# INTERNATIONAL ORGANIZATIONS AND THE GOAL OF "HEALTH FOR ALL"

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**MASTER OF PHILOSOPHY**

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# CERTIFICATE

Certified that the dissertation entitled "International Organizations and the Goal of 'Health for All'", submitted by me in partial fulfillment of the requirement for the award of the degree of MASTER OF PHILOSOPHY, has not been previously submitted for any other degree of this or any other university and is my own work.

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We recommend that this dissertation may be placed before the examiners for evaluation.

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# CONTENT

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# CHAPTER –I

# INTRODUCTION: APPROCHES TO HEALTH

The global spread of infectious diseases, health care has become a worldwide concern. The health has emerged as the solid social policy and field of global action. The health related the network of Intergovernmental, International Nongovernmental and transnational organizations coordinates activities. While international organizations worked around the world on health related issues from the middle of the sixteenth century, it is since the late nineteenth century and again after the Second World War that the network of activities enhanced dramatically. Since its creation in 1946, the World Health Organization (WHO) functioned as the paramount organization in the health field. Along with WHO, the number of intergovernmental organizations more notably the UNICEF, UNDP, World Bank and some International Nongovernmental Organizations such as Rockefeller Foundation, World Vision International has actively engaged in health deliberations. This proliferation of health related organizations and the intensification of the international organizational network on health are marking the broadening the contours of the global organizational field of health.

The Declaration of Alma Ata Conference embraced the principles of Primary Health Care (PHC) as the means to overcome gross health inequalities between and within countries. "Health for All" became the slogan for a movement. It was not just a normative goal but it is an organizing principle to pursue highest possible standard of health. The principles defined at that time remain indispensable for a coherent vision of global health. Turning this goal into reality calls for clarity both on the possibilities and on the hindrances that have checked the progress towards meeting the health needs of all people. This entails international community to construct sustainable health system. At the turn of new millennium all nations of the world have pledged to reach the Millennium Development Goals (MDGs) set at the United Nations summit in 2000. The MDG Declaration incorporates health as a main concern in eight subjects directly and three indirectly. This includes ambitious targets for nutrition, maternal and child health infectious disease control and access to essential medicines. To attain our goals, increased resource

commitments and intensified collaboration among partners will be required. The real progress in the health depends on stronger health system based on Primary Health Care (PHC). In most countries, there will be limited advances towards the goal of Alma Ata and UN Millennium Development Goals and other national health priorities without the development of health care systems that respond to the complexity of current health challenges. The Health regime should integrate health promotion and disease prevention on the one hand and treatment for the acute illness and chronic care on other. This should be carried across all level of the health care system, with the aim of delivering quality services to whole population.

The factors such as poverty, armed conflict, institutional stability and the state of basic infrastructure lie beyond the direct control of the health system. Understanding the importance of these factors World Health Organization advocates aggressive measures for improving the basic determinants of health. But there is much a well-functioning health care system can do to narrow health outcome gaps, even as the efforts continue to reduce poverty and socio-economic injustice exists among the population. To attain the minimum degree of health standard, there are minimum requirements, which every health care system should meet equitably. These include access to quality health services for acute and chronic health needs, effective health promotion and disease prevention services and appropriate responses to new threats as they emerge. The new threats would include emerging infectious diseases, but also long-term shifts such as the growing burden of no communicable diseases and the health effects of global environmental changes. These challenges must be met simultaneously, inclusive and sustainable at the same time as underlying health determinants are improved. This chapter argues that the key to success is health systems strengthening centered out the strategies and principles of PHC constructing responses that support integrated long term health systems development for entire population. This requires both effective use of existing knowledge and technologies and innovation to create new health tools along with appropriate structures and strategies to apply them. Success will demand new forms of cooperation among health agencies, national health leaders and community health workers and other relevant sectors.(Thomas and Weber 2004:189)

