Civil Society Report

October, 2007

	Commission on Social Determinants of Health	

Civil Society Report

October, 2007

	Commission on Social Determinants of Health	

Table of Contents

1. Civil Society and the CSDH: Vision, Experiences and Values

1.1. Introduction: Historic Mission before the Commission

One of the founding fathers of modern public health, Rudolph Virchow, was known to have commented: "***Do we not always find the diseases of the populace traceable to defects in society***"?[1] He asserted, further: "*Politics is but Medicine at a large scale*" We continue to seek out "defects in society" that need to be remedied if Health is to be given its rightful place. Today, more so than ever before, we are reminded that, ultimately, politics played out at global scale, determines whether people live or die.

Civil Society welcomes the opportunity provided by the Commission on Social Determinants of Health (CSDH) to explore these issues in detail. Civil Society has been consistent in arguing for an approach to Health that echoes Virchow's famous words. Civil Society has been consistent in arguing for an approach to Health that echoes Virchow's famous words. We have watched with dismay the reduction of Health into medical services, and medical services into a serious of technological "fixes", designed at best to ameliorate individual diseases rather than to cure glaring defects in human society that give rise to such diseases. The dismay has often turned to distress and even anger as we have watched the advances in human endeavour being frittered away at the doorstep of avarice and greed on a global scale.

The symptoms of the disease plaguing human society where diseases fester and health is just a word without substance, are too numerous and too well known. Let us, nonetheless, examine just one of them here. An estimated 30,000 children die every day, mainly from preventable and easily treatable causes.[2] What is important is not just that so many children die unnecessarily, but also that they die in much larger numbers in certain regions of the world, and within regions in certain communities. We know that throughout the world, children (and other people) living in poverty become ill and die more frequently than those who enjoy a more privileged social status. What is particularly glaring is that the gap has broadened despite the fact that never before has the world had the wealth, knowledge, awareness, and concern for health issues that it has today. Thus, they die, not because we do not have the knowledge and the technology to prevent such deaths. They die because of the conditions in which they live. These conditions are determined by factors that are conventionally never addressed by medical science. For us, the CSDH represents an opportunity for us to collectively examine the factors responsible for a situation where there is a 16-fold difference in infant mortality between the 26 wealthiest nations and the 48 least developed countries.[3] We welcome the Commission's vision of addressing those determinants of Health that are related to the situation in which people live and work. **We support the Commission's contention that it is largely**

---

1 Virchow R. 1848/1985. Collected essays on public health and epidemiology. Cambridge: Science History Publications.

2 Black R, Morris S, Bryce J. 2003. Where and why are 10 million children dying each year? Lancet 361:2226–34.

3 Guest G. ed. 2005. Globalization, Health, and the Environment: An Integrated Perspective. Lanham: Alta Mira Press

futile to treat illness and send people back to the same conditions, which were responsible in the first place for their illness.

It is also important to underline that the Commission's mission is **not arriving at novel insights** or radically departing from established evidence. Virchow's words, 150 years back, echoed the very essence of what the Commission stands for. Since then there is evidence galore that supports the contention that Health is socially determined. McKeown's seminal contribution in the early 1970s[4] was an excellent summing up of the evidence, and showed that most of the substantial modern reduction in mortality from infectious diseases such as tuberculosis took place prior to the development of effective medical therapies. Instead, the main driving forces behind mortality reduction were changes in food supplies and living conditions.

The principal issue, then, that we need to first address is: what prevented us – at a global, national or sub-national level – from harnessing such compelling evidence into a cogent and comprehensive strategy for improving Health outcomes at a global level. The short answer to that would be that we did have such a strategy! A strategy, furthermore, that was endorsed, at least formally, by virtually all governments in the globe. **As the Commission embarks on its mission to, once again, construct such a strategy, we must step back and ponder over two issues. The first, to recapitulate on the global vision that arose from the Alma Ata Declaration of 1978, that explicitly located itself in a social determinants led view of Health. Second, to examine the dominant cause for the failure and virtual abandonment of the vision in the Alma Ata Declaration and the Primary Health Care concept.** It is important to do so because, as has been said: *those who forget the past are condemned to repeat it*!

---

4 McKeown T. 1976. The Modern Rise of Population. New York: Academic Press.

1.2. Two Imperatives for the Commission to Inform its Analysis and Recommendations

1.2.1 Remembering Alma Ata and the Primary Health Care Approach

The Primary Health Care (PHC) approach, abandoned by countrie s and international agencies soon after the Alma Ata Declaration, continues to be as relevant today as it was 30 years ago. Given the position that we feel that the Commission needs to build upon the Primary Health Care approach, it would be useful to remind ourselves of the important elements of this approach and the Alma Ata Declaration which elaborated it. The Declaration at Alma Ata:

- Stressed a *comprehensive* approach to health by emphasizing interventions that promote and protect health, such as food security, women's literacy, access to clean water, etc.
- Promoted *integration* of different programmes and services at all levels of the health care system
- Emphasized *equity* and recommended addressing imbalances at different levels
- Advocated the use of *'appropriate' health technology*, and health care that is socially and culturally acceptable.
- Emphasized appropriate and effective *community involvement* in the health care system.
- Adopted a strong *human rights perspective* on health by affirming that health is a fundamental human and by placing the responsibility on governments to act on this.
- Called for peace, reduced military expenditure and a 'New International Economic Order' to reduce the health status gap between developing and developed countries.

There has been a tendency to confuse the approach with health delivery at the "primary" level of the health care system. By association it is sometimes presented as cheap, low-technology care for poor people in poor countries. In some measure this has been a deliberate ploy to discredit the PHC approach. Clearly the promises made in the Declaration have remained unfulfilled, and as we now seek to redeem the promise, we need to examine the reasons. The reasons were many – some of the prominent ones were:

Health Sector Reforms and Primary Health care
The inability of poorer countries to pledge even a fraction of the resources required to sustain their health care systems has its origins in the economic crisis that engulfed poorer countries since the early 1970s. We elaborate on the reasons for this later in this document.

An alternate strategy, in the face of resource constraints, led the IMF and World Bank to launch prescriptions under the broad rubric of "Health Sector Reforms". Unfortunately, none of these "reforms" were aimed at strengthening the public health system. Instead they contained a series of policy recommendations that were designed to systematically undermine the public system and at the same time to

promote the private sector. The ideological muscle for these reforms was provided with the rise of "neoliberal" economic policies across the globe. The reforms were provided further impetus through the global, regional and bilateral trade agreements (such as the WTO, Regional Free Trade Agreements, and Bilateral Trade Agreements, especially with the US). These binding trade agreements have promoted the "market" for health care and have further reduced the policy making space available to country governments to act on behalf of their people.

The three major elements of these policy prescriptions were:

Growth in User Fees
The impact of this transfer of responsibility for health care financing onto households has been disastrous, particularly for the poor.[5] Global evidence suggests that the introduction of user fees is deterring more and more from accessing the public health system.

Segmentation of Health care Systems
Going hand in hand with the levying of user fees is the global trend to segment health care into public health care for the poor and private health care for the rich.

Commercialization of Health Care
The collapse of the public sector has led to the emergence of a disorganized and unregulated private sector in developing countries. The experience with the private sector, however, shows that the motive for profit dominates over other considerations. Ultimately, by this kind of behaviour health is converted into a purchasable commodity in the market – with only those who can afford the costs being able to access it.

Misplaced Priorities: Selective Health Care and Cost-Effectiveness
The second major blow to the PHC approach came in the form of the concept of "Selective health care" -- a limited focus on certain health care interventions, as distinct from comprehensive health care. Selective Health Care was propagated with the understanding that rather than wait for a fully resourced system that can provide comprehensive care, it is prudent to promote a few interventions that can produce the largest change in outcomes. Selective care soon came to be associated with "vertical" programmes, i.e. separate programmes with specific structures and management, each targeting a specific problem. The approach reinforced the biomedical orientation of care that is premised on the belief that a specific technology can target a specific health problem. In many countries, the approach has disrupted the development of a comprehensive health system, because of the promotion of multiple programmes that had very few elements of integration. Many of these programmes were donor driven, and controlled as well as implemented by international donor agencies.

---

5 Whitehead M, Dahlgren G, Evans T. 2001. Equity and health sector reforms: can lowincome
countries escape the medical poverty trap? Lancet 358:833–36

1.2.2 Understanding the Role of Neoliberal Globalisation

The underpinnings of the onslaught on the PHC approach -- and the Social Determinants led vision that it embodied -- need too be examined in some detail. The attack on the PHC concept was not accidental, neither did it arise in a set of fragmented policy prescriptions by multilateral agencies. The attack was ideological, globally orchestrated and globally co-ordinated. It found ideological legitimation from neoliberal economic theory and came to be known as globalisation, or to be more precise, neoliberal globalisation.

Given the enormous impact neoliberal globalisation has had in shaping the world today, and specifically in shaping the various determinants of Health, it is necessary for us to present at the inception our views on its roots, trajectory and impact – its etiology, pathology and symptoms!

In the late 1970s, the global economy was overwhelmed by a crisis, where growth of production started slowing down and rates of unemployment started growing alongside rises in prices of commodities. These changes took place together with the collapse of the Soviet Union and the state controlled economies of the socialist world. They also led to a reshaping of the capitalist world, and led to a complex of changes known as globalisation, privatisation and liberalisation.

Economic policies that were now imposed by the developed countries reflected an ideological commitment to market principles, ignoring the remarkable role that the government had played even in the advanced capitalist countries. Reduction of the role of governments and importance provided to the role of the market was thus at the center of this model of development. These policies were implemented in Latin America and Africa in the 1980s.[6] In the agricultural sector, this led to the reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops. The problem at the heart of this pattern of production is that it was implemented at a time when the prices of primary commodities (that is, products from agriculture and mining) were the lowest in history. By 1989, prices for agricultural products were only 60 per cent of their 1970 levels. This led to the further devastation of the economies of these countries and seriously affected food availability.

In the industrial sector, the new policies forced governments in developing countries to withdraw support to their own industries. The government run public sector, set up to create basic infrastructure and provide public utilities like electricity, roads, communications, water, etc. were systematically dismantled. They were privatised, or handed over to multinational corporations. Further, over this period, capital, across the globe, was concentrated in fewer and fewer hands. The driving force behind this phase of neoliberal globalisation became this accumulated capital. Countries were forced to remove restrictions on the flows of this capital in and out of their countries.

---

6 Gershman, J, A Irwin. 2000. Getting a Grip on the Global Economy. eds. Kim, JY, Millen, J, Irwin A., Gersham, J. Dying for Growth: Global inequality and the health of the poor. Monroe: Common Courage Press

This capital is essentially speculative capital -- invested for short term profits without any intention to create facilities that would promote manufacturing capabilities. Thus economies of poor countries became captive in the hands of those who have huge amounts of money - large multinational banks based in rich countries or foreign institutional investors (FIIs) - who have the ability to shut down these economies in matter of days if they decide to move their money to some other country.[7]

Together these policies and processes increased indebtedness of developing countries that they were supposed to reduce, increased the rate of exploitation of wageworkers across the globe, and shifted wealth from productive to speculative sectors. The policies also led to the increase of casual, poorly paid and insecure forms of employment. Fund cuts in education and health also meant that already weak and under-funded systems in many developing countries of health, education and food security collapsed.

Impact on Public Health
Public health was an obvious casualty of this process. In the Health sector, the adoption of neoliberal policies led to: a cut in investment on welfare and the gradual dismantling public health services; introduction of service charges in public institutions, making the services inaccessible to the poor; and the handing over of the responsibility for providing health services to the private sector and the consequent undermining of the rationality of public health. The World Development Report, 1993, titled "*Investing in Health*"[8] elaborated on this approach. In almost every developing country, where prescriptions premised on the neoliberal approach were followed, public health conditions deteriorated. In Philippines health expenditure fell from 3.45% of GDP in 1985 to 2% in 1993; and in Mexico from 4.7% of GDP to 2.7% in the decade of the 80s.[9] Even developing countries with a strong tradition of providing comprehensive welfare benefits to its people were not spared (with the exception of Cuba). In China health expenditure is reported to have fallen to 1% of GDP and 1.5 million TB cases are believed to have been left untreated since the country introduced mechanisms for cost recovery[10]. In Vietnam the number of villages with clinics and maternity centers fell from 93.1% to 75%. Because of these effects the last two decades of the 20th century have often been described as lost decades.[11] Thus, clearly, the failure to pursue the PHC approach is rooted in the ideological underpinnings of neoliberalism. Without a clear reversal of the latter's role in determining policies at a global scale, it would be impossible to realise the vision of the Primary Health Care approach, and by extension the vision of the Commission in promoting the social determinants approach.

---

7 Patnaik P. 2003. The Retreat to Unfreedom: Essays on the Emerging World Order, Tulika, New Delhi.
8 World Bank. 1993. World Development Report: Investing in health.The World Bank. Washington.
9 Heredia C, Purcell.M Structural Adjustment and the Polarization of Mexican Society: in J. Mander & E. Goldsmith
10 Liu X, Mills A. 2002. Financing reforms of public health services in China: lessons for other nations. Social Science and Medicine 54:1691–8.
11 UNICEF. 1996. State of the World's Children 1996

Looking Forward while understanding the past

This then is the past that the Commission must confront as it endeavours to look forward. **We would strongly suggest that the Commission must locate its work in an analysis of both the Primary Health Care approach and the role of neoliberal policies in deligitimising the approach.** We welcome the approach proposed by the Commission in this regard, in stating that "… *the neoliberal economic models that gained global ascendancy during the 1980s created obstacles to policy action on SDH".*[12]

Looking forward, we also welcome the focus that the Commission has on addressing "inequity". For us this is very important. Very few would deny the existence of inequality in access to resources and services and consequent inequality in health outcomes based on socio-economic, gender, ethnic and geographical differences. It is relatively easy to build a consensus that such inequalities exist and need to be remedied. But addressing mere inequality is not enough, **because the extent of inequality in health cannot give us adequate information to assess health equity**[13]. By its focus on inequity, the Commission proposes an understanding of deeper structural factors that determine differential access to resources and health consequences. There are extremely strong forces operating globally that have an interest in perpetuating such inequities, because their very existence depend on their ability to do so. **We strongly believe that the ultimate goal, is not merely to look for health policies that favour the poor. Rather we seek significant policies that directly address the social determinants of the inequitable distribution of resources at a global, national and sub-national level.** We see as a positive signal, the Commission's willingness to take the more difficult route, by locating its work in addressing inequity. **The Commission has a historic opportunity to advocate for equity and for the structural changes that will do away with the social, economic and political determinants of health.**

---

12 Solar O, Irwin A. 2007. A Conceptual Framework for Action on the Social Determinants of Health, Draft Discussion paper for the Commission on Social Determinants of Health
13 Amartya Sen in: Anand S, Peter F, Sen A -- Eds. Public Health, Ethics and Equity. Oxford University Press, New Delhi

1.3 Civil Society's Expectations of the CSDH

The Commission on Social Determinants of Health, launched by the World Health Organisation (WHO), in March 2005, has the potential to capture afresh the refreshing promises held out by the global community in the form of the Alma Ata Declaration more than three decades ago.

Civil Society Organisations, especially those actively engaged with the health sector, have been largely of the opinion that the Commission constitutes a major opportunity to address key issues in the health sector. This is especially so as the Commission is seen to be engaged in examining and taking forward some of the key fundamentals of the Alma Ata declaration – viz. a Health Systems approach that foregrounds Primary Health Care and locating health in a larger social, economic and political context.

This is perhaps the first instance when Civil Society is seen as active partners in a major global process initiated by the WHO. It is but natural that given WHO's mandate, it has essentially worked through country Governments. The decision of the Commission on Social Determinants of Health to bring in Civil Society as partners is thus a new experience for all concerned – the WHO, country Governments and Civil Society. Civil Society finds it encouraging that a number of Commissioners serving on the Commission are people of eminence drawn from Civil Society.

Imperatives for CS participation
Civil Society views its role not as that of an instrument of advocacy for the Commission, but as a significant partner of the CSDH that brings in fresh, people and community centred, perspectives and has the potential to shape the Commission's work in many ways. In order for Civil Society to play this role it is **imperative that it retains the right to formulate its own independent analysis of the Commission's work.**

It is also important that Civil Society organisations drawn into the process do not feel that they are being "co-opted", i.e. they are being asked to implement or advocate for policies and processes in which they do not play a part in shaping. Such an independent approach is necessary as Civil Society partnership was being secured a number of months after the Commission's work was initiated and after a number of key decisions related to the broad framework had been already formulated.

Civil Society is engaging in the process, thus, also with the premise that they would have an independent framework of engagement with the Commission. Such a **framework need not always be very different from that of the Commission, but nevertheless the scope for maintaining this independence is vital for real Civil society engagement.** It is vital in order to draw in sections of Civil Society who have explicit concerns about the present paradigm of development globally as well as the trajectory of Governments and organisations such as the WHO in their endeavour to address issues related to human development and specifically health and access to care. We understand that the Commission seeks to actively seek out and engage with views that are diverse and often rooted in experience of working with the people – voices that often remain unheard. In order for this to be accomplished it is necessary that Civil Society Organisations feel that they are not constrained by a rigid pre-determined framework.

1.4 Locating Civil Society Roles, Actions and Concerns

1.4.1 What do we mean by Civil Society?

Various definitions of civil society have been attempted. The London School of Economics Centre for Civil Society working definition is illustrative[14]:

"*Civil society refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organisations such as registered charities, development non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups*".

However, such conventional definitions of Civil Society do not seem to be able to capture the complex nature of Civil Society. A more rounded understanding of Civil society needs to take into account not only its variegated nature but also the fact that **Civil Society operates in a contested space**. While going along with the basic understanding that this space is one that is distinct from that in which the state and its various arms operate, as well as distinct from the space in which commercial interests operate, it is still necessary to be aware of numerous differentiations within Civil society that determine the way in which it operates. Gramsci attempted to identify three dimensions of how different actors in Civil Society may operate[15]:

- On economic issues, articulating and organising through their productive activities, economic interests and material conditions of existence.
- Acting as a group to reform the state in order to achieve political and juridical equality, claiming their right to take part in the processes of forming the laws, making decisions, formulating public policies, and in reforming the state within the current situation
- Political movements that seek to present wide-ranging and comprehensive ethical, political and cultural alternatives to transform the individual, communities and the structure of society as a whole

Clearly, **such an understanding of Civil Society is contrary to the neo-liberal view which tends to look at Civil Society as a sanitised entity, stripped of its strong ideological, political and cultural roots.** In reality, Civil Society is extremely heterogeneous and represents the different and often antagonistic currents in society. But within this heterogeneity also lies its potential to build unities that

---

14 Centre for Civil Society, London School of Economics. 2004. What is civil society?
15 Gramsci A. 1975. Quademos de la Cárcel. Edición Crítica Del Instituto Gramsci. Organizado por

have the potential to challenge established ethical and ideological norms and practices. Thus, civil society is an arena where, through social interaction and struggles, excluded, marginalized, exploited and dominated social groups and individuals, are empowered to participate in decision making processes, to build platforms of action, to build movements, and to forge civil and political actions. But the very heterogeneous nature is also responsible for Civil society voices to speak in different languages and to pull in different directions. It is natural that under specific conditions there will be Civil Society actors that will be co-opted by the dominant economic and political paradigm, while others shall seek to challenge the same paradigm.

We think it prudent to place our understanding, as discussed above, about Civil Society, in order to also clarify that what we present in this document to the Commission is **not <u>the</u> perspective of civil society** – for there is no single voice – **but <u>a</u> perspective**. Nonetheless, we would like to contend that this **perspective is one that is widely shared across continents, and is one that has its roots in the historic role that Civil Society has played in shaping debates and polices on Health and even on Social Determinants of Health**.

1.4.2 Role of Civil Society in Health

Given that Health embraces so many strands that impact on society and relations in society, it is but natural that Civil Society has always been a prominent actor in shaping Health policies, Health outcomes and actions around Health. This has happened and continues to happen in a number of ways – through articulation of needs and demands, through providing leadership when such demands take an organised form of action, through articulation of alternatives, through building of models that bear replication, etc. In all such engagements Civil Society's actions are linked to the existing economic and political realities. Thus, the actions of civil society organizations and movements are also informed by different historical circumstances. As we discuss earlier, such actions may vary, depending not only on circumstances but also on the nature of the CS organisation involved. However, there are, in particular periods defined by a dominant paradigm, discernible tendencies of Civil Society action and reaction towards this paradigm. To elaborate, for example if we take the dominant paradigm **in the current global context as the ideology of neoliberalism, then we also see that much of Civil Society action is located in this paradigm – supportive or antagonistic, as the case may be.**

An area of some debate, in this context has centred around the role of the state in the creation and maintenance of civil society. A libertarian position sees the development of civil society as a means of "rolling back the state." The state is seen to interfere in the development of civil society by restricting the freedom of individuals. By contrast communitarians see a central role of the state as advancing the development of civil society through the provision of state-funded structures to support and nurture it[16]. A related issue is the question whether economic development promote healthy civil society or does civil society promote a healthy economy? The 1993 World Bank's World Development Report Investing in Health started from the assumption that economic development leads to health. Yet, there is evidence to suggest that healthy civil societies may exist without high levels of economic development. A focus on economic development in government policy making can devalue the social and civic elements of society.

Based on Foucault's analysis, it is possible to view Civil Society's role and activities in the health sector at three levels: 1) generation of knowledge around social and environmental determinants of health; 2) the relations of power among different civil society actors and institutions, and between civil society and the state; and, 3) the relation to oneself and to others. The interconnections between these three domains of human action constitute civil society's actions and role in the health sector. Two recent examples illustrate this interconnectedness. In an era when the concept of the "welfare state" was paramount, many civil society activities complemented or were adjuncts of the state's health policies and interventions. With the rise of neo-liberal health sector reforms, both government and civil society activities have been

---

16 Baum F. 1997. Public Health and Civil Society: Understanding and Valuing the Connection, 673-675 Australian and New Zealand Journal of Public Health, Vol. 21, No. 7

grounded in market-relationships.[17] For instance, patients are now termed as clients and consumers of health care services, and civil society organizations have been used as instruments of economic adjustment programs, privatization of health services, and as promoters of market values and consumerist behaviors[18]. Community participation has been directly related to private agencies instead of public authorities; the role of the state has been reduced to be a regulator of client and provider behaviors, and the role of expert has been transformed into programme coordinators and community developers under the aegis of private agencies and their administrators.

Civil Society as Adjunct to the State's activities
The role of civil society has often been an adjunct to the dominant economic and political paradigm. CSOs have been used to replace the state or to encourage the market in providing health services in many African, and Central Asian and Latin American countries[19]. The promotion of market driven Health Care Systems has resulted in the disruption of solidarity between the middle social classes and the poor, the introduction of individual rights for those able to pay, targeted public assistance for the poor, and the use of NGO and civil society organization's activities as strategic instruments for a market driven health care system and its neo-liberal governance[20].

In fact a prominent feature of health sector reforms in many countries, under the influence of neoliberal thought, has been its "NGO-isation". In India, for example, the "retreat of the state" in providing health care has simultaneously been associated with the promotion of NGOs to fill the vacuum[21]. This is not to deny examples of excellent work being done by a range of NGOs involved on issues of Primary Health Care with no assistance from either the state or foreign donors. It is nevertheless important to address the analytical issues raised by the romanticisation of all NGOs and their increasing utilization, often at public cost, to implement government schemes.

What is extremely important to realise is that NGOs are not, necessarily, either more effective or efficient than any public funded institution and cannot be used as a substitute for a variety of reasons. First, NGO activities are discretionary and not mandatory. Thus they can be socially exclusive, and indeed the fear that NGO-isation may be against the interests of *dalits* (socially marginalized communities in India

17 Román, Vega-Romero, Torres, M. 2006. The role of civil society in building an equitable health system. Draft of paper commissioned by EQUINET and the Health Civil Society Network in East and Southern Africa. November 2006
18 Loewenson R. 2003. Civil Society – State Interactions. WHO/TARSC; May 2003
19 Brinkerhoff D, McEuen M (1999) New NGO partners for health sector reform in Central Asia: family group practice associations in Kazakhstan and Kyrgyzstan. Special Initiatives Report 19:1--29 . Cited By Lowenson 2003).
20 Sen S.1999. Some aspects of state -- NGO relationships in India in the post- independence era. Development and Change 30:327--55
21 Hartmann, B. 1993. Old Maps and New Terrain: The Politics of Women, Population and the Environment in the 1990s, Paper presented at the International Conference on reproductive Rights, WGNRR, Madras.

based on descent) has been frequently voiced by *dalit* activists and scholars22. Second, they are not necessarily accountable, often not to the people they work with. Indeed the myth that NGOs are somehow more "representative" than political bodies has been so assiduously created, that this fundamental point has often been ignored. Thus the whole "space" for "Civil Society Organizations" in policy- making bodies that rigorously include NGOs but exclude other civil society organizations like trade unions is problematic, if not suspicious.

Civil Society Action: Questioning the Dominant Paradigm
At the same time, community and Civil Society resistance has always been prominent in posing a challenge to the dominant paradigm -- to welfare state dependence earlier and now to the prescriptions of neo-liberal philosophy. In many parts of the world – and particularly in Latin America -- a new political structure, able to create a more distributive and inclusive model of economic and social development seems to be taking shape in response to the social and political crisis. However, such a new economic and social order requires a more democratic and participative political system and a more open public sphere that is able to promote new ways of participatory and self-governing practices within consensual rules and processes of governance where marginalised communities and social movements may play a stronger role in building more equitable health systems. **This is the new and exciting frontier that Civil Society needs to look towards, just as it did – three decade s back – while championing the cause of Primary Health Care and in actually preparing the ground for the PHC approach through its actions.**

---

22 Thorat, Sukhdeo. 2001. Strategy of Disincentives and targeting for Population Control: Implications for Dalits and Tribals, paper presented at the National Colloquium on Population Policies, Center of Social Medicine and Community Health and the Singamma Sreenivasan Foundation, New Delhi.

1.4.3 Civil Society Actions in Shaping Health Policies

Civil Society action on health in the modern era can be traced to its links with attempts by newly liberated countries to break out of the model of health care imposed by the colonial powers. By the end of the colonial period, the pattern of health care which had developed in most of the developing World was modelled on the system in the industrialized countries. It emphasized expensive high-technology and urban-based curative care in large hospitals. The few public health services that existed were rudimentary and urban-based. The needs of people living in rural areas and urban slums were largely neglected. This situation continued with little change until the middle of the twentieth century. The 1950s and 1960s saw most of Asia and Africa win independence from colonial rule. Most of the newly independent states drew up plans to expand adequate health services into underserved areas. Although on paper these plans often emphasized prevention and gave priority to rural areas, most government and international funding continued to go to curative, urban services. Some poor countries spent over half their national health budgets maintaining one or two huge, urban, tertiary care hospitals[23].

For example, Imelda Marcos built The Lung Centre of the Philippines at great cost but the Centre would not take tuberculosis patients because it did not want to deal with infectious diseases! Tuberculosis, at the time the Lung Centre was built, was the third leading cause of death in the country. For many years, the Lung Centre's operations had to be heavily subsidized. Meanwhile the Quezon Institute, an older establishment for tuberculosis patients, had its budget slashed each year[24].

CS Action: Paving the way for an innovative vision
It is in this context that we see one of the most significant developments in public health in the modern era take place -- the creation of the rural health centres staffed by paramedical workers or auxiliaries, called medical assistants and health assistants. This approach—promoted initially by the Bhore Committee in India (This was a committee set up to chart the course of health care in Independent India, which gave in its report just before India's Independence in 1946. Interestingly, while the Committee's report remained largely ignore in India, it generated a lot of interest in many other developing countries.) — came to be known as the *basic health services* approach. By the mid1970s, although access to health care for many people in rural parts of underdeveloped countries had been improved through the use of auxiliaries, their expected potential was still far from fully realised. This was partly because medical assistants and other auxiliaries, like their professional mentors (doctors and nurses), had little attachment or accountability to the communities they served. Frequently, they either migrated upwards in the medical hierarchy or dropped out altogether[25].

---

23 Werner D, Sanders D. 1997. Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto, CA
24 ibid.
25 Werner D, Sanders D. 1997. Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto, CA

But this was the period when Civil Society organisations, most of them small community based organisations, gave a new orientation to the approach and paved the way for a truly innovative vision. The original vision was spurred by the remarkable progress in health attained in China, which centred around its programme of training "bare foot doctors" in the 1960s. From there arose the concept of *community-based health care*. Key to this concept were *community health workers* or *health promoters:* persons selected from and by their own communities and given brief courses showing them how to help their neighbors meet their most important health needs. Self reliance and the use of low-cost, local resources were encouraged. Emphasis was placed on preventive measures, health education, and involvement and leadership by members of the community. Throughout the 1960s and 1970s concerned groups of health workers and community organizers began to pioneer what became known as "Community-Based Health Programs," or CBHP. These participatory, awareness-raising grassroots initiatives arose in a number of regions, including Nicaragua, Costa Rica, Guatemala, Honduras, Mexico, South Africa (while still under apartheid), India, Bangladesh, and the Philippines.

Most of these programs started as a humanitarian response to enormous unmet needs, with a humanitarian rather than a political agenda. But institutionalized exploitation and routine violation of poor people's basic rights so clearly contributed to ill health and high death rates that many of these community-based programs evolved strong sociopolitical components. In some regions (the Philippines, Central America, and South Africa) a wide diversity of small, isolated, community-based health programs began to form loose alliances which gradually grew into broad-based movements, linking health, social justice, and basic human rights. In Nicaragua (under Anastasio Somoza), the Philippines (under Ferdinand Marcos), and South Africa (under apartheid rule), enormous social inequities and systematic violations of human rights contributed to the abysmal health status of a marginalized majority. And in each of these countries, a strong community-based health movement played a crucial role in "awareness raising" and the development of problem-solving and organizing which enabled people to finally stand up and oust the despotic regimes. In Bangladesh, what started as a field hospital in 1971 to treat freedom fighters who were fighting for the country's liberation, grew later into one of South Asia's premier CS initiatives on public health – the *Gonosasthya Kendra* (GK). Significantly GK was to host the first People's Health assembly in 2000, which gave birth to the global Peoples Health Movement.

The biggest and probably most highly acclaimed community-based health initiative was the barefoot doctors program in China. This grew out of a national liberation movement and was subsequently incorporated into the national health system of the victorious People's Republic. As an integral part of a revolutionary development process it sought to ensure that the people's basic health needs were met. To this end the campaign was remarkable in that it promoted a decentralized process in a country that has always had a strongly centralised government. Each barefoot doctor was accountable to members of the community, although the central government was backing the program. In this way the local community acquired more influence in the nature and quality of the health service provided; millions of people were mobilized to become involved. In addition, the campaign was unique in its commitment to

ensuring comprehensive improvements in food, housing, and environmental sanitation. As a result, a number of diseases were virtually eliminated, while child mortality dropped significantly.

Nicaragua: Health Action as agent of change[26]

The case of Nicaragua serves as an excellent example of how these "health" initiatives came to embrace a much larger canvas. Here, the people's quest for health was inseparable from their struggle against unjust social and political forces, both internal and external. In the 1970s it was estimated that 90% of the health resources were consumed by just 10% of the population. undernourished. While the country was still under dictatorship under Somoza, community based health initiatives began to spring up. Most, initially, had no political motives other than to help those in need. But the desperate situation of the disadvantaged was so clearly a product of an unfair social order that those concerned with people's well-being inevitably became more socially and politically aware. Community health workers facilitated organized action at the local level in order to alleviate some of the underlying man-made causes of poor health. Thus they gradually became agents of change -- and were soon branded as subversives.

By the late 1970s, an extensive network of nongovernmental community health programs extended throughout Nicaragua, especially in rural areas and poverty-stricken urban *barrios*. These grassroots health initiatives began to play a key role in mobilizing people in defense of their well-being and rights. In response, Somoza's Health Ministry -- with the help of the United States Agency for International Development (USAID) -- launched an ambitious project to train government-managed *health promoters*. But despite millions of dollars of US funding, the government's program received limited community support, while the network of community-based programs continued to expand. In response, Somoza's much feared National Guard increasingly targeted grassroots health workers. The grassroots network of community-run health initiatives played a key role in the broad-based popular awakening and mobilization that eventually led to the overthrow of the oppressive Somoza dynasty. This experience provided the groundwork for strong community participation in national health campaigns after the Sandinistas took control of the government in July, 1979.

Promoting a Revolutionary Shift in Emphasis

Community-based health initiatives in different parts of the world developed different methods for helping health workers. In Latin America, the awareness-raising methods of Paulo Freire's renowned adult literacy program in Brazil (out of which grew his classic book *Pedagogy of the Oppressed)* were adapted to health education. A "Discovery-Based Learning" model was developed in Central America and Mexico. At the same time in the Philippines, a group process of "situational analysis" or "structural analysis" was likewise used to help people diagnose the underlying causes of poor health. These methodologies for empowerment became important tools in helping groups of disadvantaged people conduct a "community

---

26 Werner D, Sanders D. 1997. Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto, CA

diagnosis" of their health problems, analyze the multiplicity of causes, and plan strategic remedial actions in innovative and creative ways.

In Latin America, the seeds of a novel approach to health was linked to an important event in Latin American history: the Cuban Revolution. The experience of post revolution Cuba presented an alternate model for provision of basic necessities and services in the social and economic sphere. It was premised on policies that, on one hand broke the dependency upon the United States, and on the other curbed the power of local elites.

