NGO COALITIONS FOR GLOBAL HEALTH PROMOTION

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1. Introduction – NGOs, the origins of primary health care and health promotion.

The primary health care movement sprang up in an autonomous manner in different parts of the world, in the 1960s and 1970s. Rooted in the community and voluntary sector, initiatives developed in different social and cultural situations, exhibiting a rich diversity. The movement gained global visibility and legitimacy from national governments through the World Health Assembly in 1977, and the International Conference on Primary Health Care jointly organized by WHO and UNICEF in 1978 in Alma Ata. Ever since then there have been ripple effects and cross currents in the health and health care related sectors. One of the strong positive currents that emerged was that of health promotion. It is important to recall the different collective experiences, forces and perspectives that developed the Health for All goals and strategies. Dr. Mahler Director General of WHO at the time publicly states that it was the non- governmental organizations (NGOs) who pressed WHO strongly to move beyond a disease focused, expert dependant, techno-managerial approach, based on the dominant system of medicine, to one wherein community participation, inter-sectoral coordination and appropriate technology were important. The key underlying principles of primary health care (PHC) were social justice and equity with a shift beyond doctors, diagnostics and drugs to addressing the conditions for health. An important component was health education, which grew in strength to emerge as health promotion. NGOs, professionals and people across the globe sustained the spirit of primary health care through decades when it met with resistance and neglect. The Ottawa Charter of 1986 introduced a clear focus on fundamental conditions or basic determinants for health such as peace, shelter, education, food, income, ecosystems and resources. Ownership and initiatives by states, international bodies and experts provide a professional strategic approach and increase coverage. However communities and community based organizations (CBOs) may get excluded in decision making, while powerful interests get accommodated. Public health ethics and principles of universal human rights suggest that the challenge before the health promotion community is to build partnerships upholding the public good in health, by addressing health

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determinants and respecting cultural diversity in a transparent manner. The role of communities, CBOs and NGOs along with the state should be central.

2. Contextual challenges to global health promotion

In the year 2005, despite increasing knowledge and wealth, health goals remain a distant dream for the social majority globally. Inequalities in wealth and health have grown. Efforts to medicalise health, with professional control over information, are now compounded by commercial and corporate interests in medical and health care and professional education. The stakes of multinationals, producers of pharmaceuticals, medical equipments, and medical insurance companies are at a much higher scale. Globalisation provides for free flow of information and ideas. The use of information and communication technology has benefited many. However, macro-economics, speculative financial flows and global trade policies adversely affect livelihoods, food and human security, the environment, and purchasing capacity of a significant proportion of people. While health status has improved for some, disparities are growing, health gains are being lost and new problems are emerging. Community impacts of corporate led globalization point to increasing denial of health and access to health care. Conflicts of interest that underpin many of these developments need to be clearly addressed by the health promotion community. Strategies need to address health determinants including war and conflict, unhealthy trade practices, environmental injustice, recognizing the complexities involved. Partnerships with affected communities and NGOs are critical. This paper reviews the role of NGOs, The strengths and opportunities of potential and existing partnerships and peoples movements in health promotion and in addressing health determinants.

3. NGO Partnerships for Global Health Promotion

The role of civil society organizations (CSOs) has received increasing importance in public policy and health policy over the past decade. As more financial and other resources were invested in this sector, the profile of its constituent groups changed. Different agencies define CSOs and NGOs differently. There is need for clarity in understanding the heterogeneity of this sector, and to recognize the unique roles of different constituents for global health promotion. NGOs in the 1960s and 1970s were largely not –for – profit voluntary organizations working towards integral development. In health they included medical service through hospitals, health centres, and mobile clinics run by charities, missions and philanthropic organizations. With experience and reflection this group developed a deeper community based understanding of the dynamics of health, health care and development in different socio-cultural situations. They were often able to achieve what governments in resource poor situations could not. With professional and social skills developed through working in difficult circumstances they became alternative experts, and the sector soon became an additional policy option. With growing recognition, money and influence, the profile of NGOs and new entrants to the sector changed . NGOs now include corporate NGOs, with companies setting up Trusts and Societies, building brand images, obtaining tax benefits and blurring the profit and not for profit sector. Government NGOs (GONGOs) and other new entities developed to overcome the bureaucracy of government. Professional associations' and research bodies with a high degree of knowledge

and expertise, such as the International Union for Health Promotion and Education comprise another important section. NGO networks developed at national and global levels with a specific focus on health. During the past decade a global people's health movement emerged with a strong focus on health determinants and a right's based approach to health care. The potential for partnerships are thus many. Including those that can impact on health determinants provide a strategic option to global health promotion.

