NGO FORUM FOR HEALTH

— partnering to make health a reality —
— promoting equity and justice in health care —

(5)

(1)

GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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NGO FORUM FOR HEALTH

— partnering to make health a reality —
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1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2)

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

* Marked differences present in health status :
* The poor, the majorities, the women have less access
  in absolute terms (no health centres)
  in terms of poor utilization (poorly staffed health centres)
  in terms of purchasing power (cannot afford it)
* The rich too have a problem – risk to life & good health because of over-supply!

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

The main tactic is of accepting on paper & translating much of it in a reformulated way into schemes & then to blame failure on administrative gaps & people's resistances & use failure to justify further retreat of the state. Govt has remarkable ability to incorporate all criticism @ these 3 levels – semantics of statements, tactical reformulation; implementation failure!

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

Many : I would like to focus on the phenomenon of state health infrastructure being underutilised / wasted & utilised to grow a corrupt 'commercialised' pvt. sector.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

Both

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

c) What about the accuracy and transparency of Government data?

Need to comment on it source by source. The more important an indicator is as target — the less reliable it may be. At least IMR, MMR is unreliable !

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

Primary collection is a MUST.
We need to generate studies thro' an informed network.

e) How is it possible to gain access to this data?

Since most of this is 'sensitive' by law/ privileged,
One should use both 'legal means' & "sources" as part of worked out action.

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f) How will it be possible to verify if the data is reliable and accurate? (4)

Cross-checking ± primary data from select areas.

g) Is there a need to protect sources and is so how?

h) Who would monitor the data and how?

i) What are the cost implications?

Primary data costs! One way to justify it is link it to health intervention.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

- Without mobilization of the affected, one cannot make an impact. Advocacy if effective, more if the threat of mass mobilization exists!

b) How can these issues be taken up?

- To mobilize & mass action on people's action. Policy changes need to be linked to helping people safeguard their health

c) With whom should they be taken up?

- With politicians, bureaucrats & health professionals
- With & thro' local action.

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d) What is the likely impact of such initiatives?

(5)

Depends on what percent we mobilize.
At 2% we would be heard } % of people who would
At 20% change may occur } be sensitised to this

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

b) What different roles could they play?

5. ORGANISATION

a) How would a national watch be organised?

Let it be a health watch network with some autonomous bodies accredited by WHO / NGO to play certain critical roles (like in disease surveillance)

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NGO FORUM FOR HEALTH

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b) What should be the structure?

Two aspects — Autonomous funded institutions; Network of people's movements & NGO groups

The need for institutionalisation vs the need to retain the activist spirit

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

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

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

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

(*) The whole dimension of Watching 'Medical Profession & even Medical Science' has been missed. The shaping of medical ethics & the medical practice needs to be monitored.

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b) What should be the structure?

A steering group which represents geographical areas of the country — important that it does not get cut off from the NGOs it would speak for

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

Should be close communication, information & ideas going BOTH ways

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

Stronger networks — a website for NGOs where we can keep abreast of/ share our experiences, needs, ~~etc~~ concerns etc.

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

Appropriate donor organizations & perhaps also funding from the right kind of business / industrial groups in the country

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

No specific suggestions beyond networking with groups who are involved with these issues

7. ADDITIONAL POINTS

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Feedback to the basic units of such a group is critical — & some mechanisms for constant, rather than an intermittent, flow to & fro.

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GLOBAL HEALTH WATCH

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Rajaratnam 6/10/99 438

1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

a) What are the inequalities and inequities in health in your country?
Consider, for example:
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- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

- Tribal populations are disadvantaged.
- Interior and isolated areas are often underserved.
- Women do not seek help because often only male doctors are available.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

There is a desire and plan to implement. However when plans are made subtle changes are gradually introduced over time resulting in an insignificant real achievement

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

There are regional ~~imp~~ imbalances. Corruption is universal. In Southern State of India, there is generally better services. Planning & supervision is better. As one goes northwards the commitment is less. The ~~WC~~ North - South divide in health care is quite visible..

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

- Idle time in PHC & one high.
- Absent doctor PHC -
- Pattern of unfilled posts - more in periphery

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

~~Staffing pa~~

→ Rural Health Bulletin.

→ State level report

c) What about the accuracy and transparency of Government data?

- Very often under reporting -
- Sometimes data is just made up.

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

Primary data collected on a sample basis periodically with rigid supervision would be better than just existing data.

e) How is it possible to gain access to this data?

It is not easy.
Special approved broad research could incorporate such data

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f) How will it be possible to verify if the data is reliable and accurate? (4)

Cross checks and verification mechanisms have to be developed
Focus on one or two important areas rather than a large no.

g) Is there a need to protect sources and is so how?

Classify data as common property and confidential data. Common property data may be freely published

h) Who would monitor the data and how?

Special research team
NGOs programmes with capacity -
It has be an individual / organisation that is outside the govemt hierarchy -

i) What are the cost implications?

- Depends on design.
- Staffing
- Travel.
- Analytical
- Reprint cut
- Dissemination.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

- Media
- Focused conferences.
- Concerned officials
- Raise questions in legislature through representatives

b) How can these issues be taken up?

- Participate in policy making bodies in national/State planning Commissions
- Articles / Special programmes in the media
- School / college competitions.
- Community group meetings etc.
- Scientific articles in leading journals.

c) With whom should they be taken up?

- Concerned officials.

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d) What is the likely impact of such initiatives?

(5)

There will be some response if presented in a diplomatic and proactive manner rather than just be critical.

e) Is there a need for alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes. It could be considered as a National Health/Management Information System.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

→ NGO's with capable infrastructure
→ Selected Grass Organisations.
→ Interested individuals.

b) What different roles could they play?

NGO who are interested in this area can Network on an equal partnership manner.

5. ORGANISATION

a) How would a national watch be organised?

→ Initial mutual network of interested individuals and organisations
→ Periodic meetings of individuals.
→ Discuss issues & problems
→ Allow the key outputs to gradually evolve.
→ Involve and invite key policy makers to meetings.

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b) What should be the structure?
Initially informal
Later formal may be registered.

c) How should it relate to a global health watch?
Whatever happens to India will have a global impact

d) How should the capacity of national and local NGOs from the South be strengthened? Describe relevant data collection process.
- Value of data - accuracy of data that is timely.
- Data handling mechanism
- Management Information System -
- Advocacy role.

e) How can a wide, sustainable and independent funding base be maintained?
- It has to be private funds.
- If Govt. can participate it will be useful. especially in supportive research.
-

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?
If in India NICNET could link up with all available sources of data it would be helpful
A web site for the National watch

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?
- There is generally a large volume of data collected.
- It is necessary to provide a value in ~~data~~ sharing data that is not confidential.

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NGO FORUM FOR HEALTH

Amar Jesani

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I. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

a) What are the inequalities and inequities in health in your country?
Consider, for example:
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race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

- There are structural social, economic & political inequalities in India. Class, caste, gender, ethnicity & religion, sexual orientation etc. are all present. & also impinge on health
- Socio-economic & geographic differences in:

  Health indicators – Yes
  Access to health care – Yes
  Resources spent on health care - Yes.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

India is signatory & participants in many or most international covenants, declarations & conferences.

However:
(1) In some such instruments, India has refused to sign protocols for operationalising some accountability.
(2) All such commitments are not translated in formulation of policies.
(3) Policies are not translated in legislations which give power to people to seek redress.

Thus, international commitments are not met or fulfilled.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

All above factors are compounding inequalities.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

- Most of these inequalities are obvious - experienced on daily basis.
- Bringing out cases, analysis of statistical data, media reports, religious, social & cultural norms etc could be used to show that.

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

We have numerous sources of data, but each one has its deficiencies, limitation & lack of standardisation. However, they could be well used to show inequalities. Some of them need more analysis. Some macro & micro data need to be collected from time to time.

c) What about the accuracy and transparency of Government data?

Accuracy & transparency of Govt data is low in some cases but not in all. Another problem is access to such data. The access is becoming more difficult.

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

Both need to be done.

e) How is it possible to gain access to this data?

- We need to campaign on two aspects: (1) Right to access to data ~~data~~ in public, NGO & private sector (2) Demand that research findings must be published.
- An effort is needed to create time series & vast data base in electronic format.

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f) How will it be possible to verify if the data is reliable and accurate? (4)

- Data on cases & calamities need to be locally verified
- Comparing data with smaller local survey & qualitative data
- Mechanism is needed to control fraud, doctoring, distortion etc. in data system & research

g) Is there a need to protect sources and is so how?

- Yes, when data are of survey & studies, the participants need to protected. That is ethical requirement
- Researchers & institutions need to be protected from plagiarism & misuse of their data & studies.

h) Who would monitor the data and how?

- Nobody should control data - they should be accessible to all.
- All concerned need to monitor data

i) What are the cost **implications?**

This depends on what & how big a task we are setting.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

The first priority should be public sphere. It must find credibility & support from public at large. That would also provide more strength in dealing with policy makers.

There is no limit or restriction on fores where it could be taken up

b) How can these issues be taken up?

- Campaign - public. - Educational / confrontationist / use of courts etc.
- media exposures - print / electronic etc.
- Education institutions & training centres / meetings / conferences
- Publications

c) With whom should they be taken up?

(1) Public at large.
(2) Professional association.
(3) Judiciary
(4) Govt. functionary & policy makers

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d) What is the likely impact of such initiatives?

- Varied - small successes & big disappointments are common.
- So to work with long term strategy

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

This could be one of the ways provided:

1. NGO creates a system of information on ~~their~~ the subjects of their interest
2. Their reports & data are accurate & validated

3.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

There are many groups & NGOs - there is no dearth of them - But what is required is interest, commitment, time & resources for such work.

b) What different roles could they play?

✓ Providing information + research data, field data, Cases & case studies
✓ Analysis & interpreting data keeping in mind main issues for monitoring
✓ Dissemination of information - publication, media etc
✓ Campaigns & advocacy.

5. ORGANISATION

a) How would a national watch be organised?

- One organisation need to make commitment to act as anchor, coordinator & run the secretariat
- Ideally it needs to emerge from a national campaign. Or a campaign would coalesce a committed group of individuals & organisation.

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b) What should be the structure?

Difficult to envisage at this stage. It is better to begin with an adhoc committee.

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

- National watch should be completely independent & should decide its own agenda, orientation & method of work.
- Watches from developed countries should be primarily watching their own countries & not other countries.
- Reciprocal support system should be worked out

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

- By making them independent financially & organisationally
- Sharing & solidarity among Watches from the south

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

- Who could provide corpus fund & that could be supplemented by resources raised locally.
- Some of the tasks could be taken up as projects & could be separately funded

6 All the above questions have been related to a health watching network. Do you have any suggestions of how a network can also feedback on global economy, trade, policies and projects that affect National policies? ie South-North dialogue

6. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

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NGO FORUM FOR HEALTH

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GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
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- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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NGO FORUM FOR HEALTH

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1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

I am answering this from the perspective of our work on rural F's health — the general answers are well known & obvious, so will not belabour them

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health **care**

Absolutely, & the gaps are growing to an extent that is not even fully recognized.
Women & the poor.
Our health indicators are scanty & suspect

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

Not at all except for token responses to Cairo — & even the programmes agreed to are suspect to the extent that they are donor driven
Even to the extent that there appear to be responses to these commitments, the ground realities are very different

eg Target Free policy VS what happens at grassroots

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

Private sector is developing a stranglehold on the health care system, even at prim. care level. Corruption at all levels in govt. services, lack of accountability to community, & the communities' lack of organization, awareness are problem

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

Collect all good studies & data — micro/macro

If poss. design ~~a~~ data collection by the Watch - could be through existing groups

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

c) What about the accuracy and transparency of Government data?

↓ Poor ↓ Non existent

Need restructuring of data collection/monitoring mechanisms

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

Both - especially some method of cross-checking accuracy of existing data.

e) How is it possible to gain access to this data?

?!

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f) How will it be possible to verify if the data is reliable and accurate? (4)

See (d)

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

h) Who would monitor the data and how?

i) What are the cost implications?

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

- Community is the most important
Then all the further levels – state + central govt, NGOs, media of all sorts, donors

b) How can these issues be taken up?

c) With whom should they be taken up?

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d) What is the likely impact of such initiatives?

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

b) What different roles could they play?

5. ORGANISATION

a) How would a national watch be organised?

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b) What should be the structure?

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

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

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

6 All the above questions have been related to a national watch [illegible] watching nationally. Do you have any suggestions of how a [illegible] watch can also feed back on global economic [illegible] and projects that affect national [illegible] ie South-North [illegible]

~~6~~7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

RETURN TO: ~~Dr.~~ Eric Ram at the address below
D, R[illegible] CHC

Page handed in separately

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GLOBAL HEALTH WATCH

COUNTRY STUDIES

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NGO FORUM FOR HEALTH

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1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2)

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

(BS) Serious inequalities exist with regard to health status, and availability of ~~access to~~ health care resources. But so far very little attention has been shown on inequity in access to quality of care.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

There is no national or state level health policy that reflect adequately govts' commitment to international agreements. We are good rate for

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

Corruption in public hospitals is very high. Corruption in private sector is also very high. This occurs largely thro' referral systems within private system. Whereas in public system, it occurs often thro' outright extortion of money from patients and thro' misuse of 'official' work-hours and public resources

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

I would emphasise district level collection of mortality and morbidity data on most common illnesses (5 or 6), extent of financial burden on those seeking primary care from public and private sectors.

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

We need to undertake very large scale primary surveys to reflect extent of inequities and to address them in a more meaningful manner

c) What about the accuracy and transparency of Government data?

very poor. It is inadequate and unreliable; in fact Most Govt officials do not even know the data available in their own office!

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

Census data at village + district data have not been fully examined. They can throw much light on access to care. But Collection of Primary Data is a MUST"

e) How is it possible to gain access to this data?

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f) How will it be possible to verify if the data is reliable and accurate?

(4)

Data collection methodology and methods of analyses should be transparent & should be open to public.

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

Sources should be protected from misuse. Checks must be built-in at district & local-level to ~~ensure~~ prevent contamination and misuse of data.

h) Who would monitor the data and **how?**

Data collection, and analysis may be assigned to independent research organization.

i) What are the cost implications?

a separate budget for research (as part of health planning) at state-level and district-level should be set aside.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

at local ~~[illegible]~~ governmental (PRI) level.

b) How can these issues be taken up?

c) With whom should they be taken up?

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d) What is the likely impact of such initiatives?

(5)

likely to be substantial

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

An independent research forum could be created. this should be funded by various stakeholders, who will require such information ~~for addressing~~ in performing their roles (such as advocacy, dissemination, etc)

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

PRI, and other stakeholders at district level

b) What different roles could they play?

District level watch could best play their role in collection and monitoring. They can also be involved in District Planning exercise. Media can/should use such information for dissemination.

5. ORGANISATION

a) How would a national watch be organised?

What ever be the structure at national level / state level, we must ensure that issues at village / town level can be effective by taken up and followed at/by the local govt / representatives

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b) What should be the structure?

Village Panchayat — District — State — national

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

By having National Health Watch represented in Global Health Watch

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

First, NGO, must enhance their own credibility. ~~[illegible]~~ They must now more willingness to collaborate with themselves. There is at present a high level of unhealthy competition amongst them. Their

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

collective capacity to play a true role cannot be enhanced unless the unhealthy competition and mutual suspicions are addressed

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

The National Watch should be invited to participate in National Health Policy making process, as in N-S dialogues etc.

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

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1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2)

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Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc. — yes:
- are there socio-economic and geographical differences in access to health care — Yes
- are there socio-economic and geographical differences in the resources spent on health care — Yes.

Arising from caste, class, community and region, and gender.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

Is the WHO fulfilling its obligations?
The Indian State has forfeited its responsibility in respect of health care — Total failure on all fronts where health is concerned.
Paradigm of development ignores/addresses concerns of health

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources

(3)

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist? System of data Collection must should be sensitive non-existent
↳ to determinants of health

b) Which sources of data and information in your country can be used for monitoring?
decentralized & sensitive Collect data at the primary level.
Aggregated Data

c) What about the accuracy and transparency of Government data?

Transparency of Government data
could lead to verification/accuracy.

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

e) How is it possible to gain access to this data?

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f) How will it be possible to verify if the data is reliable and accurate? (4)

g) Is there a need to protect sources and is so how?

h) Who would monitor the data and how?

i) What are the cost implications? cheaper to have system of in place;

3. ADVOCACY

a) Where can questions of inequality in health be taken **up?**
Communities be made aware of this at all levels, Legislature, etc-

b) How can these issues be taken up? Through media, litigation, awareness Campaigns- → legal languages.

c) With whom should they be taken up?
NHRI, human rights groups
YMCAs- + other social action groups + Trade Unions,

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d) What is the likely impact of such initiatives? (5)

would shape opinion & build up pressure to influence State policy.

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

Human rights & Social action groups: NGOs, Trade unions;

b) What different roles could they play?

To highlight different perspectives in respect of Health issues.

5. ORGANISATION

a) How would a national watch be organised?

With representation of women, human rights, medical and social action groups and also from legal profession & the media.

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b) What should be the structure? Formal, with a Constitution, with a General body electing office bearers

c) How should it relate to a global health watch? By Autonomous body but

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

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

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

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NGO FORUM FOR HEALTH

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GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

(i) Rural - Urban
(ii) Paying Capacity (Created by System of graded services)

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

No!

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health **resources**

Acceleration of inequity due to Stratification of Services as a result of Neo-liberal shift in Dev. ~~Paradigm~~ Perspective and SAP and TRIPS.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

- Fees structure of various services available in a given habitat
- Adequacy of equipment and competence of staff and its link with fees structure.

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

N.S.S. data is relatively accurate Existing data system is inadequate to address the above.
Grate amount of "inferences" have to be done to exist?

c) What about the accuracy and transparency of Government data?

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

Both

e) How is it possible to gain access to this data?

Investment in terms of Time, Energy and money.

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f) How will it be possible to verify if the data is reliable and accurate? (4)

Gut feeling

g) Is there a need to protect sources and is so how?

h) Who would monitor the data and how?

i) What are the cost implications?

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

Media ; Legislatures ; Local Bodies
Professional Associations

b) How can these issues be taken up?

(i) Fellowships for Journalists
(ii) Starting feature Stories
(iii) Questions in Parliament ; Assemblies, Zila Parishads
(iv) Website and e-mail campaign.

c) With whom should they be taken up?

Members of Parliament ; Assemblies
Editors and Bureau Chiefs.

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d) What is the likely impact of such **initiatives?**

Public Attention leading to pressurise policy makers

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes. But it should not be progerative of NGOs alone. Professional Associations and Mass organisations affiliated or non-affiliated to Political Party.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

o - Community Health Departments in Univ.s & Medical Colleges
o - Social Work Departments in Universities.
x - Field Groups; their networks - Intermediary Support orgn.s.
x - Anganwari Workers Unions
x - Panchayat Sec. Unions - Patwari Sangha

b) What different roles could they play?

- Accessing info. x o
- Consolidating info o ☑
- Analysing info. o ☑
- Repackaging info o ☑
- Disseminating info x o ☑

5. ORGANISATION

a) How would a national watch be organised?

As an non-institutionalised Platform of various actors working on principles of Shared Responsibility

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b) What should be the structure? ↑ Core Group ↓
↑ Advisory Group ↓
↑ Consultative Group ↓
Forum Of Participating Organisations

c) How should it relate to a global health watch?
Affiliation with autonomy

d) How should the capacity of national and local NGOs from the South be strengthened?
By sensitizing field organisations about criticality of information – equip them to handle info. National and S.O.s should support their efforts

e) How can a wide, sustainable and independent funding base be maintained?
Multiple sources and broad base of recipients.

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

Critiquing and giving feed-back to Global Watch on their activities. Keeping Global Fraternity apprised of National issues

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

Health Watch shall not be constrained by official Charters and shall not be accountable ~~for~~ to any multilateral agencey.

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IIMB
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Attn: Dr. Ravi Narayan,

Sub.: Global Health Watch Questionnaire

From: Prof. Gita Sen Gita Sen

System, the Directorate General of Health Services and the International Institute for Population Sciences (NHFS). National level statistics allow us an overview of state variations, urban-rural distributions and, to some extent, differences between economic categories and across gender. But the full extent of inequalities can be appreciated only through micro studies which actively seek to record - and understand - them.

c) What about the accuracy and transparency of Government data?

Government data is not always accurate nor are the processes - and limitations - of data collection transparent. But it is something that we have to work with.

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

An alternate national data set would be great but would it be possible? Also where is the money for such an exercise to be found? In such a case, it might be useful to do smaller studies that can validate the findings of larger studies on a few indicators.

e) How is it possible to gain access to this data?

Government data is available in all major libraries. Smaller studies - especially those done by NGOs - are more difficult to access since they are poorly distributed.

f) How will it be possible to verify if the data is reliable and accurate?

By comparing the findings of smaller studies (with sound methodologies) with relevant sections of the national data? Or by working out independent and theoretically sound estimates?

g) Is there a need to protect sources and if so how?
h) Who would monitor the data and how?
i) What are the cost implications?

3. Advocacy

Questions (a) to (e) should be discussed in the meeting

4. Partners

Questions (a) and (b) should be discussed in the meeting

5. Organisation

Questions (a) to (e) should be discussed in the meeting]

6. Suggestions of how a National Watch can also feedback on global economy issues and projects that affect National Policies, i.e. South-North dialogue - to whom and how? &
7. Additional Points

[Should be discussed in the **meeting]**

Global Health Watch Questionnaire

1. What are the inequalities in health in your country?

a) What are the inequalities and inequities in health in your country?

Inequalities are apparent in almost all facets of health and nutritional status, as well as health outcomes and health care. There are gross variations in mortality, morbidity, life expectancy and health care utilization across regions, urban & rural divides, caste and class. Caste, class and history interface with gender in crucial and complex ways. So the intricacies and the manner in which inequalities are lived out are better understood through a gender analysis of health and health care.

b) Implementation of treaties, conventions, plans of action, etc. Is the government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing, etc.

In the case of the ICPD, the Indian government's commitment to promote reproductive health has led to a flurry of activity on the part of multilateral funders who have been working with the government on the shift from the erstwhile Family Welfare Programme to a Reproductive and Child Health Approach. Such a shift has occurred but the pace and process of change has inevitably been slow and somewhat checkered. Above all, there is a paucity of knowledge about what the ICPD has meant in terms of population policies and women's health. As far as I know, there is little documented evidence of women demanding a fuller range of reproductive health care services.

A problem that is bound to limit the efforts of even those governments that are serious about implementing the sentiments of international agreements stems from the disparate character of the health care services. India does not have a health care system: there is an absence of holistic planning involving the public and private sectors, there is no unifying framework of regulation & financing and a non-existent referral system. Implementation of the POAs of international agreements is mainly in the public health services which is not the dominant sector in health care.

c) Specific examples where these inequalities are being compounded by other factors such as activities of private sector organisations, corruption and inefficiency in health management, etc.

2. How would you measure these inequalities

a) How would you show that these inequalities exist?

Disaggregated data, comparative perspectives and narratives of those who are in a position to access so little

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

We have to build a foundation on whatever exists by way of national data sets like Census figures as well as data of the National Sample Survey Organisation, the Sample Registration

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GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

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- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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I. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2)

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

All Answers are in attached sheet

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

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

c) What about the accuracy and transparency of Government data?

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

e) How is it possible to gain access to this data?

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f) How will it be possible to verify if the data is reliable and accurate?

(4)

g) Is there a need to protect sources and is so how?

h) Who would monitor the data and how?

i) What are the cost implications?

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

b) How can these issues be taken up?

c) With whom should they be taken up?

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d) What is the likely impact of such initiatives?

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

b) What different roles could they play?

5. ORGANISATION

a) How would a national watch be organised?

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NGO FORUM FOR HEALTH

— partnering to make health a reality —
— promoting equity and justice in health care —

(1

GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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Received 23/9/99

NGO FORUM FOR HEALTH

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1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(4

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

* The economically backward
* Rural folks
* urban slum dwellers
* where focus is exclusively on RCH, men do not receive adequate care.
* The backward castes are worse off in all the above.
* The tribals.
* The elderly (v. less services; no sponsored care; no insurance; little savings to fall back on.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

No.

* If this was so - our health system spelly. public health system would not be in such a deplorable stage & state..
* The government is trying - but efforts are v. inadequate - e.g. GDP spent on health -
* RCH is an effort - but implementation is very slow, disjointed, ill planned -
* Literacy-efforts useful in most parts - spelly - where there is a need to do qn - East-Central etc (BIMARU)

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

Yes - In all states possibly.
- Corruption in Govt-sector - is one bane
- Inadequate & untimely release of promised funds - puts all programmes in jeopardy
- Pvt. sector efforts are few, localised often lack credibility & are not on scale.
- Public expects Govt. to take care of all its health needs - there is no sense of participation or by ("self effort") for ("self improvement")

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?
- By studying per capita expenditure in different areas - rural/urban; tribal-non tribal; male-female.
- By studying morbidity, mortality rates in diff. groups
- By " - health related indices - literacy, housing, env., etc.

^5

b) Which sources of data and information in your country can be used for monitoring?
- Health statistics from - "Smaller groups" -
- (Census for baseline)
- Sample - health data collected regularly by Govt. (SRS, etc.)
- Sentinel centres data

c) What about the accuracy and transparency of Government data?
- very variable
- Need many checks - & cross-verification

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

There is a need for primary collection but keeping in mind the size, distribution - it has to be sample/sentinel based.

e) How is it possible to gain access to this data?
- By asking Govts./NGOs - to be open & transparent.
- By requesting the funding agencies to seek these data

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f) How will it be possible to verify if the data is reliable and accurate? (4)

- Regular monitoring
- spot checks
- Evaluation -
- Sample surveys.

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

Yes - or else data maybe withheld.

h) Who would monitor the data and how?

- Has to be non-Govt. - as a lot of basic data is collected by Govt.
? NGO - ? vol-sector agencies - but there def^{n}. is a lack of adequately trained manpower for this.

i) What are the cost implications?

- Monitoring | Evaluation never comes cheap!

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

- At all possible forums → Govt | non-governmental -
- At every opportunity - spclly. in (health, education, environment, Watsan, etc..)
-

b) How can these issues be taken up?

In writing; In discussions — In meetings (forums).

c) With whom should they be taken up?

All Govt. representatives - spclly. those on top.

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d) What is the likely impact of such initiatives? (5)

The results of advocacy - are immeasurable before any major commitments / expenses

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes - Definitely - these are likely to give more accurate & realistic pictures.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

1) Recognized, "reliable", "reputed" NGOs.
2) Quasi-Govt. / industry sponsored Institutions
3) Training institutions - colleges ← medical, social, nursing, etc.

b) What different roles could they play?

- Based on their expertise / capabilities / manpower.
- There is a tremendous need to enhance the M/E skills of these personnel in these orgns.

