes. It also does social analysis, organization building and helps in organizing campaigns.

According to Anil, to understand anything it must have experiential basis and should be local-specific. It campaigned against the New Economic Policy and also produces handbooks on various acts and conventions that India signs. He stressed the need for NGOs to be continuously updated and PEACE attempts to do this by enabling people to generate / analyze data. PEACE's main aim, he said, was to bring back the culture of questioning, instead of accepting. RN said that any such training or awareness building should be towards a questioning of the situation rather than adjusting to circumstances. An innovative form of networking that was apparent with PEACE was the concept of sharing infrastructure, where other groups were welcome to use computers, stationery and skills etc., of PEACE during their campaigns, this led to credibility and trust and solidarity and information sharing.

BELAKU TRUST

Sarswathi Ganapathy talked about her experience as a neonatologist turned social activist, after visiting areas on the outskirts of Bangalore. Her initial visits to the rural areas had shocked her because of the poor quality of care in community and partum practices. She talked about intramuscular Pitocin administration to mothers in labor, and of payments that poor patients had to pay for greasing the palms of every health care provider, leading to a very high 'cost' of 'free' treatment. She, also like Amar earlier, spoke of the easy acceptability of private practice regardless of 'quality' due to the fact that they treated the patients better that the generally rude governments doctors.

Her method of campaign is to talk to everyone about her indignation. This spreading of awareness itself was enough as the collective response to her anguish showed the possible ways ahead. Another crucial part of the Belaku experience was the openness to learn as one went along, this was crucial as each problem was so complex that ready made answers were never available. This in her view has paid dividends because she has now got the local pharmacist and the local nurse with her and with them had formed village health fora that discuss health matters. Saraswathi wondered if these fora could be linked to the national Health Watch to "collect' data on how bad it is'. Another interesting point highlighted was that not only was the quality of data available bad, but there seems to be a subconscious filtering out of the socio-economic-cultural flavors of the data collection and the data itself. She also noted that with the researcher lies a big responsibility, that was not only analyzing what you have learnt but what you are going to do about what you have learnt.

RN endorsed her experiences and said that the corruption that she had seen and we all see, somehow never forms a variable in research and hence escapes being analyzed as a cause of ill health.

VIMOCHANA

Donna Fernandes gave a passionate account of Vimochana's campaign of highlighting the issue of homicidal killings of young brides that were being written off as accidental deaths. She shocked many in the audience from outside Bangalore when she said that 7-8 cases a day were being admitted to the Victoria Hospital Burns ward. And 70 to 100 of those admitted were dying every month in Bangalore. She talked about how VIMOCHANA started by documenting all such women's names, speaking to the parents, and using this data as a base, and getting many police cases reopened. They held press conferences and public awareness programs where VIMOCHANA highlighted the callousness towards such a horror at every level from the filing of FIRs to the performing of post-mortems to society as a whole. She claimed that the biggest criminals were the professionals, a charge she substantiated with instances which VIMOCHANA had found, where doctors had taken money for a false post-mortem, and police had taken a portion of the dowry for the price of their silence, showing the depth to which they could stoop.

The VIMOCHANA campaign also included a public TRUTH COMMISSION and its efforts paid off when the police commissioner was hauled up to the floor of the legislative assembly and censured by the legislative house committee.

Despite this, Donna felt that it was important to sensitize the police, a task VIMOCHANA is carrying out. Its efforts had also led to the drastic improvement of the condition of the once horrific burns ward.

The meat of her narration was her statement that 'it would not be enough to be a watchdog; GHW would have to be a barking dog to be effective. However one cannot bark if one is not watching."

DEPARTMENT OF SOCIAL MEDICINE AND COMMUNITY HEALTH.
JAWAHARLAL NEHRU UNIVERSITY

Dr. Mohan Rao from JNU shared his experience about the Quinacrine campaign in which he and the faculty of the School Of Social Medicine and Community Health had launched.

He started by providing a background about China's entry into the WHO in 1978 coinciding with the Alma Ata Conference and how it had successfully raised its life expectancy of 22 years to 62 years in a matter of just 30 years. He also talked about the decline of the role of WHO and the rise of WB's importance on health since the late eighties.

Terming RCH as a now acceptable term for Family Planning, he was worried the 'target free' would be translated to 'responsibility free' as already shown during the quinacrine scandal. He detailed the abuse of Quinacrine that was being used by a Calcutta gynecologist running an NGO as a research project for permanent sterilization of women despite ICMR having failed at it and WHO's strong views against it. Couched in

language of 'women's empowerment', the research had incensed various sections of society and as individual members, many of the faculty of JNU and the women's groups out of the many backing the campaign, had filed a Public Interest Litigation. The PIL sought to highlight,

- The issues of accountability of NGOs / voluntary organizations
- Punishment for doctors involved in such practices
- ICMR to trace the thousands of recipients of such corrupt practices and compensation given as in Bhopal.
- Need for a system to monitor the Public Health Action and research.

However in a shockingly superficial judgement, the court had trivialized the matter by merely banning quinacrine and closing the case. Mohan Rao tried to highlight how even well planned activism can miss the target once you get entangled with the tangles of bureaucracy and judiciary.

PEOPLES SCIENCE MOVEMENTS

Dr Sundar Raman talked about his NGO and said that its main aim was to question the scientific profession and acheivements. Because of the fact that the scientific professionals and their work had not benefited the poor and the marginalised, Peoples Science Movements (PSM) had attempted to raise people's consciousness about this fact in an effort to make Science and Technology more relevant to the needs of the majority. For anyone trying to do this, he felt that one needed

- Public awareness
- Possibility of organized action by people
- A place on the political agenda.

Sundar said that any campaign needed about 2% outreach to remain visible as a movement, more than 20% to make an impact, but to effect a change, one needed to reach out to at least 50% of the people.

PSM has also been making advocacy campaigns of which the main is

- Demands on the state for policy change and state intervention making the state pro-masses in letter and spirit and action
- Demand on medical profession to sensitize them on existing inequalities, their role in its continuance and their responsibility.
- Demand on the people culturally and educationally making them more aware of their rights and duties.
- Demand on PRI's to make health and local appropriate development part of their agendas.

The advocacy work of the PSM has had a large support base especially from women's groups / progressive writers / cultural societies and trade unions. Talking about PSM's campaign for drug policy he said PSM had used mass awareness drives, mass publications and organized jathas, rallies, lecture dialogues, seminars and boycotts.

page no Abbreviations used.
go to first & ask for
capital letters only.

He felt that Community Action for Health must not be a substitute or a parallel to the state action, but should try to improve them by empowering communities, women, and PRI's and by creating awareness. He felt that any community health action program must be able to provide visible gains in health to sustain the interest of the community and the health activists. He felt that a campaign must be able to link up with other sections of society and mobilize people for policy issues.

Anurag endorsed his view about science moving away form the people and said that unless medical professionals so not look beyond the germ theory of disease, people will not be benefited. Other members felt that not only should the discussions include germ theory vs social theory but question the much broader conceptual framework (reductionism) in which these arose.

SESSION VI

The last session saw a discussion on the questionnaire that had been circulated before the dialogue. Sunil made a presentation of the range of responses each question had elicited form the responders and the groups fed in their perspectives on the rather comprehensive list of responses. An attempt was made to prioritize and practically simplify the issue at hand. A report of the same is attached as annexure no ---

The meting ended with Dr. Benjamin and Dr Ravi Narayan trying to elicit at least one commitment from each of the participants. It was decided to set up a core group to carry the process forward. The members who volunteered were

1. Dr. Mohan Rao.
2. Dr Muraleedharan.
3. Dr Sundar Raman.
4. Dr Sunil Kaul.
5. Dr. Ravi Kumar
6. Mr As Mohammed.

Anil committed that PEACE would send monthly monitor of multilateral and trade agreements to CHC. Ravi on behalf of CHC gave a commitment to send a report to everyone and to the NGO forum of health. There was also the suggestion to form an e-group. CEHAT which has a website (www.cehat.org) said that GHW could be part of the website and be updated regularly.

Dear Rakhal, 12th Oct

Thanx for everything. The bloody train started only at 07.15 and reached Chennai at 3.45 P.M. There was just time enough to have some lunch and catch GT.

Wrote up the last page or so on the train. Hope this reaches fast enough for you to punch in.

Bye. Regards to Ravi et al.

Sunil

P.S. Hope you passed my message to Dr Deva / Roopa. Tell Roopa I'd her & Deva's name in my address diary since 1994 or so — had wanted to visit it when I'd read about Ravi programme to involve TB patients in employment generation schemes. Also had responded to a general letter of Ravi — that's how it must've been in my address book.

Sunil

(432)
15/10/99 Received by courier.

→ Not only germ theory ~~but~~ → and ∴ germ is social.

→ but broader conceptual framework

- Need to build credibility

= Dhenkanal: → mutual suspicion.

→

- Procedure etc
- Core group. → Mohan.
  → Murali.
  → Sunder.
  → Sunil Kaul
  → Ravikumar
  → Mohanna

Arvind
Anil
1 packet every month

→ Final e-group.
→ Address of participants
→ CEHAT has website. WWW.cehat.org.

#1 The Macroeconomic policies are the cause of inequalities
- Regional...
- Rural-urban...
- Caste-Class
- certain regions systematically neglected..

(b) - At whether WHO is fulfilling Health for all - HHO is not forsaken leadership as govt's are forcing to follow Int. agencies in contradiction to HFA.
SOI. interested in donor driven areas.

Three levels of loss Int } loss of commitment ← even if you change this the
Nat. } loss loss still occur
District. so if you really want to change you must change

- funds being diverted to arms
- Who are the people who make the policies → the middle class
↓
they want the policies

- In terms of measuring inequalities → ensure autonomy/authority
↓
of govt bodies
centers

Aman Jesani → Medical Malpractice
→ Medical Ethics

- Health is not political
- Data churned out to be focussed on those who can understand/use
- Govt. not anyway providing major chunks - the private sector seen as major player.
- Imp. of negative info to catch attention
- Exp in Health — confronting dominant
  - accept loopholes
- Media
  - Medical Council forum — importance of professional body recognition
  - Judiciary
- spread by word of mouth - awareness
- general issues - pt. no right over copy of medical records
- Bombay High court — judgement that Patients have a right to medical records
- Power lobbies in pvt./corporate sector
- Voting process
- Mainstreaming.
- Though against business - yet educational

AJ → Doctors are under CPA upto Civil court

KN → Letter to editor → generates response

RLK → Sp NGs campaigning / confrontation / education.

AKC Popular education and action centre.

work through field based org.

→ facilitation of learning

→ supply material continuously.

→ learning on different issues

→ counselling / within / with groups.

→ linking people & other org - esp specialist organis.

to do above - we have to 'watch' these organisations.

- Public Interest Research Group.

simplifying data → making relevant to reader

↓

policychanges ← dissemination

- Social analysis
- org. building.
- Campaign organisers.

to understand anything it must have experiential basis

local specific

- Handbook
- needs continuous updating
- therefore needs continuous monitoring
- enabling people to generate / analyse / data

RN → Training - Questioning reality
now - adjusting to vertical jumps
~~xxxxx~~ - people go back to themselves analyse themselves

→ { working - satisfaction
making money
Technical intervention

→ sharing of infrastructure

Saras

- reason to go to pvt. practise because treat co well
- Oxytocics IM - at home -
- cost of free care
- just spread awareness
  → response → can ~~Govt~~ we do something?
- connexions strengthened at taluk level/ BHC level

- imp. of collecting data on how bad it is.
- the openness to learn as you go along.
researchers filter out socio econ-dist. data that comes to them even as they are ~~in~~ researching -
Watch → should also not filter thus
↳ not enough - what do you do with what you have to learn

Vimochana Donna - Domestic Violence

→ Stove Bursts / clothes burn etc → Is it truth.
the truth of deaths of a woman.
70 deaths / month in Bangalore.
violence the young women is subjected to.
Callousness / at every level.
1st tackled the hygiene etc of Burns Ward
Not only Watchdog → Barking dogs
The biggest criminals are professionals -

Mohan Rao

→ Affect of political instability
→ Demonetisation
→ Monkeypox → through Indian Red Tribune
→ Supreme Court
→ Issues of accountability of NGO/Vol. org.
→ Punishment of Doctors
→ ECHR → Trial / compensate / support.
(≠ to Bhopal)
→ ~~No~~ need for a system to monitor
the ~~need~~ Public Health action
and research.

Target free → becomes responsibility free.

Sandel

One Needs - public awareness
- Possibility of organised action
- a place on the political agenda

Advocacy → Demands on state
a) for policy change
b) for state intervention

→ Demands on Medical Profession

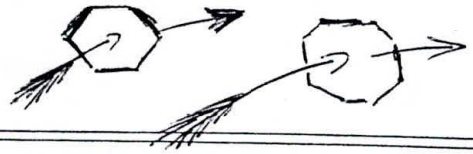
→ On People - Individual.
Educational

→ Panchayats.

Support from women / progressive writers / artists / Trade Union

Anuraj

→ we are too caught up on germ theory of disease.



II Day

Session IV

The first session of the day was spent discussing the ~~questions mentioned in~~ types of inequalities seen in India, ways to measure them, the spheres for advocacy, roles that partners can play in a GHW framework, organisational structure, and ~~its~~ the relation of a national watch with the Global watch. The three sub groups were given some common issues and some individual themes for detailed discussion.

Session V

~~The session after the tea break was devoted~~ to some case studies of advocacy or campaigns carried out by leading groups related.

CEHAT

Dr Amar Jesani shared the experience of 2 campaigns launched by CEHAT - one against medical malpractice, and the other to promote medical ethics. He said that CEHAT had identified that the private sector was more popular and has

~~the semi-parties~~ as it is
providing the major chunk of health care because
it was better than the others in understanding
people's beliefs and cultures.

He stressed the importance of "negative information" to launch a campaign, something that he has learnt from his ~~experience~~ successful experience. Mr Amar said that focusing on the ills of society by advertising or writing letters to the editor and asking people to send information about malpractice brought a flood of letters highlighting ~~the~~ and cases of malpractice of doctors & hospitals ~~in~~
~~a case check in Mumbai and very soon~~
in the High Court also encouraged the media to take up such cases and very soon the whole city had ~~set up to~~ woken up to the cause. Mr Ma said that challenging the government was important, and ~~it was~~ one should be ready to

face isolation from medical peer groups. Amar also cautioned that it was necessary to keep good relations with socially conscious journalists as media may often try to prevent the cases of some hospitals catching the spotlight.

Regarding the medical Ethics campaign, he said the COHAT had started the Journal of Medical Ethics and it was continuing for five years on subscription, which should be considered a success. He also told that COHAT had managed to get together a lobby of ethics minded doctors who have now been regularly contesting elections for the medical council but every time the elections have been rigged, and this has been brought out by an enquiry as well.

Answering questions, he informed that in one of the malpractice cases filed by COHAT's campaign, Mumbai high court has decreed that patients have a right to their medical record.

PEACE.

Anil Chowdhury of Popular Education and Peace Centre ~~[illegible]~~ listed out the activities of his NGO which works through field based organisation in the Hindi belt.

: facilitating learning
: supplies material continuously
: ~~learning on different issues~~
: networking to distribute information
: counselling within/with groups
: linking people/grassroots organisation with other organisation/specialist

To do this, PEACE has a Public Interest Research Group which simplifies data, makes it relevant for the readers, distributes it and ~~helps~~ helps in advocacy for policy changes ~~[illegible]~~ It also does social analysis, organisation building & helps in organising campaigns.

Accordg to Anil, ~~[illegible]~~ to understand anything

it must have experiential basis & should be local-specific. It campaigned ~~fast~~ against the New Economic Policy and also produces handbooks on various acts & conventions that India signs. She stressed the need for NGOs to be continuously updated and PEACE attempts to do this by enabling people to generate / analyse & data.

~~Q~~ ~~Q~~ PEACE's main aim, she said, was to bring back the culture of questioning, instead of learning what to do.

Saraswati Ganapathy talked about her experience as a neonatologist-turned social activist after visiting areas ~~outside Bangalore~~ on the outskirts of Bangalore. Her initial visits to the rural area had shocked her because of the poor quality of care in the community and post-partum practices. She ~~talked~~ talked about intramuscular ~~P~~ Pitocin administered to mothers in labour, and of the payment that poor patients had to pay for greasing the palms of every health care provider.

Her method of campaign is to talk to

everyone about her indignation. This, in her view has paid dividends because she has now got the local pharmacist or the local nurse with her and with Rem has formed village health fora that discuss health matters. Saraswati wondered if these fora can be linked to the National Health Watch "to collect data on "how bad it is."?

RN endorsed her experiences and said that the complain that she had seen and we all see, comedown never forms a variable in research and hence escapes being analysed as a cause of ill-health.

VIMOCHANA: Donna Varghese gave a passionate account of Vimochana's campaign of highlighting the issue of homicided kittings of daughters-in-law that were being written off as accidental deaths.

She shocked many ~~ff~~ in the audience from outside Bangalore when she said that 7-8 cases a day were ~~beig~~ admitted to Victoria ~~xxxx~~ Burns ward and 70 of them were dying every month in Bangalore. She talked about how VIMOCHANA started by ~~xxxxx~~ documenting all such women's names, ~~xxxxx~~ spoke to the parents, and using this data as a base, got many police cases reopened. They held a ~~xxxxx~~ press conference where people of all classes told the tales of their daughters.

Dr Donna felt that all professionals were overtly or covertly involved in a criminal conspiracy ~~xx xxx~~, a charge she substantiated with instances which VIMOCHANA had found where doctors had taken ~~a percentage of the~~ money for false post-mortems, ~~xx xxxxx~~ and the police had taken ~~xx~~ a portion of the dowry for the price of their silence.

VIMOCHANA's campaign ~~xxxx xxx~~ also had a public TRUTH COMMISSION ~~xxx~~ and

its efforts ~~were~~ paid off when the police commissioner was ~~then~~ hauled up ~~by the~~ to floor of the legislative Assembly and condemned by the legislative ~~body~~ House Committee.

Despite this, Donna felt that it was important to ~~not~~ sensitise the police, a task that VIMOCHANA is carrying out. Its efforts had also drastically ~~on~~ improved the condition of the once-horrific burns' ward.

The meat of ~~the email~~ her narration ~~by saying~~ was her statement that "it would not be enough to be a watchdog; GHW would have to be a ~~watching~~ barking dog to be effective. But one cannot bark, if one is not watching."

Mohan Rao from the Jawaharlal University Delhi, shared his experience about the Ordinance

~~on~~

campaign in which he and the faculty of the School of Community Health & Social Medicine had launched.

He started by providing a background about ~~Kas~~ China's entry into the WHO in 1978 coinciding with the Alma Ata Conference and how it had successfully raised its life expectancy of 22 years to 62 yrs in a matter of just 30 years. He also talked about the decline of the role of WHO and the ~~rise~~ of WB's importance in ~~the~~ health since the late eighties.

~~Terming~~ Terming RCH as an acceptable form of Family Planning, he detailed the abuse of Depo-Provera that was being used by ~~a~~ Calcutta gynaecologists, ~~as a research project~~ running an NGO, for permanent sterilisation of women despite ICMR having failed ~~to~~ at it and ~~the~~ WHO's strong views against it. Couched in language of "women's empowerment" the research had incensed ~~the~~ various sections of the society

and as individual members, ~~they had~~ many of the faculty of TNU and one women's group out of the many backing the campaign, had filed ~~the~~ a Public Interest Litigate. Although the prayer in the PIL asked for accountability of NGOs & private practitioners and also asked for compensation for the deaths of women subjected to the research,

People's Science Movement.

Dr Sunder Raman talked about his NGO and said that its main aim was to question the scientific movements. Because of the fact that the scientific professionals and their work had not benefited the poor and the marginalised, People's Science Movement (PSM) has attempted to raise the people's consciousness about this fact. ~~In view of this~~ For anyone trying to do this, he felt that one need :

- public awareness
- possibility of organised action by people
- a place on the political agenda

Sunder ~~Lal~~ said that any campaign needs around 2% outreach to remain visible as a movement, more than 20% to make an impact, but to effect a change, one needs to reach out to at least 50% people (??)

PSM has also been making advocacy campaigns of which the main are:

- demands on state
  - ⇒ for policy change
  - → for state intervention
- demands on medical profession
- demands on people ⇒ cultural
  - → educational
- demands on PRIs

The advocacy work of PSM has had a large support base especially from women's groups / progressive writers / cultural societies and trade unions.

Talking about PSM's campaigns for drug policy he said that PSM had used mass awareness drives, & mass publication and organising of jathas, rallies, lecture-dialogue seminars and ~~[illegible]~~ boycotts.

He felt that Community Action for Health must not ~~[illegible]~~ substitute or be parallel to ~~[illegible]~~ State action, but should try to improve them by empowering communities, women, and PRIs and by creating awareness. It felt that it must be able to provide visible gains in health to ~~[illegible]~~ sustain the interest of the community: He felt that a campaign must be able to link up with other sections of society and mobilise people for policy issues.

Anurag endorsed his view about science moving away from people and said that unless a medical professionals do not move ~~[illegible]~~ look beyond the germ theory of disease, people will not be benefited.

SESSION 6 Chair ——

The last session saw a discussion on the questionnaires that had been circulated before the dialogue. Sumil made a presentation of the range of responses each question had elicited from the respondents and the groups fed in their perspectives on the rather comprehensive list of responses. An attempt was made to prioritise and ~~streamline~~ practically simplify the issues at hand. A report of the same may be seen as ~~Appendix~~ an annexure no??

The meeting ended with Dr Benjamin & Dr Rai trying to elicit at least one commitment from each of the participants. It was decided to set up a core group to ~~manage the task~~ ~~ahead~~ carry the process forward. The members who volunteered were:

1)

2)

3)

4)

And ~~please~~ committed that ~~he would~~ ~~send~~ PEACE would send a monthly monitor of

multilateral aid and agreement to CHC. Rajiv on behalf of CHC, gave a commitment to send a report to everyone and to be ~~GHHS focus~~ NGO focus for health.

GLOBAL HEALTH WATCH

10.00 AM — 33 people.

Introduction self.

10.50 Ravi Narayan.

- basis of GHW
- process in WHO over the years where WHO grp started GHW to involve groups outside the WHO set-up e.g. NGO/CSO.
- NGO group to watch INDEPENDENTLY.
- funding by different ~~orgs~~ funders in Europ/USA although one funder was ready for full funding
- presented at Geneva of concerns of multitude of people — what are the problems

What to do

~~equity~~ — Health policies

Int. health policies — Industrial policy

Control diseases — Global market exploitation

How? - Grassroots initiative
- credibility of info
- combining research & advocacy

Unanswered Questions

- how will data collected or 'watched' reach people in these groups
- how could this be truly democratic / global process?
  - not state dominated
  - not funder directed
  - not top-down perspective
- how could methods be
  - independent
  - ethical

Health Watch:

- origins
- importance

What → define priorities
- remove targets now TFA at policy
- improve quality of services — instead of protecting against, how to change it into imp.
- act as network → regional (8) meetings to 1 national meeting.
- studies organised

vagaries of bureaucratic appointments prevent permanent change — need to institutionalise a mechanism.

