Community Health Cell

From: Goa Desc <goadesc@sancharnet.in>
To: <goacan@sancharnet.in>
Sent: Tuesday, May 04, 2004 1:38 PM
Subject: HEALTH WATCH:Goa still grappling with tuberculosis

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Goa still grappling with tuberculosis

World Tuberculosis Day will be commemorated the world over on Wednesday, but does Goa have any reason to pat itself on the back? Are government officials really serious about alleviating the situation in the State which has remained status quo for the last decade or so?

Goa ranked number one in terms of health has still not implemented the Directly Observed Treatment Shortcourse (DOTS) chemotherapy for treatment of tuberculosis as compared to 70 per cent of the country already covered under this programme.

The number of tuberculosis patients in the State is estimated to be around 16,000 to 20,000, of which one forth is infectious. This situation has certainly not improved in the last decade, and in fact, the seriousness of the situation is now being compounded with increasing incidence of HIV-AIDS.

Training of doctors and staff for the implementation of the DOTS programme started in the year 2002, informs a doctor of the Health Services. In fact, assurances were given by a senior bureaucrat of the Directorate of Health Services (DHS) last year that this programme would be implemented from April to May 2003, and that too Nearly a year has gone by, and the programme has still not been implemented.

"We wanted to start the programme by March 24 (tomorrow), but it is not possible. The work is still going on, such as renovation of laboratories. Orientation of private practitioners also has to be done", says Dr V A S Palekar, Chief Medical Officer, TB Control Programme.

A senior bureaucrat of the DHS, who prefers to remain anonymous says, "Goa is in the final stage of preparing for the programme. Almost all the training of medical officers is done. Civil work is being undertaken. The programme may be launched in the first week of May, after the elections."

"It has been observed the world over that the National Tuberculosis Control Programme (NTCP) which is followed in Goa is not the best way to treat Tuberculosis", says Dr L Da Costa, Associate Professor, TB and Chest Disease Hospital. "The hallmark of the new treatment (DOTS) is directly observed treatment, which eliminates default", he adds.

Explaining the advantages of the DOTS programme, Dr Da Costa says that it makes sure that there is no default on account of shortage of medicine as a complete kit of medicines is given to the patient. In addition, it checks default at the earliest and facilitates early diagnosis of side effects.

One of the main aspects of the DOTS programme is that it involves sputum microscopy diagnosis, which detects 'positive' sputum, the more serious

type of case and the patient who can spread the disease.

For the purpose of implementing the programme, Goa has been divided into three units: Panjim, Margao and Ponda. Each unit will have five sputum microscopy centres where diagnosis will be done. Each centre will then have a number of DOTS centres where treatment will be given. The entire setup will ensure that the patient will get the treatment at the closest place to him

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COMH-48

Medact
challenging barriers to health

People's Health Movement

GEGA
Global Equity Gauge Alliance

Global Health Watch

Global civil society has not adequately participated in international health advocacy. Although high-profile success has been achieved with some campaigns, most notably around access to medicines and breastfeeding and certain diseases, there has been a striking lack of involvement and pressure from health campaigners on broader public health and health systems issues. In addition, disparities in health between the rich and the poor have grown at alarming rates both within and between countries, leaving society and the public health movement with a large humanitarian and moral challenge.

The increasingly global dimensions of poverty, disease and health policy require a much more vigorous input from public health experts, civil society and non-government organisations. The People's Health Movement, the Global Equity Gauge Alliance and Medact therefore propose to mobilise a fragmented global health community through the publication of an annual **Global Health Watch.** This publication will be used to shift the health policy agenda away from a technocratic approach to delivering health, to one that recognises the important political, social and economic barriers which prevent the achievement of better health.

We want the Watch to strengthen the calls for a broad approach to health amongst policy-makers, health professionals, campaigners, researchers and others concerned with health and to act as a reality-check on those formulating health policy by providing a forum which magnifies the voice of the poor and vulnerable and those who work with them.

The Watch will consist of a compilation of chapters on various global health issues written by NGOs and academics. Stories, experiences and analysis direct from poor communities will be threaded through the chapters and enable those who are traditionally unheard to voice their concerns on global health issues:

The Global Health Watch team is now looking both for authors to write chapters and for stories and experiences from around the world. For more information on the areas we are covering, go the Medact website www.medact.org

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October, 2003

SUMMARY OF CHAPTER HEADINGS

Preface
Introduction

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A1: Health in a Divided World (Socio-economic, health and health systems inequities)

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B2. Failing Prescriptions - Social Sector Policy and Ideology

B3. Health Policy: The Privatisation Agenda

B4. Where are our doctors? The Global Brain Drain of Health Personnel

B5. Big Pharma and the Future of Accessible Medicines

B6. Global Heath Leadership

SECTION C: BEYOND THE HEALTH SECTOR

C1. Agriculture and food security (long)

C2. Water (short/medium)

C3. Militarism and health (medium)

C4. Environment (medium)

C5. Gender and 'Women's Access to Health Care and Reproductive Rights (medium)

SECTION D: MONITORING AND ADVOCACY SECTION
This section will consist of a number of sub-sections each of which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and at the same time inform the advocacy and lobbying actions of a global progressive health movement committed to a just world and health for all. There would be a number of sections, for example:

- Trade and WTO
- ODA
- HIPC initiative
- IMF
- Global political and economic governance
- WB Watch
- WHO and other international health agencies
- GATS and Health Watch
- Global medicines watch
- Global health research watch
- Donor watch

	Suggested individuals or NGOs to co-author or endorse chapter
Preface	Nelson Mandela / Desmond Tutu / Graca Machel
Introduction Why have an alternative world health report. Why a focus on equity. Structure and purpose of report	GEGA/PHM/Medact
SECTION A: INTRODUCTION TO GLOBAL HEALTH INEQUITIES	
A1: Health in a Divided World (Socio-economic, health and health systems inequities) Introduce the socio-economic and political determinants of health and how socio-economic inequities affect health inequities Overview of the distribution of wealth (poverty) / health (ill health and mortality) / health care resources. Provide historical overview of socio-economic development and equity since WW2 and describe the current concentration of economic wealth amongst rich nations and fewer and fewer TNCs, and the existing levels and distribution of poverty Describe trend of growing inequities within rich countries as well as within in poor countries. Describe health inequities globally, inter-regional and in-country – emphasise HIV/AIDS, TB and malaria, but also of childhood killers, trauma and violence related health. There are many reasons for this picture, but this section of the report will highlight the political and economic causes at a global level; with the understanding that poverty will not be addressed without inequities being reduced. Describe the state of health care in relation to the state of health, and the way health systems can determine health inequities Describe health care and health systems inequities globally, inter-regional and in-country - incorporate a case study on the collapse of African health systems.	WDM Oxfam SCF GEGA / Equitap
SECTION B: THE POLITICAL ECONOMY OF HEALTH, DEVELOPMENT POLICY AND HEALTH SYSTEMS	
B1. The Politics and Economics of Poverty – A Global Public Health Priority Explain and summarise key global trends that are relevant to the current picture of growing inequities and the poverty traps that many poor countries are in. Highlight: ➢ Unfairness and effect of the global trading system (including double standards re tariffs and subsidies)	• Noreena Hurtz • George Monbiot • Naomi Klein