These experiences, and the experience of numerous community based initiatives in the developing world, promoted a revolutionary shift from the existing medical establishment to strong community participation, with emphases on prevention, and prioritisation of rural areas. This meant literally turning the system upside down, from a top-down system to a bottom-up approach. As a culmination of this extremely rich process, in 1978 in Alma Ata, an unprecedented commitment was made by virtually all the governments in the world to actually locate Health in an approach which put disease in its social context.[27]

Post Alma Ata: Launch of the People's Health Movement
After 1978 Civil Society actions in Health centred around the promotion of the PHC approach. Soon, however, it started becoming clear that the promise of Alma Ata was being drowned by the rising tide of neoliberal thought and polices that were determined by neoliberal theories, across the globe. **One of the principal reasons why the promise of Alma Ata and the PHC approach did not wither away entirely, is to be found in countless civil society initiatives across the globe that strove to keep it alive – through advocacy and through community based programmes modeled on the PHC approach.** In the past few years a major achievement has been the attempt by CS organizations from across the globe to co-ordinate their activities around the promise of Alma Ata. A major landmark in this endeavour was the First People's Health Assembly, organised in 2000 in Bangladesh, attended by CS representatives from over 90 countries. The People's Health Movement that evolved from it was a civil society effort to challenge health policy makers around the world with a Peoples Health Campaign for Health for All-Now![28]

The Health Assembly in Bangladesh also endorsed the People's Charter for Health[29]. The charter, now translated into over 50 languages, has formed the basis of a new global movement. Some of the major elements of the Charter include:

---

27 WHO/UNICEF. 1978. Declaration of Alma-Ata.
http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
28 Narayan R. From Savar to Cuenca via Bangalore: A background paper by PHM Secretariat team for the PHM Transition / Strategy meeting in Frankfurt, 7-8 February 2006.
www.phmovement.org
29 People's Health Charter.2000. Peoples Health Movement
http://www.phmovement.org/charter/pch-index.html

- Endorsement that Health is a social/economic and political issue and a fundamental human right;
- It identifies inequality, poverty, illiteracy, exploitation, violence and injustice as the roots of ill health;
- It underlines the imperative that Health for All means challenging powerful economic interests, opposing globalization and drastically changing political and economic priorities;
- It tries to bring in new perspective and voices from the poor and the marginalized (the rarely heard) encouraging people to develop their own local solutions; and
- It encourages people to hold accountable their own local authorities, national governments, international organizations and national and transnational corporations.

The Peoples Health Movement represents the coming together of health and non-health networks to work on global solidarity in health. In the last three years the PHM has started building even broader alliances through its engagement with the World Social Forum (WSF) process – which some identify as the key counterpoint to neoliberal globalisation today. Significant progress has been made in the ensuing 7 years after the formation of the PHM. The Second Peoples Health assembly in Cuenca, Ecuador, attracted representatives from over 100 countries and culminated in the adoption of the "Cuenca Declaration" which was, both, a reiteration of the relevance of the People's Charter for Health and its contextualization to today's realities. The PHM has set up a International Peoples Health University (IPHU) to train the next generation of health activists just before the assembly. The IPHU is an unique endeavour of an university without a campus, classrooms or permanent faculty. The PHM has also recently announced the launch of a Global Right to Health Campaign[30]. It has been a partner in the launch of the first Global Health Watch – an alternative world health report. Over the past 7 years the PHM has engaged consistently with the WHO and was a major Civil Society force in encouraging the setting up of the CSDH.[31]

---

30 Global Right to Health and Health Care Campaign of the People's Health Movement. http://phmovement.org/

31 For details of the activities of the PHM see: www.phmovement.org

1.4.4 Factors Shaping Civil Society Action

While we have discussed the broad conceptual issues regarding CS actions earlier, there are several other related issues that shape both the ability as well as the direction of Civil Society action. Political contexts determine how effective CSOs are, and this is especially true when democratic rule is relatively new and formal institutions function poorly. Linked with this is the question of engagement with the state. Often, in order for policymakers to be seen to be fair and open, CSOs are invited to join the agenda-setting 'debate', but only once the government has made up its mind, and made a decision irrespective of the outcome of the debate with the CSOs.

There are occasions when models of partnerships are built around specific issues. In fact the CSDH is one such model of partnership (perhaps with a peripheral role for the market). Unfortunately, very often, such models assume that state, civil society and markets share common interests. As we can well understand that is seldom if ever the case. This is of importance to a large number of UN agencies, donor organizations and multilateral agencies as well as national agencies. Clearly, any partnership involving the 3 actors requires a negotiated consensus that is sensitive to the needs and perceptions of each. Too often, the consensus does get negotiated between the state and the market, and civil society is seen as an "add on" required to play along with this consensus. This leads to one of two results. It either attracts only that part of Civil Society that is willing to go along with the "manufactured consensus" or Civil Society is forced to pull out of such partnerships. Consequently Civil Society is left feeling that in partnerships with the state there role is seen as that of a 'subcontractor' and not as that of an equal[32].

Civil Society research or knowledge produced by Civil Society is another area of contention. There is a tendency to question both the accuracy of knowledge produced by Civil Society, as well as the ability of Civil Society to be able to be a source of credible research that can be relied upon. To be fair Civil Society organizations tend to be less than rigorous in documenting their work and in following up research on a sustained basis. It is important for CSOs to have access to good quality evidence, and networking between CSOs, for example, can make this possible. Many governments still tend to view data as a source of power and access to accurate data may also be difficult in settings where data collection is poor in the first place. This is especially true in community settings where primary data is hard to come by. In fact, in remote settings attempts to access information may even invite retaliation on the part of the state. An interesting initiative in India in the form of the "right to Information" campaign has actually led the government to enact a "right to Information" legislation in 2006.

Notwithstanding credibility gaps that plague civil society research and knowledge generation, it cannot be denied today that Civil Society has been instrumental in

---

32 Chowdhury N, Finlay-Notman C, Hovland I. CSO Capacity for Policy Engagement: Lessons Learned from the CSPP Consultations in Africa, Asia and Latin America. Working Paper 272. Overseas Development Institute

adding to the body of research and knowledge in many key areas. We have discussed their contribution in laying the ground for the primary Health Care approach earlier. Similarly on issues such as the environment, intellectual property related issues, global campaigns by the Civil Society have generated knowledge and research that is sourced today by the academia and governments. There is however a need for capability building of Civil Society to undertake and present research in a form that is comprehensible to a larger audience. At the same time academia and the government need to be sensitive to knowledge that is produced by civil society, and be primed about the value and utility of suck knowledge. In settings where government data and information is virtually non-existent or extremely unreliable – as is the case for resource poor settings in most developing countries – CSOs constitute the principal source of credible and live data and information.

Globalisation and the discontent that has gone with it has been instrumental in creating the conditions for the development of several international civil society movements. The World Social Forum, the Peoples Health Movement, the Access Campaign on Medicines, the anti-war movement, are all examples of this. With the locus of policy making moving to global institutions or being globally determined by a few countries such as the United States, the value of such movements and associated international CS organizations is undeniable.

At the same time there lies the danger of the CS view being only articulated by such global networks, thereby marginalising the voices of locally rooted CS organizations. In other words, care must be taken to ensure that agendas are locally owned and not dictated by external influences – however well meaning such influences may be. Most conscious international CSOs are conscious of this and do attempt to temper their global reach with local perceptions ("think globally, act locally" has been the key slogan of this consciousness). Nevertheless the threat of local CSOs being made irrelevant in policy-making, by this process does remain, and is often reinforced when multilateral institutions find it more convenient to attach importance primarily to internationally networked CSOs. Donor organisations naturally aim to work with research institutions that fit their criteria and understand their reference points and ideas, especially with regards to financial matters[33]. In reality, this is more often than not Northern NGOs, whose members share similar backgrounds but have the benefit of local knowledge and influence. While a global approach is important, it should not act as a barrier to local initiatives. Examples of global NGOs dictating the agenda have been articulated, for example, in the aftermath of the South-East Asian Tsunami of December 2004. CSOs from Sri Lanka commented that, "INGOs arrived at the scene of the disaster in such large numbers that they sometimes pushed aside (even if unintentionally) local CSOs, undermining their capacity and forcing them to close down".[34]

---

33 Chowdhury N, Finlay-Notman C, Hovland I. CSO Capacity for Policy Engagement: Lessons Learned from the CSPP Consultations in Africa, Asia and Latin America. Working Paper 272. Overseas Development Institute
34 Dr Vishaka Hidellage of ITDG Sri Lanka and Dr Vinya Ariyaratni of Sarvodaya quoted in Menocal and Rogerson, 2006.

1.5 Civil Society Values

1.5.1 A Rights Based Approach to Health

Human rights have come a long way – moving from the concept of philanthropy and charity to rights that can be demanded of the state. A rights based approach, as we understand it, requires taking sides and mobilising to force the retreat of human rights violation. This is very different from the early concept of human rights as individual rights and where the rights were sought to be located in a framework devoid of politics. For us, a rights based approach needs to recognise that structural causes, (a prominent example today would be neoliberal globalisation, but there can be many other like colonialism, structures of the state, etc.) determine the enjoyment or the violation of rights.

While advocating for particular rights, like in the case of right to health, we also recognise the need to locate such campaigns or struggles in the broader mobilisation to transform structural factors that give rise to human right violations in the first place. We view rights as **rooted in social, economic and political structures and relations** and would locate rights violations in the broader analyses of power and social inequality While individual rights are important, for us a rights based approach is primarily about addressing them at a societal level. **We view the human rights framework as, not one that legitimises and helps maintain the status quo, but one that questions the status quo by pointing out how it is structurally violative of human rights.** Thus we strongly advocate that rights are realised by changing the prevailing power relations. Rights can and are conceived at various levels, but here we are specifically concerned about a set of rights that can be termed as "universal" or "global". For the rights based approach to have sufficient ability to make an impact, there are certain globally accepted rights that need to be formulated, and which form the rallying point for mobilisations for the enjoyment of such rights.

A focus on attention to health as a human right began after World War II with the Universal Declaration of Human Rights and the creation of the World Health Organization. The real focus of these efforts, however, was on access to health care. It is only in the past two decades that this framework has been broadened to encompass not just access to health care but also other determinants of health[35]. Substantial progress has been made in the understanding of the synergy between health and human rights and of the potential of this approach to transform public health policies and practice.

---

35 The Universal Declaration of Human Rights 1948 was followed subsequently by two international treaties, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights have made these rights part of international law.

We welcome the fact that the CSDH, in its approach, appears to have embraced the international human rights framework as the appropriate conceptual and legal structure within which to advance towards health equity through action on SDH. **We believe that one of the Commission's principal mandates is to broaden and deepen our understanding of the "Right to Health" and specifically to formulate indicators that chart the progress of governments in safeguarding the right to health.** In doing so, the Commission should be guided by existing covenants that describe in detail obligations towards provision of comprehensive health services and care. Even in the limited sphere of health care, we hope that the Commission, through the fulfillment of this mandate shall unequivocally **challenge the dominant global discourse of** *'Health care as a commodity'* **and** *'safety nets for those left outside the benefits'* **and replace this with a** *'Health care as a human right'* **discourse.**

Right to Health: Going Beyond Health Care

The Committee on Economic, Social and Cultural Rights, which monitors the Covenant and issues General Comments has rightly recognised that the right to health is closely related to and dependent upon the realization of other rights, such as the rights to food, housing and freedom of movement. The Committee has also interpreted the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, expressly noting an adequate supply of food and nutrition, as well as access to safe and potable water and adequate sanitation as key determinants; in other words, they are determinative of the extent to which one can enjoy the best attainable standard of health.

We look upon the Commission as the appropriate medium for extending this analysis of the Committee. At present General Comment 14 of the UN Committee on Economic, Social and Cultural Rights, adopted in the year 2000 (*see Annexure I*) is not a binding instrument36. **We strongly urge the Commission to add its analytical weight towards recommending that Comment 14 is transformed into a binding commitment by signatories.** Further, the Commission needs to recognise and articulate the impact of global factors that impinge upon the enjoyment of the right to health in all nations across the globe. These factors would include:

Those Related to Health Care and Services
- *Health systems*: The effect of globally-promoted health system reforms of the past two decades on equity in access to care through changes in financing, delivery and privatisation. There is need to establish universal norms regarding a basic standard of essential health care services that must be ensured.
- *Health workers*: The impact of the global migration of health workers from countries in greater need to countries with greater resources on the health, and mitigating policies to reduce global health inequities arising from such flows.

---

36 Committee on Economic, Social and Cultural Rights, General comment 14: The right to the highest attainable standard of health, E/C.12/2000/4, 12 August 2000

- *Trade in health services*: The role of trade liberalisation in health services in impacting on global health equity.
- *Access to Essential medicines*: The effect of extension of intellectual property rights on access to essential medicines, and alternative policies to ensure such access is not compromised.

Other Determinants of the Right to Health
- *Water/sanitation*: Globalisation's role in modifying access to potable water and sanitation, and measures that can ensure and safeguard equity in access and sustainability in use.
- *Food security*: The effect of an increasingly integrated global market in food production, marketing and distribution on food security at the national level and at the level of households.
- *Economic Sanctions*: Their use by nation states and international organisations and the impact on the right to health
- *Labour and Employment*: The impact of globally integrated production systems on labour markets, unemploymemt, conditions of employment and social security linked to employment.
- *Poverty*: The impact of neoliberal policies in the distribution of poverty between nations and within nations
- *Gender*: Global factors determining the position of women in society in different settings and their changing roles superimposed in existing inequities
- *Social Exclusions*: The role of neoliberal globalisation in creating new kinds of exclusions and reinforcing existing ones.
- *War and Militarisation*: The impact of militarisation and war (or the threat of military aggression) on the right to health

An unraveling of the above would clearly lead us to examining the social determinants of health that the Commission in seized with. We look towards the Commission to strongly locate its recommendations in the Rights frame work, in a manner that places concrete demands on governments to act.

1.5.2 Empowerment for Health

Empowerment is a social and political process. Few would disagree that if the goal is to address Health inequity, strategies would need to be located in processes that empower people and rescue them from a situation that places them in various degrees of dependence. To put it in another way, people's Health can be ensured in the long term only if people have control over their lives. While there needs to be little or no debate to establish that empowerment is a desired goal, there is room for debate on what we mean by empowerment and what are the processes that lead to this desired objective.

The term "empowerment" has become an integral part of the discourse of most agencies linked to the state or to multilateral agencies, and even donor agencies. It is necessary, however, to examine whether the liberating potential of the concept is retained during such usage. **We would define empowerment as a concept that challenges established hegemonies and bases itself in a discourse that recognizes basic rights.** When we talk of empowerment in the context of health, we recognize the need for people to be aware of conditions that affect their health. But we also would assert that empowerment is not just knowledge. It is the recognition and the building of abilities to change power relations in society. For, ultimately empowerment is about power. So we would also assert that power is not something that is voluntarily by established hegemonies, it is something that ahs to be fought for and won.

It is, thus important to understand that outside agencies cannot and do not "empower" anybody. They may facilitate, or help create favourable conditions. But **ultimately it is the people who wrest power and thereby empower themselves. This distinction is important for us as it demarcates itself from the position that it is possible to empower people or communities.**

Turning specifically to Health, what do we mean when we talk of empowering people to achieve Health? We do not just mean helping people to improve access to services or even just helping people to improve their conditions of living. These are important but do not change power relations. Empowerment to achieve health means wresting the power to fundamentally change the causes of inequity. Thus empowerment for health is a process by which disadvantaged people work together to increase control over events that determine their health. Using a social determinants lens to define health, this means gaining the capability and the power to change economic relations, conditions of work and living, and access to resources. Ultimately it also means the ability to change global power relations that determine Health.

If we were to explain the concept with greater clarity by the use of an example, let us consider the seemingly simple task of empowering a community to prevent deaths among children due to diarrhoea[37]. At the first level, empowerment of a community

---

37 Example adapted from: Werner D, Sanders D. 1997. Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto, CA

to prevent diarrhoeal deaths would require access to knowledge – very importantly the knowledge to recognize symptoms of dehydration and the ability to prepare oral rehydration solution at home or locally. This is very important but addresses a small part of the problem if children are to still continue living in conditions that make them vulnerable to repeated episodes of diarrhoea. A higher level of empowerment would require the community to be able to organise and demand better access to clean drinking water and sanitation facilities. At another level it would require the community to be able to articulate and fight for policies that ensure access to food and control over land. Even this may not be enough, and the process of empowerment may have to extend to the ability to change global policies that give rise to inequity and the unequal distribution of resources.

In the current global context that is dominated by the neoliberal paradigm, the struggles for health, development, and social justice, even in a remote village or slum, are inseparable from the global struggle for a more just world economic and social order. **In our view, thus, empowerment is a complex social and political process. In its essence resides the entire spectrum of power relations and the processes required to change existing relations.**

2. Civil Society's Work with the CSDH

*We present below a generic summary of the work that civil society from the four regions – Africa, Asia, Latin America and Easter Mediterranean -- has been engaged in while working with the Commission. More detailed summaries of the work for each region is provided in **Annexure II** of this report.*

Civil Society Organisations and the CSDH

Civil Society was invited to be one of the arms of the work of the Commission on Social Determinants of Health. The decision to involve CSOs in the Commission work allowed CSOs to play a role in the work of the Commission and influence its recommendations by bringing in experiences that are people and movement centred. It was conceived that CSOs would engage with the Commissions through its other 4 arms, i.e.
1. Commissioners – by initiating a dialogue with them at the country level
2. WHO – by working with and providing inputs to the Secretariat
3. Country Work – by involving in the country work of the Commission
4. Knowledge Networks – by working with the KNs and contributing to their output

Civil Society's engagement with the Commission was mediated by key CS organisations in 4 regions – Latin America, Eastern Mediterranean, Asia and Africa – who were identified as Civil Society Facilitators for the respective regions. The organisations invited to facilitate CS engagement were identified based on an assessment of their work, specifically their experience in promoting the concept of health in the context of social determinants. Civil Society participation in the Commission's work represents a convergence of interests between Civil Society and the Commission, and was seen by Civil Society as an opportunity for joint effort in the promotion of the paradigm of health as a social process and a human right.

Methodology of Civil Society's Work with the CSDH

Phase I: Mapping of CS Organisations, Resources and Concerns
Civil Society's work with the Commission included 2 phases of work. The First Phase involved a mapping of CS organisations, resources and concerns around social determinants of health in all the four regions. Mapping of different actors and opportunities to promote the issues around social determinants of health encompassed the following:
1. Mapping or identification of spaces for discussion of the CSDH and the positioning of social determinants of health in public policy: for example meetings, conferences, regional forums or other activities carried out by or with civil society
2. Mapping of actors that may obstruct the implementation of CSDH agendas in the region
3. Mapping of organisations linked with the State or the market that have relevance to civil society processes or special importance for action on social determinants of health

4. Mapping of international development agencies working in the region
5. Mapping of civil society proper. The criteria for this could be:
    a) Have interest or expertise in social determinants of health
    b) Can promote relevant issues with government and other institutions in their countries and regions
    c) Can advocate on these issues with the public through media, progress reports and other mechanisms
    d) Can promote these issues with civil society constituencies and other actors
    e) Can contribute to analysis, policy development, implementation and defence of these issues
    f) Can link communities and civil society voice to the development of CSDH country work in the region.

This Phase of work also included mapping of regional/national situation analysis/political mapping of civil society concerns and potential for action on SDH. Such a mapping included the following:

(a) Socio-political situation with respect to key determinants, based on regional, country and local experiences

(b) Priority assigned to specific SDH, including those identified for CSDH Knowledge Networks and others

(c) Multiple roles and modes of action of civil society (viz. participatory action research; political mobilization and action, lobbying and advocacy; service delivery)

(d) civil society goals around SDH and planning for processes/ mobilisations

(e) major obstacles anticipated

(f) entry points for most effective intervention of Civil Society

(g) long-term view of working with the CSDH

Mapping Methodology

The mapping methodology in the four regions revolved around the following strategies:

- Identification of civil society networks, people's movements, campaigns, trade unions, workers organizations engaged in defending rights of people in the area of health and its social determinants, such as nutrition, housing, water, employment, education, environment and rights of children, women, disabled, socially marginalised and the economically weak. The general criteria for identification were that they have clear positions around SDH, have organisational capability to promote these positions and also are willing to engage with the process around the CSDH.
- Organising of regional meetings (one in each region) associating identified regional and national organisations to discuss about the perspectives and strategy for engagement with the CSDH processes. These meetings were designed to discuss how diverse civil society initiatives could fit into the objectives of the CSDH. The meetings formulated plans in each region for

collecting information from various levels of civil society in different countries. The Regional Meeting led to the development of an initial "core team" of CSOs in each region, who initiated country and sub-regional processes.

- Encouraging partner networks with help from the "core team" in countries of each region to hold country, sub/regional meetings with civil society structures covering a broad cross section of civil society.
- Encouraging smaller networks and groups to hold grassroots level meetings with the above objectives

The process was further facilitated by the use of loosely structured questionnaires, that helped the collection of information at the country level. Questionnaires were also developed to elicit information from CSOs across the regions about their interest and scope of involvement in the CSDH process. This process enabled civil society structures built around the CSDH to collect and collate voices from community based organisations and also to develop and maintain an ongoing process of dialogue and discussion with them.

Synthesis of Information
The synthesis of the information collected from the above process led to the development of Regional CS perspectives on social determinants of health and a strategy for long term civil society engagement around them. determinants of health. It also resulted in an extensive map of civil society partners in the region who were sensitised and showed interest in promoting a vision of Health that located itself in the social determinants' approach.

Outcomes from Phase I:
In brief, the salient outcomes of the Phase I of CS work with the Commission included the following:
1. The work of the CSDH was shared with key civil society organisations in the regions
2. Identification of roles and opportunities for civil society engagement with the CSDH, and of key concerns related to the CSDH
3. A preliminary political mapping/situation analysis in countries from the four regions identifying:
    a. Relative importance of different social determinants and opportunities and barriers in relation to key determinants
    b. key civil society actors in the country -- existing capacities and gaps
    c. possible processes and forums for mobilisation of civil society
    d. major obstacles and means to address these
    e. entry points for most effective intervention by Civil Society

Phase II of CS Work with the Commission: Knowledge from Civil Society

It had been **initially envisaged that the First Phase of work, that CSOs in the four regions were engaged in, would culminate in the development of regional strategies for more intensive engagement with the Commission's work. Such regional strategies were developed for each region. However resource**

constraints did not allow these regional strategies to be fully realised in the second Phase. Instead, it was decided that in order to maximise CS inputs into the final report of the Commission, CS work in the four regions would largely limit itself to the identification and collection of knowledge from Civil Society. In order to systematise the collection of such knowledge the following methodology was adopted.

The Second Phase of work was thus constructed around a methodology to provide an opportunity for CS voices to be reflected in the Commission's report. The principal goals were to:

- Collect Civil Society perspectives on key social determinants of health
- Research, collect, and systematise evidence from case studies, life stories and interviews that reflected selected community and grassroots experiences on SDH

Towards this end the four regions divided the responsibility to set up CS Reference Groups that dealt with thematic areas covered by the nine Knowledge Networks (two Reference Groups, each, located in Asia, Africa and Latin America and three located in the Eastern Mediterranean Region). Each reference group is required to work with the relevant KN to provide inputs into its output from a CS perspective and also to conduct a peer review of the output of each KN. In addition, each region is required to identify appropriate focal points for each of the nine KNs – i.e. nine focal points in each of the regions. With the support of the reference groups, regional focal points are required to collect information for use by the respective KNs and in the Civil Society report.

3. Civil Society Positions on Key Determinants

This section articulates Civil Society positions on some key social determinants of health. This is, of course, not an exhaustive presentation of CS positions on social determinants, but a selection of positions on issues considered of crucial importance. The process of identification of these issues has been detailed in the previous section that deals with the methodology of CS engagement with the Commission.

We are aware that many of the positions discussed here have also been dealt with by the Knowledge Networks. However, we still feel it is important that CS articulates its positions based on the wide range of consultations held with a variety of CSOs across the globe. **The articulation of our positions in this section draw from the basic framework that we elaborated in the first section – located in a critique of neoliberalism and in an understanding that the social determinants approach must build upon the primary health care approach.**

A special mention needs to be made here of a major source of material that we have used while developing this section. Extensive use has been made of a major Civil Society initiative called the "Global Health Watch: An Alternate World Health Report"[38]. The Global Health Watch, the first edition of which was published in 2006, is a collaborative effort led by three CS organisations – Medact, U.K, GEGA (Global Equity Gague Alliance), and the Peoples Health Movement – and partnered by several other CS organisations. The first edition of the Global Health Watch received contributions from several hundred scholars and activists. The next edition of the Watch is scheduled to be released in 2008.

---

38 Global Health Watch: mobilising civil society around an alternative World Health Report. Available from: http://www.ghwatch.org/index.php.

3.1 Globalisation

Balancesheet of Globalisation

Social and economic inequalities translate into nutritional and health inequalities. Despite remarkable achievements in global health over the last four decades, there is a 16-fold difference in infant mortality between the 26 wealthiest nations and the 48 least developed countries. Of the world's 6 billion people, an estimated 3 billion survive on the equivalent of less than $2 a day; 1.3 billion of them on less than 1 $ a day. Every day 840 million people go to bed hungry. Half of the people in the world's poorest 46 nations are without access to modern health car; three billion people - half the world's population - do not have access to sanitation facilities; one billion do not have access to safe drinking water.

Of the 100 largest economies in the world, 51 are multi-national corporations and only 49 are countries. The ratio between the wealthiest and the poorest countries in terms of per capita income has grown from 11 to 1 in 1870, to 38 to 1 in 1960, to 52 to 1 in 1985. In 1988, the average income of the world's wealthiest 5 per cent of people was 78 times that of the world's poorest 5 per cent; just five years later, this ratio had increased to 123 to 1. The gap continues to widen[39].

The per capita income in 100 countries is now lower than it was 30 years back. In Africa, the average household consumes 20 per cent less today than it did 25 years ago. 1 billion people saw their real incomes fall between 1980 and 1993. At the end of the 1990s, the wealth of the three richest individuals on earth was greater than the combined annual GDP of the 48 least developed nations.

Three hours of world-wide military spending is equal to the WHO's annual budget. Three weeks of world arms spending could provide primary health care, including water and sanitation, for all individuals in poor countries.

Genesis of the Current Phase of Globalisation

Human beings, as long as they have lived on earth, have been moving around the world, trading, learning and interacting. But from the seventeenth century arose a new situation, that of colonialism. Colonialism is often referred to as the first wave of globalisation and contributed to the most significant feature of the global economy today: the division between the First World, of, by and large, colonial nations, and the Third World, of colonised ones.

After the Second World War, newly liberated nations attempted to break free of the colonial chains that had forced their countries into underdevelopment. Policies of self-reliant development were put in place in the newly independent nations of Asia, Africa and Latin America that minimised dependence on the developed nations for import of resources and technology. Food availability and incomes rose in these countries, as did investment in social sectors such as health, nutrition and education.

---

39 World Bank. 1999. Inequality: Trends and Prospects, Washington D.C.

Reflecting all these changes, there were improvements in health indices as life expectancy rose, and morbidity and mortality rates declined.

In the late 1970s, however, the global economy was overwhelmed by a crisis, where growth of production started slowing down and rates of unemployment started growing alongside rises in prices of commodities. These changes took place together with the collapse of the Soviet Union and the state controlled economies of the then socialist world. They also led to a reshaping of the capitalist world, and led to a complex of changes known as globalisation, privatisation and liberalisation. They are also described, equally accurately, as corporate globalisation, or imperialist globalisation.

Economic policies that were now imposed by the developed countries, called "neoliberal" policies, reflected an ideological commitment to market principles, ignoring the remarkable role that the government had played even in the advanced capitalist countries. For example, after the Second World War, government involvement in public health had been considered crucial and essential in developed countries of Europe. Soon neoliberal policies came to be imposed in the developing countries as well, at the insistence of the developed nations and the institutions controlled by them, such as the World Bank and the International Monetary Fund (IMF). Reduction of the role of governments and importance provided to the role of the market was thus at the center of this model of development. Economic growth, it was maintained despite extensive evidence to the contrary, would trickle down to the less fortunate and thus result in overall development[40].

Impact of Globalisation on Developing Countries
We discussed earlier, the developed countries in North America and Europe were engulfed in an economic crisis in the 1970s. But very quickly they found a way out of this, by transferring the major impact of the crisis on to developing countries. One method they used was to open up the markets of these countries by dangling the promise that a "borderless world" under globalisation would benefit everybody. The rich countries and the large banks that they controlled had already used the bait of easy loans to trap many developing countries into a debt crisis.

The debt crisis meant that many poor countries could not even pay back the interests on the loans they had borrowed. Now the developed countries used this situation to their advantage. They said that they would bail out these countries facing a debt crisis by giving even more loans! But now these loans would be tied to certain conditions. Future loans were now linked to accepting a broad package of policies called Structural Adjustment Programme (SAP)[41]. These policies, that were now forced upon poor debt ridden countries, included conditions that governments need to spend much less on social sectors like food security, health and education. The conditions also required these countries to open their markets to goods and services from the

---

40 See for example: Patnaik, P. 2003. The Retreat to Unfreedom: Essays on the Emerging World Order, Tulika, New Delhi.
41 Sparr, Pamela. 1994. What is Structural Adjustment?: in Pamela Sparr (ed), Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment, Zed Books, London.

rich countries. In agriculture these countries were asked to produce for exports and not worry about producing food grains for their own people.

These policies were implemented in Latin America and Africa in the 1980s. In the agricultural sector, this led to the reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops. The problem at the heart of this pattern of production is that it was implemented at a time when the prices of primary commodities (that is, products from agriculture and mining) were the lowest in history. By 1989, prices for agricultural products were only 60 per cent of their 1970 levels. This led to the further devastation of the economies of these countries and seriously affected food availability.

In the industrial sector, the new policies forced governments in developing countries to withdraw support to their own industries. The government run public sector, set up to create basic infrastructure and provide public utilities like electricity, roads, communications, water, etc. were systematically dismantled. They were privatised, or handed over to multinational corporations.

Further, over this period, capital (money) across the globe was concentrated in fewer and fewer hands. The driving force behind this phase of imperialist globalisation became this accumulated money. Countries were forced to remove restrictions on the flow of capital in and out of their countries. This money is called speculative capital because it is invested for short term profits - just like a gambler would do - without any intention to create facilities that would promote manufacturing capabilities. Thus economies of poor countries are captive in the hands of those who have huge amounts of money - large multinational banks based in rich countries or foreign institutional investors (FIIs) - who have the ability to shut down these economies in matter of days if they decide to move their money to some other country[42].

Together these policies and processes increased indebtedness of Third World countries that they were supposed to reduce, increased the rate of exploitation of wageworkers across the globe, and shifted wealth from productive to speculative sectors. The policies also led to the increase of casual, poorly paid and insecure forms of employment. Fund cuts in education and health also meant that already weak and under-funded systems of health, education and food security collapsed. It is thus not accidental that these policies increased levels of poverty in already poor countries even as a small section of the population became richer; this section of the middle and upper classes obtained access to consumer goods that were earlier available only in the rich countries.

Between 1990 and 1993 sub-Saharan Africa alone transferred 13.4 billion dollars annually to its creditors, substantially more than it spent on education and health combined. From 1987 to 1993, the net transfer of resources from Africa to the IMF was 38 billion dollars. As a result, inequalities within and between countries have risen sharply: the income gap between the world's richest and poorest has more than

---

42 United Nations Development Programme. 1999.Human Development Report 1999, OUP, New York.

doubled, although the world has never been as rich as it is today. In 1960 the 20 per cent of the world's people in the richest countries had 30 times the income of the poorest 20 per cent; today they command 74 times more. The same richest 20 per cent of the population command 86 per cent of the world GDP while the poorest 20 per cent command merely 1 per cent. More than 80 countries have per capita incomes lower than they were a decade or more ago; 55 countries, mostly in sub-Saharan Africa, Eastern Europe and the former Soviet Union, have had declining per capita incomes[43, 44].

Impact of Globalisation on Health

Public health is an obvious casualty of this process. There is a clear contradiction between the principles of public health and neo-liberal economic theory. Public health is a "public good", i.e. its benefits cannot be individually enjoyed or computed, but have to be seen in the context of benefits that are enjoyed by the public. Thus public health outcomes are shared, and their accumulation lead to better living conditions. It does not mechanically translate into visible economic determinants, viz. income levels or rates of economic growth. Kerala, for example, has one of the lowest per capita incomes in the India but it has public health indicators that approach the levels in many developed countries. The Infant Mortality Rate in Kerala is less than a third of any other large state in the country. But neo-liberal economic policies do not even acknowledge such benefits. Laying down the fundamental prescriptions of neoliberal economic theory in the health sector, the World Bank document titled "Financing Health Services in Developing countries"[45] made the following recommendations for developing countries.

1) Increase amounts paid by patients for health care provided by the public sector.
2) Develop private health insurance mechanisms (this requires a dismantling of state supported health services, because if free or low cost health care is available there is little interest in private insurance).
3) Expand the participation of the private sector.
4) Decentralise government health care services (not real decentralisation but an euphemism for "rolling back" of state responsibility and passing on the burden to local communities).

These recommendations were further fine-tuned and reiterated by the Bank's World Development Report, 1993 titled "Investing in Health". Today the Bank is the decisive voice in the health sector, and tragically, organisations like the WHO and the UNICEF have been reduced to playing subsidiary roles.