- networks of unions — to continue
  - accountable
  - democratic } important!

Questions — son preference

—

SOCIAL WATCH → Geeta Sen's quest
Who will be the punching bag
advocacy with bottom.

( )

( )

Amit Chowdhury ⇒ do we need to watch. If some clauses are wrong, good that they are not implemented

Manjunath — good thing that indices — measurable — should be used. are being considered.
— good Rat advocacy - oriented watch.

Lawrence Kay - indices & indicators - reductionist ideas.
Vinay Mehta indices may hide things, but indicators necessary

Reuben Samuels NADHI (basically a disease surveillance

Disease reduction consequent to improved vaccine coverage

- GPI. Cases (except measles) of 6 diseases to be brought to the hospital

Case Reporting - post cards simple
last dose - early reporting & detection of diseases

Later, Meningitis, Encephalitis, Rabies, Hepatitis
Malaria
HIV
V. Cholera & S. typhi
RTA
Partnership Govt & govt
Funds - ICMR
↳ EEC.

Structure ; methodology ;

Rs → 25 lakhs to 50 lakhs

Rs 0.05 per person

Polio Control — includes Siddha system and Siddha healer who treated paralysis cases

↓ ed.

Measles control ↓

Simple,
inexpensive indigenous, innovative
private participation
Government sponsorship
voluntary organisation

credit to returns / incentives

Limitations — run by one private institute
- limited interventions for some diseases
- limited list of diseases.

Challenges
- common criteria of diagnosis

Copied in Kerala ← Alleppey
Kottayam.

Dr Mohan Rao
- GHW must have even socio-economic data & not just disease data

~~Sundaraman~~ → politics, ~~caste~~ hostility etc

Ravi — How was the data reported back to people / people's organisation

Can animals ~~be also~~ health also be included.

?? Informat may ~~get~~ be missed/overreported depending on who collect it.
- why is data being collected?

Answer - in kerala, attempt to move from disease surveillance system to a public health surveillance system.

- how much, how simpli

PEOPLE'S WATCH:

2 objectives
- ensure state accountability ready to policy changes
promote culture of human rights
thru strategic internal & educat

~~monitoring/~~
monitoring/internal
- monitoring HR violat thro fact-finding missn
custodial deaths
- caste violence.

- providing legal assistance & victims of HR violations ex. torture victims -
fact-finding missions ~~by STF~~ ~~as~~
- Intervening through national & international HR mechanisms NHRC/SHRC

- ~~protest~~ solidarity / building

- undertaking campaigns on HR related issues
  - Campaign against POTA.
  - against Dalit atrocities

Docn & Publication

- dissemination of info on HR, performance of National/Internal HR organisations
SC judgement on sexual harassment in workplace

TRAINING & EDUCATION

Inter college student, young lawyers
HR activists
movement leaders

undertaking HR Educal programme in
400 schools of all types
- missionary schools / municipal schools etc

In reply to questions

Public inquiry into the causes of police
attacks in Tirunelveli

violence against women.

linkages : dalit movement

training programmes for police officers

Evaluat sheets to students to
evaluate teachers.

Prof Hasan Mansoor.

PUCL

~~Fundamental~~
usually HR limited to political rights
& not including economic/social rights

- third world perspective of HR
needs to include health.

- apart from state violence, we also have
societal violence — gender
caste
communal

- working & slums 7 to slums of
Bangalore

- accountability of governments

HR groups have a mandate to include health in it mandate.

- violence is going to ↑; state will be a big killer.

Aman — HR need not be confined to ~~constitutional rights~~

Links between PUCL & PUDR

Mohan Rao —

- Bandra epidemic

only epidemic banned; tracing pts & getting them compensated was not commented upon by SC

Aman — HR organisations vs women's rights organised.

HRalth rights may also be seen as political.

Champion — Sukant Sinah

Dr Abel : Experiences of 'Watch'
- Block

— female infanticide no. 1 cause of IMR
— & not just Madurai & Salem — everywhere in TN
— not managed to do anything

— growth monitoring was a failure when everyone had declared it a success
— women didn't want to weight the child

~~Pankaj Mehta:~~

— grassroots observation different from stated achievements

TINP worse than RUHSA

then TINP worse than non TINP village

TI WP closed down.

NO condom no AIDS

eventually found it difficult.

Studies:

1% rural girls } premarital sex
6-12% rural boys }
15-18% national — highest

found promoting condoms to adolescents may not be useful.

Nov WB has accepted that no ~~AIDS~~ district has been helped by any WB loan given for any health programme.

EQUITY

Dr Pankaj Mehta
manipal hospital
HOD Community Health

→ Equity vs short-term efficiency

Equity means fairness

It means that people's needs rather than their social privileges guide the distribution of opportunities for social well-being

Equity in health care would mean:

equity in — resource allocation
— services received
— services paid for

Inequity has moral & ethical dimensions

refers to differences that are unnecessary, avoidable, unfair, unjust.

- Disregard for equity is socially destabilizing
- disregard for health equity is incompatible with long term productivity

Inequity in health

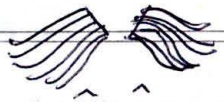
Global level	North - South rich - poor nations
Central level	low sp, low & very budget
State level	Some worse than others
Comm level	Some more disadvantaged than others, — rural & tribals
family.	Women, children.

sociocultural norms
poverty
pop. explosion

- Globalisation, Urbanisation, SAP etc.
- communal revolution
- environmental degradation

Gender Inequity - analysis & awareness
- gender sensitivity

Words to Tomb



Spillover of equity
— crime, etc

Ravi — stereotyping "developed" more inequitable than "developing"

Dr Ravikumar Regional
national health progrm

— manpower ↓
Karnataka 25% has technician available
all CHCs have USS
urban centres have no HWs.

HDI Indi
gender related depnds

Exp on social sector
- Desirable level is 4% of GDP
- Karnataka spends 3% on social sects
- Assam, WB & Kerala spend ~

Mohammad

key indicators for monitoring ——————

health equity in health & health care

process
morbidity

Sources

District & village level → Census — Min of Home Affairs — village level data in 10 years

District level → Central Registral System CRS — Dept of Panchayat Police Health Person

State level → SRS Sample Reg (Sampling unit 6671 Pop > 0.6%) (SRS) — Directorate of census for SRS

State level → Model Registral System (MRS) — stopped

District level & PHC level → (Cause of death survey) → HMIS — Dir of H & FW

NFHS — Min of H & FW

State level — other — other MICS/A

→ → →

Group discussion:

1. (a) Inequalities / inequities of health

- urban - rural personnel skew. (HQ skew)
  - ⇒ hence access to care/service / quality / care received.
- age
- sex/gender
- geographical
- race
- caste.
- socio-economic

2. (b) No, not fully.

3.

CAMPAIGNS

2.

CEHAT. Amar Jesani.

medical ethics campaign.
pvt sector better than others to understand people's culture.

important to bring out a negative campaign
- to bring out ills of society. Especially the private health sector.
challenges most important
accept isolate from peer group in metrics

Dr. Phis's case - wife's cancer
negligence of doctor - refused to be successful in getting focus on private sector

Media response.

— media does not take up ~~some~~ cases of some hospitals.

Public enthusiasm not necessarily helpful in some cases.

Important to keep relations with socially conscious ~~doctors~~ journalists.

Medical council elections 'rigging' — basis of medical ethics campaign

finally ethically minded group doctors stand for election.

→ Journal of medical ethics

Cut practice of consultants

— Instead of advertisements, letters & to editors

PEACE Amit Chowdhury

Work through field level orgn in Hindi belt
for new characters
+ trainings

- network & distribute info

- consulting

- linking grassroots orgn to bigger
specialist organisation.

Campaign for NGP

through watershed work, booklet at NREP
translated & simplified english pamphlet very early
generated very large interest
Uruguay round signed away
Not Tried to ~~attend~~ interact & grassroots

but now it is proving unfeasible to international NGOs

" Spread the word that "question" rather than "do". Campaign to make people question & take control of their lives.

Saraswati Jonapoly

working out

~~Shocks~~ bad case in community; post partum practices

→ Intramuscular oxytocin

payment to doctors & ANMs

Campaign - ~~talk~~ to everyone about ~~etc~~

now nucleus of village pharmacist,

nurse

Village health form

↳ can we link it up as log

( )

- Collecting data even of "how bad it is"?
- ready to learn even as researchers

Ravi Nanaya Corruption never gets seen as a variable in protocols; hence gets sieved out & not reported.

→

~~Vimochana~~ VIMOCHANA - Donna Fernandes

- Domestic violence
  deaths of young, married women.
  stove burst
- tabulated ~~co~~ women's name - spoke to women's parents
- found total collusion from ~~women~~ society & government

- data provided as a base
- case number — name - way she died

good documented & then confronted the police.

Victoria burns ward — 7 - 8 women per day in Bangalore.
bad conditions

- parents at press conference - said that all women were "discharged dead".

some changes but again

not just watch dogs - barking dogs

"unless we watch, we can't bark"

now 2 Auditors from Vimochana in the victoria burns.

A/c filled, ward improved.

- Campaign ⊂ the police

collective conspiracy - professional crime

more than 100 cases reopened

- helpline
- did not allow ourselves to be co-opted by police.
- manual on "how to investigate a woman's death".

Post-mortem reports of tailor-made.

- lackle at all levels — one level cannot help
- House Committee

TRUTH COMMISSION

adults in Dhanbad, Gulbarga — to panels whose daughters are killed & feel justice has denied

Khorendra

police invited to be members of jury

help desks at every police stations
run by volunteers from law schools

set up as system which is transparent
accountable, accessible

498(A) - plain harassment & cruelty.
- & harassment because of dowry

1. 7 years death
2. hope that

Mohan Rao

China 1952 life expectancy 22yrs
= 1982 → 62yrs

1978 entry of China into WHO

Importance of WBT as WHO ↓ since 1990s

- Family Planning came back as an acceptable form in Rep.

- Immunization campaign

Need to strengthen public health institutions

- need to improve research

Whole faculty got involved as individuals.

- ICMR tried Quinacrine sterilisation but failed 8- foam tablet + ectopic
- WHO had taken a strong view already.
- all Delhi's women's groups had backed it

But court case PIL - only faculty + one women's group

- tried to lobby parliamentarians.

Indian Medical Trust had exposed it.

Issues -

- issue of accountability of NGOs & Private Practitioners
- compensating for deaths

" research couched in women's empowerment

Anuradha Rajan — People's Science Movement

(a) mainly questioning the scientific movement

one needs - public awareness
- possibility of organised action by people
- a place on the political agenda

? 2° outreach for viability
>20% for impact
>?% for change

Advocacy – demands on state
a) for policy change
b) for state intervention
demands on medical profession
on people – cultural education
on Panchayats

Drug policy – mass publicity
– mass awareness
– campaigns – jathas
– rallies
– lecture-dialogues
– seminars – media articles
– boycotts

Health policy – health education campaign

Seminars

Community action in health

(a) not parallel or substitute to state action
- to better utilize existing facilities
- to empower women
- to empower panchayat
- to create awareness

(b) must be able to provide visible gains in health.

(c) must be able to mobilise on policy issues

(d) must be able to sustain:
(no funds for sustaining will ever be available)

(e) must be able to link up with other sectors (first look @ curative / preventive balance in community actions)

(f) capital costs (of replication)
about Rs 1 to 2 lakh per block of 1 lakh people

(g) maximal of people's action supported by panchayat & govt sector

stay Rs 7 — PSM — links with Progressive Writers Assocn
— links to Women's organn

Key Indicators for monitoring equity in health and health care

Indicator Categories	**Indicators measuring differences between groups**
1. Health determinants indicators:	Prevalence and level of poverty Educational levels Adequate sanitation and safe water coverage
2. Health status indicators :	Under 5 year child mortality rate Prevalence of child stunting **Recommended additional indicators** : Maternal mortality ratio; Life expectancy at birth; Incidence/prevalence of relevant infectious diseases; Infant mortality rate and 1-4 year old mortality rate expressed separately
3. Health care resource allocation indicators :	Per capita distribution of qualified personnel in selected categories Per capita distribution of service facilities in primary, secondary, tertiary and quaternary levels Per capita distribution of total health expenditures on personnel and supplies, as well as facilities.
4. Health care utilization indicators :	Immunisation coverage Antenatal coverage % of births attended by a qualified attendant Current use of contraception TB treatment completion rates Cervical cancer screening rates

VARIOUS HEALTH INFORMATION SYSTEMS

Systems	Objectives	Freq.	Coverage	Indicators measured	Organised by	Information available at
Census	Total count of population with respect to demographic social and economic ch.	Once in ten years	Nation	Demographic, social and economic characteristics	Ministry of Home affairs	District level / village level
CRS	To generate the statistical information on births & deaths	Cont. registrati on	Nation (local)	Births & Deaths by other demographic and social characteristics including religion, literacy and occupation	Dept. of Panchayat Police Health Revenue	District wise
SRS	To provide reliable estimates of births & deaths	Cont. enumer ation	National State S.Unit = 6671 Pop.= 0.6%	Births & Deaths with age, sex, rural/ urban	Directorate of Census opm., Eco. and Stat. Health & FW	State level
MRS	To provide most probable cause of death for rural India	Cont. enumer ation	Nation and State Sample PHC = 1,731	Deaths & Births Age, sex and cause wise death rates for rural India	Directorate of H&FW and Eco. and Stat.	State level
HMIS	To provide timely aggregated information on health upto PHC level	Cont.	Nation	Births & Deaths Age and sex and cause wise death rates Fertility rates	Directorate of H & FW	Dist ict level
NFHS	To provide state and national level estimates of fertility, IMR, practice of FP, MCH care and utilisation of MCH services	Ad-hoc	Nation	Fertility, IMR, FP practice, MCH care and utilisation of MCH services by sex, age, urban/rural, caste/religion	Ministry of H & FW	State level
Others MICS/R CH						

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ಸಮುದಾಯ ಆರೋಗ್ಯ ಕೋಶ
COMMUNITY HEALTH CELL

Phone : 5531518 / 5525372
Fax : (080) 5525372
Email : sochara@vsnl.com

No. 367, 'Srinivasa Nilaya', Jakkasandra, 1st Main, 1st Block, Koramangala, Bangalore - 560 034.

Communication Two

24th September 1999

Dear

Reg: Global Health Watch (National Meeting : India)

Further to our invitation to you dated 9th September with enclosures, we have noted the confirmation of your participation and welcome you to the National Dialogue on Global Health Watch.

Enclosed are the following:

(i) A registration form to be filled in and sent to us as soon as possible (to reach us not later than 3rd October, 1999;

(ii) An extract from the WHO-NGO Policy Consultation in 1997 when the GHW with equity focus was developed;

(iii) An overview of NGO initiatives on Watches' all over the world. Though the compilation from WHO is strong on 'Northern Watches', we hope through this meeting to enhance the information of 'Southern Watches' as well.

(iv) We await the questionnaire sent to you earlier. Due to oversight, page 6 which was corrected was sent without modification. A replacement of this page is enclosed.

Do send us the questionnaire and registration form **to reach us not later than 3rd October, 1999. The questionnaire is really a stimulus to think about the idea. There may be sections you do not wish to fill. There may be ideas you have that are not included. Please complete as much as you feel is relevant and send as soon as possible** so that we can compile the responses and enhance the interactive / participatory nature of the meeting.

Looking forward to your participation,

With best wishes,

Yours sincerely,

Dr. Ravi Narayan.

Enclosures : as above

P.S: ***You can use fax No. (080) 552 53 72 or Email : sochara@vsnl.com to speed up the process.***

GLOBAL HEALTH WATCH (National Meeting : India)

Date : 7th / 8th October 1999
Venue : Ashirvad, No. 30, Off St. Mark's Road, Bangalore 560 001.

Registration Form

1. Name			
2. Academic / Work Background (Mention Discipline and focus of experience)			
3. Organisation Represented			
4. Address			
Tel No.		Fax No.	
Email :			
5. Postal address (If different from above)			

6. Arrival on		By (mode)		At (time)	
7. Departure on		By (mode)		At (time)	
8. Accommodation : required / not required:		Dates	6th night		
			7th night		
			8th night		
9. Will like to Present experiences / or issue of					
10. Travel supported by own organisation		Yes ☐		No ☐	
11. If no in 10, then Require Fare		(estimate)			
12. Any Special suggestions?					

Date :
Place :

Signature

(Send back latest to reach us by 3rd October, 1999)

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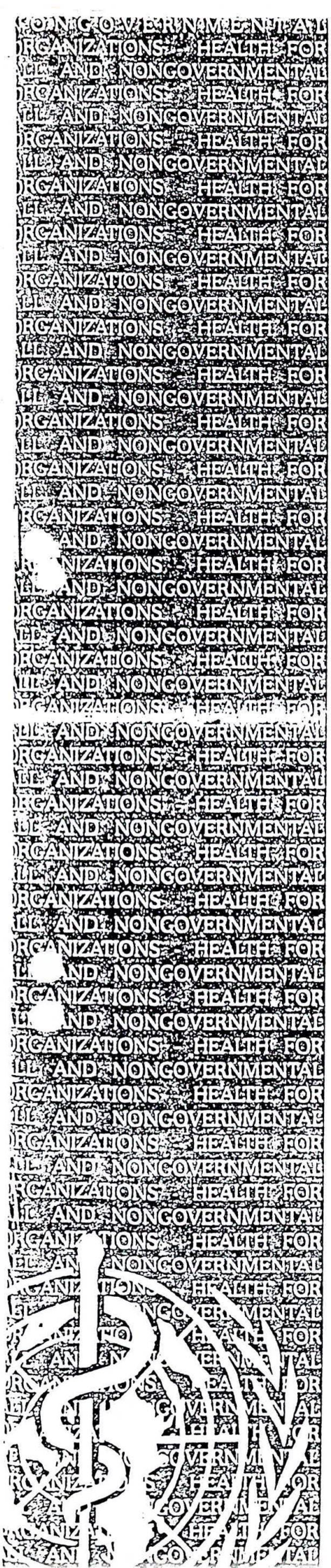

A New Global Health Policy for the Twenty-First Century

An NGO Perspective

Outcome of a Formal Consultation with
Nongovernmental Organizations held at WHO Geneva
2 and 3 May 1997

WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

Special thanks must go to the following individuals in NGOs who made an important contribution to the preparation of this report:

Dr Giovanni Ballerio, **Bahai International Community*
Dr Beth Bowen, **Health for Humanity*
Mrs Betsy Bumgarner, **Global Food and Nutrition Alliance*
Professor Andrew Haines, **Action in International Medicine*
Mrs Irene Hoskins, **American Association of Retired Persons*
Mrs Joanna Koch, **Associated Country Women of the World*
Mrs Adrienne Taylor, **Public Services International*

This report from NGOs was coordinated by Dr Roberta Ritson together with Mr Peter Iversen and Ms Kimberly Inge of WHO's Policy Action Coordination (PAC) team

Executive Summary

The WHO Policy Action Coordination Team convened a formal consultation in Geneva on 2 and 3 May 1997 with representatives of more than 130 nongovernmental organizations (NGOs) to review the new global health policy, "Health for All in the 21st Century."

The WHO/NGO consultation brought together not only NGOs working directly in public health, but also those NGOs in sectors that indirectly influence health, such as education, agriculture, business, environment, and habitat, as well as NGOs that address inter-related issues such as human rights, gender, women, children and individuals with disabilities. Multisectoral NGOs representing a broad and diverse spectrum of concerns contributed specific examples from communities worldwide that "health is everybody's business."

WHO's major aims for the meeting were to consult NGOs on global health policy development; to identify the potential roles of NGOs in implementing the new global health policy; and to identify, strengthen, and create new structures for NGOs to collaborate with WHO at the local, national, regional and international levels.

In the past five years, the series of United Nations Summits have abundantly illustrated the immense influence of NGOs in global policy development.

A Global Health Watch system, to be managed and operated by an NGO group and modelled after Amnesty International's work in human rights, was proposed as a new collaborative structure that could serve a crucial function in stimulating the political will necessary to prompt the timely translation of policy into action and to monitor how well governments, NGOs, and the private sector are fulfilling Health for All responsibilities.

The views of NGOs which participated in this consultation on renewing the Health for All strategy were explicit in calling for NGOs to promote the adoption of a universal "Health for All Value System." Its essential features include:

1) championing the importance of health as a human right, based on principles of social justice that maintain:

-Everyone is of equal worth
-Everyone is entitled to respect and personal autonomy
-Everyone is entitled to be able to meet his or her basic needs.

2) promoting ethics, equity, solidarity and sustainability as well as a gender perspective in all health policies.

The call for Health for All is fundamentally a call for social justice.

Specific priorities, such as promoting the advancement of women and increasing the participation of women in decision-making, have direct effects on health status. NGOs shared a wealth of experience in approaches to influencing policy and practice related to improving women's health, with far-reaching effects on policies and programmes on improving the well-being of men, women, and children. Some NGOs expressed the opinion that only when women are able to function as full partners in every level of decision-making will the moral and psychological climate necessary to attain Health for All be achieved.

There was common agreement amongst NGOs on the need to promote a vision of health as being central to sustainable development. They deplored the fact that 1.5 billion people around the world still do not have access to basic health services. Eradication of poverty is essential in all efforts to achieve a good standard of health.

The NGO Forum for Health, a group of multinational NGOs with a common interest in primary health care and global health, stated that: "At its heart, Health for All is a moral and ethical imperative. We call for a more profound definition of health to include the spiritual dimension as an essential component."

Many NGOs echoed the belief that unless and until the spiritual implications and ethical challenges of Health for All are acknowledged fully and addressed systematically through a process of consultation with all key players, including WHO, NGOs, and governments, the achievement of Health for All will be hampered.

There was general agreement that WHO could work more effectively with NGOs in the future if it were able to work with a broader range of multisectoral NGOs and not just the narrow range of NGOs now admitted into official relations with WHO. This would mean a review of existing criteria and arrangements for official relations with WHO, as well as a strengthening of WHO's

current NGO liaison office to promote expanded partnerships and working relations.

The renewed and strengthened partnership of WHO and NGOs, and the efforts to reach out and involve the diverse communities represented by the NGOs, contributed to promoting a sense of hope and a vigorous renewal of effort in a spirit of world citizenship to achieve the vision and aims of Health for All.

Chapter 3: Future action by NGOs to enhance health

The need for a gender perspective will be vital for planning and implementing policies and strategies and is complementary to the advancement of equity.

Representing the most vulnerable groups

NGOs have a long experience of working with communities and representing their needs and priorities. In many countries, NGOs provide the only health care or social welfare services available to the poorest and most vulnerable groups. They operate where no government or formal health care services are available, often free of charge, and work with volunteer staff or at very low cost. They are much closer to the grass-roots of society than any government services, or United Nations agency, and are in many cases the only voice of these underserved populations. NGOs often complement and support the work of formal government services. To enhance the effectiveness of this work by NGOs, there must be better coordination between WHO and NGOs, with clearer priorities and goals.