➢ Effect of protectionism and subsidies amongst rich countries ➢ Declining levels of ODA, inequitable distribution of aid amongst developing countries and poor quality ODA (tying of aid; donor uncoordination; appropriateness of aid; linkage to privatisation policies) ➢ Burden of debt and inadequacy of debt relief ➢ Effect of global financial system on macro-economic stability and development in poor countries ➢ Capture of the wealth of natural resources by small numbers of people ➢ Policies which transfer assets from sovereign debtors to international creditors ➢ Impact of Washington Consensus policies on development and equity. Describe the political processes that underpin the current global economic structure and system and highlight issues about global economic and political governance. These issues include the accountability of global governance institutions to civil society and the democratic deficit; lack of transparency and accountability; corporate control and influence; lack of power of developing countries in the face of increasing economic and financial globalisation and concentration of political and economic power amongst rich nations and corporate sector; the elevation of the rights of foreign creditors over those of citizens. Relate these issues to (each as a sub-section): • International financial system; • Regulatory structures and systems for trade + WTO • Regulatory structures and systems of TNCs • IMF • UN • Intellectual property rights regime Emphasise the link between all of this with health and that unless the underlying socio-economic determinants of poverty are addressed and unless countries are adequately resourced to ensure effective health systems, we will not deal with the 30,000 preventable childhood deaths a day, the HIV and TB epidemics etc. Conclude that there is a need for: ➢ Reform of global economic and political institutions ➢ Much greater transfers of resources and wealth from rich to poor. ➢ Bold and radical departure from business as usual. ➢ Global health institutions such as WHO and other health associations and organisations to elevate the political economy of health as a public health priority.	• Susan George + staff and fellows of Transnational Institute • Martin Khor and Chakravarthi Raghavan (Third World Network)
B2. Failing Prescriptions - Social Sector Policy and Ideology Describe the current (neo-liberal) economic theories and ideology that underpins the general social sector development discourse, and the influence of WB, IMF and OECD. Describe the growing privatisation agenda and the policy convergence among WB, IMF and bilaterals. Make link between the privatisation agenda in the social sector with the global political economy. Explain the effects of such policies on poverty alleviation and inequity.	Citizens Network on Essential Services (Nancy Alexander and Tim Kessler)

Contrast with examples of countries whose social policies have been pro-poor and where real advances have occurred. Include sub-sections: • Critique of the current World Development Report • Critique of selected PRSPs • Extent of and the effects of the privatisation of basic services (water and electricity) on health, poverty and inequities	Patrick Bond (South Africa) WEED - German NGO working on privatization of water. Bretton Woods Project and BIC Public Services International Research Unit (PSIRU)
B3. Health Policy: The Privatisation Agenda <u>Overview</u> Overview of development of international heath systems policy since the 1960s. Describe the heterogeneity of health systems, but the growing worldwide trend of a shrinking public sector. Describe the demise of the principles of the PHC Approach and how it is misunderstood and misapplied. Report on the growing emergence of selective primary health care and the global verticalisation of health interventions in contrast to the development of coherent health policy and health systems development. <u>Privatisation</u> Describe the trends on the privatisation of health care. Describe trends in public health budgets and health care expenditure', declining public health budgets and rise in out-of-pocket expenditure. Describe the lack of regulation of the private medical care in developing countries and the growth of the private medical insurance industry. Describe the various forms of privatisation incl. cost recovery mechanisms, user fees and subcontracting of services to NGOs, and critique the targeting of services approach (as opposed to strong universal care systems). Emphasise also how public sector budget cuts lead to 'de fact' privatisation. Describe the policies, ideologies, reforms and forces that are contributing to this and raise the issue of increased inequities, inefficiencies, segmentation of health systems and weakening public health capacity. Make reference to WB and WHO positions in this regard. Review evidence about the performance of the private for-profit sector in terms of efficiency and effectiveness, as well as their	Mike Rowson Fran Baum Ravi Narayan David Sanders David Woodward Andrew Green / Charles Collins Abhay Shukla John Hilary / WDM (Jessica Woodroffe and Claire Joy) / Sarah Sexton Maureen Mackintosh

impact on equity. In contrast, discuss the evidence that exists to suggest that universal public sector state services are inherently inefficient and inequitable – will need to tackle some of the WB papers and views on this directly. Build on case studies – for example, describe what is happening in a number of countries (for example, India, Mexico, South Africa, Australia, Malaysia, USA and one East European country), and then propose an appropriate health sector reform package. Describe Free Trade Agreements and GATS, and their impacts (or likely impacts) on increasing privatisation, increasing health systems inequities and weakening government regulatory capacity. <u>The new Public Management</u> Another increasingly dominant policy / approach within development and social service delivery is the new public management – the promotion of market-based, private solutions to public sector management. Describe extent to which this is being promoted and critique its appropriateness for the delivery of social goods and services such as health care (develop a box summarising the reasons why health and health care require the state and are failed by the market and market-based reforms of the public sector).	
B4. Where are our doctors? The Global Brain Drain of Health Personnel Indicators to monitor the equitable distribution and availability of health personnel Describe the central importance of health personnel to functioning health systems, and the picture of global health personnel inequities. Describe the aggressive recruitment of health personnel from the south. In short, the political economy of health personnel availability and training. Describe efforts underway to address this problem, including the Rockefeller / WHO initiative. Describe what WHO, ILO and other UN agencies are doing. Describe some of the other stakeholder positions. Monitor development and implementation of policies to mitigate the global brain drain	Equinet-HRH network Rockefeller – WHO team members
B5. Big Pharma and the Future of Accessible Medicines Describe the multi-billion dollar pharmaceutical industry in relation to global health and world poverty Report on progress with respect to: • TRIPs and the implementation of the Doha agreement • Accelerated access initiative • Regulation of the pharmaceutical industry • Progress towards EDP implementation Describe the efforts of the pharmaceutical industry to remain non-transparent, to inflate their research and developments costs; as well as to promote a deregulation of the market whilst strengthening their capacity to protect patents and to fix prices.	MSF, HAI and TAC