The implementation of these policies resulted in dramatic reversals of health gains made after the Second World War. Reversals took place in other sectors as well, with clear impact on Health. Women and cildren were impacted upon the most. In many

---

43 United Nations Development Programme. 1992. Human Development Report 1992, OUP, New York.
44 Dollar D. 2001. Globalization, inequality, and poverty since 1980. Washington, DC, World Bank
45 World Bank. 1987. Financing health services in developing countries: An agenda for reform. Washington DC: World Bank.

countries, more women entered the labour force but typically at lower wages and with inferior working conditions than for men; in many others, women were displaced from employment as levels of unemployment increased markedly. Simultaneously, the extent of unpaid labour in households, performed largely by women, increased as public provision of basic goods and services declined. Young children, especially girls, were increasingly withdrawn from school to join the vast and grossly underpaid informal labour market or to assist in running the household. Rising food prices, along with cuts in subsidies for the poor, meant that an increasing proportion of families with precarious resources were pushed under the poverty line, affecting women and girl children disproportionately. They had to work for longer hours to purchase the same amount of foods as before, thus getting increasingly exploited. This also meant an increase in young women - and indeed women in general - being pushed into the sex industry, now increasingly global.

Given increasing levels of under nutrition, infant and child mortality rates, which had earlier shown a decline, either stagnated or in the case of some countries, actually increased. So widespread were these effects that the UNICEF issued calls for "a human face" to structural adjustment programme.

In the face of such evidence, even the World Bank was forced to modify its earlier recommendations. The World Bank started talking about investing in the poor through investments in health and education; and about the promotion of safety nets and targeted social programmes. This was a clear recognition that specific programmes are necessary to protect the poor from the consequences of structural adjustment and that economic growth by itself does not reduce the problem of poverty. **But these changes in the World Bank's thinking are still too inadequate and have come too late for millions who have died as a result of the policies it had promoted.**

World Trade Organisation and the Health Sector
We have discussed the role of two major global institutions in serving the interests of neoliberal globalisation. We turn now to the third and most recent addition – the World Trade Organisation. Different portions of the World Trade Organisation agreement, signed in 1994, have an impact on the health sector. Some of the important agreements under the WTO, which have an effect on health, are described below:

The General Agreement on Trade in Services (GATS)
Historically trade agreements involved reducing tariffs, eliminating trade barriers like quotas on imports on goods produced in a country and sold elsewhere. However, this has changed in recent years, spurred by the decreasing profitability of the manufacturing sector. Presently, the services sector is growing at a much larger rate in developed and many developing countries. It accounts for two thirds of economy and jobs in the European Union (EU), almost a quarter of the EU's total exports and a half of all foreign investment flowing from the EU to other parts of the world. In the US, more than a third of recent economic growth has been because of service exports.

37

As the service sectors of the economies of developed countries grew, trade in various types of services was exported. Multinational Corporations started lobbying for new trading rules that will expand their share of the global market in services. This was a particularly lucrative segment, given that governments spend a considerable amount of their budget on social services[46].

This is what the General Agreement on Trade in Services (GATS) under the WTO is targetting today. GATS cover some 160 separate sectors. The GATS as in all the other agreements contains provisions which allow further deregulation of any national legislation which is seen to be hostile to "free" trade. GATS identify the specific commitments of member states that indicate on a sector-by-sector basis the extent foreigners' may supply services in the country.

Today private insurance companies, managed (health) care firms; health care technology companies and the pharmaceutical industry of the developed countries are looking for opportunities to expand health care markets. In the developing countries, much of private health services were by and large provided by non-governmental organisations like charities, religious societies and community oriented associations, which were not entirely profit driven. This has started changing, with private investments in health services expanding and the corporate sector playing a prominent role, especially in countries where there is an affluent elite willing to pay or where there exists a private health service base. This move to open up the health and social sectors to allow privatisation and competition from the private sector means that, the latter is encouraged to take over health and social services of countries for profit.

Trade Related Intellectual Property Rights (TRIPS) - No Medicines for the Poor
The WTO agreement on Patents (called the Trade Related Intellectual Property Rights - TRIPS) sanctifies monopoly rent incomes by pharmaceutical MNCs. The WTO defines 'Intellectual Property Rights' as, "the rights given to persons over the creations of their minds. They usually give the creator an exclusive right over the use of his/her creation for a certain period of time." TRIPS protects the interests of big biotechnology, pharmaceutical, computer software and other businesses and imposes the cost of policing on cash-strapped governments, while slowing down or preventing altogether the transfer of useful technology.

The Trade Related Intellectual Property Rights (TRIPS) agreement, signed as a part of the WTO agreement, was the most bitterly fought during the GATT negotiations. Till 1989 countries like India, Brazil, Argentine, Thailand and others had opposed even the inclusion of the issues in TRIPS in the negotiating agenda. They did so based on the sound argument that Intellectual Property Rights - which includes Patents over medicines - is a non-trade issue. India and others had argued that rights provided in domestic laws regarding intellectual property should not be linked with trade. They had further argued that the history of IPRs shows that all countries have

---

46 Hilary J. 2001. The wrong model: GATS, trade liberalisation and children's right to health. London, Save the Children

evolved their domestic laws in consonance with the stage of economic development and development of S&T capabilities. Laws that provide strong Patent protection limit the ability of developing countries to enhance their S&T capabilities and retard dissemination of knowledge. Japan, for example, was able to enhance its domestic capabilities through the medium of weak patent protection for decades - well into the second half of the twentieth century. Italy changed to a stronger protection regime only in 1978 and Canada as late as in 1992. It was thus natural that many countries like India had domestic laws that did not favour strong protection to Patents before the WTO agreement was signed. It was illogical to thrust a single patent structure on all countries of the globe, irrespective of their stage of development[47].

These arguments were however systematically subverted during the GATT negotiations, leading to the signing of the TRIPS agreement. The TRIPS agreement required all countries to change over to a strong patent protection regime. A regime that would no longer allow countries to continue with domestic laws that enabled domestic companies to manufacture new drugs invented elsewhere, at prices that were anything between one twentieth and one hundredth of global prices. In India, for example, its 1970 Patent Act encouraged Indian companies to develop new processes for patented drugs, and facilitated the development of world class manufacturing facilities in a developing country.

The TRIPS agreement has placed enormous power in the hands of MNCs, by virtue of the monopoly that they have over knowledge. They have generated super profits through the patenting of top selling drugs. But drugs which sell in the market may have little to do with the actual health needs of the global population -- for, often, there is nobody to pay for drugs required to treat diseases in the poorest countries. Research and patenting in pharmaceuticals are driven, not so much by actual therapeutic needs, but by the need of companies to maintain their super profits at present levels. Simultaneously, new drug development has become more expensive because of more stringent regulatory laws. This is a major reason for the trend towards global mergers, as individual Companies wishing to retain the huge growth rates of the 1970s and 80s, are trying to pool resources for R&D. As a consequence, we are looking at a situation, where 10 -12 large Transnational conglomerates will survive as "research based" Companies.

Given their monopoly over knowledge, these companies will decide the kind of drugs that will be developed -- drugs that can be sold to people with the money to buy them. Thus on one hand we have the development of "life-style" drugs, i.e. drugs like viagra, which target illusory ailments of the rich. On the other hand we have a large number of "orphan" drugs -- drugs that can cure life-threatening diseases in Asia and Africa, but are not produced because the poor cannot pay for them. Today's medical research is highly skewed in favour of heart diseases and cancer as compared to other diseases like malaria, cholera, dengue fever and AIDS which kill many more people - especially in developing countries. Just 4% of drug research money is devoted to

---

47 Drahos P, Braithwaite J. 2004. Who owns the knowledge economy: political organizing behinds TRIPS. Corner House briefing 32

developing new pharmaceuticals specifically for diseases prevalent in the developing countries.

Some drugs developed in the 1950s and 1960s to treat tropical diseases, on the other hand, have begun to disappear from the market because they are seldom or never used in the developed world.

Agreement on Agriculture -- Assault on Food Security

The present phase of globalisation also has grave consequences for food security, which is an integral part of good health. The Agreement on Agriculture (AoA), under WTO has further skewed the balance against developing countries. In most developing countries, the lifting of restrictions on imports, as required by the AoA has resulted in widespread disruption of the rural economy.

The AoA ensured that subsidies provided to domestic agriculture by developing countries would be phased out while those being provided by developed countries would be retained. This has resulted in exports of primary commodities by developing countries becoming uncompetitive while their domestic markets are being flooded by subsidized imports from developed countries. This has been compounded by pressures of the SAP induced policies to produce for the export market. Because a few developed countries control the global rules of the game, in the past decades the global prices of agriculture exports from developing countries have fallen steadily. As a result farmers get less and less for their products, while the growth in production of staple food grains has fallen sharply.

3.2 Health Systems and Approaches to Health Care

We have discussed in the first section of this report the factors which led to the abandonment of the Primary Health Care approach and the vision of the Alma Ata Declaration. Here we elaborate further on the impact neoliberal policies had on Health Systems, and also outline at the end some proposals to remedy the situation. We stand now, almost 30 years after the Alma Ata Declaration. Clearly the promises made in the Declaration have remained unfulfilled. What were the reasons for this? What were the reasons for the abandonment of the PHC approach by the global community, within a few years of it being proposed? The reasons were many – here we discuss some of the most important ones.

Economic Factors
Health care systems need to be adequately financed and be resourced with trained human-power. **It has been estimated that low and lower middle -income countries need to spend at least US\$30–40 (2002 prices)[48] each year per person if they are to provide their populations with essential health care. This is over five times the average government health spending of the least developed countries and about three times that of other low-income countries**. The inability of poorer countries to pledge even a fraction of the resources required to sustain their health care systems has its origins in the economic crisis that engulfed poorer countries since the early 1970s – which we have discussed in the previous section. **This crisis came within a few years of the Alma Ata Declaration and prevented its bold and visionary aspirations from ever being put into practice.**

The crisis translated into savage cuts in government spending on social sectors such as health. Government health facilities suffered severely, leading to their virtual dismantling and the severe loss of morale among public health workers. Thus, in less than a decade after the Alma Ata Declaration, instead of an increase in public spending on Health (as the Declaration envisaged), what we saw was severe and sustained cuts on public expenditure.

This attack on the public system of health care led to it following into disarray and in its attracting criticism from those who depended on it. Ironically, the same forces who brought about this change (the World Bank and IMF, and even country governments themselves) joined in the chorus to blame public health services. It forced people to look for other options, leading to a boost to the private sector and its increasing legitimization.

Health sector reforms promoted by the IMF and World Bank
As we have noted earlier, the IMF and World Bank promoted reforms that were designed to systematically undermine the public system and at the same time to promote the private sector.

---

48 Commission on Macroeconomics and Health. 2001. Macroeconomics and Health:
Investing in Health for Economic Development. Geneva, WHO.

The ideological muscle for these reforms was provided with the rise of "neoliberal" economic policies across the globe. The reforms received further impetus through the global, regional and bilateral trade agreements (such as the WTO, Regional Free Trade Agreements, and Bilateral Trade Agreements, especially with the US). These binding trade agreements have promoted the "market" for health care and have further reduced the policy making space available to country governments to act on behalf of their people.

The three major elements of these policy prescriptions were:
- The growth in user fees;
- The segmentation of health care systems;
- The commercialization of health care.

User Fees and the Denial of Access

As we have seen, a prominent effect of health sector reform was the promotion of a greater privatization of health care. This meant that people have to spend more money themselves to access health care. Curiously, this effect has been used as an argument to introduce systems of payment (in the form of "user fees") in the public health care system as well. The argument used has been: if people are already paying in the private sector, they can also pay to access the public sector! The attempt has also been to use such payments as a way to offset government expenditure in running the public system.

The impact of this transfer of responsibility for health care financing onto households has been disastrous, particularly for the poor. Global evidence suggests that the introduction of user fees is deterring more and more from accessing the public health system.[49] User fees also work against people being able to use the system regularly, leading to their stopping medication before they should. We now know that much of anti retroviral resistance is being caused by people not being able to afford to continue treatment – thus leading to increasing instances of antibiotic resistance.

Moreover, what people have to pay "up front" now as user fees, is often a fraction of other expenses that they incur in accessing the public system. For example, maternity services in Bangladesh, are free, but in practice are accompanied by hidden and "unofficial payments" – these payments can be the equivalent of 50–100% of an user's monthly income. There is growing evidence that user fees are becoming a major cause for increasing poverty. In rural Vietnam, an estimated one fifth of poor households were in debt primarily because of paying for health care.

Votaries of the use of user fees argue that the negative effects can be offset by not levying user fees on the poor. Unfortunately this is something that almost never works. On the contrary it encourages extortion and patronage when care providers are poorly remunerated. Nor is there evidence that user fees prevent the so-called "frivolous" use of government health services.

---

49 Whitehead M, Dahlgren G, Evans T. 2001. Equity and health sector reforms: can lowincome
countries escape the medical poverty trap? Lancet 358:833–36

Given such clear evidence it is ironical that it is the poorer countries who have been proactive in levying user fees (usually at the behest of World Bank/IMF promoted policies). On the other hand most high-income countries continue to maintain public health systems through financing from general taxation, national health insurance or mandated social health insurance, and rarely take recourse to user fees as a method of financing the public health system.

The segmentation of health care systems

Going hand in hand with the levying of user fees is the global trend to segment health care into public health care for the poor and private health care for the rich. On the face of it this seems an attractive proposition, one that the World Bank has been actively propagating. The Bank now advocates that governments in poorer countries should not attempt to provide comprehensive care to all. Instead, it says, they should only spend in providing a "minimum" package of services. Clearly this is in direct contrast to the PHC approach that recommends "comprehensive" health care services for all.

This segmentation is being actively promoted — in some middle- and high-income countries, tax breaks on private insurance are used to entice higher-income groups away from publicly health services. In some developing countries like India, South Africa, Mexico, etc. we see another kind of segmentation being promoted, as private providers try to carve out a market for foreign 'medical tourists' from high-income countries.

The argument in favour of this segmentation is obvious – government resources can be directed at those who cannot pay, while those who can are serviced by the private sector. Unfortunately this argument is based on an extremely shallow and simplistic view of how health systems work. Such a system results in the rich opting out of the public system and at the same time also drawing away resources, political clout and accountability from the public system. What is left is a 'poor service for poor people'.

An expansion of the private sector also draws away resources from the public system in different ways. It draws on a limited pool of health professionals, and on limited foreign exchange for the import of drugs and equipment in developing countries. Ultimately it sucks resources away to the extent that the public system is even more hard pressed to cope with its workload.

It must be understood that there are powerful interests that are involved in propagating the segmentation of health care as described above. The most prominent is of course the private sector itself and those who invest in it. If they can entice the rich into the private sector it means large profit margins. Thus across the globe – in Latin America, Asia and transitional Europe (all regions with histories of strong public health care provision) – we see pressures by commercial interests and trade agreements to dismantle the public health system.

A parallel private and public sector also allows the private sector to choose to cater to the most lucrative and leave the poor, the elderly and the seriously sick for the public

sector. The division of health care systems into one for the poor and the other for the rich is not accidental, it appears to be a clear ploy that reflects the present socio-economic inequities and is an effort to reinforce them further.

Commercialization of Health Care

The collapse of the public sector has led to the emergence of a disorganized and unregulated private sector in developing countries. In middle and high income countries, the private sector takes many forms – ranging from not-for-profit charitable institutions to large corporate run institutions. The growing private sector in health care is being helped along in many countries by tax subsidies, and also directly by governments who decide to outsource parts of the functions of the public sector to private providers. The private sector also works through private insurance companies, which again are interested in targeting the affluent.

In many regions of the world the private sector is the only available health care option, given the steady decline of the public sector. The experience with the private sector, however, shows that the motive for profit dominates over other considerations. This leads to poor quality of care, or the elimination of the poor from their clientele – or often both. Unethical behaviour by private providers is common and includes recourse to unnecessary investigations and medication. Health care for profit promotes such behaviour at the expense of ethical and scientific treatment. Further, with profit from individual patients being the main focus, the private sector rarely engages in preventive care or in the promotion of public health measures.

Ultimately this kind of behaviour converts health into a purchasable commodity in the market – with only those who can afford the costs being able to access it. This trend is backed by the medical-industrial complex and pharmaceutical companies. Market driven health care is starting to affect the public sector as well. Starved of finances, these institutions are being asked to raise their own resources, making them act in ways similar to the private sector and resulting in the exclusion of those who are poor and most in need of care.

Votaries of commercialization argue that a market based system improves quality of care and efficiency, because of competition between providers and because consumers have more choice. Nothing could be farther from the truth. Patients – especially poor patients — rarely have enough knowledge to choose between different options, or to negotiate better terms. Competition does not improve quality if people cannot make an informed choice. Instead multiple providers only target the affluent, and the poor are left with virtually no options. Private care is notorious for flouting regulations, and the necessity to regulate them places a burden on public finances. A system with multiple providers is inefficient because it cannot make use of "economies of scale" in the case of purchases, or in the provision of services. Such a system also works as a barrier to developing important public health instruments that need to be applied consistently and universally, such as disease surveillance

systems. Competition between providers also harms collaboration between different providers – an important part of quality care[50].

Misplaced Priorities: Selective Health Care and Cost-Effectiveness
We have seen earlier, how the PHC approach was undermined by the collapse of the public health system. The second major blow to the PHC approach came in the form of the concept of 'Selective health care'. The concept refers to a limited focus on certain health care interventions, as distinct from comprehensive health care.

Selective Health Care was propagated with the understanding that rather than wait for a fully resourced system that can provide comprehensive care, it is prudent to promote a few interventions that can produce the largest change in outcomes[51]. Selective care soon came to be associated with "vertical" programmes, i.e. separate programmes with specific structures and management, each targeting a specific problem. The approach reinforced the biomedical orientation of care that is premised on the belief that a specific technology can target a specific health problem. Clearly this is in direct contradiction of the PHC approach that located health in a complex set of social, economic and environmental factors.

The successful introduction of the concept lay in the fact that it had the backing of powerful institutions. By the early 1980s, WHO, UNICEF and major bilateral donors, notably USAID, had endorsed this approach. The approach was best captured by the 'Child Survival Revolution' launched in 1982, which launched seven child health interventions: growth monitoring, oral rehydration therapy (ORT), breastfeeding, immunization, family planning, food supplements and female education,. Collectively, they became known as the acronym GOBI-FFF. In the initial years the strategy seemed to be working, and child mortality rates started falling in many countries which adopted it. The average number of under-5 deaths fell from 117 per 1000 in 1980 to 93 per 1000 in 1990, while immunization coverage expanded rapidly between 1980 and 1990.

Soon, however, it was apparent that the approach had several problems. In the case of the 'child survival revolution' itself, the focus on a limited set of technological interventions took attention away from a comprehensive approach to child health. Thus, for example, treatment of diarrhoeal disease was not accompanied by interventions to improve childcare, feeding or access to clean water. Complex health problems with underlying social and economic determinants were reduced to unidimensional problems that were attempted to be treated with a "technological fix". Thus, for example, the valuable, community empowering method of using home-based rehydration fluids to treat diarrhoea was replaced by the propagation of packaged Oral Rehydration Salts.

---

50 Liu X, Mills A. 2002. Financing reforms of public health services in China: lessons for other nations. Social Science and Medicine 54:1691–8.
51 Walsh J, Warren K. 1979. Selective primary health care: an interim strategy for disease control in developing countries. New England Journal of Medicine 301: 967–74.

In many countries, the approach has disrupted the development of a comprehensive health system, because of the promotion of multiple programmes that had very few elements of integration. Many of these programmes were donor driven, and controlled as well as implemented by international donor agencies. Multiple programmes also led to the de-skilling of health workers, and one was left with health workers trained to do only a limited set of tasks pertaining to the programme she or he was attached to. Multiple vertical programmes also puts the burden on consumers to access each of them separately through multiple visits.

Selective health care, we would recall, was introduced on the grounds that important interventions cannot wait for the setting up of basic health care infrastructure. However, experience suggests that when selective interventions are promoted, rarely are their simultaneous efforts to put in place a comprehensive infrastructure. As a result, the short-term gains of these interventions become difficult to sustain and follow up on. Worse still, selective interventions can actually undermine the development of health care systems. Mass immunization campaigns, for example, have often been prioritized to such an extent that other services have been disrupted. Paradoxically, the threat of narrow, disease-based programmes disrupting health care systems is most acute where such systems are already fragile and under-resourced – as they are in many poor countries.

Let us turn back to the "child survival revolution" which was used as evidence for the success of a selective care approach. Today, in spite of the it, 11 million children die each year from mainly preventable causes. Globally, the target set by the World Summit for Children in 1990 to reduce child mortality below 70 deaths per 1000 live births by the year 2000 has not been met. In many countries, immunization coverage rates are stagnant or declining. In others, the reduction in child mortality rates has slowed down. Clearly, the early promise has not led to a sustainable outcome[52,53].

In spite of such sobering evidence, selective approaches continue to be a prominent feature of the international health policy landscape. Country governments are expected to dance to the tune of an international agenda rather than developing targets, policies and plans based on their own circumstances. Health care responses to high morbidity and mortality continue to reflect a biomedical and 'technological' bias (vaccines, medicines or new technologies such as insecticide treated bednets) while an agenda for the development of a sustainable health system remains absent.

Today, the Millennium Development Goals, set by the United Nations, are also placing health services under pressure to achieve targets through selective interventions. It has been calculated that in order to achieve the MDGs, 15 preventive interventions and 8 treatment interventions would need to be made universally available in 42 counties. There is further pressure to launch selective interventions, as governments join the race to apply for funds such as the Global Fund to fight AIDS,

---

52 UNICEF. 2001. Progress since the World Summit for Children: a statistical review. New York, UNICEF

53 Black R, Morris S, Bryce J. 2003. Where and why are 10 million children dying each year? Lancet 361:2226–34.

TB and Malaria (GFATM). Importantly, many of the new selective health care initiatives operate as Global Public Private Initiatives – thus introducing a much higher level of involvement from the commercial/private sector.

With the active promotion of selective interventions, it is but natural that there would be attempts to design tools that would help to identify which interventions should be propagated. In 1993 the World Bank proposed a methodology that was designed to analyse the cost-effectiveness of different interventions and also to propose a minimum package of services based on this analysis. The tool used to determine the effect of each disease was called "Disability Adjusted Life Years (DALYs)". On first glance this would seem like a rational approach. But such an approach reduces Health to mere numbers and fails to capture the complex set of determinants that. It reinforced a selective approach to health care and undermined equity. In its proposal the Bank recommended that only those interventions that showed up as "cost-effective" should qualify for funding from the Government. At best, the minimum package proposed would avert no more than one third of the estimated burden of disease in low-income countries and less than a fifth in middle-income countries.

Understandably, the World Bank tended to apply its analysis to discrete interventions rather than those interventions that have more complex direct and indirect impacts on health. A clear example of this is that in the Bank's analysis that provision of clean drinking water would not qualify as a cost-effective intervention!

Role of Global Factors in Public Sector failure
We have noted earlier how economic factors undermined the public sector in countries across the globe, and thus ensured that the Alma Ata Declaration was given a silent burial. It was, however, not just economic factors which were responsible for this. The failure and collapse of the public sector in many countries was also brought about by corruption and incorrect priority setting, viz. huge military budgets and declining attention to social sectors. These causes are not just local in nature, but have been influenced by global forces. Over the last two decades the rich countries and global multilateral institutions have played a major role in supporting corrupt governments and inappropriate policies that harm Health. They have been instrumental in supporting and promoting the arms trade; and banks and tax havens actively harbour money looted by the elites from poor countries. Western corporations have been involved in bribing corrupt governments to obtain contracts.

In addition poor management and lack of community participation have also led to the collapse of the public sector. Health systems in many countries are run by career bureaucrats who have little or no understanding of Health. Moreover, in countries donors contribute a significant proportion of health care finances. In these countries donors wield enormous influence on national health policies. Such donor-driven policies, too often, are not located in local conditions. With the recent proliferation of global health initiatives, we have the added problem of very poor co-ordination between individual donor-driven initiatives. Clearly, sovereign decision making and community participation are obvious casualties of this entire process of donor-driven agendas deciding health priorities and policies in poor countries.

Bringing Back the "Public" in Health Care Systems

Our analysis till now has shown that the "public" has virtually disappeared from health care systems in many parts of the world. At the same time health care systems are either hostage to donor-driven agendas, or are being handed over to the private sector. If we are to reverse this trend, short-term solutions will not work. All the complex factors responsible for the demise of the public sector will need to be addressed.

In order to do so it is necessary to nail the wrong perceptions and blatant untruths about the public sector. There have been systematic attempts to portray the private sector as more "efficient" and to argue that market-based competition and incentives lead to better care and more choices. Such arguments turn a blind eye to the fact that the public sector has played the major role in almost all situations where health outcomes have improved significantly. Health systems that have depended on the public sector have been the norm, rather than the exception, in almost the whole of Europe. **The success stories of he alth system development – viz. Sri Lanka, Costa Rica, Cuba – are success stories of public sector health systems. The success of the public sector is not limited to health care systems.** Publicly-funded research in national institutes of science and universities has laid the foundations for many, if not most, developments in the medical sciences.

There are several important reasons why the public sector needs to play a leading role in health care systems – no matter which part of the world we are talking about. First, **people have a right to health care that is not dependent on their ability to pay.** This cannot be ensured unless the health care system in a country is public funded and administered. Not markets, but Governments, can ensure that health systems address the needs of the poorest and the most marginalized. This does not mean that public health services are "poor services for poor people". They should be seen as attempts by to provide the best services possible to all, while addressing the special needs of those who are most vulnerable.

Second, **an equitable and efficient health care systems requires to be planned systematically based on local conditions. Only a public sector driven system can do this.** It is impossible for a profit-driven, fragmented system with multiple (often contradictory) objectives, to do so. It is only a public system that can effectively strike a balance between preventive and curative services. It needs little intelligence to comprehend that a private system cannot and will not be involved in preventive services.

Third, **only an adequately financed public service can break the link between the income of health care providers and the delivery of health care.** Unethical behaviour of health care providers is directly linked with the fact that if care is linked to profit, more ill health means more profit! Non-governmental initiatives – especially the not-for-profit kind – have a role to play in health systems. But this role supplements public funded systems and cannot be asked to replace such systems.

There is evidence that the larger the role of the public sector in health care systems, the better the outcome. Healthy life expectancy (HALE), is higher, and child mortality lower, in countries with lower levels of private health expenditure relative

to public expenditure. Countries that spend more of their GDP on health through public expenditure or social insurance also have better health outcomes in terms of HALE and child mortality. What we often forget is that better health in richer countries is associated with more public health expenditure relative to GDP.

Agenda for Health Systems Development

Our analysis now brings us to a point where we can suggest a broad agenda for health systems development. The following recommendations need to be implemented together, and tailored to the particular social, political and economic realities of a given country.

Valuing and revitalising the public sector health worker
Health workers work in very difficult situation and face the brunt of the criticism (often motivated and ill-judged) heaped on the public system. It is crucially important to address issues of motivation and demoralization of health workers, support systems that are adequately resourced (viz. referral services, consumables, skill development), adequate living wages for them, etc. It is also important to optimize the mix of health care personnel and move away from a system that only sees the qualified medical practitioner as important to the system. Within such support should be located the strategies to address issues of ethical behaviour of health personnel.

Raising Resources to achieve Health For All:
We have seen earlier that global factors determine the amount of money poorer countries have to finance their health sector. These factors need to be addressed urgently, including issues such as debt cancellation, fair trade, increased development assistance, and new forms of global financing. At the same time country governments need to apply the principle that health systems need to be financed through direct taxation of the rich and the well off and not by asking for upfront payment when people access health services. This would also address and reverse the issue of segmentation of health services – good care for people who can pay and poor care for the poor.

Regulating and shaping the private sector:
While we stress on the development of an adequately resourced public health system we cannot be blind to the reality that in most of the poorest countries, the bulk of health care provision is carried out by the private sector. It is thus of critical importance that, while we build a public system, the private sector be regulated. For this governments need to develop standards and regulatory mechanisms that minimize the unethical behaviour of the private sector. In this context, it is important that Governments revoke any commitments they have made to liberalize their health care and health insurance markets through the World Trade Organization's General Agreement on Trade and Services (GATS) or regional and bilateral trade agreements, and should reverse any agreements that undermine their ability to regulate the health care sector.

Political and social mobilization:
There are several vested interests that draw public resources towards the elite or promote the private sector. Clearly, large social and political mobilization against such interests is necessary. Examples of such mobilization that have started making a

difference include the Treatment Action Campaign in South Africa, which challenged the patent monopolies of drug companies, and the mobilization of civil society against the privatization of health services in El Salvador.

Public and community involvement in health care systems:
For public sector bureaucracie s to work effectively, efficiently and fairly, they need to be held accountable to communities and the public.

More effective assistance from donors and global initiatives:
Donor and international health agencies must improve the quality, coordination and appropriateness of their programmes and initiatives. Donors should divert more funding away from agencies based in donor countries towards the public sector and NGOs in recipient countries. Donor programmes and international health initiatives must find ways that strengthen health care systems and not just concentrate on narrow disease-specific agendas. Donors must avoid self-promotion and not insist that governments show quick results from their grants — instead donor funding should be judged by the performance of the overall health care system over time.

3.3. Gender Dimensions of Health

Globalization, Health Care Financing and the Rights of Women
In the current context of globalization and health sector reform, today's health sector debate is defined more by the language of costs, adjustment and low budgets. It is necessary to introduce some crucial aspects of gender equity into this debate, in order to balance out this perspective. While looking at the specific case of Latin America, the broad issues find resonance in most developing countries. The following areas are of particular importance:

- Reform, financing mechanisms and health insurance and specific gender inequities in the funding of health practices
- Gender discrimination in (contributory) risk-based health coverage

Reform, financing mechanisms and health insurance and specific gender inequities in the funding of health practices [54]
Neoliberal Health sector reforms have brought about numerous changes in the area of public health policy in many countries, two of which were:

- Separation between financing and provision of health services
- Reform of the public health system when private insurance companies began to capture mandatory health care contributions from formal employment

Pubic health system with publicly-funded health insurance schemes
Health sector reforms have changed the public health care system in a number of countries that formerly had such a system (Chile, Colombia and Argentina, among others). Health services and systems have been decentralized and many decentralization processes have been accompanied by the introduction of publicly-funded health insurance, but with a division between funding and provision of care (one of the reform measures). In this new configuration health care is provided by either self-managed public health facilities or private facilities, which establish practices such as maximum coverage levels that users can access depending on their health plan, even when their plan is publicly financed. This means, among other things, that there is no guarantee of adequate care for health needs; instead, the level of care depends upon the plan that one has.

As the bulk of public health policy in recent years has been oriented towards handing the public provision and financing of health care over to private interests, it is important to note that to date no public policies aimed an ensuring gender equity in private health sector practices have been introduced; neither have their been any policies aimed an ensuring social security in heath.

---

[54] Tajer D. 2004. Experiencias de Movilizaciones contra los efectos de la Globalización en la Salud: Latinoamérica. La Medicina Social Latinoamericana en los 90: hechos y desafíos" En "Salud y Globalización". Sanchez Bayle M, Colomo C, Repeto L (comp) Edic. FADESP, Madrid, España,

Another important way of illustrating gender inequity among publicly-financed systems is to show what they do not cover[55]. The phenomenon has been studied in Argentina by following up on health care provided to women heart patients in the public sector. That study concluded that while women were hospitalized, it was possible to guarantee that medicine was administered equitably in regard to gender. However, when they were discharged, and medication costs become an out of pocket expense, women became the losers in family negotiations to define health priorities, coming last on the list; the study concluded that gender equity in ambulatory treatments such as the proper administration of medication cannot be ensured.

Health insurance schemes for workers in the formal labor sector

In Latin America, the gender inequity produced by a risk-based insurance model has been well studied in Chile, the most mature of the neoliberal reform experiences in the region[56]. Studies show that in Chile women of childbearing age must pay an extra premium to be covered for the cost of reproduction, or accept a lower level of coverage and pay for such "reproductive" expenses out of pocket. These plans are popularly called "with uterus and without uterus" in Chile, with the former costing up to three times as much as the latter for women and/or men of the same age. In addition, these health insurance plans do not adequately compensate for the difference in earning power between men and women in the labor force. Such differences are exaggerated by the fact that women's work patterns and history are more diversified and fragmented than those of men. As many women go through periods without formal employment, they experience periods where their coverage is interrupted, sometimes for up to 18 months at a time. Furthermore, women's concentration in lower paying workforce jobs and more flexible contract situations also impedes their fair access to such services, a further gender-based discrimination. In fact, in 2001 men accounted for 66.4% of all health plan holders (846,430) among Chilean health insurance companies (ISAPREs), while women accounted for just 31.8% (448,033)

Basic insurance, micro-credit and catastrophic illness funds for the "deserving" poor

These programs have been promoted in developing countries, including those of Latin America, by diverse international agencies. From a gender perspective, it is true that women are by far the most numerous beneficiaries of these programs, given the present composition of those living in poverty and the well known "feminization" of poverty, which is itself a widespread result of gender inequity. In regard to basic insurance in particular, the fundamental issue from this perspective is whether it covers and responds to women's unique needs.

---

55 Standing H. 2000. Gender impacts of health reforms. The current state of policy and implementation". Paper for ALAMES Meeting, Havana, Cuba, 3-6th July 2000
56 PAHO/WHO. 2002. Discriminación de las mujeres en el Sistema de Instituciones de Salud Previsional. Regulación y perspectiva de Género en la Reforma" Serie Género, equidad y reforma de la salud en Chile, cuaderno 1,2002

It is also important to begin a critical analysis of whether, as international agencies claim, there are real equity effects achieved by such credits and/or savings plans for the poor in regard to resolving health problems.