Equity and gender

Helping to ensure equity in health is one of the most important contributions of NGOs, and there is ample evidence of their impact in this area, particularly through their work with the most vulnerable population groups. More particularly, NGO groups with a special interest in women's affairs and gender differences can have significant influence in ensuring gender sensitivity in health policies and practices through effective advocacy, information sharing and lobbying.

NGOs have already played an important role in getting equity and gender issues high on the development agenda through their effective action at the numerous United Nations Conferences, and Summits, of the past decade. NGOs from all sectors played a significant and successful role at these summits in consciousness-raising, advocacy for equity and gender equality, and lobbying of governments and development agencies. This will continue to be a vital contribution by NGOs in the future.

WHO-NGO partnership should be open to all those that can contribute to certain issues within the scope of the entire work of WHO, including the renewal of the Health-for-All Policy. Mechanisms for ongoing NGO consultations twice a year should be established.

Many women's groups had a strong focus on health, several of which participated in the Geneva consultation on the new global health policy, such as the All India Women's Conference, Associated Country Women of the World, International Council of Jewish Women, as well as the Global Alliance for Women's Health and the International Community of Women Living with AIDS. For the future, stronger alliances were needed amongst these NGOs, with each partner identifying its specific strengths and future role.

Healthy Women's Counselling Guide

Several NGOs recently joined WHO's Special Programme for Research and Training in Tropical Diseases (TDR) in a project to advance gender perspectives in health through the development of the **Healthy Women's Counselling Guide.** This guide focuses on women's health in a holistic sense across the lifespan, not restricted to their role as a mother or to specific periods in their life.

A number of WHO technical programmes worked with a group of women's interest NGOs to develop a series of clear and simple health messages. These were to be distributed by NGOs and health workers to literate and illiterate women. The messages were developed in collaboration with rural women and community-based women's groups in Sierra Leone, Kenya and Nigeria in the form of "soap opera" radio tapes, and illustrated booklets. The impact of the guide on women's health issues has involved a number of international donors and foundations as well as the United Nations Drug Control Programme in a model of participatory cooperation on gender and health.

Advocacy and political support

NGOs can also play an important and increasing role in the future in advocacy for health, drawing the attention of governments to inequities in health services, in housing and education or in exposure to environmental hazards. They already play an important role in the political arena through successful lobbying of government to address inequalities and social injustices. They exert considerable influence on public opinion and act as the moral conscience of society.

NGO Global Health Watch

NGOs at the Geneva consultation expressed deep concern that one and a half billion people throughout the world still did not have access to basic health care services. To address this glaring inequity, a group of NGOs, known as the NGO Forum for Health, proposed to set up a **Global Health Watch** to monitor how governments, United Nations agencies, including WHO, and NGOs themselves were fulfilling their commitments to Health for All.

The NGO Forum for Health, formerly known as the International Primary Health Care Group, is long-established with members from a wide range of multisectoral interests, and has a major focus on primary health care and the Health-for-All initiative. Its members are particularly well-placed to monitor and report on equity in health and development at country, regional and global levels.

Today, the State faces pressures from above, below and within. From above, globalization of trade, travel and communication has in some countries led to marginalization from world trade and increased exposure to a range of transnational threats to health. From below, demand for decentralization and the growth of local government have reduced the need for centrally planned policies.

NGOs and the changing role of government

The changing role of government is one striking feature of the closing years of the twentieth century, which will become more marked in the coming decades of the next century. There is certainly a loss of power and prestige, as well as resources, in the government sector, which has a significant impact on health and social welfare in general. This is in part due to the economic constraints of the recent past.

Privatization in the health sector, as well as in many other sectors, is another trend which has an immediate impact on health. Private enterprises, as well as nongovernmental organizations, are stepping in to fulfil the role of government in many areas of health care services. It is clear that market forces operating in the health sector, if left unchecked, will prevent access to services by the poorest and most vulnerable communities, operating counter to the principles of equity.

If NGOs are to play an important role in the future by providing services for the poorest groups and helping to ensure equity, this means a closer collaboration with government and a clear definition of roles for NGOs.

It is clear that multisectoral NGOs, operating in all areas of social development, will have an equally important role to play in promoting health, working alongside and in partnership with NGOs representing the health science professions and formal health care sector.

Better coordination and cooperation

For the future, it is clear that NGOs could be much more effective if their work was coordinated amongst themselves, and if there was much closer cooperation with both the government sector and the efforts of WHO and other development agencies. This will require changes within both WHO and NGOs and give a broader scope of interaction.

For joint policies and plans to achieve this greater cooperation and coherence, there needs to be a much closer relationship between NGOs and WHO, with joint policies and strategies for action, based on common goals and a recognition of clear priorities. The expertise of NGOs at country level, especially with the poorest communities, should be clearly recognized by WHO, which lacks effective direct contact with the grassroots levels of society. NGOs should be invited by WHO to collaborate on policy formulation and strategy development, instead of merely being acknowledged for their successful implementation.

The criteria for admitting NGOs into official relations with WHO should be revised to take account of the new policy directions which emphasize social development. The new criteria should recognize different organizational structures for NGOs, such as networks.

WHO should look more closely at effective mechanisms for collaboration with NGOs and establish joint committees and procedures for partnership in the health sector. Changes are needed both within WHO and within NGOs to facilitate these joint ventures, and WHO could benefit in particular from the experience of NGO groups in the many different sectors which impact on health, such as education, environment, food and agriculture.

WHO can contribute by promoting the role of NGOs to governments, and by emphasizing the complementarity of the NGO contribution to health and health care. To facilitate this at the country level, WHO country offices could make an inventory of the NGOs working in each country, their resources and their areas of cooperation. This would form the basis for a joint and coherent plan of action for future cooperation on health between governments, NGOs and WHO or other international development agencies.

NGO action on the Family and Medical Leave Act

The National Council of Jewish Women (NCJW) in the United States has recently proposed significant changes in the Family and Medical Leave Act to make provision for more parental involvement in children's education and welfare. A comprehensive study carried out by the NCJW called **Parents as School Partners** showed that constraints in both the workplace and the school setting made it difficult for parents to participate in school and community activities.

The findings of the NCJW study will be used to enhance community participation in a wide range of projects, involving public Information campaigns and information fairs.

Possible Threats of Globalization for Health

Global Factors Health Status	Consequences and possible negative impact on:
Macroeconomic prescriptions (e.g. SAPs*)	= marginalisation, poverty, inadequate and decreased social safety nets
Trade	+ tobacco, illicit drugs and alcohol, increased marketing, availability and use
Travel	# infectious diseases South to North; harmful lifestyles and products North to South
Migration	+ inequalities and ethnic conflict leading to refugee growth and civil conflict
Food security	+ greater vulnerability in Africa as China imports more grain
Environment	+ global and local threats from rapidly increasing, unsustainable consumer-led demand
Technology (direct medical)	# diagnosis outstrips treatment; treatment increasingly unaffordable for poor
Values	# equity and human rights under pressure from global homogenizing forces
Foreign policy	# xenophobia, tough immigration laws as some States try to isolate themselves from global forces; threat to multilateralism in face of common global challenges
Communications and media	# marketing of health-damaging behaviour; erosion of cultural diversity

= possible short-term problem that could reverse in time
+ long-term impact profoundly negative
# great uncertainty

* Structural Adjustment Programmes

1. INTRODUCTION

During the last 15 years there has been a dramatic increase in the number of NGOs and an increase in their areas of activities. Many of these NGOs fill a "watchdog" function, *e.g.* NGOs or networks of NGOs monitor State's behaviour in relation to Human Rights (HR) and social security systems, or they monitor the environmental degradation, alerting the global and national community when action is needed. One common feature of these "watchdogs" is that they are associations of human beings in their private sphere of life or NGOs, coming together for a cause and acting as citizens with or without special expertise. This development has been especially marked in the developing world. Civil society steps in where States fail to, are reluctant to, or cannot act. Some of the most well known watches are active within the field of HR, such as Amnesty and Human Rights Watch. These watches are prominent and have been successful within their field. Another area where watches have had success and have been acting for a 10-15 year period is the environment (for example Earthwatch, World Watch Institute and Earthscan). There is an emerging demand and need for a "watch" to focus on health and public health.

This document will
1) present conclusions relevant for a Global Health Watch (GHW)
2) discuss likely parameters for "success", of a watch: What working methods, what level of cooperation and with who, and what form of information dissemination has been successful?
3) give an example of a method for impact assessment of advocacy developed by the "Social Watch".
4) give an overview of NGO's/watches active in the field of health/health rights.

For a description of NGO's contacted or discussed see annex 2.

2. CONCLUSIONS TO BE DRAWN FOR A GLOBAL HEALTH WATCH

- There is a need for a global network with *unified* objective/focus on health and health rights, since no such watch exists.

- The founding idea of an NGO has to be a grassroot initiative, and cannot be fed into an NGO. There are today many initiatives within health. A GHW would profit from cooperating/networking with them.

- The active participation of volunteers even within research has shown to be very successful and to increase the sense of ownership: a GHW could be enriched by the energy that volunteers provide.

- Networks seems to be the most profitable way of cooperation, combining a unified goal with freedom of work. This would also make it possible to profit from all the already existing NGOs working in health and avoid duplication of efforts.

- The rights perspective is increasingly common in all parts of the world!

- Using scientific methods, striving for measurable comparable results gives credibility. GHW could benefit from cooperating with the Social Watch and their fulfilled commitments index, also considering that their mandate partly covers health.

- Considering the capacity for disseminating information and making an impact already existing within the NGO community, a GHW would profit from cooperating with most global NGO's mentioned in this document.

3. DETERMINANTS OF SUCCESS

3.1 What is "success" in this context?

Relating the success of these NGOs to their objective, which is generally broad and unattainable (for example, a world with "no human rights abuse" or a world with "no environmental damage") it is difficult to measure results. In some cases however, clear results are seen, such as Amnesty's success in some of their individual cases of political prisoners, China's change of agricultural policy as a result of Lester Brown's report "Who will feed China"[1], the International Baby Food Action Network's (IBFAN) work together with WHO and UNICEF on the International Code of Marketing of Breast-milk Substitutes which was subsequently adopted by the World Health Assembly in 1981 or the fact that the Pugwash Conferences[2] and Joseph Rotblat received the Nobel Peace Prize in 1995 for the work on stopping the nuclear arms race.

Other signs of successful advocacy are less visible. Some NGO's have mentioned a change in the public debate[3], or that politicians and legislators use a vocabulary and concepts earlier introduced by that NGO. SIPRI has pointed out that there is a discussion/dialogue at all is a sign of success, since an NGO has a unique possibility to provide a non committing forum for discussion.[4] SIPRI also mentioned that the public is more aware of issues relating to peace and conflict research now than 10 years ago, which can partly be ascribed to the work of all NGOs active in this field. Amnesty acknowledges that the fact that work is being done at all in certain fields, even if no tangible results can be shown, is better than letting issues being completely forgotten.

3.2 Possible denominators of success

Listed below are some of the factors that the NGOs themselves identify during interviews as having been important for their success, see also table in annex 1 for an overview of denominators. The watches perceive their success differently and their work methods differ, explaining why not all factors are applicable to all watches. The factors listed are core factors found in many successful watches.

Abbreviated version of table, annex 1

Overview of Global NGOs and determinants of success

	1	2	3	4	5	6	7	8
Amnesty	x	x	x	x	x	x	x	x
Earth summit W	x	x	x					
Earthscan				x	x			
Earthwatch	x	x		x				x
GLOBE				x	x	x	x	x
Human Rights Watch	x	x	x	x	x	x		x
IBFAN	x		x			x		
IPPNW	x		x		x	x	x	
IPPF	x	x	x	x		x	x	x
MarineWatch	x			x				
Multinational Monitor		x						
Northwest Environment	x	x	x	x	x			
PRIO		x		x	x			

[1] The author Lester Brown is the director of World Watch Institute.

[2] The Pugwash Conferences on Science and World Affairs, inception in 1957, members are scientists, some former nuclear engineers.

[3] Freds och konflikts forskning, Uppsala Universitet

[4] Stockholm International Peace Research Institute (SIPRI), that acted as a bridge East-West during the Cold War. Interview Jean Pasqual Sander

Project Ploughshares		x	x					
Social Watch	x	x	x			x		
The Pugwash Conf.	x			x	x	x	x	x
Women's Rights Action						x		
Alan Guttmacher Inst		x		x	x		x	
Women Watch				x				
World Watch Institute	x	x		x	x	x		x

1. Grassroot initiative, 2. Combining research & advocacy, 3. Cooperation with national NGOs, 4. Credibility, 5. Effective dissemination of information, 6. Flexible networks, 7. Members professional status, 8. Participation of volunteers

"Being a grassroot/citizen's initiative" (1)

That the NGO is a true grass root initiative has been shown to be a cornerstone of success. A movement based on the initiative of people that have a strong urge to work/fight for their issue is immensely important for the strength of a watch. An NGO with this foundation will have a large number of volunteers ready to work for it and it will benefit tremendously by the word of mouth method of spreading their information. In practice this is the core of a functioning, active, civil society. For examples, see table in annex I.

Active participation of members/volunteers (8)

Members of NGOs are involved to different degrees. They may hold a passive interest, they may actively participate within designated fields or they may be involved in higher level functioning of the organisation. To use members and volunteers in research missions and advocacy, has shown to be successful. For example, Amnesty is a democratic organisation who's mandate is entirely defined by its members. Members also take part in the research and fact finding missions together with employed researchers and representatives of the organisation, besides acting as members on behalf of political prisoners. Earthwatch does not conduct any research without having the research teams consist of approximately 50% volunteers. In fact, Earthwatch builds its organisation on the idea of linking researchers and the public for a common cause. IBFAN is another organisation that ascribes their success partly to the fact that their organisation is founded on grass root initiatives.[5]

Cooperation with other national NGO's/Country representation (3)

In order to access information, to reach a broader population when disseminating information and to activate people at the grass root level, many of the watches cooperate with national NGO's. Being affiliated with a global reputable NGO also legitimizes the work of smaller NGOs in countries where civil society is not functioning freely. In areas where it is impossible for national NGOs to function the watches have country representation, or regular fact finding missions.

Credibility (4)

The information the watches 1) receive and 2) disseminate must be 100% reliable or the NGO will loose its credibility, especially since the "watches" function as a kind of citizens police. Many of the successful watches like Amnesty and Human Rights Watch have developed systems to collect information and rigorously assess it. By being active, independent and objective and at the same time identifying new important issues many of the organisations have achieved credibility.

How is this done?

The NGOs use renowned researchers employed long term by the NGO to perform fact finding missions and conduct research, as well as in some cases members or volunteers. The watches constantly monitor activities using the media, official documents and most importantly, the organisations own contacts on the ground, such as local NGO's and like-minded organisations. Naturally information from reputable research institutions

[5] Tina Pfenninger IBFAN 22/9

which are not themselves trying to change public opinion is used. Also fact finding missions and in some cases "representational" missions to influence a country are used.[6]

Effective dissemination of information (5)
When the NGO has access to objective information it must inform the relevant population. For many of the NGO's the target population is very large to achieve maximum impact in a global society. These factors have been considered by successful watches:

- *Timing*: some of the watches perform an analysis to get maximum impact for their report.[7] World Watch Institute tries to time their publications with for example large symposiums on different issues, such as the tobacco and the climate issues.

- *Accessibility/availability*: Information must be accessible and available both to professionals and laymen to achieve broad recognition. For example "The State of War and Peace"[8] by D. Smith director of PRIO is written in a pedagogical and easily accessible way, accessible to an interested member of the public. World Watch Institute's yearly publication "State of the World" is available in 28 languages and in a number of universities over the world. The use of new information technology like websites on internet and e-mail has made information available to a very large population previously not reached.

- *Targeting population*: If the target population is identified at the stage of writing a report it will get a better public response. "Who will feed China" by Lester Brown, World Watch Institute, is an example of that. Human Rights Watch has offices in all regions of the world to be able to target policy makers and legislators.[9]

Flexible networks/cooperation (6)
Many NGO's discussed in this document are networks of NGOs, following a loose organisational structure, which seems to promote ideas and cooperation.

Members status (7)
Some NGOs lend credibility of their members, that is the members professional background. These are the NGOs where professionals, as *individuals*, have joined themselves together for a cause related to their professional life. For example; the Pugwash movement where nuclear scientist are working for a nuclear weapon free world, and GLOBE, an association of legislators and policy makers working to enhance cooperations between parliamentarians on global environmental issues.

Combination of research with advocacy and participation (2)
To combine performing research, with advocacy and participation of members is a fruitful work method

Prioritizing
For NGOs with a broad mandate, prioritizing is difficult, but necessary. This implies choosing to act or not

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[6] Director, media programme Amnesty, Anita Tiessen 24/9

[7] Human Rights watch, Susanne Osnos 23/9

[8] Published by Penguin 1997, ISBN 01405137365

[9] For example in Brussels, Tokyo (Japan is a major donor), and Washington.

balancing urgency and the possibility to make an impact with available resources. A pragmatic application of International Law is required, i.e. to base the activities on the demands of the real world and then to apply necessary and applicable international and national law.

3.3 System of measurement, qualitatively and quantitatively, an example

Not many NGOs have a formal system of measurement available for outside researchers, to evaluate the impact of their advocacy. A system is a set of indicators, thus making comparison possible between projects or even between NGO's. However, many of the interviewees trust their "experience". This makes it difficult to objectively conclude which methods of work have been more effective than others.

An exception is the newly instigated Social Watch and their "Fulfilled Commitments Index" (for a description of the Social Watch see annex 2). The Social Watch has developed a system of indicators, both qualitative and quantitative, to measure the "rate" of fulfilment of a number of Conventions ratified by a individual states. They divide their indicators into two categories "Political Will" and "Distance from Goals" and have managed through a complex but comprehensive system to create internationally comparable fulfilments status report for individual countries (see annex 3). Each category is divided into subcategories, and they in turn are divided into packages of variables. The Political Will category is aimed at measuring the degree to which the governments express their political will to change social policy. The Distance from Goals category describes how far or near a country is from what they have committed to.

4. OTHER NGOS INVOLVED IN HEALTH

Some global NGO's are involved with health related questions within specific areas, mostly regarding health determinants. There are also a number of national NGO's involved in health, more or less focused on special issues. As a result, there are a number of initiatives within many different areas of health, all striving towards different goals. No NGO is working solely with a unified focus on human health and health rights.

Overview of global NGO's activities in the health field

NGOs *Italics indicate national NGO*	**HEALTH ACTIVITIES**
Amnesty	Amnesty fights torture and has recently started to work for the elimination of female genital mutilation (FGM). They organised a conference in Ghana 1996 on FGM and has a mailing campaign.
Earth Summit Watch	Addresses health determinants. Monitors states fullfilment of promises made at the Earth Summit in Rio, has the past 5 years monitored treaties in the following areas: climate change, biodiversity, forests and Agenda 21. Specific reports: An assessment of national action to implement agreements made at the International Conference on Population and Development (for example concerning the availability of family planning services), a report on the fulfilment of the Cairo Programme of Action "Clean Drinking Water: A new Paradigm for Providing the World's Growing Population with Safe Drinking Water" and a report that lead to the global phase out of leaded gasoline.
Earthscan publisher	Publishes in the area of a sustainable development, specific areas regard children and the environment and primary health care.

Earthwatch	One of Earthwatch's programme areas is World Health; projects studying Public Health and Indigenous Systems of Resource Management and Medical Care. Specific projects are; "Maternal Health in Africa (Zimbabwe)", "Helping the Homeless", and "Community Health in Cameroon".
GLOBE	One of GLOBE's working groups is dedicated to Human Health, while other working groups address health determinants such as Fresh Water and Population. Specific outcomes of the Human Health working group are two action agendas: Children's Environmental Health Action Agenda and Sexual and Reproductive Health/Rights Action Agenda.
Harvard Women's (and Men's) Health Watch A Publication	Empowers patients with concise accurate information to help readers make informed decisions about their own care.
Health Action Information Network	Is involved in health education and research, works mainly with community based organisations. Work is emphasised on reproductive health.
Health in Action	Develops and maintains a centralised information system on prevention and promotion programs research and evaluation initiatives in Alberta.
IBFAN	Aims at improving infant health through the protection of breastfeeding, and especially the implementation of the International Code of Marketing of Breast Milk Substitutes.
International Physicians for the Prevention of Nuclear War	Educates and advocates to prevent nuclear war (by humanising statistics) and antipersonnel mines.
IPPF	Promotes the reproductive and health rights of women and men
Lymphovenous Canada; Health Watch	An NGO focused on the treatment and daily life of people suffering from dysfunctioning lymphatic systems. Monitors treatment and research of the disease.
Multinational Monitor	Published by "Essential Information Inc. " tracks corporate activity, especially in the Third World focusing on the export of hazardous substances, worker health and safety, and the environment. Is disseminated in the Third World and the United States.
Social Watch	Founded after the Copenhagen Social Summit and the Beijing Conference to monitor and report on the implementation of conference commitments by governments and international organisations. It's mandate covers health as a part of Social Policy. The Social Watch also uses public health indicators to measure progress of social systems in individual countries
The Alan Guttmacher Institute	Protects reproductive rights of individuals and families focusing particularly on young, poor or otherwise disadvantaged people. Provides reliable information on contraception, sexual activity, abortion and child bearing.

The International Women's Rights Action Watch	Monitors the implementation of the Convention on the Elimination of All Forms of Discrimination Against Women and the human rights of women under the other human rights treaties.
Welfare Watch	Provides data on the consequences of implementing the new Welfare Act in the United States.
Wham!	A direct action group committed to demanding, securing and defending absolute reproductive freedom and quality health care for all women, in the United States.
Worldwatch Institute	Within health WWI focuses on life style issues such as smoking (the lessons that can be learned from the west really makes it possible to act in other parts of the world). Earlier their focus was on population and reproductive health.