The global Health Policy (GHP) has received a significant boost in the context of the renewed efforts to tackle the global Acquired Immunodeficiency Syndrome (AIDS) pandemic. Although there is a large body of literature that deals with the questions relevant to GHP from the perspectives for various issues and interests groups, the discipline of international relations has proved slower in providing systematic approaches to interpreting and analyzing international health policies. There are number of reasons for such stagnation, but the most significant is probably the general paucity. Great amount of scholarly effort is still directed primarily at security related fields, amending its existing theoretical approaches and developing methodologies, which reflect these theoretical concerns.(Thomas and Weber 2004:189) The case of global health regime offers a number of interesting insights that ought to advance conceptual as well as political debates. In this section we approach the problems of GHP by considering the competing political projects that underpin respective GHP concepts, the actors that represent, defend and advance them. We begin by briefly outlining the scope and nature of the current global health regime, which is to reestablish within the policy environment the linkage between specific disease-oriented health care interventions and the underlying socioeconomic context. In the next part we analyze various approaches, which consider health as an international issue. In doing so the chapter will explore the shifts and changes in the general approaches and technical approaches.

**Diseases and the National Boundaries**

The first section will analyze the historical evolution of international health cooperation. The modern nations have been working together on international health problems over a century. They have collaborated because they have realized that disease does not honour national boundaries. In this means of cooperation, the Nation-states have learned that their self-interests are best served by worldwide collective action to eradicate communicable disease and to promote positive health conditions (Fidler 2001:82). International health collaboration became necessary as the result of the increased volume range and intensity of trade and travel. The expansion of trade and travel increased the possibility of proliferating infectious diseases. The overcrowded living conditions,

inadequate sewage systems, and unclean drinking water made international community vulnerable to unsafe from the threat of epidemics. As a result of globalization of diseases the World Government realized that no longer they could protect their citizens without international cooperation (Boudreau 1953:5). But great power interest in the infectious disease control waned due to there over commitment in real polity. This decline in disease diplomacy seems to be counterintuitive. The intensity and volume of trade and travel continues to grow crating unprecedented opportunity for pathogens to spread worldwide. Advances in Scientific research helped developed countries to reduce from the ravage of tuberculosis or cholera but on the other hand developing societies continues to toil from the spread of pathogens (Boudreau 1953:5). Even after two decades of landmark Alma Ata initiatives the disparities in accessing the health care has widened, expenditure on health spending considerably declining. The contemporary disease diplomacy proved to be cruel disaster.

**From Quarantine to World Health**

Early in the nineteenth century European Governments invoked quarantine measures at their homeports as precautionary measures against the cholera and plague epidemics. But such unilateral measures proved to be ineffective and detrimental to commerce, the European countries embarked on mutual cooperation to solve health problems. This States devised two fold manners (Fidler 2001:3)(Allen 1950:7). They established Collective Sanitary Council at strategic points and periodic conferences for international sanitary regulations. These localized arrangements were not adequately augmented by international sanitary regulations. The eleven health conferences held between 1851-1903 produced only modest results without permanent establishments for governing health administration (Allen 1950:30). Nevertheless these conferences are the role models for the later developments.

The medicalisation of health gradually gained momentum in the mid 1830s. This is due to the realization of practitioners about the linkage between poverty and ill-health. Sickness and ill-health were largely due to bad sanitation. Edwin Chadwick and John Simon were the prominent practitioners pioneered broad health movements (McDonald

1990:43-44). The discovery of precise causes of diseases by Louis Pasteur and Robert Kotch followed by rapid progress in bacteriology provided the knowledge of source diseases (McDonald 1990:57). This main three factors transportation, national health services and medical knowledge provided major impetus for international health cooperation. The need for such work became steadily more acute during the late part of the nineteenth century as faster ships reduced travel time between continents and became mandatory suppress communicable diseases at its source. This requires development of effective public health services in all countries and the coordination of their activities through international organizations. The necessity of efficient coordination and advances in preventive and curative medicine persuaded nations to move beyond localized and ad hoc arrangements to the creation of permanent international health organizations (Russel 1950:393-394).