Sexual and Reproductive Health

The UN International Conference on Population and Development, held in Cairo in 1994 marked a change in approach to Sexual and Reproductive Health[57]. The Cairo Conference shifted focus away from the earlier approach, which was techno-centric and obsessed with controlling population through delivery of a set of services. The Cairo Conference defined sexual and reproductive health as *'a state of complete physical, mental and social well-being ... in all matters relating to the reproductive system and to its functions and processes ... Reproductive health implies that people are able to have a safe and satisfying sex life and have the capacity to reproduce and to have the freedom to decide if, when and how often to do so'*.

'Reproductive rights' emerged as a concept in the 1980s, and included concerns being raised by Women's movements related to women's equality and liberation, violence against women, the fight for abortion and the need felt by women to have control over their bodies. It also included concerns from poorer countries related to the health of mothers, and the high levels of mortality and morbidity related to child-birth. Over a period the issues have expanded to also include access to reproductive and sexual health services in the face of religious and state oppression, coercive population control policies in many countries that target women, the health of the girl child, sexually transmitted diseases and HIV/AIDS.

The Cairo Conference proposed a rights-based framework for population stabilization, discrediting old population control programmes[58]. Its goal was to make reproductive health care services universally accessible through primary health care no later than 2015. It also defined health services as including family planning care during pregnancy, prevention and screening of sexually transmitted diseases, basic gynaecological care, sexuality and gender education and referral systems for other health problems. It proposed a "life cycle" approach with services for all aspects of reproductive health rights, that is services that were needed throughout a woman's life and not just in the period when she is pregnant or lactating. In the face of opposition from conservative elements, the Cairo Conference could not find a consensus that would demand for universal safe and legal abortion.

What is Undermining the Consensus reached in Cairo?
Despite some advance, a ten-year review shows that the programme charted is still far from being implemented. Much of the reason for this gap in implementation lies in global economic factors that have a negative impact on the vulnerable and the marginalized, and women are often the first victims. This is compounded by the rise

---

57 UNICPD. 1994. Programme of action of the UN International Conference on Population and Development
58 The Corner House and WGNRR. 2004. A decade after Cairo: women's health in a free market economy. Corner House Briefing, 31 June.

in conservative ways of approaching women's rights and equality. This is reflected, for example, in the fact that the UN's Millennium Development Goals (MDGs) do not include sexual and reproductive rights, though they do include the goal to reduce maternal mortality[59].

In the name of "morality" fundamentalist tendencies are eroding the emerging consensus reached in Cairo. The US has been the global leader in pursuing this agenda, as exemplified by the US Government prohibiting overseas NGOs from receiving US government aid if they promote or provide referrals for abortion[60]. The US also continues to fund the anti-abortion lobby. The agenda has also been promoted by the Vatican, which consistently attack the sexual and reproductive health rights agenda. These agendas, promoted in the rich countries of the global North threaten many sexual and reproductive health and rights projects in the poorer countries of the global South.

More importantly, global factors which determine economic and political conditions, are proving to be the major reason why women continue to be denied good health and control over safe sex and childbearing. With public health services in disarray in many countries, women are the worst sufferers. Women are also the most prominent victims of economic policies that plunge marginalized sections into the poverty trap.

Clearly, while the consensus arrived at in Cairo was a step forward, it is necessary to go beyond this to look at women's health and sexual and reproductive rights in a much larger framework. It is necessary to view these rights in the context of global economic policies. Thus, structural adjustment and trade policies are leading to greater exploitation of women. Privatization of health services is shifting the focus back to narrow family planning package targeting women, and some treatment for sexually transmitted illnesses and child health.

It is also being argued now that the focus on abortion and reproductive rights in Cairo prevented clearer discussions on issues related to primary health care, social security and investment in health systems. The reality that is emerging is that women's health is largely determined by economic and social constraints, and it is difficult to separate out reproductive rights and health from other economic and political rights and needs (such as land rights, food security and communal harmony) that impact on the lives of poor women.

Given this emerging understanding, women's movements have started linking their demands on health and reproductive rights to issues of trade, globalization and fundamentalism. The links between neoliberal globalization and fundamentalism are becoming clear, with both joining forces to deny women the right to livelihoods, economic security and control over their lives and bodies.

---

59 Barton C, ed. 2004. Seeking accountability on women's human rights: women debate the millennium development goals. New York, Women's Coalition for Economic Justice
60 Jacobson J. 2003. First global women's scorecard on Bush administration. Women's Global Network for Reproductive Rights Newsletter, 80, 12–19, November

Challenges to Women's Health and Rights

The increasingly hostile economic and political environment in which women's health is being shaped and their rights undermined, makes it necessary to identify the challenges that we face. Some of the important ones are:

- *Macroeconomic environment*: Health activists need to understand how economic issues at a global and national level are influencing women's autonomy, sexual and reproductive rights and health.
- *Fundamentalisms*: It is necessary to confront different forms of fundamentalism that undermine women's rights, including the right to health.
- *Poverty*: Women are the worst victims when poverty levels increase. Clear linkages need to be drawn between poverty and current development model.
- *HIV/AIDS*: The HIV-AIDS pandemic has worsened dramatically since the Cairo Conference. Linkages should be made between HIV/AIDS and sexual and reproductive health, keeping in mind special concerns and needs of groups that are most vulnerable to the pandemic.
- *Abortion*: Unsafe illegal abortion is still a major cause of maternal death, particularly among young, poor and rural women.
- *Sexuality*: It is important to ensure sexuality can be spoken about in relation to rights, equality, and freedom from shame and fear.
- *Maternal health*: Extremely high rates of maternal mortality in Asia (especially South Asia) and Africa is a matter that requires far greater attention. It should be understood as a complex political, socioeconomic and cultural issue that requires major changes in health care and services, and cultural and political attitudes.
- *Women's rights and men's responsibilities* : Beyond the economic underpinnings there are also cultural and social needs to increase men's involvement and responsibilities through recognizing how masculinity operates in traditional power relations. More work and funding are needed to encourage men in non-violent behaviour, and to support women's rights and gender equity.

3.4. Employment Conditions

The Historical Context
Employment conditions are a product of economic relations in a specific historical context and relate to the negotiated terms under which workers sell their labour in return for some form of remuneration and other benefits. These other benefits include contracts related to tenure and security of employment, working hours, quantum of remuneration, access to health care, post retirement benefits, etc. Over and above these, and of particular interest to Health are the conditions of work, which relate to conditions under which a worker performs her or his duties. In the developed countries, till the 1970s, it is possible to trace a secular accretion of positive benefits in the conditions of employment, as well as in the conditions of work. In fact the period after the IInd World War, till the 1970s, also termed as the "Golden Age of Capitalism", is characterised by significant improvement in "welfare" measures in most parts of the developed world.

The situation in developing countries has been very different. Employment conditions in these countries – constituting more than 80% of the globe's population – never matched what could be achieved in developed countries. There existed in these countries a very large "informal" sector that was largely out of the purview of secure employment conditions. Moreover, with a majority of the workforce engaged in agriculture, the welfare model of employment was never a prominent feature in the world's poorest countries. However, democratic aspirations in the post-colonial era in developing countries did give rise to some improvements in employment conditions, led by the improved bargaining capacity of labour.

In this context, while it is important to underline the existence of poor employment conditions in developing/poor countries in contrast to developed countries, it also needs to be put in the context that colonial and neo-colonial loot and imperialist globalisation, perpetuated by the developed countries are major contributors. The ruling classes in developed countries are able to subsidise their working class by sharing with it a small proportion of what it appropriates from the developing world. It needs to be underlined that MNCs based in the "West" do not fare any better when they operate in developing countries.

Neoliberal Reforms and Labour Market Flexibility
While vastly different in actual achievements, it still is a fact that there was a discernible improvement in employment conditions in most parts of the world till the 1970s. A radical break is seen in the 1970s with the economic crisis in the developed world and the consequent rise of neoliberal policies. Specifically, it led to a reversal of much of the gains that labour had made in the past decades. Unemployment increased in most parts of the world, secure tenures of employment were replaced by "labour market flexibility" where large parts of a the workforce who were in a secure employment environment suddenly found themselves in insecure or "precarious"

forms of employment – in the informal sector, as contract workers, etc.[61].

The situation also changed with changes in the way production was organised. Increasingly, the market for labour became globalised and workers now had to compete and sell their labour in the global marketplace. Alongside this, a new strategy, defined as the "flexible firm" came into being, which divided labour into a multi-skilled and functionally flexible protected core and a disposable periphery with fewer labour rights that resulted into a segmentation of the labour market. These changes have affected both developed and developing countries, but the brunt is felt by the latter, given that conditions were precarious even before these changes came to be instituted. These changes also went hand in hand with the weakening of the bargaining power of labour, and its increasing inability to wrest better conditions for itself.

Several other features characterise the present phase of employment conditions and labour relations. In many parts of the developing world, a phenomenon called "feminisation" of labour is described. While this is a visible trend, it has seldom translated into real benefits for women workers. To the contrary, women have been forced into the most poorly paid jobs and forced into working in conditions that are the worst. Neoliberal globalisation has also led to increased migrations, marginalisation and exclusion of newer sections, and a rise in sex work and trafficking.

There is a globally driven agenda for labour market reforms that seek to legitimize the "flexibility" that we discuss earlier. The agenda is being pushed by global institutions and a few powerful developed countries, thereby compromising the ability of sovereign states to take independent positions.

Employment conditions, especially in the context of developing countries, needs to be examined in contexts beyond Industrial modes of production. While this is by far the most important while examining labour and employment in the North, the situation changes dramatically in the South. Globally an estimated 50% or more of the work force is engaged in agriculture (e.g. about 2/3rds in India). While employment in agriculture has not declined sharply in most parts of the developing world, its share of GDP has fallen much faster. This phenomenon, coupled with the relative insignificance of agriculture in the global North, tends to colour perceptions regarding employment by not paying adequate attention to employment (or unemployment/ under-employment) in the agriculture sector. If we seek to capture employment conditions in large parts of the world, it is vital that we are able to capture this reality. It is further important as health consequences and possible prescriptions in the labour sector would need to be very different for those employed in the agriculture sector.

---

61 See for example: International Labour Organization. 2004. Definitions: What we mean when we say 'economic security', Socio-Economic Security Programme fact sheet. Geneva, ILO

Historically, the welfare state concept arose in developed capitalist economies as a response to the growing demands in labour movements and to partially offset the threat posed by socialism as an alternate economic system. Welfare benefits were a way of Capital trying to subsidise labour through a small portion of the huge surplus that it could generate – especially in Europe. For obvious reasons the classical welfare state concept never took off in most developing countries. Today, thus we are looking at widely varying contexts. In the global North its an issue of defending earlier gains and preventing erosion of welfare benefits under the onslaught of neoliberal policies. In much of the global South it is still about fighting for welfare benefits from the State and about ensuring the little gains are not taken away. These differences need to be considered, especially as one of the pillars of classical welfare measures was public health.

The relation between employment and health benefits is also related to the level of development of health systems. When health systems are underdeveloped even standard benefits for the regularly employed do not translate into better access. For obvious reasons "non-standard" forms of employment are not accompanied by assured access to health services as part of employment benefits. In a major part of the world, such employment is the norm rather than the exception. Interventions in these regions need to look beyond standard ways of looking at employment benefits.

Practices such as bonded labour, child labour, forced sex work, etc. are extreme manifestations of social and economic equalities. It is relatively simple to see the obvious negative consequences on health associated with them. But the larger reality in countries where they flourish is almost as stark, characterised largely by subsistence and informal forms of employment. For example, 93% of employment is of this kind in India. Large swathes of humankind, thus, work in conditions that defy definition of any standard kind, where laws and regulations disappear or exist only on paper. The challenge for the Commission would be to capture this reality in all its dimensions.

Hazardous Work and Conditions of Living
The issue of dumping of hazardous industries and hazardous work in developing countries as a feature of neo-liberal globalisation needs to be addressed in some detail. Further, there is a planned move towards ghettoisation of workers in many countries, that pushes the working people away from the city to miles of shanty structures in the periphery. This practice of "cleansing" of cities of the poor is being advanced rapidly in may mega cities of the developing world – Sao Paulo, Mumbai. A further related issue are the kinds of housing and living facilities afforded to workers in the newly developed Export Processing Zones (EPZs)[62]. The phenomenon EPZs merits attention. Some of the worst forms of working conditions and the virtual non-operation of labour laws (often as explicit state policy) exist in such zones. There is the added dimension of the displacement of people from where such zones are set up, without adequate compensations

---

[62] ICFTU. 2003. Export processing zones – symbols of exploitation and a development dead-end. Brussels, ICFTU

Labour Unions and the Need to Adapt and Innovate

Labour unions too need to look at innovative ways of organising workers, given that the workplace as conventionally understood is disappearing in many industries. Moreover they need to develop strategies for new sectors such as the IT sector. Labour unions, however well meaning, are being too slow to adapt. The fall in unionisation is partially also explained by the inability of unions to address new realities. Further, they continue to be embedded in concerns of the "organised" "formal" sector. Unfortunately, especially in developing countries, they constitute a fraction of the work force. Labour unions also need to face up to the tendency of depoliticisation, and of ignoring large political macro issues and confining themselves to shop floor bargaining.

Occupational Safety and Health

The Commission needs to pay special attention to the issue of working conditions and impact on health – occupational safety and health. This need to be also contextualised in the phenomenon of relocation of hazardous industries and hazardous work to poorer countries. The necessity for skill upgradation and introductions of tools to reduce drudgery and physical stress also merit attention. The agriculture sector needs attention in this context – for example the health impact of women engaged in sowing operations because of hours required to maintain an unhealthy posture. The need for research on replacement of tools that add to hazard or tools that can decrease drudgery all needs to be emphasised. Specifically some areas that could be emphasised are:

- need much better data about the distribution of occupational injury and disease and about causation
- the WHO collects every last case of SARS or maternal mortality (rightly so) but the data which are collected about OSH are generally poor
- closer links with ILO for a framework convention on occupational health and safety
- work with developing country Govts. to progressively raise the minimum standards
- pressure on developing countries to upgrade the standards of occupational health and safety
- closer collaboration on OHS with ILO and UNCTAD -- if the UN agencies can collaborate on AIDS why not on OHS

Traditional Artisans

In developing countries, as larger numbers enter the industrial workforce, traditional skills and techniques are lost. Traditional artisans such as potters, weavers, leather workers, etc. (all parts of the huge informal workforce) lose their skills and enter a workforce that is totally alienated from traditional skills. The alienating impact of this shift would perhaps also merit some attention, especially as it also means the destruction of a centuries old lifestyle. The answer is not to go back to traditional methods of artisanal production but to explore if artisans can compete in the modern market through infusion of appropriate technology and skill upgradation and a shift to community based production systems, from traditional individual and family based systems.

Labour Standards and Trade
The issue of formulating global labour standards has been debated extensively. We need to be careful in conferring the global trading regime and multilateral institutions with greater powers to intervene in policies at the national level. Second, developing countries legitimately feel that labour standards would be used by the developed countries as another form of non-tarrif barriers against developing country exports. Third, it is widely understood that the global trading regime is structured and administered by the developed nations. It makes little sense to have them – those who are responsible for the gross inequities in today's world – police labour standards in the poor countries. This does not mean that occupational health and safety laws should not be promoted; that unions who struggle for safer workplace and fair workers compensation should not be supported. However the balance has to be struck in the context of the political decision making of the affected country and not imposed through the WTO.

3.5. War and Militarisation

War has an enormous and tragic impact on people's lives. It accounts for more death and disability than many major diseases; destroys families, communities, and sometimes entire nations and cultures; diverts limited resources from health and other human services and damages the infrastructure that supports them; and violates human rights. The mindset of war – that violence is the best way to resolve conflicts – contributes to domestic violence, street crime, and many other kinds of violence. War damages the environment. In sum, it threatens not only health but also the very fabric of our civilization[63].

The Impact of War on Health

Some of the impacts of war on health are obvious, some are not. The direct impact on mortality and morbidity is apparent. An estimated 191 million people died directly or indirectly as a result of conflict during the 20th century, more than half of them civilians[64].

Millions more people are psychologically impaired from wars during which they were physically or sexually assaulted; were forced to serve as soldiers; witnessed the death of family members; or experienced the destruction of their communities or even nations. Psychological trauma may be demonstrated in disturbed and antisocial behaviour such as aggression toward others, including family members. Many combatants suffer from post-traumatic stress disorder on return from military action.

Children are particularly vulnerable during and after wars. Many die as a result of malnutrition, disease or military attacks; many are physically or psychologically injured; some are forced to become soldiers or sexual slaves to military officers. Their health suffers in many other ways, as reflected by increased mortality and decreased immunization[65].

The health-supporting infrastructure, which in many countries is in poor condition before war begins, may be destroyed – including health-care facilities, electricity-generating plants, food-supply systems, water-treatment and sanitation facilities, and transport and communication systems. This deprives civilians of access to food, clean water and health services. For example, during Gulf War I in 1991 and the ensuing 12 years of economic sanctions against Iraq, an estimated 350,000 to 500,000 children died, mostly owing to inadequate nutrition, contaminated water and shortages of medicines, all related to destruction of the infrastructure. The 2003 attack on Iraq led by the US and UK devastated much of its infrastructure, leading again to numerous civilian deaths[66].

---

63 Levy BS, Sidel VW. 1997. War and Public Health. New York, Oxford University Press.
64 Rummel RJ. 1994. Death by Government: Genocide and Mass Murder since 1900. New Brunswick NJ, and London, Transaction Publications.
65 Machel G. 1996. Impact of Armed Con.ict on Children. New York, UNICEF.
66 Medact. 2004. Enduring effects of war: health in Iraq 2004. London, Medact.

Armed conflict, or the threat of it, accounts for most of the refugees and internally displaced persons in the world today. Refugees and internally displaced persons are vulnerable to malnutrition, infectious diseases, injuries, and criminal and military attacks. At the start of 2002, there were an estimated 19.8 million worldwide. Twelve million were officially recognized as refugees by the United Nations High Commissioner for Refugees (this excluded three million Palestinians). Donor governments and international organizations have generally failed to provide adequate financial support for refugees and internally displaced persons. In 2002, there were 20–25 million internally displaced persons, many living in more extreme conditions than those who received refugee assistance – only 5.3 million of them received UNHCR aid in 2002[67].

In addition to its direct effects, war and preparation for war have indirect and less obvious impacts on health that fall into three categories: diversion of resources; domestic and community violence; and damage to the environment.

First, war and the preparation for war divert huge resources from health and human services and other productive societal endeavours. Second, war often creates a circle of violence, increasing domestic and community violence in countries engaged in war. It teaches people that violence is an acceptable method for settling conflicts, including children and adolescents. Men, sometimes former military servicemen who have been trained to use violence, commit more acts of violence against women. The return home of servicemen and women can damage health and well-being, through separations, divorces, dysfunctional family interactions and other forms of posttraumatic stress.

Finally, war and the preparation for war have profound impacts on the environment. Military activities consume huge quantities of non-renewable resources, such as fuels to power aircraft and ships, and rare metals used in the production of equipment and weapons. More profoundly, military activities contribute to widespread pollution and environmental contamination. Less obvious are the environmental impacts of preparation for war, such as the huge amounts of non-renewable fossil fuels used by the military before (as well as during and after) wars and the environmental hazards of toxic and radioactive wastes, which can contaminate air, soil, and both surface water and groundwater.

The changing nature of war
Overall, war takes an increasing toll on civilians, both by direct attack on them or by 'collateral damage' caused by weapons directed at military targets. During some wars in the 1990s, approximately 90% of the people killed were noncombatants[68]. Many were innocent bystanders caught in the crossfire of opposing armies; others were specifically targeted civilians. The changing nature of war includes use of new weapons, drone (unmanned) aircraft and high-altitude bombers, and the increasing

---

67 WorldWatch Institute. 2003. Vital Signs. Washington DC, WorldWatch Institute.
68 Garfield RM, Neugut AI. 2000. The human consequences of war. In: BS Levy,

use of suicide or homicide bombers in guerrilla warfare and what is termed 'terrorism'.

The US has claimed the right to conduct a 'preventive' or 'pre-emptive' war against nations that it perceives as posing a threat to its security and has initiated a 'war on terrorism'. In addition, its 2002 nuclear policy says it may choose to use nuclear weapons not only in response to a nuclear attack but also against attack by other weapons of mass destruction (US Department of State 2002). The pre-emptive strike against Iraq by the governments of the US and UK may lead to abandonment of the rules and procedures of law and diplomacy that have prevented many wars.

Underlying causes of conflict and militarism
The underlying causes of armed conflict and militarism include poverty, social inequities, adverse effects of globalization, and shame and humiliation. Some of the underlying causes of war are becoming more prevalent or worsening, including the persistence of socioeconomic disparities and other forms of social injustice. The rich-poor divide is growing, as documented in part A. Abundant resources, such as oil, minerals, metals, gemstones, drug crops and timber, have also fuelled many wars in developing countries. Globalization, may be among the causes of violence and war if it leads to exploitation of people, of the environment and of other resources.

The consequences of colonialism are still felt in many countries. Colonialism destroyed political systems, replaced them with new ones unrelated to the population's cultural values and created commercial dependence. Neocolonialism, through multilateral agencies, transnational corporations and international organizations, and in some instances with the use of the military, is responsible for social inequality, control of natural resources, and lack of democratic processes.

Militarism
Militarism is the subordination of the ideals or policies of a nation's government or of its civil society to military goals or policies. It has two major components, ideological and financial. In 2003, nations spent US$ 956 billion on war and the preparation for war; the US spent almost half of that. World military spending that year increased by about 11% from 2002, mostly due to spiralling US military spending. Expenditures for war and the preparation for war divert huge human, financial, and other resources from health and human services and other productive endeavours. In the US, for example, as military expenditures soar, there have been ongoing and substantial cutbacks in government-operated and financed health and human services. This problem is often more acute in less developed countries affected by armed con.ict or the threat of it. Their populations have high rates of death and disease and relatively short life expectancy, but many spend much more on military activities than on public health. Governments in some developing countries annually spend US$ 10–20 per capita on military purposes, but only $1 on health[69].

---

69 Stockholm International Peace Research Institute. 2004. SIPRI Yearbook 2004:
Armaments,
Disarmament, and International Security. Stockholm, SIPRI.

The health sector response

The health sector should play an important role in leading efforts by civil society to recapture government from the corporate sector and particularly from the military-industrial complex. These efforts must include controlling weapons, preventing armed violence, promoting multilateralism, ending poverty and social injustice, and creating a culture of peace. While support of these efforts requires action from many sectors, health workers and their organizations
have major responsibilities, as follows:

Controlling weapons People in the health sector are already playing a major role in action to prevent war, control weapons and outlaw weapons of mass destruction. For example, International Physicians for the Prevention of Nuclear War was awarded the 1985 Nobel Peace Prize for work to prevent use of nuclear weapons and ban their production, testing, and transfer. Health professionals and others have made similar efforts to strengthen the conventions on biological and chemical weapons.

Promoting multilateralism Since its foundation in 1946 the UN has attempted to live up to the goal in its charter, 'to save succeeding generations from the scourge of war'. Its mandate also includes protecting human rights, promoting international justice, and helping people achieve a sustainable standard of living. Its programmes and agencies have made an enormous difference to people's lives. Yet the resources allocated by its member states are grossly inadequate.

Ending poverty and social injustice Poverty and other manifestations of social injustice contribute to conditions that lead to armed conflict. Growing socioeconomic and other disparities between the rich and the poor within countries, and between rich and poor nations, also contribute to the likelihood of armed conflict. Rich countries can help to address these underlying conditions through policies and programmes that redistribute wealth within and among nations, and by providing financial and technical assistance to less developed nations.

Creating a culture of peace The Hague Appeal for Peace Civil Society Conference was held on the centenary of the 1899 Hague Peace Conference, which explored ways of making war more humane. The 1999 conference, attended by 1000 individuals and representatives of civil society organizations, was devoted to finding methods to prevent war and to establish a culture of peace

3.6. Food Security and Nutrition

Undernutrition is by far the most important single cause of illness and death globally, accounting for 12% of all deaths[70]. Low weight for age is associated with more than half of all deaths in young children, accounting for more than six million children a year. Babies who survive the early disadvantages of low birth weight are far more likely to develop obesity, diabetes and hypertension in adulthood. The costs of undernutrition in terms of lost development and productivity are enormous. Even mild to moderate undernutrition in the womb reduces future cognitive development.

Trends and causes

Every day 799 million people in developing countries – about 18% of the world's population – go hungry. In South Asia one person in four goes hungry, and in Sub-Saharan Africa the share is as high as one in three. There were reductions in the number of chronically hungry people in the first half of the 1990s, but the number increased by over 18 million between 1995 and 1997. The situation regarding the proportion and numbers of people who are undernourished is even bleaker. The number of undernourished people actually increased by 4.5 million a year in the late 1990s. Twenty-six countries, most already with a large proportion of their population undernourished, experienced increases: between 1992 and 2000, the number of hungry people went up by almost 60 million. Only three of the 10 African countries with maternal nutrition data showed a decline in the last decade in the prevalence of severe maternal undernutrition (defined as a body mass index of less than 16). Around 175 million children under five are estimated to be underweight, a third of preschool children are stunted, 16% of newborn babies weigh less than 2.5 kg, and 243 million adults are severely malnourished. The proportion and absolute number of malnourished children has increased in Sub-Saharan Africa[71].

The food production and supply system

The global value of trading in food grew from US$ 224 billion in 1972 to US$ 438 billion in 1998. The globalization of food systems is nothing new, but the current pace and scale of change are unprecedented. Food now constitutes 11% of global trade in terms of value, a higher percentage than fuel[72]. This increase has been accompanied throughout the food chain by the consolidation of agricultural and food companies into large transnational corporations, whose growth has allowed them astounding control in key sectors such as meat, cereal, processing and retail.

---

70 Pelletier D, et al. 1995. The effects of malnutrition on child mortality in developing countries. Bulletin of the World Health Organization, 73:443–8.

71 Food and Agriculture Organization. 2003. World Hunger Report. Rome, FAO.

72 Pinstrup-Andersen P, Babinard J. 2001. Globalisation and human nutrition: Opportunities and risks for the poor in developing countries. African Journal of Food and Nutritional Sciences, 1:9–18.

A right or a commodity?

Food not only fulfils a fundamental need but also has great symbolic and social value. Legitimization of the erosion of control of such an important commodity by communities and nations has required the hijacking and redefinition of basic terms such as development and food security. More specifically the idea of food security has been reconstructed as a global market function based on the presence of a free market and governed by corporate rather than social criteria.

The overproduction of food supported by massive subsidies in the US and Europe in particular has led to the 'dumping' of food on developing countries. US subsidies result in major crops being put on the international market at well below their production costs: wheat by an average of 43% below cost of production; rice 35%; soya beans 25%; and cotton 61%. This depression of commodity prices has a devastating effect on farmers in developing countries. Subsidies to farming in the OECD countries, which totalled US$ 311 billion in 2001 (US$ 850 million a day) displace farming in the developing countries, costing the world's poor countries about US$ 24 billion a year in lost agricultural and agroindustrial income.

There has also been a decline in agricultural and rural investment in many developing countries, resulting in falling agricultural productivity[73]. Only about 4.2% of land under cultivation in Africa is irrigated; fertilizer application is 15% lower today than in 1980; the number of tractors per worker is 25% lower than in 1980 and the lowest in the world. Agricultural productivity per worker has fallen by about 12% since the early 1980s, while yields have been level or falling for many crops in many countries. Cereal yields average 1120 kg per hectare, compared with 2067 kg per hectare for the world as a whole. Yields of the most important staple food grains, tubers and legumes (maize, millet, sorghum, yams, cassava, groundnuts) in most African countries are no higher today than in 1980. Africa's share of world agricultural trade fell from 8% in 1965 to 3% in 1996[74].

The story is similar in nearly all developing countries. For example, the average Indian family of four reduced consumption of foodgrains by 76 kg between 1998 and 2003 – to levels last seen just after Independence[75]. This dramatic fall can be traced to the collapse in rural employment and incomes resulting from liberalization of the agricultural sector. The shift away from national food sufficiency has increased drastically across developing countries – world cereal, wheat and rice imports have grown from 80, 46 and 6.5 million metric tonnes respectively in 1961 to 278, 120 and 27 million metric tonnes in 2001. The fastest growth of food imports has occurred in Africa, which accounted for 18% of world imports in 2001, up from 8% 15 years

---

73 World Bank. 2002. From Action to Impact: the Africa Region's Rural Strategy. Washington,

DC, World Bank, Rural Development Operations, the Africa Region.

74 Stevens C, Kennan J. 2001. Food aid and trade. In: Devereux S, Maxwell S, eds. Food security in Sub-Saharan Africa. Pietermaritzburg, University of Natal Press.

75 Patnaik U. 2004. External trade, domestic employment and food security: Recent outcomes of trade liberalisation and neo-liberal economic reforms in Inda. at: International Workshop on Policies against Hunger III. Berlin, German Federal Ministry of Consumer Protection, Food and Agriculture, 20–22 October.

earlier. Governments are often powerless to reverse this as policies imposed by the IMF/World Bank, such as removing subsidies for fertilizer or charging user fees for dipping cattle, directly affect the cost of agricultural inputs.

Women are bearing the brunt of globalization, trade liberalization and HIV/AIDS. They are responsible for 80% of food production in Africa, including the most labour-intensive work such as planting, fertilizing, irrigating, weeding, harvesting and marketing. They achieve this despite unequal access to land (less than 1% of land is owned by women), to inputs such as improved seeds, fertilizer, information and credit (less than 10% of credit provided to small farmers goes to women). Their work also extends to food preparation, as well as nurturing activities.

In summary, the current wave of liberalization is occurring in the context of massive concentration and control of the food system by corporations based in developed countries. Liberalization of agricultural trade has therefore further strengthened and consolidated an international division of labour in agriculture. In 1990, the OECD countries controlled 90% of the global seed market. From 1970–1996, the OECD share of the volume of world cereal exports rose
from 73% to 82%; the US remained the world's major exporter of commercial crops such as maize, soya bean and wheat; and the share of Africa, Latin America and Asia in world cereal imports increased to nearly 60%. Liberalization has, on the whole, contributed to increasing inequalities within both developed and developing countries.

3.7 Urbanisation, Urban Settings and Health Equity

The world is becoming increasingly urbanized and poverty is also becoming an increasingly urban phenomenon. In 2007 more people live in urban centres than in rural areas. According to recent projections, the world's urban population will increase from 2.86 billion to 4.98 billion by 2030, when about 60 per cent of the world's population will live in urban settings. This trend, according to the State of the World Cities report, will equal "the addition of a city of one million residents every week". However, high-income countries will account for only 28 million out of the expected increase of 2.12 billion. The biggest cities in the world – 'Metacities', with conurbations of over 20 million people – will be concentrated in developing countries (UN Habitat, 2006), but the majority of the population will live in smaller towns and cities. The proportion of the population living in unplanned and deprived settlements in cities is estimated to vary between 5 to 10 per cent (advanced and transition economies), 43 per cent (developing) and 78 per cent (least developed countries). Poverty is growing and living conditions are deteriorating in *all* cities[76]. However, in low and middle-income countries the population living in densely populated, informal settlements ("slums") is likely to double in less than 30 years[77].

Understanding urbanization

Rapid urban growth is increasingly attributed to natural population growth (UN Habitat, 2006). However, there are important regional differences and there is also a need to examine the process of urbanisation within the political economy of capitalism in order to understand the impact of wider social, economic and political changes in rural areas (Harvey, 1985; Castells, 1997). Policies implemented in the agricultural sector of many developing countries in Asia and Africa, that have reinforced colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops, have dramatically increased rural poverty and pushed and pulled people into the cities. By 1989, prices for agricultural production were only 60 percent of their 1970 levels.While Africa and Asia were still almost wholly rural in 1950, in the past 20 years the pace of urbanisation has been especially high in the less developed regions of the world where the rapid growth of the urban population is expected to continue for decades and the growth of squatter settlements often equals urban growth itself (UN Habitat, 2006). In Africa urban growth rates are twice as high as average and this urbanisation is not accompanied by economic growth. The nature of this rapid urbanisation has important implications for public health

Urban settings and health

Urban services and infrastructure have not kept pace with rapid urbanisation and an increasing proportion of the people in urban areas will live without adequate social infrastructure, especially housing, water supply, drainage and sanitation facilities. While still exposed to the traditional health hazards related to poverty, unemployment, malnutrition, poor shelter and inadequate environmental and social services, the urban poor are also more exposed to hazards related to

---

76 UN Habitat. 2004
77 UN Millennium Project 2005. UN-Habitat 2003

"modernization", unhealthy urbanization, pollution - while the lack of social support systems in cities and social exclusion increases the risk of mental health problems. Cities also concentrate resources and wealth and social exclusion in this context is particularly felt. In Cape Town e.g. rapidly growing townships where children die of preventable diseases as diarrhea are located near to exclusive beaches and tourist centres, while in many cities expensive shopping malls arise next to informal settlements where people lack even basic sanitation.. In several least developed countries and countries undergoing rapid urbanisation, child malnutrion in informal settlements is comparable to that of rural areas. Also, in many Sub-Saharan cities, children living in informal settlements are more likely to die from waterborne and respiratory illnesses (UN/Habitat 2006/7) than rural children and an increasing number of urban households is headed by children due to HIV/AIDS. The impact of living conditions on health is particularly felt by women, children and adolescents. Children in households with no toilet are twice as likely to get diarrhoea as those with a toilet[78]. Investments in household latrines and local sewer networks are directly linked to security of land tenure. These conditions are not addressed by health systems that prioritize curative care above prevention or that focus on changes in lifestyle only. They demand a comprehensive approach of all the social, political and economic as well as environmental determinants of health.