ANNEX 1
Overview of Global NGOs and determinants of success

	A Citizen's initiative	Combination of research with advocacy and participation	Cooperation with national NGO's	Credibility	Effective dissemination of information	Flexible networks/forms of cooperation	Members specific professional status	Participation of volunteers
Amnesty	yes	yes	yes	yes	yes	yes	yes, sometimes	yes
Earth Summit Watch	yes, after Earth summit in Rio	yes	yes					
Earthscan A publisher	–	–	–	yes A leading publisher	yes, publications in general ordered by other org that disseminates	-	–	-
Earthwatch	yes	yes		yes		no. not a network	–	yes. The idea of EW is joining scientists and laypeople in missions
GLOBE	no		-	yes Members are legislators and parliamentarians around the world	yes Annual conference and ongoing exchange of information	yes	yes, Members ARE Globe	yes
Human Rights Watch	yes Responded to need in hr groups in Moscow and Warsaw	yes	yes Closely cooperates with HR monitors in other countries	yes Scientific methods and proven to right on numerous occasions	yes Offices in strategic locations, strategic plan for each report published	yes Works like an umbrella organisation	–	yes Uses local monitors, but not volunteers b/c of risks

"A GLOBAL HEALTH WATCH" - INITIAL OVERVIEW OF NGO INITIATIVES

PREPARED FOR THE NGO FORUM FOR HEALTH, GENEVA

	A Citizen's initiative	Combination of research with advocacy and participation	Cooperation with national NGO's	Credibility	Effective dissemination of information	Flexible networks/forms of cooperation	Members specific professional status	Participation of volunteers
Social Watch	yes	yes	yes			yes	–	?
The Pugwash Conferences	yes, manifesto issued by B. Russel and A. Einstein			yes Organisation of reputable scientist and members of government	yes Members being policy makers, so info quickly reaches policy makers level	yes	yes Highly distinguished participants with direct possibility to influence policy	yes
The International Women's Rights Action Watch						yes		
The Alan Guttmacher Institute	no	yes	-	yes	yes Publishes a wide range of material and educates	-	yes	-
Women Watch (UN initiative)	no	no	no	yes UN information and organisation		no		no
Worldwatch Institute	yes	yes	?	yes	yes timing, targeting and planning	yes	–	yes

"A Global Health Watch" - Initial overview of NGO initiatives

prepared for the NGO forum for health, Geneva

	A Citizen's initiative	Combination of research with advocacy and participation	Cooperation with national NGO's	Credibility	Effective dissemination of information	Flexible networks/forms of cooperation	Members specific professional status	Participation of volunteers
IBFAN	yes		yes, is a network			yes partnership of 150 national groups	-	
IPPNW	yes	no	yes		yes	yes	yes	no
IPPF	yes by leaders of family planning associations in Bombay	yes combines advocacy, expert panels and participation	yes, IPPF is an international network	yes, uses scientific methods with advisory expert panels		yes is a federation of autonomous and voluntary associations	yes a majority of family planning experts	yes
Marine Watch a publication	yes	–	?	yes	?	?	?	?
Multinational Monitor	no	yes	no			no	–	no
Northwest Environment Watch A publisher	yes. linked to Worldwatch Institute	yes	yes	yes	yes Wide distribution in region			
PRIO Research Inst.	no	yes, individual researchers	no	yes. highly renowned researchers	yes Publications are accessible, popular and timed			
Project Ploughshares		yes. uses data to influence Canadian government	yes cooperates with researchers in Africa, Sweden and the EU		? Publishing mainly reaches Canadian gov and donors	-	-	no Engagement model for change, but no active volunteers participation

Health in Action Alberta Centre for Well Being 11759 Groat Rd, Edmonton, AB T5M 3K6, USA Phone: +1 403 453 8692 Fax: +1 403 455 2092 e-mail: cjsmith@incentre.net internet: www.health-in-action.org	HiA s aim is to maximise the effectiveness of injury prevention and health promotion programs in the province (Alberta), by developing and maintaining a centralised information system that will consolidate descriptive information about prevention and health promotion programs in Alberta.
Health Action Information Network 9 Cabanatuan Rd, Philam Homes, Quezon City 1104, Philippines, Phone: +63 2 927 6760 Fax: +63 2 927 6760 e-mail: hain@mnl.sequel.net internet: www.hain.org	Involved in health education and research, publishes the twice-a-month publication "The Drug Monitor" to provide objective and independent information on pharmaceuticals and the drug industry.
Human Rights Watch 485 Fifth Avenue, New York, NY 10017-6104, USA Phone: +1 212 972 8450 Fax: +1 212 972 0905 e-mail: hrwnyc@hrw.org internet: www.hrw.org	Investigates and exposes human rights violations, globally. Challenges governments and stands with national activists.
IBFAN The International Baby Food Action Network (Tina Pfenninger 22/9) Europe Regional Office GIFA, PO Box 157, CH-1211 Geneva 219, Switzerland Phone: +41 22 798 89 64 Fax: +41 22 798 44 43 e-mail: philipec@ipro.link.ch internet: www.IBFAN.org	Aims at improving infant health through the protection of breastfeeding. Implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly Resolutions relating to infant health are a key part of IBFAN's work.
IPPNW International Physicians for the Prevention of Nuclear War 126 Rogers Street Cambridge, MA 02142-1096, USA Phone: +1 617 868 5050 Fax: +1 617 868 2560 e-mail: ippnwbos@igc.apc.org internet: www.healthnet.org/IPPNW	Is a foundation of national medical associations committed to the elimination of weapons of mass destruction. Combining prophecy (describing the reality), education and advocacy IPPNW have been so successful that they received the Nobel Peace Price in 1985. They have now broadened their mandate to include land mines and other weapons of mass destruction.
IPPF, International Planned Parenthood Federation Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom Phone: +44 171 487 7900 Fax: +44 171 487 7950 e-mail: info@ippf.org internet: www.ippf.org	Promotes and defends the reproductive and health rights of women and men. In particular advances family planning through information, advocacy and services

ANNEX 2
NGO's
INTERVIEWED OR INVESTIGATED

Amnesty United Kingdom 99-119 Rosebery Ave, London EC1R 4RE Phone:+44 171 8146200 Fax: +44 171 8331510 e-mail: amnestyis@amnesty.org internet: www.amnesty.org	Amnesty International aims at contributing to the observance of human rights as set out in the Universal Declaration of Human Rights, by promoting awareness, adherence and to oppose violations of political freedoms.
Earth Summit Watch 1200 New York Ave., N. W., suite 400 Washington D.C. 20005 USA Phone: +1 202 289 6868 Fax: +1 202 289 1060 internet: www.earthsummitwatch.org	Monitors action by governments to implement the declarations made in the Earthsummit in Rio and to move towards a sustainable development
Earthscan Earthscan Publications Limited 120 Pentonville Rd, London N1 9JN, United Kingdom Phone: +44 171 278 0433 Fax: +44 171 278 1142 e-mail: earthinfo@earthscanco.uk internet: www.earthscan.uk	Earthscan is a publisher of books on environment and sustainable development. It`s aim is to increase understanding of environmental issues and to influence opinion and policy to promote a sustainable development.
Earthwatch (Tom Coward 15/9) 680 Mt Auburn Street, PO Box 403 Watertown, Massachusetts 02272, USA Phone: +1 800 776 01 88 Fax: +1 617 926 8532 e-mail: info@earthwatch.org internet: www.earthwatch.org	Supports scientific field research through volunteers and scientists working together (an active partnership scientist-citizen), to improve public understanding of a sustainable world. Earthwatch believes that this will empower people and governments to act as global citizens.
Essential Information Inc, publisher of "**Multinational Monitor**" Phone: +1 202 387 8030 e-mail: monitor@essential.org	MN tracks corporate activity in the Third World focusing on the export of hazardous substances, worker health and safety, labour union issues and the environment
GLOBE Global Legislators for a Balanced Environment e-mail: globeinter@innet.be internet: www.globe.org	Enhances international cooperation between parliamentarians on global environmental issues. Tries to provide a forum for parliamentarians to forge balanced, informed policy responses to pressing global environmental challenges.
Harvard Women's (an Men's) Health Watch 164 Longwood Avenue Boston, MA 02115 e-mail: hhp@warren.med.harvard.edu internet: www.med.harvard.edu/publications	Newsletter from Harvard School of Public Health that seeks to clarify issues around women`s health and to proved accurate information to help readers make informed decisions about their own care.

The Alan Guttmacher Institute 120 Wall Street, 10005 New York, N.Y. USA Phone: +1 212 248 1111 Fax: +1 212 248 1951 e-mail: info@agi-usa.org internet: www.agi-usa.org (att Beth Friedrich)	An independent not for profit corporation for research, policy analysis and public education in the field of reproductive health. Provides the public with the latest news releases, research findings, publications and policy developments within the field and publishes periodicals such as "Family Planning Perspectives" and "State Reproductive Health Monitor"
Welfare Watch the Annenberg School of Communication University of Southern California internet: www.welfare.org	WW is an information centre for legislators, citizen activists, journalists and the general public and provides data on the implementation and effects of the Welfare Reform Act.
Wham! P.O. Box 733, NYC 10009, USA Phone: +1 202 560 71 77 internet: www.echonyc.com/~wham/wham.htlm	A direct action group committed to demanding, securing, and defending absolute reproductive freedom and health care for all women.
Worldwatch Institute 1776 Massachusetts Ave., N.W. Washington D.C. 20036-1904, USA Phone: +1 202 452 1999 Fax: +1 202 296 73 65 e-mail: worldwatch@worldwatch.org internet: www.worldwatch.org	Conducts interdisciplinary non-partisan research and widely disseminates the results of it in order to foster the evolution of an environmentally sustainable society. Publishes yearly "State of the World". Lester Brown published highly successful "Who will feed China?"

Source: W.H.O (1995)

Marine Watch PO Box 810, Point Reyes Station, CA 94956 USA Phone: +1 415 663 8700 Fax: +1 415 663 8784 e-mail: subscriptions@marinewatch.com internet: www.marinewatch.com	An international news journal focused on the Earth`s oceans, in depth substantive reporting aimed at the reader with a high level of comprehension
Northwest Environment Watch 1402 Third Avenue, suite 1127 Seattle, WA 98101-9743 Phone: +1 202 447 1880 or +1 888 643 9820 e-mail: new@northwestwatch.org internet: www.northwestwatch.org	Research and publishing organisation, fosters a sustainable economy and way of life in the Pacific Northwest.
PRIO International Peace Research Institute Oslo Fuglehauggata 11, N-0560 Olso, Norway Phone: +47 22 55 71 50 Fax: +47 22 55 84 22 e-mail: info@prio.no internet: http://macink44.uio.no	PRIO is an independent international institution conducting information activities trough seminars, guest researchers and publications, for example "State of War and Peace Atlas" by Dan Smith.
Project Ploughshares Institute of Peace and Conflict Studies, Conrad Grebel College, Waterloo, Ontario, Canada N2L 3G6, Canada Phone: +1 519 888 6541 Fax: +1 519 885 0806 e-mail: plough@waterserv1.uwaterloo.ca internet: http://waterserv1.waterloo/~plough	Using publications, student participation and letter writing campaigns to reduce Canada`s military spending.
Social Watch c/o IteM, Jackson 1132, Montevideo 11200, Uruguay Fax: +598 2 419 222 e-mail: socwatch@chasque.apc.org internet: www.chasque.apc.org/socwatch/	Was established after the World Summit on Social Development in 1995 to produce an annual report on the fulfilment of what was agreed at the summit. The Social Watch is a network of global watch dogs monitoring social development policies. Reports are produced inside each country by NGOs actively working in social development.
The Pugwash Conferences 69 Rue de Lausanne 1202 Geneva Switzerland Phone: +41 22 906 1651 Fax: +41 22 731 0194 e-mail: pugwash@hei.unige.ch	Strives to bring together influential scholars and public figures concerned with disarmament and a nuclear free world seeking solutions for global problems
IWRAW The International Women's Rights Action Watch Humphrey Institute, 301- 19th Avenue South Minneapolis, MN 55455 USA Phone: +1 612 625 5093 Fax: +1 612 624 0068 e-mail: iwraw@hhh.umn.edu	A global network of individuals and organisations that monitors the implementation of human rights of women. Independently reports to the human rights bodies.

Health and climate change

On Nov 1 and 2, 1993, at the World Health Organization's headquarters in Geneva, an international group of experts met to discuss the potential health impacts of climate change. The meeting was organised for the WHO Division of Environmental Health and was chaired by Dr Rudi Slooff of WHO. Their task is now to update and expand the 1990 WHO publication *Potential Health Effects of Climate Change*. They will also contribute to the work of the Intergovernmental Panel on Climate Change, especially to the working group on impacts of climate change. The proposed WHO publication is planned for 1995 and will include contributions on direct effects of increased temperatures on cardiovascular and cerebrovascular deaths besides potential impacts on vector-borne diseases, other communicable diseases such as cholera and algal biotoxin poisoning, effects on fresh water supply and food production, and impacts of a rise in sea level. Almost all these topics were covered in a *Lancet* series, that ends this week with the initiation of a discussion of questions to be tackled by the WHO group—namely, how to monitor possible health effects and what strategies are needed to prevent them.

Global health watch: monitoring impacts of environmental change

*Andrew Haines, Paul R Epstein, Anthony J McMichael, on behalf of an international panel**

The eleven articles published in *The Lancet* over the past seven weeks have shown how anthropogenic damage to the biosphere has potentially important implications for health. The underlying processes are global in scale, and the natural systems affected are part of earth's life-supporting infrastructure. This type of health risk thus differs noticeably from more local environmental health hazards that are usually addressed at a toxicological or microbiological level. The impacts of global environmental change on health may be indirect and present only after a long delay. How can public health scientists predict and monitor the population health impacts of this novel challenge?[1] We need to detect effects early so that countermeasures can be developed and tested, to find out if there are previously unsuspected impacts, and to give impetus to policies to reduce greenhouse gas emissions (and other causes of global environmental change).

Climate change, the chosen focus of the *Lancet* series, could affect health in a variety of ways. Direct effects of a rise in temperature (particularly increases in the frequency and intensity of heatwaves) may include deaths from cardiovascular and cerebrovascular disease among the elderly. Indirect effects are secondary, such as changes in vector-borne diseases or crop production, and tertiary, such as the social and economic impacts of environmental refugees and conflict over fresh water supplies.[2]

Traditional epidemiological monitoring of disease and mortality has limitations because there may be undesirable delays before changes in chronic diseases are detected. Other approaches must also be used, including biological markers to give early warning of damage, the monitoring of carriers of infection such as insects and rodents, and remote sensing for large-scale monitoring. There is growing

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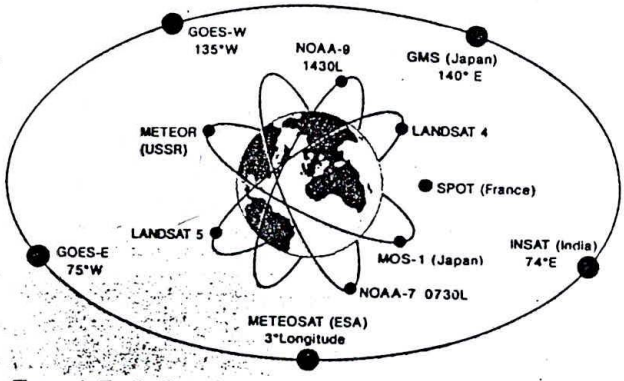


Figure 1: Earth observing satellites in operation (as of April, 1992)

awareness of the need to link environmental issues with health—for instance the 1993 World Bank report *Investing in Health* includes forest and fresh water resources.[3] We argue for integration of health into existing and planned environmental monitoring systems. In this final article we consider five aspects of monitoring, with cross-reference to the series where appropriate: biological, environmental, and human health indicators; data needed to monitor indicators; technology for measuring them; organisations doing the work; and gaps in information.

Climate (Maskell et al, Oct 23)

The scientific assessment of climate change is being updated by the Inter-Governmental Panel on Climate Change (IPCC).[4] The Second World Climate Conference in Geneva (1990) recognised the need for a Global Climate Observing System (GCOS) and a committee for GCOS has now been set up. GCOS will cover all components of atmosphere, biosphere, cryosphere, hydrosphere, and land surface climate, and that coverage is beyond the scope of current monitoring programmes such as Global Atmosphere Watch and the World Weather Watch network of satellites, telecommunication, and data processing facilities (figure 1).

Two other observing systems (ocean and terrestrial, GOOS and GTOS) will enable GCOS to provide a fuller picture. More than eighty international organisations and programmes are involved in global environmental monitoring, and the potential for overlap and lack of coordination is great. Until now health has not been adequately taken into account. A selection of these organisations is shown in figure 2.

Direct Impacts (Kalkstein, Dec 4)

The direct effects of temperature on health are mainly manifest as an increase in death rates amongst the elderly during periods of high temperature and can best be detected through analysis of mortality data collected daily. Such data are currently available mainly in developed countries but this information is needed for urban centres in less developed countries. Aggregation of deaths into weekly or monthly statistics is of much less value because an increase in mortality tends to be short-lasting and may be followed by a period of lower than expected mortality. Changes in morbidity and in seasonal patterns of disease can be detected in primary care data such as those collected from sentinel general practices around the UK.[5] This database demonstrates, for instance, that consultations for asthma

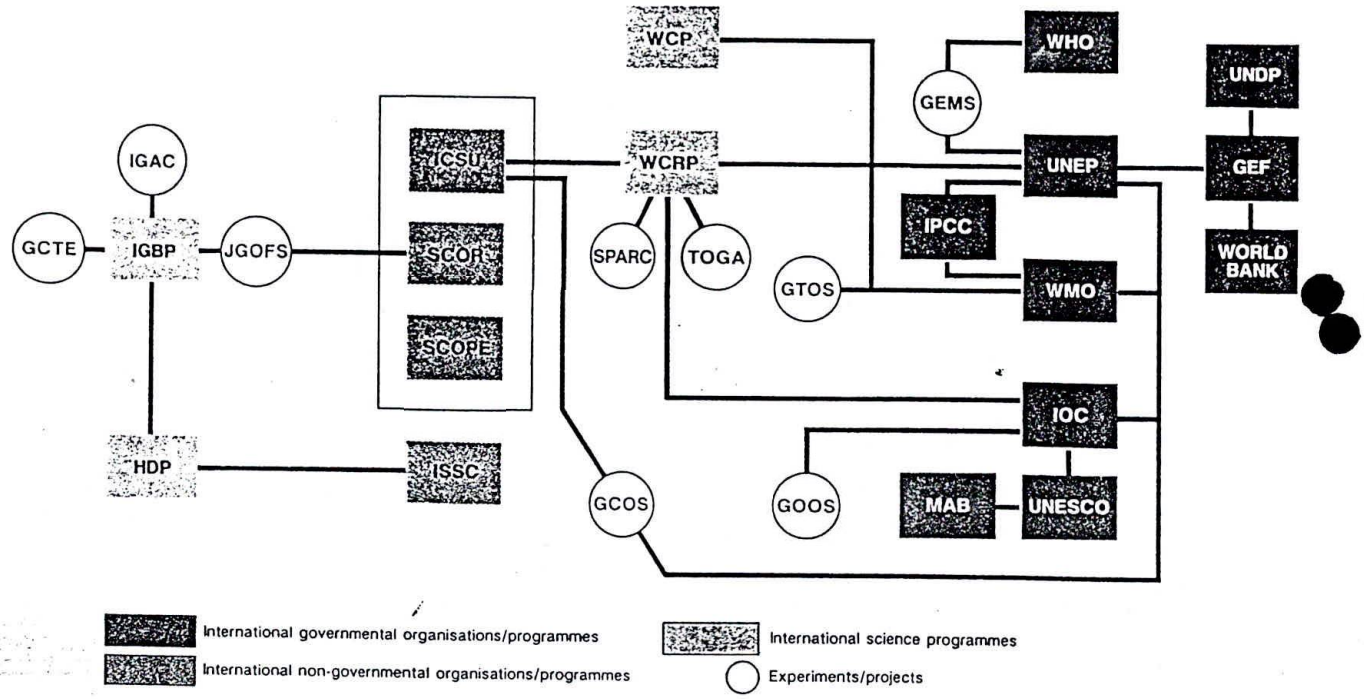
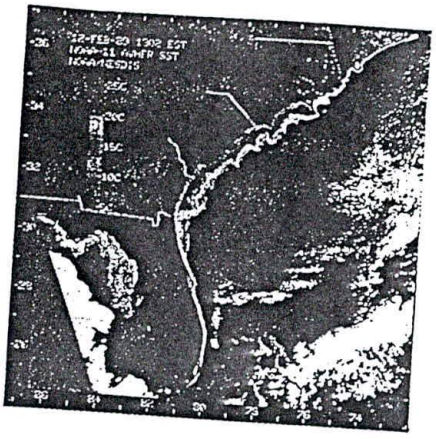


Figure 2: Links between major international global environmental organisations, programmes, and projects

Connecting lines indicate organisational links or "memoranda of understanding". (Adapted from figure 5 in *Global Environmental Change: the UK Research Framework 1993*, published by the UK Global Environmental Research Office, Swindon; this figure has been simplified to emphasise programmes mentioned in *Lancet* series.)
UN agencies etc—Development (UNDP), Environment (UNEP), Meteorological (WMO), Education and Science (UNESCO), Health (WHO).
Other International bodies with UN links—Global Environment (GEF), Climate Change (IPCC), Oceanographic (IOC), Man and Biosphere (MAB), Scientific Unions (ICSU), Social Science (ISSC), Problems of Environment (SCOPE), Oceanic Research (SCOR).
Other programmes/projects—Environmental Monitoring (GEMS), Climate Observing (GCOS), Ocean Observing (GOOS), Terrestrial Observing (GTOS), Human Dimensions (HDP), Terrestrial Ecosystems (GTEC), Geosphere-Biosphere (IGBP), Atmospheric Chemistry (IGAC), Oceanic Flux (JGOFS), Stratospheric Processes (SPARE), Tropical Ocean and Atmosphere (TOGA), World Climate and Climate Research (WCP, WCRP).



(Pat Tester)

Figure 3: **Sea surface temperatures off south-eastern United States (Feb 12, 1989)**

have risen lately (for reasons that are unclear) and that they show seasonal variations with peaks in the summer and towards the end of the year. The increasing use of computers should make it possible to collect routine data about consultations and hospital referrals in large populations.

Ecosystems (Dobson and Carper, Oct 30)

Illnesses of plants, birds, fish and mammals can be indicators of environmental ill-health. The factors which influence the growth of parasites and pests are nutrients, competitors, predators, and climate. When more than one factor is disturbed at the same time, the system's resilience declines and its resistance to pests may decrease. Bioindicators are used to monitor environmental toxins. The abundance and distribution of key species such as insects and algae can be used as indicators of ecosystem health. When an indicator is also a disease, vector surveillance for health outcomes can be directly linked. The Global Terrestrial Observing System (GTOS) requires a network of sentinel sites. The only global network available now is that run by UNESCO's Man and Biosphere programme, comprising 311 biosphere reserves. Some of these may become part of GTOS and could also be suitable for monitoring of health-related indicators. As they are generally composed of natural systems they will need to be supplemented by other sites, including agricultural, rangeland, forestry and fresh water systems.