Describe progress re: development of pharmaceutical manufacturing capacity in developing countries Set out an agenda of action for WHO, including distancing itself from the influence of the pharmaceutical industry and calling for a international framework for the transparent regulation of the pharmaceutical industry as well as the development of generic manufacturing capacity in developing countries.	
B6. Global Heath Leadership The whole concept of global health governance needs to be described and explained in relation to many of the earlier chapters. It should point to a lack of global public health leadership in addressing the underlying determinants of poverty and disease; inadequate mechanisms for civil society engagement and participation; dangers of GPPIs etc. This chapter will include a critique of some of the key health sector specific multi-lateral agencies: • World Health Organisation • UNAIDS • UNICEF It will look at overall performance; the extent to which a broad public agenda is acknowledged and supported; the extent to which there has been adequate civil society engagement especially with developing country civil society; the extent to which they have been compromised by corporate interests etc. It should build on some concrete case studies including: • involvement and influence of pharmaceutical industry within WHO • breastfeeding, the state of play re: infant feeding code and the influence of baby food industry on health policy agencies • the tobacco control initiative + WHO's desire to stand up to the sugar and food industry .... positive examples of health leadership	
SECTION C: BEYOND THE HEALTH SECTOR	
C1. Agriculture and food security (long) • Describe state of hunger and malnutrition, and growing inequities in food consumption • Increasing oligoopolisation of food industry • Critique of agri-business, GMOs and TRIPS-related developments • Comment n the weakening of public distribution systems for food security (e.g. various forms of rationing and food subsidies) under neo-liberal regimes • Report on unfair agricultural subsidies and dumping Critique of UN / donor / FAO approach to household food security. Critique WHO's approach and performance related to food security, agriculture, nutrition. Report on WHO's recent battles with the sugar and food industry. Make mention of the millennium development project's background paper.	Tim Lang is Professor of Food Policy at Thames Valley University. Alliance for People's Action in Nutrition Vandana Shiva

Propose alternative strategies Emphasise the importance of this as a health issue. Determine some key recommendations that we can ask health associations and health-related NGOs, as well as the global health institutions such as UNICEF and WHO to advocate for, and which GHEW can monitor on an annual basis.	
C2. Water (short/medium) Explain importance of basic utility services (water, sanitation and electricity services) to health, emphasising again the importance of addressing the broader determinants of health. Describe the global situation in terms of coverage, access and utilisation (including inequities in consumption). Review, assess and critique the current state of international treaties and conventions related to water and energy.	
C3. Militarism and health (medium) • Report on trends related to military expenditure and its direct and indirect effects on development and health (describe inequitable distribution of the consequences of war and conflict) • Report on trends related to the effect of war, violence and conflict on health • Describe on-going threats of nuclear weapons and its impact on health • Case studies (possibly from Bosnia, Sri Lanka, Afghanisatan, Iraq, Sierra Leone, Congo, Columbia and Palestine / Israel): o What is happening from a health perspective o What have been the post-war responses to reconstructing the health system Brief summary of what is happening in the UN and the various other weapons control treaties and conventions. Construct this as a report card of progress and failure – naming and shaming of perpetrators and problem countries. Emphasise the importance of this as a health issue. Determine some key recommendations that we can ask health associations and health-related NGOs, as well as the global health institutions such as UNICEF and WHO to advocate for, and which GHEW can monitor on an annual basis.	Medact / IPPNW Centre for Humanitarian Dialogue (Human Security and small arms project) Saferworld - independent foreign affairs think tank; has two research programmes: Arms and Security, and Conflict Prevention Federation of American Scientists - Arms Sales Monitoring Project - works for transparency, accountability and deep reductions in global conventional weapons production and trade. Case studies: The Regional Centre for Strategic Studies in Sri

	Lanka Regional Human Security Center in Jordan Institute for security Studies in South Africa
C4. Environment (medium) Report on the continued and growing threats to health from environmental degradation and pollution: • global warming • ozone depletion • water pollution from pesticides, sewage etc. • deforestation Make link between poverty, environmental degradation and health. Introduce concept of ecological debt. Summary of what is happening in the UN and through the Commission for Sustainable Development. Describe the shortcomings of the current system of global economic governance in protecting the environment as well as the weakness of the international regulatory system to identify and punish environmental offenders. Construct a short report card of progress and failure related to the various treaties and conventions – naming and shaming of perpetrators and problem countries. Relate this back to the health community. What should they be doing? What should WHO be doing? For example, has it spoken out against the failure of the Kyoto protocol from a public health perspective?	Bank Information Centre (BIC) has been working on the multilateral development banks from an environmental perspective. The Center for International Environmental Law – NGO that provides environmental legal services, as well as policy research, advocacy, education and training. Friends of the Earth Greenpeace
C5. Gender and 'Women's Access to Health Care and Reproductive Rights (medium) Highlight the specific needs and challenges to addressing women's health. Describe the progress that has been made since Cairo, but highlight the fact that while the world is long on bold policy statements and declarations, it is short on changing the lives of millions of women who suffer from discrimination and a lack of adequate health care. Provide what data there is to demonstrate the health inequity between men and women. Make the link between the collapse of health systems to women's health. Make the link to broader social and cultural issues, and describe attempts to empower and liberate women through health care. Critique the role and effectiveness of international and multi-lateral agencies to address this issue.	Womens Global Network for Reproductive Rights
SECTION D: MONITORING AND ADVOCACY SECTION	

This section will consist of a number of sub-sections each of which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and at the same time inform the advocacy and lobbying actions of a global progressive health movement committed to a just world and health for all. There would be a number of sections, for example: Trade and WTO • In terms of trade, concrete issues to monitor might include the rich country tariffs and subsidies; and the removal of appropriate protectionist barriers in poor countries. This might include a 'report card' of the fairness of the Cancun talks. • In terms of WTO, highlight the need for reform of purpose, governance and accountability. ODA • Provide detail of good and bad performers. • Develop donor country case studies (possibly a mix of good performers and bad performers) – to look at quantity, quality, conditionality and politicisation of aid • G8 report card HIPC initiative • Describe the lack of progress related to debt cancellation as well as the inappropriate / unfair conditionalities. IMF Global political and economic governance • Regulation of global financial and capital markets • Recommend and monitor progress towards policy proposals such as Tobin tax • An effective global tax system WHO and other international health agencies Assess their positions and actions on the political and economic issues listed above (include absence of such issues in macro-economic commission on health). WB Watch Develop a critique of the World Bank which can be used to make specific demands of the Bank and to monitor the Bank – this can be tracked in subsequent GHEWs. Include issues related to governance, transparency and policy (possibly the other MDBs?) WHO and other international health agencies Assess their views, positions and actions on issues raised in C1 and C2. For example, WHO's position on privatisation within health care systems + critique WHO's position and policies with regard to GATS and FTAs. GATS and Health Watch	Development Initiatives – they compile an annual review of all ODA • Kees Biekehart. TNI Fellow working on aid impact • David Sogge. Works on development aid and aid policy in Southern Africa. • North-South Institute - independent institute that conducts research on Canada's relations with developing countries and its foreign aid programs. Anne Pettifor – works on debt relief and HIPC

Global medicines watch Global health research watch Progress on the widely publicised 10:90 mismatch between the allocation of research funds and the burden of disease. Donor watch Although the WB is probably the biggest influence on health systems policy / health sector reform, bilateral donors can be influential at the country level. Therefore important for there to be a greater "donor assessment" within the health care sector to determine how well aid is being used to support appropriate health systems development and equity. Also how are donor countries choosing between different countries? How much aid is recycled back to home country consultants? To what extent are trade objectives and religious agendas being promoted through donor programmes?	
APPENDICES : VOICES FROM THE GROUND	
End with something positive that talks about various alternatives (the PHM network can provide many examples) and which illustrates the vision envisaged in the People's Health Charter. Identify and promote good models and countries which have continued to strengthen universal health care systems.	PHM

Main Identity

From: "Ruggiero, Mrs. Ana Lucia (WDC)" <ruglucia@PAHO.ORG>
To: <EQUIDAD@LISTSERV.PAHO.ORG>
Sent: Tuesday, January 13, 2004 8:37 PM
Subject: [EQ] Towards a global health workforce strategy

-----Original Message-----

From: Mario R Dal Poz [mailto:dalpozm@WHO.INT]

Towards a global health workforce strategy

A new book on human resources for health issues was launched in December:

Ferrinho, P,Lisbon University, Dal Poz M. World Health Organization & Rio de Janeiro University (eds.)