Urban PHC and governance
In 1978 the Alma Ata conference defined health as linked to the living and working conditions of the population and acknowledged the role of community participation in health. This was underlined again in 1986 by the Ottawa Charter for Health Promotion which focused on processes of advocacy, enablement and mediation and on strategies to build healthy public policy, empower communities, create supportive environments and reorient health services. Healthy Cities and healthy settings (districts, neigbourhoods, workplaces, schools,etc) were seen as "a means to take these broad concepts and strategies and applying them at the local level".

Although the relevance of participation has been recognized by many agencies, in practice it has been more difficult to achieve and often took place in name only. Political commitment is often found lacking and the ideology of government influences the extent to which demands by people's organizations are neglected, manipulated, rejected or accepted (Pacioni, 2005). Also political commitment for long-term planning processes is limited particularly in a context of limited resources, donor dependency, increased fragmentation. Intersectorial collaboration e.g. on the issues of urban planning, water, sanitation, housing, health is limited as health – and even less health equity- is still not considered a cross-cutting issue that is influenced by all sectors of government. There is poor co-ordination and unclear roles and responsibilities, both horizontal and vertical, among the government departments exacerbated by conflicting policy, legal and regulatory frameworks across sectors.

---

78 From WELL briefing note on the MDG on child health :
http://www.lboro.ac.uk/well/resources/Publications/Briefing%20Notes/WELL%20Briefing%20Note%203%20-%20Child%20Health.pdf

Equity related objectives have been difficult to achieve. Progress towards equity is difficult given entrenched patterns of disadvantage and inappropriate resource allocation as well as the increasing impact of global and political determinants that operate beyond the influence of city decision-makers (Barten, 2007- Robotham 2005 – van Naerssen and Barten 2002). Nevertheless examples exist where local governments have developed healthy public policy and/or civil society organisations have influenced public policy in cities.

4. Case Studies on CS Actions and Concerns on Social Determinants of Health (Abstracts)

This section presents a selection of Case Studies develeped by CSOs in the four regions. **For reasons of brevity we present here only the abstracts of the case studies.** The studies have been selected from a much larger number collected through the process of CS's work with the Commission. The studies have been selected keeping two main considerations in view. One, they represent major concerns of CS around specific social determinants. Two, they represent studies of CS action at a large scale, capable of making a difference in the situation, or represent studies that foreground a major concern of CS.

4.1. Revival of Maya medicine in Guatemala and Impact on Social and Political Recognition.

This case study brings together the experience of the Guatemalan Association of Community Health Services (ASECSA) in efforts to restore and advance indigenous Maya medicine and combines this with advocacy work and its effect on public health policies designed to promote a health system with intercultural relevance.

Guatemala is a multicultural and multilingual entity. The Mayan people consists of 22 ethnic groups accounting for more than half the population. Mayan native medicine, part of this ancient culture, is supported by the three pillars of the Mayan people's understanding of the universe: a holistic approach, balance, and spirituality.

The official health care system in Guatemala is rooted in Western medicine, biology- and welfare-based, and has a low healing potential. It also tends to exclude other alternative systems such as the medicine of the Mayan people.

For the purposes of the case study, the experience built up between 2002 and the present has been put in order and in the process strategic medium- and long-term components have been incorporated for follow-up. The experience is based on the need to arrive at an objective visualization of the components making up and underpinning the Mayan medical system. To that end, two interactive studies were conducted with six ethnic groups representative of the Mayan people. The results revealed an organized system of Mayan healers or physicians, whose general or specialized functions respond to a differentiated epidemiological profile. The knowledge base has its foundations in the Mayan people's world view. It has a social application in the promotion, prevention and care dimensions, and its acceptance by the community is evident because it heals and operates effectively.

Based on the foregoing, the following phase, which includes a determined effort to disseminate results at various levels, also makes provision for promotion and consciousness-raising in local authorities, departmental, regional and national levels. Advocacy and political impact strategies are being embarked on with the Ministry of Health for recognition, assessment and for adopting an inclusive health system .

Among the main outcomes success has been achieved in internally influencing the 63 bodies affiliated to ASECSA, making it possible to incorporate in their plans and programmes the theme of Mayan medicine. In association with ASECSA, the indigenous and peasant movement and other organized sectors include in their demands and claims the social and political recognition of indigenous Mayan medicine. Interest has also been generated in PAHO, UNDP and other international agencies for fostering other studies.

Other important results have included creation of the national traditional and alternative medicine programme in the Ministry of Health, and the undertaking of a manpower education and training programme for health centres and posts. The subject of Mayan medicine has also has also been successfully incorporated in the curricula of nursing training schools, undergraduate and master's programmes in public health at the San Carlos de Guatemala University.

4.2 Health System in Cuba

In the political features of contemporary Cuba, the most significant fact is the triumph of the people's revolutionary movement led by Fidel Castro in 1959. Today, Cuba is an independent, sovereign, socialist state, developed by all, for the benefit of all, as a united democratic republic enjoying political freedom, social justice, individual and collective welfare and human solidarity.

In its economic life, the country has been subjected to constant aggression, including terror methods, and to an economic, trade and financial blockade that has already lasted for almost half a century. Cuba, in this period, has advanced by adopting a model rooted in a centralized economy; by the existence of a policy that seeks social justice and equity; by heavy reliance on the outside world and a high concentration of imports, by great dependence on generating resources in a limited number of sectors; and   by a framework of a economic and trade ties that have had to adopt new decentralized forms of cooperation. The direct damage done to the Cuban people by the blockade has been estimated at 86 108 million dollars, or more than 1800 million dollars per annum.

The economic context thus enunciated has had a negative impact on vital aspects such as education, health, nutrition, housing, transport, employment and recreation. In recent political and economic developments there has been a manifest recrudescence of aggression against Cuba. In this case the aim, inter alia, would be to build a civil society based on the capitalist interpretation of the word to replace the present Cuban type of civil society which is failing to obey its orders to rise against the revolutionary government, of which it forms an active part.

The National Health System

A health system is all those organizations, institutions and resources whose prime goal is the improvement of human health, so it embraces all activities that have the aim of promoting, restoring or maintaining health.

1961 saw the commencement in Cuba of a health system for the entire population, under the direction of the State, and organized, led and funded by the latter. Health became a right of the people and free health care was provided to the entire community.

This national system is undivided, integrated and decentralized, and coverage reaches the entire population. Intersectoral coordination between the government, different agencies of the economy, and social and popular organizations for formulating policies and carrying out actions to improve and maintain the population in good health, is expressed in economic and social development programmes for all the agencies of State and government.

This system is based on the following guiding principles of health activities:

- The state and social character of medicine
- Access and free care by the different agencies
- The preventive approach
- Proper application of scientific and technical progress
- Community participation
- International collaboration

The foregoing explains the major achievements in the field of community health such as the eradication of certain diseases (including poliomyelitis, measles, and malaria), control of others (such as TB, tetanus and AIDS), the high degree of professional coverage in the services (1 physician per 159 pop.) or the infantile mortality rate of 5.3 per 1000 live births (2006 figures) etcetera..

Two aspects of great relevance for the system are popular participation and international collaboration. The first forms part of the way civil society bodies fit into the health system. One example is the 524 351 blood donors (2005) who were largely called in to give blood by the Revolutionary Defence Committees and trades unions.

Another example is the effective national epidemics control campaigns, where 40 years of experience have taught us their three governing principles:
1. the scientific groundwork that epidemic control must be based on;
2. the political will (of the government) supporting the actions, and
3. community participation (population, the masses) in the campaign against the epidemic.
The latter means participation by organized civil society.

International health collaboration is part of the solidarity programmes of the Revolutionary government. Examples: the 10 661 students receiving undergraduate bursaries for study in Cuba. In 2005, Cuban collaboration was conducted with 68 countries. More than 30 000 health workers are engaged on regular employment in them, to which must be added those who, for short periods, provide aid in disaster relief situations such as earthquakes and tropical storms. The figure for workers in the national health system is 447 023 (6.9% of the population of working age). Of them, 70.2% are women. Our internationalist workers are volunteers, and civil society bodies play an important part in mobilizing them.

Civil Society and Health System
Civil society and the health system can enjoy confrontational, indifferent or passive relations, or be in cooperation or harmonious integration. That will depend on the political shape of the society lying behind them. In the case of Cuba, we maintain that they are ties of harmonious integration and cooperation. The examples we give hereunder are partial evidence of the latter.

In 1962, one of the organized forms of civil society, the Federation of Cuban Women called on a group of specialists (physicians, educators, communicators, etc.) together with others to begin the work that led to the programmes in sex education,

family planning and reproductive health, which included activities in the community, aimed at eliminating stereotypes and taboos and increasing the amount of information and guidance on these health aspects with an approach that was as scientific as possible.

From the outset, provision was made for a Cuban sex education programme, to be implemented not only by the Federation of Cuban Women and the Ministry of Public Health, but by the Ministry of Education and organizations for the young as well.

In 1972, the *Grupo Nacional de Trabajo de Educación Sexual (GNTES)* [The National Working Group for Sex Education] was established, with a multidisciplinary and intersectoral approach. This group, consisting of professionals from the Ministries of Public Health, and Education, the Federation of Cuban Women and young people's organizations, had the task of creating and establishing policy and the national sex education programme, for development throughout the country, at a time when they were having to train those who would work in sex counselling, research, education and therapy.

The national group went on to establish its equivalent structures at provincial and local level. These had the social task of coordinating, implementing and developing Cuba's sex education programme, which, as a range of options for enriching the human being, covers sex education from the very first moments of life and involves the whole of society in its implementation.

This account shows how a civil society group gave rise to an initiative which ended up by changing into a national health programme, in which state and other social agencies come together, each working in its own sphere on a community health problem.

Another activity agreed on between social bodies and State agencies aimed at preserving the health of the community can be seen in the work of the Revolutionary Defence Committees and health authorities, guided and coordinated by the Civil Defence in case of natural disasters. This is a regular situation given the tropical storms that lash Cuba, where notable experience has been built up, very successfully, in the preservation of life and control of morbidity resulting from disease, accident or injury.

Another different expression of the ties between civil society and the health system comes about directly, not through organizations such as those mentioned, in public audits or meetings of electoral constituency delegates, (councillors, elected officials or mayors). They consist of neighbourhood or municipal groups with elected representatives who must periodically report on their terms of reference and receive new mandates from their electors. Very frequently, these assemblies discuss and propose answers to health problems, getting involved in the solutions where appropriate. The most frequent subjects are: environmental sanitation and primary health care. This is a form of highly interactive direct democracy, where the public has open access to a municipal authority. It is a real manifestation of integration between civil society and the health system.

4.3. The Brazilian Health Care System *(translated from Portugese)*

The Brazilian health care system is a national service called the Unified Health System (Sistema Único de Saúde - SUS), and is the result of a long process of political and institutional process called the Sanitary Reform, aimed at transforming the health care services and conditions in Beazil. More than an institutional arrangement, it is a project that intends to promote changes in the prevailing values in Brazilian society, with health care as the axis driving the transformation and solidarity as the underlying value.

It is an ongoing project, a policy for the construction of democracy that aims at extending the public sphere, increasing social inclusion and reducing inequalities. The system came about from a doctrine of a group of intellectuals and health care professionals and managers as well as various social movements and workers' movements. It grew together with the struggles for democracy in Brazil, that brought an end the military regime and the same time ensured popular participation in different spheres. Health was the first aspect that the new governament organized. This began in the 8ª National Health Conference in 1986. It was the first popular initiative in health, and culminated in the inclusion of "Health as a Right for All and a Duty of the State" in the Brazilian constitution. The basic principles have not changed in spite of the influence of neoliberal policies, because this process was sustained throughr the strenght of popular participation and decentralized actions. At the same time there was an accretion of health rights and a strengthening of public health care .

This model of health is decentralized amongst different governmental levels within the Brazilian federative system, and involves collaboration between government and peoples organisations. This is ensured through popular participation in councils at every level of government and health care delivery. These structures determine policies to be followed. This model has different formal participation spaces between the levels of the government and differente sectors. Councils are constituted by 50% representation from civil society and 50% from health professionals, and representatives of the government. Popular participation is also ensured at all levels (local, state and national) and these mechanisms define the policies that the goverment follows.

This model has now been extended to other sectors: social protection and security, education and urban development, along with a guarantee of popular participation in all of them. There are similar council in areas related to Social Assistance, Education, Disability, Elderly, Children and Adolescents, Urban Development, etc. This space has allowed popular participation in government decisions and more empowerment of the people – most prominently mainly the disadvantages. It is a political process to strenghten democracy and reduce health inequities, althought there is still need for additional action, and new social policies from the State.

4.4. The Impact of Conflict on Health
(Extract from a larger Case study from the EMRO region)

Mortality directly and indirectly due to conflict

The first question usually asked in a conflict situation concerns mortality and morbidity: how many, who, when, where and why? This information provides an indication of the severity of the crisis, and can be used to advocate for humanitarian intervention. Conflicts in EMR are characterized by high rates of civilian mortality. Pre-existing poverty, ill-health and lack of health services are exacerbated by long standing conflict in Afghanistan, Somalia and Sudan.

In Iraq, estimates of deaths during and after the 2003 invasion vary widely, according to source. The first epidemiological survey of excess mortality during the 17-18 months after the invasion, based on cluster sample methods, estimated an excess mortality of at least 98,000. Over half the deaths recorded in this 2004 study were from violent causes and about half of them occurred in Falluja (Roberts et al. 2004). A follow up cluster sample survey, in May-July 2006, identified an escalation in the mortality rate that surprised the researchers, an estimate of 654,965 excess deaths since the invasion, of which 600,000 were due to violence (the most common cause being gunfire). These figures indicate that the Iraq conflict is the deadliest international conflict of the twenty-first century. These national surveys were conducted by academics from Johns Hopkins University, in the USA, with the essential support of local researchers and field workers, many of whom risked their lives to carry out the work (Burnham et al. 2006).

In West and South Darfur cluster sample surveys conducted by the staff of Epicenter, the Paris-based research division of Medécins sans Frontièrs identified high mortality rates. In West Darfur, in 2003: "in the four sites we surveyed high mortality and family separation amounted to a demographic catastrophe." The death rates (calculated, in the short term, as numbers per 10,000 per day) were highest among adult and adolescent males, especially during the destruction of settlements and during flight; but women and children were also targeted. During the period in "camps" the overall mortality rate fell but remained greater than the emergency bench-mark (that is, double the normal mortality numbers for the region, 1 per 10,000 per day) (Depoortere et al. 2004). In South Darfur, in September 2004, in the three survey areas overall mortality was 3.2, 2.0 and 2.3, and mortality for children under 5 years was 5.9, 3.5 and 1 (Grandesso et al. 2005).

In Kohistan District, Afghanistan, a study in April 2001 identified a humanitarian crisis on the basis of their findings that the crude mortality and <5 deaths per 10,000 per day was 2.6 and 5.9 respectively, representing, over a period of 4 months, 1,525 excess deaths among the 57,600 people in the district. Most of the child deaths were due to diarrhea, respiratory tract infections, measles and scurvy, reflecting underlying malnutrition. This study was conducted by staff of Save the Children-USA (Assefa 2001).

In Palestine, by 2005, the MoH reported that deaths due to accidents associated with the conflict became the leading cause of death for those over 20 years of age. Seventy per cent of *intifada* activists killed were in the age group 18-39 (Palestine CS report).

In Iraq a cluster survey found infant and child mortality increased more than three fold between January 1991, when the first Iraq war began, through August 1991; 128.5 for < 5 mortality, compared to a baseline in Baghdad of 34 in 1985-90. The increased risk of death was found for all levels of maternal education and for all regions. The association between war and mortality was stronger in north and south Iraq than in the central areas and Baghdad (Aschero et al. 1992: see annex for methodology of cluster surveys in crisis settings).

Maternal mortality rates in Afghanistan are among the highest in the world, due to a combination of persistent poverty and conflict, at around 1,600 per 100,000 live births in 2002 (EMRO 2007). According to a national 2000-2002 RAMOS (Reproductive Age Mortality Study), figures ranged from 418 in Kabul city to a horrifying 6,507 in Ragh, Badakshan, the highest maternal mortality rate ever recorded. Even though Ragh was not directly affected by conflict, it was affected by the general paucity of health services found in Afghanistan; it was in a remote region in the Hindu Kush mountains, up to 10 days ride or walk from the nearest hospital with emergency obstetric care. Given the high total fertility rates, these figures translate into a total life time risk of maternal death of 1 in 42 in Kabul and 1 in 3 in Ragh,. On the basis of such figures, Afghanistan can be considered the worst place in the world to become pregnant (Bartlett et al. 2005: Smith & Burnham 2005; see also Amowitz et al. 2002).

Deaths and injuries due to mines and unexploded ordnance
Unexploded land mines and ordnance remain a serious hazard after the end of conflict, as people attempt to resume their economic activities. Cluster bombs represent a new type of ordnance, that break open in midair and disperse bomblets that were expected to explode on impact.

During 2001 and 2002 Afghanistan had the largest number of reported landmine and unexploded ordnance casualties world wide. Between March 2001 and June 2002 as in other affected areas, a high proportion of those injured were civilians (81%), most were males (92% were men and boys), and a high proportion (46%) were younger than 16. Overall risks were mostly associated with economic activities, children tending animals (and playing), and adults farming, traveling and involved in military activity. The small proportion of women injured probably reflects their more restricted mobility. (Bilukha et al. 2003).

Cluster bombs were targeted at southern Lebanon by Israeli forces in the closing days of the July-August 2006 war, in defiance of international law against excessive incidental loss of life and injury to civilians. According to an Israeli media source, Israel fired at least 1.2 m cluster bomblets. By October 2006, more than 20 Lebanese civilian deaths and 150 injuries resulted from the delayed explosion of these cluster bomblets, and rendered much of the fields and olive groves of southern Lebanon useless (Al Ahram Weekly 25-31 January 2006, p 13; UN 10 November 2006).

Other measures of health status - morbidity

Morbidity data is much more difficult to capture than mortality data. This is especially the case in a conflict setting, where many sick and injured fail to reach health facilities (such as there are) and thus do not enter a data base. However, it is possible to focus on a few areas where detailed epidemiological studies have provided a general view of the impact of conflict on health.

Mental health

Poor mental health and inability to cope with daily life are the cumulative results of deprivations found in all countries in conflict situations. As there is no universal response to conflict and its deprivations, there is no universal measurement of mental health (Summerfield 2000). It is important to present whatever evidence is available, as mental health remains a serious and neglected public health problem in conflict settings.

In Iraq, in June 2005, after 12 years of economic sanctions and two wars, there were about 5 million people (20% of the population) experiencing "significant psychological symptoms" and at least 300,000 people suffering from "severe mental health related conditions" (Iraq June 2005). Of 2,000 people interviewed in 18 provinces of Iraq in late 2006, a period of increasing insecurity for the civilian population, 92% feared being killed in an explosion and 60% said that the level of violence had caused them to have panic attacks (Association of Iraqi Psychiatrists 2007). Such high levels of mental distress are likely to affect people for many years to come.

In Afghanistan, in 2002 a national survey supported by the Ministry of Health, Centers for Disease Control (USA), UNICEF and other organizations found a high prevalence of symptoms of depression, anxiety and PTSD, even compared to other population in a conflict setting. Two thirds of the survey participants had experienced multiple traumas, and 42% experienced PTSD symptoms. The disabled suffered higher levels of anxiety (85%) than the non-disabled (69%).

The prevalence of mental health problems among females is usually found to be higher than among males, and the same holds for crisis settings. The national Afghanistan study also reported significantly lower mental health status among women than among men (Cardozo et al. 2004, 2005).

Mental distress in children is common in conflict settings. In Iraq in early 2007 it was estimated that over 90% of 1,000 children studied had learning difficulties, mainly due to the current climate of fear and insecurity (Association of Iraqi Psychologists 2007). In Palestine in 2002/3, among boys and girls in aged 6-16 years, girls were more affected than boys, with 58% suffering from severe PTSD. Symptoms were related to both the extent of exposure to violence and the family setting, showing that military violence affected the ability of the family and home to protect children ; the authors were staff of the Gaza Community Mental Health Program (Qouta et al. 2003; Qouta & Odeeb 2005; see also Thabet et al. 2002; and for adolescent mental health in Palestine (Giacaman et al. 2006; Al-Krenawi et al. 2006).

As each society is likely to interpret their experiences differently, and have different ways of expressing them, a more nuanced, and less biomedical approach to psychosocial distress may yield useful insights that reflect what those involved feel and how they express themselves. In Darfur, researchers from an NGO, the Tear Fund, found that most of those interviewed interpreted their experiences of distress in terms of the social body, rather than the "self". For them what counted was the effect on the social life of their community of fleeing from their villages, and the loss of dignity and of the social roles they had enjoyed in their villages (Murray 2006).

Malnutrition

Measures of malnutrition (stunting, underweight and wasting) for children < 5 years old, are good indicators of changing health status among a vulnerable group, and relatively easy to identify. Long term chronic malnutrition, stunting, is often highlighted as it can result in long-term health damage.

In Iraq, three nutrition surveys in 1996/7, which together covered all Iraq, found alarming rates of malnutrition among children after the UN oil-for –food agreement of December 1996. Almost one third (32%) of children < 5 were stunted, chronically malnourished, an increase of 72% since pre-war 1991 surveys, and almost one quarter (23.4%) were underweight. Some regions suffered more severely than others. The Multiple Indicator Cluster Survey (MICS) for the Governorate of Missan, in eastern Iraq, showed almost half of children < 5 were malnourished (UNICEF 26/11/1997; http://www.unicef.org/newsline/97pr60.htm accessed 15/4/07; see also annex 1).).

MICS for 2000 and 2006 showed continued chronic malnutrition (stunting), 22% and 21.4% respectively (MICS Iraq 2006, 2000). A survey in Baghdad just after the war in 2003 found 16% of children were stunted (UNICEF 2003). Even higher rates of stunting (63.7% of children 6-59 months) were found in Kohistan, Afghanistan in 2002 after three years of civil war and drought (Grandesso et al. 2004)

Diarrheal diseases and other infectious diseases among children

Infectious diseases become major causes of morbidity (and mortality) among children in conflict setting, especially among refugees and IDPs, especially diarrhea, ARI and, to a lesser extent, vaccine preventable diseases. One camp in Darfur recorded a 50% weekly attack rate of diarrhea among children (Grandesso et al. 2004). In contrast, in Palestine, as of June 2006 (before the July-August war), only 6.6% of infant mortality was caused by infections diseases. Other health status indicators also appeared to hold up well. As of mid-2006, the immunization programme was functioning well, with a coverage of more than 95% for DPT, HepB, and MMR (EMRO August 2006).

Injuries directly due to conflict

Children were often injured during the conflict. In Afghanistan, 25% of injuries due to anti-personnel mines during the early 1990s were in children under 16 (Moss et al. 2006). In Palestine, of the total of 31,232 people injured between 29 September 2000 and 31 January 2007, 18% have acquired a permanent disability that will affect them for the rest of their lives (Palestine CS report, based on data from the Palestine Central Bureau of Statistics).

4.5 The contribution made by Women's and Feminist Movements to Equity in Health:the Chilean experience

Thirty years ago, a neo-liberal economic model was introduced and consolidated in Chile. It achieved high rates of macroeconomic growth (the average annual rate of growth during the decade 1990-2000 was 5.6%) with a high concentration of wealth and considerable inequalities.79 During the same period, Chile underwent a process of political transition and economic continuity during the changeover from a military dictatorship to the restoration of a democratically elected civilian Government.

Social inequality is compounded by gender inequality, expressed inter alia by the low level of women's participation in the labour force,80 a wide wage gap between women and men performing similar jobs,81 the feminization of poverty - with a high percentage of women heads of households living in poverty and casual employment characterized by flexibility, informality and instability.82 The health system is in the throes of a neo-liberal reform concerned more with institutions than health, with a marked bent towards privatization and limitation of State participation.

*The women's health movement and its contribution to reducing gender inequitie*s
During the years of the military dictatorship, the women's movement was noteworthy for its particular strength and capacity to resist repression and poverty, as well as for putting forward gender-specific demands denouncing the violence and discrimination practised by the military regime against women. But differences also developed within the women's and feminist movement over political strategies, between those in favour of working within the movement independently from institutions and those who preferred to influence public policies from within the universities, non-governmental institutions or via direct participation in the State, which to some extent undermined their action within civil society.

Over these years, the Forum has been active in the field of sexual and reproductive health. Women's right to take decisions about their own bodies, and by extension about all aspects of sexuality and reproduction, is the basic tenet of the organizations that belong to the Forum. Consequently, the right to safe and legal abortion and the adoption in Chile of the principle of voluntary motherhood, have been the cornerstones of its action.

---

79 The poorest 20% receive 3.9% of national income, while the richest 20% receive 56.5%. (ALAMES - PIDHDD. 2005, figure from Mideplan 2003). According to the Gini index, Chile and Brazil count among the Latin American countries in which inequality is greatest (UNDP 2004).
80 In 2000, 39.3% of women belonged to the labour force. MIDEPLAN, Government of Chile. CASEN survey. 2000.
81 Women are paid wages that are 36% lower than those of men with the same level of education; with 13 or more years study women earn on average 52% less than men. MIDEPLAN, Government of Chile. CASEN survey. 2000.
82 "According to the World Bank, the Chilean labour market is 2.5 times more flexible than the Latin American average and almost twice as flexible as the most developed economies (OCDE)". Escuela Continental, Chile document. Alames – Chile.

Another of the points of reference for the women's health movement has been the Chilean Network against Domestic and Sexual Violence. This network is made up of social organizations and women's/feminist NGOs that have developed health care models to provide basic mental-health care and legal guidance and worked with self-help[83] and self-awareness groups; provision of shelters; training for a range of social and institutional actors; helping to draft both the initial and the current legislation on domestic violence, together with other strategies at a time when neither society nor the Government had any response to the problem.

From 2001, in Latin America and in Chile, the Chilean Network against Domestic and Sexual Violence launched the campaign: "Protect women's lives: no more deaths" whose purpose is to raise awareness of killings of women. It was against the background of this campaign that the first research was carried out to highlight the problem and offer a tool that has proved effective in influencing public policies.

A later version of this exercise in civic participation has been the organization since 2002 -with the support of PAHO - of four women's health parliaments, bringing together more than 1000 women, which have addressed analysis of health reform and put forward proposals from the gender perspective. Some major issues addressed in the period under study include:

Quinacrine. In 1994, the Forum intervened in experimental research into sterilization with quinacrine, undertaken by Dr. Jaime Zipper in two hospitals in Santiago and another in Valdivia in southern Chile, involving a group of 700 to 1000 women.
Sexual and Reproductive Rights. The idea that sexual and reproductive rights are inalienable and indivisible human rights was one of the cornerstones of the women's health movement acting in coordination at the international level.
Gender violence. The Chilean Network against Domestic and Sexual Violence took an active part in the promulgation of the first law on domestic violence because at the time it was the only entity that had acquired any knowledge and experience of addressing violence against women.
Emergency contraception. Since 1997, several women's and feminist organizations, essentially grouped within the Health Forum, demanded the distribution free of charge through the public health system.
Health Reform. During the early stages of health reform, when the Government of Ricardo Lagos presented the key legislative projects of the reform, the women's health movement made a huge effort to provide and disseminate information among women, to undertake analyses and put forward proposals,[84] denouncing the absence of a gender perspective and the promotion of a process of privatization of health and liberalization of the State, whose main victims would be women, because they are the system's main users, both as patients and staff.

---

83 Maira, G; Olea, P; Santana, P; Rojas, S. Resource Guide for Action: Services dealing with violence against women. Chilean Network against Domestic and Sexual Violence. 2006.
84 The movement for health reform with a gender focus has been formed. It comprises more than 20 women's social organizations, feminist collectives and NGOs. PAHO provided noteworthy support in organizing days and discussion seminars on health reform and gender.

4.6 Case Study Based on Focus Group Discussion with Sudanese Refugees in Egypt

Problem, causes and results

The FGD revealed that the main problem that led them to refuge is the current war between the ruling government and the rebels. Most of the times, an attack is conducted on the different areas and villages with the pretext that they harbor rebels. Also, the rebelling forces attack villages using the excuse that they are loyal to the ruling government. The result in both cases is the destruction of these villages and the escape of their people and their scattering. They are pushed towards the North thinking its safer, and once there they face oppression by the government and accusations, sometimes, of their betrayal.

In most of the times, the government refuses to present them with services except after their joining the army. In addition to their inability to cope with the communities of these areas, and bad living conditions especially after they left all their positions behind.

Participants agreed that the reason behind the current war is the ethnic problem and not the religious problem as government as well as the global media tries to show. It was since the independence of Sudan, that the ruling government (the Arabic sect) was continuously oppressing the African Sudanese who are concentrated in the Western and Southern parts of Sudan. The group claimed that the ruling government kept on isolating them in these parts of Sudan and kept them away of any political positions. Moreover, the government accused parties that demand the rights of the rest of Sudanese (African 95%) with racism. African Sudanese were banned from education and were forced to be taught in Arabic (As the official language in education), which was very difficult for a large sect of them because they had other languages (Nuba Language for example which is spoken by 99 sect and it is very different from the Arabic Language)

Reasons for oppression as expressed in FGD:
– The government which represents the Arabic element does not present more than 5% of the whole population. They ruling government tries through this imposed war to control the country and most of the population (African Sudanese)
– "The Arabic element loves authority" one of the group said.
– The Southern and Western parts of Sudan enjoys most of the country's animal fortune which is important to Sudanese.
– The parts too contain the biggest parts of oil and it reserves.

Situation of Refugees in Egypt:
"the sea is in front of us and the enemy is behind us…where is safety"
The group expressed that when the world got very small to them in North of Sudan for the above reasons, and through some of provided facilitations of some friends in

the different embassies, they decided to come to Egypt. This choice was for several reasons.

– Egypt is geographically close to Sudan
– The safety and stability the Egypt enjoys in comparison to Sudan
– The historical relationship between the two countries

It was thought by the group that coming to Egypt is only as a transitional period (transit) and afterwards they would move to any other rich country for work opportunities and better living conditions. *"Egypt for us is the door to the outside world...we think of it as a transitional phase because it is a poor country and does not have oil...we go to Egypt first and then we go either right or left...the Gulf or Europe"* one of them said.

Residency:
Sudanese refugees, as a result of their bad economic condition, had to reside in the peripheries of the city. They either live mostly in slum areas. Most of the houses they live in are badly built using "red brackets". The houses are not linked to a sanitation (Sewage) system. Water is cut from houses most of the day although they have water tubes. More than one family lives in one house of one or two rooms. Aziza says *"I live with 11 person in a house of two rooms."*

Work:
The Sudanese refugees suffer from bad working conditions. In general it is hard from them to find an appropriate job with good salary. This is due to several reasons as they expressed them:

– Most of the Sudanese refugees are from African origins. And the level of education among them is low.
– Part of any job's requirements they have to present is official papers like a permanent place of residency or a statement from the embassy. These papers are not available for the refugees.
– Most of the refuges live in far areas where job opportunities are minimal.
– The Egyptian market has a big number of labor, and in all fields. The economy is not doing well in a way that would absorb new labor in the market and compete.
– All these reasons made it difficult for refugees to have permanent jobs which led a lot of them to work as free lancers in construction of commerce with weak wages. It also lead women to work as house servants.

Education:
Refugees suffer from lack of education due to absence of schools. They don't have but elementary schools (till 6th grade), some secondary schools and they don't have any high schools and they are not allowed to join Egyptian Universities. Their Sudanese certificates are not recognized in the Egyptian education system. Laila says *" my son, Mohamed, is in the 6th grade and when the final exams came..the school asked him to provide a paper from the embassy as a condition for taking his exam...I could not get the paper and as a result he did not take the exam and left school".*

Health:
"We ask God never to get sick"
The Sudanese refugees suffer from bad health conditions as a result of their difficult living conditions…crowded houses…lack of sanitation…lack of clean water. Also, it is difficult for refugees to go to public hospitals when they are sick because hospitals, like any other governmental institution, ask them for official papers (statement from the Sudanese Embassy…permanent residency…which they don't have)

Moreover, there is a wide spread fear among them from organs stealing. (they mentioned a story of a girl who went to a hospital on her own to have a plastic surgery for her breast. Her organs were stolen which led to her death)

As concerning the different bodies they might seek for help in the time of sickness, the say they do not have an official body that would provide them with help in this issue except for some civil society organizations. For example, Caritas offered some of them medicine and some elementary treatment. Also these organizations, as a result of pressures, cant treat every one continuously. *"One prefers to stay sick better than starts treatment that can not be continued"*. They are only left with few medical centers that started working with Sudanese but unfortunately a lot of refugees can't afford its costs.

Common Diseases:

Skin diseases:
"Most of us suffer from skin disease, irritations which perhaps is the result of the small bugs spread in our crowded houses"

Malnutrition: *"Our children suffer from mal-nutrition and bone because we cant provide them with healthy enough food"*.