5. ORGANISATION

a) How would a national watch be organised?

Through a network of "elected, selected, involved agencies" each working in designated areas and geographic regions.

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b) What should be the structure?

(6)

Depends upon involved agencies.
-Should be coordinated by a non-Govt. person/agency. Govt. to participate - just like any other agency of at all.

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

Has to be a part & parcel of it -
"In the coming millenium - "global" - will not have the same connotation - because of easier comm", & the cutting short of distances.

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

By inculcating in them a pro-advocacy role - as envisaged for all activies as given in HFA) strengthening capacities & proving M/E skills.

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

Obviously through CONTRIBUTIONS.
Funding though easier always carries a tag the "Tag" of the donor's wishes.

6 All the above questions have been related to a global watch [illegible] taking individually. Do you have any suggestions of how a global health watch can also feedback on global economy, trade [illegible] and projects that affect N and [illegible] ie South-North dialogue

6. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

* 2000 - will be a unique year - the convention / Rights of children & so many other goals have to be met by then - Global H-watch should give serious thoughts to these & their fulfillment and assure that words get converted into actions. It calls for sacrifices, leadership role, commitment & concern for mankind as a whole & for the disadvantaged in particular.

RETURN TO: Dr. Eric Ram at the address below

Dr. Ram's copy - CHC

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International Centre
For Health Sciences
(Manipal Hospital Unit)

MANIPAL
HOSPITAL

Dr. Pankaj Mehta
MBBS., M.D.
ASSOCIATE DEAN
PROFESSOR, HOD
COMMUNITY MEDICINE

3

19/9/99
Calcutta.

Dear Ravi,

I reached here today afternoon. Have filled the Questionnaire - but was not able to do full justice. Am leaving early tomorrow for Nepal.

Hope things go well with the workshop.

I travelled with the Proshika team - and spent some time discussing with them. They were taken good care of at Manipal.

Regards,

Pankaj

RN
24/9

391
23/9/99
23/9/99

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NGO FORUM FOR HEALTH

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— promoting equity and justice in health care —

GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
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- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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I. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

- Based on caste; gender; rural-urban location and diversely commensurate to the autonomous state in a federated structure – states vulnerable to cross border terrorism, migration and insurgencies are worse off
- Resources spent on health care are also dependent on how monetised the day-to-day economy is. While people in Rajasthan may spend thousand to save a life, people of similar class would give up after a couple of hundred rupees in rural Assam.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

An unambiguous 'no'; but am not sure if it should be trying to meet the targets which have often been signed simply to appease pressure groups.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3

- by the media explosion highlighting cures available, which often lead to peer pressure for saving lives at the cost of future hunger for the family.
- the dichotomy of all management structures being a secular western phenomenon that need to be placed in societies held together and working through socio-religious mechanisms

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

- Qualitative studies, case studies.
- Imaginative analysis of existing data

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

- govt data.
- NGO data (national/international)
- occasional cross sectional 'topical' data.

c) What about the accuracy and transparency of Government data?

- Very suspect if picked up from one source alone however, it remains one of the best methodological source and may need impressions

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

- Govt infrastructure for info collection can be improved.
- Primary collection occasionally to cross-check government data.

e) How is it possible to gain access to this data?

By partnership with the government.

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f) How will it be possible to verify if the data is reliable and accurate?

(4)

Cross sectional cross-checking + statistics as by representative sampling.

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

If so,

h) Who would monitor the data and how? A parallel monitoring group which can collate and verify existing data, or undertake "cross-check" studies.

i) What are the cost implications? Surely many, but by using NGO sector areas, & resources for carrying out surveys, costs can be curtailed.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

- Public fora
- Media
- Govt-NGO interactions

b) How can these issues be taken up? - after collating & analysing data

- Publication / Announcement
- NGO / ~~&~~ community group meetings
- ~~Before~~

c) With whom should they be taken up?

- Govt
- Public / community groups.
- Main political parties before Election time.

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d) What is the likely impact of such initiatives?

- keeping govt health info system on its toes (5
- watchdog on different types of policies that may have health implications.

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

NGOs — grassroots
research NGOs
persons with professional capabilities & outside govt/political parties

b) What different roles could they play?

- provide data on health status
- feedback on implications of economic/agricultural policies on health
- dissemination for wider debate.

5. ORGANISATION

a) How would a national watch be organised?

a central secretariat with regular and meaningful interaction with state based, civil society organisations. Special emphasis on those states not in good communication facilities

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NGO FORUM FOR HEALTH

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b) What should be the structure? International Secretariat (for collaby & organisn)
Autonomous National secretariats.
NGO networks ↑ NGOs ↑ Civil Society ↑ Individuals

c) How should it relate to a global health watch?
Political Expediency in non-democratic state may demand announcement made from foreign soil. Global watch for global issues & global advocacy.

d) How should the capacity of national and local NGOs from the South be strengthened? Capacity building for:
- Research & ideas
- communicate facilities
- reference (libraries/web based info etc)

e) How can a wide, sustainable and independent funding base be maintained?
- Independent fund-raising.
- Tie-ups with UN organisation for % age of funds allocated to the organisation

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how? ~~with~~ dialogue & International organisation; & Media cell for highlighting issues.

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

There needs to be an emphasis on constructive criticism, impartial conduct in analysis/a parity, and regular interaction & national GOs as well.

RETURN TO:

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JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067

26/9/'99.

Dear Ravi,

The questionnaire is rather difficult. Perhaps I could complete it in B'lore?

Sorry for the delay, but I tried!

Regards,

Mohan

RN
2/10/99

419
1/10/99 Recd. by courier on 1/10.

1/10/99.

GRAM : JAYENU TEL. : 610 7676, 616 7557 TELEX : 031-73167 JNU IN FAX : 91-011-6165886

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GLOBAL HEALTH WATCH

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Telephone number: N. Delhi 110 067
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— promoting equity and justice in health care —

I. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

1) Regional
2) Rural - Urban
3) Class and gender

While data on health inequalities by region and rural-urban residence are available, there is very scanty data on health inequalities by socio-economic groups.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

Health inequalities are being widened under the structural adjustment programme

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

Through data generated by governmental institutions, whatever be their limitations

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

Annual Reports, Publications of CBHE, NNMB etc.

c) What about the accuracy and transparency of Government data?

Although there are problems with reliability, the more serious issue is the need for systemic data; ad hoc studies are inadequate.

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

In addition to analysis of existing data, there is a need to strengthen the existing system and refine it.

e) How is it possible to gain access to this **data?**

The govt publishes the data albeit with a time lag.

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f) How will it be possible to verify if the data is reliable and accurate? (4)

Through internal consistency checks, thro data on time trends and not by ad hoc studies

g) Is there a need to protect sources and is so how?

h) Who would monitor the data and how?

Academics, researchers, policy-makers and activists.

i) What are the cost **implications?**

I would suggest that neglect of the system of health information, relying on ad-hoc studies, has been more expensive.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

There are political issues, to be discussed in all fora.

b) How can these issues be taken up?

c) With whom should they be taken up?

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d) What is the likely impact of such initiatives?

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

Our Centre would be involved. I would personally also be involved

b) What different roles could they play?

Design and analysis of studies.

5. ORGANISATION

a) How would a national watch be organised?

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b) What should be the structure?

(6)

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

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

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

6 All the above questions have been related to e.g. [illegible] National working nationally. Do you have any suggestions of how [illegible] watch can also feedback on global economic issues [illegible] and projects that affect National policies ie South-North [illegible]

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

RETURN TO: ~~Dr. Eric Ram~~ Dr Ram at the address below

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NGO FORUM FOR HEALTH

— partnering to make health a reality —
— promoting equity and justice in health care —

GLOBAL HEALTH WATCH

COUNTRY STUDIES

27

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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NGO FORUM FOR HEALTH

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I. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

1) There have been no well defined programs for adolescents
2) The urban poor are neglected
3) The nomadic people are not well covered.
4) More resources spent on secondary and tertiary health care.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

There have been honest efforts on the part of the Govt to initiate the programs based on international agreements.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

The non governmental organizations mainly are concentrated in and around towns / cities

No debate on loans for the program from external agencies.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

By measuring the indicators of health area wise

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

Routine reports, SRS data, reports of expert committee

c) What about the accuracy and transparency of Government data?

Govt. data covers only a limited population / area.

Most reports are not shared with public.

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

Detailed analysis of existing data is required.

There is no need for elaborate collection of data.

e) How is it possible to gain access to this data?

The Govt must make available, the data to public

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f) How will it be possible to verify if the data is reliable and accurate? (4)

There are internal checks in the reports themselves which help in checking the accuracy. Crosschecking can be done on a sample basis.

g) Is there a need to protect sources and is so how?

- No -

h) Who would monitor the data and how?

The program planners themselves. They would share the data with representatives of professional agencies who are conducting the 'watch'

i) What are the cost implications?

Not much of additional cost is involved.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

At the planning stage itself. Resource allocation to be done properly. Regular monitoring is required.

b) How can these issues be taken up?

Commitment and vision are required on the part of planners and implementing agencies.

c) With whom should they be taken up?

Professional bodies should take up the advocacy process with Govt health authorities.

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d) What is the likely impact of such initiatives? (5)

Achievement of equity by lessening the disparities.

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

There is a definite need for NGO's to provide a broader view of the things. Case studies would help.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this **kind?**

Public health professionals in academic institutions, voluntary organizations. Professional bodies like IMA

b) What different roles could they play?

Interaction with Govt.
Think tank
Lobby and pressure groups; advocacy

5. ORGANISATION

a) How would a national watch be organised?

Networking of different organizations

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b) What should be the structure?

(6)

There is no need for a formal structure.
The existing structure of VHAI, etc can be used.

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

By exchange of information

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

By providing funds for regular interactive sessions
By advising the Govts to listen to the groups.

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

Periodic release of funds directly

6 All the above questions have been related to a National health watching network. Do you have any suggestions of how such a network can also feedback on global decisions, processes and projects that affect National actions? ie South-North dialogues

6. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

RETURN TO: Dr. Eric Ram at the address below

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NGO FORUM FOR HEALTH

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GLOBAL HEALTH WATCH

3

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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RN 4/10

I. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

Refer to UNDP Report on : Diversity and Disparities in Human Development : Key Challenges for India, January 1999.

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

No. Government commitment is weak and it falls presy to pressure from multinational agencies/grants. This is compunded by diverted priorities, poor information base, uncommitted professionals and an unaware citizenry.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources

Control of tuberculosis and malaria.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

It is time to move on from attempting to show that inequalities exist. Their existence is apparent and unquestionable.

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

Micro level studies from deprived sources and locations maybe considered to monitor specific conditions that could serve as indications.

c) What about the accuracy and transparency of Government data?

Inaccurate and not transparent.

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

Refer to Prof. K. Ramachandran, 45 Bakhthavalsalam Road, Mylapore, Chennai 600 004. (Tel : 4994874).
A network of data collectors and disseminators need to be formed. Perhaps a non-governmental annual publication of Health Status of the Indian people needs to be published independently.

e) How is it possible to gain access to this data?

as in 2 d.

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f) How will it be possible to verify if the data is reliable and **accurate?**

(4)

g) Is there a need to protect sources and is so how?

Protection of sources would lead to lack of transparency in the activity and would in all probability lead to lack of reliability in data.

h) Who would monitor the data and how?

i) What are the cost implications?

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

Judicial intervention is becoming more frequent but sometimes it is counterproductive and ill-informed. Academic meetings addressing these issues are normally aimed at policy planners.

b) How can these issues be taken up? What is never said however is the recourses one should take if representations fail : The efforts must be redirected to create awareness amongst ordinary people who after all bear the onslaught of these inequalities. Health must be one of the top priorities of a political agenda.

c) With whom should they be taken up?

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d) What is the likely impact of such initiatives?

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

Yes. As in 2 d and 2 e.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

To be arrived at after consultation.

b) What different roles could they play?

5. ORGANISATION

a) How would a national watch be organised?

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b) What should be the structure?

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

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

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

6 All the above questions have been related to a National watch nationally. Do you have any suggestions of how ... watch can also feedback on global economy, unwo... and projects that affect National policies' ie South-North dial...

6. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

RETURN TO: Dr. Eric Ram at the address below

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29

GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

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- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

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Fax number: 080-5520777

E-mail

Contact addresses:
Dr. Eric Ram, Chairman, c/o World Vision International, 6 Chemin de la Tourelle, CH-1209 Geneva, Switzerland
Tel. (41-22) 798 41.83 Fax (41-22) 798 65 47 E-mail: wvi.gva@iprolink.ch
Dr. Alireza Mahallati, Treasurer, c/o The International Federation of the Red Cross and Red Crescent Societies, P.O. Box 372, CH-1211 Geneva 19 Switzerland
Tel. (41-22) 730 44 88 Fax (41-22) 733 03 95 E-mail: mahallat@ifrc.org
Mr. Giovanni Ballerio, Secretary, c/o Baha'i International Community, 15 rte. des Morillons, CH-1218 Grand-Sacconex, Switzerland
Tel. (41-22) 798 54 00 Fax (41-22) 798 65 77 E-mail: gballerio@geneva.bic.org

4/10/99

NGO FORUM FOR HEALTH

— partnering to make health a reality —
— promoting equity and justice in health care —

1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

a) What are the inequalities and inequities in health in your country?
Consider, for example:

(1) - are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.

(2) - are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.

(3) - are there socio-economic and geographical differences in access to health care

(4) - are there socio-economic and geographical differences in the resources spent on health care

1 – yes, There are inequities

2 – yes " "

3 – yes " "

4 – yes. " "

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing etc.

→ yes Govt is fulfilling its commitments upto 70%.

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

- yes

2. HOW WOULD YOU MEASURE THESE INEQUALITIES : Now most states have Health commissionares, SRS should be shifted to Health

a) How would you show that these inequalities exist? Dept and shd work as Complimentary to HMIS: SRS shd be an independent agency under Health commission.

→ By dis aggregated data on various characteristics of community and Health indicators

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

- Sample Registration system (SRS) (Reg)
- Model Registration system (cause of death survey).
- HMIS - by dept of Health
- National family Health survey - (Adhoc) (Reg)?
- NSS data

c) What about the accuracy and transparency of Government data?

- SRS accuracy can be believed, though sample size is small for calculation of various specific ratios.
- NFHS - also gives good data

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

Present systems of data collection can give good quality data if supervised properly.

- Sample size of SRS can be increased with addition of certain characteristic (variable) and existing data can be analysed.
- HMIS - needs proper supervision and inclusion of certain characteristics

e) How is it possible to gain access to this **data?**

⇒ Now Govt Depts have started responding positively to data users.

⇒ Right to Information law, should be implemented properly.

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f) How will it be possible to verify if the data is reliable and accurate? (4)

- findings from various system can be compared.

g) Is there a need to protect sources and is so how?

- There is need to enhanced the capabilities of system and encourage them to over come the sources of error.

h) Who would monitor the data and how?

- Govt agencies along with NGO (National + Local)

i) What are the cost implications?

→ Nil or little ~~more than~~ amount.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

- local level - International level.
→ Regional level
→ National level. ad

b) How can these issues be taken up?

- By creating awareness among local community and National level.

c) With whom should they be taken up?

- local self Govt.
→ Ministries (Dist)
→ State (Govt)
→ National & International agencies (Multilateral)

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d) What is the likely impact of such initiatives? (5)

→ Policy makers may become aware of the need for equity on the basis of problem faced by various segment of the community..

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

→ No need to start parallel system. Need is to collaborate with existing system.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

- Govt agencies and NGO's at all level. (SRS + HIMS)

b) What different roles could they play?

- complimenting to each other.

5. ORGANISATION

a) How would a national watch be organised?

- Govt and NGO agencies can collaborate at all level. (SRS + Health Dept + NGO) at State level can form a body and same could done at National level.

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b) What should be the structure? It could be like SRS where. local NGO is providing data to Districts and onwards to state and National level.

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

Through Multi lateral agencies like WHO, UNDP etc.

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

NGO manpower can be trained through WHO funding

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

- Through Multilateral agencies
→ National Govt.
→ Local funding. Users fee, data users.

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

- By written communications to policy makers.

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

RETURN TO:

Dr. Ravi Narayan,
Community Health Cell,
Society for Community Health Awareness, Research and Action
No.367, 'Srinivasa Nilaya' Jakkasandra I Main, I Block, Koramangala,
Bangalore - 560 034.

Phone : (080) 553 15 18 & 552 53 72
Fax : (080) 552 53 72 Email : sochara@vsnl.com

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GLOBAL HEALTH WATCH

COUNTRY STUDIES

Questionaire for participants attending national meetings on the establishment of a Global Health Watch

- Please read the background paper attached which looks at the issue from a broad perspective and gives general thoughts on the need and prospects for setting up a Global Health Watch.
- It is now necessary to move ahead and consider more specifically how such a health watch would function at the national level in terms of types of issues it would focus on and the ways in which it would carry out its work.
- It would be very useful if you could complete the questionaire prior to the meeting as it would be good preparation for the discussion itself. Please **be as specific as possible** in answering the questionaire, highlighting particular issues and giving names of people, places, documents etc. as relevant. Add additional sheets if necessary.
- Please hand this questionaire to the organisers of the meeting as it will be returned to the co-ordinating committee of the NGO Forum for Health in Geneva.

Name: DR ARVIND KASTHURI

Organisation: DEPT. OF COMMUNITY HEALTH
ST JOHNS MEDICAL COLLEGE, BANGALORE 560034

Address: - same as above -

Telephone number: 5530724 extn 413

Fax number: 5520777

E-mail arvindk@vsnl.com

Contact addresses:
Dr. Eric Ram, Chairman, c/o World Vision International, 6 Chemin de la Tourelle, CH-1209 Geneva, Switzerland
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NGO FORUM FOR HEALTH

— partnering to make health a reality —
— promoting equity and justice in health care —

1. WHAT ARE THE INEQUALITIES IN HEALTH IN YOUR COUNTRY

(2)

a) What are the inequalities and inequities in health in your country?
Consider, for example:
- are certain groups particularly disadvantaged in terms of health provision based on class, caste, gender,
race, ethnicity, sexual orientation.
- are there socio-economic and geographical differences in health indicators such as mortality, morbidity rates etc.
- are there socio-economic and geographical differences in access to health care
- are there socio-economic and geographical differences in the resources spent on health care

Inequalities of ACESS TO & thereby UTILISATION of
- INFORMATION / awareness
- HEALTH CARE SERVICES
- The "roots" of ill health i.e.
  EDUCATION
  EMPLOYMENT

b) Implementation of treaties, conventions, plans of action etc.
Is the Government fulfilling commitments made in international agreements such as WHO Health For All strategy or the health provisions of the various international conferences of the 1990s such as Rio, Copenhagen, Cairo, Beijing **etc.**

I feel that while the spirit is willing, the flesh is weak, rotten with corruption & malnourished by lack of infrastructure.

The Government's progress towards its own stated HFA goals for HFA 2000 is not nil, but could be better. The question is is it the fault of the policy maker, or the executive which fails to implement?

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c) Are there any specific examples where these inequalities are being compounded by other factors such as the activities of private sector organisations, corruption and inefficiency in health management, lack of public accountability, unequal allocation of health resources (3)

Powerful lobbies include
- Drugs & Pharmaceuticals
- Unbridled "power" projects
- Non eco - tourism.

2. HOW WOULD YOU MEASURE THESE INEQUALITIES

a) How would you show that these inequalities exist?

Compare indicators of health status in different SE groups.
Document stories of lack of access.

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

Census.
NGO - run surveys

c) What about the accuracy and transparency of Government data?

Transparency - I do not know
Accuracy - problematic, since there is a reliance on "reported" figures.

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

Possible to analyse existing data.

e) How is it possible to gain access to this data?

Get the govt. to understand that this is NOT an anti-establishment group, but pro-people & pro-progress.

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f) How will it be possible to verify if the data is reliable and accurate? (4)

Small sample surveys.

g) Is there a need to protect sources and is so how?

—

h) Who would monitor the data and how?

Ideally, ~~Dss~~ elected govt. officials in key positions who are willing to monitor the data would be better.

i) What are the cost implications?

Should not be high.

3. ADVOCACY

a) Where can questions of inequality in health be taken up?

Ideally, with the govt, and with the elected representatives of the people.

b) How can these issues be taken up?

By framing it in a non-threatening, positive manner.

c) With whom should they be taken up?

With govt officials, the press, the people

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d) What is the likely impact of such initiatives? (5)

Mistrust & hostility if done in a confrontationist way, grudging acknowledgement, and maybe, some action.

e) Is there a need for a alternate reporting system whereby NGOs can provide shadow reports to official Government reports (as in the Convention on the Rights of the Child for example)

No. Existing reports show inequalities.

4. PARTNERS

a) Which organisations and persons would be able to participate in monitoring of this kind?

- NGOs
- Press
- Govt.

b) What different roles could they play?

- Develop & implement accurate monitoring systems
- Train govt workers on data collection, sample surveys.

5. ORGANISATION

a) How would a national watch be organised?

—

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b) What should be the structure?

—

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

A set of periodic monitoring indicators, prepared region wise could be used.

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

Their capacity needs no strengthening. Credible leadership & true commitment channelising their energies in a common direction is all that is required.

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

—

6. All the above questions have been related to a National Watch, watching nationally. Do you have any suggestions of how a National Watch can also feedback on global economy, issues, processes and projects that affect National Policies ie., South-North dialogue - to whom and how?

—

7. ADDITIONAL POINTS

Have you got any other points you would like to raise either from a global or national perspective regarding the creation of a Global Health Watch?

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Bangalore - 560 034.

Phone : (080) 553 15 18 & 552 53 72
Fax : (080) 552 53 72 Email : sochara@vsnl.com

Subject: Re: ghw
Date: Mon, 18 Oct 1999 09:25:00 -0700
From: Eric_Ram@wvi.org (Eric Ram)
To: COMMUNITY HEALTH CELL <sochara@blr.vsnl.net.in>

Dear Thelma,

Could you please resend your attachments as a word for window 95 document, version 7.0. as we have some difficulties to retrieve it.

Many thanks.

Gladys for Eric Ram

Reply Separator

Subject: ghw
Author: COMMUNITY HEALTH CELL <sochara@blr.vsnl.net.in> at INTERNET
Date: 16.10.99 12:09

Dear Eric & Asmita,

Reg : GHW - National Meeting - India.

Greetings from Community Health Cell!

Just a note to keep you informed about the successful completion of the National Meeting on Global Health Watch on 7/8th October 1999. Our team is working on the proceedings and a compilation of the responses to the questionnaire. We shall send this to you by the end of the month.

1. The meeting was attended by 44 participants including 10 from our local CHC network. There was great enthusiasm and we were overwhelmed by the participation.

2. Five watches were represented in one way or the other. These were Health Watch (A Women's health issues watch in India - post ICPD 1994); Social Watch (via a fax presentation since neither Sundar nor Jagadananda could attend due to some local constraints - however they will be here end of the month for further discussions on collaboration); People's Watch - a dalit oriented watch in Tamil Nadu; the People's Union for Civil Liberties - Karnataka; and the North Arcot District Health Intelligence - a watch initiative of Christian Medical College-Vellore.

3. Six campaigners were represented - who had moved from 'watching' to 'advocacy' and lobbying for policy action. These were Tamil Nadu Science Forum (which is lobbying to empower People to support the Back to Alma Ata movement); Vimochana (lobbying for action to tackle violence against women); The Anti Quinacrine Sterilisation Campaign (spearheaded by the staff of the Centre for Social Medicine and Community Health of Jawaharlal Nehru University; the campaign against medical malpractice by the medico friend circle group in Mumbai; the campaign and watch on initiatives of bilateral / multi laterals in India by PEACE, New Delhi; the campaign against female foeticide and so on.

4. We had participants from Delhi, Mumbai, Pune, Chennai, Pondicherry, Anand (Gujarat). While the Bangalore contingent was slightly larger than initially planned many were representing institutions associated with other networks and campaigns. Tamil Nadu had the strongest representation and there is the potential of initiating a Tamil Nadu Health Watch by networking among a host of ongoing initiatives as a distinct possibility for 2000 AD. India may be too large to evolve an effective watch too soon, but this meeting has generated an evolving collectively and a core group will work on this process gradually.

975
Apam
20/10/99

5. The questionnaire was useful to get participants to think of the issues in advance though many had some difficulties in the focus and the implicit framework. The compilation is proving to be an interesting challenge especially when respondents gave responses from different perspectives - local, district, state, regional, national, global perspectives. But the wealth of perspectives is rich and wide!

6. The National organisations were represented to some extent. CHAI was represented by Fr. Jose, editor of Health Action, who will feature the discussions and issues in the next issue. CMAI - Dr. Sukant Singh chaired the session on Equity. VHAI - involvement was not possible due to existing commitments. PRIA and VANI were preoccupied with some recent post-election developments affecting NGOs and the FCRA Act and could not attend even though they were keen to. CSE was expected to participate because of their phenomenally successful Environment watching but Anil Aggarwal - who was attending - called it off - because of an unfortunate recurrence of cancer and sent a note at the last minute.

7. We are forwarding separately a copy of the final programme and the participants list. A copy is also being posted to you. The rest will come with the proceedings (a tentative content list of the proceedings is enclosed).

We enjoyed the opportunity to collaborate with the International NGO forum,

All the best from the CHC team,

Yours sincerely,

Dr. Thelma Narayan Dr. Ravi Narayan.

Subject: ghw
Date: Sat, 16 Oct 1999 12:09:24 +0530
From: COMMUNITY HEALTH CELL <sochara@blr.vsnl.net.in>
To: Eric_Ram@ccmailgw.wvi.org, naik@ifrc.org

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All the best from the CHC team,

Yours sincerely,

Dr. Thelma Narayan Dr. Ravi Narayan.

GHW Proceedings list.doc	**Name:** GHW Proceedings list.doc **Type:** Microsoft Word Document (application/msword) **Encoding:** base64

GHW-PROCEEDINGS.doc	**Name:** GHW-PROCEEDINGS.doc **Type:** Microsoft Word Document (application/msword) **Encoding:** base64

Subject: Global Health Watch
Date: Thu, 4 Nov 1999 16:23:00 -0800
From: Eric_Ram@wvi.org (Eric Ram)
To: sochara@blr.vsnl.net.in
CC: naik@ifrc.org

To: Dr. Thelma Narayan
To: Dr. Ravi Narayan

Dear Thelma and Ravi,

Thank you very much for your kind note of October 16, 1999. I am very happy to learn that the National Meeting on Global Health Watch turned out to be such a success with 44 enthusiastic participants attending it.

I am glad also that both VHAI and CHI were represented. The list of participants is impressive.

We are keenly looking forward to receiving the report and the proceedings of the conference and the compilation and analysis of the responses to the questionnaire. Can you please send a copy in a diskette along with a hard copy. (word for windows 95, version 7.0 or in wordperfect 7.0)

The Africa Regional meeting has also taken place in Harare and we are awaiting their report as well.