Antwerpen: ITGPress, 2003: 488 pp. |ISBN 90-76070-26-1|

A free downloadable full-text copy [PDF file] is available at:

http://www.itg.be/itg/GeneralSite/InfServices/Downloads/shsop21.pdf

"....The papers presented in the book cover the main dimensions of HRD in health: planning and managing the workforce, education and training, incentives and working conditions, managing the performance of personnel and policies needed to ensure that investments in human resources produce the benefits to which the investing populations are entitled.

Authors write from diverse professional, regional and cultural perspectives, and yet there is a high degree of consistency in their diagnosis of problems and proposals for strategies to address them. They all agree on the multidimensionality of problems and on the need for solutions that take into account all dimensions. They also agree that if problems tend to be similar in nature, they take forms that are time and context-determined.

This set of papers raised questions and give insights into strategies that are relevant to developed and

developing countries....." Orvill Adams (World Health Organization) and Gilles Dussault (World Bank Institute)

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This message from the Pan American Health Organization, PAHO/WHO, is part of an effort to disseminate
information Related to: Equity; Health inequality; Socioeconomic inequality in health; Socioeconomic
health differentials; Gender; Violence; Poverty; Health Economics; Health Legislation; Ethnicity; Ethics;
Information Technology - Virtual libraries; Research & Science issues. [DD/ IKM Area]

PAHO/WHO Website: http://www.paho.org/

EQUITY List - Archives - Join/remove: http://listserv.paho.org/Archives/equidad.html

(9)

1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

1.a) This question is rhetorical in the Indian context, where gender, class, ethnic group, age, area of residence all have bearing on factors such as availability of food grains,access to safe drinking water ,sanitation,education,and health care services.The infant mortality rate varies from 13 (Kerala) to 97 (Madhya Pradesh) (1996 figures), while in Madhya Pradesh itself the rural areas have an IMR of 102 compared to an IMR of 61 in the urban areas. Whereas the average no.of villages covered by a PHC in Kerala is 1.44, the figure for Madhya Pradesh is 51.98(ref. Health Monitor 1997). The expenditure by the state on health is also variable, e.g. with a percapita expenditure of Rs 14.49 in Bihar in 1980-82, to Rs.101.29 in Himachal Pradesh. (Health Status of the Indian People

1 b) Many of the goals outlined in the Declaration of Alma Ata have yet to be realized. Most critical to health is the absence of implementation of the minimum wages act, which keeps a large no. of unorganized labor (especially farm labor)in poverty. The govt. is yet far from fulfilling its commitment to provide safe drinking water to every village by 2000 A

1 c) The problems resulting from inadequate allocation of resources, administrative failure are exemplified by the performance of the National Tuberculosis Control Program, and the National Malaria Control Program. Corruption in health regulatory bodies like FDA, have led to deaths due to administration of contaminated glycerol(Bombay), IV fluids (Delhi), and the recent dropsy epidemics in North India. The influence of pharmaceutical companies on the drafting of the National Drug Policy, has caused great harm to the people's right to essential drugs at affordable prices. Health resource allocation continues to suffer from an urban and curative bias. The expansion of the private sector in health care has been abetted by large scale exemptions on import duties,and in some cases provision of land at ridiculous prices(the Apollo Indraprastha hospital in Delhi, one of India's most expensive, was provided land at the cost of Re 1/.by the Delhi administration)

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) These inequalities manifest themselves in the form of differentials in morbidity and mortality,life expectancy, malnutrition,percapita food grain consumption, the access to and utilization of health services.

b) The Census data, the sample registration system and other reports of the from the office of the Registrar General of India, research studies conducted by health and social science professionals, documents brought out by voluntary agencies & focus groups, and the Central Bureau of Health Intelligence.
However there is a serious lacuna due to the absence of a surveillance mechanism for monitoring disease status , demography,

nutritional status at the district level. The community health centers being established now were to have a post of community health officer who is a public health specialist who would undertake surveillance at the local level, so that the center could function as a epidemiologic surveillance station. However this has not been implemented in most of the states. Also the private sector which caters to the health of a large no.of people should be involved in surveillance programs. An initiative of this kind to document morbidity due to six communicable diseases, was successfully attempted in North Arcot district by faculty of the Christian Medical College, Vellore.

c) It is a widespread belief that data from the Government, lacks accuracy and transparency. The data pertaining to immunization and family welfare activities are often overestimates, while the figures for morbidity/mortality due to communicable diseases are often grossly underestimated.e.g vital statistics of India collected separately reported malaria deaths as 137,846 in 1985 and 75,285 in 1987 whereas the NMEP figures were 213 and 188 respectively.(Ref.Towards an appropriate malaria control strategy 1997. VHAI-SOCHARA document.)

d) Yes, there is a need for primary collection of data, although it is possible to analyze the existing data.

e) Some of this data is readily available as reports, documents.

f) Verification is a difficult task unless a system for monitoring and surveillance involving both the government and private sector run services is in place. Crude estimates of the problem can sometimes be had from the estimates of drug consumption e.g. of chloroquine for malaria, antitubercular drugs for tuberculosis.

g) The need to protect sources may arise in case the data is being provided by voluntary agencies and is at variance with the official data.

h) The national level data may be monitored by an independent body which actively networks with academics and public health specialists, health professionals, voluntary agencies(e.g.the voluntary health association of India and the community health cell) and focus groups (e.g. those active in the areas of women's health, drug issues, worker's and consumer rights, environmental groups), and associations of health professionals.(e.g. the Indian Medical Association).

i) The benefits of knowing accurately the magnitude of health problems, and of monitoring trends will far outweigh the modest costs incurred.