Respiratory diseases including Tuberculosis: *"As a result of bad stuffed weather and the crowded houses, a lot of us especially our children suffer from TB."*

Rheumatoid: *"If you searched among this group…you discover how wide spread this disease is among us. Most of us suffer from it due to the difference in weather between Egypt and Sudan"*

Mental and psychological disorders: *"We noticed lately that a lot of us, especially youth, suffer from psychological disorders. A lot of them suffer from depression, isolation or memory disorders or even lose"*

Sexually transmitted diseases: *"Before, we were not suffering from such problems. Maybe this problem exists among us but most of us have not checked up. Now it is brought up, especially after the Sudanese sit it in Mustafa Mahmoud Sq. in front of UNHCR. We think this issue was brought up as a mean to pressure us and push us for more isolation which we all suffer from socially. It is a mean to turn the public opinion against us and push us to break our sit in"*

Finally, the group talked about the difficult social and security conditions they are living in. most of them live in poor and slum areas and are seen as a competitive force against the original population in residency and work. A huge percentage among them are illiterate which makes them easy target for oppression and push them towards isolation.

"Our children do not go out of house because when they do, they get beaten and sworn against (ex. Chocolate..)

In addition to the above, Egyptian security does not provide them with the needed protection and treat them on the bases that they do not have any rights and as if they are "intruders" (Awad mentioned his story, in the time of their sit in, when he went to the police station after the sit in was over to report on his lost objects…the officer make fun of him. When Awad mentioned that there was some jewelry among the objects, the officer refused to mention it in his report)

At the end of the FGD, the group asked about the application of the signed Egyptian Sudanese agreement which is known by "the agreement of the four freedoms". The agreement refers to the rights of the Sudanese which involves the right to housing, work, education and health services. They mentioned that this agreement is only applied on the Arab Sudanese).

4.7. Right to Health Care Campaign of the Peoples Health Movement Learning from the Indian Experience

The Right to Health Care Campaign, initiated by the Peoples Health Movement, India (Jan Swasthya Abhiyan) in 2004, in collaboration with the National Human Rights Commission, is an unique Civil Society initiative. The objective behind this exercise is not to find faults and point out the inefficiency of Public Health Care Delivery System but to work in close partnership at various stages with State Governments, State Human Rights Commissions, National Human Right Commission, Health Departments, Government Organizations and CSOs and to evolve meaningful relationship and come out with suggestions in the common interest of promotion and protection of Human Rights.The chief elements of the campaign are:

Participatory surveys of public health facilities from village to District levels. Based on these surveys, development of status reports for different regions in the country (ranging from Blocks to Districts to states) which include reports on the different tiers of the public health system – from primary to tertiary. Each level of care is surveyed based on a specially designed questionnaire for that level.

Collection of cases of denial of health care. The cases are systematised on the basis of a detailed protocol that identifies different forms of denial, ranging from non-availability of essential health care equipments for treatment in government health centres, mass scale Tubectomy operations without confirming the health status of the women, non-availability of transport facility to refer patient to better health services, to non-availability of essential drugs and equipments for essential testing. Denial is also identified keeping in mind the entitlements that are required to be made available at each tier of the public health system.

Public hearings at sub-district, District, State, Regional and National Levels. At the public hearings the status reports and the cases of denial are presented as testimonies before a joint panel that includes representatives from the Human Rights Commission, Civil Society and persons of eminence. The hearings are also attended by public health officials, who get a chance to reply to the reports and cases presented. Based on these the panel pronounces recommendations. The chief objectives of the public hearings, and the preceding process are:

- To mobilize communities around the issue of right to Health care
- To document and highlight specific instances of denial of health care
- To present testimonies that detail these instances of denial to public health officials and expert
- panelists so as to emphasize the structural deficiencies in particular health facilities underlying such cases

- To create awareness amongst local communities about the various health services which the government at different levels should provide

The testimonies presented are not just individual cases of denial but are representative examples of the kind of health care denial that takes place in public health services. The objective of is not to target individuals or facilities but to focus on the problems in the system that are larger and structural in nature. Following are the summaries of two testimonies presented at one of the public hearings:

1) Child Loses his eyes due to Lack of Proper Diagnosis and Treatment

A two and a half year old child from a village of Badwani district, in the state of Madhya Pradesh, had fever and vomiting for which he was taken to a private doctor for two days. Later because of no improvement he was taken to a Primary Health Care center, where after treatment of 2-3 days he developed drooping of the left eyelid (ptosis). He was referred to the Community Health Centre, where the doctor treated him for 5 days. By this time the child had developed rigidity of limbs and the doctor gave eye drops and ointment.

He was finally referred to Badwani District hospital. Here no proper treatment was given to the child even through he remained there for 8 days. Since condition of his eye worsened, he was asked to get admitted to the eye ward. The child was taken to the eye department again and the doctor there without treatment referred him back to the Pediatric department.

He was again kept in the Pediatric department for 6 days. By then both his eyes were infected. When his father protested he was referred to an opthalmologist. The hospital, instead of treating him further, discharged the child. The unfortunate child is now blind for life due to the continued denial of proper treatment and health services at all the levels.

2) Negligence of Health Officials towards reported epidemic

*In one of the villages under Khodala PHC, Thane District, Coastal Maharashtra, an epidemic of diarrhea and vomiting occurred in October 2003. Sensing the danger, a villager rushed to inform about the epidemic to the Block Development Officer (BDO) who unfortunately ignored this warning. He then tried to contact concerned authorities in the PHC. However the Medical Officer was not available to take stock of the situation. At last he called the Chief Medical Officer (CMO) of Thane District. Finally he arranged for a doctor and a vehicle. In the mean while, **one woman lost her life in this epidemic where as 5 others were taken seriously ill**.*

Rather than complimenting the efforts taken by the villager, PHC officials were furious that he had dared to contact the CMO directly. In spite of specific instructions by the District authorities to the PHC doctor to monitor the situation regularly, he visited the epidemic area subsequently, just thrice in 2 months.

Follow up with joint monitoring (involving the Human Rights Commission and PHM-India) of action taken on recommendations. The monitoring stresses on the systemic gaps in the public health system that led to the reported cases of denial.

In the first phase of the campaign several districts and most of the states organised public hearings based on the above format. These culminated in five regional hearings and finally a national hearing in New Delhi in December 2004. The national hearing was attended by the national Minister for Health and all senior

officials from the Ministry of Health. At this hearing a National Action Plan to Operationalise the Right to Heath Care, was jointly presented by the National Human Rights Commission and PHM-India.

The next phase of the campaign now involves deepening of the process and of building political consensus and mobilization around the national action plan. Towards this end peoples' District Health Plans are being prepared. Simultaneously a nationwide awareness building campaign is helping mobilize opinion around the peoples' plans. A highlight of this phase was the organisation of a National Health Assembly in March, 2007, attended by over 2500 CS activists.

Launching of a Global Campaign

Given the positive response to the campaign in India, the Peoples Health Movement has recently launched a global campaign on Right to Health. Countries interested and with capability to initiate t5he campaign are being identified. Detailed protocols have been worked out, that can be adapted suitable at country and local levels. Through this campaign the PHM sees an opportunity to promote the agenda of the Right to Health, at national as well as global levels. The PHM also sees the campaign as a means towards mobilizing people around the issues of Health and Health care.

4.8 Adult Literacy in a Campaign Mode:
     The Total Literacy Campaign in India

It has been demonstrated, worldwide, that a change in social order is facilitated through efforts in mass literacy. With over fifty percent of India's population still illiterate, integrating processes that fight political, social and economic marginalization of people with mass literacy can provide the necessary vigour and capability for rapid change.The impetus to initiate a mass action for renewal was propelled from such an understanding. A prominent CSO in India, *Bharat Gyan Vigyan Samithi* (Indian Association for Learning and Science) emerged to put such an understanding into action. BGVS considers literacy as a possible starting point for social transformation and the crusade against illiteracy as a crusade against conditions that maintain illiteracy, a crusade against religious secttarianism, a crusade against dependence. It is a second independence struggle, for national integration and for self-reliance, a struggle to make democracy meaningful to the millions.

The earlier experience with adult education programmes, culminating in the formation of the National Adult Education Programme (NAEP) in 1978, suggested that it had not created a demand for literacy among the people. There was a lack of people's participation. The response of the government was to set up a National Literacy Mission Authority in 1988. But the NLM had no clear strategy. In 1989, the Kerala Sastra Sahitya Parishad (KSSP), one of the pioneering People's Science Movements (PSMs) in the country, undertook a massive literacy campaign in the district of Ernakulam in collaboration with the district administration. KSSP made use of its time-tested medium of *kalajathas* (cultural caravans) to reach out to every nook and corner of the district to create an ambience for the literacy programme. The District administration and KSSP, along with various other voluntary and mass organizations worked hand in hand on the platform of the now famous *Zilla Saksharatha Samithi* (District Literacy Association). Hundreds and thousands of young men and women came out to become voluntary literacy teachers. The campaign approach of Ernakulam proved to be a major success, and the District was declared the first 100% literate distric t in India.

In 1989, the NLM decided to replicate the Ernakulam experiment at a nationwide level with the idea of a broad-based experiment for propagating literacy, the All India People's Science Network (AIPSN), at the request of the Government of India, decided to form the Bharat Gyan Vigyan Samithi, with the primary responsibility of placing literacy on the national agenda. The BGVS. since its formation partnered the Indian government in carrying the lamp of learning to about 40,000 villages in some 250 districts across the length and breadth of the country. In the decade between 1989 and 1999, the organisation and its concepts were magnetic enough to attract more than **12 million entirely voluntary activists** to its fold. More remarkably still, these messengers of hope managed to **reach and teach close to 140 million illiterates**.

It was far from smooth sailing. The casual complexities of crystallising such a complicated initiative aside, in the poorest districts the organisation came up against

that old brick wall of education taking a back seat to everyday survival. In the years between 1994 and 1997, the BGVS pushed to place literacy in the context of a host of development issues and factors: health and sanitation, food and water, local self government, natural resources, women's empowerment, etc. Despite the change of tack, BGVS entered a period of regression, accentuated by an erosion of its relationship with government agencies. Differences of opinion on strategy and implementation with the government agencies involved in the literacy drive had a debilitating effect on the programme. In spite of this setback the **adult literacy rate in the country rose by 14 percentage points between 1991 and 2001**.

There were **328 million non-literates in the country** in the age group seven and above in 1991. The extensive scale of the literacy campaigns may be understood from the fact that out of the 588 then existing districts of the country 529 had been covered by the campaigns by 2000. Significant gains have been made by way of the large scale participation of women and their enhanced status, the growing demand for primary education, the capacity of the campaigns to reach out to SCs, STs and the rural poor, a changed orientation to developmental administration in some sections of the administration, and the relative success of the popular cultural style of mobilisation that set in motion a process of decentralised, coordinated participation of different sectors of society, especially during the early years of the campaign. Some interesting and inspiring elements of the campaign included:

- Teaching volunteers – required to have completed at least 8 years of formal schooling – were mostly unmarried women: unlike the women they taught, hardly any were from scheduled (lower) castes.
- Organisers and volunteers did not earn any income, but were compensated in other ways, including recognition and responsibility in public.
- Often, for lower caste women visiting upper caste areas to participate in BGVS activities was going against social limitations: many risked physical and mental abuse to do so.

The tide has turned once again and the government is starting to shed its bureaucratic attitude to the campaign. In the mean time BGVS is engaged in the task of post literacy activities that span areas such as continuing education, village library movement, health care, women's credit co-operatives, and technology transfer to rural artisans.

4.9 Female Genital Mutilation in Sub Saharan Africa: Violation of Women's rights.

Female Genital Mutilation (FGM) involves the cutting and/or removal of the clitoris and other vaginal tissue, often under unsanitary conditions. It is practised in at least 28 countries globally. The United Nations children's fund, Unicef, estimates that up to 140 million girls and women around the world have undergone some form of FGM. It is practised extensively in Africa, and also found in parts of the Middle East and among immigrant communities around the world.

Female genital mutilation (FGM), often referred to as 'female circumcision', comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. The most common type of female genital mutilation is excision of the clitoris and the labia minora, accounting for up to 80% of all cases; the most extreme form is infibulation, which constitutes about 15% of all procedures (WHO 2003)

Among communities that practise FGM, the procedure is a highly valued ritual, whose purpose is to mark the transition from childhood to womanhood. In these traditional societies, FGM represents part of the rites of passage or initiation ceremonies intended to impart the skills and information a woman will need to fulfil her duties as a wife and mother.

Local organisations are working to eradicate the custom in many communities, and are achieving a higher level of success because they are able to communicate more easily with

The UN World Conference on Human Rights as reflected in the Vienna Declaration and Program of Action affirms that the human rights of women and of the girl child are an inalienable, integral and indivisible part of the universal human rights.

The women's rights as human rights, stressed the importance of the elimination of violence against women in public and private lie and the eradication of all forms of discrimination against women. FGM is considered to be a fundamental violation of human rights, according to various international and regional organisations. Three international conventions and declarations, namely the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984), the Convention on the Rights of the Child (1989), and the Declaration on the Elimination of Violence against Women (1993), all represent the legal framework, which campaigners and legal experts consider significant in detailing how FGM transgresses agreed norms and why it needs to be outlawed. Consequently in this perspective it is widely recognized that FGM is a violation of human rights.

Legislating against FGM

In sub-Saharan Africa, the following countries practice FGM at different levels within their population. These include Benin, Burkina Faso, Cameroon, Chad, Central Republic, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Ivory Coast, Kenya, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Somalia, Tanzania, Togo and Uganda. These countries have or are in the process of enacting legislations to cub this heinous act

FGM is currently illegal in many countries in Sub Saharan Africa but this has not reduced the number of the girls that are mutilated every year. The governments of these countries have no way of monitoring the spread and practice of FGM. Due to the legislations in place, FGM has now been focusing on the girls at the young age who are defenceless, even as young as 1 day old. However, trying to fight FGM on legal terms is ineffective because the practice is always in high secrecy and is also widely practiced in villages and remote places where the government does not have an easy access.

Due to the deeply entrenched cultural importance of FGM to those societies practising it, there has not only been reluctance in many countries to legislate against it, but attempts at implementing legislation have met firm resistance. A research carried out in Serengeti district in Tanzania in 2002, 6 out of 11 girls of standard 5 in a school had already been circumcised. When probed further whether the remaining will not be circumcised, the boys in the class responded that only those practising Christianity would be spared. In a further discussion with women in the village, one of them retorted that "the day my husband refuses to offer my daughter for circumcision will be the day of my divorce". In most areas where it is practiced, the women who have been through FGM are highly respected and honoured in the society. In this kind of situation, women of age who have not gone through circumcision are compelled to voluntarily offer themselves for FGM in order to attain a respectable social status amongst their clans and community members including participation in important decision making processes and ritual functions. After the enactment of the sexual harassment legislation in 1998, there was a decline in the number of girls being subjected to FGM. At the moment, due to lack of sustained efforts to advocate against it, the numbers are on the increase.

Senegal outlawed FGM in 1999 with the support of UNICEF, International and local NGOs and the practice have substantially decreased in the northern and southern areas especially in Matam and Kolda districts. One woman interviewed, Oureye, who was a previous practitioner of FGM, had stopped it after wide sensitization of her community and now she is spearheading the campaign on zero tolerance on FGM in the country. She realized the disastrous health effects of FGM e.g haemorrhage, shock, infection and problems at childbirth. "We used to believe that these problems were caused by evil spirits. We learned differently in our education program," she emphasized.

In Nigeria, FGM is also explained by some as a decree by the ancestors while others consider it a prerequisite for all girls that want to marry. When it is not seen as a

puberty rite, it is rationalised as a way of making the female genitals aesthetically more pleasing or cleaner. Also, it is said to increase fertility of women as well as to ensure easy child birth.

An international day on Zero tolerance on FGM was instituted and In 2007 a banner parade organised by the Federal Ministry of Health in collaboration with the United Nations Fund for Population Activities (UNFPA) Nigeria to advocate against FGM.

In Uganda, FGM violates the right to life in the event that death results from the ritual. Since the practice is premised on the notion that women's bodies are inherently flawed and require correction, it does not respect women's inherent dignity. Respect for women's dignity implies acceptance of their physical qualities – natural appearance of their genitalia and their normal sexual function. A decision to alter those qualities should not be imposed upon a woman or girl for the purpose of reinforcing socially defined roles. (Lule 2004)

Deprivation of liberty is obvious when girls are forcibly restrained during the ritual. Young women are highly susceptible to coercion by adults. The child may also feel coerced due to various types of persuasion. Children are also unlikely to understand and have access to information about the consequences of the practice and potential complications.

In a study done in Kapchworwa district in 2003, the sebei women interviewed stated that refusing to undergo the practice may jeopardise a woman's family relations, her social life and her ability to find a spouse. The fear of these consequently made meaningful consent impossible. Therefore, a woman may consent not because she accepts the tradition but because she fears the repercussions of refusing.

Even in immigrant populations living outside Africa, these cultural practices are still in force for instance recently, an Ethiopian immigrant, Khalid Adem 30 was convicted of the genital mutilation of his 2-year-old daughter and was sentenced to 10 years in prison in what was believed to be the first such criminal case in the United States. He was found guilty of aggravated battery and cruelty to children. Prosecutors said he used scissors to remove his daughter's clitoris in his family's Atlanta-area apartment in 2001. The child's mother, Fortunate Adem, said she did not discover it until more than a year later.

In some countries such as Niger, the cultural practices of FGM, have caused polarization, to the extent that Niger's parliament voted down Africa's Maputo Protocol on women's rights in June 2006, in a setback for the accord which aims to guarantee women equality and to end the practice of female circumcision.

4.10 How Conflict, War and Sexual Violence have affected Social Determinants of Health in the Democratic Repblic of Congo

While rape has, tragically, never been far from conflict in humanity's history, in the DRC it was clearly used by armed groups as one of the main weapons against their opponents and the civilian population. These situations are found in many other parts of the continent e.g. Sierra Leone, Chad, Darfur, Somali, Uganda, Southern Sudan etc. The DRC conflict is particularly marked by the systematic use of rape as a weapon of war. In eastern DRC, members of armed groups have raped tens of thousands of women, including young girls and the elderly, as well as a number of men and boys. At least 3.3 million people, mostly women, children and the elderly, are estimated to have died because of the conflict, most from disease and starvation. More than 2.25 million people have been driven from their homes, many of them beyond the reach of humanitarian agencies. In the Democratic Republic of the Congo (DRC), rape is a very powerful weapon than the bullets they use. Rape is used in order to terrorize, humiliate and subjugate civilian populations.

Mass rape in the DRC has contributed to the spread of HIV, which is predicted to have a catastrophic future effect on the health of the country. The DRC National Aids Program estimates that the rate of infection has reached 20% in the eastern provinces and could threaten more than half of the population within the next ten years. Some experts believe that the HIV prevalence rate in the Eastern part of the country may be much higher.

The healthcare infrastructure in the DRC has broken down completely, fighters deliberately targeted medical centres and hospitals; attacking, looting and destroying many, forcing the sick and injured to flee. The conditions in those that remain in operation are overcrowded, unhygienic, lacking basic means to sterilize equipment and often without water or electricity. The Eastern province has turned into one of the bloodiest war zones in the Great Lakes region and in the continent.

Narration by Aimee Mwadi Kadi
Aimee Mwadi Kadi, heads an NGO of women living with HIV/AIDS in the DRC: She narrated this story on how conflict; War and sexual violence are determinants of health. She said; "Eight years of conflict in DRC has affected the health sector, nutrition, education and gender. DRC cannot have access to funds which means no new investment in infrastructure, equipment and medicines will be purchased. People cannot access quality care and services, and there has been an increased morbidity and mortality in women and children.

People cannot do their agricultural activities, so many cases of malnutrition in women and children are prevalent, which cause them to become vulnerable to disease. There is no education or employment, because people are migrants. Further, there is sexual violence to women and children with the consequences of HIV/AIDS and STIs. No program of ARV treatment for those who are infected with HIV,

resulting in high morbidity and mortality. DRC has AIDS orphans, widows and widowers who are a burden to the community.

The Great Lakes Region of Africa's main problems are: poverty, political instability, armed conflicts and the HIV/AIDS pandemic. The troubles will hinder any development endeavour if appropriate measures are not taken quickly in order to reduce the poverty, put an end to insecurity and armed conflict, and control HIV/AIDS. Internal armed conflicts that some countries in the sub region have faced have resulted in the massive and prolonged displacement of the populations.

Conflict resolution in Africa should not just be a matter of national or regional concerns but also of global interest. Doctors Without Borders reported on the war and said that HIV/AIDS is a key health emergency in DRC.

Therefore, the world, the region and the great lakes region in particular, need to act fast and can do the following as a start:-

- Actions should be taken in favour of the youth in cities and the countryside primarily.
- Actions in favour of women and ex-combatants and soldiers should be envisaged at the level of the sub-region if they are to be sustainable bearing in mind the mobility of the populations.

References:
UNAIDS Report, 2003.
Amnesty News (01.12.2004): Democratic Republic of Congo: HIV/AIDS the longest lasting scar of war.
Medicins Sans Frontiers: Democratic Republic of Congo: The Forgotten War; A Photographic Exhibition (September 22 – October 8, 2005).

4.11: Sexually Abused and Exploited Children:
Learning from Aparajeyo Bangladesh
(Emma Crewe and Marta Persiani, ChildHope)

ChildHope and Aparajeyo Bangladesh

Aparajeyo Bangladesh (AB) is a national child rights organisation that emerged out of Terre des Hommes Bangladesh office in 1995. Since 1997, AB has been the National Coordinator in Bangladesh of the worldwide movement on the Global March of Children against Child Labour movement.

Background

The Bangladesh context is challenging for children and especially girls. According to UNICEF[85], an estimated 6.9 million children aged 5-14 years (12.9 per cent of the total labour force) are working and are exposed to hazardous and risky conditions, especially in metropolitan cities. Gender discrimination and related violence, including abuse, exploitation, trafficking, and acid-throwing, create a socio-economic context that denies the rights of the child. Many adolescents migrate from rural to urban areas, work in precarious situations as day labourers, rickshaw-pullers, domestic servants, hotel boys and garment factory workers. Many are compelled to accept high risk and hazardous jobs. it is estimated that up to 29,000 children are victims of prostitution. The children forced into sex work explain that they get involved in order to meet their basic needs, such as food and clothes. While some of them are motivated by hunger and/or by the idea of earning quick money, others are forced by pimps or coerced into sex work after rape or sexual harassment.

The project and its strategy

CH and AB started their collaboration in 2000 and developed a project focusing on child sex workers in the capital city Dhaka. They both recognised the need to develop child-friendly, peer-led programmes to prevent children becoming victims of sexual abuse, exploitation and trafficking, and to facilitate the reintegration into society of those already victimised by the sex trade. CH and AB designed a 3 year action-based research. The project's main focus was to reduce the incidence of sex work, raise awareness on safer sexual practices, improve living and health conditions, and promote greater community tolerance and understanding.

Most importantly the project created a protective environment for children, providing emotional and material sources needed to achieve their potential and to empower them to take decisions about their future. A Drop In Centre (DiC) encouraged children's attendance and assured a friendly environment through recognition of dignity, tolerance and acknowledgments of the rights of children. Preventing and curative health care services and medicines were provided. A first medical aid was

---

85 **http://www.unicef.org/bangladesh/children_356.htm**

made available for all the children attending the centre and health workers and doctors attend to the patients. After the first year of the project alone, more than 70% of the children who attended the DiC, felt that their health condition was better than at the time of enrolment. An important part of the project was centred on counselling and group motivation to face the psychological problems and trauma derived from the abuse and exploitation that children suffered. The project's main success lies in the fact that it prioritised children's participation, so that they have actively influenced their own and other children's lives.

Children's participation

One of the project's priorities was to allow children's active participation through their involvement in a range of social, cultural and political activities. A Joint management Committee became a space for children to hold discussions about selected topics and to elect their own candidates. The children were also actively involved in all the project meetings and workshops, the content of which was designed after consulting the children about what they thought would be useful; participatory methods (group discussion, group works, etc) were used. The children who graduated from schools and training classes were put in charge of small successful enterprises (a flower shop and a communication centre). The children developed their own 'Children's Development Bank', developing and agreeing their own constitution, rules, and criteria for membership.

Education and learning

Children were given the chance to get a scholastic, health and sexual education. In a few cases the children were also admitted to formal schools (public or NGOs) after graduating from the non-formal courses. Health education classes taught the children about basic hygiene rules and how to protect themselves from common diseases; special attention was given to reproductive health, STI and HIV/AIDS. Children were also given the time to join recreation activities.

Community awareness and acceptance

To re-integrate the children into society, and fight the prejudices towards them, the project team challenged community attitudes through meetings, workshops and events, promoting awareness and acceptance. The project created a network with other NGOs, media, government institutions, families and community members with the aim of improving mass public opinion, awareness, responsiveness and acceptance.

Achievements

During the first 3 years of the project:
- 928 children received direct help, 1042 children received indirect help;
- 105 children (or 42%) of the 250 children enrolled in the project gave up sex work completely;
- 169 children were provided with individual counselling (128 girls and 40 boys) in 203 sessions (exploring a wide range of issues, including: love affairs between children, sexual violence, safe sex practice, self-infliction of wounds, family bond, early marriage, sexual trauma in brothels);

- 38 counselling sessions were held and an average of 8 girls and 1 boy attended (the issues explored included early pregnancy, sexual violence and importance of family);
- 293 children attended non-formal education from preschool level to class three.
- 82 children (52 girls and 30 boys) attended skills development training courses (such as signboard and banner writing, embroidery, flower designing, screen printing).

Recommendations

After the first phase of the project, the staff developed a series of recommendations for policies and future work. They underlined the need for a revision of Bangladeshi law in accordance with the United Nations Convention on the Rights of the Child (UNCRC), especially banning prostitution for any person below the age of 18. They also recommend better collaboration between government and civil society in sharing their resources and work and further studies on sexual exploitation and abuse in Bangladesh.

They also developed phase two of their own work by (a) scaling-up impact by working with children in new geographical areas of Bangladesh, (b) establishing a 24-hour safe shelter and toll-free child help-lines, and (c) consolidating their model of peer education and community mobilisation.

4.12. Addressing the Social Exclusion of Kenyan Adolescents with Effective HIV/AIDS Tools
(AfriAfya, Kenya, and Street Kids International, Canada)

Street Kids International has been working for over 15 years on health and more specifically, HIV/AIDS issues with marginalized youth. AfriAfya was established in April 2000 as a consortium86 of Kenyan development agencies and the Ministry of Health to explore ways of harnessing information and communication technology for community health in rural and poor communities.

HIV, Social Stigma and Gender Inequality
The UNDP lists social stigma and gender inequality as two of the five drivers87 of the HIV pandemic that facilitate the spreading of the virus, thus increasing the vulnerability of local populations to infection and resulting in the break down of the social and national structures. Social stigma is now said to be the latest significant barrier impeding the successful control of HIV. There exists stigma towards people who are living positively with HIV with respect to employment opportunities, treatment in health care facilities and community inclusion. This stigma also pervades the community such that people who consider getting tested may feel that simply entering a clinic will suggest that they are positive. In Kenya it is commonly believed that HIV/AIDS is associated with promiscuity and prostitution, and this sense of inappropriate behaviour is directed at anyone who is HIV positive or who may be thought to be HIV positive.

While social stigma pervades both genders and all elements of society, gender inequality in Kenya is one of the primary reasons for an increased incidence among young women. Gender inequality typically takes the form of enforcing policies or promoting programs which do not recognize conditions and situations unique to girls and women thereby excluding them from opportunities. As an example, programs promoting abstinence do not recognize the power differences, cultural norms and domestic abuse and violence that girls experience. These factors heavily impact girls' ability to choose if they will practice abstinence. In sub-Saharan Africa, 57% of those who test positive for HIV are women, and at least one-third of these women are married88. In Kenya, the prevalence of HIV in adolescent girls is almost four times as high as that of adolescent boys.

---

86 including Aga Khan Health Services, AMREF, CARE Kenya, Christian Health Association of Kenya – CHAK, Health Net Kenya, PLAN Kenya, and World Vision
87 Other three drivers include: poverty and income inequalities, lack of access to social services (including education), weak governance and instability
88 Joint United Nations Programme on HIV/AIDS (UNAIDS), UN Population Fund and United Nations Development Fund for Women (UNIFEM), *Women and HIV/AIDS: Confronting the Crisis—A Joint Report* (Geneva: UNAIDS, 2004

Table: Prevalence Estimates for Kenyan Youth aged 15-24 in 2004[89]

	Prevalence	Number who are HIV +
Male	0.9%	35,911
Female	4.9%	189,372
Average/Total	**2.9%**	**225,284**

Since most adolescents begin sexual intercourse early, there is need for both boys and girls to know that the first sexual intercourse can result in infection. High rates of infection can be attributed to a combination of biological and social factors. Available evidence indicates that girls start sexual activity earlier than boys, have large numbers of sexual partners, a high prevalence of sexually transmitted infections, and are victim to a high incidence of violent sexual contact. In Kenya, 25% of 12-24 year old girls lose their virginity by force[90].

The disproportionately high rates of HIV infection among women and girls are starting to trigger a national awareness of violence against Kenyan women and its effects. Traditional, deep-rooted gender inequalities are often expressed in violence, coercion or physical or emotional intimidation. Women may also give in to male demands for unprotected sex, despite the danger, as they often have nowhere else to go, limited financial options, limited land rights and fear of losing their children. Young girls are often preferred by older men who believe that unprotected sex is less likely to lead to infection, and the myth that sexual intercourse with a virgin will cure a sexually transmitted disease. Young girls living in poverty may find older men attractive because of their wealth, power and position and thus making them to be at very high risk of HIV infection.

An Effective Response to the Issue

Establishing healthy behavioural patterns during adolescence is much easier than changing risky behaviour later on. Around the world, the evidence shows that wherever the spread of HIV is slowing or even declining, it is primarily because young men and women are being given the tools and the means to adopt safe behaviour. In fact, in every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred. This fact encourages the possibility of change within youth's sexual behaviour, however the majority of adolescent girls in Kenya continue to feel that there is no chance in them contracting HIV (table).

Table: Perception of Risk of Getting Aids among Adolescent Girls in Kenya[91]

No chance	51.8%
Small chance	36.2%
Moderate chance	6.7%
Great chance	5.0%
Don't know	0.3%

---

89 AfriAfya, 2007
90 AfriAfya, 2007
91 *AIDS in Kenya,* NASCOP – Ministry of Health, 2005

While youth are bombarded by HIV and AIDS messaging, they still do not necessarily feel that they are susceptible to the virus, or that they do not have the power to make healthy decisions for themselves. AfriAfya, Street Kids International and many other organizations involved in HIV education have learned that HIV prevention messaging must be targeted to specific groups and crafted to be 'meaningful' to that specific population (e.g. young women). It is this lack of effective targeted HIV prevention messaging for adolescent girls that has resulted in apathy by demonstrated by many female adolescents.

Tools and Methods Intended to Reach Youth

Organizations have applied a variety of techniques to attempt to connect with youth to change behaviour. Different tools and mediums have been used to try and reach all aspects of Kenyan society, particularly youth. Many incorporate arts, such as music, or theatre and others use traditional media such as television and advertising to reach youth. There exist some success stories which indicate a change or impact in social behaviour:

- Social marketing and mass media campaigns have reduced the social stigma associated with condoms, which in turn have facilitated their increased availability and use. A generic "condom efficacy" behavior change campaign has increased Kenyans' faith in the effectiveness of condoms in preventing disease from 50% to over 80%.
- Kenyan musicians have come together and collaborated to write a song with an AIDS message called "vumilia" (hold on). This song passes the message that youth need to practice safer sex, postpone sexual activity and limit the number of their sexual partners.
- Films such as The Silent Epidemic and Karate Kids create scenarios for youth to see and hear about youth who have similar lives to their own. Such films initiate discussions and interactions among youth workers and youth to address the issues that affect them.
- The ABC's (Abstinence Be faithful and Use Condoms) is an extremely popular program which has been used in many countries to address HIV/AIDS. In recent years this program has evolved to ABY's: Abstinence, Positive Behavior Change among Youth. This tool is mainly used to give the youth choices in regards to sex and protecting themselves against HIV and STI's.
- Various Kenyan media outlets air short stories on sex and how the use of condoms is an effective tool for preventing HIV/AIDS. This initiative was started in West Africa where students wrote and filmed short stories on how to prevent contracting HIV/AIDS which are now aired in Kenya.
- Commercials whose main theme is "fungua roho yako" (open up and speak) are aired to encourage Kenyans to break the silence.

All these initiatives however, do not resonate adequately with adolescents and youth to effectively change their behaviour. Even when young people have the information they need it is often not enough to make them act. They also need to develop 'life skills' – the attitudes, empowerment and negotiating capacity to put what they know

into practice and to make informed choices about sex, drugs and other issues. These life skills will trigger a shift in behaviour.

The Initiative

This project, "**Effective Tools to Combat HIV/AIDS in Kenyan Adolescent Girls**" specifically focuses on awareness and strategies for HIV/AIDS prevention for the reduction of vulnerability of these women to HIV/AIDS and social stigma. Through working and focus groups, youth participate in the collaboration and development of tools such as workshop activities, social dramas, and communication materials. The tools will be further tested with other groups of adolescents.

As has been shown, girls are particularly at risk of HIV infection. More than simply additional adult generated messaging (see poster below), girls and youth in general need to feel part of the development of the messaging that they create. Street Kids International's material and tool development process promotes an approach that is respectful of young peoples' ability to make changes at an individual, peer group and community level. The approach promotes a shift away from the worker as 'expert advisor' and youth as 'dependent client', to a relationship that respects young peoples' ability to articulate their own reality and define their own goals and objectives. This shift is more than an ideological nicety: it reflects the practice-based wisdom that to successfully engage street-involved youth, helping professionals have to move away from traditional and self-satisfied ideas that "youth are hard to reach" towards a more self-critical idea that even institutions like their own are "hard for youth to access". Street-involved youth have already rejected the central role of adults in their lives and need to be engaged through a process that blends respect for self-determination with individual accountability and access to information.