**International Organizations concern with Health**

The first international health organization pan-American Sanitary Bureau (PASB) was established in 1902. In 1909 the first universal health organization the International Office of Public Health (IOPH) was brought into existence. Since then international efforts to improve world health have been carried forwards through regional and universal organizations. When the League of Nations was established the promotion of global health was explicitly recognized as essential to universal well-being. This led to the creation of League Health Organization, which was partially coordinated by, with both the IOPH and PASB (McKinze 1950:517) But there distinct operations produced a confusion of mandate; jurisdiction and responsibility which made it necessary to bring all international health agencies under the auspicious of single worldwide organization. Subsequently in 1946 nations agreed to establish World Health Organization to coordinate and integrate all existing international health agencies.

IOPH and Functional Autonomy in the course of development international health organizations have assigned greatly expanded functional responsibilities by the member States and have been granted moderate growth in functional autonomy and authority. This increase in responsibility and authority has been gradual and progressive. The sharp

advances occurred with the creation of new health organizations after both the world wars. The IOPH functioned as the clearing agency through which its member States can exchange the information about the prevalence of communicable diseases (McKinze 1950:521). Its functional responsibilities increased rapidly as States employed IOPH as the principal medium of formulating recommendations to sanitary conventions and for the study of many health issues not previously considered to be of international concerns. But IOPH acquired moderate authority to carry out its expanding mandate. The member States suspected that organization would intervene in national prerogatives. Thus IOPH functioned without acquiring significant authority to facilitate its work.

**LHO and its Responsibilities**

The League Health Organization (LHO) was assigned much broader responsibilities on issues of international concern. Its activities widely ranged from medicine, sanitation, scientific coordination and medical education. It accelerated the activities initiated by IOPH in many ways (Winslow 1951:292). League Health Organization was instrumental in developing the permanent and effective epidemiological intelligence system, which covered eighty percent of world's population. In addition Health Organization assumed responsibilities in many fields including technical assistance to domestic Governments, which are unequipped to meet the rapid spread of diseases. These activities marked the extension of international responsibility from quarantine to the strengthening of undeveloped national health services. During its later years of its existence health Organization pioneered the application of preventive health measured such as nutrition, housing and health insurance. But League Health Organization assumed these broad responsibilities without commensurate increase of power and authority. Its technical advisory committee was unable to discharge its duties without the approval of League Council. Nevertheless Health Organization was the specialized agency with scientific knowledge of health issues, which others lacked; it enjoyed considerable freedom in its operation.

## HISTORICAL EVOLUTION OF WORLD HEALTH ORGANIZATION

The creation of World Health Organization in 1946 is the landmark in the history of international cooperation in public health and medicine. In this historic even the Governments of sixty-one nations affirmed their interests of bringing all Inter-Governmental health actions under the edges of a single agencies which it is hoped has embraced the entire family of States. The WHO constitution, some refers as world health "Magna Carta", envisages an organization far wider in scope and function than any previous establishments in this sphere of international collaboration. The most significant approach is that to the problem of disease embodied in the WHO constitution and the approach, which takes full cognizance of the revolutionary advances of the previous decade in preventive and curative medicine.

It is important to situate this initial development within its wider context of the political and economic reconstruction of the world after the defeat of fascism in Europe and Asia in 1945. With the defeat of fascism the old European empires in crisis and there was a revival of enlightenment humanism promoted on a global scale which took two main forms in ensuing years as the Cold War. Both Soviet and the US programme promised a post colonial future of modernization and competed for the support of the people in what came to be known as the third world.