3. **ADVOCACY**

a) In public forums including citizen groups, panchayati raj institutions, the the printed and the electronic media, in academic forums, with the bureaucracy ,judiciary and the legislatures.

b) The inequalities in health should form part of the agenda of any voluntary agency active in health and allied areas, and should be brought to the attention of the public using the media, and available public forums including the panchayati raj institutions. The academia , the focus groups and the associations of health professionals should use the leverage they possess to highlight health issues. The judiciary which has become increasingly responsive to health issues can be approached to provide/enforce the legal provisions to address public health problems. Finally voluntary agencies should create a climate where issues of health and health care, and allocation of resources are seen as priority issues for the people, and taken up by the legislative structures.

c) The answer to this question has been covered in response to question 3(b).

d) These initiatives would be deemed successful if they result in health issues being highlighted at a national and international level, and create pressure for remedial actions to address inequities in health. The gross neglect of public health by governments, resulting in denial of safe drinking water, sanitation, and a clean environment, and a public health care system which does not deliver the goods, are concerns which this watch should address.An increase in allocation to health by governments and the utilization of these resources in a manner which meets people's basic health needs should be one of the goals. By monitoring the activities of international organizations, one should be able to provide a counterpoint to inappropriate prescriptions which less developed countries are being made to follow because program funding is made conditional to their acceptance. A case in point was the allocation of funds by the World Bank to the Indian government for the Revised National Tuberculosis Program, on the condition that Direct Observation of Therapy would be universally followed in the program. The effects on the health status of a people , of the rapid changeover to a market economy under the regimen of globalisation, need to be urgently studied.

Apart from the above a health watch could provide reliable information about changing trends in the health status of people and help focus attention on priority areas, feedback which could help change policies as well as systems and early warning of public health disasters.

e) Yes.

4 PARTNERS

a) Voluntary organizations working at the grassroots level, coordinating agencies (like the VHAI), research institutions

(ICMR, ICSSR, Malaria Research Center, National Tuberculosis Institute , National Institute of Health and Family Welfare, National AIDS Research Institute , National Institute of Occupational Health, National Institute of Environmental Engineering, etc), the various centers of development studies, organizations like SOCHARA, and focus groups including advocacy groups.

b) The primary data collection would be done by the NGOs , research institutions as a part of their work, and by focus groups. The watch would thus receive inputs from multidisciplinary sources. The analysis and dissemination of this data would be done both at the state level and at the national level by an independent body.This data could also be provided to various focus groups, advocacy groups, media, citizen groups, and the decision makers in the bureaucracy and legislature,which they would then respond to.

5.ORGANIZATION

a) How would a national watch be organized ?

This question is difficult to answer at this preliminary stage, and much thought and discussion needs to follow. But a decentralized approach with strong involvement of grassroots level organizations and of persons with a strong pro-people commitment should be central to the character of the watch.

GLOBAL HEALTH WATCH

1 What are the inequalities in Health ?

- Regional - access/spending - interior and isolated areas , north / south
- rural-urban
- economic status
- level of monetisation
- terrorism and insurgency affected states
- urban slums
- nomadic/immigrant labour
- inequal budgetary allocation against PHC
- historical processes through states go through
- information / awareness / education
- employment status

(ii)

- gender - esp as sex of doctor available is most often male
- caste
- life expectancy
- age - geriatrics / adolescent
- tribals-2
- religion

(b) Implementation of conventions / performance of government

- No - 4
- not fully -4 , due to subtle changes being made over time
- yes- 1

(c) Factors compounding inequalities.

- SAPs
- media explosion leading to changed values
- management structures not suiting Indian ethos
- corruption-3
- inadequate / untimely release of funds
- lack of infrastructure.
- drugs and pharmaceuticals
- lack of private sector effort / involvement
- complete dependence of government
- lack of seense of participation
- lopsided priorities
- poor information base
- illiteracy / unaware citizenery
- uncommitted proffessionals, lack of monitoring / supervising
- external aid
- urban bias of NGOs
- insurgency / violence
- environmentally unfriendly development projects
- eco non-friendly tourism
- western based education / medical education.

2 How would you measure Health inequalities ?

(a) How to show they exist ?

- government data including - census /SRS / NFHS / - by disaggregating for different variables
- comparative perspectives
- qualitative and case studies , narratives
- per capita expenditure in various areas
- sale of drugs etc / utilisation of hospital services.
- NO NEED TO DEMONSTRATE.
- pattern of unfilled posts./ idle time in PHCs

(b) Sources of data ?

- 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

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

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

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

- Not required - 3
- yes - 6 small sample size and rigid supervision / would it be possible?

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

- right of infornation 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

(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?
- large costs-2

- not much-3
- depends on design

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

(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*
- 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

(c)With whom should they be taken up?
- as in 3(a)
- corporate sector

(d)What is the likely impact?
- keepinh govt MIS on its 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

(e)Is there is a need for alternate reporting systems?
- yes-5
- no-2

4. Partners.

(a) Which organisations or persons would be able to participate in this kind?
- academic institutions like JNU / TISS
- 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

(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

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

(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

(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

(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!

(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
- Medical science/ generally/ Medical knowledge/ profession as objects of watch.
- Professional Watch.
- existing regulatory mechanisms to be strengthened.

OED

Précis

WORLD BANK OPERATIONS EVALUATION DEPARTMENT SPRING 1999 NUMBER 186

Global Health: Meeting the Challenge

THE WORLD BANK'S INVESTMENT IN THE HEALTH, nutrition, and population (HNP) sector has evolved from relatively modest investments in population and family planning in the 1970s, to direct lending for primary health care in the 1980s, to support for health system reform in the 1990s. The Bank is now the major source of external finance for the sector in the developing world, with average annual commitments of $1.3 billion. Its advice and research influence HNP policies at many levels.

Assessing Effectiveness

The Bank has made important contributions to strengthening health, nutrition, and population policies and services worldwide with support for HNP activities in some 92 countries. To assess the effectiveness of this effort, the Operations Evaluation Department (OED) recently carried out the first comprehensive study of Bank assistance to the HNP sector.

Because lending has expanded dramatically during this period—three-quarters of the total has been lent since 1990—the HNP portfolio is young. By fiscal 1997, only a third of projects had been completed and evaluated. As a result, the OED evaluation incorporated assessments of both completed and ongoing projects. This Précis summarizes the final synthesis report of the OED evaluation, which included a review of the evaluation literature, a desk review of the HNP portfolio, four country case studies (Brazil, India, Mali, and Zimbabwe), and consultations with Bank staff, borrowers, NGOs, and donors.

The overarching recommendation of the study is that the Bank should seek to do better—not more. The rapid growth of the portfolio—and the complex challenges posed by health system reform—requires consolidation, with a focus on selectivity and quality. OED specifically calls for increased attention to institutional development in project design and supervision, and substantial improvement in monitoring and evaluation.

OED also recommends strengthened efforts in health promotion and intersectoral interventions; a renewed emphasis on research; greater understanding of stakeholder interests; and the forging of strategic alliances with development partners at the local, regional, and global levels.

Health and the Health System

Morbidity, mortality, nutritional status, and fertility are determined by many factors in addition to health services. The most important are income, education, and the quality of the environment—including access to safe housing, clean water, and sanitation. Also important are individual and community practices related to nutrition, sanitation, reproduction, alcohol and tobacco use, and other behaviors that affect health, behaviors that are shaped by social and economic status and culture.