The pre European Regional meeting took place in the form of Intercollegiate Forum on Poverty and Health about the same time as yours. Their big meeting will be in March 2000..

The North and South American meetings will also take place in the first quarter of 2000. We will be a bit late in completing the other regional meetings but I am quite pleased with the progress we have made thus far. And, there is a growing interest internationally on Global Health Watch.

Once again I want to thank you very sincerely for your hard work in organizing these meetings.

With my warm greetings and best wishes,

Sincerely,

Eric Ram

RN 4/11

1079

RS 4/11

Subject: Re: hello
Date: Mon, 3 Jan 2000 23:56:06 +0530 (IST)
From: Muraleedharan V R <vrm@acer.iitm.ernet.in>
To: chc <sochara@blr.vsnl.net.in>

Dear Ravi/Thelma:

I have read the draft guidelines of the RBM meeting. I was part of the discussion on "role of private sector" and "Research and Development" (guidelines 5 and 10, respectively). I think the draft cover very much what we discussed in the meeting. It only requires some editorial corrections.

I shall soon send my comments, if any, on the notes on Global Heatlh Watch.

I read Andy haines and Iona heath's article on poverty and health, BMJ, 1 March 2000..

with regards
Muralee

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RN
17/1/2000

1345
4/1/2000

20/12/99

Dear Eric Ram / Amrik Nath

Greetings from Community Health cell

We have been through a hectic phase of meetings and consultations since the GHW workshop. These included the South Asian Dialogue on Poverty and Health (Nov 99), and the "Tuberculosis" consultation in ~~Delhi~~ (Nov 99) and the Guidelines for Community Mobilization and Advocacy in Malaria Control for RBM-WHO SEARO in Dec 99 and so ~~we have delayed~~ the forwarding of the proceedings of the GHW meeting got a bit delayed. Hope you received a copy of the cover memo that was also sent by e

The first draft is now ready and is circulating among a ~~GHC editorial group and the~~ a core group of partners for their comments and suggested modifications. These were selected during the meeting.

In compiling these suggestions may take us till mid-Jan but in case you would like to have a copy of this first draft even at this stage, please let us know. It may help us begin incorporating the ideas in to the larger ~~Project~~ your ~~feasibility~~ study report. A copy of the ~~Proceedings~~ conclusions of the total output of the meeting including the sections and subunits as they evolved, is enclosed for your information.

With best wishes for Christmas & the New Year

Yours Sincerely,

Rao
GHC Team

sent on 22/12
Nath

Get details of
- INCOHSI
- MMI
- Int NGO Forum
CHC Membership
RN

medicus mundi international

Community Health Cell
Bangalore
India
Dr. Ravi Narayan
Fax : 080.55.333.58

Brussels, 3th of December 1998

Dear Dr. Narayan,

The contribution and initiatives you gave to the start of a Global Health Watch have impressed us, as Medicus Mundi we hope that the NGO Health Forum is receiving the proper means to start the feasibility study.
In your fax dated 3th of July 1998 you put the question how CHC could become a member of MMI.
Medicus Mundi International is very much willing to have members from low income countries. They have, however, to face certain conditions as good sustainability, PHC oriented and not-for-profit acting.
CHC seems to correspond to these conditions.
Recently, a NGO in Benin, AMCES, has officially become an 'associate member' of MMI.
MMI has formulated in the statutes two types of membership:
1. full member with the right of vote and paying full contribution, and
2. associate membership, with full participation in the MMI network, conferences and assemblies, but without the right of vote and paying a voluntary 'pro forma' yearly contribution according to their financial possibilities.
We would like to know if CHC is still interested in such an (associate) membership. If so, and we really are very much inviting you to do so, we invite you to contact us and start the application procedures.
Tell us what MMI can do for you, what your expectations are and what we could offer in our MMI network.

Have our best regards.

p/o Dr. Sake Rypkema
For Medicus Mundi International

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Bank account
149 0012601 35

International organization
for cooperation in health care

In official relations
with WHO
resolution eb63.r27

To take a decision after discussion & Ulrich etc
RN
3/3/99

COMH 48.1

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.
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 vi. 'Environmental' Watch (Each presentation of 15-20 minutes will be followed by 10 minutes of clarifications / questions)	**Chairperson :** Dr. C.M. Francis, CHC Dr. Gita Sen Dr. Sunder Misra / Mr. Jagadananda Dr. Reuben Samuel Mr. M.A. Britto Prof. Hasan Mansoor CSE Nominee
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*	
Session 4 4.15 – 5.45 p.m.	**Group Discussion – I** Inequalities / Measurements / Sources of Information / Analysis for GHW	**Moderators/Resource persons to be selected for each group.**
8th October 1999 (Friday)		
Session 5 9.30 – 11.30 a.m.	**Evolving the Framework of a Watch(I)**	**Chairperson :** Prof. R.L. Kapur, CHC.
	a) Plenary : Presentation of Group Discussion	By Rapporteurs
	b) Advocacy / Campaigns – some Case Studies	A short presentation by a few participants selected for campaigns/struggles. (Participants to volunteer)
11.30 – 11.45	*Tea / Coffee*	
Session 6 11.45 a.m. – 1.15 p.m.	**Group Discussion II** **Themes** : Organisational / Action /Advocacy / Partners for GHW	**Moderators/Resource persons to be selected for each group.**
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.

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 **level**[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.

Notes

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UK Coalition Against Poverty

COM H 48.3

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 (incl Society org.
- 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 vulnerable groups as far as reliable data permit.

NOT SURE

Basic Entitlement

Learning

- access to literacy and basic education in keeping with the specific linguistic and cultural context
- access to further educational opportunities, building upon local knowledge systems 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

NEXT SLIDE

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 (or 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.

NEXT SLIDE

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 preventable illnesses

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.

NEXT SUBJECT →

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

NATIONAL HEALTHWATCH MEETING

NEW DELHI, 18-19 JANUARY 1999

Summary of presentations as presented in the concluding session.

The backdrop:

HealthWatch is a network of field based voluntary organisations, researchers, women's health advocates and social activists who are concerned about issues surrounding women's health. This group informally came together prior to ICPD Cairo and has since then expanded to include organisations and individuals who are committed to promoting an a holistic approach to health, population and development. The members who are part of this informal network can be categorised as follows:

1. Grassroots voluntary organisation working among the people on issues ranging from women's empowerment, primary health care and child health. For example: VGKK of Mysore, SEWA of Gujarat, CINI of West Bengal, Sahaj - Sarathi of Gujarat, Sahyog of Almora.
2. Organisations with a national character working in the area of health research and advocacy for voluntary family planning and engaged in implanting their own projects and programmes of the Government. Voluntary Health Association of India, Family Planning Association of India.
3. Voluntary organisations engaged in training, research, material production, and advocacy. For example: CHETNA of Gujarat, CEHAT of Maharashtra, Centre for Advocacy and Research, SOCTEC, Mumbai and IWID of Chennai.
4. Research and teaching institutions with a mandate to work in the area of health, population and development and related fields. For example Indian Institute of Management, Bangalore, IIHMR Jaipur, IPAS Mumbai, FRHS Ahmedabad.
5. Social activists, researchers, trainers and other professionals involved in this field - who may or may not be affiliated to any organisation.

In 1996-97 HealthWatch network organised regional meetings across the country on the newly adopted Target Free Approach of the Government. These meetings were co-ordinated by different organisations. The findings of these regional thematic meetings were shared in a National Meeting in April 1997. It is now almost one and a half years since the first round of regional consultations. In September 1998 the Steering Committee of HealthWatch (consisting of 17 persons from almost all regions of the country) decided to conduct small qualitative studies in two Districts each in ten States to gather information on the implementation of the TFA (now called Community Needs Assessment Approach) and the RCH programme of the Government. Dr. Leela Visaria prepared a format to gather information through focus group discussions, interviews and review of data at the District level. She had already done the exercise in Rajasthan and Tamil Nadu. Seven HealthWatch members volunteered to do the study during the months of November and December 1998. This meeting was convened to share the findings of these studies. The following organisations / individuals presented the studies:

1. Andhra Pradesh: Dr. M Prakashamma of Academy of Nursing Studies, Hyderabad.
2. Haryana: Ms Kiran Kalway of Family Planning Association of India, Yamuna Nagar.
3. Karnataka: Dr. H Sudarshan of VGKK, Mysore, Dr. Gita Sen and Ms Anita Gurumurthy of IIM Bangalore
4. Madhya Pradesh: Dr. C Vijayendra of Family Planning Association of India, Jabalpur.
5. Rajasthan: Dr. Leela Visaria, New Delhi
6. Tamil Nadu: Dr. Leela Visaria, New Delhi
7. Uttar Pradesh: Jashodhara Dasgupta of Sahyog, Almora
8. West Bengal: Mr Shekar Chatterji and Dr. K Pappu of CINI, 24 Parganas.

[Gujarat: Ms Mirai Chatterji of SEWA did the study but could not come for the meeting.]

In addition to the seven studies presented, HealthWatch reviewed recent documents on the RCH programme of the Government. This initiative was co-ordinated by Dr. Prakashamma. Dr. Radhika Ramasubban convened a Media Advocacy meeting and presented the recommendations of that group.

The good news:

- Government of India has sent directives to all the states and does not fix any central targets.
- Government of India has advised all the States to organise six-day orientation training on RCH approach.
- The level of awareness across the board is much greater that what it was in 1997. Field workers like ANMs were aware of TFA, RCH and also about the new CNA approach.
- The impact of the six-day RCH training done in many states has been positive.
- Sense of relief among ANMs over the elimination of competition on targets with non-health personnel.
- District RCH and IPD projects are being formulated in many States.
- Some innovations with promise:
- Tamil Nadu has initiated a very effective system to streamline the supply of drugs to PHCs - and this is a replicable model. 7 Tamil Nadu had linked admission to post-graduate medical education to three rural services by giving priority to those who have worked in rural areas.
- Again, Tamil Nadu has recently mobilised private sector for infrastructure development of PHCs and Sub-Centres. 7 The integrated RCH approach has led to improvement in the rapport between ANMs and women - in Karnataka, Andhra Pradesh and Tamil Nadu. ANMs no longer seen only as target hunters.

The disturbing news:

- There is tremendous variation in the level of understanding across states and also across levels - i.e. State level officials, Training Institutions, Medical Officers to ANMs.
- Not all State Government officials are convinced about the new approach.
- Political leadership in many States continues to believe in the old approach.
- There are many misconceptions - like "old wine in new bottle", no real change we still have to focus on sterilisation as the principle method of fertility control 7 Medical Officers, in particular, seem to have been bypassed by training and orientation workshops.
- The new approach implies a significant increase in the workload of ANMs, while the Male Multipurpose Workers have escaped yet again. 7 Policy documents and RCH projects silent on the role of Traditional Birth Attendants - as a result there is little discussion on the role of TBAs in improving maternal health, and also motivating couples to space children and use contraceptives.
- Male involvement is still a neglected area.
- Record keeping continues to get priority - with a great deal of time in training and in the day to day work of service providers devoted to it.
- Safe abortion is yet to be addressed - only the Districts taken up under the UNFPA assisted IPD projects have included management of complications arising out of unsafe abortion as a priority area.

Targets and incentives - have they gone?

- Again there is tremendous variation across the country, and studies recorded different perceptions.

- In some states terminal method of contraception continues to be the mainstay of the programme - with the exception of Tamil Nadu where it was reported that people are so motivated that they come automatically. 7 In some states incentives to sterilisation acceptors continue. Andhra Pradesh takes the cake! The private sector has been mobilised to provide gold chains and other material incentives to sterilisation acceptors. 7 The political leadership across the country is still talking about targets and incentives. This is also true for senior civil servants and corporate heads.

Who is fixing the target?

- Mixed picture emerged

- In some States it is fixed at the District level, in others it is done one the basis of computer data base, in others it is decided on the basis on ANMs reports with the help of LHVs, and in some ANMs send their targets and it is revised by Medical officers.

Is quality of care and client centred approach a priority?

- No significant change in service environment in most States.
- There is not much evidence to show any marked improvement in service providers' attitude towards clients.
- The community is still looking at quality as regular and reliable availability of services.
- Quality of care, even in static centre based sterilisation camps have not improved - women are still treated carelessly. Even where the technical quality indicators have been adhered to, there is still no change in service environment.
- Counselling is equated with motivation - thereby negating the importance of dispassionate counselling on spacing methods vis-'-vis terminal method.

Some area of concern:

- As it stands today, Government of India has given the option of withdrawing incentives and channelling those funds to improve quality to the States. Can the GOI play a more proactive role in discontinuing incentives?
- Availability of trained persons to conduct deliveries is linked to the safety of ANMs. In most of the States the percentage of Institutional deliveries is extremely low (for example in Rajasthan it is only 23 per cent). Inability of ANMs to move with a sense of security hampers their ability to attend deliveries. This issue is linked to the importance of empowering ANMs and enabling them to build a rapport with the community and other women workers in their area. While universal access to institutional deliveries may be the goal - we still have a long way to go before other regions catch up with Kerala and Tamil Nadu. 7 Maternal mortality and morbidity continues to be a area of concern - and given the prevalent situation in most parts of the country, TBA continue to be the first line of care givers. Training them and improving their ability to identify complications and referring them in time to the nearest Sub Centre, PHC or District Hospital is important. Therefore, we cannot afford to ignore the training needs of these care providers.
- There are a bit too many training programmes underway - and in many districts ANMs were running from one programme to another. Rationalisation and integration of in-service training is necessary. 7 The Panchayat representatives do not seem to have been involved in the new programme. Given their proximity to the people - involving them and giving PRIs a mandate to work in this area is acknowledged - but little has been done in this direction. In view of the fact there is very little community mobilisation for RCH - PRIs could play a crucial role in influencing the health seeking behaviour of people. 7 ANMs are being informed about RTIs and STIs - but there is still no mechanism to provide medical care to women (and men) suffering from these ailments. Some studies revealed that people still go to private doctors / RMPs / Quacks for STD. But women suffering from RTIs and STIs still suffer in **silence.**

- In many areas - i.e. Haryana, Madhya Pradesh, Rajasthan and Uttar Pradesh -client interviews revealed that there is no perceptible change in the picture on the ground. Targets may have gone and non-health personnel no longer chase people, but the fact remains there that there is little evidence of any other change.
- In view of the fact that a lot of external funds are being pumped into the RCH programme - the long-term sustainability of this programme needs to be debated.
- While Government of India documents discusses the importance of involving NGOs in the RCH programme, GO-NGO relationship is still tenuous. There should be greater transparency about new schemes / programmes.
- The Mother-NGO concept needs a careful look. Mother NGOs present in the meeting asked for a debate on the concept of mother NGOs.

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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.

Objectives

The basic objectives of "HealthWatch" are:

1. To translate the ICPD Programme of Action for the national context by defining priorities for public policies and action, and the mechanisms for their implementation;

2. To engage in a process of constructive but critical dialogue with the government at multiple levels; and to lobby for a shift in the government's Family Welfare Programmes from provider-driven to people-based programmes;

3. To explore mechanisms to link reproductive health services to strengthen public and primary health care, and related aspects of development, especially education and women's economic, political and social empowerment; in particular to advocate restructuring government programmes based on the vibrant NGO experiences in this area;

4. To provide a forum for effective networking among like-minded NGO's to make progress on the above objectives;

5. To provide a forum for continuous exchange of information and sharing of ideas and experiences among NGOs themselves.

For further information or any comments and suggestions, please write to:

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HealthWatch,
a Network for Action and Research on Women's Health

At a meeting of NGO s, held in Ahmedabad on December 1-2, 1994, it was decided to form a network to explore the feasible approaches to move forward from the Programme of Action adopted at the International Conference on Population and Development (ICPD) in Cairo in September 1994. We visualized "HealthWatch" as a vehicle to increase the attention paid to women's health needs and concerns in public debate and national policy. In fact, a series of meetings and workshops which had begun during the preparations for ICPD focussed on defining and clarifying women's health issues, particularly reproductive health and rights, had prepared the basis on which like-minded NGOs can work together, and begin a process of constructive dialogue with the government on policy and programme directions.

Background

Our Constitution guarantees each citizen the right to life which includes effective provision for work, food security; protecting access of poor people to resources such as land, forests, and water; safe, green, pollution-free environment; safe drinking water and adequate sanitation; adequate shelter and the right to health. The state must allocate adequate resources and design supportive policies to provide these basic needs to all people.

The Constitution also guarantees non-discrimination on the grounds of sex; yet biases against women are rampant in every aspect and stratum of society. It is therefore the responsibility of the state, as articulated in the Directive Principles, to undertake strong measures to remove all forms of discrimination against women, and protect their human rights.

In our country, women's ill-health is mainly caused by

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DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health System bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential **drugs;**

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

iii. Research and advocacy groups can provide 'valid' data from their studies especially community based and policy oriented.

iv. Professionals and professional associations can contribute technical expertise especially in analysis and interpretation. A multidisciplinary approach and a strong public health orientation are necessary.

v. Consumer groups and associations can provide data and support lobby / advocacy with the 'health watch' findings.

vi. Other watches can share their health related data to reduce duplication of efforts.

vii. Regional networks of NGOs and International health agencies could provide access to their data bases especially from their partner agencies at the community / local / national levels.

viii. WHO and its regional offices could support with regular monitored data from member countries and data from special surveys, research projects and programme monitoring system.

An effective 'Health Watch' will need to be able to access all these resources without getting controlled by one group – so that authenticity, accountability and objectivity are maintained.

4. 'HOW' could such a watch function

The credibility and authenticity of the watch is crucial and its accountability 'to watch on behalf of the poor and disadvantaged' who are most affected by the processes and trends being watched.

An effective 'watch' will therefore have to be a combination of all these features.

- Grassroots networks and citizens initiatives should be central.
- Information collated and analysed should be credible.
- The 'rigorous' research approach must be balanced with committed information dissemination and advocacy.
- Local/national NGOs especially from the South must be actively involved and in the lead, for it to be representative of a global democratic initiative.
- Its functioning should be flexible and responsive to emerging needs and concerns and interactive with a large group of resource networks.
- There must be a large component of participation by volunteers.
- Data and reports must be effectively and widely disseminated to reach all those who could participate in responsive action.
- Inspite of its 'activist' concerns, the watch should be highly professional so that the 'counter expertise' generated is very evidence based.

5. Some unanswered questions

While the 'Health Watch' concept has been receiving increasing and enthusiastic support, there are some unanswered questions:

- How will the 'data' collected or disseminated by the 'watch' reach the people, the community, the citizens groups – particularly the poorest communities who could be empowered with this information to understand their situation and fight for their rights?

- How could such an initiative be prevented from becoming another north-dominated and international NGO-dominated structure, providing solutions and top down prescriptions to the governments and communities of the South in a condescending or charitable way? How could the initiative be a truly democratic global process?

- How could such a initiative keep its independence and objectivity and credibility and not become subservient to the conditionalities of funding partners or international agencies including WHO, who will contribute to it but also be watched by it? **How could the global health watch be a truly independent Global Health Ombudsman?**

Those who help to initiate and develop the watch will have to face these questions in the days ahead.

6. Challenges ahead

The challenges of contributing / participating in the evolution of a Global Health Watch are many:

- It could be a strong commitment to building a truly equitous and ethical global society and a healthy one
- It could be a significant example of north-south solidarity
- It could be an opportunity to relook globally and locally at our life styles; our values; our societal relationships
- Finally, it could be an opportunity for professionals to commit themselves with courage to standing up for the poor and the marginalised and to making Health a reality for all.

ARE WE READY FOR THIS CHALLENGE??

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1. Haines, Andrew et al (1993)
   Global Health Watch : monitoring impacts of environmental change
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2. World Health Organisation, (1997)
   A new Global Health Policy for the Twenty first century : An NGO perspective.
   Report of a formal consultation with NGOs held at WHO, Geneva, 2/3 May, 1997.
3. NGO Forum for Health (1997)
   Concept paper for the Global Health Watch
   (several stage drafts over the period) , Sept 97 – May 1998, NGO Forum for Health, Geneva.

NOTE

All those who would like to respond to these reflections and participate in the process of actually evolving such a 'Watch initiative' are requested to :

- Send their comments/suggestions to Dr. Eric Ram, Chairman, NGO Forum for Health, World Vision International, 6 Chemin de la Tourelle, 1209 Geneva, Switzerland.
  Tel : +41 (22) 798 41 83
  Fax : +41 (22) 798 65 47
  Email : wvi.gva@iprolink.ch
  A project feasibility proposal has already been circulated by the Forum. Interactive dialogue would help the initiative 'get on track'.

- A copy of the above marked to the author would be an opportunity for a continued interactive dialogue as well.
  Dr. Ravi Narayan,
  Society for Community Health Awareness, Research and Action,
  No.367, 'Srinivasa Nilaya', Jakkasandra I Main,
  I Block, Koramangala, Bangalore – 560 034, India.

  Tel : 91 – 80 – 553 15 18 AND 91 – 80 – 552 53 72
  Fax : 91 – 80 – 553 33 58 (mark Attn. Dr. Ravi Narayan, CHC)
  Email : sochara@blr.vsnl.net.in

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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

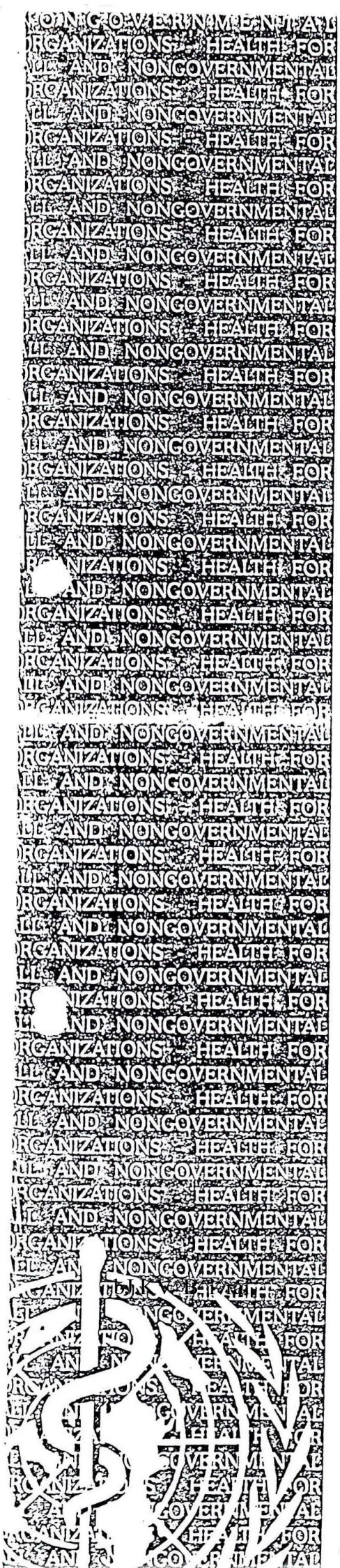
(Send back latest to reach us by 3rd October, 1999)

WHO/PPE/PAC/97.3
ORIGINAL: ENGLISH
DISTR.: LIMITED

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 fulfilment 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	Member professi tu
Amnesty	yes	yes	yes	yes	yes	yes	ye some
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	
GLOBE	no		-	yes Members are legislators and parliamentarians around the world	yes Annual conference and ongoing exchange of information	yes	ye Members
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	

"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 spe professional tus
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 distingui participants wit rect possibility t fluence polic
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	
Worldwatch Institute	yes	yes	?	yes	yes timing, targeting and planning	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	Memb profes
IBFAN	yes		yes, is a network			yes partnership of 150 national groups	
IPPNW	yes	no	yes		yes	yes	
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	a major plann
Marine Watch a publication	yes	–	?	yes	?	?	
Multinational Monitor	no	yes	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	–	

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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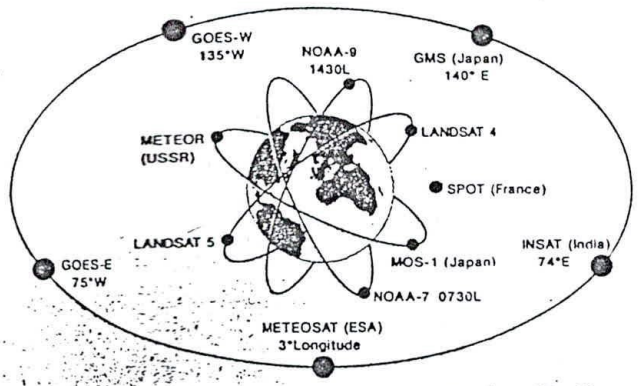


Figure 1: **Earth observing satellites in operation (as of April, 1992)**

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

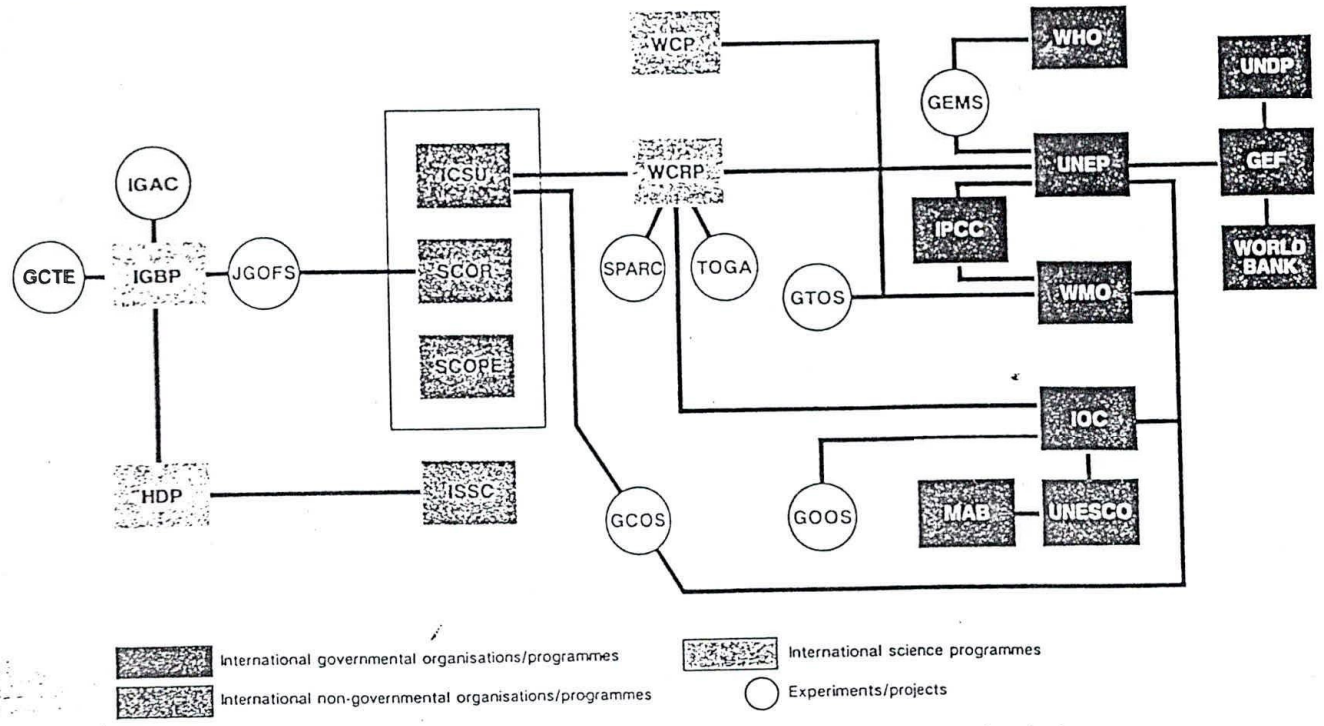
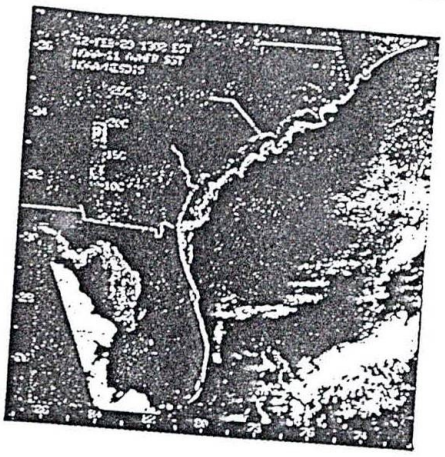


Figure 2: **Links between major international global environmental organisations, programmes, and projects**

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.