Vector-borne diseases (Freier, Rogers and Packer, Nicholls, Nov 20; Almendares and others, Dec 4)

The WHO task group identified several vector-borne diseases that might be influenced by climate change. Examples are malaria, lymphatic filariasis, African trypanosomiasis, dengue and yellowfever.[6]

Changes in terrestrial ecosystems—detected for instance, by satellite imaging—can help monitor vector-borne diseases. In particular, vegetation indices produced by high-resolution radiometry have been correlated with mortality rates and population density of tsetse flies. Several types of remote sensing can be used to indicate animal and vector habitats; the LANDSAT and SPOT satellites (figure 1) have resolutions of 30 m and 10 m, respectively, and have been used to identify habitats of ticks and mosquitoes. The US National Aeronautics and Space Administration is sponsoring research on the use of satellite information for vector-borne disease monitoring and control.[7] Improved surveillance systems should be incorporated within the next generation of earth observation platforms. Integrated systems combining meteorological, topographic, and epidemiological data must become more accessible and simpler to use.

Climate change may first have impact on vector-borne diseases at the margins of their current distributions. In global warming isotherms shift polewards and vector-borne disease may follow in the same direction (10°C for yellowfever,[8] 16°C for vivax malaria, 20°C for falciparum malaria). Climate change might also affect the altitude at which vector-borne diseases are found, and high altitude sites in Kenya, Rwanda, Costa Rica, and Argentina may be good sites for monitoring. Field studies have been done but they must be kept going indefinitely. Low cost continuous

(Charles Hutchinson)

Figure 4: **Satellite views of Ethiopia**

Left: third dekad (10-day period) of June, 1992, compared with 1982–90 averages for same period. Red shows significantly poorer than average conditions for 1992, green areas are better, and grey areas are clouds. Red areas in central part of Ethiopia are result of late start in main growing season. Right: third dekad of September, 1992, compared with average greenness values. In 3 months since preceding image, exceptionally high rainfalls in late August created favourable growing conditions (green) in northern Ethiopia, Eritrea, and Sudan.

What	Where	How
Direct effect of temperature	Urban centres in developed and developing countries (urban heat island effect)	Daily mortality data
Changes in seasonal patterns of disease	"Sentinel populations" at different latitudes	Primary care morbidity data, hospital admissions
Vector borne diseases	Margins of distributions (latitude and altitude)	Primary care data, local field surveys, communicable disease surveillance centres, remote sensing
Algae/cholera	Marine (and freshwater) ecosystems	Local studies ("sea truth"), communicable disease surveillance centres, remote sensing
Freshwater supply	"Critical regions" especially in the interior of continents	Measures of run-off, irrigation patterns, pollutant concentrations
Sea levels	Low-lying regions	Local population surveillance
Food supply	Critical regions	Remote sensing, measures of crop yield, food access, and nutrition from local surveys
Skin cancers	High and low latitudes (taking distribution of ozone depletion into account)	Cancer registries Epidemiological surveys
Cataract	As for skin cancers	Epidemiological surveys
Emerging diseases	Areas of population movement or ecological change	Identification of "new" syndrome or disease outbreak population-based time series Laboratory characterisation

Summary of main elements of monitoring scheme

monitoring may be possible through local primary care facilities with health staff trained to diagnose malaria and other conditions reliably and to keep accurate records.

In Latin America, Chagas' disease could be monitored in Chile and Argentina, currently at the edges of the endemic area. Schistosomiasis could also be susceptible to climate change, especially if irrigation patterns change. In the USA there is a possibility of the spread of five vector-borne diseases—malaria, yellowfever, Rift Valley fever, dengue fever, and arbovirus-induced encephalitides.[9] The use of the Southern Oscillation Index, based on differences in atmospheric pressure, to predict outbreaks of Australian encephalitis was discussed by Nicholls.

Climate change may result in the elimination of some vectors and/or pathogens—for instance, as a result of very hot dry conditions, as in Honduras (Almendares et al). Local influences, such as deforestation, need to be distinguished from climate change.

Large marine ecosystems (Epstein and others Nov 13)

Changes in coastal ecology from local and global influences have direct impacts on health. Environmental monitoring of nutrients, currents, algae, and fish must be supplemented by: (1) monitoring algae for *Vibrio cholerae*; (2) surveillance of coastal communities for cholera and for fish (eg, ciguatera) and shellfish poisonings; and (3) surveillance of coral reefs (warming and ultraviolet radiation may cause bleaching[10]).

Marine algal blooms can be detected by remote sensing and satellite radiometry is useful for monitoring sea surface temperatures to guide sampling (figure 3). Microwave bands (to measure salinity) may be helpful for following particular toxic phytoplankton species. The next generation of satellites (Sea WiFS, to be launched in early 1994) will improve monitoring. Remote sensing needs to be supplemented by local sampling to examine individual species of algae and zooplankton associated with gastrointestinal pathogens and biotoxins. Data on winds and currents, nutrients (including nitrogen and phosphorus originating from sewage), fertilisers, and industrial pollutants will help to determine when conditions are propitious for the growth of algal blooms. In 1994 the monitoring of large marine ecosystems (funded by the Global Environment Facility) is scheduled for the Gulf of Guinea, then the Yellow Sea, and ultimately the world's other 50 coastal marine ecosystems.

A temperature increase of 2·5°C between 1990 and 2100 is projected to lead to a rise in sea level of 48 cm.[11] The impact will depend on land subsidence, erosion, and the frequency and intensity of storms.

There are currently 204 monitoring stations for sea level rise with planned expansion to 306 in eighty-five countries. Measurements are improving under the auspices of the Global Seal Level Observing System (GLOSS), which has a tide-gauge network. The countries most vulnerable to a rise in sea level include Bangladesh, Egypt, Pakistan, Indonesia, and Thailand, all with large and relatively poor populations. Several low-lying islands such as Kiribati, Tokelau, and the Maldives would also be in danger. The health consequences will be direct (eg, due to flooding) and indirect effects (eg, due to displacement of populations and changes in vector habitats).

Fresh water

Fresh water is rapidly emerging as a limiting factor for human development. Rivers, lakes, and underground aquifers show widespread signs of degradation and depletion, even as human demands on water resources rise inexorably. Some twenty-six countries now have indigenous water supplies of less than 1000 m^3 per person per year, a benchmark for chronic water scarcity. By the end of this decade, some 300 million people in Africa—one third of that continent's projected population—will be living in water-scarce countries.[12] Although domestic water use accounts for less than one-tenth of water use, there already exists a large shortfall for safe drinking water. Globally, the expansion of irrigated areas—which currently produce one-third of the world's food—has slowed to about 1% per year whilst the world population grows annually by 1·7%.

Temperature increases resulting from the equivalent of a doubling of the concentration of heat-trapping gases will probably raise both evaporation and precipitation globally by 7–15%. Rainfall patterns will shift, with some areas getting more moisture and others less. Hurricanes and monsoons may intensify and the sea level rise will salinate some supplies of fresh water.[13]

There is no global monitoring of water quantity, although most countries individually monitor the flows of rivers and the levels of lakes. The Global Runoff Data

Centre, under the auspices of the WMO and based in Koblenz, Germany, maintains a database on daily river flows from 1664 stations in ninety-one countries. These data could serve as a baseline for examining possible shifts resulting from climate change were a global system to be established.[14] The monitoring of water quality on a global scale is the responsibility of the WHO/UNEP Global Environment Monitoring System (GEMS). It promotes the measurement of about fifty indices of quality but practice among the 340 stations in forty-one countries varies considerably. The monitoring of pollutants and bacteria are relevant to climate change because changes in runoff may alter the concentrations; however, it is the use of fertilisers and pesticides, irrigation patterns, and industrial effluents that are key determinants of pollutant levels.[15]

A specific fresh water indicator of warming could be algal blooms, measured as chlorophyll a. There is increasing awareness of the formation of large floating masses of blue-green algae. Certain species can produce toxins which may be poisonous, and rashes, eye irritation, vomiting, diarrhoea, and myalgia have occurred in people who swim through algal blooms. The blooms are considered to be caused by a combination of calm sunny periods and sufficient nutrients, notably phosphorus.[16]

Food (Parry and Rosenzweig, Nov 27)

Several systems have been developed by international agencies to provide early warning of food shortages, notably in Africa. These systems rely on routine data of three sorts, that indicate food supply, food access, and wellbeing. Data obtained on the ground, such as food stocks and planted areas early in the season, supplement satellite data to indicate supply; food prices in local markets reflect access; and anthropometric measures or, in extreme cases, mortality rates give evidence of health impacts on populations.

Satellite data, as indicators of food supply and impending famine, improve consistency among countries and are more accurate and more timely than information had from farmers or local markets, for example. "Greenness" indices (red and near-infrared spectral reflectance) are available from daily data from satellites. This index is linked closely to cereal and forage production, and can be used to predict locust infestations. Figure 4 illustrates this approach for Ethiopia. Rainfall estimates are based on duration of cloud cover (presumed to indicate rain).

One International Geosphere Biosphere Programme project is a global network modelling crop yield responses to environmental change. Another, jointly with an International Social Science Council programme on dimensions of human environmental change, will monitor long-term changes in global land for agricultural use driven by non-climatic influences such as population growth and trade agreements.

Agricultural yields can also be affected by pests and predators, which are themselves susceptible to climate change. Potential examples from the USA are anaplasmosis (a rickettsial disease of cattle) and hornfly.[17]

Ozone (Lloyd and Jeevan and Kripke, Nov 6)

To assess the impact of enhanced ultraviolet-B (UV-B) radiation resulting from stratospheric ozone depletion, two trends must be monitored—global changes in column ozone abundance and changes in UV-B flux at ground level.

Ozone trends have been monitored by instruments on a satellite,[18] and by ground-based spectrometers. Observations on trace gases (especially chlorine and bromine containing compounds) that catalytically deplete the ozone layer are needed to predict future trends in ozone loss. A lightweight unmanned aircraft shows much promise here; a fleet of them could fly for days or even weeks at a time in the lower stratosphere and provide continuous data that remote sensing techniques cannot. Serious international cooperation on monitoring UV-B has only just begun, although many governmental agencies are now acquiring the expensive instrumentation. In the UK for example the National Radiological Protection Board has been monitoring solar UV (visible, UV-A, and erythemally weighted UV-B) at three sites since 1988.[19] Until recently, only broad-band measurements of UV-B region were available but we now have instruments that provide spectral resolution, and serial data from Toronto, Canada, published last month[20] illustrate what can be achieved.

Epidemiological monitoring of skin cancers (basal cell, squamous cell, melanoma), cataract, and other possibly UV-B induced disorders of the eye are needed over a range of latitudes. Recently studies have been initiated in southern Chile, where there has been appreciable stratospheric ozone depletion. Whilst data on melanoma can be captured by cancer registry data, basal cell and squamous cell cancers may be less reliably reported. Reliable estimates of cataract prevalence are likely to require periodic epidemiological surveys using a standard system to grade lens opacity.[21] However, these potential effects may take years to become manifest so markers which respond more rapidly are needed. The International Agency for Research on Cancer is exploring methods of making early estimates of changes in skin cancer risk. One possibility is to use biological markers, for instance certain dimer-forming mutations of the p53 gene in skin cells, which appear to be related to UV exposure.[22]

Emerging Infectious diseases

Emerging infectious diseases are infections that are new in the population or are rapidly increasing in incidence or expanding in geographical range; examples are dengue, hantavirus pulmonary syndrome,[23] and some haemorrhagic fevers. Most emerging diseases are caused by "microbial traffic"—that is, the introduction and dissemination of existing agents into human populations either from other species or from smaller populations. This process is often precipitated by ecological or environmental change and is facilitated by population movements and other social factors. Re-emerging diseases are those that had been decreasing but are now rapidly increasing again. Often previously active control programmes against well-recognised threats to public health have been allowed to lapse.

Our capabilities for health monitoring and rapid response are seriously fragmented, with insufficient coordination and communication let alone provision for future needs. Inexpensive reliable communications (eg, by e-mail) are still not available worldwide, although initiatives such as SatelLife's HealthNet, providing low-cost access to medical databases for remote areas, and Internet e-mail offer hope that this can soon be achieved. A secondary network directly linking interested field scientists could greatly aid early recognition.

In conventional epidemiological surveillance, only a small fraction of cases may be recognised and reported. With emerging diseases, even a single unusual incident can

be significant and investigation of such a pointer requires linked capabilities for clinical identification of a "new" syndrome or disease outbreak, for the epidemiological investigation of the event (usually the weakest link), and for laboratory characterisation. Existing facilities with all the necessary capabilities, including some WHO collaborating centres for arboviruses and haemorrhagic fevers, can be a starting-point. ProMED (International Program for Monitoring Emerging Diseases) has lately been proposed and the idea is supported by the Federation of American Scientists and by WHO. Targeting so-called "critical geographical areas" undergoing rapid ecological or demographic change would be most effective. US Centers for Disease Control and Prevention has lately set up a programme on emerging diseases.

Role of WHO

WHO could have a key role in coordinating a "Global Health Watch" (in quotes because there is no such system) based on environmental health initiatives in its regional centres.[26] It will therefore need to be involved in the design and implementation of aspects of GTOS and GOOS. It can help select sentinel populations in critical regions where specific impacts seem most likely. Monitoring of health and climate change should be linked to information about the global health picture, including population growth. Existing collaborative programmes with other UN agencies (FAO, ILO, UNEP) places WHO in an excellent position to promote interdisciplinary activity on climate and ecosystem health

The WHO database Climedat specifically focuses on work on the public health aspects of global climate change. It lists investigators, organisations, and projects dedicated to research on climate health.† In addition the UN International Decade for National Disaster Reduction can provide practical input on preparedness and mitigation.

Conclusion

Greater integration of efforts to collect data on health and global environmental change is needed. Many of the potential effects of climate change will be insidious and will take a long time to manifest themselves, and sometimes the links between ecosystem damage and health are unclear. However, the creation of a monitoring network must not be used as a "wait and see" argument against action to reduce greenhouse gas emissions. The Framework Climate Change Convention signed in Rio de Janeiro last year has not yet come into force (it must first be ratified by fifty countries) but may be in 1994. It stipulates only that developed countries should reduce their carbon dioxide emissions to 1990 levels by the year 2000,[27] whereas the IPCC states that a 60% reduction is required to stabilise atmospheric concentrations.

Much of the burden of global environmental change may fall on poorer countries, which are less well equipped to monitor, and the danger is that monitoring will focus disproportionately on the problems affecting the rich nations. This raises important ethical and practical issues. If monitoring is to be effective international collaboration on epidemiological surveys, field studies, and routine data collection to complement satellite data will have to improve. This means a partnership between the technically advanced nations with access to remote sensing capacity, for example, and others. A global health monitoring network is essential not only to determine the impact of climate change but also to shape strategies to prevent climate change as far as possible and mitigate those effects which do occur.

†If you have information on new projects related to health effects of climate change or desire information from the Climedat database, please contact: Division of Environmental Health, World Health Organization, CH-1211 Geneva 27, Switzerland.

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EXAMPLES of SOCIAL WATCH REPORTS

INDIA
COMMITMENTS: A BARREN FLUENCY?

Jagadananda
Sundar N.Mishra

Economic reforms and liberalistion is nearing a decade in India. These years have been marked by a consistent effort to link up with international economy and spur on economic growth. While there has been adequate mouthing of social concerns, liberalisation agenda have never been accompanied by corresponding social development policy and programme initiatives to specifically cushion/further the interests of vulnerable communities. While Copenhagen declaration had been supported with zeal it has never seemed to be a signal guiding influence in chalking out policies and programmes. Now, standing at the completion of a quinquennium of the Social Summit, it is important to look back at the situation and achievements with respect to different commitments. We attempt to take a summary look below which is broadly categorised into four thematic domains.

BASIC SERVICES AND HUMAN SUPPORT

1. Education: The Basic Enabling

The educational situation in India marked by a literacy rate of 52.21%, and a lag o female literacy of about 25 percentage points indicates the distance to the goal of education for all. This becomes particularly challenging as the depressed sections (37% literacy for the schedule castes and 30% for scheduled tribes) have been deeper in illiteracy.

Universalisation of primary education has been sought to be achieved by increasing the number of formal schools, non formal education centres, launching a volunteer based total literacy campaign targeting adults and supporting the programmes through capacity building of personnel and innovating teaching-learning materials and methodology. Women have been treated as a special target group.

Between 1991 and 1996, the gross enrolment ratio at the primary and upper primary level have shown annual growth rates of 0.4% and 2.6% respectively. At the secondary level it has grown annually by 2.8%. Over the same period the drop out rate have not come down considerably. (by 15.2% at the primary whereas only by 8.2% and 2.3% at the upper primary and secondary levels). Enrolment in higher education (general + professional) has grown by about 18% against an estimated population growth of about 14% in the relevant age group.

Educational attainment has largely been sought to be achieved through enhancing the formal system of schools etc. Comparatively the attempt through informal means for elementary and adult education has been small. The management of education remains the business of a centralised educational bureaucracy where the role of civil society organisations is limited to only implementation of certain programmes. Though in many of the states the self- governance institutions (Panchayati Raj Institutions) are now made responsible for primary education, the lack of resource and technical support disallows one to be optimistic in this respect.

Apart from other functional difficulties, the sheer financial crunch (an estimated shortfall of Rs. 32 billion in 2000) will hamstring this ponderous system to extend

better quality primary education.

1.2 Health, Sanitation and Potable Water: wellbeing for Momentum

The illusive goal of Health for All by the year 2000 have been restated as 'Health for Under privileged by 2000 which is however unlikely to be achieved. Basic health services are sought to be provided throughout the country by a three-tier institutional structure comprising primary, secondary and tertiary health care facilities with appropriate referral linkages. The system spans the whole stretch from community level to district and state levels and includes super-specialty facilities in urban areas.

But this system has fallen short of adequacy considering the objective of health for all. The number of institutions at the primary level suffer from combined shortfall of as many as 31601. The medical/paramedical personnel manning these centres number only 53.6% of the requirement. Only 11.2% of the specialist positions required have been filled up. These shortfall are most accentuated in remote areas where no alternative facilities are available.

Public investment on health though rising in absolute terms, has declined to as low as 1.6%. of plan expenditure. The investment has shown an urban bias. While three-fourths of the population live in rural areas, two-thirds of hospitals are in urban areas. Only around 200 hospital beds are available per million population in rural areas as compared to 2180 in urban areas (1993).

Notwithstanding these negative trends, the health situation has somewhat looked up. Access to basic care is enjoyed by 85% of (UNICEF, 1996) people. Infant mortality rate has come down from 80 in 1990 to 72 in 1996. Crude death rate has come down from 9.6 to 8.9. Under 5 mortality is still 93 for male and 108 for female children. Life expectancy has risen from 58.1 years in 1990 to 62.4 in 1996 for men and from 59.1 to 63.4 for women. However, 16% of total population are not expected to reach age 40 as against a world average of 13% (Human Development Report, 1998, UNDP)

The problem of shelter lessness and bad sanitation worsens the health situation. Up from 31 million people in 1991, 41 million (close to 80% of them in rural areas) will have no proper roof over their heads by the time next century begins. About 40% households had unclean or no water supply. There was no electricity for 69% rural and 23% urban households. About three fourth of households had no access to sanitation. this blea scenario brings out the ineffectiveness of the National Housing Policy. The goal of eradicating hosuelessness has seen scanty follow up action. The special programmes providing shelter to the weaker sections are totally insufficient and public spending on this aspect has been out of step with the requirement.

1.3 Food Security: The Groundwork of Growth

The food security situation seems to have improved with 94.5% of rural and 98.1% of urban households reporting adequate availability of food (two square meals a day) in 1993-94. This picture shrouds a dire nutritional profile. More than 60% of the children suffer from protein energy malnutrition. Pregnant women largely (50-90%) suffer from anemia. Women in poor families experience energy deficits of 1000 calories per day during pregnancy.

The strategy for reaching 'food security for all' broadly has three components: a) growth in food grain production, b) widespread distribution targeting the weaker sections, c) guarding against loss of entitlement by raising purchasing power. The growth rate in total food grain output has slid to reach an annual rate of mere 1.2% in 1995-96. Adding fuel to fire, the agricultural export in cereals has posted a rising trend (35% in 1995). The public distribution system with rising number of outlets continue to benefit mostly the non-poor in urban areas. While growth and distribution aspects of the strategy do not appropriately further the food security goals, the attempts to improve the ability of the poor to 'earn' food is also not adequately furthered through employment and livelihood support programmes.

2. SUSTAINABLE LIVELIHOOD

2.1 Rights to Resource Use : Assets to Assert

Land is an important productive asset for the rural poor who are more than three fourths of all poor and their number is on the increase. The trend of concentration of land in a few hands is continuing in the 90s. The percentage decline in the average size of marginal holdings is much higher than the per centage decline in the average size of large holdings. This indicates the marginalisation of peasantry making access to land for agricultural households difficult.

Against such background, the land reforms initiatives of the government have not yielded desired results. The areas redistributed till 1996 accounted for only 1.5% of the net cultivated area and assignees 3.5% of the poor. Most of such holdings are unlikely to provide economic sustenance to the beneficiaries. Despite tenancy being banned in several states the area under concealed tenancy is increasing and there is a hike in rent in many areas. It has been established that there are about 15 million concealed tenants going without any legal protection.

Another important intervention through legal and administrative arrangements is to arrest land alienation of tribal farmers (an estimated target population of 63 million). These efforts have so far fallen flat because of the inbuilt loopholes. The current initiative to amend the land acquisition act, 1894 to expedite land acquisition for different 'development' projects will further endanger the land-based livelihood of a vast number of poor.

A sizeable chunk of people (including, of course the tribal population) depends on forest produces for livelihood. While the forest management system of government had been hostile to these people, from 990 onwards a new framework of joint forest management has been introduced which gives certain usufructuary rights and a stakeholder status to these people. The JFM results have been mixed and often the people have been taking up protection responsibilities without being able to meet their livelihood needs. There has been a radical enactment i.e. the Panchayats (Extension to Scheduled Areas) Act., 1996 giving the ownership right over minor forest produces to local self governance institutions. However, the governments at the country and provincial level are dragging their feet in so far as the implementation of the new legal provisions in favour of the forest dependent poor communities is concerned.

2.2 Employment: Working Poverty Away

The Indian Labour force has grown by about 27% between 1990 and 1997. If future projections are considered, 10 million new jobs need to be crated per annum

at the very least. Against this backdrop the organised sector has provided only 1.6 million jobs throughout the 90s (upto March,1 997). In fact the average annual rate of growth of organised sector employment has sharply decelerated from 1.68% during the 80s to merely 0.82% during the 90s (1990-97). So it is the informal employment sector which absorbed most of the work force in the 1990s (about 92%).

This vast opportunity lag for employment is sought to be eased for the poor by the government through self employment programmes (SEPS) and wage employment programmes (WEPs). SEPs provide credit and subsidy for procurement of income generating assets and also develop employable skills of beneficiaries. The WEPs provide casual manual work through public works programmes.