HNP interventions can reduce the burden of disease through preventive services, by encouraging healthy behavior, or by providing curative care. Increased understanding of the causes of disease and improved interventions for both preventive and curative services—such as antibiotics and vaccination—have improved HNP outcomes throughout the world. Prevention is often—although not always—more cost-effective than treatment, but strong demand for curative services can lead to a disproportionate emphasis on the medical care system, both in public policy and in the health care market.

Project Performance

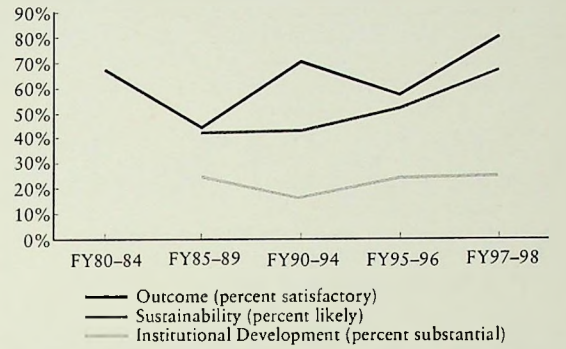
Of the 107 HNP projects completed between FY75 and FY98, OED rated 64 percent satisfactory, compared with 79 percent for non-HNP projects. But efforts by the Bank and sector staff to improve performance may be showing results. Seventy-nine percent of projects completed in FY97/98 satisfactorily achieved their development objectives, close to the Bank average. Although only half of all completed HNP projects were rated as likely to be sustainable, this figure rose to two-thirds in FY97/98.

Yet recent improvements should not be a cause for complacency. A third of ongoing HNP projects are currently rated "at risk" by the Bank's portfolio monitoring system. Moreover, high rates of completion of physical objectives disguise difficulties the Bank has encountered in achieving policy and institutional change in HNP. OED rated institutional development as substantial in only 22 percent of completed HNP projects, which increased to only 25 percent in FY97/98, well below the Bank average of 38 percent for the same period (figure 1). Improving institutional development performance is therefore a major priority for the Bank's HNP sector.

Factors Influencing Performance

Based on a statistical analysis of completed HNP projects, OED found *borrower performance* to be the most important determinant of HNP project outcome. But borrower performance is not entirely independent; it is influenced by the Bank's assessment and encouragement of project ownership, the fit between the project design and borrower capacity, and the effectiveness of supervision.

Figure 1: Outcome, Sustainability, and Institutional Performance



The country *institutional context*—including the prevailing levels of corruption—was the next most important factor. Although national institutions evolve slowly, this suggests that the institutional context must be clearly understood, and informed choices made of instruments and objectives.

With regard to *Bank performance*, quality at entry—particularly the quality of institutional analysis—was found to be the most important element, followed by the quality of supervision. OED found that quality at entry has improved in recent years, but institutional analysis remains a key HNP weakness. OED also tabulated the most commonly cited lessons from completed projects. Among unsatisfactory projects, inadequate assessment of borrower capacity and commitment, inadequate Bank supervision, little or no monitoring and evaluation, and excessive complexity of project design were at the top of the list.

Major Findings

World Bank support has helped to expand geographical access to basic health services, sponsored valuable training for service providers, and offered other important inputs to basic health services. The Bank has also used its lending and nonlending services to promote dialogue and policy change on a variety of key issues, including family planning, health financing, and nutrition strategies. Clients find the Bank's broad strategic perspective an asset, and the Bank has taken on a growing role in donor coordination.

Despite an initial focus on government health services, the Bank has moved increasingly to deal with issues of private and NGO service delivery, insurance, and regulation. In recent years, the Bank has also placed greater emphasis on client ownership and beneficiary views in project design and supervision. With the current

Box 1: Successful Institutional Development

OED RATED THIRTEEN PROJECTS COMPLETED between FY91 and FY98 as having substantially achieved their institutional objectives. These projects shared several characteristics:

- *A consistent commitment to achievement of institutional objectives.* Consensus was promoted among stakeholders regarding priorities and approaches. When necessary, strategies were developed to anticipate and soften resistance.
- *Project design based on solid analysis of the underlying constraints to improved performance.* Sector work, evaluation of previous experience, and dialogue with key stakeholders were combined to reveal impediments. Designers developed realistic strategies to address these constraints, including attention to the proper sequencing of interventions.
- *Flexible project implementation.* Progress toward institutional objectives was reviewed regularly, with proactive attention to problems by Bank staff and borrowers. About half the projects that substantially achieved institutional goals were significantly modified during implementation.
- *A governance and macroeconomic context supportive of institutional and organizational development.* If this was not the case, the above factors were particularly important.

generation of projects, the Bank and its partners are attempting to address underlying constraints to sector performance, while recognizing the difficulty of improving health sector effectiveness and efficiency—even in developed countries. The following broad concerns emerge regarding the Bank's performance to date.

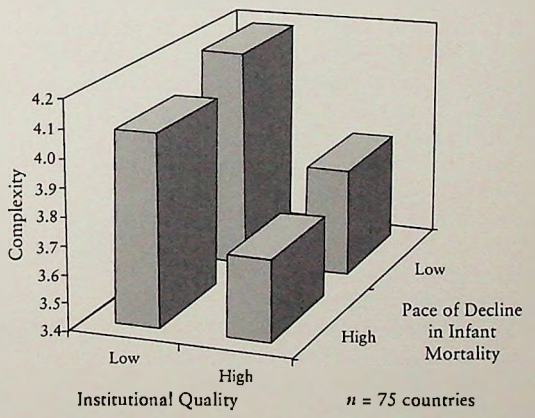
Disappointing Institutional Impact

The Bank generally has been more successful in expanding health service delivery systems than in improving service quality and efficiency, or promoting institutional change. There are several dimensions to this problem. First, in seeking to promote institutional change and build borrower capacity, the Bank often does not adequately analyze the constraints underlying current performance. Although the quality of institutional analysis has improved in recent years, the Bank is often better at specifying *what* practices need to change than *how* to change them or *why* change is difficult.

Second, weak analysis contributes to a lack of clarity in the articulation of institutional development objectives, including whether the instruments selected are the best choices to bring about change. Bank projects have traditionally addressed capacity constraints through the provision of training and additional resources. The absence, until recently, of appropriate indicators for institutional goals has contributed to the tendency to assert that "capacity was built" because training or technical assistance was provided. The Bank is adopting increasingly sophisticated approaches to promoting sector reform, but the institutional problems being addressed are increasingly difficult. Yet experience shows that realistic objectives, together with increased attention to *why's* and *how's*, increase the likelihood of achieving institutional objectives (see box 1).