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†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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Reflections

on

a

Global Health Watch

by

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Reflections on a Global Health Watch

Ravi Narayan*, India

Background:

The idea of a Global Health Watch was first outlined by a group of professionals (1) concerned about the health impacts of environmental change. They suggested that WHO in collaboration with FAO, ILO, UNEP and others could play a key role in coordinating such an initiative 'to monitor health and climate change and link it to global health picture and population growth'.

In May 1997, WHO organised a formal consultation with Non-Governmental organisations in Geneva on a New Global Health Policy for the twenty first century (2). At this consultation, the NGOs 'expresed deep concern that one and a half billion people throughout the world still did not have access to basic health services. To address this glaring inequity, a group of NGOs known as the NGO Forum for Health (Formerly known as the International Primary Health Care Group) 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'. By early 1998, through a process of informal consultation a concept paper has been developed on such a watch – which takes the idea further (3).

These reflections are intended to provoke all those who have similar concerns, to think about the issues of 'Health Watching' and what they, especially groups like the Memisa Mundi International could do to make it a reality.

1. 'WHY' a health watch?

The Global health scenario is characterised by many alarming features:

i. Disparities between and within countries, in both economic and health status is becoming significant.

ii. Global environmental changes leading to global warming; loss of bio-diversity; and deforestation all have a great impact on health

iii. Globalisation and the evolving trade / aid policies are detrimental to health especially of those who are poor and marginalised.

iv. Downsizing of health systems support by government through increasing privatization and market concepts such as 'user fee' and the consequent breakdown of the public health system are reaching 'crisis' proportions.

v. The growth of the 'arms industry' complemented by growing racial/religious/ethnic fundamentalism are resulting in small wars and continuing racial and ethnic conflicts with devastating health consequences

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*Dr. Ravi Narayan is the Coordinator of the Community Health Cell, Society for Community Health Awareness Research and Action, Bangalore, India. He was part of a small informal team who facilitated the evolution of a concept paper for a Global Health Watch, an initiative of the NGO Forum for Health, Geneva. While drawing from this concept paper, he reflects on the Why? What? Who? How? of a potential Global Health Watch and the challenges of such an initiative. These reflections were presented at the Medicus Mundi International Meeting at Geneva in May 1998.

vi. A series of UN summits and conventions are promising Health for All by 2000; charters of Rights of patients; Rights of children and so on but the translation of rhetoric to reality is minimal.

A Health Watch is urgently needed to keep watch on all these trends and their effects on Health of People.

2. 'WHAT' could it watch?

There's much to watch. For a beginning, this could include:

i. Equity between and within countries especially regional / class / caste / gender / geography (rural vs urban) differences

ii. National Health commitments to Primary Health Care and their translation into adequate health budgets and adequate training and placement of health human power.

iii. International Health policies of WHO, UNICEF, World Bank, WTO, keeping track of their effects on health, especially of the poor.

iv. Industrial policies at National/Global level particularly focussing on
   a) Industrial pollution b) Alcohol and Tobacco industry c) the Pharmaceutical industry d) The arms/weapons industry

v. The Health of those affected by conflicts / disasters and wars and the effects on health of responses such as embargos, sanctions and 'relief activities'.

vi. Globalisation and its effects on Health of people and also on 'means' to health including – basic survival issues llike food availability, herbal medicine and so on.

The list can be enormous but some prioritization in the context of the Health of the poor will be required.

3. 'WHO' will support or contribute to such a watch?

A Health Watch will need the support of a large number of groups if it has to do its work effectively and meaningfully.

i. Citizens groups and grassroots NGOs can contribute greatly by keeping their 'ears to the ground' and watching the realities of health at the level of the lives of people especially the poor.

ii. National and regional NGOs and coordinating networks and associations and the increasing number of issue raising NGOs can contribute to the watch, providing data on regional diversities and disparities and broader intersectoral issues.

iii. Research and advocacy groups can provide 'valid' data from their studies especially community based and policy oriented.

iv. Professionals and professional associations can contribute technical expertise especially in analysis and interpretation. A multidisciplinary approach and a strong public health orientation are necessary.

v. Consumer groups and associations can provide data and support lobby / advocacy with the 'health watch' findings.

vi. Other watches can share their health related data to reduce duplication of efforts.

vii. Regional networks of NGOs and International health agencies could provide access to their data bases especially from their partner agencies at the community / local / national levels.

viii. WHO and its regional offices could support with regular monitored data from member countries and data from special surveys, research projects and programme monitoring system.

An effective 'Health Watch' will need to be able to access all these resources without getting controlled by one group – so that authenticity, accountability and objectivity are maintained.

4. 'HOW' could such a watch function

The credibility and authenticity of the watch is crucial and its accountability 'to watch on behalf of the poor and disadvantaged' who are most affected by the processes and trends being watched.

An effective 'watch' will therefore have to be a combination of all these features.

- Grassroots networks and citizens initiatives should be central.
- Information collated and analysed should be credible.
- The 'rigorous' research approach must be balanced with committed information dissemination and advocacy.
- Local/national NGOs especially from the South must be actively involved and in the lead, for it to be representative of a global democratic initiative.
- Its functioning should be flexible and responsive to emerging needs and concerns and interactive with a large group of resource networks.
- There must be a large component of participation by volunteers.
- Data and reports must be effectively and widely disseminated to reach all those who could participate in responsive action.
- Inspite of its 'activist' concerns, the watch should be highly professional so that the 'counter expertise' generated is very evidence based.

5. Some unanswered questions

While the 'Health Watch' concept has been receiving increasing and enthusiastic support, there are some unanswered questions:

- How will the 'data' collected or disseminated by the 'watch' reach the people, the community, the citizens groups – particularly the poorest communities who could be empowered with this information to understand their situation and fight for their rights?

- How could such an initiative be prevented from becoming another north-dominated and international NGO-dominated structure, providing solutions and top down prescriptions to the governments and communities of the South in a condescending or charitable way? How could the initiative be a truly democratic global process?

- How could such a initiative keep its independence and objectivity and credibility and not become subservient to the conditionalities of funding partners or international agencies including WHO, who will contribute to it but also be watched by it? **How could the global health watch be a truly independent Global Health Ombudsman?**

Those who help to initiate and develop the watch will have to face these questions in the days ahead.

6. Challenges ahead

The challenges of contributing / participating in the evolution of a Global Health Watch are many:

- It could be a strong commitment to building a truly equitous and ethical global society and a healthy one
- It could be a significant example of north-south solidarity
- It could be an opportunity to relook globally and locally at our life styles; our values; our societal relationships
- Finally, it could be an opportunity for professionals to commit themselves with courage to standing up for the poor and the marginalised and to making Health a reality for **all.**

ARE WE READY FOR THIS CHALLENGE??

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NOTE

All those who would like to respond to these reflections and participate in the process of actually evolving such a 'Watch initiative' are requested to :

- Send their comments/suggestions to Dr. Eric Ram, Chairman, NGO Forum for Health, World Vision International, 6 Chemin de la Tourelle, 1209 Geneva, Switzerland.
  Tel : +41 (22) 798 41 83
  Fax : +41 (22) 798 65 47
  Email : wvi.gva@iprolink.ch
  A project feasibility proposal has already been circulated by the Forum. Interactive dialogue would help the initiative 'get on track'.

- A copy of the above marked to the author would be an opportunity for a continued interactive dialogue as well.
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Com H 48.11

TOWARDS A TAMIL NADU HEALTH WATCH

In 1994, the concept of a GHW was introduced in an article in the Lancet. This was highlighting the need to watch such global phenomenon as warming, pollution and degradation of bio-diversity and their impact on Health. The mandate of such a Watch was expanded during the late 90s especially in the context of the fall of the Asian Tigers and the bitter experience of the South American economies. It became clear that such global phenomena as Liberalization – Globalization and privatization and the gradual retreat from HFA commitments of WHO and increase in power of international monetary agencies on national policies, also lead to ill health directly and indirectly. There was growing recognition of the need for an independent and credible ombudsman to monitor growing inequality in health and development as well as monitor the negative health impacts of various policies including economic, industrial, trade realted, both national and internationally. Following upon meetings organised by the NGO Forum for Health at Geneva on the whys, whats and hows of such a Watch organisation, it was decided to hold national/regional meets to discuss this. As part of this program, there was a meeting held in Bangalore November **7-8.**

The Bangalore meeting decided that there was a definite need for such a watchdog network:

That inequities need to be documented – such data is to a large extent available, but whatever data is collected has to be sensitive to the socio-economic-cultural reality – that this data has ~~looked~~ to feed back to the community from where it came – that any working mechanism would undertake advocacy, and this would be done on the basis of an aware and sensitive public.

This paper is an attempt to document the evolution of the concept of the GHW post the Bangalore meeting.

Why? The Philosophical Framework

A watch is a process. It occurs constantly and is quick to highlight inequalities and discrepancies. It is unencumbered by pressures from vested interests and its only pressure is that of the values of justice and equity. The presence of a 'watch' implies that there are inequities, and injustices, the fact that it is being wholeheartedly welcomed shows that these inequities are not only present and large but growing.

At another level is the crucial understanding that Health is in fact intimately connected with the whole of development, and no single intervention in isolation can bring about any change for the better. A 'watch' is also a reflection of a feeling of unhappiness with the complete and unchallenged adoption of the philosophy and goal of 'materialistic development' along a 'western' 'first world' model, and the forcing of these upon us by international agencies. If there is one thing that we have learnt in 50 years, it is the absolute futility of top-down, prescriptive programs,, planned and implemented in

splendid isolation from the socio-economic-cultural milieu. Despite this experience, the fact that such programs continue to be forced upon is disturbing to say the least.

At yet another level, there is a need for data. In black and white, to show and to convince. This despite the recognition that data, any data, hides as well as reveals. Any documentation - objective or subjective – is crucial to highlight, spread awareness and mobilise. Moreover, such documentation (at various levels of watching) highlights the intimate relationship between the global and local that is so easy to forget.

What? The focus

At the outset, one must understand that not only must we focus on the various inequalities present and increasing, but also the context in which these inequalities arose. As much as we must spread awareness amongst all levels of society regarding the inequalities we must not forget to focus on the causes of these.

Watch organisations in the past have been broadly of two kinds some such as Health Watch and Social Watch were formed with the specific mandate of monitoring the implementation of the governments commitment to various conventions and summits it signs. The other group like Amnesty, People's Watch have a much broader mandate but still focus only on Human Rights, democratic or civil rights violations.

Recognising that conventions and summits signed on the international arena present an opportunity to use positive developments globally to push for changes Nationally, it is important to realise that many of these conventions have clauses that are in fact detrimental to us. It is also a fact that many such conventions are signed under political and economic pressure.

Compared to these, the mandate of a Health Watch is vast. Even as we recognise the intimate links of Health with every facet of development, we begin realising the vastness of this canvas. From the effects of pollution and global warming, the effects of conflict and war, market-forces, privatization, disinvestment, the possible sub-focusses are infinite. However, one can keep justice and equity as the basis and focus on inequities at various levels and relate these to the various forces, circumstances causing them.

How? The method

Data: There is already a lot of data present. This data is being and has been collected by both governmental and non-governmental institutions. Like any data, much of these data suffer from a lack of reliability. However, especially the government data like census etc. are the most regular and wide ranging. Two other factors that are crucial before using any data is one, the accessibility, and two, the sensitivity to the socio-economic-cultural milieu.

Unless there is a regular source of data of equal reliability, it is impossible to 'watch' and unless this data is accessible, it can't be used. The socio-economic-cultural sensitivity of

any data is vital especially when we are focussing on the causes of these inequities. Though there are a large number of regular and even reliable sources on objective indications like IMR, MMR, % malnourished, etc. vary often it impossible to disaggregate these. Also the comparative lack of qualitative data means the loss of the flavour of socio-economic-cultural milieu from this data.

Structure: Most people during the Bangalore workshop as well as subsequently during individual meetings conceived of the 'watch' as a nodal organisation, where data from various sources could be collated, analysed and relevantly and sensitively presented. The separation of the function of 'watching' from primarily collecting data is crucial so that the watcher does not lose the contextual focus in the complexities of the local problems. Also, realising that along with collection of data lies the responsibility of 'doing something about what you find', it is best to leave data collection to locally active and respected institutions.

Thus, in the structure conceived, is a two way flow of information. Field data collected by local grassroots level organisation (including government where relevant) being passed on to a nodal 'watch' organisation. And passing back of a relevant analysis of the data collected that may be used at one level by the local NGO to spread awareness and mobilise and at another, analysis that can be used by pressure groups to influence policy makers, and the general public.

Functions: Outputs

One important point stressed is that any presentation and analysis of data must be relevant to the user. For example, discussing and showing globalisation as the cause of ill health may be true at one level, but may not be appreciated at another, where the physical actuality of lack of access to primary health care is more real than an open market.

The Watch could bring out a bulletin where data from specific case studies/specific communities are presented, compared and superficial analysis done. This bulletin would be a regular source of information, education, help in awareness building as well as a source of solidarity to the various groups that send in data. The Watch could also bring out quarterly/half yearly reports that are collations and analysis of much larger amounts of data that show trends etc and links to the causes be they environmental related, globalisation related or policy related. This could be used at different levels and especially for pressurising policy makers, academicians, researchers and bureaucrats.

At a certain point in certain situations, the 'watch' may also plan primary data collections, this may be both objective and subjective.

Organisation

There would be broadly three aims to the Watch. One would be in charge of data collection / documentation / publication. There would be one aim for research / analysis

and one for advocacy / public relations, etc. There is also the need to discuss funding. A few general principles that include any funding must be .
Dependence on any single source of funding would lead to a questioning of the two most fundamental values of any 'watch' autonomy and credibility.

Conclusion

In this paper, I have tried to present my conception of a Watch agency that will monitor inequities in health. By the very complexity in the definition and facets of Health, and Health's intimate connection with development as a whole, the canvas of such a 'watch' will be very very large. The underlying principles that form the bedrock are justice and equity. Such a watch is not only sensitive of the inequities present and growing but also aware of the reasons that these inequities arose and are growing. Such a Watch will attempt to spread awareness amongst the public and use this mass support along with the analysed data to bring about change in policy and society.

COM H 48.13

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 SYST

Systems	Objectives	Freq.	Coverage	Indicators measured	Organi by
Census	Total count of population with respect to demographic social and economic ch.	Once in ten years	Nation	Demographic, social and economic characteristics	Ministry Home
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. Pancha Police Health Reven
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	Directo of Cen opm., and St Health
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	Directo of H&F and Eco. a Stat.
HMIS	To provide timely aggregated information on health upto PHC level	Cont.	Nation	Births & Deaths Age and sex and cause wise death rates Fertility ratio	Directo of H &
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	Ministr & FW
Others MICS/R CH					

Public health

Disease surveillance at district level: a model for developing countries

T Jacob John, Reuben Samuel, Vinohar Balraj, Rohan John

For over a decade we have maintained within a district of 5 million people, a system of prompt reporting of cases of childhood vaccine-preventable diseases, encephalitis, meningitis, hepatitis, and rabies; together with a sentinel laboratory surveillance of cholera, typhoid fever, malaria, HIV infection and antimicrobial-resistance patterns of selected pathogens. The system combined government and private sectors, with every hospital enrolled and participating. Reports were scanned daily on a computer for any clustering of cases. Interventions included investigations, immunisation, antimicrobial treatment, health education, and physical rehabilitation of children with paralysis. All vaccine-preventable diseases have declined markedly, whilst malaria and HIV infections have increased steadily. Annual expense was less than one US cent per head. The reasons for the success and sustainability of this model include simplicity of reporting procedure, low budget, private-sector participation, personal rapport with people in the network, regular feedback of information through a monthly bulletin, and the visible interventions consequent upon reporting. This district-level disease surveillance model is replicable in developing countries for evaluating polio eradication efforts, monitoring immunisation programmes, detecting outbreaks of old or new diseases, and for evaluating control measures.

Introduction

Public health cannot progress without disease surveillance. For example, documenting the elimination of polioviruses from any country requires that every case of acute flaccid paralysis (AFP) is detected, reported, investigated, and shown not to be due to poliovirus. The same principle will apply to future targets for eradication, such as measles. The need for early recognition of new or resurgent infectious diseases has been illustrated by several recent outbreaks such as Ebola virus disease in Zaire and plague in India.[1,2]

The expanded programme on immunisation (EPI) has achieved very high vaccine coverage in developing countries, but the success of EPI can be measured only by surveillance of vaccine-preventable diseases. Had surveillance been designed from the very beginning of EPI for poliomyelitis, the inadequacy of three doses of oral vaccine in tropical/developing countries would have been detected straight away, and poliomyelitis eradication could have been achieved sooner.[3]

More than 10 years ago, we established a vaccine-preventable-disease surveillance system in our district as part of a project to control poliomyelitis, and later expanded its scope. A brief preliminary report of our experience is presented here in the hope that it will serve as a model for other districts in India as well as in other developing countries, especially where efforts are being made to eliminate poliomyelitis.

Disease surveillance

The North Arcot district (area 12 275 km², population about 5 million; capital, Vellore) is in the southern Indian state of Tamil Nadu. During the course of this study the district was divided in two, but for the purpose of this report the name represents both districts. There are 12 municipal towns (population 30 000–250 000) and about 3000 villages organised in 38 development blocks (total population 4 300 000) in the district. The nodal centre for surveillance consisted of one part-time senior medical supervisor, one full-time medical officer, five field workers, one typist, one car, four motorcycles, and one personal computer.

Administrative approval was obtained to collect data from all government health-care institutions (hospitals in every town and primary-health centres in rural areas). A list of all private hospitals in the district was prepared and they were individually enrolled in the reporting network by visits from the medical officer or field workers. Letters requesting enrolment were written to as many private clinics run by medical practitioners—particularly paediatricians—as we were able to identify either through professional associations or through surveys.

We began in 1984 with the reporting of AFP, measles, pertussis, diphtheria, tetanus neonatorum, and tetanus in older ages. 4 years later, rabies, encephalitis, meningitis, and hepatitis were added. Private hospitals and clinics were supplied with printed, self-addressed, post-paid cards to be mailed as and when a listed disease was diagnosed. The card had space for identification and address of the patient; the diseases were listed with boxes to mark the diagnosis. If a vaccine-preventable disease was reported, the number of doses of the pertinent vaccine taken by the child was also marked in boxes. Because the staff of the government hospitals were too busy to report each case, they were supplied with notebooks, each page printed with the replica of two post cards. Our field staff would copy the data from them once every month. Municipal health offices in the towns and the health centres in the villages submitted a line list of vaccine-preventable diseases once a month through the district health offices; they did not mail cards nor fill in the note books. Laboratory confirmation was not

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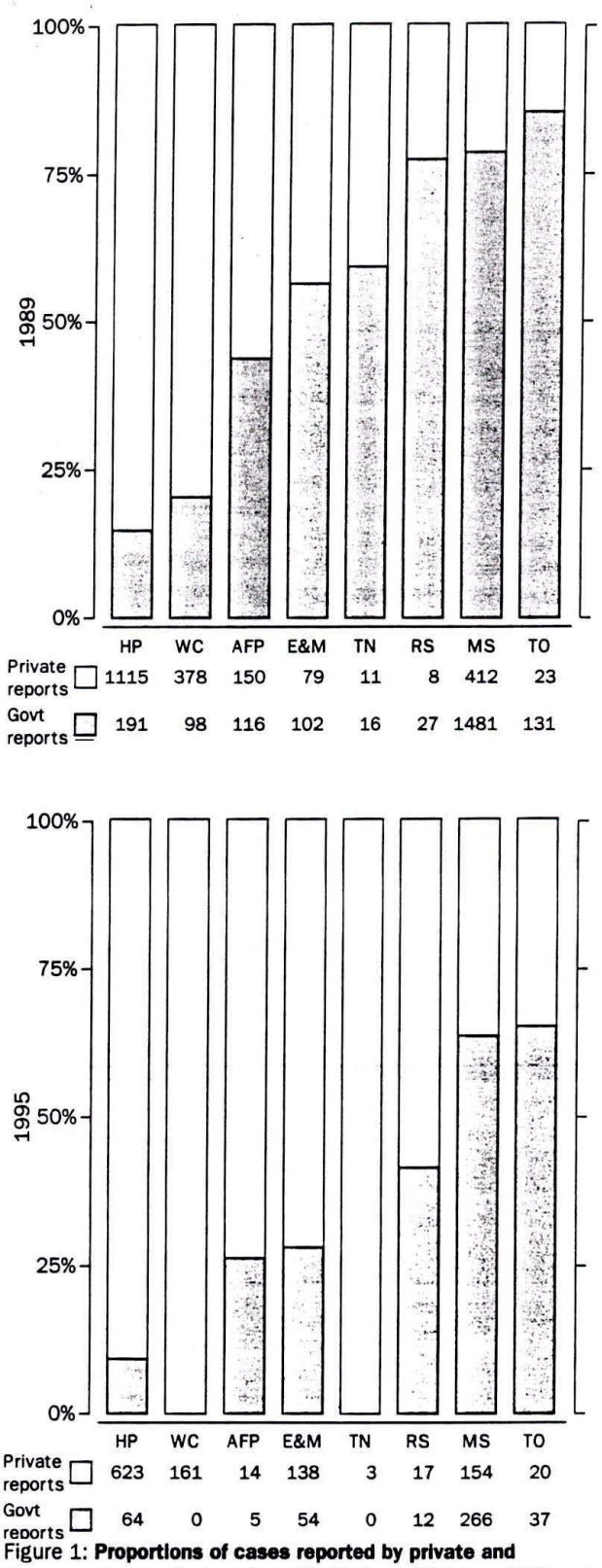

Figure 1: **Proportions of cases reported by private and government reporting centres, North Arcot District, 1989 and 1995**

Reported numbers of cases given below names of diseases. HP=hepatitis; WC=whooping cough; AFP=acute flaccid paralysis; E&M=encephalitis and meningitis; TN=tetanus neonatorum; RS=rabies; MS=measles; and TO=tetanus in older people. Diphtheria not included since cases were very few. Govt=government.

required for any diagnosis. Although case definitions were supplied, compliance was not checked.

All data were entered in a computer and duplicate reports (from different sources), if any, were deleted. Diagnoses and their geographical distributions were scanned daily by the medical officer. Every child with AFP was visited by field staff and brought to our hospital for clinical and virological diagnosis and acute care and rehabilitation, at no cost to the family. The bus fare and cost of food during travel were reimbursed. Any clustering of vaccine-preventable diseases was investigated by a visit from the field staff, followed by the medical officer, if it was deemed necessary. Intervention by way of immunisation (eg, during measles outbreak) or antimicrobials (eg, erythromycin to children in the catarrhal stage of pertussis) was offered.

Disease summaries were printed in a monthly bulletin (named NADHI, an acronym for North Arcot District Health Information; *nadhi*, Tamil for river) and distributed free of charge to all participating hospitals and clinics, the health administration (state and national) and the Indian and international offices of WHO and the United Nations Children's Fund (UNICEF). The bulletin listed the names of physicians or institutions against the diseases and numbers they had reported in the preceding month. The number of reported cases was also summarised by geographical location. In addition, the bulletin reported monthly cases of blood-smear-positive malaria (recorded by the district office of the national malaria control programme) and the numbers of the district residents detected to have HIV-1 infection by the national HIV surveillance centre at Vellore, irrespective of the reason for testing. The frequency of isolation of *Vibrio cholerae* and *Salmonella typhi*, and the antibiotic sensitivity pattern of the latter, were collected from one sentinel laboratory and also published each month. Every issue of the bulletin contained an article on a relevant and timely topic of public health interest, or news alerts of outbreaks or unusual infections.

The motive for health professionals to report cases was maintained by periodic visits from the field staff; by occasional continuing medical education meetings carried out in the towns by the medical officer and a guest in collaboration with professional associations; by regular mailing of NADHI; and by the supply of free vaccines (which we obtained from the national immunisation programme) to the private doctors to use in their immunisation clinics.

Results

Enrolment of reporting centres began in 1984; by 1985 all rural health centres and all government and private hospitals were participating. Subsequently, numbers grew with the opening of additional health centres and new private hospitals, and the continued recruitment of private clinics. In 1987, there were 111 government and 279 private reporting centres; in 1989, 143 government and 381 private centres and in 1995, 197 (32%) government and 426 (68%) private centres. Most (80%) of the government centres are rural and most (66%) private centres are urban.