4. Creating enabling environments for NGO coalitions for health promotion

The Millennium Development Goals (MDGs) provide a renewed framework for partnerships between governmental and nongovernmental organizations to create an environment conducive to development and elimination of poverty[1]. Investment in health is critical for development and achievement of the MDGs. Through advocacy for healthy public policy, NGOs increase community health literacy and knowledge. NGOs with diverse structures and functions are the *sine quo non* in health promotion due to their grass roots presence and closeness with communities, which enables them to respond to people's health needs, concerns and aspirations.

> *One of the corner stones of solidarity is sharing and defining common objective, in this case the promotion of health. The objective to be attained should be time bound and measurable. It requires carefully designed strategies with each partner assuming specific roles* (Berhane Ras Work, Inter Afrocan Committee)

NGOs understand that health is produced not just by hospitals and health professionals, but by individuals and families in the context of their daily lives and by influencing health determinants. NGOs are a positive force through direct health empowerment and action with people, as well as by working on the deeper issues. They apply the principles of health promotion including capacity development, knowledge transfer, community participation, empowerment, intersectoral collaboration, equity and advocacy for sustainable development.[2]

The agenda for health promotion involves tackling multiple determinants of health. No single governmental or nongovernmental organization can deal with the multiplicity of issues. This is a sound rationale for NGOs to establish networks and alliances between themselves and with academia, governmental and other organizations to maximize their resources and achieve better outcomes. Partnerships provide an opportunity to make best use of the strengths and comparative advantage of each organization. However NGO coalitions do not occur by chance.

To be effective partnerships must be planned, fostered and managed. Partnerships can be focused and time bound to achieve defined outcomes or work through long-term commitments. An example is the Geneva based NGO Ad Hoc Advisory Group on Health Promotion.

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[1] General Assembly resolution 55/2, para. 12
[2] Ottawa Charter for Health Promotion, (1986).

NGO Ad Hoc Advisory Group on Health Promotion

Born as an outcome of the WHO 4th International Conference on Health promotion in Jakarta in 1997, the Group supported implementation of its recommendations, and worked in partnership with others towards the Global Conference on Health Promotion in Mexico City, 2000. The Group comprises several NGOs whose activities include health promotion and education, health co-operatives, nursing, rural women; social welfare, women's health and those whose main mandate may not be "health".

Member's commitment to health promotion helps pool resources and expertise in tackling health determinants. For example, Associated County Women of the World (ACWW) partners with local NGOs, and Governments to provide literacy centers in Mali. ACWW provides partial funding and expertise to help local NGOs achieve their goals with community ownership and ongoing monitoring[3].

The wide diversity of activities, international structures and grass root involvement give the NGO Ad Hoc Group its richness of approach, experience and expertise. Working collectively and individually, and in close partnership with WHO headquarters, the Group has kept the Jakarta and Mexico agendas in the forefront of the NGO community. The Group hosts briefings at the World Health Assembly on NGO and government partnerships in health promotion. This would not have been possible for any single NGO. By their work and commitment, the Ad Hoc Group contributes to the attainment of the Millennium Development Goals.

4.1. Investing in Human Resources and Capacity Building

Human resources are the lynchpin to achieve health and development goals. Distortions in health care priorities hinder progress in health promotion. Major distortions include concentration of health facilities and personnel on urban populations rather than rural, on tertiary care rather than primary, on curative care rather than on promotive and preventative services and on the middle-class and better off rather than on the poor[4].