The SEPs have reached about 3 million households annually as an average during 1991 - 1996. The NSS data suggest that participation in SEPs (IRDP) increased by 18% for STs and declined for SCs by about 10%(between 1987-88 and 1993-94). Though it has been seen to be taking families above the poverty lines various evaluation studies have demonstrated that much of it has gone to less poor and even not infrequently to families above poverty line. The WEPs over the same period have generated person days of employment adding upto about 3.3 million jobs annually on an average. This only indicates the vast shortfall which still neec to be met. On the contrary, these are without any sustainability. The NSS data suggest that participation in WEPs declined by 28% among STs, stagnated among SCs and declined by 5% for others (between 1987-88 and 1993-94). The assets created through these programmes in about one fourth of cases have been found to be 'missing' and others of hardly any income generating potential. Considering the widespread leakage and dubious targeting it is difficult to determine precisely what benefits they have caused to the poor.

Real wages in the unorganised sector fell in the rural areas almost throughout the last decade, while it rose in agriculture till 1992 and then continued to fall. In the dualistic labour market in India, the governmental wage policy favoured the microscopic well paid organised segment and cold shouldered the expanding unorganised sector. The practice of wage determination for the unorganised/informal sector across the states and regions has belied the concerns of ensuring basic subsistence of workers which can be attributed to concerns for employer's capacity to pay or political expediency. On the other hand, the practices of setting minimum wages in the organised sector have moved beyond the concerns of basic need or even the 'fair wage' to higher levels of living wage. Moreover wages in the organised sector are provided with fuller cost of living adjustments which does not accrue to overwhelming majority of the workforce in the informal sector. Thus one comes across the phenomenon of minimum wages for the unorganised sector not being revised for years together which is further worsened by the weak enforcement of the existing wage rates.

Most of the protective legislation apply to workers in the formal sector. Those relating to stipulating of minimum wages, disputes on wages, non-discriminatory remuneration, payment of wages, maternity benefits etc. have uncertain influence on and little implementability for the informal sector workers.

In the face of job loss and redundancy, the concept of employment security has seen some policy action in the industrial sector through the National Renewal Fund in the form of worker counselling, retraining, redeployment and labour reconversion. there is little information available with respect to its actual

effectiveness. Outside the industrial sector the WEPs and SEPs are the only programmes which help workers to survive, not to talk of employment security.

3. PARTICIPATION/PARTNERSHIP AND GOVERNANCE

the constitution emphasized a decentralised structure of governance from the very beginning which was to be realised through self- government institutions from the local (village) level onwards. At long last, such system (the Panchayati Raj system) came into being with constitutional status in 1993. These institutions are now empowered to carry out development planning, implementation and other agency functions which will meet the state system at the macro provincial level. Such institutions are targeted to usher in citizen's role in governance in a big way. But the system is operationalsied in such a manner that these institutions do not enjoy functional, administrative and financial autonomy. In most states the functions can be amended/overridden by the governments. Relevant provincial level acts empower the state to inspect, enquire into and suspend Panchayats resolutions. Financial autonomy is also not granted to the Panchayats so far, though the centre has accepted the recommendation of the tenth finance commission for adequate allocation. On the otherhand, the Centre has been using Panchayats as agencies to distribute grants meant for schemes sponsored by the central government. Such schemes by becoming the orders of the Centre smother local initiatives. The Acts giving ownership rights over local resources (land, forest, water etc.) to local bodies especially in areas dominantly populated by indigenous and tribal people making have been diluted/obstructed by the Central/Provincial governments.

Apart from this the record of involvement of citizens and civil society organistaions in development, planning and programme management has been dismal. Beyond a role in strait jacketed implementation nothing much has came about. There is no institutional role of CSOs in planning, designing and management of development under the state auspices. There is an operational space for CSOs which often depends upon discretion and patronage of the government. whenever this involvement goes beyond implementation it stops at 'democratic consultation' without incorporating any dimensions of decision making.

4. GENDER SENSITIVITY AND EQUITY

Primary education and total adult literacy is pursued with a special focus and incentives on girls and women. Enrolment ratios and drop out rates are still unfavorable to girls; but the Girls Boys Disparity Index (GBDI) has improved for girls by 5 percentage points in enrolment ratios at primary and secondary levels. The fall in drop out ratio has been quicker for girls than the boys. Growth in higher education has been higher (24.1%) for girls as compared to boys (18.1%).

In the domain of health, programmes to extend health care specifically to girl children and mothers exist which are improving in performance despite being plagued by inadequacy of resource provisions. Though food security has improved, it is difficult to say how the women have gained. Since women suffer from intrafamily and intragender discrimination the current picture of household food security might be glossing over far greater deprivation of women. This problem has attracted little policy action over the years.

while labour force as a whole showed a confirmed tendency towards informalisation, the little growth (little above 1%) that occurred in the organised

sector in the 1990s was favourable to women, who registered a numerical growth of 8%. But women continued to suffer discrimination at workplace. About 50% of women in India perceive themselves as victims of discrimination, according to a study by

National Commission on Women (NCM). Even in the organised sector, women earned 23% less than men. As much as 64%n of the gender gap in earnings was brought about by discrimination while about 36% could be attributed to differences in productive endowment. The situation in the unorganised sector is far deteriorated with women getting sometimes as less as 50% in comparison to men.

Looking at policy action to reduce gender inequity one does not come across an encouraging picture. The reports of various pay commissions instituted by governments at different periods of time give no indication of any systematic attempt to consider the prevalence/extent of men-women wage differentials in any given job/occupation in arriving at new pay scales. The Equal Remuneration Act, 1976 seeks to provide for equal remuneration and prevention of discrimination across the sexes. Though the act straddles all employment sectors including the informal, its vagueness in defining work equality allows for disparities to escape with impunity. Minimum wages under the Minimum Wages Act, 1948 have not been revised regularly as required and the wage rates fixed by many states in sectors with women worker concentration fall below the levels suggested by National Commission on Rural Labour (1993). While women in the organised sector enjoy reasonable maternity benefits, there is now a provision made by central/state governments a kin to paternity leave. But in the unorganised sector women face job loss, and undernutrition. There is some respite given by some state governments in the shape of a maternity allowance for upto two children to rural/urban poor women. Similarly, the payment of compensation, provision of creches etc. have been availed of by women in the organised sector to some extent which is not available to women in the unorganised sector. The investigation of employer's compliance with various labour- protective legislation discussed above is not done regularly reducing many of the entitlement to mere promises particularly for women. Another collusive factor is that the labour unions have viewed the survival of women labour as more important than achieving gender equality, in wages, employment and their access to social security. Thus equity in above lines remains a distant goal only.

Women's access to different tiers of democratic power and the systems of decision making has shown little improvement and promises which at the same time illustrate the limitations. Political parties do not have appropriate policies/inclination to raise women's access to elective offices. The Women's Bill seeking to give more access to women to political party positions and to the Legislatures has wobbled in the Parliament all along for the

last few years without getting required endorsement by party leaders/representatives. Only exception is the local self governance structure of Panchayati Raj where one third of the representatives are women. Political parties have a poor profile of women leadership (less than 8% of top party pasts) at the national level.

Percentage constitution of women cadres in the development administration, the police system and the diplomatic corps improved by about 10% in the 1990s. The presence of women in the top judicial system remained quite marginal (about 3%). While reservation for women in these positions has helped to some extent, lack of

training and other facilities for capacity building has retarded women's progress in this respect.

5 UNFINISHED AGENDA AND THE NEW CENTURY

As we see, the country and its development actors are left with a burden of responsibility rather than a sense of fulfillment at this juncture. Looking from the vantage of the people whose problems and sufferings elicited the global response of the Copenhagen Summit, we see that most of the non-achievement can largely be ascribed to a tendency of development administration to stand apart and away from the people it serves. The unfinished agenda which the Copenhagen commitments hold aloft, will forever be elusive but for a qualitative shift in this tendency. Redefining the goals alongwith the concerned poor and vulnerable, working out a functional partnership with the civil society organisations, PRIs and organisation of the poor for resource use and development from local level onwards, recognising them as equitable stakeholder and releasing their initiatives are the key processes of action which must needs to be begun to fulfil the objectives of commitments early in the next century.

* Produced by Centre for Policy Research and Advocact, a Unit of CYSD, Orissa in collaboration with Voluntary Action Network India (VANI), New Delhi

UNITED KINGDOM
MAKING PROGRESS... BUT NOT ENOUGH

Fran Bennett

The new Labour government has identified poverty and social exclusion as key issues, and declared its intention to tackle their root causes in a cross-departmental, integrated way. It is committed to mainstreaming gender awareness, and improving representation of women and ethnic minorities. But its approach to social development is not couched in the language of social and economic rights, or redistribution, but of inclusion, opportunity and responsibility;[1] and the Copenhagen commitments are not used as reference points. Critics have accused it of failing to challenge sufficiently the current supply-side and market-oriented orthodoxies, and of echoing the residualist rhetoric about welfare common in the USA.

«We Commit Ourselves to creating an economic, political, social, cultural and legal environment...»

The UK government has incorporated the European Convention on Human Rights into British law, facilitating legal challenges on civil and political rights. But it is more sceptical about the value of legislation guaranteeing social and economic rights; and, although it has signed the Council of Europe's revised Social Charter, it has refused to ratify the collective complaints procedure. In the area of children's rights, however, the government has set up a group which includes NGOs to help monitor progress on achieving the goals of the UN Convention on the Rights of the Child.

The government has made progress towards devolution in Scotland, Wales and Northern Ireland. Regional development agencies are also planned in England, bu fairly tight financial control of local authorities is still maintained.

Power over resources for social regeneration may be devolved to some local communities.[2] In some areas (especially crime), ministers tend to perceive the views of NGOs as not reflecting the real concerns of local communities.[3]

Proposed legal reforms to decision-making and appeals in social security and asylum/immigration, and availability of legal aid, affect important policy areas for disadvantaged groups. Although some changes are positive, others have been criticised for sacrificing fairness and individual rights to speed; and measures to tackle `anti-social behaviour' are seen as draconian by some.

«We Commit ourselves to the goal of eradicating poverty in the world...»

The Prime Minister says the government should be judged on whether it improves the living standards of the poorest.[4] The government also highlights «social exclusion», seen as dynamic and multi-dimensional. It set up a social exclusion unit in the Cabinet Office, which can take a cross-departmental approach. The unit is tackling specific issues, and investigating indicators of social exclusion. But its direct communication with people in poverty is rather unstructured; and outside organisations are consulted, not involved as co-participants.

The government has not drawn up a national anti-poverty strategy with

goals and targets. However, the Prime Minister describes government policies as an anti-poverty strategy in action, which includes: cutting unemployment; tackling low pay; getting benefits to people in need; education, to prevent future poverty; regeneration of the poorest neighbourhoods; getting public services to people in need; and bringing in new allies as partners[5]. **He has promised an annual progress report**. The government is also investigating the exclusion of low-income people from financial services and the withdrawal of shops from poor areas. But one commentator suggests between 350 thousand and 1.95 million more people could be in poverty (on under half average income) by 2002, depending on government policies and unemployment levels[6].

Poverty has become more concentrated in small areas. Funds are being released from local authority housing sales for reinvestment, and a series of area-based programmes is targeted at disadvantaged neighbourhoods. But these areas often have to compete with one another in bids for additional resources.

The government embarked on «welfare reform», widely interpreted as meaning reductions in social security spending. Following opposition to benefit cuts for lone parents, and protests about threatened cuts for disabled people, the government is now proceeding more cautiously, with increases in benefits for specific groups. But most benefits will probably increase only in line with prices, not rising prosperity.

The government says tackling the root causes of poverty means focusing on opportunities, especially education and employment. This approach has been welcomed -but criticised for under-emphasising low income, and over-emphasising paid work rather than unpaid caring.

The government has fulfilled its manifesto commitment to reverse the decline in spending on overseas aid, and made encouraging statements on the need to tackle the debt burden. Its creation of a separate department for international development, and Cabinet status for the minister, moved international poverty up the policy agenda. Its policy on development includes a clear focus on poverty, which is consistent across departments.[7] But on trade and investment issues, it could give more emphasis to the extent to which globalisation creates «losers», and to poverty as an issue to be tackled internationally.

«We commit ourselves to promoting the goal of full employment...»

A government aim is «full employment for the 21st century»[8]. But the emphasis is on employability and other supply side factors, not direct job creation; and the Bank of England's control over interest rates is seen as prioritising controlling inflation over reducing unemployment.

«New Deals» have been set up for young and long-term unemployed people, lone parents and disabled people. They include temporary job subsidies, work experience, education/training and personal advice. They have been broadly welcomed, though critics point to the disproportionate share of resources for the young unemployed, the one-off nature of the funding, and compulsion (with potential loss of benefit) for young people.

There is concern about the low quality of «entry level» jobs for unemployed people, who often do not progress to better employment;[9] marginal jobs are not a

route to social inclusion.[10] The government signed the European Social Chapter, but has made clear it will not support all proposals for more regulation. Rights at work, including union recognition and employment protection, are to be improved.[11]

Another goal is to «make work pay». A statutory minimum wage will be introduced, benefiting some 1.5 million workers.[12] But unions criticise its inadequate level, and in particular the lower rate for young workers. There will also be reductions in national insurance contributions for low-paid workers and their employers.

«...To Promoting Social Integration by fostering societies that are stable, safe and just...»

The government created a Race Relations Forum, to give ethnic minority communities more direct access to it, and is consulting on anti-discrimination action.

Asylum and immigration policy and practice are now less secretive. But the government's use of detention has been strongly criticised; and proposed policy changes include abolishing asylum-seekers' rights to cash benefits and choice over housing location, and curtailing appeal rights.[13] This is in line with proposals for more restrictive policies towards refugees in the European Union as a whole.

One in four ethnic minority electors has not registered to vote.[14] Turn-out rates for black Africans and black Caribbeans in the general election were lower than for other groups,[15] reflecting political alienation. New measures give additional powers to tackle racial incidents; but police treatment of black people is repeatedly criticised.

The government inherited anti-discrimination disability legislation widely perceived as ineffective. It is tightening up the provisions; but many disabled employees will still be unprotected, due to small company exemptions.

«...To Promoting full respect for human dignity and to achieving equality and equity...»

The government set up a «women's unit», which has now moved to the Cabinet Office. A minister for women was appointed (**unpaid**). Mainstreaming of gender issues was promised, but policy guidance to departments has not yet been published. The government's priorities are child care, family-friendly employment policies and violence against women. Women make up only 18% of MPs and 31% of public appointments;[16] «quangos»[17] are to have a target of 50% women.

Women still receive only half men's average weekly income[18] Government proposals would improve maternity provision, and introduce paternity and parental/family leave[19] -although unpaid leave may have limited value. The UK signed an EU directive improving part-timers' employment rights. Whilst the government is making progress, the Equal Opportunities Commission has called for a «super-law» to overhaul and update sex equality legislation.

«...Universal and Equitable access to quality education»

The government has put high priority on education, from nursery schools to higher education. Primary schools must prioritise literacy and numeracy, and targets have been set to cut truancy and school exclusions by a third by 2002.[20] Twenty-five «education action zones» are being created in deprived areas to experiment with different approaches. The government emphasises «life-long learning», and a working group is to tackle poor basic skills among adults.

Proposals to finance a means-tested staying-on allowance for teenagers by abolishing universal child benefit for this age-group are controversial. Tuition fees are being introduced for higher education for the first time. Some commentators say anti-poverty measures would be more effective for children from low-income families than the current emphasis on raising «standards».[21]

«...To Promoting the highest attainable standard of physical and mental health...»

The government launched an inquiry into health inequalities. Other policy areas are now recognised as influencing health status of the population. Twenty-six «health action zones» are being created, to improve the health of the poorest. The social exclusion unit will investigate teenage pregnancies, which are higher in poor areas.

The influence of the internal market in the health service is being reduced. Ethnic minority groups' access to health care is being investigated. But fewer low-income individuals visit doctors and dentists regularly than five years ago.[22]

The health divide between rich and poor has widened over recent years.[23] Many commentators welcome the government's policies -but say there is still a long way to go.

«We commit ourselves to an improved and strengthened framework for International, Regional and Sub-regional co-operation...»

The government has not publicised the Copenhagen commitments relating to the UK, nor organised monitoring with outside organisations. Its anti-poverty goals have not publicly been linked with the Social Development Summit.

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UK Coalition Against Poverty

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AN ALTERNATIVE VIEWPOINT ON GLOBAL HEALTH WATCH

You have given me a difficult task of responding to the GHW proposal. I have many questions but I will try to put down my basic response as simply as I can.

1 The Roles of the 'Intellectual' and the 'Organization'

It seems to me that many of the impacts of the various 'Watch' has been in the realm of ideas. The Work of Lester Brown (Overview:1), for example, is the impact of ideas not organization. To make it clear, let us examine the impact of the works of Darwin or Marx. The impact has been much greater that what any NGO can claim to have made.

There is a danger of relying on the honours such as Nobel Prize as well (Overview:1, reg Pugwash). My impression is that such honours are reserved for people following a certain world view which is amenable to the dominant Western viewpoint.

The point is that the real and 'vested-interest-free' impact can come from ideas. It does not require an organization, NGO or otherwise. Organizations often develop their own narrow vested interests.

I feel that many of the 'NGO networks which have unique capacity' (Draft 2:2) are in fact a fifth column in the developing countries. Funded by foreign money they have little roots in the body politic of their own countries.

It is significant that there is no 'Indian' concept of an NGO. We have the concept of an 'ashram' and 'vanaprastha'. The NGOs appear to take their inspiration from the Christian ethic of loving the neighbour. This is fine. The problem arises when this 'love' becomes organized. It is acceptable if a person was earning his own bread by running a shop or whatever and then he loved others by giving away part of his well earned income. But that is not what NGOs do at all. They earn their breads by 'serving'. It then becomes difficult to ascertain whether the 'loving is a facade for bread winning' or 'loving is the high altar on which income has been sacrificed'.

I find that more often than not, the service ethic has been turned around to sustain the vested interest of the NGO

bureaucracies. These bureaucracies support the Western political interests by which they are well fed and sustained. This is my criticism of WHO, UNDP and Human Rights Watch, two of the parallel institutions which find high mention in your notes. My considered view is that these institutions are taking us in the wrong path of welfarism (see following section).

The Indian tradition of love insists that it is an individual affair. There is a fundamental difference between loving another as an individual with his own well earned income (Indian tradition); and loving another by building an organization which is also the basis of one's economic sustenance (Christian-NGO tradition). The former is okay. It has no vested interest. The latter is highly questionable. One does not know whether the 'service' is a facade for operating as a fifth column; or it is genuine sacrifice.

In other words, I am questioning whether the objective of 'loving' can be served by building an organization at all. An organization inevitably smacks of 'political' aspirations--power in one form or the other. It becomes worse when advocacy and 'to work/fight' is explicitly accepted as an objective (Overview:2).

What does advocacy built on foreign money mean? To me it means that foreign donors, often governments working through churches and the UN system, will tell the Government of India to behave itself. If Government of India does not behave then it will be hauled up before 'international community'--read Western powers. Is that not a fifth column?

The point I am making is like this:

1 'Love' and 'Service' make sense only when undertaken from self earned income. They cannot be made vehicles of earning one's own bread as NGOs, including the proposed GHW, seek to do. 'Organized' social service is essentially politics, not love.

2 Political activity--advocacy and fighting, as the NGOs and GHW inherently are, should be done within national domain with strictly national money. There in no locus standi for GHW to advocate.

3 NGOs and GHW would be acceptable only if they provide a platform for brainstorming and think tank to such individuals who might be serving and loving with their own incomes.

4 The existing WHO, UNDP and Human Rights Watch are engaged in fifth column intellectual activities.

2 <u>Welfare State</u>

The documents sent by you emphasize the aspects of equity (redistribution of income) and access or 'rights' to health (Draft 2:1; Draft 3:2-3). This approach is premised on the belief that people are powerless vegetables who cannot themselves earn and secure good health. The emphasis shifts from increasing incomes to increasing rights, access, feeding,

giving or charity.

There is a fundamental economic conflict in the world today. The Western powers want unequal exchange to continue. They want that the developing countries should continue to sell their manufactures cheap (tea, ores, textiles, etc); and import hi-tech goods (financial services, technologies, etc.).

This unequal exchange is being sold to the developing world in the name of international capital flows, free trade and globalization.

One of the consequences of this unequal exchange is the developing countries are getting poorer while the developed countries get richer. The West wants to preserve this economic order.

Another consequence is that there is increasing unrest in the developing countries due to increasing poverty etc.

The objective of the West is to contain this unrest to 'manageable' levels lest it spill over and destroy this unequal exchange. The talk of equity and access to health is a part of this containment strategy.

The objective is not to liberate the people of the developing countries but to ensure just enough relief that they do not understand the unequal exchange and rebel at the existing world order.

The NGOs are an important instrument of this 'risk management'. They are given money by the West to ensure that discontent does not spill over. Thus the talk of safety nets (Draft 2:1), district health system approach (Draft 3:2), etc. These approaches do not seek to increase the economic incomes of the people so that they can acquire good health on their own self-respectedly earned incomes; they seek to make them intellectually dependent on the government (and World Bank and foreign donors), kill their self-esteem and make them dependent upon doles so that they never question why they are poor in the first place.

The proposed GHW appears to be yet another instrument in this 'risk management'. It may be yet another instrument to distract us from the basic task of resisting the unequal exchange and becoming economically stronger.

It is important to note that the first para of Draft 2 was strong on trade policies and globalization. This has been diluted in Draft 3. That is but to be expected. The global NGOs are all votaries of globalization and they will not tolerate any fundamental questioning of economic supremacy of the West. That is a consistent theme of WHO, UNDP and the like.

The inner content of Draft 3 is entirely silent on this aspect.

3 <u>Culture</u>

It has become fashionable to salute 'different cultural beliefs' (Draft 3:2). But, this salute is circumscribed by certain 'unquestioned' values. For example: (1) Gender equity by making the woman work in addition to her role as species propagator. Women must be made additional economic inputs (although their house work must be 'economically valued'; (2) Equity must be ensured within the developing world but not between the industrial and developing world; (3) Democracy is okay within the industrial countries but not at the world level. Here it is the money-weighted vote that counts as in the Bretton Woods institutions like World Bank or the Security Council.

This talk of culture is hollow.

This problem cannot be sorted out without examining the very purpose of life. For the West it is increased consumption, albeit of 'wilderness' and 'tigers-preserved-for-man-to-gape-at'. Within this paradigm they will accept local culture. If you want to consume temples, that is okay.

For Indian tradition the purpose is evolution of the individual to his higher potential. If the purpose is so specified it is no longer certain whether making the woman work will lead to her evolution or devolution. Even, increased consumption by the poor, if fed by the welfare state, may be devolution. These questions appear to be out-of-bounds in the documents circulated.

The point I am making is that the documents are fundamentally based on consumption-as-objective and the role of the state in ensuring consumption. They do not permit questioning of this objective. If this objective is questioned, to apparently obvious sanctity to gender justice and equity may well evaporate into thin air.

4 Conclusion

I am not enthused about GHW. I see it as a perpetuation of unequal global economy. I see it as yet another instrument to keep countries like India in perpetual intellectual subservience. I see it as a result of 'organized love or service', which is a contradiction and a smokescreen for fifth column activities.