The private centres reported about half the vaccine-preventable diseases in rural residents (46% in 1995) and almost all (99%) in urban residents. Other diseases were reported only by private centres and government hospitals, but not by any government rural health centre. The relative proportions of cases reported by the private and government centres is shown in figure 1. With increasing vaccine coverage (measured but not reported

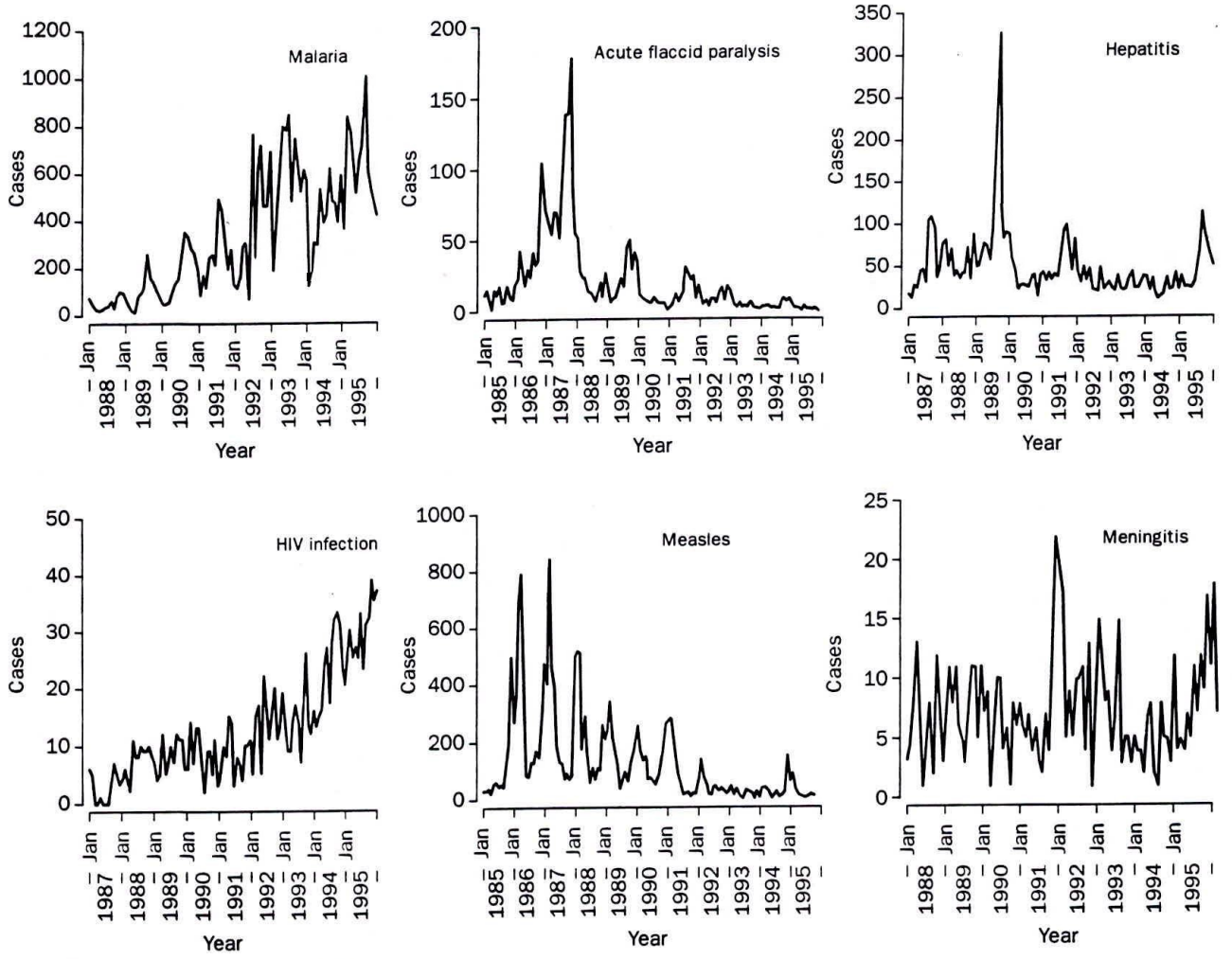

Figure 2: **Reported cases of infectious disease**

here), the prevalence of reported vaccine-preventable diseases has been reduced substantially, but that of other cases have remained stable over the years. Malaria and HIV-1 infection have shown alarming increases.

On several occasions outbreaks of measles and pertussis were recognised very early and successfully contained. The fact that we were interested in knowing about diseases, and that intervention measures were being taken, emboldened health personnel and citizens to report other diseases perceived by them to be of public-health importance. Thus the system detected, investigated, and reported outbreaks of human and animal anthrax, resulting in a concerted effort by the department of animal husbandry to control animal anthrax. On three occasions we investigated reports of bite by jackals (*Canis aureus*) in villages near woodland and gave rabies prophylaxis to several people; the villagers told us that in the past no-one had helped them even when human rabies had occurred after jackal bites. The sentinel laboratory report has enabled us to investigate outbreaks of cholera and food poisoning and to help resolve them. When an outbreak of typhoid fever occurred due to a multidrug-resistant organism, the bulletin alerted physicians and told them the correct methods of diagnosis and treatment.

Although our primary objective was to control poliomyelitis by improved vaccination guided by surveillance, we believed from the beginning that a single-disease AFP surveillance was unlikely to motivate private-sector physicians to cooperate fully. Moreover, the extra effort needed to include other vaccine-preventable diseases was thought to be small, but the data important. Reviewing data on vaccine-preventable diseases up to 1984, we found that most of the rural health centres were not reporting any cases; the excuse was that the workers feared (not without reason) the consequences of reporting, since the occurrence of vaccine-preventable diseases was deemed indicative of their own lapses in achieving immunisation targets. We had to overcome two hurdles: to remove the fear of reporting from the government-sector staff and to obtain private-sector participation. Both have been achieved by the NADHI system. If government-sector reporting alone had been successfully strengthened, the majority of cases of AFP and pertussis would have been missed. In 1995, pertussis and neonatal tetanus were reported only by private centres.

Most cases of rabies, encephalitis, and meningitis in 1989 and in 1995 were reported by the private sector. At both times, most cases of hepatitis were reported by private centres and most cases of tetanus beyond neonatal age (mostly adults) by government reporting centres. It is clear that successful disease surveillance must combine the government and private health-care agencies. Urgent steps are essential to investigate the causes of hepatitis, encephalitis, and meningitis, and to design and deploy control measures. With tetanus, for example, a concerted effort to prevent neonatal tetanus by immunisation of

pregnant women has reduced its incidence substantially. However, year-by-year more cases of tetanus among older people were detected. Tetanus immunisation needs to be targeted more widely to protect the entire susceptible population.

We have verified the reporting efficiency of AFP and have data (not presented) to show that it was near 100%. The completeness of reporting of other diseases has not been verified. However, we do know that most children with measles are not brought to medical attention by the family; hence only a fraction of cases are reported by health-care workers. Yet, the annual seasonal peaks, their declining trend over the years up to 1992 and the widening of the inter-epidemic interval since then, all suggest that NADHI has correctly reflected the time trend of measles (figure 2).

The data on malaria and HIV-1 infection were those already being generated by their own independent systems and reported to the respective national agencies. However, no-one has used the data nor examined time trends at the district level before; the situation is alarming for both diseases. In India, data on malaria are available in nearly all districts, and on HIV-1 in several, but remain hidden for want of a district-level information system.

Discussion

There are several shortcomings in this model. Perhaps the most important is that it is run voluntarily by one private institution; unless the government adopts it and replicates it in other districts in the country, it will remain a research project. Fortunately, moves are afoot to establish a district-based disease surveillance system in India. When surveillance is established in several or all districts, the monthly disease-summary bulletin need not be district-based, but instead could be at state level for large countries such as India, or national level for small countries. We have not been able to intervene to establish aetiological diagnosis, epidemiological investigation, or prevention, against hepatitis, encephalitis, or meningitis, even when outbreaks were detected early. There is no microbiology laboratory in any government hospital. In this population of 5 million, there are only four microbiology laboratories and all are in private hospitals. Although the government has established a network of rural and urban health-care institutions covering the entire population—a very laudable achievement—evidence-based diagnosis is deficient in primary and secondary health care, and public health is paralysed for want of epidemiological tools and expertise. Where we have had intervention tools, such as vaccines, success has been obvious.

Many other diseases of public-health importance are not on our list of reportable diseases; this situation can be remedied by increasing funds for surveillance. The annual running expenses of NADHI, including printing and mailing of the monthly bulletins free of charge, was roughly 100 000 Rupees, amounting to less than one US cent per capita per year. If the government runs an expanded disease-surveillance system and applies control measures for infectious diseases, net economic profit in addition to improvement of the health of the people is likely.

For the sake of completion, we must point out that the notification of a list of diseases is legally required in Tamil Nadu State (Madras Public Health Act 1930) and in every other state. However, hardly anyone complies with this requirement because there has been no system of enforcement. Paramedical workers in the rural health centres are expected to send weekly summaries of morbidity including vaccine-preventable diseases. Even after establishing NADHI we found that rural health centres did not report non-vaccine-preventable diseases, partly because sick people prefer to seek help elsewhere. Physicians, both in government and in private institutions, face no consequences for not reporting disease. Surveillance is not merely for statistics, but for information for action. In the absence of action or at least feedback even when action is not possible, people lose interest in case notification. These problems are prevalent in many developing countries. The NADHI model is a practical and sustainable surveillance system. The system is appropriate for developing countries because it is inexpensive, and entails the participation of both government and private health-care personnel. It can be easily established and also improved upon.

This research was funded by grants from the Indian Council of Medical Research, New Delhi and from the European Economic Community, Brussels, for poliomyelitis control in the district. We thank the Directorate of Public Health of the Tamil Nadu State and successive district health officials who approved and participated in the project. Without the cooperation and encouragement of participating physicians, the dedicated services of the field, secretarial, and computer staff, this project would not have been successful.

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NGO FORUM FOR HEALTH

GLOBAL HEALTH WATCH WORKSHOP

(18 May 1999 : 14.00 - 18.00 : Salle IX/UN)

BACKGROUND PAPER

Prepared by Ms. Asmita Naik, (B.A. Hons. Law, Solicitor), Consultant for Global Health Watch

INTRODUCTION

The idea of a Global Health Watch to act as an independent and credible monitor of inequalities in the health status of different populations, and to promote a more even distribution of resources to ensure equal health rights for all, was first raised in February 1997 by the NGO Forum for Health. In September 1998, a Task Force was established and a feasibility study was begun to consider the scope and potential of such a watch. Various steps have been taken since then to further develop the idea including the production of various conceptual papers as well as consultations with established watch mechanisms such as Social Watch and Amnesty International, to explore potential areas of overlap and lessons learned. A survey of NGOs in the Forum was also carried out to establish data collection activities and their relevance to a potential Global Health Watch. Representatives of the task force also participated in a Rockefeller Foundation workshop on the proposal of a health watch. The purpose of this background paper is to gather many of the ideas which have emerged during this period and to raise key questions for debate and clarification.

THE NEED FOR A GLOBAL HEALTH WATCH

The huge disparities in the health status of populations in the developing and developed world are evident. Even within nations, there are major differences in the health condition of different populations depending on class, gender, ethnicity, regional and geographical factors. The following statistics illustrate these inequities:

- Around 1.5 billion people live on less than US$1 per day
- The prevalence of child malnutrition reaches staggering proportions - 38% in Sri Lanka, 45% in Vietnam, 66% in India, and 68% in Bangladesh over the period 1990-96
- The average life expectancy in Least Developed Countries was just 62.2 in 1995, compared with 74.2 in industrialised countries
- 43% of the population in Least Developed Countries over the period 1990-96 had no access to safe water, 51% had no access to health services and 64% had no access to sanitation

(Source: World Bank/UNDP)

The question of health equity has drawn increasing attention in recent years from health organisations and governments. The causes of these inequalities are deeply rooted in the world economic and political order and WHO has categorically identified poverty as the greatest threat to health. Modern day trends in globalisation, environmental degradation, civil wars, privatisation of health care to name but a few, will in turn have an impact on the health enjoyed by the world's populations. Watch mechanisms have shown some success in recent years in the areas of civil and political rights, social inequality and the environment, and this has led commentators to ask whether the same approach can positively influence issues of health equity.

BASIC PRINCIPLES

A range of values and principles, such as equity, justice, human dignity, universality, gender mainstreaming and sensitivity, and ethical codes of conduct have been touted as fundamental principles for a global health watch. Most of these values are enshrined in existing UN human rights treaties and the International Covenant on Economic, Social and Cultural Rights - ICESCR (1966) recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (art. 12.1).

The question of the implementation of socio-economic rights and the long-standing argument that the root causes of such problems lie in world economic inequality and not only in the hands of individual governments is recognised by ICESCR which says that state obligations are relative and progressive, a state party should aim "to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognised in the present Covenant by all appropriate means"(art. 11.1). Thus a Global Health Watch would need to identify tangible areas for monitoring and advocacy where individual governments and organisations have the capacity to make positive changes.

It is also important to take a holistic approach to the issue of human rights and recognise that a wide range of activities can count as implementation of the right to health, from administering vaccinations at ground level to advocacy before UN human rights treaty bodies. This perspective would embrace a variety of initiatives instead of viewing a rights based approach as something totally new. The link between health and human rights needs to be further explored at the conceptual level, including the impact of human rights violations on health: the impact of health policies on human rights standards: and the commonalities between public health and human rights strategies.

THE FUNCTION OF A GLOBAL HEALTH WATCH

The function of a Global Health Watch would be essentially to find information on inequalities in health and then to take steps to encourage the responsible authorities to initiate change to redress these injustices.

The focus of a Global Health Watch:

A global health watch would focus on the policy and practices of:

- Governments
- International organisations such as WHO, UNICEF, World Bank
- Private sector organisations
- International NGOs

To monitor the following aspects of their activities:

- Fulfillment of commitments made in international agreements
- Harmful effects of activities on the health of populations
- Discrimination against certain groups based on class, caste, gender, race, ethnicity, sexual orientation
- Effectiveness of policies and practices
- Efficiency, oversight and public accountability of operations
- External input into policy development process

Possible activities of a Global Health Watch:

- Monitoring data, treaties, and current issues and providing analysis and commentary
- Data collection /alternate reporting
- Dissemination and sharing of information
- Advocacy - taking up issues with responsible authorities, raising public awareness, work with the media
- Policy development
- Early warning function
- Networking
- Technical assistance to NGOs through training (e.g. data analysis, advocacy), sharing best practices, capacity building
- Resource mobilisation
- Community intervention

Specific topics which have been proposed as potential subjects for Global Health Watch scrutiny:

- International agreements such as Alma-Ata declaration in 1978, WHO Health for All, Beijing Platform for Action, Population and Development Programme of Action (Cairo)
- Age/gender mortality rates showing cause of death
- Morbidity data from selected vulnerable populations
- Disease surveillance making use of data on emerging and re-emerging diseases
- Critical appraisal of reports produced by WHO
- Pollution
- Tobacco
- Pharmaceutical drugs
- Bio-technology industry
- Alcohol
- Embargoes
- Sanctions
- Signaling outbreak of communicable diseases
- Developing measures and standards
- Equal availability of basic needs for a healthy life, such as food, clean water, sanitation
- Equal access to health care and removal of barriers, such as user fees
- Prevalence of strong primary health care systems integrated into district health systems
- Proportion of health care budgets spent on primary, secondary and tertiary care
- Availability of trained health personnel
- Community participation in health care
- Monitoring of government policies across a range of sectors which may influence health such as education, transport, energy, housing etc.
- Maintenance of adequate health infrastructure, progress on water and sanitation
- Effectiveness of disaster preparedness and unequal impact of natural disasters
- Identify priority health needs
- Timely response to global health challenges
- Encourage international conventions on health
- Inform research priorities

METHODOLOGY

Pre-requisites for the effective functioning of a Global Health Watch:

Consultations have taken place regarding the way in which a Global Health Watch would carry out its work. Other watches have identified the following points as vital for the effective functioning of a watch **mechanism:**

- A strong grassroots national base which interacts with a global network
- Collection of accurate, reliable and unbiased data
- Monitoring of data after collection

- Cooperation with other national and international NGOs in the collection and dissemination of information
- Effective dissemination of information in terms of style, content, timing, methods and target groups
- A flexible network of organisations with a strong central steering structure to identify common goals and avoid duplication
- Active participation of volunteers
- Prioritization, this is especially important where there is a broad mandate dealing with wide-ranging and complex issues
- Monitoring and evaluation of the impact of the activities of the watch itself
- Balancing research and advocacy activities

Sources of data:

- NGOs
  A survey has been conducted among members of the NGO Forum for Health which showed that 67% of respondents collected data which may be relevant to a Global Health Watch as it includes information on demographics, mortality and morbidity, health care policies and practices and access to health care. This data is not comprehensive as it is usually restricted to particular target groups such as women and children. It is being collected for the purposes of advocacy, monitoring and public policy formulation.
- International Organisations
  International organisations monitor data provided by governments on a range of issues such a population health, disease incidence, access to health care.
  Examples - WHO is creating a global database on country health profiles and a health systems performance index. WHO also has a programme and budget document which can be used to check what is being achieved across the board. OECD also collects statistics.
- National governments
  National government reports on health may be useful but vary enormously in quality.
- Academia and research community

Partners:

The Global Health Watch would liaise and coordinate with many different local, national and international organisations and individuals **including**:

- Grassroots community groups
- Advocacy groups
- Health research and academia
- Professionals and practitioners
- Consumer groups
- Other watch mechanisms
- National, regional and international organisations

Benchmarks for progress:

Another issue is to evaluate, firstly, whether progress has been made regarding the health situation of specific populations and secondly, whether Global Health Watch activities are having an impact. External benchmarks may be used to establish comparisons between different countries such as infant mortality rates, or internal benchmarks which carry out successive measurements in the same place over a period of years, such as the rate of vaccinations. Available indicators which have been identified include the UNDP Human Development Index and the UNDP Gender-related Index, as well as an index developed by USAID. Measurements would need to measure both the level of attainment and efforts which have been made.

ORGANISATION

The organisational framework is still under discussion but one possibility may be a network of national health watches linked to a small secretariat which would coordinate watch activities globally. Questions remain regarding the staffing of the secretariat, the membership and governance and decision-making processes. Another important issue is how funding can be generated which would allow the watch to maintain its independence from donors and have a wide sustainable base.

NEXT STEPS

- The Workshop on 18 May will be held to obtain national, regional and global perspectives on the establishment of a Global Health Watch.

- The feasibility study will continue with a consultation taking place in six countries to obtain regional perspectives on a Global Health Watch and to establish lessons learned from other watches. A set of recommendations will be prepared and a final report sent to potential donors. A more formal workshop will be held to present the final report and explore ways of launching the Global Health Watch, possibly in the year 2000.

CONTACT DETAILS

The idea of a Global Health Watch is at an evolutionary stage and we would very much welcome your input, suggestions, contributions and participation. Please send comments to the following:
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COM H 48.15

RELEVANCE OF EQUITY IN HEALTH AND HEALTH CARE A PRIORITY FOR TODAY

Routine health information often hides social gaps in health and health care.

These gaps are unacceptably wide and they keep widening throughout the world.

Government spending on social services, too, is being constrained by many powerful pressures.

Countries are finding it difficult to implement equitable policies and are often caught between considerations of equity and short-term efficiency. There is a mistaken belief that "too much emphasis on equity now will jeopardise economic growth and perpetuate poverty and deprivation.

Hence equity in health and health care must be placed higher on the public agenda.

WHAT DOES EQUITY MEAN?

- Equity means fairness
- It means people's needs rather than their social privileges guide the distribution of opportunities for social well-being.
- Pursuing equity in health and health care means trying to reduce avoidable and unnecessary social gaps in health status and health services among groups with different levels of social privileges while working efficiently to achieve the greatest improvements for **all**

Equity in health care requires equity
(a) in the way health care resources are allocated
(b) in the way health services are actually received and
(c) in the way health services are paid for

It implies a commitment to *ensure for all* high standards of real (not only theoretical) *access, quality and acceptability* of health services.

Real access requires active efforts to remove a range of important obstacles :

- financial, geographical or physical barriers
- logistical barriers like conflicting family or work responsibilities
- linguistic, cultural or educational barriers
- barriers of a perception of low quality of the services

Widening gaps in health status as well as in health care may be one of the most sensitive indicators of problems with broad economic or social policy.

The term **INEQUITY** has moral and ethical dimensions. It refers to differences that are ***unnecessary*** and ***avoidable*** and are considered ***unfair*** and ***unjust***.

Living in an inequitable society could harm health through many *economic, social, psychological* and *physiological pathways*.

Disregard for equity in health and health care means disregard for guaranteeing equal opportunity for all to achieve an acceptable level of health care.

It means that some people because of being disadvantaged in society will experience unnecessary suffering, physical disability or limited physical and mental development or maybe even die before their time.

Equity in health and health care is not only an ethical need but also a pragmatic and practical imperative.

- Disregard for equity is socially destabilizing.
- Disregard for health equity is incompatible with long-term productivity. No society can afford to discard its human capital.

Economic growth does not automatically lead to more equity. Economic growth can create opportunities to achieve more equity, but only when there is a strong commitment to equity and a sustained series of actions towards that goal. More importantly, equity in health development is possible even when growth is most constrained. Many interventions in health sector can yield improvements at relatively low cost.

Efficient strategies make the best use of available resources, but savings in greater efficiency are unlikely to be sufficient. Equitable financing methods must be sought. Donor support must reinforce, not undermine equitable policies.

CONSTITUTIONAL GUARANTEE

Says the Preamble to the WHO constitution, 1946:"The enjoyment of t6he highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Says the Constitution of India: "The Constitution of India aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health and strength of the workers, men and women, especially ensuring that children are given opportunities and facilities to develop in a healthy manner."

Representing the same concern for equity in health care, WHO developed the visionary global policy of "Health for All by 2000 AD". The Alma Ata declaration, adopted in the 1978 World Health Assembly, stated : "The existing gross inequality in the health status of the people is unacceptable." The strategy of Primary Health care suggested to help reach this goal was specifically designed to achieve this equity effectively and efficiently even in settings with severe resource constraints.

Compression of data to common health and health care indices hide various disparities. To obtain a clearer picture, data must be broken down according to differences in socio-economic status, geographical

location, gender and race which reflect differences in social advantage.

Inequity in health	
At the global level	North-South divide, rich nations-poor nations
At the Central level	Low support, low and decreasing budget
At the State level	Some worse than others (allocations vary widely)
At the community level	Some more disadvantaged than others – rural, tribals, SC, marginalised, poor, females, less educated
At the family level	Women, children, girl child and the aged

Factors leading to inequity

Over the years, many factors have contributed to the inability of implementation of equitable policies. Predominant among them are:

Historically

- Socio-cultural norms
- Socially, culturally and behaviourally determined roles and responsibilities
- Poverty
- Politics of selfishness and personal enhancement
- Population explosion
- Suppression of healthy lifestyles, habits and health care behaviour

More recently

- Continuing population growth leading to changing health and demographic scenario
- Industrial revolution
- Globalisation, liberalisation and Structural Adjustment Programme (SAP) leading to diminished social spending with health sector affected maximally
- Communication revolution
- Appearance of newly emerging and re-emerging health problems
- Environmental degradation
- Imbalanced expenditure and health policies favouring the better-off.

GENDER INEQUITY

A gender perspective is vital for planning and implementing health policies and strategies. Gender sensitivity should be a basic value in health policies. A gender perspective includes:

- gender analysis and awareness,
- gender sensitivity to the special needs of women,
- enhancing the participation of women in policy and decision-making and
- strengthening the dignity and self-worth and capacity of women.

An analysis of the current status of the female sex in India clearly reveals that from womb to tomb, most of them are at a disadvantage compared to their male peers. More important is the fact that these gender differentials get worse in groups where other criteria leading to inequity exist. Thus rural females are worse off than urban females and tribal females are worse off than rural non-tribal females.

INEQUITY IN A FEMALE'S LIFE FROM WOMB TO TOMB	
PERIOD	**INEQUITY ASPECTS**
NEWBORN	* **Foeticide**
NEONATE	* **Higher neonatal deaths**
INFANCY	* **Higher IMR**
PREADOLESCENCE	* **Less numbers than males demographically** * **Higher prevalence of malnutrition, higher degrees of malnutrition** * **Less educated** * **More abused**

ADOLESCENCE	* **Learned helplessness**
	* **Establishment of "set" cultural behaviour**
	* **Submissive**
	* **"Untouchable" during menstruation**
	* **Males matter more**
	* **Further, higher education restricted**
	* **Early marriage**
	* **More abused**
PREMARRIAGE AND EARLY MARRIED YEARS	* **"Hawked for marriage"**
	* **Husband always comes first**
	* **The dowry menace**
	* **Dual role bread earner and hearth/cooking/running a home**
	* **Adjustment (in-laws) problems**

MIDDLE AGE	* **Work, work, work!**
	* **Bear ill-health in silence**
	* **Husband, children always come first**
	* **Eat last and left-overs as usual**
	* **Little support from husband**
MENO PAUSE	* **Menopausal symptoms including psychological problems**
	* **Often lonely and single**
	* **No attention, love and care from family members, no empathy**
	* **Hardly any health care expertise available for the health problems of her age**
DEATH	* **Cheaper**
	* **Not much to regret about**
	* **No accumulation of "Property hungry relatives" hovering around at death time**

REPRODUCTIVE PERIOD	* **Too Early, Too Close, Too Many Pregnancies** * **Anaemia** * **Infections** * **Promiscuous behaviour of husband leading to many infections like STDs** * **Financial constraints** * **Poor, inaccessible, expensive health care facilities** * **Antenatal, natal, and postnatal problems** * **Focus on tubectomies as the family planning technique**

Disregard for equity jeopardizes the health of everyone because of spillover effects (crime, infectious disease, increased cost of treatment than for prevention).

What we now require is to proceed forwards from information to action:

- Public attention and consensus must be mobilized to ensure political will for action. Information alone is not enough.

- Real changes are needed in resource allocation. Some countries have been able to counterbalance the strong tendency to allocate more to those who already have more. It must be noted that identifying and reaching those in greater need requires conscious, focused efforts.

- The best technical efforts are needed, not just good intentions.
- Health services alone will not suffice. Committed Intersectoral cooperation and actions are **required**.

Health For All was a clarion call to overcome this lack of equity. However, after the initial enthusiasm the sustained support required for its success did not materialise and like most good ideas it remained a slogan – words with no teeth. The WHO admitting this and in keeping with the changing circumstances, thus proposed a new policy called "Renewing the HFA strategy (RHFA) in which equity in health and health as a human right are given prominence.

Says WHO in a recent document "Equity recognizes that everyone is of equal worth, is entitled to respect, personal autonomy and is able to meet ones' basic needs; an equitable health system ensures universal access to adequate quality care without an excessive burden on the individual".

PARADIGM SHIFT IN EQUITY IN HEALTH AND HEALTH CARE

SOCIAL PRIVILEGES	**➔ PEOPLE'S NEEDS**
RICH, POWERFUL, INFLUENTIAL	**➔ ALL *(Specially the deprived- dalits, tribals, rural, urban poor)***
HIGH STANDARDS FOR FEW	**➔ GREATEST IMPROVEMENTS AND SHARING OF PROGRESS *FOR ALL***
LEVEL DOWN	**➔ LEVEL UP**
DEPENDENCY ON OUTSIDE RESOURCES	**➔ SELF-RELIANT TECHNOLOGY**
TOP-DOWN PATERNALISM	**➔ DEMOCRATIC UTILISATION**
ACTS OF CHARITY	**➔ CAPACITY BUILDING**
SHORT – TERM	**➔ LONG – TERM**
RESTRICTED ACCESS	**➔ UNIVERSAL ACCESS**

Global Health Watch
(National Level Meeting - India)

Background

The idea of a Global Health Watch to act as an independent and credible monitor of inequalities in the health status of different populations, and to promote a more even distribution of equal health rights for all was first raised in April 1997 by the NGO Forum for Health. Since then, a task force was established and a feasibility study begun to consider scope and potential of such a watch. The NGO Forum for Health had an in-depth workshop on this issue in May 1999 during the last session of the World Health Assembly, Geneva. Now, a series of National Level meetings are being held to debate this further.