This approach to tool development enables youth to be critical actors in the development of the content as well as the medium. They know the pressures, realities and what messages are critical to have known to their peers. Instead of being seen as the recipients of messages, youth and in this case, adolescent girls can been seen as vital resources who will assist health and education institutions in accessing a population which is often left behind.

Creating and Disseminating the Tools

The process of developing and disseminating the tools needed to help young women have choices and the ability to make healthy decisions include:
   1) Engage young women in the creation and dissemination of the message
   2) Engage schools and other centres for youth (e.g. drop in centres in communities)
   3) Help young women learn the necessary 'life skills', and empower them to be able to make the right choice
   4) Engage institutions including schools, government ministries, health care providers to prioritize the importance of getting accurate and meaningful messages to youth

5) Establish and support local health centres that are accessible to young women and understanding of their needs
6) Engage local/national media to be a vehicle for the messaging.

Both AfriAfya and Street Kids International believe that adolescent girls themselves must play a role in the development of messaging for their peers. Through several studies both in Kenya and in other East African countries the approach to disseminating the message as well as the content of the message are equally important. A study carried out in Uganda on adolescents and reproductive health services recommended the following for effective reach to adolescents:92

- Gear STI and HIV/AIDS education efforts towards adolescent realities and acknowledge their sexual activity
- Promote education and counseling to address negotiation skills within relationships from a gender-sensitive perspective using real-life situations
- Address the different needs of adolescents not yet sexually active, as well as those who are sexually active
- Make condoms accessible to adolescents and promote their use with males and females
- Test models for providing reproductive health services that are affordable, accessible and accepted by adolescents, including HIV testing

The tools for the project **"Effective Tools to combat HIV/AIDS in Kenyan Adolescent Girls"** applies the lessons learned from organizations who have tried different tools to connect with youth, as well as Street Kids International's steps to tool development to engage the active participation of adolescent girls. The tools for the collaborative project between Street Kids International and AfriAfya are being created to address this stigma with education. These tools will be created using the ideas and messaging developed by youth. They include not only content about HIV but more importantly, the role of empowerment, relationships and self-confidence in being able to give adolescent girls the ability to play a more active role in the controlling their lives.

The tools are being developed with three groups of urban and rural young women. The tools include: 1) an audio program including songs, written and depicted by adolescent girls; 2) a CD of activities to be used in schools developed by university and high school girls; 3) a series of stories written and illustrated by rural adolescent girls about their experiences with relationships and sexuality. These tools will be developed over the next few months and tested with other communities of adolescents and youth. They will then be finalized and published for wide distribution in 2008.

---

92 *Access to Reproductive Health Services: Participatory Research with Adolescents For Control of STDs.* Pacific Institute for Women's Health

Recommendations

Education represents the best opportunity not only for delivering crucial information on HIV/AIDS, but also for chipping away at the ignorance and fear that perpetuate stigma and discrimination, and while some institutions are beginning to see the value and importance of treating youth as active agents in their lives, there is still a way to go. Institutions such as government ministries, schools, often feel that they are already playing a role in impacting the spread of HIV. As an example under the recommendation of the Kenyan Ministry of Education sex education was introduced in some schools starting from primary school. This new step has however been met with much opposition because some people feel it promotes sexual promiscuity.

These institutions, including community clubs need to recognize that they have a significant role to play in reaching youth about HIV/AIDS. Applying both informal and formal education and learning opportunities will address the various needs of both in school and out-of-school youth. While there is a place for formal institutions to inform youth and create opportunities for youth to informal themselves, Street Kids International has seen the value of informal education which is based in the experiences of youth themselves. Using informal education techniques including peer education will often mean the difference between youth acting on what they learn or not.

Moreover, youth need affordable, 'youth-friendly' health services that are sensitive to gender issues and provide voluntary and confidential HIV testing and counseling, along with condoms and treatment for other sexually transmitted infections. VCT (voluntary counseling and testing) centres have made it easier for young people to access information without being discriminated against in hospitals. In past years some doctors and nurses have disclosed a patient's HIV/AIDS status openly in front of hospital staff and without patient sensitivity. VCT centres and youth friendly clinics provide an outlet to gather accurate information without stigma and discrimination

Providing youth with the self-confidence and empowerment to make their own decisions is essential in order to offset the power dynamic that often renders them unable to play an active role in their sexual life. This active engagement with youth will also enable them to build the life skills to be able to take control over their lives and ensure a healthy life and future.

4.13. The SDH in the context of EU migration control policies

Discussing the social determinants of health can't be without addressing more and more stringent EU migration control policies. Through the years it has become clear, that the paradigm on migration is about control and regulation, partly as a result of perceived increasing migration flows towards Europe, changing attitudes and policies after 9-11 and the growing attention for national and regional security issues.

Within the EU, migrants are often subjected to precarious working and living conditions. Information on the scale of the problem is still lacking. However, while the skilled migrant is welcomed and the legal migrant has some social and health security privileges, the illegalized migrant is withheld from any civil rights and subjected to stigmatization, "razzias", isolation and deportation. Therefore in the light of current EU policy, it can be argued that a distinction is made between those migrants that can be of benefit to the state, while excluding and labelling the others as the "unwanted" or surplus humanity[93].

Since April 2001, Dutch migration policy aims at the "voluntary" return of migrants who have not qualified for a residence permit. Half open or completely closed "vertrek-centra" (VC) (detention and departure-centres) have been established for facilitating the return of these illegalized refugees and migrants. In principle, in Europe the Refugee Convention is respected and the right to seek asylum is acknowledged. Europe has also adopted the so-called Qualification Directive, spelling out a common definition of who qualifies as a refugee. However, it is worthwhile noting that many of the "residents" of these detention and departure centres still have ongoing asylum procedures.

VC Ter Apel is such a half-open centre that continues to be active under the current legislation, and where individuals and families are housed together in barracks. Daily or twice daily stamping, being situated in a sparsely populated area and needing permission to leave the municipality, deprives them of any free movement. Visitors have to register. Audio-visual press is not allowed on the site. Economically, the "residents" get a limited allowance, from which installed fines are withheld. Not stamping for a day will get you a fine. Children going through loops in the fence will have their parents be fined. Working is not allowed, and there aren't any real activities on the site.

Since 1992, with the introduction of the so-called "Koppelingswet"(Coupled Law), illegalized refugees and migrants are withheld from any social and health security. This also counts for the people in VC Ter Apel. During a small uprising a young woman had slit her pulses. Instead of immediately taking her to hospital, she fainted inside a police cell still being handcuffed. Occasionally there is a doctor, who is being referred to as "doctor paracetamol". Children up to the age of 18 years have to go to school, even when illegalized. But in VC Ter Apel, school is just a way of

---

93 Marrus M., 1987. The Unwanted: European Refugees in the Twentieth Century.

passing time. When children ask their teachers why they don't teach them real subjects like Dutch language, mathematics, physics, the standard reply is that they have to return anyway, so it is not very useful to them. Everything is focused on "voluntary" return to the country of origin. So if people do not cooperate, they are sent on the streets or into detention for refugees. In this process there is an important role for the IOM (International Organization on Migration), which claims it can "help" people, when they have the right papers. In practice many persons have lost their passports or papers and they have to turn to the embassy of the country of origin, which equals for many "entering the lions' den". However, refusing to go implies that "not cooperating accordingly". Some people, who went to the embassy, have been confronted with remarks like, "we know who you are, and we know you still have family over there"[94] .

In the end individuals and whole families are transported in closed white vans towards the so-called detention centres. One of them is Detention enter Camp Zeist. Not just from VC Ter Apel, but also directly from the streets, from the workplace, from their houses, or even from their favourite bars people are picked up in "razzias".

Because of the recently installed obligation of identification in the Netherlands, being illegal is a crime. Apart from being convicted for a crime (sanctioned by over three years of imprisonment), people who structurally fail to meet the duty to "check in" (or "to report themselves") and whose presence in the country is illegal can be declared "unwanted". This h can lead to confinement for years. Detention of illegal immigrants is criminalizing and deprives 'innocent' people from their freedom. Also, there is much critique on the absence of any time limit (contrary to procedural arrangements in criminal law, that set maximums) and on top of this: judicial review is limited.

Camp Zeist originally confined only women, but soon after men and children where being detained there as well. Although the European Court of Human Rights[95] has condemned Dutch migration policy and the fact that refugees and migrants are being returned to unsafe areas, this has not influenced current practice. Defence of Children, Human Rights Watch[96] and the UNHCR have pleaded. The Netherlands to stop violating the rights of children. Inside Camp Zeist children have marginal freedom of movement, are confined in their cells for 16 hours a day, they lack a room to play or express themselves in, don't go to school, and have only 2 hours a day in the open air; a space confined by four walls. Judicial and medical aid is almost non-existent inside Camp Zeist. Occasionally refugees and migrants see their lawyer. While according to estimates of MOA (medische opvang asielzoekers, medical support asylum seekers) 80% of refugees suffer from mental health problems,

---

94 Werkgroep Vluchtelingen Vrij, 2005. Zwartboek VC Ter Apel.
95 European Court of Human Rights, 5th July 2005. Ruling that Dutch policy went against article 3 of the Convention on Human Rights.
http://www.worldlii.org/eu/cases/ECHR/2005/461.html and again in January 2007. Ruling that a Somali can't be deported, because he belonged to a minority.
96 Human Rights Watch ao, http://hrw.org/english/docs/2003/04/09/nether5528.htm and Humanity in Action,
http://www.humanityinaction.org/docs/Page,_Bogaerts,__Pascual_Alvarez.doc

structural health care is not provided. As visitors are only allowed by personal invitation, people that lack personal social networks, also continue to suffer from isolation[97].

Since February 2003 EU policy has gradually towards a focus of migration control on the borders of the EU and in the regions that produce refugees. The latter has led to, highly militarized, interventions in regions that produce refugees, to contain them and to realize their return. The former has to do with the creation of a "global network of safe havens", or "regional protection areas", that might be set up just on the outer borders of Europe. Not only to prevent people from crossing the borders, but also as "safe havens" to which refugees already inside the EU can return to. Many, including UNHCR, welcomed this concept. In practice, however, these "protection areas" are often nothing more than militarized detainment camps, with poor housing and hygiene, bad ecological circumstances and low food and health security, which prevent any free movement and lack possibilities for community building, that might lay the basis for any form of a self sustained subsistence way of living[98].

Never before have the Spanish colonies Ceuta and Melilla on the North African mainland played such a big role as frontiers of this policy against refugees and migrants. The fences around them have been raised and guarded by military; barbwire has been extended, movement sensors being placed and infrared cameras installed. Inside the colonies the police is hunting down refugees and migrants.

Viewing the above mentioned, there is an urgent need for the protection of human rights and a human migration policy. Attention should be given to the rights and the lack of entitlements of illegal migrants in Europe, as well as the situation at Europe's outside borders. However, some have argued that a defensive migration policy critique based on human rights arguments falls short, "because it mystifies the aspect that European migration policy portrays just a facet, which upholds the global order of inequality from which the wealth of the Metropole is sustained"[99].

A social determinants approach of health clearly implies the struggle for political and social rights for ALL, not depending their status. This calls for a broader than already existing network of solidarity groups, human rights groups, other civil society organisations, Unions and individuals that work together with refugees and migrants, their self-organizations and the people in the countries of origin, to achieve these goals.

---

97 Komitee Sluit Kamp Zeist 2007. Sluit Kamp Zeist, geen Nieuwbouw. Brochure.
98 Gunâer C. 2005. Chronologie der EU Lagerpläne: der europäische Krieg gegen Flüchlinge. In: Ausgelagert by Flüchtlingsrat and FFM.
99 Vogelskamp D., September 2004. Krieg gegen die Armen, discussionpaper.

4.14: Health and early childhood education in Cuba
   (Prepared by Alfredo Tinajero)

Basic early childhood indicators and services

Cuban infant mortality and under-five mortality rate are comparable with those of North America and Western Europe. Cuban percentage of infants with low birth weight equals the percentage present in Canada (UNESCO, 2006). Interestingly, these indicators improved during the special period.

TABLE: BASIC EARLY CHILDHOOD INDICATORS

	Cuba			Latin America & Caribbean	North America & Western Europe	Arab States	East Asia and the Pacific
	1960	1990	2000-2005	2000-2005			
IMR	39-62	11	6	26	6	49	35
U5MR	50-87	13	7	35	7	65	44
% of Infants low birth weight		8	6	9	6 (Canada)	15	7
% under 5 moderate/ severe underweight			4	7		14	15

At the beginning of the revolution *early child development* (ECD) services in Cuba were almost inexistent. In the year 1961 the program *Circulos Infantiles* was opened to provide service to children of working mothers. The number of *Circulos Infantiles* increased rapidly, from 37 in 1961, to 832 in 1980 (Dirección de Estadísticas Sociales, 2002).

In 1985 Cuba introduced the program *Educa a Tu Hijo* (Growing-up with your child), a non-formal, non-institutional, community based, family centered ECD service which is under the responsibility of the Ministry of Education (Preschool Education). Program *Educa a Tu Hijo* operates with the participation of the Ministries of Public Health, Culture, and Sports; the Federation of Cuban Women; the National Association of Small Farmers; the National Committee for the Defense of the Revolution; and student associations. This extended network includes 52.000 "Promotres" (teachers, pedagogues, physicians, and other trained professionals), 116.000 "Executors" (teachers, physicians, nurses, retired professionals, students, volunteers), and more than 800.000 families.

During the 90´s *Educa a Tu Hijo* was extended to provide service to a larger sector of the population. In the year 2000 ECD services in Cuba reached 99.8% of the population ages 0-5, becoming the highest enrolment rate in the world.

TABLE: HISTORIC INCREASE OF ECD SERVICES IN CUBA

	Description	1970	1980	1993	2000	2005
Circulos Infantiles	Ages 15 days to 5 years	4.4%	9.4%	27.5%	16.63%	15.5%
Pre-escolares	Ages 5-6	ND	ND	32%	13%	15%
Educa a Tu Hijo	Ages 0-5	-------	-------	40.5%	71%	69%
Total Coverage		4.4	9.4%	48%	99.8%	99.5%

TABLE: AGE OF ECD ENROLMENT100 101

Age ECD Enrolment	Cuba102	Denmark (year 2000)	Finland (year 2003)	Sweden (year 2005)	Norway (year2003)
0-1	99.8%	12%	1.3% 103	---	---
1-2		83%	27.5%	45%	48%
2-3		85%	43.9%	86%	
3-4			62.3%	91%	77%
4-5		93%	68.5%	91%	84%
5-6		92%	73.0%	96%	87%

Primary and Secondary Education

Cuban children present a low-grade retention in primary school, a high survival rate to last grade of primary school, and a high gross enrollment ratio in secondary education. Interesting, pupil/teacher ratios in primary and secondary school are low, and GDP investment in education is higher that that of the regions and countries presented.

The First International Comparative Study of Language, Mathematics, and Associated Factors (UNESCO, 1998) indicates that third and fourth grade Cuban students significantly outperform their counterparts of other Latin American countries in test of Mathematics and Language. The study also found that Cuban children are less likely than their Latin American counterparts in being engaged in school fights.

---

100 OECD (2006). Starting Strong II. Early Childhood Education and Care.

101 OMEP (2005). Early Childhood Education for Children 0-3 years old in Europe.

102 UNESCO (2006). Strong Foundations. EFA Global Monitoring Report 2007.

103 Valimaki, A.L., & Lindberg, P. (2004). Early education and care in Finland. Childcare in a changing world.

The results of the UNESCO study can be explained in terms of the characteristics present in the Cuban education system (sustained investments, consistent policies, professional high status teachers, low cost-high quality instructional material, system-wide evaluation, and a link between schools and work) (Gasperini, 2000); in terms of the social capital present in Cuban society, which provides children a "safety, health, and moral support needed to function well in classroom environment", thus influencing the amount of learning that takes place in school (Carnoy, 2007); and in terms of the early child development programs, which as we have seen, are comprehensive and universal. A follow-up of *Educa a Tu Hijo* showed that 87% of children participating in the program present satisfactory results in different developmental areas (motricity, cognition, social-personal, and good habits-hygiene-culture)104.

Health services
As Table indicates, Cuba has more physicians and certified nurses per inhabitant than Chile and Finland. This large number of health professionals is crucial for the operation of the Cuban health system, which is universal, starts before birth, is preventive, and works hand-in-hand with families, communities, ECD units, and the education system.

Remarkably, during the "special period" the central government not only maintained its high investments on health and education, but increased them. Indeed, it was during this period that program *Educa a Tu Hijo* extended, helping increase the total ECD service to 99.8% of children 0-5. The sad part of the story was that between 1990 and 1995 daily per capita caloric intake dropped 25%. In 2003 Cuban daily caloric intake was back to normal105 (PAHO, 2006).

Cuba's health services are organized hierarchically into six levels: Nation (quaternary care), Province (tertiary care), Municipality (secondary care); and Area, Sector, and Neighborhood (primary care). At the neighborhood level, family doctor and nurse teams assume responsibility for a group of people. At the same time, local self-government units promote social involvement and encourage residents in protecting their own health (Iatridis, 1990). This simple although highly effective design allows Cuba to offer health services to 98% of the population (PAHO, 2002).

Conclusions, lessons and comments
- Cuba overcame the special period without renouncing what might be the nation's first value: Child development. As a lesson to the world, GDP investment in health and education not only remained high, but was increased during the special period.
- Indicators of child and human development are comparable with those of developed countries.

---

104 UNESCO (2006). Cuba: Programas de atención y educación de la primera infancia (AEPI). Compilado por la Oficina Internacional de Educación de la UNESCO (OIE), Ginebra, Suiza.
105 Interesting, in 2002, 88% of daily caloirc intake came from vegetable products, and 12% from animal products (Encyclopedia Britanica, World Data).

- Cuba posses an extended social network which supports and benefits child development. The State generates social capital.
- Health and education services integrate into a single system which favors health, learning, behavior, and life trajectories during prenatal life, infancy, childhood, and adolescence.
- ECD services start early, are universal, and are conducted with the participation of different Ministries, social organizations, families, and an extended social network.
- The Cuban economy and health and education services face the problems of globalization. The country experiences a growing double economy, arising from tourism and private business operating locally. In addition and as a result of Cuba's global health diplomacy, more than 2.900 Cuban physicians have joined health campaigns worldwide (Keck, 2007), reducing the number of family doctors on the island.

Will Cuba be able to sustain the quality of its health and education system?

4.15: Gonoshasthaya Kendra -- Bangladesh:
Pioneer in Rural Health Care Delivery

The founders of Gonoshasthaya Kendra (GK) had participated in the liberation struggle of the then East Pakistan (now Bangladesh) against Pakistan in 1971. They built a 480 bed makeshift hospital at the border of Tripura state of India and Bangladesh called *Bangladesh Field Hospital* to treat wounded freedom fighters and refugees in India from Bangladesh. Except 5 doctors and few medical students, none of the other staff working as ward Nurses, Operation Theatre (OT) assistants and laboratory technicians had any previous training or experiences of health care delivery. They were young women with ages between 16 and 25 years and varying levels of education. All staff including doctors, medical students, nurses and technicians worked voluntarily.

After the independence of Bangladesh in December 1971, some of the volunteers of Bangladesh Field Hospital formed Gonoshasthaya Kendra GK to provide health care to rural communities as part of the national effort to rebuild the war torn country. GK started its work with the motto *Gramey cholo, gram goro* (Let us go to the village and build the villages). Gonoshasthaya Kendra (GK) is a Bangla phrase meaning Peoples Health Centre. *Gono* stands for people, *Shasthaya* means health and *Kendra* for centre i.e. Peoples Health Centre. GK started its first pilot project in April 1972, in Savar *upazila* (*upazila:* an administrative unit*)* in Dhaka district.

GK: The Early Days

GK started its programme near Nayarhat, Savar – in the form of a clinic and treatment centre working out of two large tents. Soon it was clear that the clinic was able to achieve very little. Very few women and children were among those who attended the clinics. Women, in the conservative environment of post-liberation Bangladesh, were not encouraged to move out of their homes.GK changed its strategy and decided to take primary health services to the doorstep of the poor people. It was also clear that such a large coverage would not be possible only by depending on doctors. The initial team working with GK tried to motivate local people to work for health services for their own community. It was a great challenge for them to bring out those village girls from their houses and train them as health workers. Most of the early trainees had very little formal education. These volunteers had been trained particularly on primary health care. Thus, a group of experienced human resources were built up to work in rural areas to provide primary health care services and they were GK's earlier health workers. Today trainee health workers need to have a secondary school certificate! By 1973, GK trained paramedics had learnt use of a microscope and could perform basic blood, stool and urine investigations. They could also perform first trimester abortions and minor surgical procedures.

Evolution of GK

In the 1980s, GK extended its attention to reduction of maternal and child mortality. The familiarity and acceptance of GK paramedics at village level and in the clinic was tremendous. One thing is important to underline -- GK has always attempted to train TBAs and village doctors instead of antagonising them. In those days GK was the only quality health service provider in the programme area, there was no private clinic and there was hardly, any existence of government health care facility. Subsequently, GK expanded into the area of primary education for the poor and destitute children. GK also started its adult education and vocational training for poor women.

GK has come a long way since 1972, both in terms of Programme coverage and achievements. During the last three decades and a half, it has increased its basic health care coverage, including reproductive and child health care, from serving about 50,000 populations in 50 villages in 1972 to now over one million populations in 592 villages geographically spread across the country in 31 unions of 17 *upazilas* in 15 districts. GK is now one of the largest service providers in the health sector outside of the Government of Bangladesh.

GK also offers a locally organised *'Gonoshasthaya Bima'* *a* community based cooperative Health Insurance scheme. Under this scheme, all clients, irrespective of their socioeconomic status, are entitled to receive the same basic primary health services, whilst the premium amount is based on a sliding scale depending on their socioeconomic status. GK also runs a continuing training programme for TBAs to upgrade their skills to become *Trained* Traditional Birth Attendants (TBAs). GK health workers link with the TBAs to ensure an effective referral system. A routine Demographic Surveillance System is also in place.

GK is known for its advocacy role on many issues and its innovations to promote gender equity. GK recruited young female paramedics in the early 1970s and trained them to ride bicycles through the villages, which was contrary to the then village tradition and norms. GK promotes recruitment and training of women in different skills especially in non-traditional vocational trades such as carpentry, welding, electrical work, boiler operation and vehicle driving with a view to break down traditional barriers and expand job opportunities for women.

GK was instrumental in persuading the Government of Bangladesh in 1982 to adopt a National Drug Policy (NDP) in line with WHO's concept of essential drugs, which led to the banning and withdrawal from the market of approximately 1800 unnecessary and/or harmful drugs.

Presently, GK runs **two 150-bedded hospitals** - one in Savar and another in the Dhanmondi area of Dhaka city. GK has 2 other rural hospitals with 30 beds each, and all other centres run by GK have 5 hospital beds where patients with severe diarrhoea, respiratory infections, simple fractures, abortion complications and difficult delivery are admitted. GK had started a community oriented medical college (Gonoshasthaya Institute of Health Sciences) in 1998 through its own University

called *Gono Bishwabidyalay* (People's University). Gonoshasthaya Institute of Health Sciences also runs undergraduate courses on Physiotherapy, Microbiology, Pharmacy and Paramedical courses. GK also runs a **Pharmaceutical manufacturing unit – GK Pharmaceuticals** -- in its campus at Savar, that produces quality generic medicines which are essential.

GK was honoured in 1978 with highest national award 'The Independence Day Award for 1977', for its innovative family planning and primary health care programme. Dr.Zafarullah Chowdhury -- Project Coordinator of Gonoshasthaya Kendra was awarded the Magasasay Award in 1985 for community leadership and GK's contribution in Bangladesh National Drug Policy (1982).

Anchoring of GK Program within the Local Community

Today GK provides health services at the village/community level through a cadre of village based trained health workers -- mostly young women. females and have passed SSC (Secondary School Certificate) examination in science. GK's health workers work in tandem with a senior to visit a village every month and carry simple medications with them. The salary of a paramedic is comparable to her counterpart in the Government sector. But the GK paramedic has much more opportunity of improving her skills in diagnostic work in the Pathology Laboratory, in the Operation Theatre, in X ray/ Ulatrasonography. Most importantly, a paramedic gets up to 2 years study leave with full pay in order to improve her general education. But her/his real incentive to work with GK mostly stems from prestige and better future earning potential associated with being an ex-GK worker.

Transparency & Accountability in Service Delivery : Two-way Accountability

Paramedics are primarily answerable to local Gonoshasthaya Health Committee as well as to their field level and central level supervisors. Paramedics organise a meeting in the presence of the Chairperson and members of the Village Health Committee to discuss possible causes of maternal/neonatal death and explore whether or not this death could have been avoided by overcoming lapses of the health worker and/or of family of the deceased person, and if so, how? This has a huge social awakening impact. No such rigorous social auditing of maternal and infant deaths is performed at the national level.

Beyond this village level social auditing, all GK field level health workers, ranging from village level paramedics to their immediate supervisors, have to independently prepare detailed case history and submit reports to their respective manager/director within 72 hours, preferably within 24 hours explaining why the maternal and neonatal/infant death could not have been prevented. Health-in-charge or Manager of the concerned GK Health Sub-centre will verify the reports submitted by GK paramedic and his/her supervisor through field visit and share his/her observations with the field workers and submit the investigation report within the next seven days to higher authority. A GK doctor attached to its Union level Health Sub-centre also investigates the death reports submitted by GK field staff on random selection.

Community and Local Government Participation in Health Service Delivery

GK underscores the importance of decentralisation and community participation in decision-making on all critical issues affecting the quality of life, including health. Pursuant to this motto, GK ensures village/community participation in health service delivery through constitution of a Gonoshasthaya Health Committees. Gonoshasthaya (Union) Health Committee consists of:

Elected female UP members	3
GK Staff	2
TBA	1
Donor (of the land on which the GK health centre is built)	1
Priest	1
Representative from ultra poor and poor households	1
Other Members	2-4

Social Health Insurance: Poor Centred

In an effort to increase the accessibility and utilisation of basic health services at an affordable cost to the villagers, in particular the poorest of the poor, GK has introduced a social health insurance scheme that covers most villagers' basic health costs. Under this insurance scheme, premium rates vary with income.

Integrated Package of Health Services

GK provides an integrated package of health services, in which basic primary health services including reproductive health, child care, family planning and elderly services are provided to all concerned population under its programme coverage areas through its village/community based health workers and secondary and tertiary level care through a strong referral linkages to both GK and Government hospitals. In this effort to promote nutrition education, GK organizes *Bou-Shasuri* (Daughter-in-laws and mother-in-laws) meetings 2-3 times in a year in different programme villages.

Not a Substitute for the Government Health Sector

GK is not in competition with the Government. It role is to supplement the public health system of the government. GK's primary focus is to work with the Government, so that its innovative schemes, if found result-yielding, can easily be adopted by the Government.

GK Hospitals

Gonoshasthaya hospital at Savar is a referral hospital for integrated community based health care services. It has 150-beds and also used as training hospital for internee doctors qualified from *Gonoshasthaya Community Based Medical College of Gono Bishwabidyalay*. *GK Hospital, Sreepur* is a 50-bed referral hospital located at Tangra, in a remote place of Sreepur upazila, under Gazipur district. Modern diagnostic facilities, are also available here. In this hospital premises, the government has

approved its long awaited *Gonoshasthaya institute of Health Sciences* to train students working for diploma courses in laboratory medicine, Pharmacy, Radiology and Physiotherapy from 2006. *Gonoshasthaya Nagar Hospital, Dhaka* is a secondary and tertiary health care hospital, which is also the academic hospital of Community based Gonoshasthaya (Gono Bishwabidyalay is a Bangla phase which stands for People's University) Medical College of Gono Bishwabidyalay. It is a 150-bed referral hospital located in Dhaka town. All indoor facilities for pediatrics and neonatology, paediatric surgery, burn and plastic surgery, general surgery, dental surgery, general medicine, orthopedics, general Psychiatry, obstetrics care, gynecology and Eye and ENT are available in Gonoshasthaya Nagar Hospital. Out patient department (OPD), modern diagnostic facilities for X ray and Ultrasonography, General Pathology, Biochemestry, Haematology, physiotherapy, counseling, Ayurveda, Yoga and other primary and preventive essential services, and 24 hours emergency services are also available. A new cardiac unit will be made functional soon.

Training Centres

There are two major training centres of Gonoshasthaya Kendra; one is at Savar in Dhaka district and other is at Sreepur in Gazipur District. Savar Training centres can accommodate nearly 300 trainees at a time, and Sreepur training centre can accommodate 150 trainees at a time.

Community Based Organization (CBO)

GK Health Committees have the responsibility of supervising and monitoring Health activities in 592 villages. In addition to these committees there are some Community-based organization (CBOs). In over 100 villages, residents are showing interest in CBO committees. Paramedics/health workers work as a facilitator for these CBO committees. Now GK paramedics and CBO committee jointly call for mass meetings for social mapping, resource mapping, number of facilities available, in that particular village. In this meeting all general problems of the people are identified by them, Each CBO committee comprises between 9 to 17 members. Every health committee has five sub-groups i.e. child group, male adolescent group, female adolescent group, men's group and women's group. Each of these groups identifies the problems usually faced by their peers; they also identify their common needs to be solved.

5. Conclusions

Principals that this report embodies

We present this report to the Commission with the following principles guiding it:

- Health is An inalienable human right guaranteed by the United Nations and signed by all governments around the world more than six decades ago.
- Health is not a commodity but a public good.
- As defined by the WHO in its charter, health is a complete state of physical, mental and social well being and not merely the absence of disease.
- Accordingly, the attainment of health, does not revolve around bio-medical curative interventions alone, but basically on comprehensively addressing the structural social determinants of health including, but not limited to factors such as food security, safe water, sanitation, housing and working conditions.

The major factors that hindered and continue to hinder the attainment of this goal and that increase the gap between people are the ruling neoliberal paradigm of development led by and reflecting the narrow interests of the rich, of transnational corporations and of financial capital.

More than 150 years ago, Virchow, the father of public health, said that health is politics on a large scale. We too believe that the attainment of health can only take place if the necessary political will is mustered --and it is only through political action on the part of the masses and global decision makers that these issues can be addressed. **The attainment of the above goals cannot be achieved without policies that aim, in the end, to reverse the policies that reproduce the neoliberal framework.**

We welcome the revival of the concept of Primary Health Care as declared by WHO in its 60th WHA session. However, to be successful, such an approach must be seen in the context of comprehensively addressing the Social Determinants of Health. Accordingly, we stress the importance of reviving the spirit and basic principles and values of the Alma Ata Declaration, and stress the responsibility, in 2007 as much as before, of governments to provide health for all.

Specific recommendations

We strongly suggest that the Commission makes specific recommendations -- addressed to WHO, as well as to public and global institutions and country governments-- that address key issues, backed by the considerable evidence it has been able to harness since its inception, in the following areas:

- Clearly declare that health is not a commodity to be purchased in the marketplace and neither is it an item that should be traded.
- Promote physical and economic access to health care and to medicines by suggesting changes in the present framework on global trade. Specifically, suggest that the TRIPS Agreement and the General Agreement on Trade in

118

Services keep matters related to health --including medicines and health services-- out of their respective purviews.

- Call for the reversal of unequal terms of trade embodied in the WTO.
- Encourage countries to selectively delink from the global economy , especially from global financial markets, when required, in order to secure the interests of the poor and the marginalized.
- Promote real debt cancellation and not just transfers from one account to another to reverse the unacceptable situation where the world's poorest countries still pay back more than what they receive
- Promote a system of agriculture that places food security and food sovereignty of the poorest nations at its core.
- Working with trade unions and political parties, promote a global consensus that reverses the trend towards non-secure and casual forms of employment.
- Promote a global consensus so that country governments adopt laws that prevent all forms of violence against women.
- Suggest concrete measures to address climate change and environmental degradation and their effects on the equity gap.
- On top of promoting the peaceful resolution of conflicts, ensure protection of populations, health workers, and infrastructure in situations of conflict and war.
- Once again secure for WHO the leading role at the global level in health policy making.
- Most importantly, recognize that structural changes in the world's political and economic architecture are indispensable in order to make a meaningful changes in the current health inequities.

The report that we present to the Commission suggests that things can change for the better. A series of case studies, collected as a companion to this report, are indicative of ways to move forward. The Cuban and the Brazilian experiences show that health systems can be made to work for the people, if premised on the principles of a comprehensive care that is accessible to all, irrespective of the capacity to pay. The examples Gonoshashthya Kendra in Bangladesh, the Literacy Campaign in India and the growing Global Right to Health Campaign of the People's health Movement are examples of the power of Civil Society to change situations. The case studies from Africa on Female Genital Mutilation and Rape as an instrument of hegemony, the Case studies on Social Exclusion from Kenya and Bangladesh, and the case studies from the Eastern Mediterranean on the brutal side of war and conflict are reminders from Civil Society about the magnitude of changes that need to be brought about. The Case Study from Europe on migration policies brings out the fact that for all the rhetoric about a globalised world, some privileged people continue to be more equal than others. We do hope that the Commission shall prove to be consequent and committed to the enormous task it has set for itself.