Though the primary health care strategy promoted by WHO was designed to achieve greater equity and universal coverage, health reform and economically driven models of care reduced public spending on health and social services leading to growing inequities[5].

Besides misallocation and mal-distribution of resources, access to health care is hampered by shortage of competent health professionals capable of providing comprehensive health care. Poor investment in training, recruitment and retention, force health care workers to look for 'greener pastures' leading to brain drain. Nurses and physicians trained at public cost migrate from

[3] Joanna Koch, Associated County Women of the World
[4] Swedish International Development Agency (undated), Health is Wealth.
[5] Braveman, P. & Tarimo, E., Social inequalities in health within countries: not only an issue for affluent nations. Social
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poorer countries to the developed world, leaving health care facilities in a state of collapse.

Nursing staff shortages cause closure of essential health care facilities, including emergency rooms. Serious shortages in all health professional categories in Zimbabwe resulted in closure of health facilities and reduced access to services[6]. The New York Times reported, "*the nation is currently engulfed in a huge nursing shortage which is going to get worse*"[7]. In the United Kingdom there is concern that: "*the National Health Service (NHS) does not have enough pairs of hands to deliver the care that the nation needs... and hospitals are turning abroad to find staff*"[8].

Shortages of doctors are reported in several countries including Botswana, Ghana and Guinea Bissau. In some developing countries, shortage of nurses and doctors often results in staffing rural clinics by poorly trained personnel ill-equipped to provide comprehensive services including health promotion. In these circumstances, it is likely that investment in health promotion will continue to be eroded and neglected. NGO coalitions and all stakeholders need to address this issue on priority.

Health promotion strategies draw upon multiple actors and stakeholders including multilateral organizations such as UN agencies; development banks; national and local governments; faith-based groups, citizen's organizations; international, national and local NGOs; WHO collaborating centres; academic institutions; trade unions; the arts and entertainment industry; the private sector and others. Collaborative efforts by stakeholders who promote the public good in health is crucial for success. For example, the progress made in onchocerciacis control was only possible with committed partnerships. While reducing under-nutrition and universalizing access to water and sanitation attract less attention, regressive policies of some organizations also reverse health gains.

Community Empowerment

Different stakeholders, working with empowered communities can become a powerful voice, lobbying governments to invest in human resources particularly for health promotion training and capacity building. NGO networks have a convening power and a large outreach capacity enabling them to bring about a "paradigm shift" from the curative to the preventive, promotive and social health model.

Training and capacity building by NGOs are characterized by active community participation, empowering individuals and families to increase control over the determinants of their health, and to demand universal access

[6] Mutizawa-Mangiza, D (1998), The impact of health sector reform on public sector health worker motivation in Zimbabwe.
Major applied research, 5, working paper 4. Partnerships for Health Reform, Bethesda.
[7] New York Times 12 April 2001
[8] Jeremy Laurence, Health Editor, The Indipendent, 26 November 2002.

to health care. NGOs and health profession associations should be enabled to become "social health activists".

4.2. Strengths, weakness, opportunities and threats to coalition building

Strengthening NGO coalitions for health is necessary in the current landscape characterized by declining development resources, increasing privatization of services, and reverse transfer of resources from developing countries[9]. Coalitions need to be built with skill, care and mutual trust using strategies that include identifying opportunities and partners with shared goals; reaching agreements; maintaining and evaluating partnerships [10]. This takes time and resources.

Challenges faced include selecting partners, working with communities, defining partnerships goals, setting time frames, mobilising resources and keeping long term commitments to meet complex evolving needs. Often unequal distribution of power and decision-making within NGO groups or between NGOs and governments can negatively impact outcomes and sustainability of partnerships. Corporate interests working through governments and international bodies can be counterproductive. Lack of trust and suspicion between NGOs and governments is a potential threat.

Coalitions can multiply actions outlined in the Ottawa Charter: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services[11].

Mutual commitments to engagement between governments, civil society and NGOs would help achieve better health. Governments need to see beyond their term in office and to see the long-term role of health promotion. NGOs and civil society need to be rooted in their reality, and to see beyond that reality and their own constituencies to engage with a wider spectrum of stakeholders. Both need to recognize barriers that prevent the realization of health promotion in the community and to undertake cooperative measures to tackle this[12].