An India-level meeting was held in early October 1999, in partnership with the Society for Community Health Awareness, Research and Action, Bangalore (Community Health Cell) who have already been involved in the preliminary conceptual dialogue.

Date : 7/8th October 1999.

Venue : Ashirvad, St. Mark's Road, Bangalore - 560 001.

Organised by : NGO Forum for Health (Geneva);
Community Health Cell (Bangalore).

Participants : A cross-section of health groups were invited which included
WATCHES: Social Watch, Health Watch, Peoples, Watch, North Arcot District Health Intelligence, Peoples Union for Cicil Liberties-Karnataka.
GRASS ROOTS COMMUNITY GROUPS: Belaku Trust, Jana Swasthya Sahayog, Rural Unit for Health and Social Affairs, All India Peoples Science Network;
ADVOCACY GROUPS: Vimochana, PEACE.
HEALTH RESEARCH / ACADEMICS: Center for Enquiry into Health and Allied Themes Jawaharlal Nehru University, Foundation for research in Community Health, St. John's Medical College, Dept. Of Humanities-Indian Institute Of Technology.
HEALTH PROFESSIONALS: Community Medicine, Demography/Statistics, Epidemiology, Public Health policy, Health Management.
CONSUMER GROUPS: CREAT, Public Affairs Center.
NATIONAL & REGIONAL ORGANISATIONS: Voluntary Health Association of India, Medico Friends Circle.
REGIONAL ORGANISATIONS: Regional Office For Health and Family Welfare, Kerala Shastra Sahitya **Parishad.**

Output : The proceedings of this meeting and an informal country level opinion survey among the participants of the meeting will feed into a feasibility study now underway on the GHW idea.

Objectives of the Meeting

1. Dialogue on the concept / role of a Global Health Watch.

2. Inequalities, Inequities and problems relevant to the Indian context to be included in the agenda of a Watch.
3. Learning from the scope and experience of other Watches and networking in the Watch efforts'.
4. How to measure/monitor these inequalities? Existing source of data? Access, transparency and validity?
5. The relevance, structure, framework and linkages of a 'Indian Watch' linked to the emerging GHW.

DAY ONE

SESSION I ; Chair : Dr. V. Benjamin

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 national body that would be able to keep an eye on the health inequalities which are increasing and making life worse for the poor and marginalised* – a section of India she 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 which transformed it into a concept for 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 although an organization had agreed to fund the entire initiative, 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. It was well recognized that there was no shortage of data and that the only problem was that

it 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. These were:

- 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 from the Indian Institute of Management, Bangalore, speaking on behalf 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 platform 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 of organizations with similar agendas had decided to prioritize its activities and had focused on two issues.

- Removal of targeted approach to 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 a 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 continue grappling with the government.
- The relationships between larger and small groups need to be kept open in a ntework 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.

Gita appreciated Thelma's concern about the population lobby being behind the RCH program and 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 and non-state actors involved.

Sunil explained that Social Watch had chosen to analyze three major themes of social development, namely 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 Panchayat 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 focused 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.

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 and a methodology was quickly set up 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. He however added 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, Veerappan. It tries to intervene by providing information to national and international human rights agencies eg, the National Human Rights Commission and state HRCs. Peoples Watch 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 its 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, which he had brought to light with the help of an organized studyhe had brought to light 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 the 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 which 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 that 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 lack of 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 focused 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 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. As 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 used by the subgroup to modify, add to, prioritize the list of issues that had been culled out from the responses to the questionnaire circulated before the meeting and presented in Session VI

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

Amar Jesani shared the experience of 2 campaigns launched by The Center for Enquiry into Health and Allied Themes (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 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 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 that 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 also. The participation in these various processes was in a spirit of mainstreaming the ideas of ethical medical practise.

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 Chowdhury 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 in order to understand anything it must have experiential basis and should be local-specific. PEACE campaigned against the New Economic Policy and also produces handbooks on various acts and conventions that India had signed. 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 the community and post-partum practices. She talked about intramuscular Pitocin administration to mothers in labour, 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, like Amar earlier, spoke of the easy acceptability of private practice regardless of 'quality' due to the fact that its practitioners treated the patients better than 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 because 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 Saraswathi's 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 7to8 such 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, to get 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 this Peoples Organisation 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 PRIs to make health and local appropriate development part of their agendas.

Making WHO Work Better

An Advocacy Agenda for Civil Society

A discussion document
Produced by the Global Health Watch

The Global Health Watch is an initiative aims at presenting southern-based

Introduction

Every year at the World non-government organisa health agendas by lobb and other stakeholders. T topics and issues: particul treatment; pharmaceutica health of children and ot and many others.

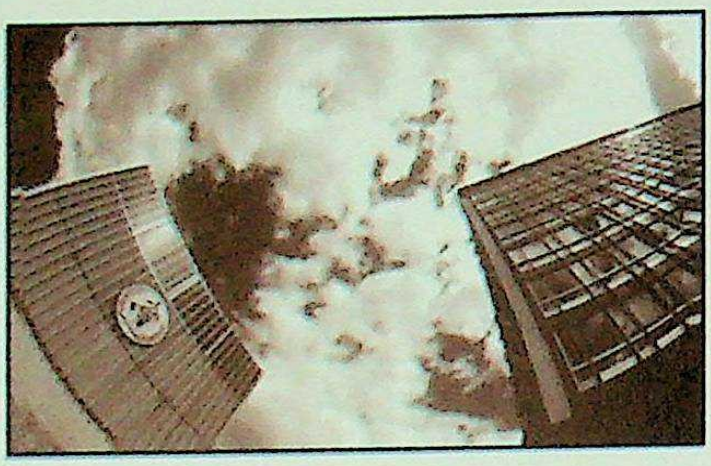
The benefits and import participating in the advar health governance structu providing a counter-weig governments towards the the poor; corporate greed that preside over the prese that is unjust and harmful t

Progress made in the area of breastfeeding and acc been as great without th society action.

However, one topic that attention of civil society Organisation itself. While of advocacy messages, i advocacy efforts.

This document is intended civil society and the NG strategy to strengthen t accountability of WHO to equity.

Why WHO is impor



A second reason is the historical legacy of WHO and its contribution to the Alma Ata Declaration - a progressive conceptualisation of health that remains vital to the needs of billions of people. WHO continues to embody a conception of health embedded in a developmental, human rights and social justice framework that is not always shared by other global health institutions. In addition to this historical legacy, WHO has a proven track record in providing technical leadership on a range of issues that is unsurpassed.

A third reason relates to the present chaotic nature of the global health architecture, caused in part by the proliferation of global health initiatives and global public-private "partnerships", which is undermining a coherent global response to poor health as well as the development of national health systems in many countries. The situation calls out for WHO to bring order to the chaos.

However .....

..... while WHO may be seen by many as the lead global health organisation, several factors contribute to it being ineffective. The reasons for this have been more extensively documented in the Global Health Watch and include the following:

- The deepening and entrenchment of poverty through the unfair structure of the global political economy point to the fact that other actors such as the governments of the G8, transnational corporations and global economic institutions (particularly the World Bank, International Monetary Fund and World Trade Organisation) have an influence on population health that outweighs WHO's. On top of this, groups with an interest in preserving the

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a financing system that undermines coherent planning and which forces WHO departments and divisions to compete with each other (and other organisations) for scarce funds. The consequence of this is that health priorities are distorted and even neglected to conform with the desires of donors and the requirement to demonstrate quick results to them.

- As government contributions to WHO have stagnated, WHO has been forced to be increasingly reliant upon private sources of financing and 'public-private partnerships'. This however has resulted in a subtle erosion of public accountability and public health principles to accommodate the commercial and business interests of its new partners, whilst adding to the problems of fragmentation by adding even more institutional partners to the international health aid mix.

- In addition to external factors, there are factors internal to WHO which have rendered the organisation less effective. There are documented examples of internal management and administrative weaknesses. Other criticisms include the over-abundance of doctors within WHO (relative to other professionals such as nurses, social scientists, economists, lawyers and political scientists) which is said to sustain a bias towards biomedical approaches to health improvement. Deficiencies in human resource management and unfair labour practices have also resulted in a considerable demoralisation amongst staff.

Remedies?

Many of the remedies to resolve the problems with WHO described above are obvious, and include:

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global health. These CSO

Should there be support for taking this agenda forward, some actions that could be taken forward as part of an advocacy strategy could include:

- *More coordinated lobbying during the World Health Assembly.* Civil society presence at the World Health Assembly is inadequately coordinated. There are a wide range of organisations competing with each other to disseminate their materials and having their voices heard. A process to coordinate civil society participation could be much more effective and efficient. One CSO could be tasked to monitor the programme of the World Health Assembly, identify key issues and help plan more coordinated civil society participation six months in advance of the World Health Assembly.
- *A naming and shaming campaign* targeted at countries not fulfilling their commitments to the funding of WHO.
- *Engaging with the election of the new director general.* The politicised nature of the elections of the director-general (and regional directors needs) to be tempered. In the wake of the sad and sudden death of Dr Lee, it is vital that civil society ensure a successor who will live up to the stated commitment of Dr Lee towards improved and more equitable global health. In the run up to the forthcoming election, civil society should demand that candidates publish a manifesto and that WHO should facilitate widespread debate about them.
- *A strategic assessment of where WHO should be influential in the interests of health in relation to other multilateral bodies,* and in particular the existing liaison mechanisms between WHO and the international trade and financial institutions. This should be accompanied by an assertive and explicit campaign to promote the mandate of WHO to engage (more vigorously) with the structural and social determinants of health, as well as with the development of public policy that guides the financing and organisation of health care systems.
- *Monitoring and watching.* Civil society should consider getting together to collaborate on the development of a 'monitoring and watching' programme to strengthen

What next?

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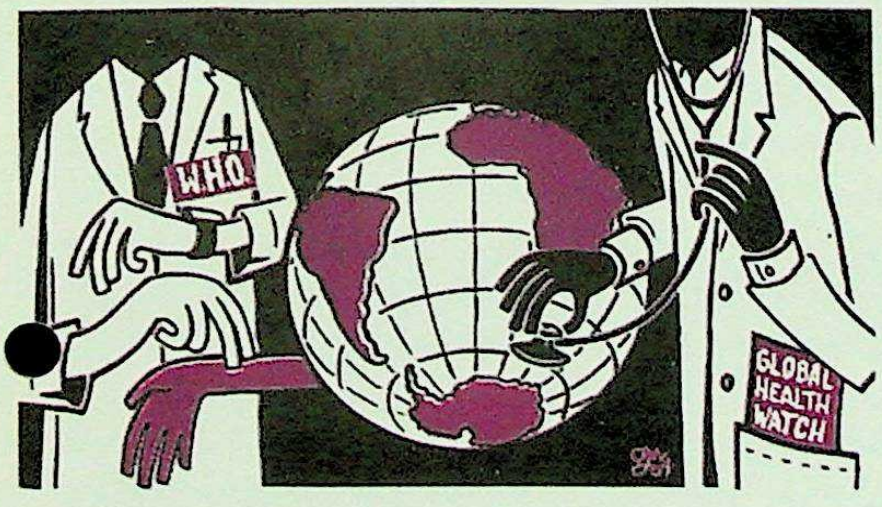
A Health Systems Development Agenda for Developing Countries

Time to be clear and visionary

A discussion document for civil society and NGOs

Produced by the Global Health Watch



The Global Health Watch is an initiative aimed at

What is the issue?

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Identifying the caus

But there are other reasons for the collapse and chronic under-development of health care systems. These include the effects of fragmentation. At the level of governance, planning and management, the health care systems of many countries resemble an orchestra of competing musicians playing different tunes without a conductor! Official development assistance (ODA) programmes, new GHIs, private foundations, UN agencies, the World Bank, IMF and international NGOs are pulling communities, health workers and Ministries of Health in different directions. This not only undermines coherent health systems planning, but also weakens Ministries of Health through: a) inappropriate conditionalities and externally-imposed agendas, often designed to suit the interests and needs of the external agency; b) the loss of skilled personnel from the public sector into the non-government sector, thereby reinforcing the dependency of Ministries of Health on external agencies; and c) the imposition of large transaction costs upon Ministries of Health and health workers who have to liaise with and report to a multitude of stakeholders.

The fragmentation of health systems governance, planning and management is also associated with a fragmentation of programmes and service delivery. The last few years have witnessed a proliferation of vertically-organised programmes and selective health care interventions, particularly in the poorest countries. These programmes and initiatives have arisen as a consequence of dysfunctional health care systems, as well as the imperative to urgently extend coverage of life-saving interventions.

However, they also aggravate the lack of coordinated and effective health systems governance and management; create an inefficient duplication of systems and services (for example parallel drugs and supplies systems); cause health workers at the coalface to be pulled in different directions by the demands of different selective and vertical programmes; and retard the development of integrated, context-based local health plans. And where vertical programmes and selective health care initiatives are implemented through non-

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inappropriate; accentuating a bias towards biomedical interventions at the expense of public health approaches to prevent illness and promote good health; the replacement of provider collaboration with provider competition; and a deterioration in trust between patients and providers.

Global economic integration and 'free trade' have further accelerated the impact of market-driven health care outcomes. The international brain drain of skilled human resources from poor to rich countries is well known. But in addition, the scarce domestic health care resources of some countries are being diverted away from national priorities and the needs of the poor towards a growing 'health tourism industry' serving economically-advantaged foreigners and towards the provision of services (e.g. histopathology and radiology services) to contractors in high-income countries. And through new trade rules, multinational health corporations now have the ability to force the break up of universal, public health care systems in order to extract profits from the health care market, particularly in countries with a critical mass of high-income consumers.

Finally, health care systems in many countries have to struggle with a growing burden of disease and poverty. The AIDS epidemic on its own threatens to overwhelm the capacity of many health care systems. And in sub-Saharan Africa, the doubling of the numbers of people living in poverty since the 1980s means that more people are vulnerable to the threat posed by infectious diseases, as well as to the costs of seeking heath care.

The vision of a 'good' health care system

There are no simple, quick-fix solutions to the numerous reasons for poorly functioning health care systems. The strengthening and development of health care systems will require a multi-dimensional programme of reform and change, guided by a long-term vision and commitment towards a set of clear health systems goals.

However, health care systems can exist in different shapes

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care systems can also act as a catalyst for improving public accountability and good government more generally); and support community empowerment.

Key elements of a health systems development plan

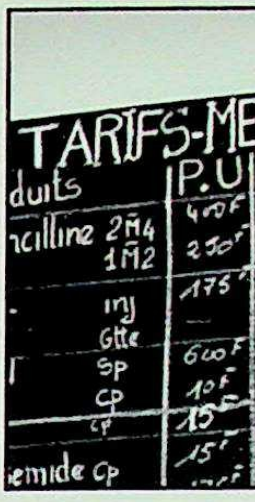
With these principles in mind, what might be the key elements of a health systems development agenda for low-income, developing countries?

Human resource planning

Getting the right number, mix and competencies of the health workforce is possibly the single most important element of a health care systems development strategy. The 2006 World Health Report describes this challenge in greater detail.

Some of the demands that can be made by civil society are to see evidence of:

- A comprehensive situation analysis of all existing public and non-government workforce. Such an obvious and simple first step is often absent in most countries and points to the need for immediate investments in human resource (HR) information systems and data bases to assist with HR planning and management. This should be followed by regular periodic audits of the geographic distribution of health workers, set against locally derived norms.
- A ten year human resource for the health sector that would incorporate:
  - a clear definition of the number and skills mix of the health workforce required to provide essential health care (including important non-clinical personnel, such as health economists, accountants and human resource logisticians who are vital to improving the management capacity of the Ministry of Health),
  - A medium term investment plan in schools of nursing, medicine, public health and other disciplines in order to attain the medium and long term production



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rather than the exception. Civil society could call for an international declaration for the donor community to co-fund core public sector health worker salaries on condition that countries have reached reasonable targets for the investment of domestic revenue into the health sector and that there is evidence of an effective human resource administrative system.

- The development of non-financial, professional incentives to reward good performance, coupled with the implementation of clear civil service rules and codes of conduct, and public accountability mechanisms at different levels of the health care system.

Resource generation

A meaningful and adequate human resource plan would require an increase in the health budget. Furthermore, it would require sustainable, reliable and long-term increases in the budget.

The cost of a comprehensive human resource plan, together with other key health systems costs such as medicines, transport and infrastructure development, could form the basis of an indicative sector-wide budget for the core infrastructure required to provide essential health care to all.

A demand that could be made by civil society would be for:

- Every country to develop such an indicative budget, measure the financing gap between it and current expenditure, and publish a plan for plugging the gap with additional domestic and external financing.

Within countries, governments must be enabled to strengthen their capacity to increase tax revenue in a fair manner, and prevent unethical capital flight. Civil society could advocate for:

- All countries to set a target to raise at least 20% of their GDP as tax revenue, and to allocate at least 15% of total

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Sector-wide approach of financing

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must advocate for:

- A revitalised commi
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judged by the performance of the overall health care system over time.

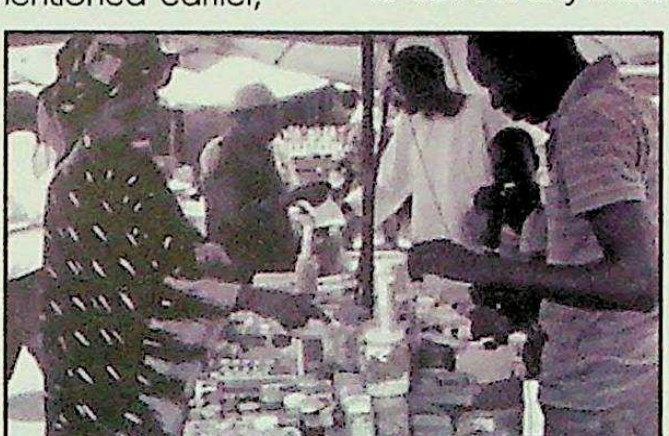
Abolish user fees

User fees in poor countries are an unjustifiable barrier to health care. Efforts must be made to abolish user fees in the public sector. Civil society could advocate for:

- ➢ Countries to adopt a target to reduce direct out-of-pocket payments to less than 20% of total health care expenditure, with timetable of steps towards the full abolition of the vast majority of out-of-pocket payments.
- ➢ Donors to support governments to help maintain quality of care in the face of increased utilisation following the abolition of user fees.

Strengthening health sector management

To achieve the goal of a strong, effective and publicly-based health care system, more investment needs to be directed at strengthening public sector health management capacity at all levels of the health care system. As mentioned earlier, HR planning and management requires particular attention. Other aspects of health management that should be highlighted include: resource management and planning; expenditure monitoring; financial management; essential drugs management; and improvements in health systems research. Civil society can advocate for:



- ➢ The regular production of national health accounts to describe the way in which health care is financed, as well as the pattern of health care expenditure, including measurements of the per capita expenditure variations between geographic areas, between socio-economic groups, and between secondary / tertiary hospitals and district health services.
- ➢ Evidence of investments in the strengthening of the financial management systems of the public health

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Managing the tension be health care with compre development

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care system, will help impro

Civil society can advocate

- ➢ Agreement on a comm
  systems goals to be sh

At the global level, there is a need to debate the current architecture of global health policy making and governance. Civil society can:

- Call for a discussion to consider whether we have too many separate international and GHIs adding to the already uncoordinated field of official donor agencies, and whether there is a need for a paradigm shift in the way the international community responds to the health crisis in sub-Saharan Africa and other poor regions / countries. For example, rather than multiple strands of health funding attached to disease-based or selective interventions, there could be a single fund for comprehensive health systems financing which would then form the platform for designed disease-based or selective interventions.

Public and community involvement in health care systems

For public sector bureaucracies to work effectively, efficiently and fairly, they need to be held accountable internally through rules and codes of conduct as well as to communities and the public. Sector-wide budgets and a commitment to public stewardship are insufficient in themselves to get health systems working well - the public sector also needs to be kept honest and accountable. The scope of civil society activities involved in strengthening health care systems include advocacy; monitoring; and participating in planning and decision-making. The design of health care systems can enhance community involvement by incorporating community structures and forums such as district health committees, clinic committees and hospital boards into the health governance structure; inculcating a culture of consultation and respect for lay people; disseminating information about the rights of service users; and publicising disparities in key indicators such as maternal mortality and immunisation coverage. Civil society can call for:

- Streams of funding to support civil society engagement

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- Laws and regulations to enforce community rating and prescribed minimum benefits where private insurance schemes exist, and to block payment systems that encourage over-servicing and supplier induced demand.
- Regulations to control and improve the geographical distribution of all private health services, such as the issuance of certificates of needs.
- Appropriate strategies and policy instruments (such as licensing requirements, formal accreditation and price controls) to regulate and improve the quality of care of this sector.

What next?

The vision, principles and recommendations presented here are generic, and would need to be tailored to the historical, economic and political contexts of different countries. Furthermore, fragile states and countries in states of conflict or under oppressive rule are likely to need different approaches.

One of the next steps is to promote discussion about the challenge to strengthen health care systems and provoke questions about the appropriateness of the current paradigm and efforts to improve health in developing countries. It is only with a greater civil society consensus and momentum that donors and governments are likely to be influenced by such a challenging set of recommendations and aspirations. The Global Health Watch therefore invites you to respond to this proposed advocacy agenda and to recommend further key actions that could be taken to facilitate further dialogue and discussion.

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The Global Health Watch i
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Contact us

An electronic copy of this
feedback form is available f

www.ghwatch

Please send your comments

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Acknow

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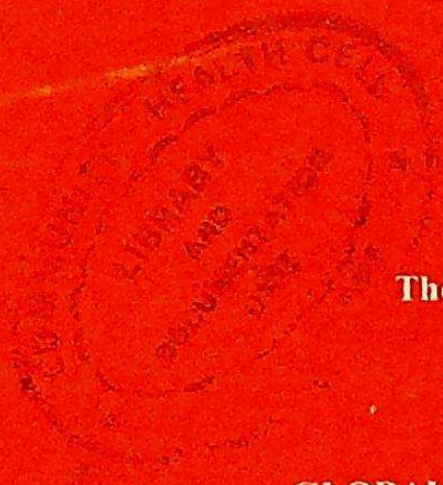

The NGO Forum For Health

GLOBAL HEALTH WATCH PROJECT

SUMMARY REPORT ON STATUS OF FEASIBILITY STUDY CONCERNING THE ESTABLISHMENT OF A GLOBAL HEALTH WATCH

March 2001

Prepared and submitted by
Asmita Naik, Consultant

Geneva, Switzerland

Resource file

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SUMMARY REPORT ON STATUS OF FEASIBILITY STUDY CONCERNING THE ESTABLISHMENT OF A GLOBAL HEALTH WATCH

March 2001

Prepared and submitted by
Asmita Naik, Consultant

Geneva, Switzerland

The NGO Forum For Health

April 4, 2001

Foreword:

One of the major initiatives of the NGO Forum for Health is to promote, and eventually establish, an independent, credible monitoring entity. We call it: Global Health Watch and we continue to work toward that goal. This project was initiated by the Forum in February 1997 in Geneva.

Since then a number of workshops and regional consultations have taken place. Ms. Asmita Naik, our consultant for this project has captured the main findings in a full report. This report represents the Executive Summary of the main report. A number of recommendations have been included in the report which the Steering Committee of the Forum will consider carefully and advise us on the next steps.

We are very encouraged by the positive feedback and enthusiasm shown by the members and supporters to move ahead with this project. The NGO Forum for Health is well positioned to play a leading role. We will also work closely with "other watches" who have similar visions and interests.

May I take this opportunity to acknowledge with many thanks the excellent work done by Ms. Asmita Naik, our current consultant, and Ms. Adrea Mach, our first consultant who did the initial work.

Thanks are also due to Dr. Thelma and Dr. Ravi Narayan for organizing the South Asia Regional Conference and to Dr. Dan Kaseje for the Africa one.

We are also grateful to our donors: NOVIB; MISEREOR; ICCO; DIFAM and WORLD VISION INTERNATIONAL for their generous and timely contribution which made it possible for us to carry out this feasibility study.

Thanks also to all the members of the Steering Committee, especially Dr. Roberta Ritson, Dr. Manoj Kurian, Mr. Giovanni Ballerio and Dr. Alireza Mahalatti for their extensive inputs and continued guidance and support.

Eric R. Ram, Ph.D.
President
The NGO Forum for Health

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PREFACE

The Global Health Watch project was initiated in 1998 by the NGO Forum for Health in order to explore how monitoring and advocacy regarding inequalities in access to health care could be improved with the aim of promoting equal health rights for all. Since then a number of initiatives have been carried out to take this idea further in terms of considering the establishment of a Global Health Watch to monitor and report on inequalities in health worldwide. Research has been carried out to see what is already being done in this field by other agencies. Three workshops have also been held, one at the international level, and two at the national level, in India and Zimbabwe. These initiatives have stimulated considerable interest in the idea and have resulted in a deep reflection on the need and functioning of a Global Health Watch. Challenges remaining include taking the project one step further through a pilot study in one country to consider the practical functioning of a Global Health Watch at the national level. In addition, the idea needs to be taken to other regions in order to test its applicability on a truly global scale. This paper is a summary of a status report completed at the end of 2000 on action and findings so far. The following pages give an overview of the main steps taken, the outcomes, and challenges ahead in terms of taking the Global Health Watch forward.

A. INTRODUCTION

The idea of a Global Health Watch (GHW) to act as an independent and credible monitor of inequalities in the health status of different populations, and to promote a more even distribution of resources to ensure equal health rights for all, was first raised in February 1997 by the NGO Forum for Health. In September 1998, a Task Force was established and a feasibility study was begun to consider the scope and potential of such a watch. This summary report describes the various activities that have been carried out and then draws out the findings of these activities in terms of the need and functioning of a Global Health Watch.