Third, the Bank often does not adequately assess borrower capacity to implement planned project activities. For example, Bank project designs tend to be more complex—with a greater number of components and organizational units—in countries with weak institutional capacity and with slower rates of decline in infant

Figure 2: High Complexity in Difficult Settings



mortality (see figure 2). This partly stems from an understandable desire to address many problems at once. The challenge therefore is to get complexity "right," including proper assessments of existing implementation capacity, greater effort to prioritize and sequence interventions, and targeted provision of technical assistance and training.

Weak Monitoring and Evaluation

During project implementation, the Bank typically focuses on providing inputs rather than on clearly defining and monitoring progress toward HNP development objectives. Because of weak incentives and systems for

Box 2: Successful M&E: Lessons from Country Experience

SUCCESSFUL APPROACHES TO ASSESSING THE effectiveness of project interventions, strengthening borrower health information and disease surveillance systems, or monitoring progress toward sectorwide objectives have been demonstrated by a number of projects, including the following:

- *Brazil's Amazon Basin Malaria Control project* helped to train malaria fieldworkers and strengthen disease surveillance systems, which—together with a shift in strategy from eradication to control, early treatment, and case management—contributed to a decline in malaria incidence and fatality rates.
- *Tamil Nadu's Integrated Nutrition project* in India established a community-based system for regularly monitoring the growth and weight of children found to be malnourished. The project significantly reduced severe malnutrition in the target group. The monitoring system both contributed to and documented the impact.
- *Mali's Health and Rural Water Supply project* (1991–98) eventually helped establish a nationwide health information system, although data were not available until the final years of the project. This illustrated the importance of balancing long-term efforts to strengthen borrower monitoring capacity with provisions for periodic external qualitative or quantitative assessments, including rapid assessments.
- In the current *sectorwide health reform programs in Bangladesh and Ghana*, government and donors (including the Bank) agreed—after lengthy negotiations—on a limited number of national indicators that will serve as benchmarks for joint annual reviews of sector performance. Remaining challenges include better linkage of system performance indicators to HNP outcomes, and ensuring that national indicators create incentives for performance at lower levels of the system.

monitoring and evaluation (M&E) within both the Bank and borrower governments—and inadequate attention to building borrower M&E capacity—there is limited evidence regarding the impact of Bank investments on system performance or health outcomes for the poor. The Bank therefore has not used its lending portfolio to systematically collect evidence on what works, what does not, and why.

Experience shows that effective M&E design enhances the focus on results and increases the likelihood

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of achieving development impact. This would include the selection of a limited number of appropriate indicators and attention to responsibilities and capacity for data collection and analysis. But methodological challenges can make it difficult to conclusively link project interventions with changes in HNP outcomes or system performance. Yet while most HNP projects identify key performance indicators, and design of M&E has improved in recent years, the overwhelming problem stated in project completion reports is that the data required were not adequately collected or analyzed.

A number of Bank HNP projects have included components to strengthen health information systems, but these have tended to focus excessively on hardware and training, and not enough on increasing demand for, and the use of, information in decisionmaking. Strengthening borrower systems for the collection, analysis, and use of health information in policymaking is a long-term process. But progress can be achieved if sufficient attention and resources are mobilized during program design and implementation, including measures to strengthen incentives for M&E (see box 2).

Weak Intersectoral Coordination

With some notable exceptions, the Bank has not placed sufficient emphasis on addressing determinants of health that lie outside the medical care system, including behavior change and cross-sectoral interventions. The incentives and mechanisms for intersectoral approaches currently are weak, both within the Bank and in borrower governments, and intersectoral coordination can be difficult, so priorities must be carefully chosen. The Bank has a fundamental responsibility, however, to more effectively link its macroeconomic dialogue with sector dialogue, particularly on issues of health financing, the health workforce, and civil service reform.

Flexibility and Learning

Promoting health reform requires strategic and flexible approaches to support the development of the intellectual consensus and the broad-based coalitions necessary for change, but the Bank is still in the early stages of adapting its instruments to emphasize learning and knowledge transfer. System reform is difficult and time-consuming, and stakeholders outside ministries of health can determine whether reforms succeed or fail. This highlights the importance of realism in project objectives, strong country presence, stakeholder analysis, and a more strategic use of the Bank's convening role. While incremental approaches are arguably more appropriate, the Bank may have been excessive in its encouragement of dramatic, overly ambitious reforms.

Recommendations

The overarching recommendation of the review is that the Bank should not seek to do more, but to do better. To move in that direction, OED recommends the following measures.

Organizational Strategy

- *Enhance quality assurance and results orientation.* To improve portfolio quality, the HNP Sector Board and regional technical managers should continue current efforts to strengthen their role in monitoring portfolio quality, establishing mechanisms to provide timely support to task teams in project design and supervision. The HNP sector should develop standards and good practice examples for M&E, and increase staff training. But strengthening incentives to achieve results and to *use* information, both within the Bank and in client countries, is critical to enhancing borrower M&E capacity. Increased experimentation with and learning from performance-based budgeting mechanisms in Bank projects would be an important step.
- *Intensify learning from lending and non-lending services.* In light of the institutional challenges facing the health sector and weak institutional performance, the Bank should seek to establish appropriate tools, guidelines, and training programs for institutional and stakeholder analysis. This should include strengthening analytic work on major institutional challenges and providing flexible support to task teams facing difficult institutional problems.
- *Strengthen partnerships and increase strategic selectivity.* Achieving change in HNP requires effective partnerships with local stakeholders, international partners, and within the Bank. It also requires judicious use of limited resources. The Bank should select a few strategic areas for enhanced intersectoral coordination, including macroeconomic dialogue and health workforce issues. In client countries, the Bank could encourage communication and collaboration among government ministries, and between government and other partners. At the international level, the Bank could strengthen its partnership with WHO and other interested agencies to address such priorities as strengthening M&E and performance-based health management systems in client countries.

Policy and Practice

- *Increase emphasis on health promotion and behavior change,* including attention to information, education, and communication campaigns and the broader policy and regulatory changes essential to success.
- *Avoid overly complex project design* by combining an assessment of the capacity of implementing organizations with a greater effort to prioritize and sequence interventions.
- *Place a stronger emphasis on targeting the poor,* measuring HNP outcomes, and assessing the poverty impact of HNP policies and programs. More work is needed to analyze factors that lead to ill health among the poor and to select interventions that are likely to achieve the maximum impact on their overall disease burden.
- *Develop the intellectual consensus and broad-based coalitions necessary for change.* This requires an understanding of the political context of reform, the interests of the broad range of stakeholders, and facilitating increased "voice" for the community in the planning, implementation, and management of HNP programs.

Management Response

OED CONSULTED WITH THE HNP SECTOR Board throughout the study, including an intensive review of the draft synthesis report and policy ledger. Management has broadly endorsed the findings of the review, and the HNP Board has prepared an action plan to respond to the recommendations. The HNP Board plans to phase implementation, however, in light of the wide-ranging recommendations and constraints on staff and resources.