As an intergovernmental agency, WHO has a long history of working with NGOs In health promotion WHO – NGO partnership from decision making to evaluation has been fruitful. While partnerships are strong at WHO headquarters, there is scope for improvement at country and regional levels.

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[9] United Nations Research Institute for Social Development, States of disarrary; the social effects of globalisation. London,
UNRISD, 1995.

[10] Kickbusch, I, and Quick, J 81998), Partnershps for Health in the 21st Century. World Health Statistics quarterly, 51, 61-
74.

[11] Ottawa Charter for Health Promotion, 1986

[12] Manoj Kurian, World Council of Churches, E-mail correspondence

5. Global coalition's promoting health, addressing determinants

Concern about the social determinants of health, and the difficulties faced by governments and international bodies to effectively work on their own towards Health for All goals, resulted in the emergence in the late 1990s of a much broader global coalition, the Peoples Health Movement (PHM). Unlike the 1970s, health groups and NGOs are now joined by women's movements, the science and literacy movement, the environment movement, trade unions, development groups and many community based organizations, all of whom recognize that better health is a common concern. Collective analysis, planning, action and reflections with affected communities build solidarity. Groups from varied backgrounds and cultures have become connected locally and globally through horizontal and vertical linkages. This awakening culminated in the first Peoples Health Assembly (PHA 1) in December 2000 in Savar, Bangladesh, wherein 1493 persons from 75 countries debated health related issues over five days and adopted the Peoples Charter for Health [13]. Through thousands of prior community, village and town meetings, the Charter built on perspectives of people, whose voices are rarely heard. It clearly addresses health determinants, namely:

a) economic challenges posed by the global trading system, third world debt, intellectual property laws, speculative international capital flows;
b) social and political challenges, including the right to work and livelihood, gender issues, rights of expression, political participation and religious choice, the weakening of public institutions and services;
c) environmental challenges including water and air pollution, climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of bio- diversity, deforestation and soil erosion ;
d) war, violence, conflict and natural disasters.

Action points concerning these issues, and for developing a people-centered health sector with people's participation resulted in much follow up.

Spontaneously translated into 50 languages (see www.phmovement.org) the Charter has become one of the largest consensus documents on health providing a framework for action. Since 2000, country, regional and issue based circles evolved leading to specific action such as the right to health care campaign in India; advocacy regarding global public private initiatives; policy dialogue with the WHO; a global campaign on patents; the Peoples Charter on HIV/AIDS and Asian People's Alliance for Combating HIV/AIDS; the first Global Health Watch report; International Health Forums; state national and UNESCAP health policies; a Tsunami Watch; and most importantly advocacy, street action and community work, including training thousands of community health workers. Media strategies resulted in greater national and local reporting of health issues and controversies, including corruption. In some countries health moved higher on the public and political agenda with commitments to increase budgetary allocations. There has been support for the peace movement in the USA, Europe and Asia, and a PHM response to disasters in Iran, Sri Lanka, and India. The second Peoples Health Assembly in Cuenca, Ecuador in July 2005 raised issues and concerns of the Americas and reviewed progress since PHA I.

These activities took place without centralized funding and through a loose networking structure. Partners from the South played an important role in developing the Charter and strategies for action. The PHM identifies people, particularly those excluded, as its greatest resource and reservoir of talent and energy. Providing space for community voice and agency has brought in dynamism, diversity and focus on priorities. The health movement, along with allied movements, is a force that is part of a globalization of solidarity from below.

6. Conclusion

NGO coalitions with communities, governments and other organisations can mobilise human, political, financial and scientific resources to make health promotion the backbone of health care systems and services. There is a need for the health promotion community to develop and sustain working links with local communities, groups and movements working beyond the traditionally defined health sector in order to influence health determinants. Working for equity in health would involve challenging powerful interests. Public health ethics requires that this be done. The paper provided an overview of NGO coalitions and movements, their strengths, weaknesses, opportunities and threats, suggesting how they make a difference in the health and wellbeing of communities

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