B. ACTION TAKEN

i) A number of research activities and consultation meetings have been carried out at the international and national level by the NGO Forum for Health in order to explore the idea of setting up a Global Health Watch.[1] These initiatives have sought to consider five main questions:

- why is a Global Health Watch needed;
- how would it function – basic principles; focus; activities; topics; methodology (data; partners; benchmarks); organization;
- what commitments have been made by governments and international organisations on health;
- what other NGOs are doing in the area of health and human rights;
- what information exists which would be of use to a GHW.

ii) Research has been conducted into the following areas:

- Health commitments made by governments at international conferences held in the 1990s show that wide-ranging commitments have been made on all areas of social development including health.
- Activities of other international and non-governmental organisations in terms of data collection and monitoring show a reliance on government data and the clear need for independent verification of information.
- Mandates of other non-governmental organisations reveal an ad hoc involvement and monitoring of health issues but an evident gap and need for an organisation which solely focuses on monitoring and advocating on the right to health.

iii) The following workshops have been held:

- **A one-day workshop was held at the time of the World Health Assembly in 1999** involving 28 speakers and participants from different regions. Presentations were made by other watches (INFACT and IBFAN)

1 This is very much a brief summary of activities that have been carried out. A full report is available from the NGO Forum for Health

which provided important lessons learned while regional speakers gave their perspectives on the idea of a Global Health Watch. Working group themes that were discussed included the measurement of inequities and inequalities in health; data collection and analysis; monitoring and advocating on specific topics; identification of topics; and organisational points.

- A **national level meeting was held in India in October 1999**. It was organised by the Society for Community Health Awareness, Research and Action (Community Health Cell) in Bangalore and brought together an impressive collection of participants with considerable enthusiasm and expertise in the area of health issues and human rights. There were 40 participants for the two day workshop from varied backgrounds including government representatives, academics, physicians, NGOs with primarily research agendas, activist NGOs, individual activists, economists, lawyers, management experts etc. The meeting brought out lessons learned from other watches, gave an opportunity to air case-studies, and conducted working groups to look at conceptual and methodological issues from an Indian perspective. A wealth of knowledge and information was amassed at this meeting which will certainly help the Global Health Watch project to move forward. [2]

- A **pan African one day meeting took place in October 1999 in Harare, Zimbabwe**, within the context of a larger conference on health issues. It was convened during the Africa Community Action Network for Health (Afri-CAN) Think Tank Conference on "Mobilising health for all". Afri-CAN members were invited to attend this session to put forward their ideas on the establishment of a Global Health Watch and the meeting revealed much interest in the proposal. Afri-CAN is a pan-African network of some 60 institutions which seeks to advocate on behalf of the poor and marginalized and to enhance the capacity of vulnerable populations to cope with the demands of their daily lives. The meeting comprised of plenary and working group discussions. [3]

- The NGO Forum also participated in a **Rockefeller Foundation sponsored meeting in Bellagio, Italy in November 1998**, in which general consensus emerged about the need for a global health watch with a strong, national grassroots base.

C. FINDINGS

The various initiatives outlined above have resulted in an in-depth enquiry into the

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2 A full report of this meeting was prepared by the Community Health Cell, Bangalore and is available from the NGO Forum for Health. In addition, the full status report on the feasibility study incorporates most of the Indian national meeting report.

3 A full report of this meeting was prepared by Afri-CAN and is available from the NGO Forum for Health. In addition, the full status report on the feasibility study incorporates most of the Afric-CAN report.

need and functioning of a Global Health Watch. This section draws together these many different ideas and represents the findings of the project so far.

The need for a Global Health Watch

The huge disparities in the health status of populations in the developing and developed world are evident. Even within nations, there are major differences in the health status of different populations depending on class, gender, ethnicity, regional and geographical factors. The following statistics illustrate these inequities:

- Around 1.5 billion people live on less than US$1 per day.
- The prevalence of child malnutrition reaches staggering proportions: - 38% in Sri Lanka, 45% in Vietnam, 66% in India, and 68% in Bangladesh over the period 1990-96
- The average life expectancy in Least Developed Countries was just 62.2 years in 1995, compared with 74.2 years in industrialised countries
- 43% of the population in Least Developed Countries over the period 1990-96 had no access to safe water, 51% had no access to health services and 64% had no access to sanitation

(*Source: World Bank/UNDP*)

Even in the world's most affluent nations, there are major inequities in health and health care. Studies have shown a clear link between high levels of poverty and income disparity in the US: 1 in 4 American children live below the poverty line; 43 million Americans do not have health insurance; and the rate of suicide is especially high among young people. Research has indicated that greater life expectancy is linked to the least disparity in income in a country and not simply to the absolute wealth of a nation. (*Daniel Werner speaking at the NGO Forum for Health meeting at the World Health Assembly in May 2000*).

The question of health equity has drawn increasing attention in recent years from health organisations and governments. The causes of these inequalities are deeply rooted in the world economic and political order and the World Health Organisation (WHO) has categorically identified poverty as the greatest threat to health. Modern day trends in globalisation, environmental degradation, civil wars, privatisation of health care, to name but a few, will in turn have an impact on the level of health of the world's populations. Watch mechanisms have shown some success in recent years in the areas of civil and political rights, social inequality and the environment, and this has led commentators to ask whether the same approach can positively influence issues of health equity.

Basic Principles

A range of values and principles, such as equity, justice, human dignity, universality, gender mainstreaming and sensitivity, and ethical codes of conduct have been proposed as fundamental principles for a global health watch. Most of these values are enshrined in existing UN human rights treaties and the International Covenant on Economic, Social and Cultural Rights - ICESCR (1966) recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"(art. 12.1). It should be noted here that health is defined broadly in a number of

international instruments to encompass physical, mental and social aspects. The Global Health Watch will adopt a broad definition of health which encompasses physical, mental, spiritual and social aspects.

The question of the implementation of socio-economic rights and the long-standing argument that the root causes of such problems lie in world economic disparities and not only in the hands of individual governments is recognised by the ICESCR. This states that state obligations are relative and progressive, a state party should aim to implement these rights "to the maximum extent of its available resources, with a view to achieving progressively the full realization of the rights recognised in the present Covenant by all appropriate means"(art. 11.1). Thus a Global Health Watch would need to identify tangible areas for monitoring and advocacy where individual governments and organisations have the capacity to make positive changes.

It is also important to take a holistic approach to the issue of human rights and recognise that a wide range of activities can contribute to the implementation of the right to health, from administering vaccinations at ground level to advocacy before UN human rights treaty bodies. This perspective would embrace a variety of initiatives instead of viewing a rights based approach as something totally new. The link between health and human rights needs to be further explored at the conceptual level, including the impact of human rights violations on health: the impact of health policies on human rights standards: and the commonalities between public health and human rights strategies. In addition, research carried out by the NGO Forum for Health indicates that no NGO is currently focusing exclusively on human rights and health.

The function of a Global Health Watch

The function of a Global Health Watch would be essentially to find information on inequalities in health and then to take steps to encourage the responsible authorities to initiate change to redress these injustices.

The focus of a Global Health Watch:

A global health watch would focus on the policy and practices of:

- Governments
- International organisations such as WHO, UNICEF, World Bank
- Private sector organisations
- International NGOs

To monitor the following aspects of their activities:

- Fulfillment of commitments made in international agreements
- Adverse effects of activities on the health of populations
- Discrimination against certain groups based on class, caste, gender, race, ethnicity, sexual orientation
- Effectiveness of policies and practices
- Efficiency, oversight and public accountability of operations
- External input into policy development process

Possible activities of a Global Health Watch:

- Monitoring data, treaties, and current issues
- Data collection
- Data analysis and commentary
- Alternate reporting i.e. producing shadow reports of official reports prepared by governments and international organizations to human rights treaty bodies etc.
- Dissemination and sharing of information
- Advocacy - taking up issues with responsible authorities, raising public awareness, working with the media
- Policy development
- Early warning function
- Networking
- Technical assistance to NGOs through training (e.g. data analysis, advocacy), sharing best practices, capacity building, information exchange
- Resource mobilisation
- Community intervention

Specific topics which have been proposed as potential subjects for Global Health Watch scrutiny:

- International initiatives such as Alma-Ata declaration in 1978, WHO Health for All, Beijing Platform for Action, Population and Development Programme of Action (Cairo)
- Age/gender mortality rates showing cause of death
- Morbidity data from selected vulnerable populations
- Environmental protection and impacts on health
- Disease surveillance making use of data on emerging and re-emerging diseases
- Critical appraisal of reports produced by WHO
- Pollution
- Tobacco including cooperation with WHO's Tobacco Free Initiative programme
- Pharmaceutical drugs
- Bio-technology industry
- Alcohol
- Embargoes
- Sanctions
- Corruption
- Signaling outbreak of communicable diseases
- Developing measures and standards
- Equal availability of basic needs for a healthy life, such as food, clean water, sanitation
- Equal access to health care and removal of barriers, such as user fees
- Prevalence of strong primary health care systems integrated into district health systems
- Proportion of health care budgets spent on primary, secondary and tertiary care

- Availability of trained health personnel
- Community participation in health care
- Monitoring of government policies across a range of sectors which may influence health such as education, transport, energy, housing etc.
- Maintenance of adequate health infrastructure, progress on water and sanitation
- Effectiveness of disaster preparedness and unequal impact of natural disasters
- Identify priority health needs
- Timely response to global health challenges
- Encourage international conventions on health
- Inform research priorities

Methodology

Lessons learned from other Watches:

Consultations have taken place regarding the way in which a Global Health Watch would carry out its work. Other watches have identified the following points as vital for the effective functioning of a watch mechanism:

- A strong grassroots national base which interacts with a global network
- Successful campaigns often benefit by mobilizing the public through grassroots activism such as boycotts and petitions
- Important to have allies across the world at local, national and international levels.
- Need to be tough as enemies may be formidable
- Visibility is an important defence, so the more public the campaigns are the better it is
- Careful selection of campaigns and allies especially if resources are limited
- Be attuned to public opinion and aware of what is acceptable and what is not
- Collection of accurate, reliable, unbiased and unassailable data
- Use publicly available information
- Use existing sources of data as primary collection is very costly
- Involve the community in data collection
- Multiple data sources should be used and a variety of methods such as fact-finding, public inquests. Rank data according to quality
- High quality analysis of data after collection
- Cooperation with other national and international NGOs in the collection and dissemination of information
- Effective dissemination of information in terms of style, content, timing, methods and target groups
- A flexible coalition of organisations with a strong central steering structure and effective oversight works best. Can achieve more through coalition than working independently
- Active participation of volunteers
- Prioritization, this is especially important where there is a broad mandate dealing with wide-ranging and complex issues
- Monitoring and evaluation of the impact of the activities of the watch itself
- Balancing research and advocacy activities

- Advocacy should not only be confrontational but should give an opportunity to "culprits" to respond to private approaches first of all
- The right publicity at the right time can lead to outpouring of public support
- Ensure a wide sustainable financial base. Individual membership can allow for this diversity and independence
- Develop measurable criteria for monitoring
- Present data in a comparative way, for example through use of charts comparing different regions and countries, as this can be an effective pressure tool.
- Important to contribute, teach and build capacity and not merely be critical. Governments may not act appropriately, not simply because of lack of will but also because of lack of resources and know-how.
- A watch should be independent, transparent, moral, objective and credible
- Make maximum use of electronic media as the internet allows for a rapid and cheap way of exchanging information
- Important to access existing networks e.g. International Network on Population and Health (INPH), a network of 170 organisations initiated by WHO, and the Voluntary Health Association of India (VHAI)
- Need to focus on positives as well as negatives
- The organization must be democratic, accountable and open, especially, if there is a disparity in the size and status of different groups participating
- Bureaucrats and politicians should be brought on board as they may be a major obstacle
- Ensuring a consultative democratic process in setting up a watch is as important as the watch itself
- Allow diverse voices and dissent
- There should be a mechanism of reporting back to the people so that ownership clearly lies with them
- Education and awareness building should go hand in hand with negative campaigning and confrontation.

Sources of data:

- NGOs

A survey has been conducted among members of the NGO Forum for Health which showed that 67% of respondents collected data which may be relevant to a Global Health Watch, as it includes information on demographics, mortality and morbidity, health care policies and practices and access to health care. This data is not comprehensive as it is usually restricted to particular target groups such as women and children. It is being collected for the purposes of advocacy, monitoring and public policy formulation.

- International Organisations

International organisations monitor data provided by governments on a range of issues such as population health, disease incidence, access to health care. Examples – WHO, OECD, WB, UNDP, UNFPA.

- National governments

National government reports on health may be useful but vary enormously in quality.

- Academia and research community

There are many existing sources of data which should be used wherever possible as primary data collection is very costly. Furthermore, there is value in analyzing existing data as it may provide an opportunity to make critical commentaries, which the collectors of the data are unable to do. As there is much reliance on government data, there is a need to a greater or lesser extent, to verify existing data. There are also important gaps in current data, although there is some breakdown in terms of gender, there is rarely further breakdown by social group in terms of class, ethnicity, race etc. In addition, there emerges a gap in data collection at the grassroots level. These are gaps which a GHW could seek to fill.

Partners:

The Global Health Watch would liaise and coordinate with many different local, national and international organisations and individuals including:

- Grassroots community groups
- Advocacy groups
- Health research groups and academia
- Professionals and practitioners
- Consumer groups
- Other watch mechanisms
- National, regional and international organizations and networks

Benchmarks for progress:

Another issue is to evaluate, firstly, whether progress has been made regarding the health situation of specific populations and secondly, whether Global Health Watch activities are having an impact. External benchmarks may be used to establish comparisons between different countries such as infant mortality rates, or internal benchmarks which carry out successive measurements in the same place over a period of years, such as the rate of vaccinations. Available indicators which have been identified include the WHO basic health indicators. In addition it is important to recognize health as a social process and look at social indicators and policy indicators to see how decisions are taken. Other possible indicators include the UNDP Human Development Index, the UNDP Gender-related Index, as well as an index developed by USAID. Measurements would need to measure both the level of attainment and efforts which have been made.

Organisation

The organisational framework is still under discussion but one possibility may be a network of national health watches linked to a small secretariat which would coordinate watch activities globally. Questions remain regarding the staffing of the secretariat, the membership and governance and decision-making processes. Another important issue is how funding can be generated which would allow the watch to maintain its independence from donors and have a wide sustainable base.

D. CHALLENGES AHEAD

The GHW project has now completed the initial two phases envisaged in its plan for a feasibility study. Research and consultations have been carried out at the international level and country consultations have been initiated. Since the inception of the project in 1998, key initiatives at the international level including research, completion of a survey, and the organization of a workshop during the 1999 World Health Assembly have been carried out.

Since 1999, there has been an effort to move this exploration to the national level. Attempts were made to initiate country-level meetings in 5 regions. Eventually, only 2 meetings were held, one in India and one in Zimbabwe, due to difficulties in finding suitable partners in other regions. The intention of these meetings was to explore the issue from a national perspective and to specifically consider how a watch would function at that level. Both meetings showed enthusiasm for the idea. The meeting in India was particularly productive revealing a deep interest in this issue and an excellent grasp of the issues concerned. The participants at the Indian meeting brought with them a vast and extensive experience of grassroots monitoring activities.

Recommendations:

- Although the two envisaged stages of the feasibility study have been completed, more work needs to be done to establish whether the GHW is a useful and viable proposal. Considerable discussion on the concept of a GHW has now taken place. The project should now move from an abstract to a concrete level.

- As the tangible issues and work required relate to specific country situations, it is proposed that one country be selected for a pilot phase. Given the deep interest and excellent capacities shown by our Indian partners, it is proposed that they should be approached regarding a pilot project. The pilot project could include developing local links and networks; and producing a sample report on health rights and inequalities in India. A realistic and feasible pilot proposal, perhaps concentrating on one state, will need to be developed, given the size of the country.

- At the same time, efforts to stimulate interest in the Global Health Watch in other regions should not be forgotten. As a parallel measure, efforts should be

made to hold meetings in other regions. It is proposed that initiatives should be pursued in Eastern Europe, Western Europe, Africa, North and South America. There should also be some follow-up to the meeting in Zimbabwe.

- Work to further develop the GHW concept should be continued by the NGO Forum for Health. Particular issues which still need to be explored include for example: how and where the issues identified by the GHW could be presented to the international community – for example, how they could feed into the human rights treaty bodies; details of data available at the international level; how the GHW idea fits in with ongoing work at WHO and other organizations.

- There is a need to approach funding agencies for the next phase including the proposed pilot phase in India and further meetings in other regions.

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Making WHO Work Better

An Advocacy Agenda for Civil Society

A discussion document
Produced by the Global Health Watch

The Global Health Watch is an initiative aims at presenting southern-based

Introduction

Every year at the World non-government organisa health agendas by lobb and other stakeholders. T topics and issues: particul treatment; pharmaceutica health of children and ot and many others.

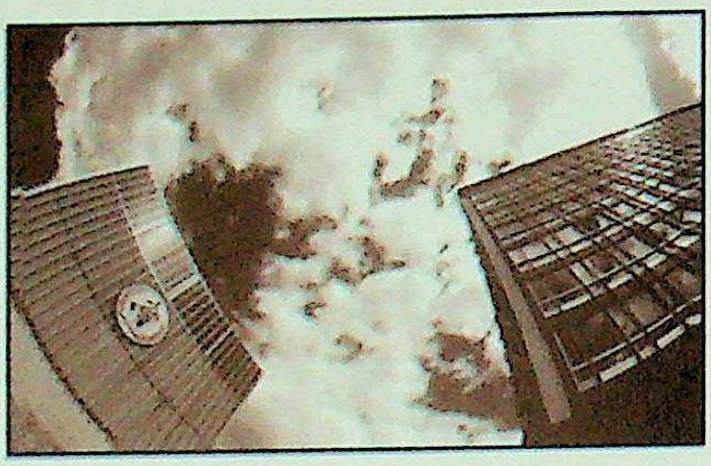
The benefits and import participating in the advar health governance structu providing a counter-weig governments towards the the poor; corporate greed that preside over the prese that is unjust and harmful t

Progress made in the area of breastfeeding and acc been as great without th society action.

However, one topic that attention of civil society Organisation itself. While of advocacy messages, i advocacy efforts.

This document is intended civil society and the NG strategy to strengthen t accountability of WHO to equity.

Why WHO is impor



A second reason is the historical legacy of WHO and its contribution to the Alma Ata Declaration - a progressive conceptualisation of health that remains vital to the needs of billions of people. WHO continues to embody a conception of health embedded in a developmental, human rights and social justice framework that is not always shared by other global health institutions. In addition to this historical legacy, WHO has a proven track record in providing technical leadership on a range of issues that is unsurpassed.

A third reason relates to the present chaotic nature of the global health architecture, caused in part by the proliferation of global health initiatives and global public-private "partnerships", which is undermining a coherent global response to poor health as well as the development of national health systems in many countries. The situation calls out for WHO to bring order to the chaos.

However .....

..... while WHO may be seen by many as the lead global health organisation, several factors contribute to it being ineffective. The reasons for this have been more extensively documented in the Global Health Watch and include the following:

- The deepening and entrenchment of poverty through the unfair structure of the global political economy point to the fact that other actors such as the governments of the G8, transnational corporations and global economic institutions (particularly the World Bank, International Monetary Fund and World Trade Organisation) have an influence on population health that outweighs WHO's. On top of this, groups with an interest in preserving the

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a financing system that undermines coherent planning and which forces WHO departments and divisions to compete with each other (and other organisations) for scarce funds. The consequence of this is that health priorities are distorted and even neglected to conform with the desires of donors and the requirement to demonstrate quick results to them.

- As government contributions to WHO have stagnated, WHO has been forced to be increasingly reliant upon private sources of financing and 'public-private partnerships'. This however has resulted in a subtle erosion of public accountability and public health principles to accommodate the commercial and business interests of its new partners, whilst adding to the problems of fragmentation by adding even more institutional partners to the international health aid mix.

- In addition to external factors, there are factors internal to WHO which have rendered the organisation less effective. There are documented examples of internal management and administrative weaknesses. Other criticisms include the over-abundance of doctors within WHO (relative to other professionals such as nurses, social scientists, economists, lawyers and political scientists) which is said to sustain a bias towards biomedical approaches to health improvement. Deficiencies in human resource management and unfair labour practices have also resulted in a considerable demoralisation amongst staff.

Remedies?

Many of the remedies to resolve the problems with WHO described above are obvious, and include:

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Action

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global health. These CSO

Should there be support for taking this agenda forward, some actions that could be taken forward as part of an advocacy strategy could include:

- *More coordinated lobbying during the World Health Assembly.* Civil society presence at the World Health Assembly is inadequately coordinated. There are a wide range of organisations competing with each other to disseminate their materials and having their voices heard. A process to coordinate civil society participation could be much more effective and efficient. One CSO could be tasked to monitor the programme of the World Health Assembly, identify key issues and help plan more coordinated civil society participation six months in advance of the World Health Assembly.
- *A naming and shaming campaign* targeted at countries not fulfilling their commitments to the funding of WHO.
- *Engaging with the election of the new director general.* The politicised nature of the elections of the director-general (and regional directors needs) to be tempered. In the wake of the sad and sudden death of Dr Lee, it is vital that civil society ensure a successor who will live up to the stated commitment of Dr Lee towards improved and more equitable global health. In the run up to the forthcoming election, civil society should demand that candidates publish a manifesto and that WHO should facilitate widespread debate about them.
- *A strategic assessment of where WHO should be influential in the interests of health in relation to other multilateral bodies,* and in particular the existing liaison mechanisms between WHO and the international trade and financial institutions. This should be accompanied by an assertive and explicit campaign to promote the mandate of WHO to engage (more vigorously) with the structural and social determinants of health, as well as with the development of public policy that guides the financing and organisation of health care systems.
- *Monitoring and watching.* Civil society should consider getting together to collaborate on the development of a 'monitoring and watching' programme to strengthen

What next?

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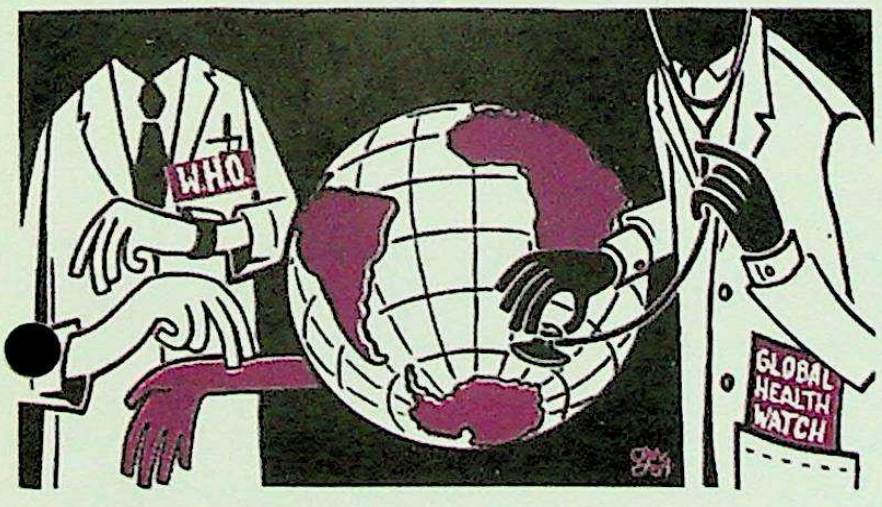
Ackno

A Health Systems Development Agenda for Developing Countries

Time to be clear and visionary

A discussion document for civil society and NGOs

Produced by the Global Health Watch



The Global Health Watch is an initiative aimed at

What is the issue?

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Identifying the caus

But there are other reasons for the collapse and chronic under-development of health care systems. These include the effects of fragmentation. At the level of governance, planning and management, the health care systems of many countries resemble an orchestra of competing musicians playing different tunes without a conductor! Official development assistance (ODA) programmes, new GHIs, private foundations, UN agencies, the World Bank, IMF and international NGOs are pulling communities, health workers and Ministries of Health in different directions. This not only undermines coherent health systems planning, but also weakens Ministries of Health through: a) inappropriate conditionalities and externally-imposed agendas, often designed to suit the interests and needs of the external agency; b) the loss of skilled personnel from the public sector into the non-government sector, thereby reinforcing the dependency of Ministries of Health on external agencies; and c) the imposition of large transaction costs upon Ministries of Health and health workers who have to liaise with and report to a multitude of stakeholders.

The fragmentation of health systems governance, planning and management is also associated with a fragmentation of programmes and service delivery. The last few years have witnessed a proliferation of vertically-organised programmes and selective health care interventions, particularly in the poorest countries. These programmes and initiatives have arisen as a consequence of dysfunctional health care systems, as well as the imperative to urgently extend coverage of life-saving interventions.

However, they also aggravate the lack of coordinated and effective health systems governance and management; create an inefficient duplication of systems and services (for example parallel drugs and supplies systems); cause health workers at the coalface to be pulled in different directions by the demands of different selective and vertical programmes; and retard the development of integrated, context-based local health plans. And where vertical programmes and selective health care initiatives are implemented through non-

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inappropriate; accentuating a bias towards biomedical interventions at the expense of public health approaches to prevent illness and promote good health; the replacement of provider collaboration with provider competition; and a deterioration in trust between patients and providers.

Global economic integration and 'free trade' have further accelerated the impact of market-driven health care outcomes. The international brain drain of skilled human resources from poor to rich countries is well known. But in addition, the scarce domestic health care resources of some countries are being diverted away from national priorities and the needs of the poor towards a growing 'health tourism industry' serving economically-advantaged foreigners and towards the provision of services (e.g. histopathology and radiology services) to contractors in high-income countries. And through new trade rules, multinational health corporations now have the ability to force the break up of universal, public health care systems in order to extract profits from the health care market, particularly in countries with a critical mass of high-income consumers.

Finally, health care systems in many countries have to struggle with a growing burden of disease and poverty. The AIDS epidemic on its own threatens to overwhelm the capacity of many health care systems. And in sub-Saharan Africa, the doubling of the numbers of people living in poverty since the 1980s means that more people are vulnerable to the threat posed by infectious diseases, as well as to the costs of seeking heath care.

The vision of a 'good' health care system

There are no simple, quick-fix solutions to the numerous reasons for poorly functioning health care systems. The strengthening and development of health care systems will require a multi-dimensional programme of reform and change, guided by a long-term vision and commitment towards a set of clear health systems goals.

However, health care systems can exist in different shapes

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care systems can also act as a catalyst for improving public accountability and good government more generally); and support community empowerment.

Key elements of a health systems development plan

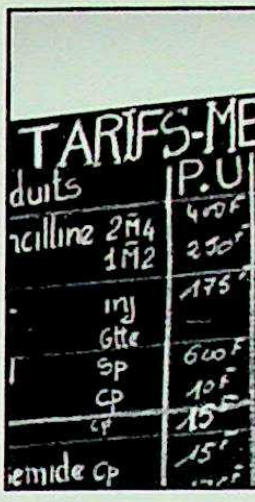
With these principles in mind, what might be the key elements of a health systems development agenda for low-income, developing countries?

Human resource planning

Getting the right number, mix and competencies of the health workforce is possibly the single most important element of a health care systems development strategy. The 2006 World Health Report describes this challenge in greater detail.