The World Bank Executive Board's Committee on Development Effectiveness (CODE) endorsed the analysis and recommendations of the OED study, and welcomed the collaboration between OED and the HNP Board. The committee noted that some of the issues highlighted are Bank-wide, and will require efforts beyond the HNP sector. While recognizing the need for a phased approach to the recommendations, it emphasized that strengthening borrower capacity in monitoring and evaluation must be given sufficient priority if results are to be achieved in the medium term.

►This *Précis* is based on *Development Effectiveness in Health, Nutrition, and Population: Lessons from World Bank Experience*, by Timothy Johnston and Susan Stout, Report No. 19266, May 1999. The following case studies are also available: Brazil (18142), India (19537), Mali (18112), and Zimbabwe (18141). Available to Bank Executive Directors and staff from the Internal Documents Unit and from regional information service centers, and to the public from the World Bank InfoShop.

People's Health Watch : Skeletal Framework

Overview

Given the profound on-going changes in global, national and local economies and societies, the concept of a Global Health Watch and the subsequent People's Health Watch emerged from various forums as a means to

a) independently and credibly monitor health inequalities.
b) promote the concept of health as a fundamental human right.
c) promote a more equitable distribution of health rights.
d) confront/dialogue with and hold governments, Ngos, and policy makers and health practitioners accountable.
e) explore credible ways of advocacy through adverse publicity, campaigns, censure and sanctions (suggestion).

Working definition

Tool that enhances everything that Community Health Cell and its partners do in terms of empowering people and communities to demand and access health as a fundamental right and to participate in health action as a responsibility.

Password : **Watch----Bark----Bite---Watch---etc.**

Communication Model

The basic components of the model are

Inputs ------Filtering/Processing------Outputs-----Feedback Loop---Linkages

Conceptual Core

Andrew Haines and his colleagues first proposed the idea of a Global Health Watch in 1993, as a means of monitoring the impacts of environmental change[1]. The idea for a Global Health Watch (GHW) was taken by the Ngo Forum for Health in May 1997 in Geneva after it came up again as an idea in a consultation of WHO with Ngos from all over the world on evolving a Global Health policy.[2] The concept was further developed by a small group of resource persons including RN of CHC and supplemented by an in house study of other watches by a department of WHO. The group met at various policy meetings to elaborate on the idea. Similarly, meetings were held in different regions. CHC hosted an Indian meeting in Bangalore.

The GHW was meant as a tool to "monitor the progress of WHO and member countries towards ***Health for All*** goals and ..other key health hazards and

[1] The *Lancet* vol 342, Dec 11, 1993, p 1464.
[2] Concept paper /initial stage of GHW.

problems"[3]. The GHW is modelled after similar frameworks used in the tracking of human rights (Human Rights Watch, environment and ecology (World Watch Institute).

As formulated in the concept paper the GHW was seen as "a body which can
a) respond to globalization from a positive perspective.
b) work against the negative effects (of globalization) on global, national and local health".

The Watch process was deemed necessary because of the following reasons (*Why?*)

- increasing ***disparities*** within/between countries in socio-economic and health indicators
- global environmental changes are adversely affecting health
- globalisation of trade/aid policies have serious implications for the health of poor and excluded groups
- the downsizing of public health systems/privatisation and user fees with crisis implications for the vast majority in the South.
- The series of UN summits/conventions promising "***Health for All by 2000***"
- The explosive growth of the global arms trade/intensifying racial/religious/ethnic pogroms/wars with "devastating health consequences"[4].

The **Objects** of the Watch process (*What?*) include

- *Equity* between/within countries and between/within social, cultural and geographical divisions
- National Health commitments to primary care/the adequacy of health budgets/viable training/placement of health workers.
- International health policies of agencies like the WHO, UNICEF, World Bank, WTO and their impacts on poor communities.
- Policies focussing on environmental pollution/alcohol & tobacco/pharmaceuticals/bio-technology/weapons industries.
- The impacts of wars/disasters/ and the ***effect of responses*** such as embargoes/sanctions/'relief activities'.[5]

Contributors to the Watch process *(Who?)*

- ***People and communities***.
- Ngos working with poor and excluded communities

[3] Supporting WHO's GH policy process.
[4] Reflections on a Global Health Watch. RN
[5] See footnote 4.

- National, regional and international, ngos, networks/associations providing data on regional diversities/disparities and intersectoral issues.[6]

Focus of Monitoring and Reporting

GHW is meant to monitor and report

- Development/implementation of policies which promote/protect health directly/indirectly
- Implementation of health related human rights
- Performance of governments
- Progress towards "Health for All".

Key Focus of People's Health Watch

Evolving from GHW, the idea of a ***People's Health Watch*** (PHW) emerged out of CHC's reflections on its involvement in the **People's Health Assembly**, process in India, leading up to the Jana Swasthya Sabha in Kolkata and the People's Health Assembly held in Dhaka, in December 2000. The strategic core of the evolving PHW idea consists of the following:

- A primary focus on People's Action
- Facilitating direct people/community generated inputs and people's/community access to information and data.
- Emphasis on direct and meaningful people/community participation in reporting/monitoring and holding accountable of local, regional, national and international actors and institutions
- a process of "Watch-Bark-Bite" within the many layered institutional arena of health.
- It seeks to meaningfully empower people and communities to act as self-conscious and well-informed agents in the shaping and practice of health .

The PHW could ultimately evolve into an initiative that includes much of what the GHW idea included. The impetus for the change of name was inspired by PHW's emphasis on one specific aspect that tended to get disregarded or inadequately addressed in most initiatives, namely the focus on **people's action** at the community or other levels. This was somewhat true even in the PHA. Even though an effort was made consciously to focus on people's action the tendency was to privilege networking between ngos/activist academics and policy researchers.

[6] See footnote 4.

Instrumental Structure

The PHW will operate as

- a web-based information sourcing, filtering/processing and broadcasting system.
- PHW will actively incorporate the most effective of the range of emerging information and communication technologies. Examples: web-broadcasting, community radio, net-conferencing, wireless technologies, mobile phone based audio-visuals, community information/alternate technology-resource centers, liquid crystal display bulletin boards.

Data[7] Collection

Key words:

- Authenticity/credibility
- Objectivity/Autonomy
- Reliability/validity
- Sources
- Agents/Inclusiveness/(rmps?/compounders)
- Education/training for data collectors.
- Translation from/into local languages

Data Processing

Key words:

- ***Inputs/Processing/Outputs/Feedback loop***
- Translate from vernacular.
- Active/Passive reception/broadcast
- Decode/Translate/Demystify
- Direct Uploads/Automatic Alerts
- Measure/Monitor/Question/Evaluate
- Interpret/Verify
- Audit/Account

Data Types

Key words:

- Drug Policy/Health Budgets/Health Policy
- PHCs/CHCs/Emergency Services
- Communicable diseases
- Non-communicable diseases
- Patents/Licensing/Pharmaceutical companies
- Drug testing and approval

[7] Data here refers to any subject , material , information, etc. that is relevant to PHW.

- Insurance/User fees/taxes