A Global Movement for an Idea Whose Time Has Come

Finally, looking forward to the Commission's Report itself and issues around its promotion, Civil Society strongly supports the vision of a global movement around the Commission's report. But for that to happen, people around the world must see

themselves reflected in the Report in a way that they see the story of their lives being told in the Report. This is important because the Report must inspire people to be part of the movement. CS will be fully supportive of such a movement modeled around its concerns as reflected in the report.

We realise that the final product from the Commission will be a "negotiated" document. We would thus like to underline that if it is negotiated to please everybody, it will please nobody (or say nothing). There is a very large constituency waiting to embrace a report that clearly defines the root causes of health inequity. Today, a majority of countries and communities (the poor and the disadvantaged, comprising the majority of the globe's population) are starting to say "enough is enough". The global compact built using a neoliberal ideology and being promoted by most rich nations and multilateral agencies is starting to fall apart.

The Commission's work has the potential to bring to the fore an idea whose time has come --an idea that can grab the imagination of people across the globe. Civil Society welcomes the Statement's intent to involve it in the global campaign and believes that there are movements waiting to embrace the idea. We hope that the Commission will be unhesitating in realising the full potential and dimension of this idea.

Existing Covenants Relating to Right to Health

The Universal Declaration of Human Rights

Article 25 of the Declaration states: *"Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are entitled to special care and assistance..."*

International Covenant on Economic, Social and Cultural Rights

This covenant includes the Right to Health, covered by article 12: *"The states parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*

This right has been elaborated upon and clarified by the **General Comment 14** of the UN Committee on Economic, Social and Cultural Rights, adopted in the year 2000: *"The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation",* Recognition of the right to health or legislative implementation is absent in India, hence this obligation remains unfulfilled.

"..and to adopt a national health policy with a detailed plan for realizing the right to health".
No such plan exists in the National health policy 2002.

"States must ensure provision of health care,"
Gross deficiencies in provision of health care by the Government have been described in the previous section..

"...including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions."

"Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas."
India's high maternal mortality rate at 408 per lakh live births, poor coverage of antenatal and delivery services indicate large scale violation of this right.

"States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country."

There are large scale inequities in availability of doctors and hospital beds between urban and rural areas as shown below

The General Comment 14 also clearly specifies certain **Core obligations** of states related to the right to health:

"43 … States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care."

"(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;"

"(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;"

"(e) To ensure equitable distribution of all health facilities, goods and services;"

"(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups."

The General comment 14 has clearly specified 'Violations of the obligation to fulfil' as follows:

"52. Violations of the obligation to fullfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates".

"56. States should consider adopting a framework law to operationalise their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action"
Needless to add, no such legislation or framework exists in India.

United Nations Convention on the Rights of the Child
Article 24 of CRC clearly mandates the right to health and health care for children:

Article 24

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

"2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:"

"(a) To diminish infant and child mortality;"

"(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;"

"(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;"

"(d) To ensure appropriate pre-natal and post-natal health care for mothers;"

"(e) *To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;"*

"(f) To develop preventive health care, guidance for parents and family planning education and services."

Summary of Civil Society work with the CSDH in different regions

Asian Region

The Civil Society facilitation in the Asian region is being co-ordinated jointly by the Peoples Health Movement **– India (Jan Swasthya Abhiyan) and the Asian Community Health Action Network (ACHAN).** The countries being targeted for civil society work in the region include **India, China, Bangladesh, Nepal, Sri Lanka, Indonesia, Thailand, Cambodia, Vietnam and Malaysia**. A co-ordination mechanism involving the facilitators for the region and country co-ordinating mechanisms is in place.

The First Phase of CS work with CSDH, emphasized on a mapping of:

1) Civil Society in the region with potential to participate in the process of working with the CSDH
2) Civil Society concerns and opportunities perceived in the process of working with the Commission
3) Civil Society perceptions regarding identified Social Determinants
4) Identification of SDs of key concern in the region/country and their prioritisation
5) The social and political contexts in which specific determinants were of importance, as well as the broad socio-political milieu of the countries in the region
6) Entry points and obstacles for CS engagement with the CSDH
7) Forms of CS engagement with the Commission's work
8) Identification of CS work that requires documentation with a view to be an input into the Knowledge Networks
9) Identification of CS work that merits upscaling and linking up within the framework of CSDH country work

Towards this end a regional meeting in Bangkok and country meetings were organised to facilitate the exercise. The regional meeting in Bangkok led to the identification of country contact persons and focal points for co-ordination of the process at country level. The meeting also helped prepare a broad structure for discussions among CS on engagement with the CSDH, and helped plan country level activities designed to take the process forward. The country meetings were preceded by extensive consultation with CS organisations and involved dissemination of information about the CSDH and suggestions regarding ways in which CS could participate in the Commission's work. It may be underlined here that the consultations held with CS in these meetings were a culmination of a process that included sensitisation of CS on the Commission's work and the meetings were designed to take forward CS engagement with the Commission's work.

The regional and country consultations were designed to discuss and develop the following:

ii) Developing a national situation analysis/political mapping of civil society action on SDH. Discussions will bring out:

   (a) Socio-political situation with respect to key determinants, based on country and local experiences

   (b) Priority assigned to specific SDH, including those identified for CSDH Knowledge Networks and others

   (c) Multiple roles and modes of action of civil society (viz. participatory action research; political mobilization and action, lobbying and advocacy; service delivery)

   (d) civil society goals around SDH and planning for processes/ mobilisations

   (e) major obstacles anticipated

   (f) entry points for most effective intervention of Civil Society

   (g) long-term view of working with the CSDH

iii) Regional and country level strategy for civil society work with the Commission on Social Determinants of Health. Planning for and identifying:

   (a) Principal foci, country level fora and areas of intervention

   (b) Strategic targets for civil society entry point in partnership with the CSDH

   (c) Ongoing work and emerging opportunities

   (d) Obstacles

   (e) Division of responsibilities, consultation and coordination of processes

Following is an overview of the consultations organised:

Nature of Consultation	Place	*Date*
Regional	Bangkok, Thailand	14-15 November, 2005
Sub-National	Mumbai, India	28-29 November, 2005
Sub-National	Delhi, India	8-10 January, 2006
Sub-National	Bangalore, India	24-25 February, 2006
National	Dhaka, Bangladesh	3-4 January, 2006
National	Kathmandu, Nepal	29-30 December, 2006
National	Jakarta, Indonesia	5th January, 2006
National	Colombo, Sri Lanka	3-4 January, 2006
Sub-National	Colombo, Sri Lanka (Plantation Sector)	
National	Beijing, China	29th December, 2005
National	Manila, Philippines	5-6 May, 2006
National	Hanoi, Vietnam	4-5 March, 2006

In addition, country level consultations have been initiated in Malaysia, Thailand and Cambodia through country contact points (as above) though country consultations are yet to be organised in these countries. The consultations have provided useful inputs in devising this strategy too. CS Facilitators in the region also participated in the

following meetings, that helped in drawing inputs and ideas to develop a CS strategy for the Region:

Meeting Title	Place	Date
CS Facilitators meeting and meeting of Commission	Ahmedabad, India	10-14 September, 2005
CS Facilitators Meeting	Montvideo, Uruguay	12-15 December, 2005
CS Facilitators meeting and meeting of Commission	Teheran, Iran	16-20 January, 2006
Consultation on CSDH for SEARO Region	Delhi, India	15-16 September, 2005
Consultation on CSDH for WIPRO Region	Beijing, China	22-24 March, 2006

Based on the consultations and the mapping of CS that was undertaken is Phase I, some major issues that have emerged, that have a bearing in preparation of the CS Strategy for the region for Phase II. These are articulated in the following section.

Mapping of Social Determinants of Importance in the Region:

While taking note of the social determinants identified by the Commission consultations in the region underlined the need to also examine some other key determinants that have a major bearing on health in the region. These include:

1) **Poverty** -- Ubiquitous in the region and possible the most important determinant of Health outcomes. However the issue of whether poverty is a determinants or a consequence of several other determinants needs to be explored.
2) **Governance related issues** -- viz. democratic norms in polity, political will, sovereign decision making space
3) **Food security** -- with special reference to child malnutrition,
4) **Natural Disasters** -- Of particular importance in Sri Lanka, Indonesia. Includes responses to such disasters.
5) **Conflicts** -- of special importance in Sri Lanka, Nepal, Philippines, Indonesia
6) **Environment**
7) **Land Relations** – The consequence of a large sections of the population engaged in agriculture having no land or very little land has enormous social and economic effects. This is of particular importance in South Asia, Philippines and Indonesia.

It was also felt that gender should also be a cross cutting concern in all Knowledge Networks, and the priorities for the region identified were: **Poverty, Globalisation, Conflict, Social Exclusion and Gender.** It was also felt that some issues that could be accommodated within existing KNs, but require adequate focus, include the following:

1) Medical Education, Brain Drain
2) Traditional Medicine
3) Maternal and Child Health
4) Risky Behaviour/ Consumption Patterns -- viz. addictions, etc.
5) Mental Health
6) Migration/ Relocation/ Job Security/sub-contracting of labour
7) Refugees/Migrant workers
8) Maternity services
9) Education
10) Privatisation of Health Care

Possible Forms of Civil Society Action/ Intervention

The consultations also enabled a mapping of action and interventions by Civil Society. These include the following:

Participatory Research
1) Need to emphasise importance of such research and bring it on par with institution based research
2) Should try to consolidate fragmented research findings available with different CSOs
3) Should draw on existing research in order to formulate effective policy, instead of Commissioning new research.
4) Translation of knowledge into policy
5) Capacity building of CSOs required in some settings to conduct such research with a degree of rigor

Political mobilization and action
Constraints:
1) In many countries, political decisions are made by the government and are controlled by particular parties in power. Even groups close to the government may not be able to influence these processes.
2) In some countries, grassroots organizations cannot exert political influence
Opportunities:
1) CSOs working with communities are ideally situated for such intervention -- even if limited by scale of community work
2) Involvement of mass based organisations in CSDH can exert pressure and lead to political mobilisation
3) Has the potential to make effective changes in public policy

Lobbying and Advocacy
Constraints
1) Groups closely linked to the government may have better access to decision-makers
2) Grassroots organizations cannot make direct advocacy to the government.
Opportunities
1) Many CSOs today involved in advocacy and their voices are being given prominence

2) Optimal results if political mobilisation and advocacy are combined

Service Delivery
Constraints
    1) CSOs can provide certain forms of services, but not all – some, by their nature, need to be the primary responsibility of the public sector
    2) CSOs do not have enforcement role and capacity to make impact at a national level
Opportunities
    1) CSOs can reach the grassroots very effectively with service delivery.
    2) CSOs can educate communities about health services, increase the demand for these services (however, the government supply may not match   this new level of demand)
    3) CSO initiatives can be used as models in the form of advocacy tools

Entry Points for Civil Society:

The First Phase of Civil Society Work identified issues related to entry points for CS while engaging with the Commission's work. Constraints and opportunities that emerged are underlined below:

Community
    1) Often the best point of entry for CSOs
    2) International exchanges can bring opportunity to share experiences and work out effective interventions
    3) CSOs may be financially dependent on donors and this might influence agendas pursued
    4) Weak human resources capacity in many CSOs

Policy Makers and Political Processes
    1) Civil society can link local communities to national and regional policy making structures
    2) Important to be conscious of impact of actors such as global corporations (for example, tobacco corporations, pharmaceutical TNCs) that exert excessive power

Health System
    1) Opportunity for CSOs working on health delivery to create models of intervention
    2) Influence on Policy making structures important
    3) Increasing global focus on health creates important opportunities – but need to prioritise use of resources that are being pledged for health as a consequence of this
    4) Donors continue to have a very vertical, segmented model of how health programmes should function

Engagement with Knowledge Networks

Tasks of Regional Contact Points (RCPs)
- Case Studies – Identification
- Case Studies – Short summaries
- Case studies – short listed and elaborated
- Knowledge Collection (papers, experiences, reports)
- Co-ordinate with Regional Facilitators
- Co-ordinate with the Relevant Civil Society Reference Point:
  - Health Systems and PPHC   -- Africa
  - Globalisation and Employment   -- Asia
  - Social Exclusions and Gender   -- L.America
  - Early Childhood Development,   -- Mediterranean
    Urban Systems and Measurement
- Peer Review of Outputs of KNs and co-ordinate with relevant KN
- Contribute to CS Report

Regional Contact Points (RCPs) in Asia for Each KN

Globalisation
Delen De la Paz, HAIN/ PHM – Philippines
Employment
Imamuddin, PHM, Bangladesh
Early Childhood Development (ECD)
Vinya Ariaratene, Sarvodaya Shramdana Movement, Sri Lanka
Gender
Aruna Uprety, Nepal
Health Systems
Sri Rahayu Wartomo, Perdhaki, Indonesia
Priority Public Health Conditions (PPHC)
Ramon P. Paterno, National Institutes for Health, University of the Philippines

Social Exclusion
Narendra Gupta, PRAYAS/ PHM-India
Urban Settings
B. Marheni Luan, STIK Sint Carlos Health Services, Indonesia
Measurement
Thelma Narayan, Community Health Cell (CHC)/ PHM-India

129

Latin America

In the framework of the initiative for participation of civil society organizations in the WHO Commission on Social Determinants of Health, which was formed in March of 2005, and on account of our long-standing work under the paradigm that health is the result of how people live and work (the social determinants of health), three civil society organizations (Latin American Association of Social Medicine, Latin American Coordination Group for Peasant Organizations, and the Network for Health and Safety at Work) were invited by the Commission as facilitators for the promotion of the initiative and with a view to attracting other civil society organizations in the process.

In our view, the convergence of interests between our background and the purposes of the Commission is an opportunity for joint effort in the promotion of the paradigm of health as a social process and a human right.

Therefore, the aforementioned organizations contributed symbolic and political capital and resumed the work previously carried out to enthusiastically join the Commission's initiative, with a view to attaining wide participation by the civil society so that knowledge is disseminated about the relations between the social dynamic and health; that gives voice to the disenfranchised, empowering them and bringing their difficulties to light; advocating their demands; as well as consolidating both our own leadership in the region and promoting the role of other social agents committed to the defense of health.

Development of the first phase of work within the Commission allowed closer association with a wide number of social organizations in the Continent through promotion of the initiative in a context of scenarios of social organizations, four national meetings and one regional meeting (see Table):

- Initiative promotion visits between September of 2005 and March of 2006, closely related to the promotional activities of the organizations.
- four national meetings within a group of previously-selected countries, between October of 2005 and April or 2006.
- Global meeting of facilitating organizations from the civil society in Montevideo, in December of 2005.
- Regional meeting in Lima, in January of 2006.
- Working meeting of the initiative group, held in Lima in February of 2005.

Latin America Civil Society – Commission on Social Determinants of Health

PROMOTION MEETINGS	
Event	**Location**
4th Congress of CLOC	Guatemala City
4th International Public Health Congress	Medellín, Colombia
Meeting of the National Movement for Health	Asunción, Paraguay
Public Health Seminar	Santiago, Chile
Commission Presentation Forum	Lima, Peru
Continental Social Forum	Caracas, Venezuela
International APS Seminar	Havana, Cuba

NATIONAL AND REGIONAL MEETINGS		
Country	**No. of Participants**	**Participating Organizations**
Nicaragua	30	7
Colombia	38	22
Uruguay	42	26
Bolivia	46	18
Regional Meeting (Lima)	43	25

As a result of our work and previous experience with SDH, as well as from meetings held within the framework of the aforementioned Commission's initiative, we submit this proposal as a second phase of the strategy for the participation of Latin America's civil society to further actions that directly affect the present SDH in the region's countries.

We can therefore state that the proposal was designed from the experience gained over several decades in our organizations as we fought to improve the quality of life and health of large social sectors in Latin America. In addition, from what has been discussed, reflected upon and agreed at the promotion forums, in national meetings, at the Lima's regional meeting and at the basic working team in March of 2006 also in Lima, where work was devoted to the consolidation of the proposal and, later, through telephone discussions and the organizations' electronic networks, it was improved until the final version was completed. This is the version we are submitting now, which reflects a comprehensive collective work based on consensus.

Regarding the characteristics of the organizations involved so far, we have:

- Health sector workers unions
- Community and neighborhood organizations
- Human rights, environment, health and social services NGOs
- Indigenous organizations
- Academic organizations
- Peasant organizations
- Women's organizations

131

- Men's organizations
- Sexual freedom organizations
- Religious basis organizations
- Students organizations
- Professional health workers and social workers unions
- Social health movements
- Human rights networks
- Ethnic minority movements: indigenous and afro-american
- Discriminated minority movements in general
- Youth groups
- Health and housing cooperative organizations
- Alternative producers
- Network of community health educators and agents

**REGIONAL MEETING OF CONSULTATION WITH CIVIL SOCIETY
ON SOCIAL DETERMINANTS OF HEALTH
Brasilia, Brazil, April 12-14, 2007**

LETTER OF BRASILIA
Minga* to reduce health inequity in the Americas

We are a coalition of social and popular movements and organizations of women, rural people, peoples of the forest, indigenous peoples and nations, communities of African descent, Roma and other nomadic peoples, gender identity and sexual orientation (GLBT) groups, territorial neighborhood organizations, union movements of workers, academics, housing activists, health service users, patients' leagues, professional guilds, and NGOs of various parts of the Americas, from Canada to Chile, through Central America and the Caribbean, gathering in Brasilia for the regional meeting of consultation on social determinants of health, convened by the Governments of Brazil and Chile, civil society organizations of the Americas, the OAS, PAHO, and the WHO, to discuss the multiple health-related issues we face and the need and importance of recognizing social determinants of health in order to overcome them.

This meeting reaffirms profound dissatisfaction with the prevailing approach to social and economic development in the Americas, an approach that, in recent decades, has gained strength through a set of neoliberal policies associated with globalization, and that must be replaced. Based on market logic, it privatizes and medicates health to the detriment of the right to health, heightens human rights violations and inequalities that lead to health inequity, weakens and impairs health and living conditions, and is entirely avoidable and unfair.

We also reaffirm that this development approach reduces the role of the state as a promoter of health, fragmenting and privatizing health systems, shrinking public health resources, emphasizing a curative approach to individual diseases.

The growth of this approach in the Americas heightens inequalities and social exclusion, as evidenced by the concentration of wealth, land, and income and the improper use of natural resources. At the same time it heightens gender inequality and discrimination for reasons of ethnicity, race, religion, and sexual orientation and gender identity (GLBT), and increases all forms of violence in both rural and urban areas, both public and private places.

It is clear to the civil society movements and organizations present at the meeting that health is a universal human right, a duty of the state, which requires a set of factors like food safety and security; decent work and recognition of the value of childbearing; adequate income; land access, use, and tenancy; sustainable management of natural and renewable resources; decent housing in a healthy

---

     ∗   Word used by indigenous peoples and nations of the Andean region, referring to a social practice of collaboration, solidarity, and cooperation in which each person, according to ability, contributes resources for the benefit of the community as a whole.

environment; democratic civic participation; universal access to education and health services that are timely, humanized, of quality, and culturally appropriate; inclusive government social policies; social relations that are neither sexist nor racist; and cultural and religious tolerance. This means that health factors and the right to health are indivisible and interdependent.

It is clear that, in order to make progress in overcoming health inequities, it is essential to devise sustainable approaches to social and economic development that safeguard human, civil, political, economic, social, cultural, environmental, sexual, and reproductive rights; that government adopt an approach that guarantees those rights; to promote sovereignty and food security to eradicate hunger from the Hemisphere, promoting agrarian reform that ensures land access, use, and tenancy, makes possible sustainable agriculture, and preserves ownership of heritage seeds, in a context of rural family farming appropriate to the climatic diversity of the region; to have urban reform that promotes better distribution of urban land and the building of socially just and environmentally sustainable cities; to democratize human cultural capital through universal access to education; to bring about participatory democracy; and to develop government policies that are intersectoral, universal, integrated, equitable, and participatory.

Accordingly, we civil society organizations meeting in Brasilia believe it is advisable to promote a common agenda concerning determinants of health that strengthens and broadens activism, autonomy, and social mobilization–at the national and hemispheric levels–to orient government and public policies toward this integrated perspective on health factors.

Therefore, we call for a civil society alliance based on the ancestral principles and knowledge of indigenous peoples and traditional communities (Minga), to restore a social practice in which we all will feel invited and committed to contribute our experience so as to strengthen action to transform determinants of health and enforce demands for health-related rights. At the same time we call upon national governments and international organizations to respect the autonomy of social organizations –according to those same principles – and to commit their initiative, action, and resources to this transformation.

As organizations present in multiple social sectors, we pledge to publicize this discussion among popular organizations and social movements in the Hemisphere, to broaden it to include their viewpoints and contributions, and to enlist their active participation in the debate and in realizing the shared agenda, building a hemispheric movement that will continue to grow.

We also call upon the region's governments and the international organizations to commit themselves to this process, which began with the establishment of the Commission on Social Determinants of Health, in 2005, and to move forward, together with civil society, in firming up policies and programs that will affect and transform those determinants. The WHO, PAHO, and the OAS, along with the region's governments, must continue to support and broaden this process, facilitating broad and influential participation by the region's civil society organizations.

Brasilia, April 14, 2007

Eastern Mediterranean Region

Current Situation

General context of the region

In 1978, the WHO jointly with Unicef organized the Primary Health Care Conference in Alma Ata in whose declaration, the WHO member states affirmed that health is a fundamental human right and achieving the highest possible level of health is a universal social goal that requires positive action from other social and economic sectors beside the health sector. The declaration promised "Health for All" by the year 2000. Nearly all states in the EMRO region declared their adoption to the primary health care approach.

For many Civil Society Organizations, the Alma Ata declaration with its commitment to the principals of equity, community participation and multi-sectoral approach to health represented an important frame work for its missions and strategies in health action and its participation in health delivery services. This in addition to its increasing understanding of health as a an outcome of the interaction of the biological being with the social determinants of health, i.e. health as being a basically socially determined outcome.

Since Alma Ata, most countries in the region developed primary health care structures and systems. The aim being to achieve widest coverage and accessibility of health services, clean water and sewage to all populations, particularly remote, urban and marginalized groups.

In nearly all countries and as a result of these interventions and of the general development in these countries, many vital health indicators dramatically improved, as evinced by the decline of such indicators as such as child and maternal mortality.

Immunization coverage, control of many of the infectious diseases such as diarrhea and acute respiratory tract infections, increasing access to safe clean water and sanitation were but examples of interventions which contributed to such decline.

However, despite the general decline of such indicators, inequities in health between countries and within countries increased and many signs show that they are increasing, particularly during the past two decades. In addition, in some countries, particularly those torn by conflict, wars, occupation and in some cases state collapse, some health indicators have witnessed even deterioration and old diseases came back to be added to new chronic ones.

The causes behind the increasing inequities lie in many factors old and new.

In general the adoption of PHC as a system by most states was limited to selective, vertical interventions rather than being a comprehensive approach to health development. Active and genuine Community participation and involvement as well as multi-sectoral approach to health were hardly realized and these PHC structures and systems continued to be and increasingly became more medicalized and centrally controlled.

In addition, particularly during the past two decades, wars, internal conflicts, sanctions in addition to increasing global and national trends towards free market

135

economy and privatization with their bias to big business and profit orientation played a dramatic role in the increase of health inequities as well as the deterioration of general health indicators in some countries, which had previously improved.

Of all determinants that shapes people's health, occupation, wars, conflicts, violence and economic sanctions represent the main issues affecting people's lives and health within the Eastern Mediterranean Region. Afghanistan, Palestine, Iraq, Sudan, Djibouti, Somalia can be clear examples.

In Palestine for example, during the year 2004, 881 Palestinian were killed, among them 160 were children. During the same year, 4,009 Palestinian were injured, 1,443 Palestinian buildings were demolished and 13,510 Palestinian were dispossessed.

In addition the national and regional consultation meetings that were held within the framework of engagement of civil society with the commission on social determinants of health, the following issues were identified as key determinants of people's health in the region:

- Lack of good governance and democracy, which marginalizes the greatest part of the population and places decision making in the hands of few powerful groups and their interests.
- Neo-liberal, free market and pofit oriented global policies bias to big business.
- Economic structural readjustment policies adopted by most governments of countries in the region.
- International agreements within the framework of World Trade Organization (WTO) and their implication on people's health, particularly through affecting people's access to basic services and medicine.

Such policies resulted in:
- Cuts in governmental subsidies on commodities and food.
  1. Decrease in governmental expenditure on basic services (education, health, etc)
  2. Increasing trends of privatization including the basic services which affected the access of the majority to those services as well as contributing to increasing unemployment.
  3. Liberating the market for foreign investment without protecting the national industry or public service provision.
- Increased monopoly over resources, services, food.
- Domination of vertical and selective (Patchy) health interventions that address symptoms rather than comprehensive care dealing with the underlying causes.
- Bureaucracy and the wide spread of corruption.

Development of civil society:
In general, the role of civil society in the EMRO region witnessed contradictory development.
During the post colonial era, in many countries the rise of the national states was reflected in its monopoly over nearly all aspects of life. These states did not only become the major service providers but also the sole actor in decision making. In many cases nationalism became equated with authoritarianism and civil society became extremely marginalized, weakened and controlled. Syndicates and trade

136

unions became state apparatuses and NGOs were limited to charity and in many cases became appendages of the state.

However, during the past two decades and in face of the rise of the aforementioned prevailing policies and conditions, in addition to the rise of the international human rights movement, a new awakening of civil society in the EMRO region has been taking place. The declining role of the state in service provision and the increasing marginalization and impoverishment of large sectors of the population put new demands of civil society. Meanwhile, the weakening of the authoritarian grip of many states in many countries opened space for a new rise in the movement of civil society. To look at the status of civil society in the EMRO region today, we could look at some parameters which affect the roles, impact and types of challenges facing it in different countries and sub-regions. Two such parameters could be the country income and the extent of growth and space available. (See Table Below)

Division of C.S groups according to country income and space for NGOs

	Low-income	**Middle-income**	**High-income**
Weak /Lack of Space		Syria	S. Arabia Libya Kuwait
Relative growth / Restricted Pluralism	Pakistan Sudan Yemen	Egypt Tunisia Iran Jordan	Bahrain Oman Qatar Emirates
Wider growth / wider space		Lebanon Palestine Morocco	
Post state collapse	Afghanistan Djibouti Somalia Iraq		

These differences reflect on the C.S in different ways. On the one hand in countries where little space is provided for C.S to independently work, the work of most organizations is either very limited or mostly confined to charity and some service provision, or we are faced with the phenomena of semi-governmental type of C.S organizations, i.e. organizations which are controlled or run by the state.

On the other hand in countries where there is more space provided, we see a much more vibrant movements which are able to link more to grass roots and local communities and advocate and lobby to influence policy change. In many countries,

civil society is in a transitional stage, i.e. witnessing relative growth within many restrictions.

Meanwhile, different income group countries provide civil society with different challenges and accordingly different areas of focusing its work. In high income group countries for example, the major inequities exist in the migrant working population in these countries as opposed to low income countries.

In general, in most of the countries in the region, the development of civil society witnessed the following:

- Growth in size, quality and impact
    1. Increasing shift from charity approach to developmental and advocacy approach.
    2. Development of demonstrative models
        - Links to marginalized groups
        - Links to local communities on the grass root level
        - Alternative strategies in development

However, civil society organizations within the region still required to confront the following challenges:

Restrictions and lack of space from authorities
- Weak institutional development and weak Governance traditions.
- Tendency to depend on foreign grants
    Need to widen grass root linkages particularly in the rural areas.

The mapping methodology
The mapping methodology was a strategy by civil society t c.s actors working in areas related to SDH

- Utilizing available data from secondary resources on both health status and determinants in the region as well as the status of civil society including challenges it has.

    As a part of the mapping report, there was a phase of collecting data about the context of civil society organization across the region. Data was collected from a variety of sources such as available studies, reviews and reports; surfing the web; etc.

- Results of national and regional consultation meetings occurred so far.

    One regional consultation meeting has been convened in Cyprus from 3-5 December 2005, during which working groups tried to come out with an overall regional strategy and specific strategies for each of the Commission's themes.

    In addition, three national consultation meetings (Egypt, Iran and Pale stine) were conducted so far, utilizing mostly same methodology of the regional one.

    The current strategy paper is liable for change according to the findings of the other national consultation meetings that will be held during the coming weeks as well as according to other data we may obtain from the secondary resources.

- Main findings of the preliminary analysis of the <u>country reports</u> as well as questionnaires we received so far.

Within the framework of mapping process, two tools were designed to obtain data from country focal points as well as civil society organizations across the region:

1. Guidelines for short country reports. These guidelines focused on the general context of individual country, the current policies and programs addressing the social determinants of health, the development and current status of civil society. The guidelines were sent to one-two organizations in each country to reply.

2. A questionnaire (for the planned computerized database) was developed, sent and being sent to all identified civil society organization in different countries across the region (in a snow-ball manner). The questionnaire focused on the organizational identification data, legal status, fields of work, current activities regarding the social determinants of health, etc.

Strategic Objectives
Overall goal
1. To assist in addressing the increasing health inequalities within and in-between countries across the region.

Specific Objectives
2. To assist the engagement of civil society across the region into the process of the Commission on Social Determinants of Health.
3. To identify the key issues affecting people's health within the region.
4. To assist generating reliable knowledge concerning the underlying causes of inequities in peoples health.
5. To assist developing alternative policies and strategies addressing the social determinants of health.
6. To initiate, with all possible stakeholders, models for community-based interventions addressing the social determinants of health.
7. To create channels for unheard voices of the most marginalized and disadvantaged groups and communities.

Opportunities and Challenges
Opportunities

- The back-up support that formulation of the WHO's Commission created to all other stakeholders including civil society.

- The interest shown by relatively large number of civil society organization across the region.

- Presence of several civil society national, regional and global networks that are working to address the social determinants of health and are willing to be a part of the process.

- Availability of knowledge (evidence) concerning the underlying causes of ill-health and the possibility to generate more.

139

- The space for reasonable degree of independency of each partner within the framework of the Commission on Social Determinants of Health.

Challenges

- The dominant neo-liberal polices supported by powerful international organizations such as the World Bank, the International Monetary Fund and the World Trade Organization.

- Militarization of the region.

- The neolibral and structural re-adjust policies adopted by most of the governments in the countries across the region.

- The weakness of the civil society organizations and lack of available resources, especially for those who are addressing political issues.

- The rising trend of fundamentalism in the entire region.

Strategies
Knowledge Generation

- Creating evidence from the already existing information

    - Gathering the existing information relevant to SDH. This would include official statistics, literature (researches, reports and reviews)

    - Documenting civil society experience, especially the successful community models.

    - Promoting debate around key issues related to the nine themes.

    - Producing and publishing a regional health watch + national health watches. This can be achieve in collaboration with the PHM. These health watches should be able to provide an evidence-based analysis for health situation as well as providing alternative policies for better health

- Interacting and collaborating with the Knowledge Networks

    - Ensuring the representation of civil society in the Knowledge Networks.

    - Ensuring the feed-in and out by the civil society representatives within the Knowledge Networks.

    - Disseminating available information to different components of the Commission.

- Promoting the collaboration between the civil society organizations and academia.

- Implementing new studies on both national and regional levels

    - Multi-site studies with unified methodology

Lobbying and Advocacy

- Campaigns (on national, regional and global levels)

    - Identify wedge issues

- Coordinate with other networks and coalitions

- Production a civil society newsletter on social determinants of health.
  - To be hosted by a capable civil society organization in the region.
  - Recruiting focal point in each country in the region to feed-in the newsletter and translate the newsletter to the local language..
  - It provides news about the Commission (different components), publishing the findings of the meetings, announcing for the relevant national, regional or global events.

Capacity Building

- Dissemination of information to civil society organizations in the region. This includes the collected evidence on both national and regional levels as well as the knowledge generated by the Knowledge Networks.

- Inclusion of all possible civil society organization of different types into the process

- Organizing training courses on both country and regional levels on relevant issues. Two training courses are suggested on the regional level which are:
  - A training course on "Primary Health Care and Political Economy of Health. This training course can be implemented in collaboration with the PHM as a part of IPHU
  - A training course on Social Determinants of Health. A training curriculum needed to be made may be through a regional workshop.
  - These two training course can be also, replicated in different countries within the region.

- Developing and regularly update a database for relevant events and training opportunities and disseminate it to all included organization. This can be the responsibility of the regional coordinating organization as well as the country focal points.

Intervention Models on Community Level
- Build demonstrative intervention models on community level, combining knowledge generation with action.

Communication Strategy
- Activating the utilization of electronic communication (e-mail groups, the Commission website, etc.).
- Developing a regional website for the civil society network around the CSDH.
- Developing a periodical electronic newsletter (host organization – translated to local languages by the country focal organization).

Expansion of Civil Society Participation Base
- Inclusive Process.

- A space for all types of non-for-profit, non-governmental, such as NGOs, people's organizations, academic institutes and research centers, syndicates, trade unions, etc.
  - Country Focal Points.
    - Facilitators and not representatives
    - Widen the base of civil society engagement (Expansion).
    - Organizing national consultation.
    - Participating in the mapping process.

Contribution to Global Strategy

- Coordination among different regions through the civil society facilitators.

Expected Outcomes

- A reasonable number of civil society organizations, of different types, in different countries across the region are involved in the process of the Commission on Social Determinants of Health and a civil society network is established.

- Civil society participated in creating knowledge concerning the underlying causes of health inequities, as well as alternative rational policies to address them across the region in general and in some countries in the region in particular.

- Evidence-based intervention models are being implemented and tested in some local communities in different countries across the region.

- The public as well as main stakeholders are more aware of the process and contributing in different ways and degrees.

- Addressing inequities in health is placed on the national agendas of governments in the region.