Some of the demands that can be made by civil society are to see evidence of:

- A comprehensive situation analysis of all existing public and non-government workforce. Such an obvious and simple first step is often absent in most countries and points to the need for immediate investments in human resource (HR) information systems and data bases to assist with HR planning and management. This should be followed by regular periodic audits of the geographic distribution of health workers, set against locally derived norms.
- A ten year human resource for the health sector that would incorporate:
  - a clear definition of the number and skills mix of the health workforce required to provide essential health care (including important non-clinical personnel, such as health economists, accountants and human resource logisticians who are vital to improving the management capacity of the Ministry of Health),
  - A medium term investment plan in schools of nursing, medicine, public health and other disciplines in order to attain the medium and long term production



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rather than the exception. Civil society could call for an international declaration for the donor community to co-fund core public sector health worker salaries on condition that countries have reached reasonable targets for the investment of domestic revenue into the health sector and that there is evidence of an effective human resource administrative system.

- The development of non-financial, professional incentives to reward good performance, coupled with the implementation of clear civil service rules and codes of conduct, and public accountability mechanisms at different levels of the health care system.

Resource generation

A meaningful and adequate human resource plan would require an increase in the health budget. Furthermore, it would require sustainable, reliable and long-term increases in the budget.

The cost of a comprehensive human resource plan, together with other key health systems costs such as medicines, transport and infrastructure development, could form the basis of an indicative sector-wide budget for the core infrastructure required to provide essential health care to all.

A demand that could be made by civil society would be for:

- Every country to develop such an indicative budget, measure the financing gap between it and current expenditure, and publish a plan for plugging the gap with additional domestic and external financing.

Within countries, governments must be enabled to strengthen their capacity to increase tax revenue in a fair manner, and prevent unethical capital flight. Civil society could advocate for:

- All countries to set a target to raise at least 20% of their GDP as tax revenue, and to allocate at least 15% of total

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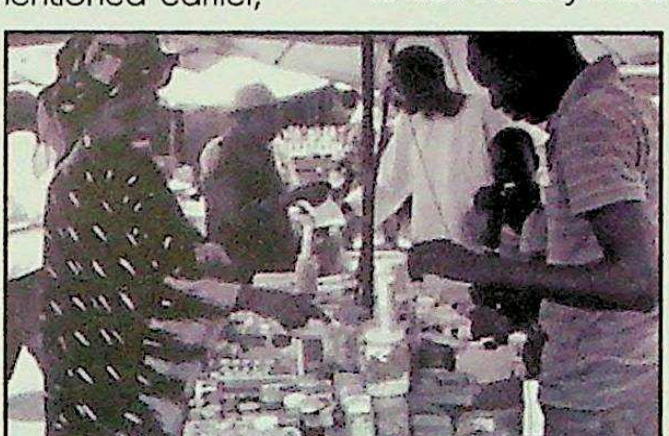
Abolish user fees

User fees in poor countries are an unjustifiable barrier to health care. Efforts must be made to abolish user fees in the public sector. Civil society could advocate for:

- ➢ Countries to adopt a target to reduce direct out-of-pocket payments to less than 20% of total health care expenditure, with timetable of steps towards the full abolition of the vast majority of out-of-pocket payments.
- ➢ Donors to support governments to help maintain quality of care in the face of increased utilisation following the abolition of user fees.

Strengthening health sector management

To achieve the goal of a strong, effective and publicly-based health care system, more investment needs to be directed at strengthening public sector health management capacity at all levels of the health care system. As mentioned earlier, HR planning and management requires particular attention. Other aspects of health management that should be highlighted include: resource management and planning; expenditure monitoring; financial management; essential drugs management; and improvements in health systems research. Civil society can advocate for:



- ➢ The regular production of national health accounts to describe the way in which health care is financed, as well as the pattern of health care expenditure, including measurements of the per capita expenditure variations between geographic areas, between socio-economic groups, and between secondary / tertiary hospitals and district health services.
- ➢ Evidence of investments in the strengthening of the financial management systems of the public health

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Civil society can advocate

- ➢ Agreement on a comm
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At the global level, there is a need to debate the current architecture of global health policy making and governance. Civil society can:

- Call for a discussion to consider whether we have too many separate international and GHIs adding to the already uncoordinated field of official donor agencies, and whether there is a need for a paradigm shift in the way the international community responds to the health crisis in sub-Saharan Africa and other poor regions / countries. For example, rather than multiple strands of health funding attached to disease-based or selective interventions, there could be a single fund for comprehensive health systems financing which would then form the platform for designed disease-based or selective interventions.

Public and community involvement in health care systems

For public sector bureaucracies to work effectively, efficiently and fairly, they need to be held accountable internally through rules and codes of conduct as well as to communities and the public. Sector-wide budgets and a commitment to public stewardship are insufficient in themselves to get health systems working well - the public sector also needs to be kept honest and accountable. The scope of civil society activities involved in strengthening health care systems include advocacy; monitoring; and participating in planning and decision-making. The design of health care systems can enhance community involvement by incorporating community structures and forums such as district health committees, clinic committees and hospital boards into the health governance structure; inculcating a culture of consultation and respect for lay people; disseminating information about the rights of service users; and publicising disparities in key indicators such as maternal mortality and immunisation coverage. Civil society can call for:

- Streams of funding to support civil society engagement

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- Laws and regulations to enforce community rating and prescribed minimum benefits where private insurance schemes exist, and to block payment systems that encourage over-servicing and supplier induced demand.
- Regulations to control and improve the geographical distribution of all private health services, such as the issuance of certificates of needs.
- Appropriate strategies and policy instruments (such as licensing requirements, formal accreditation and price controls) to regulate and improve the quality of care of this sector.

What next?

The vision, principles and recommendations presented here are generic, and would need to be tailored to the historical, economic and political contexts of different countries. Furthermore, fragile states and countries in states of conflict or under oppressive rule are likely to need different approaches.

One of the next steps is to promote discussion about the challenge to strengthen health care systems and provoke questions about the appropriateness of the current paradigm and efforts to improve health in developing countries. It is only with a greater civil society consensus and momentum that donors and governments are likely to be influenced by such a challenging set of recommendations and aspirations. The Global Health Watch therefore invites you to respond to this proposed advocacy agenda and to recommend further key actions that could be taken to facilitate further dialogue and discussion.

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The Global Health Watch i
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An electronic copy of this
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www.ghwatch

Please send your comments

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Acknow

Several people associated w
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been funded by Research Matt

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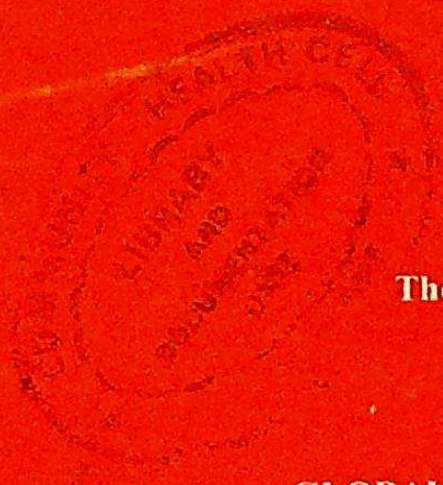

The NGO Forum For Health

GLOBAL HEALTH WATCH PROJECT

SUMMARY REPORT ON STATUS OF FEASIBILITY STUDY CONCERNING THE ESTABLISHMENT OF A GLOBAL HEALTH WATCH

March 2001

Prepared and submitted by
Asmita Naik, Consultant

Geneva, Switzerland

Resource file

The NGO Forum For Health

GLOBAL HEALTH WATCH PROJECT

SUMMARY REPORT ON STATUS OF FEASIBILITY STUDY CONCERNING THE ESTABLISHMENT OF A GLOBAL HEALTH WATCH

March 2001

Prepared and submitted by
Asmita Naik, Consultant

Geneva, Switzerland

The NGO Forum For Health

April 4, 2001

Foreword:

One of the major initiatives of the NGO Forum for Health is to promote, and eventually establish, an independent, credible monitoring entity. We call it: Global Health Watch and we continue to work toward that goal. This project was initiated by the Forum in February 1997 in Geneva.

Since then a number of workshops and regional consultations have taken place. Ms. Asmita Naik, our consultant for this project has captured the main findings in a full report. This report represents the Executive Summary of the main report. A number of recommendations have been included in the report which the Steering Committee of the Forum will consider carefully and advise us on the next steps.

We are very encouraged by the positive feedback and enthusiasm shown by the members and supporters to move ahead with this project. The NGO Forum for Health is well positioned to play a leading role. We will also work closely with "other watches" who have similar visions and interests.

May I take this opportunity to acknowledge with many thanks the excellent work done by Ms. Asmita Naik, our current consultant, and Ms. Adrea Mach, our first consultant who did the initial work.

Thanks are also due to Dr. Thelma and Dr. Ravi Narayan for organizing the South Asia Regional Conference and to Dr. Dan Kaseje for the Africa one.

We are also grateful to our donors: NOVIB; MISEREOR; ICCO; DIFAM and WORLD VISION INTERNATIONAL for their generous and timely contribution which made it possible for us to carry out this feasibility study.

Thanks also to all the members of the Steering Committee, especially Dr. Roberta Ritson, Dr. Manoj Kurian, Mr. Giovanni Ballerio and Dr. Alireza Mahalatti for their extensive inputs and continued guidance and support.

Eric R. Ram, Ph.D.
President
The NGO Forum for Health

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PREFACE

The Global Health Watch project was initiated in 1998 by the NGO Forum for Health in order to explore how monitoring and advocacy regarding inequalities in access to health care could be improved with the aim of promoting equal health rights for all. Since then a number of initiatives have been carried out to take this idea further in terms of considering the establishment of a Global Health Watch to monitor and report on inequalities in health worldwide. Research has been carried out to see what is already being done in this field by other agencies. Three workshops have also been held, one at the international level, and two at the national level, in India and Zimbabwe. These initiatives have stimulated considerable interest in the idea and have resulted in a deep reflection on the need and functioning of a Global Health Watch. Challenges remaining include taking the project one step further through a pilot study in one country to consider the practical functioning of a Global Health Watch at the national level. In addition, the idea needs to be taken to other regions in order to test its applicability on a truly global scale. This paper is a summary of a status report completed at the end of 2000 on action and findings so far. The following pages give an overview of the main steps taken, the outcomes, and challenges ahead in terms of taking the Global Health Watch forward.

A. INTRODUCTION

The idea of a Global Health Watch (GHW) to act as an independent and credible monitor of inequalities in the health status of different populations, and to promote a more even distribution of resources to ensure equal health rights for all, was first raised in February 1997 by the NGO Forum for Health. In September 1998, a Task Force was established and a feasibility study was begun to consider the scope and potential of such a watch. This summary report describes the various activities that have been carried out and then draws out the findings of these activities in terms of the need and functioning of a Global Health Watch.

B. ACTION TAKEN

i) A number of research activities and consultation meetings have been carried out at the international and national level by the NGO Forum for Health in order to explore the idea of setting up a Global Health Watch.[1] These initiatives have sought to consider five main questions:

- why is a Global Health Watch needed;
- how would it function – basic principles; focus; activities; topics; methodology (data; partners; benchmarks); organization;
- what commitments have been made by governments and international organisations on health;
- what other NGOs are doing in the area of health and human rights;
- what information exists which would be of use to a GHW.

ii) Research has been conducted into the following areas:

- Health commitments made by governments at international conferences held in the 1990s show that wide-ranging commitments have been made on all areas of social development including health.
- Activities of other international and non-governmental organisations in terms of data collection and monitoring show a reliance on government data and the clear need for independent verification of information.
- Mandates of other non-governmental organisations reveal an ad hoc involvement and monitoring of health issues but an evident gap and need for an organisation which solely focuses on monitoring and advocating on the right to health.

iii) The following workshops have been held:

- **A one-day workshop was held at the time of the World Health Assembly in 1999** involving 28 speakers and participants from different regions. Presentations were made by other watches (INFACT and IBFAN)

1 This is very much a brief summary of activities that have been carried out. A full report is available from the NGO Forum for Health

which provided important lessons learned while regional speakers gave their perspectives on the idea of a Global Health Watch. Working group themes that were discussed included the measurement of inequities and inequalities in health; data collection and analysis; monitoring and advocating on specific topics; identification of topics; and organisational points.

- A **national level meeting was held in India in October 1999**. It was organised by the Society for Community Health Awareness, Research and Action (Community Health Cell) in Bangalore and brought together an impressive collection of participants with considerable enthusiasm and expertise in the area of health issues and human rights. There were 40 participants for the two day workshop from varied backgrounds including government representatives, academics, physicians, NGOs with primarily research agendas, activist NGOs, individual activists, economists, lawyers, management experts etc. The meeting brought out lessons learned from other watches, gave an opportunity to air case-studies, and conducted working groups to look at conceptual and methodological issues from an Indian perspective. A wealth of knowledge and information was amassed at this meeting which will certainly help the Global Health Watch project to move forward. [2]

- A **pan African one day meeting took place in October 1999 in Harare, Zimbabwe**, within the context of a larger conference on health issues. It was convened during the Africa Community Action Network for Health (Afri-CAN) Think Tank Conference on "Mobilising health for all". Afri-CAN members were invited to attend this session to put forward their ideas on the establishment of a Global Health Watch and the meeting revealed much interest in the proposal. Afri-CAN is a pan-African network of some 60 institutions which seeks to advocate on behalf of the poor and marginalized and to enhance the capacity of vulnerable populations to cope with the demands of their daily lives. The meeting comprised of plenary and working group discussions. [3]

- The NGO Forum also participated in a **Rockefeller Foundation sponsored meeting in Bellagio, Italy in November 1998**, in which general consensus emerged about the need for a global health watch with a strong, national grassroots base.

C. FINDINGS

The various initiatives outlined above have resulted in an in-depth enquiry into the

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2 A full report of this meeting was prepared by the Community Health Cell, Bangalore and is available from the NGO Forum for Health. In addition, the full status report on the feasibility study incorporates most of the Indian national meeting report.

3 A full report of this meeting was prepared by Afri-CAN and is available from the NGO Forum for Health. In addition, the full status report on the feasibility study incorporates most of the Afric-CAN report.

need and functioning of a Global Health Watch. This section draws together these many different ideas and represents the findings of the project so far.

The need for a Global Health Watch

The huge disparities in the health status of populations in the developing and developed world are evident. Even within nations, there are major differences in the health status of different populations depending on class, gender, ethnicity, regional and geographical factors. The following statistics illustrate these inequities:

- Around 1.5 billion people live on less than US$1 per day.
- The prevalence of child malnutrition reaches staggering proportions: - 38% in Sri Lanka, 45% in Vietnam, 66% in India, and 68% in Bangladesh over the period 1990-96
- The average life expectancy in Least Developed Countries was just 62.2 years in 1995, compared with 74.2 years in industrialised countries
- 43% of the population in Least Developed Countries over the period 1990-96 had no access to safe water, 51% had no access to health services and 64% had no access to sanitation

(*Source: World Bank/UNDP*)

Even in the world's most affluent nations, there are major inequities in health and health care. Studies have shown a clear link between high levels of poverty and income disparity in the US: 1 in 4 American children live below the poverty line; 43 million Americans do not have health insurance; and the rate of suicide is especially high among young people. Research has indicated that greater life expectancy is linked to the least disparity in income in a country and not simply to the absolute wealth of a nation. (*Daniel Werner speaking at the NGO Forum for Health meeting at the World Health Assembly in May 2000*).

The question of health equity has drawn increasing attention in recent years from health organisations and governments. The causes of these inequalities are deeply rooted in the world economic and political order and the World Health Organisation (WHO) has categorically identified poverty as the greatest threat to health. Modern day trends in globalisation, environmental degradation, civil wars, privatisation of health care, to name but a few, will in turn have an impact on the level of health of the world's populations. Watch mechanisms have shown some success in recent years in the areas of civil and political rights, social inequality and the environment, and this has led commentators to ask whether the same approach can positively influence issues of health equity.

Basic Principles

A range of values and principles, such as equity, justice, human dignity, universality, gender mainstreaming and sensitivity, and ethical codes of conduct have been proposed as fundamental principles for a global health watch. Most of these values are enshrined in existing UN human rights treaties and the International Covenant on Economic, Social and Cultural Rights - ICESCR (1966) recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"(art. 12.1). It should be noted here that health is defined broadly in a number of

international instruments to encompass physical, mental and social aspects. The Global Health Watch will adopt a broad definition of health which encompasses physical, mental, spiritual and social aspects.

The question of the implementation of socio-economic rights and the long-standing argument that the root causes of such problems lie in world economic disparities and not only in the hands of individual governments is recognised by the ICESCR. This states that state obligations are relative and progressive, a state party should aim to implement these rights "to the maximum extent of its available resources, with a view to achieving progressively the full realization of the rights recognised in the present Covenant by all appropriate means"(art. 11.1). Thus a Global Health Watch would need to identify tangible areas for monitoring and advocacy where individual governments and organisations have the capacity to make positive changes.

It is also important to take a holistic approach to the issue of human rights and recognise that a wide range of activities can contribute to the implementation of the right to health, from administering vaccinations at ground level to advocacy before UN human rights treaty bodies. This perspective would embrace a variety of initiatives instead of viewing a rights based approach as something totally new. The link between health and human rights needs to be further explored at the conceptual level, including the impact of human rights violations on health: the impact of health policies on human rights standards: and the commonalities between public health and human rights strategies. In addition, research carried out by the NGO Forum for Health indicates that no NGO is currently focusing exclusively on human rights and health.

The function of a Global Health Watch

The function of a Global Health Watch would be essentially to find information on inequalities in health and then to take steps to encourage the responsible authorities to initiate change to redress these injustices.

The focus of a Global Health Watch:

A global health watch would focus on the policy and practices of:

- Governments
- International organisations such as WHO, UNICEF, World Bank
- Private sector organisations
- International NGOs

To monitor the following aspects of their activities:

- Fulfillment of commitments made in international agreements
- Adverse effects of activities on the health of populations
- Discrimination against certain groups based on class, caste, gender, race, ethnicity, sexual orientation
- Effectiveness of policies and practices
- Efficiency, oversight and public accountability of operations
- External input into policy development process

Possible activities of a Global Health Watch:

- Monitoring data, treaties, and current issues
- Data collection
- Data analysis and commentary
- Alternate reporting i.e. producing shadow reports of official reports prepared by governments and international organizations to human rights treaty bodies etc.
- Dissemination and sharing of information
- Advocacy - taking up issues with responsible authorities, raising public awareness, working with the media
- Policy development
- Early warning function
- Networking
- Technical assistance to NGOs through training (e.g. data analysis, advocacy), sharing best practices, capacity building, information exchange
- Resource mobilisation
- Community intervention

Specific topics which have been proposed as potential subjects for Global Health Watch scrutiny:

- International initiatives such as Alma-Ata declaration in 1978, WHO Health for All, Beijing Platform for Action, Population and Development Programme of Action (Cairo)
- Age/gender mortality rates showing cause of death
- Morbidity data from selected vulnerable populations
- Environmental protection and impacts on health
- Disease surveillance making use of data on emerging and re-emerging diseases
- Critical appraisal of reports produced by WHO
- Pollution
- Tobacco including cooperation with WHO's Tobacco Free Initiative programme
- Pharmaceutical drugs
- Bio-technology industry
- Alcohol
- Embargoes
- Sanctions
- Corruption
- Signaling outbreak of communicable diseases
- Developing measures and standards
- Equal availability of basic needs for a healthy life, such as food, clean water, sanitation
- Equal access to health care and removal of barriers, such as user fees
- Prevalence of strong primary health care systems integrated into district health systems
- Proportion of health care budgets spent on primary, secondary and tertiary care

- Availability of trained health personnel
- Community participation in health care
- Monitoring of government policies across a range of sectors which may influence health such as education, transport, energy, housing etc.
- Maintenance of adequate health infrastructure, progress on water and sanitation
- Effectiveness of disaster preparedness and unequal impact of natural disasters
- Identify priority health needs
- Timely response to global health challenges
- Encourage international conventions on health
- Inform research priorities

Methodology

Lessons learned from other Watches:

Consultations have taken place regarding the way in which a Global Health Watch would carry out its work. Other watches have identified the following points as vital for the effective functioning of a watch mechanism:

- A strong grassroots national base which interacts with a global network
- Successful campaigns often benefit by mobilizing the public through grassroots activism such as boycotts and petitions
- Important to have allies across the world at local, national and international levels.
- Need to be tough as enemies may be formidable
- Visibility is an important defence, so the more public the campaigns are the better it is
- Careful selection of campaigns and allies especially if resources are limited
- Be attuned to public opinion and aware of what is acceptable and what is not
- Collection of accurate, reliable, unbiased and unassailable data
- Use publicly available information
- Use existing sources of data as primary collection is very costly
- Involve the community in data collection
- Multiple data sources should be used and a variety of methods such as fact-finding, public inquests. Rank data according to quality
- High quality analysis of data after collection
- Cooperation with other national and international NGOs in the collection and dissemination of information
- Effective dissemination of information in terms of style, content, timing, methods and target groups
- A flexible coalition of organisations with a strong central steering structure and effective oversight works best. Can achieve more through coalition than working independently
- Active participation of volunteers
- Prioritization, this is especially important where there is a broad mandate dealing with wide-ranging and complex issues
- Monitoring and evaluation of the impact of the activities of the watch itself
- Balancing research and advocacy activities

- Advocacy should not only be confrontational but should give an opportunity to "culprits" to respond to private approaches first of all
- The right publicity at the right time can lead to outpouring of public support
- Ensure a wide sustainable financial base. Individual membership can allow for this diversity and independence
- Develop measurable criteria for monitoring
- Present data in a comparative way, for example through use of charts comparing different regions and countries, as this can be an effective pressure tool.
- Important to contribute, teach and build capacity and not merely be critical. Governments may not act appropriately, not simply because of lack of will but also because of lack of resources and know-how.
- A watch should be independent, transparent, moral, objective and credible
- Make maximum use of electronic media as the internet allows for a rapid and cheap way of exchanging information
- Important to access existing networks e.g. International Network on Population and Health (INPH), a network of 170 organisations initiated by WHO, and the Voluntary Health Association of India (VHAI)
- Need to focus on positives as well as negatives
- The organization must be democratic, accountable and open, especially, if there is a disparity in the size and status of different groups participating
- Bureaucrats and politicians should be brought on board as they may be a major obstacle
- Ensuring a consultative democratic process in setting up a watch is as important as the watch itself
- Allow diverse voices and dissent
- There should be a mechanism of reporting back to the people so that ownership clearly lies with them
- Education and awareness building should go hand in hand with negative campaigning and confrontation.

Sources of data:

- NGOs

A survey has been conducted among members of the NGO Forum for Health which showed that 67% of respondents collected data which may be relevant to a Global Health Watch, as it includes information on demographics, mortality and morbidity, health care policies and practices and access to health care. This data is not comprehensive as it is usually restricted to particular target groups such as women and children. It is being collected for the purposes of advocacy, monitoring and public policy formulation.

- International Organisations

International organisations monitor data provided by governments on a range of issues such as population health, disease incidence, access to health care. Examples – WHO, OECD, WB, UNDP, UNFPA.

- National governments

National government reports on health may be useful but vary enormously in quality.

- Academia and research community

There are many existing sources of data which should be used wherever possible as primary data collection is very costly. Furthermore, there is value in analyzing existing data as it may provide an opportunity to make critical commentaries, which the collectors of the data are unable to do. As there is much reliance on government data, there is a need to a greater or lesser extent, to verify existing data. There are also important gaps in current data, although there is some breakdown in terms of gender, there is rarely further breakdown by social group in terms of class, ethnicity, race etc. In addition, there emerges a gap in data collection at the grassroots level. These are gaps which a GHW could seek to fill.

Partners:

The Global Health Watch would liaise and coordinate with many different local, national and international organisations and individuals including:

- Grassroots community groups
- Advocacy groups
- Health research groups and academia
- Professionals and practitioners
- Consumer groups
- Other watch mechanisms
- National, regional and international organizations and networks

Benchmarks for progress:

Another issue is to evaluate, firstly, whether progress has been made regarding the health situation of specific populations and secondly, whether Global Health Watch activities are having an impact. External benchmarks may be used to establish comparisons between different countries such as infant mortality rates, or internal benchmarks which carry out successive measurements in the same place over a period of years, such as the rate of vaccinations. Available indicators which have been identified include the WHO basic health indicators. In addition it is important to recognize health as a social process and look at social indicators and policy indicators to see how decisions are taken. Other possible indicators include the UNDP Human Development Index, the UNDP Gender-related Index, as well as an index developed by USAID. Measurements would need to measure both the level of attainment and efforts which have been made.

Organisation

The organisational framework is still under discussion but one possibility may be a network of national health watches linked to a small secretariat which would coordinate watch activities globally. Questions remain regarding the staffing of the secretariat, the membership and governance and decision-making processes. Another important issue is how funding can be generated which would allow the watch to maintain its independence from donors and have a wide sustainable base.

D. CHALLENGES AHEAD

The GHW project has now completed the initial two phases envisaged in its plan for a feasibility study. Research and consultations have been carried out at the international level and country consultations have been initiated. Since the inception of the project in 1998, key initiatives at the international level including research, completion of a survey, and the organization of a workshop during the 1999 World Health Assembly have been carried out.

Since 1999, there has been an effort to move this exploration to the national level. Attempts were made to initiate country-level meetings in 5 regions. Eventually, only 2 meetings were held, one in India and one in Zimbabwe, due to difficulties in finding suitable partners in other regions. The intention of these meetings was to explore the issue from a national perspective and to specifically consider how a watch would function at that level. Both meetings showed enthusiasm for the idea. The meeting in India was particularly productive revealing a deep interest in this issue and an excellent grasp of the issues concerned. The participants at the Indian meeting brought with them a vast and extensive experience of grassroots monitoring activities.

Recommendations:

- Although the two envisaged stages of the feasibility study have been completed, more work needs to be done to establish whether the GHW is a useful and viable proposal. Considerable discussion on the concept of a GHW has now taken place. The project should now move from an abstract to a concrete level.

- As the tangible issues and work required relate to specific country situations, it is proposed that one country be selected for a pilot phase. Given the deep interest and excellent capacities shown by our Indian partners, it is proposed that they should be approached regarding a pilot project. The pilot project could include developing local links and networks; and producing a sample report on health rights and inequalities in India. A realistic and feasible pilot proposal, perhaps concentrating on one state, will need to be developed, given the size of the country.

- At the same time, efforts to stimulate interest in the Global Health Watch in other regions should not be forgotten. As a parallel measure, efforts should be

made to hold meetings in other regions. It is proposed that initiatives should be pursued in Eastern Europe, Western Europe, Africa, North and South America. There should also be some follow-up to the meeting in Zimbabwe.

- Work to further develop the GHW concept should be continued by the NGO Forum for Health. Particular issues which still need to be explored include for example: how and where the issues identified by the GHW could be presented to the international community – for example, how they could feed into the human rights treaty bodies; details of data available at the international level; how the GHW idea fits in with ongoing work at WHO and other organizations.

- There is a need to approach funding agencies for the next phase including the proposed pilot phase in India and further meetings in other regions.

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