I think the only positive role that such organizations can perform is to provide a forum for Davos-type exchange for dissenting voices. There is nothing more that can be done.

cysd
...Where development is a process, not an event

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06/10/99

Kind Attr : Dr. Ravi Narayan

Further to our telephonic conversation please find the following draft. Because of a fault in our email I am faxing it to you. Please make whatever use you want to make of it. I look forward to later occassions where there can be more clarification and prospects for inter relationship.

Regards

Sundar N Mishra

Social Watch India 2000 and Beyond : A perspective

What is Social Watch ?

- It analyses social development policies, and actions by state / non-state actors in so far as they further achievement of projected goals while bringing about equity.

- Since 1996 the Social Watch India has been generating a report on an annual basis analysing social development initiatives by mostly the government(s) and also the social development situation. This was basically circulated across different government departments, individual citizens and different NGOs across the country for public education and opinion building

- The report was basically being prepared by CYSD and VANI.

- While the report is primarily oriented to sharpen the advocacy agenda on equity issues, only this year onwards there is a plan to link up advocacy activities on relevant points of analysis in the report.

- While it takes definite pro-poor / marginalised positions on social structural / governance related inequities, it takes an inclusive approach towards (possible) partnering actors.

- It examines government action not in terms of programmes per se but also puts in perspective the fundamental policy assumptions and the context . There is now an attempt to elaborately look at what is being done by CSO/NGOs

- It aims to foster a mutually supportive and synergistic relationship between different state/non-state actors involved

- it is a process of proactively putting up a constructive development agenda in light of the innovative experiences/experiments on the ground.

Thematic Framework

The following are the components of analysis. Analysis on every aspect is sought to be disagreegated by gender, rural-urban differences and vulnurable groups as far as reliable data permit.

Basic Entitlement

Learning

- access to literacy and basic education in keeping with the specific linguistic and cultural context
- access to further educational opportunitise building upon local knowledge system and cultural ethos at the primary, secondary and tertiary levels.

Staying Healthy

- access to wholesome food and freedom from hunger/mal-nutrition
- access to hygienic and dignified shelter
- access to sanitation and potable water
- access to primary health care with emphasis on the aged, mothers and children

Sustainable livelihood

- access to productive natural resources like forest, river, etc. of dependent communities
- opportunities to strengthen existing skill-base in a need-based and market oriented manner and access to market information and linkages
- promotion of local enterprises in a market-oriented manner
- optimising access to sustainable employment opportunities for the resource-marginalised people
- examining the impact of modern production system, particularly industrialisation on livelihood opportunities of affected people
- right of fair wages, maternity benefits, and dignified and secure work environment

Participation/partnership in governance

- Functional, administrative and financial autonomy of PRIs
- Dalits, tribals and women play fully and freely their roles in self governances
- Adequate legal / operational space for participation of broad-spectrum civil society orgaisations in formulation and implementation of public policies and programmes at all levels
- Evolving forms of collaboration between state and non-state agencies and other civil society organisations.

Analysis and Indices

There is an attempt to incorporate certain nuances in the analysis from this year onward. While the analysis will be qualitative to a great extent there will be an attempt to develop two types of indices basing on both quantitative and qualitative data. The details of calculation will be finalised after collection of all necessary data. The following considerations will be used while constructing the indices.

Two major aspects of the above themes and sub-themes which the analysis will need to focus on are: a) what has been the achievement so far in the respective areas, b) to what extent, necessary and desirable steps are being taken by the government and other civil society institutions towards fulfilment of the objectives. The analysis will bring out the situational details and perhaps indicate the nature and directions of further initiatives.

In order to mark out the social development situation and the adequacy (on lack of it) of action taken precisely, it is proposed that the information be used to prepare indices in addition to analytical interpretations. The first one could be a Social Development Index, which can be prepared out of the values of different indicators on the suggested themes / sub-themes. The second one could be an Adequacy of Action Taken Index prepared out of indicators of action taken on the themes/issues. Some indicators on these two counts are suggested below.

Indicators for Social Development Index

On Education, in the domain of basic services, some indicators could be gender-disaggregated literacy rate in the rural / urban context, and across various population groups; gender disaggregated data on enrolment and achievement at the primary, secondary and professional/higher education levels across various caste population groups; outreach of schools/other educational institutions in rural / urban / tribal areas. Existence of syllabi/teaching learning materials used in school based or other educational programmes sensitive to the livelihood/cultural needs of disadvantaged communities, extent of resource support (financial or otherwise) to students from poor and dalit communities and women amongst them.

On health, some indicators could be gender-disaggregaged data on access to primary health / reproductive health care, sanitation and potable water of SC/ST/women and minorities, gender-disaggregaged data on infant/child mortality, life expectancy, incidence of

On housing, access to pucca and hygienic housing and electricity, across different caste/population groups, per capita room space across caste/population groups could be some indicators. On food security, gender-disaggregated nutrition status incidence of anemia across caste/population groups, spread of public distribution system and off take across different socio-economic groups, consumption patterns of men, women and children across different population groups, could be some indicators.

In the domain of sustainable livelihood the following indicators may be considered: Access of forest dependent people to forest resources, status of land holding across different caste/population groups, profile of credit disbursement of the scheduled banks and other financial institutions, performance of other credit programs targeted at the poor, performance of skill/entrepreneurship promotion programmes, employment rates across caste/population groups and women. Retraining / redeployment / compensation schemes and their operation in the face of job loss/redundancy etc, profile of access to employment generated, status of implementation of measures on equal remuneration, fair wages, maternity benefits, protection against occupational hazards, and pattern of displacement and rehabilitation.

In the domain of participation and governance the following indicators may be considered: number of PRIs undertaking local planning, PRIs preparing their budgets and implementing them, PRIs accessing financial resource, existence of legal provisions for functional / financial autonomy, percentage of indigenous people / women attending / actually participating in decision making processes, extent of participation of women / indigenous people in orientation / capacity building programmes, number of public policies, which include consultation with CSOs at any level.

In the domain of gender sensitivity some indicators could be the following: incidence of violence / abuse against women and girl children, percentage of women at different levels of bureaucracy, judiciary and in the state legislatures / parliament, corporate leadership, remuneration gap, status of inheritance, ownership rights, safe and friendly work environments.

Indicators of Action Taken

While considering the adequacy of action taken on any theme/sub-theme the following aspects need to be considered:

- Existence and implementation of policies / laws / government resolutions / orders enabling the achievement of stated objective
- Functionalised / practicable / time bound plan of action
- Adequate allocation and utilisation of resources (human/financial) and infrastructure with appropriate provisions for devolution
- Non-discriminatory implementation (with respect to gender, caste/class, ethnic and minority groups)
- Extent of collaboration with civil society institutions and organisations of the target groups in formulation and implementation of programmes
- Extent of operationalisation of programmes for capacity building of CSOs/CBOs etc. for above mentioned participation.
- Availability of relevant gender-disaggregated information base or plans to generate such information base
- Existence of appropriate provisions to elicit women's participation at all levels

Tamilnadu Science Forum

Restructuring Knowledge

Today knowledge is something only specialists possess. We go to them with a problem - they analyze and tell us what to do. A farmer has to listen to the agricultural scientist who decides how much fertilizer and pesticide is needed for his crop. He does not know how the scientist came to this conclusion. He cannot decide whether the advice makes sense for his crop and his financial and social situation or if there is a better alternative that applies to his case. He is a mere knowledge recipient, not an active participant in the analysis or decision-making process. Therefore he can be used, manipulated, exploited and controlled.

Why should knowledge be centralized with the doctor, the engineer or the scientist? Why cannot knowledge be restructured so that everyone can be an active participant in the use of it?

We are not saying that everyone must be a specialist. Nor are we saying that specialists are not needed. We are not saying that x, y or z should also study the profession. We are saying something of much more consequence. We are saying that the subject - medicine, engineering, economics or agriculture - itself needs a major overhaul. Restructuring knowledge so that "users" can be participants – they know what they can handle themselves (most of the things), when to go to a specialist, how to interpret the specialist's advice and the ability to question and judge the advice.

How to go about doing all this? Organize people to take up this agenda - by developing their skills so that they can handle the knowledge themselves. As they use the knowledge for their own needs, they will modify it, make it more individual specific, enrich it and in the process completely restructure it. This process will itself bring to the fore local leadership which will voice and address people's real needs.

Empowerment: I control my life. You control yours. I know how to be healthy, how to learn new things, how to access information, how to run my enterprise and how to grow my crops. So I am in control of my life. If something goes wrong, I usually handle it myself. If I can't, only then I use the specialist - for help and guidance - not to take over my life and run it for me.

So that it empowers.

Restructuring Health

Then - An Action-Research Project...

For more than 3 years, we have been working on restructuring the medical profession and the public health system. We now know that:

⇒ Health is not something that needs a doctor – doctors know how to cure diseases but their current training often makes them unsuited to focus on ways to prevent the illness.

⇒ Top-down planning of health does not work. The village has to plan for its own health needs. This it cannot do without the required skills to monitor the health status, to diagnose individual problems and to address it, to identify community initiatives to prevent diseases and promote good health. These skills are needed but easily learnt.

⇒ A large part of ill health in rural areas is due to malnutrition.

⇒ Malnutrition is caused by several factors – less food, less number of times, lack of iron, protein, and fat in the food; poverty, gender discrimination; lack of good sanitation leading to diseases; poor access to health facilities, insufficient rest, etc. Though many of these factors require large social changes, it is still possible by optimizing the resources at hand in each individual case, to help address the problem.

We did an action-research programme in 120 villages on community health. We developed modules to train the village volunteer:

⇒ To diagnose the causes for malnutrition in an individual child and help the mother to address it. This advice has to be individual-tailored taking into account several factors – food pattern, illness, family resources & time constraints, and efforts already made to address the problem.

⇒ To provide antenatal and postnatal support to pregnant women.

⇒ To help address gynecological problems, organize support structures for women, and help women victims of violence.

⇒ To identify TB patients, to cure simple ailments, and to refer more complicated cases to a doctor.

We also now know how to organize such a programme on a large scale:

⇒ Start with a cluster of 30-60 villages (a block). Train a block resource group. This typically consists of 4-6 full-time village volunteers (women) and interested part-time volunteers – both men and women. This team establishes contacts with the panchayat and forms a voluntary village health committee in all the villages in the cluster.

⇒ Each village health committee chooses a local woman as its health activist. The block resource group then trains this woman – the training (on the modules mentioned earlier) is done through camps as well as on the field.

⇒ Regular visits to the village by the block team ensures support for the activist as well as constant re-training and motivation.

⇒ A simple register helps keep track of each child, pregnant woman, birth, death and marriage in the village with very little effort. This register serves as the progress indicator and helps measure the improvements. After the initial training period of 2 years, one can see a significant measurable improvement in the health status of the village.

⇒ The input required to sustain this programme after the 2-year training period is quite small. One can therefore sustain this effort without external funding just by local efforts. How to do this has to be worked out for each place.

Now - A People's Movement for Health...

⇒ We have started initiating this programme in 17 blocks in Tamilnadu – reaching out to about 700-1000 villages. Support from more volunteers can help this movement reach more villages more effectively.

A People's Movement for People's Science

Restructuring Education

Education should be fun, interesting & relevant. This will improve learning levels and prevent dropouts. Easier said than done. A boring topic can daunt the child - but making the topic fun can daunt the teacher!

To make this dream of restructuring education a reality, the TNSF is working on a number of ideas - developing innovative experiments, teacher-training programmes, children's science clubs, teacher-networks, a model school, Children's Science magazines and book. Public hearings for the state government's "committee on reducing burden on school children" was one part of our efforts to change government policy on education, to re-write textbooks and make life easier for millions of children. While we are on this *joy of learning* trip, we are also working on ideas to directly increase enrollment and prevent dropouts. Non-formal education centers for child-labourers to lead upto 5th or 8th class equivalency (and on the sly instigating them against child labour itself) & tuition centers for children who need help are some of the other programmes.

We work not just to replace one textbook by another. We work to break the enfeebling notion that education is something *specialists* bestow on people. We work to change this perspective - to that of a continuously learning society - where education is something people do for themselves. We work to build new structures by which people can participate in designing their own learning methods and curriculum - forums for exchanging and discussing ideas, educating themselves and each other. This is exactly what our children's clubs and teacher's networks are trying to be.

Restructuring Agriculture and IT

We are also involved in action research programmes which look into ways of improving agricultural productivity, soil fertility and water management using locally available materials and labour and using very little external inputs. We are also looking into the information needs of villagers and developing software and information packages for it. This programme looks into how information and communication technologies need to be restructured if the poor are to use them and benefit from them.

Taking Stands on Issues

The TNSF also studies, takes stands on various issues that affect the poor and organizes public opinion through newspaper articles, mass rallies, demonstrations, speeches and debates on the issue. TNSF takes a stand against communalism, nuclear weapons, and big industries, vested interests and multi-nationals destroying the living habitat and the livelihood of the poor.

All India People's Science Network

The TNSF has also linked up with similar movements and organizations in other parts of the country to form the All India People's Science Network (AIPSN).

Arivoli – A People's Movement for Literacy

When will an illiterate woman feel confident that she can read and write? Does the fact that millions of people all over the world know how to read and write make her task any less daunting? How can it? Their ability is theirs, not hers. Her confidence will come only with her ability to actually read and write. Confidence never comes in the abstract. It comes only with the ability – skill and power – to do things.

The early 90's witnessed a unique mass-movement in Tamilnadu - a campaign for Literacy initiated by the TNSF. Involving the government as a partner, the TNSF mobilized tens of lakhs of people to read and write. Lakhs of volunteers came forward to take classes every day for 1-2 hours. It was a huge and successful movement. The agenda was not just literacy. Literacy was only a tool for empowerment – to move towards organizing people for other demands. But before we could move in this direction, vested interests, political forces and the government machinery intervened. The movement lost its edge and TNSF withdrew from the literacy campaigns after the first 8 districts. But even today in many districts TNSF volunteers help the literacy campaign though the organization itself is not directly involved with it.

Not everything was lost though – the strong motivation for literacy and education built up in people during the mass campaign remains. We have managed to retain a small but significant fraction of the large volunteer base and reach into every village that we could establish then. These volunteers are now doing all our development and organizing activities. Even today the literacy agenda is being taken forward through neo-literate publications and newspapers, libraries and work based continuing education modules.

Samam - Women's Equality Movement

The literacy campaigns put us in touch with lakhs of women - young and old. Samam was established to give voice to their urge for equality. Many programmes were developed - one that really took root was the savings programme. Each savings group has about 20 women who save about Rs.20 every month. This money is circulated within the group as a loan. The loan can be for anything - emergency hospital expenses, tuition fees for children, redeeming ration cards, starting small enterprises. More than 20,000 women have been so far organized into such savings groups. But savings and loans are not the only things. Weekly meetings, reading neo-literate newspapers, learning new skill, developing leadership abilities, discussing and taking steps to address local problems are even more important. The money angle is one way for the women to get together on a regular basis. In several villages, these groups have stopped arrack sales, struggled against husbands who beat their wives, taken up the cause of women victims of violence, and even fought against police injustice and inaction. The best part of these groups is that they are fully self-sustaining and need no external financial support. With the help of these groups, we are integrating health, libraries and other support activities for women to build a vibrant women's movement.

The TNSF needs your time, talent & donation!
To join us or support our efforts, please contact:

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Health and climate change

On Nov 1 and 2, 1993, at the World Health Organization's headquarters in Geneva, an international group of experts met to discuss the potential health impacts of climate change. The meeting was organised for the WHO Division of Environmental Health and was chaired by Dr Rudi Slooff of WHO. Their task is now to update and expand the 1990 WHO publication *Potential Health Effects of Climate Change*. They will also contribute to the work of the Intergovernmental Panel on Climate Change, especially to the working group on impacts of climate change. The proposed WHO publication is planned for 1995 and will include contributions on direct effects of increased temperatures on cardiovascular and cerebrovascular deaths besides potential impacts on vector-borne diseases, other communicable diseases such as cholera and algal biotoxin poisoning, effects on fresh water supply and food production, and impacts of a rise in sea level. Almost all these topics were covered in a *Lancet* series, that ends this week with the initiation of a discussion of questions to be tackled by the WHO group—namely, how to monitor possible health effects and what strategies are needed to prevent them.

Global health watch: monitoring impacts of environmental change

*Andrew Haines, Paul R Epstein, Anthony J McMichael, on behalf of an international panel**

The eleven articles published in *The Lancet* over the past seven weeks have shown how anthropogenic damage to the biosphere has potentially important implications for health. The underlying processes are global in scale, and the natural systems affected are part of earth's life-supporting infrastructure. This type of health risk thus differs noticeably from more local environmental health hazards that are usually addressed at a toxicological or microbiological level. The impacts of global environmental change on health may be indirect and present only after a long delay. How can public health scientists predict and monitor the population health impacts of this novel challenge?[1] We need to detect effects early so that countermeasures can be developed and tested, to find out if there are previously unsuspected impacts, and to give impetus to policies to reduce greenhouse gas emissions (and other causes of global environmental change).

Climate change, the chosen focus of the *Lancet* series, could affect health in a variety of ways. Direct effects of a rise in temperature (particularly increases in the frequency and intensity of heatwaves) may include deaths from cardiovascular and cerebrovascular disease among the elderly. Indirect effects are secondary, such as changes in vector-borne diseases or crop production, and tertiary, such as the social and economic impacts of environmental refugees and conflict over fresh water supplies.[2]

Traditional epidemiological monitoring of disease and mortality has limitations because there may be undesirable delays before changes in chronic diseases are detected. Other approaches must also be used, including biological markers to give early warning of damage, the monitoring of carriers of infection such as insects and rodents, and remote sensing for large-scale monitoring. There is growing

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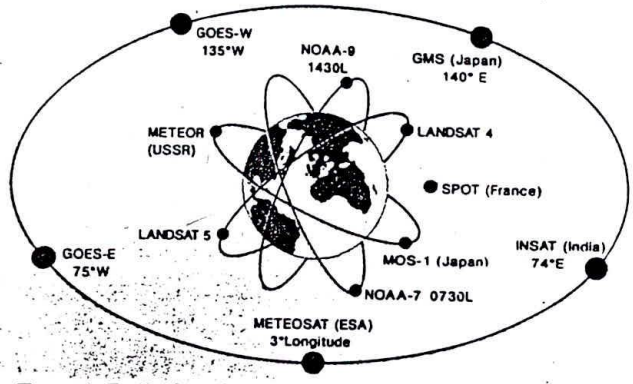


Figure 1: Earth observing satellites in operation (as of April, 1992)

awareness of the need to link environmental issues with health—for instance the 1993 World Bank report *Investing in Health* includes forest and fresh water resources.[3] We argue for integration of health into existing and planned environmental monitoring systems. In this final article we consider five aspects of monitoring, with cross-reference to the series where appropriate: biological, environmental, and human health indicators; data needed to monitor indicators; technology for measuring them; organisations doing the work; and gaps in information.

Climate (Maskell et al, Oct 23)

The scientific assessment of climate change is being updated by the Inter-Governmental Panel on Climate Change (IPCC).[4] The Second World Climate Conference in Geneva (1990) recognised the need for a Global Climate Observing System (GCOS) and a committee for GCOS has now been set up. GCOS will cover all components of atmosphere, biosphere, cryosphere, hydrosphere, and land surface climate, and that coverage is beyond the scope of current monitoring programmes such as Global Atmosphere Watch and the World Weather Watch network of satellites, telecommunication, and data processing facilities (figure 1).

Two other observing systems (ocean and terrestrial, GOOS and GTOS) will enable GCOS to provide a fuller picture. More than eighty international organisations and programmes are involved in global environmental monitoring, and the potential for overlap and lack of coordination is great. Until now health has not been adequately taken into account. A selection of these organisations is shown in figure 2.

Direct Impacts (Kalkstein, Dec 4)

The direct effects of temperature on health are mainly manifest as an increase in death rates amongst the elderly during periods of high temperature and can best be detected through analysis of mortality data collected daily. Such data are currently available mainly in developed countries but this information is needed for urban centres in less developed countries. Aggregation of deaths into weekly or monthly statistics is of much less value because an increase in mortality tends to be short-lasting and may be followed by a period of lower than expected mortality. Changes in morbidity and in seasonal patterns of disease can be detected in primary care data such as those collected from sentinel general practices around the UK.[5] This database demonstrates, for instance, that consultations for asthma

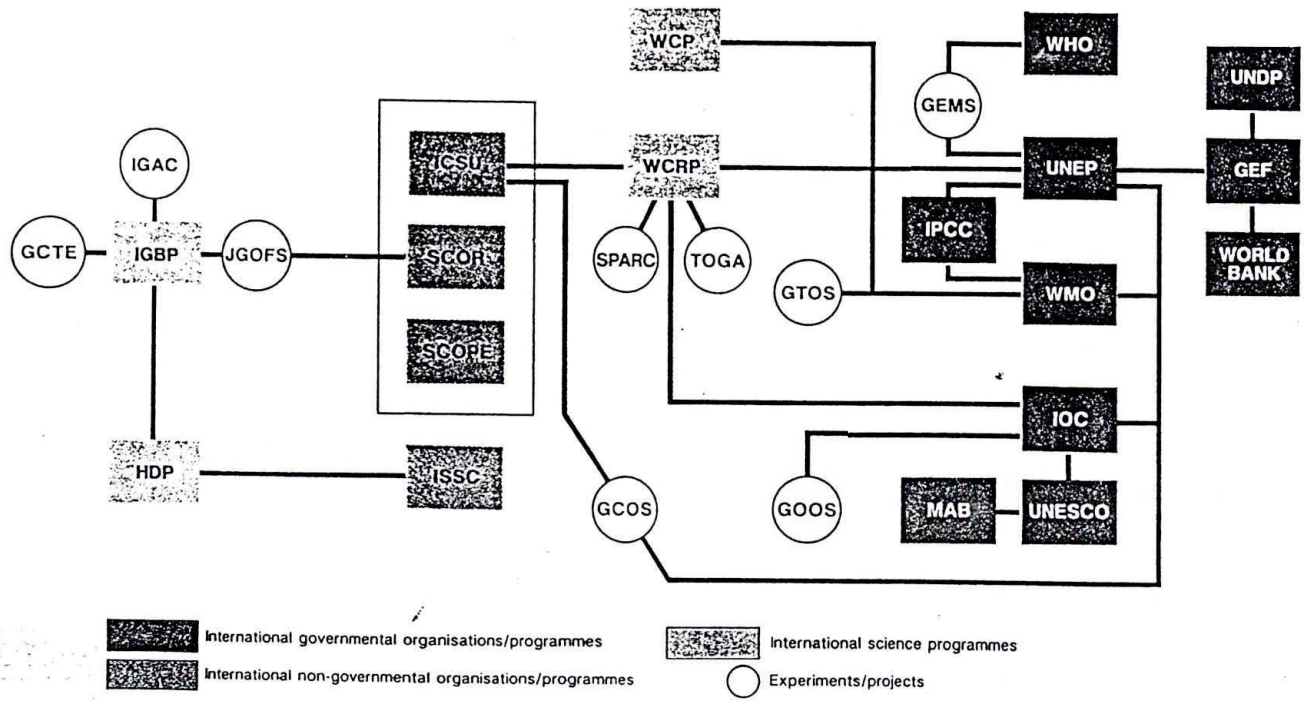
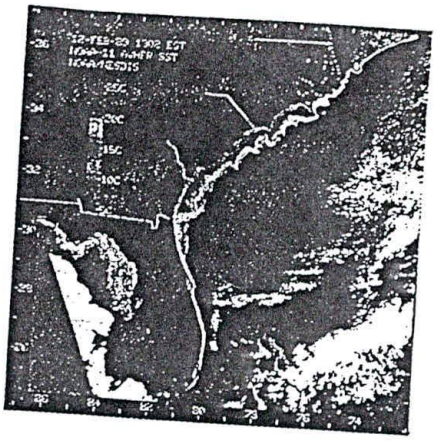


Figure 2: Links between major international global environmental organisations, programmes, and projects

Connecting lines indicate organisational links or "memoranda of understanding". (Adapted from figure 5 in *Global Environmental Change: the UK Research Framework 1993*, published by the UK Global Environmental Research Office, Swindon; this figure has been simplified to emphasise programmes mentioned in *Lancet* series.)
UN agencies etc—Development (UNDP), Environment (UNEP), Meteorological (WMO), Education and Science (UNESCO), Health (WHO).
Other International bodies with UN links—Global Environment (GEF), Climate Change (IPCC), Oceanographic (IOC), Man and Biosphere (MAB), Scientific Unions (ICSU), Social Science (ISSC), Problems of Environment (SCOPE), Oceanic Research (SCOR).
Other programmes/projects—Environmental Monitoring (GEMS), Climate Observing (GCOS), Ocean Observing (GOOS), Terrestrial Observing (GTOS), Human Dimensions (HDP), Terrestrial Ecosystems (GTEC), Geosphere-Biosphere (IGBP), Atmospheric Chemistry (IGAC), Oceanic Flux (JGOFS), Stratospheric Processes (SPARE), Tropical Ocean and Atmosphere (TOGA), World Climate and Climate Research (WCP, WCRP).



(Pat Tester)

Figure 3: **Sea surface temperatures off south-eastern United States (Feb 12, 1989)**

have risen lately (for reasons that are unclear) and that they show seasonal variations with peaks in the summer and towards the end of the year. The increasing use of computers should make it possible to collect routine data about consultations and hospital referrals in large populations.

Ecosystems (Dobson and Carper, Oct 30)

Illnesses of plants, birds, fish and mammals can be indicators of environmental ill-health. The factors which influence the growth of parasites and pests are nutrients, competitors, predators, and climate. When more than one factor is disturbed at the same time, the system's resilience declines and its resistance to pests may decrease. Bioindicators are used to monitor environmental toxins. The abundance and distribution of key species such as insects and algae can be used as indicators of ecosystem health. When an indicator is also a disease, vector surveillance for health outcomes can be directly linked. The Global Terrestrial Observing System (GTOS) requires a network of sentinel sites. The only global network available now is that run by UNESCO's Man and Biosphere programme, comprising 311 biosphere reserves. Some of these may become part of GTOS and could also be suitable for monitoring of health-related indicators. As they are generally composed of natural systems they will need to be supplemented by other sites, including agricultural, rangeland, forestry and fresh water systems.

Vector-borne diseases (Freier, Rogers and Packer, Nicholls, Nov 20; Almendares and others, Dec 4)

The WHO task group identified several vector-borne diseases that might be influenced by climate change. Examples are malaria, lymphatic filariasis, African trypanosomiasis, dengue and yellowfever.[6]

Changes in terrestrial ecosystems—detected for instance, by satellite imaging—can help monitor vector-borne diseases. In particular, vegetation indices produced by high-resolution radiometry have been correlated with mortality rates and population density of tsetse flies. Several types of remote sensing can be used to indicate animal and vector habitats; the LANDSAT and SPOT satellites (figure 1) have resolutions of 30 m and 10 m, respectively, and have been used to identify habitats of ticks and mosquitoes. The US National Aeronautics and Space Administration is sponsoring research on the use of satellite information for vector-borne disease monitoring and control.[7] Improved surveillance systems should be incorporated within the next generation of earth observation platforms. Integrated systems combining meteorological, topographic, and epidemiological data must become more accessible and simpler to use.

Climate change may first have impact on vector-borne diseases at the margins of their current distributions. In global warming isotherms shift polewards and vector-borne disease may follow in the same direction (10°C for yellowfever,[8] 16°C for vivax malaria, 20°C for falciparum malaria). Climate change might also affect the altitude at which vector-borne diseases are found, and high altitude sites in Kenya, Rwanda, Costa Rica, and Argentina may be good sites for monitoring. Field studies have been done but they must be kept going indefinitely. Low cost continuous

(Charles Hutchinson)

Figure 4: **Satellite views of Ethiopia**

Left: third dekad (10-day period) of June, 1992, compared with 1982–90 averages for same period. Red shows significantly poorer than average conditions for 1992, green areas are better, and grey areas are clouds. Red areas in central part of Ethiopia are result of late start in main growing season. Right: third dekad of September, 1992, compared with average greenness values. In 3 months since preceding image, exceptionally high rainfalls in late August created favourable growing conditions (green) in northern Ethiopia, Eritrea, and Sudan.

What	Where	How
Direct effect of temperature	Urban centres in developed and developing countries (urban heat island effect)	Daily mortality data
Changes in seasonal patterns of disease	"Sentinel populations" at different latitudes	Primary care morbidity data, hospital admissions
Vector borne diseases	Margins of distributions (latitude and altitude)	Primary care data; local field surveys, communicable disease surveillance centres, remote sensing
Algae/cholera	Marine (and freshwater) ecosystems	Local studies ("sea truth"), communicable disease surveillance centres, remote sensing
Freshwater supply	"Critical regions" especially in the interior of continents	Measures of run-off, irrigation patterns, pollutant concentrations
Sea levels	Low-lying regions	Local population surveillance
Food supply	Critical regions	Remote sensing, measures of crop yield, food access, and nutrition from local surveys
Skin cancers	High and low latitudes (taking distribution of ozone depletion into account)	Cancer registries Epidemiological surveys
Cataract	As for skin cancers	Epidemiological surveys
Emerging diseases	Areas of population movement or ecological change	Identification of "new" syndrome or disease outbreak population-based time series Laboratory characterisation

Summary of main elements of monitoring scheme

monitoring may be possible through local primary care facilities with health staff trained to diagnose malaria and other conditions reliably and to keep accurate records.

In Latin America, Chagas' disease could be monitored in Chile and Argentina, currently at the edges of the endemic area. Schistosomiasis could also be susceptible to climate change, especially if irrigation patterns change. In the USA there is a possibility of the spread of five vector-borne diseases—malaria, yellowfever, Rift Valley fever, dengue fever, and arbovirus-induced encephalitides.[9] The use of the Southern Oscillation Index, based on differences in atmospheric pressure, to predict outbreaks of Australian encephalitis was discussed by Nicholls.

Climate change may result in the elimination of some vectors and/or pathogens—for instance, as a result of very hot dry conditions, as in Honduras (Almendares et al). Local influences, such as deforestation, need to be distinguished from climate change.

Large marine ecosystems (Epstein and others Nov 13)

Changes in coastal ecology from local and global influences have direct impacts on health. Environmental monitoring of nutrients, currents, algae, and fish must be supplemented by: (1) monitoring algae for *Vibrio cholerae*; (2) surveillance of coastal communities for cholera and for fish (eg, ciguatera) and shellfish poisonings; and (3) surveillance of coral reefs (warming and ultraviolet radiation may cause bleaching[10]).

Marine algal blooms can be detected by remote sensing and satellite radiometry is useful for monitoring sea surface temperatures to guide sampling (figure 3). Microwave bands (to measure salinity) may be helpful for following particular toxic phytoplankton species. The next generation of satellites (Sea WiFS, to be launched in early 1994) will improve monitoring. Remote sensing needs to be supplemented by local sampling to examine individual species of algae and zooplankton associated with gastrointestinal pathogens and biotoxins. Data on winds and currents, nutrients (including nitrogen and phosphorus originating from sewage), fertilisers, and industrial pollutants will help to determine when conditions are propitious for the growth of algal blooms. In 1994 the monitoring of large marine ecosystems (funded by the Global Environment Facility) is scheduled for the Gulf of Guinea, then the Yellow Sea, and ultimately the world's other 50 coastal marine ecosystems.

A temperature increase of 2·5°C between 1990 and 2100 is projected to lead to a rise in sea level of 48 cm.[11] The impact will depend on land subsidence, erosion, and the frequency and intensity of storms.

There are currently 204 monitoring stations for sea level rise with planned expansion to 306 in eighty-five countries. Measurements are improving under the auspices of the Global Seal Level Observing System (GLOSS), which has a tide-gauge network. The countries most vulnerable to a rise in sea level include Bangladesh, Egypt, Pakistan, Indonesia, and Thailand, all with large and relatively poor populations. Several low-lying islands such as Kiribati, Tokelau, and the Maldives would also be in danger. The health consequences will be direct (eg, due to flooding) and indirect effects (eg, due to displacement of populations and changes in vector habitats).

Fresh water

Fresh water is rapidly emerging as a limiting factor for human development. Rivers, lakes, and underground aquifers show widespread signs of degradation and depletion, even as human demands on water resources rise inexorably. Some twenty-six countries now have indigenous water supplies of less than 1000 m^3 per person per year, a benchmark for chronic water scarcity. By the end of this decade, some 300 million people in Africa—one third of that continent's projected population—will be living in water-scarce countries.[12] Although domestic water use accounts for less than one-tenth of water use, there already exists a large shortfall for safe drinking water. Globally, the expansion of irrigated areas—which currently produce one-third of the world's food—has slowed to about 1% per year whilst the world population grows annually by 1·7%.

Temperature increases resulting from the equivalent of a doubling of the concentration of heat-trapping gases will probably raise both evaporation and precipitation globally by 7–15%. Rainfall patterns will shift, with some areas getting more moisture and others less. Hurricanes and monsoons may intensify and the sea level rise will salinate some supplies of fresh water.[13]

There is no global monitoring of water quantity, although most countries individually monitor the flows of rivers and the levels of lakes. The Global Runoff Data

Centre, under the auspices of the WMO and based in Koblenz, Germany, maintains a database on daily river flows from 1664 stations in ninety-one countries. These data could serve as a baseline for examining possible shifts resulting from climate change were a global system to be established.[14] The monitoring of water quality on a global scale is the responsibility of the WHO/UNEP Global Environment Monitoring System (GEMS). It promotes the measurement of about fifty indices of quality but practice among the 340 stations in forty-one countries varies considerably. The monitoring of pollutants and bacteria are relevant to climate change because changes in runoff may alter the concentrations; however, it is the use of fertilisers and pesticides, irrigation patterns, and industrial effluents that are key determinants of pollutant levels.[15]

A specific fresh water indicator of warming could be algal blooms, measured as chlorophyll a. There is increasing awareness of the formation of large floating masses of blue-green algae. Certain species can produce toxins which may be poisonous, and rashes, eye irritation, vomiting, diarrhoea, and myalgia have occurred in people who swim through algal blooms. The blooms are considered to be caused by a combination of calm sunny periods and sufficient nutrients, notably phosphorus.[16]

Food (Parry and Rosenzweig, Nov 27)

Several systems have been developed by international agencies to provide early warning of food shortages, notably in Africa. These systems rely on routine data of three sorts, that indicate food supply, food access, and wellbeing. Data obtained on the ground, such as food stocks and planted areas early in the season, supplement satellite data to indicate supply; food prices in local markets reflect access; and anthropometric measures or, in extreme cases, mortality rates give evidence of health impacts on populations.

Satellite data, as indicators of food supply and impending famine, improve consistency among countries and are more accurate and more timely than information had from farmers or local markets, for example. "Greenness" indices (red and near-infrared spectral reflectance) are available from daily data from satellites. This index is linked closely to cereal and forage production, and can be used to predict locust infestations. Figure 4 illustrates this approach for Ethiopia. Rainfall estimates are based on duration of cloud cover (presumed to indicate rain).

One International Geosphere Biosphere Programme project is a global network modelling crop yield responses to environmental change. Another, jointly with an International Social Science Council programme on dimensions of human environmental change, will monitor long-term changes in global land for agricultural use driven by non-climatic influences such as population growth and trade agreements.

Agricultural yields can also be affected by pests and predators, which are themselves susceptible to climate change. Potential examples from the USA are anaplasmosis (a rickettsial disease of cattle) and hornfly.[17]

Ozone (Lloyd and Jeevan and Kripke, Nov 6)

To assess the impact of enhanced ultraviolet-B (UV-B) radiation resulting from stratospheric ozone depletion, two trends must be monitored—global changes in column ozone abundance and changes in UV-B flux at ground level.

Ozone trends have been monitored by instruments on a satellite,[18] and by ground-based spectrometers. Observations on trace gases (especially chlorine and bromine containing compounds) that catalytically deplete the ozone layer are needed to predict future trends in ozone loss. A lightweight unmanned aircraft shows much promise here; a fleet of them could fly for days or even weeks at a time in the lower stratosphere and provide continuous data that remote sensing techniques cannot. Serious international cooperation on monitoring UV-B has only just begun, although many governmental agencies are now acquiring the expensive instrumentation. In the UK for example the National Radiological Protection Board has been monitoring solar UV (visible, UV-A, and erythemally weighted UV-B) at three sites since 1988.[19] Until recently, only broad-band measurements of UV-B region were available but we now have instruments that provide spectral resolution, and serial data from Toronto, Canada, published last month[20] illustrate what can be achieved.

Epidemiological monitoring of skin cancers (basal cell, squamous cell, melanoma), cataract, and other possibly UV-B induced disorders of the eye are needed over a range of latitudes. Recently studies have been initiated in southern Chile, where there has been appreciable stratospheric ozone depletion. Whilst data on melanoma can be captured by cancer registry data, basal cell and squamous cell cancers may be less reliably reported. Reliable estimates of cataract prevalence are likely to require periodic epidemiological surveys using a standard system to grade lens opacity.[21] However, these potential effects may take years to become manifest so markers which respond more rapidly are needed. The International Agency for Research on Cancer is exploring methods of making early estimates of changes in skin cancer risk. One possibility is to use biological markers, for instance certain dimer-forming mutations of the p53 gene in skin cells, which appear to be related to UV exposure.[22]

Emerging infectious diseases

Emerging infectious diseases are infections that are new in the population or are rapidly increasing in incidence or expanding in geographical range; examples are dengue, hantavirus pulmonary syndrome,[23] and some haemorrhagic fevers. Most emerging diseases are caused by "microbial traffic"—that is, the introduction and dissemination of existing agents into human populations either from other species or from smaller populations. This process is often precipitated by ecological or environmental change and is facilitated by population movements and other social factors. Re-emerging diseases are those that had been decreasing but are now rapidly increasing again. Often previously active control programmes against well-recognised threats to public health have been allowed to lapse.

Our capabilities for health monitoring and rapid response are seriously fragmented, with insufficient coordination and communication let alone provision for future needs. Inexpensive reliable communications (eg, by e-mail) are still not available worldwide, although initiatives such as SatelLife's HealthNet, providing low-cost access to medical databases for remote areas, and Internet e-mail offer hope that this can soon be achieved. A secondary network directly linking interested field scientists could greatly aid early recognition.

In conventional epidemiological surveillance, only a small fraction of cases may be recognised and reported. With emerging diseases, even a single unusual incident can

be significant and investigation of such a pointer requires linked capabilities for clinical identification of a "new" syndrome or disease outbreak, for the epidemiological investigation of the event (usually the weakest link), and for laboratory characterisation. Existing facilities with all the necessary capabilities, including some WHO collaborating centres for arboviruses and haemorrhagic fevers, can be a starting-point. ProMED (International Program for Monitoring Emerging Diseases) has lately been proposed and the idea is supported by the Federation of American Scientists and by WHO. Targeting so-called "critical geographical areas" undergoing rapid ecological or demographic change would be most effective. US Centers for Disease Control and Prevention has lately set up a programme on emerging diseases.

Role of WHO

WHO could have a key role in coordinating a "Global Health Watch" (in quotes because there is no such system) based on environmental health initiatives in its regional centres.[26] It will therefore need to be involved in the design and implementation of aspects of GTOS and GOOS. It can help select sentinel populations in critical regions where specific impacts seem most likely. Monitoring of health and climate change should be linked to information about the global health picture, including population growth. Existing collaborative programmes with other UN agencies (FAO, ILO, UNEP) places WHO in an excellent position to promote interdisciplinary activity on climate and ecosystem health

The WHO database Climedat specifically focuses on work on the public health aspects of global climate change. It lists investigators, organisations, and projects dedicated to research on climate health.† In addition the UN International Decade for National Disaster Reduction can provide practical input on preparedness and mitigation.

Conclusion

Greater integration of efforts to collect data on health and global environmental change is needed. Many of the potential effects of climate change will be insidious and will take a long time to manifest themselves, and sometimes the links between ecosystem damage and health are unclear. However, the creation of a monitoring network must not be used as a "wait and see" argument against action to reduce greenhouse gas emissions. The Framework Climate Change Convention signed in Rio de Janeiro last year has not yet come into force (it must first be ratified by fifty countries) but may be in 1994. It stipulates only that developed countries should reduce their carbon dioxide emissions to 1990 levels by the year 2000,[27] whereas the IPCC states that a 60% reduction is required to stabilise atmospheric concentrations.

Much of the burden of global environmental change may fall on poorer countries, which are less well equipped to monitor, and the danger is that monitoring will focus disproportionately on the problems affecting the rich nations. This raises important ethical and practical issues. If monitoring is to be effective international collaboration on epidemiological surveys, field studies, and routine data collection to complement satellite data will have to improve. This means a partnership between the technically advanced nations with access to remote sensing capacity, for example, and others. A global health monitoring network is essential not only to determine the impact of climate change but also to shape strategies to prevent climate change as far as possible and mitigate those effects which do occur.

†If you have information on new projects related to health effects of climate change or desire information from the Climedat database, please contact: Division of Environmental Health, World Health Organization, CH-1211 Geneva 27, Switzerland.

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GLOBAL HEALTH WATCH (National Meeting : India)

Date : 7th / 8th October 1999
Venue : Ashirvad, No. 30, Off St. Mark's Road, Bangalore 560 001.

Registration Form

1. Name			
2. Academic / Work Background (Mention Discipline and focus of experience)			
3. Organisation Represented			
4. Address			
Tel No.		Fax No.	
Email :			
5. Postal address (If different from above)			

6. Arrival on		By (mode)		At (time)	
7. Departure on		By (mode)		At (time)	
8. Accommodation : required / not required:		Dates	6th night		
			7th night		
			8th night		
9. Will like to Present experiences / or issue of					
10. Travel supported by own organisation		Yes ☐		No ☐	
11. If no in 10, then Require Fare		(estimate)			
12. Any Special suggestions?					

Date :
Place :

Signature

(Send back latest to reach us by 3rd October, 1999)

GLOBAL HEALTH WATCH

NATIONAL MEETING : INDIA, 7th – 8th October 1998

Community Health Cell – Bangalore
and
NGO Forum for Health - Geneva

Venue : Ashirvad, 30, St. Mark's Road, Bangalore - 560 001. Phone : 2210 154

Tentative Programme

7th October 1999 (Thursday)		
8.30 – 10.00 a.m.	Registration and Fellowship	
Session 1 10.00 - 11.00 a.m.	**Introduction / Inauguration** • Welcome • Self Introduction by Participants • Introduction to the theme and Objectives of the Workshop • A Presentation on the GHW idea • Finalisation of Programme • Selection of Rapporteur Team	**Chairperson** : Dr. V. Benjamin, CHC. Dr. Thelma Narayan. Dr. Ravi Narayan
11.00 - 11.15	*Tea / Coffee*	
Session 2 11.15 a.m. – 1.15 p.m.	**Learning from Other Watches** i. Health Watch ii. Social Watch iii. NATHI- District level Disease Surveillance iv. People's Watch (Tamil Nadu) v. PUCL – Karnataka (Each presentation of 15-20 minutes will be followed by 10 minutes of clarifications / questions)	**Chairperson :** Dr. C.M. Francis, CHC Dr. Gita Sen CYSD's paper was read out by Dr. Sunil Kaul Dr. Reuben Samuel Mr. M.A. Britto Prof. Hasan Mansoor
1.15 – 2.00 p.m.	*Lunch*	
Session 2 (Contd.) 2.00 – 3.00 p.m.	Presentations will continue with sharing by other participants regarding '**Watching**' on issues in their work.	Participants to volunteer

Session 3 3.00 – 3.20 p.m. 3.20 – 3.40 p.m. 3.40 - 4.00 p.m.	**Understanding Equity (including Case Study of Government Health Data) – A Panel discussion** What is Equity? Equity in National Health Programmes Equity in Government Health Information	**Chairperson** : Dr. Sukant Singh, CMAI. **Panelists** Dr. Pankaj Mehta Dr. Ravi Kumar Mr. As Mohammad
4.00 - 4.15 p.m.	*Tea / Coffee*	
8th October 1999 (Friday)		
Session 4 9.30-11.30a.m.	**Group Discussion** The group will divide into three and discuss the GHW concept with reference to the issues brought up in the questionnaire	**Moderators/Resource persons to be selected for each group.**
Session 5 9.30 – 11.30 a.m.	**Evolving the Framework of a Watch(I)**	**Chairperson :** Prof. R.L. Kapur, CHC.
	Advocacy / Campaigns some case studies. 1. CEHAT 2. PEACE 3. BELAKU 4. VIMOCHANA 5. JNU 6. AIPSN	 Dr. Amar Jesani Mr. Anil Chowdhury Dr. SaraswathyGanapathy Ms Donna Fernandes Dr. Mohan Rao Dr. Sundarraman
11.30 – 11.45	*Tea / Coffee*	
1.15 – 2.00 p.m.	*Lunch*	
Session 7 2.00 – 4.00 p.m.	**Evolving the Framework of a Watch (II)** **Plenary Meeting:** a) Short Presentation by Groups.	**Chairperson :** Dr. D.K. Srinivasa, RGUHS. By Rapporteurs
	b) Presentation of responses to pre-workshop questionnaire. **Suggestions from the Floor.**	Dr. Sunil Kaul / Dr. Rakhal Gaitonde
4.00 – 4.15 p.m.	*Tea / Coffee*	
Session 8 4.15 – 5.15 p.m.	**The Way Ahead – to Watch and how to Watch? at India level** Suggestions & Commitments on Follow-up. Winding Up	**Chairperson** : Dr. Mohan Isaac, NIMHANS.