The US model promised national democracy and a greater share of an expanding world market run according to the Keynesian principles of economic interventionism and deficit financing of expanding public provision. This would be globally facilitated by the Breton Woods system initiated from 1944 onwards-promising security through stable exchange rates pegged to the US Dollar lubricated by international institutions like the World Bank and the International Monetary Fund. The GATT regime also removed all the trade barriers to facilitate global trade in the expanding world market. On the other hand the Soviet and Chinese models encouraged an alternative road to development through national liberation involving a struggle to break free from both colonialism and the capitalist world market by forging an alliance with the State socialist world (Peets

2003:11-7). This was the wider political economic context in which the World Health Organization was launched in a wave of optimistic universalism after second world war that produced its renowned and holistic and utopian definition of health as a state of complete physical, mental and social well being and other manifestations of the same spirit such as the United Nations Declaration of Human Rights. Thus health was defined in more than medical terms in ways that challenged some of the dominant assumptions of the western medicine and linked health policy to general development aims (Constitution of WHO 1947:26). It was this end of empire climate that also gave birth to community development as preparation for a post colonialism future involving stable self Government within the capitalist world market. These international doctrines of universal rights, holistic health and community development were becoming radicalized mainly as a result of a world wide challenge from the third world which was associated with calls for a new economic settlement between north and south and the construction of the NIEO. These demands to address what were seen as neo-colonial forms of exploitation in which national political autonomy did not alter relations of unequal economic exchange in the world market between the third and first worlds.

The second State Socialist world saw tactical advantages for themselves in supporting these claims. It is quite obvious that most of the third world countries came out of the colonialism and subjugation. Their economic conditions were at shambles. Thus most of the third world States were interested in their growth and prosperity rather than ideological battle prevailing in the international system.

In the 1960s the world has witnessed an increasing trend towards curative hospital based services. This shift negatively impacted on the billions of common people in Asia and Africa denying their access for basic health needs. The expensive hospital based curative services did not offer solutions to the burgeoning health problems. The curable diseases like whooping cough continues to rise, malaria spreads fast and kills million in the rural part of Asia and Africa. Although AIDS was not arrived on the horizon, equally smallpox and polio increased the risk of death and disability (Lambo 1990:30-3).

## WHO in the First Decade

The activities of the WHO can be divided into two categories Central Technical Responsibilities (CTR) and Services to the Governments. The CTR would include (a) Epidemiological services (b) International Standardisation, (c) The dissemination of knowledge and (d) Applied research. The Services to Governments comprises (a) expert guidance on specific topics, (b) Practical aid with short-term objectives, (c) Practical aid with long-term objectives.

### Central Technical Activities

In the context of CTR the organization has to grapple with the existing sanitary regulations conventions. When WHO began its operation in 1948 sanitary had existed for over a century. For nearly half the century of this period there had been an international bureau of epidemic intelligence and also agreements about common standards for biological products (Fraser 1975:3). The scope and intensity of the organization has been enhanced due to the goodwill approach of the whole world.

#### Epidemiological Services

The first fruits of universal collaboration were seen in the control of epidemics. The total 13 sanitary conventions were replaced by new code adopted by the WHA in 1951 (Perkins 1952: 153). This new code was designed in such a way without hindering the growth of trade and freight. The new code abolished the bills of health. The adoption of these new codes was made easier by the new powers vested in the World Health Assembly. In particular it is empowered to discuss and adopt international health regulations to which member States become parties (Perkins 1952:154). These sanitary regulations came into enforcement in October 1952, subsequently the new center of epidemic intelligence at Geneva gradually extended its scope of operation to infectious diseases. The fear of attack from quarantinable diseases such as cholera, typhus, plague and smallpox did not occupy the center stage in the international health arena (Scheele 1953:76). The endemic nature of these diseases gradually reduced and their occurrence has been controlled. Thanks to the modern epidemiology and the public health, which has

become effective safeguards. Nevertheless, although the risks have been reduced there is increased need for vigilance in a volatile world in which carriers of diseases can spread with the speed of a jet engine.

In addition to introducing uniformity in sanitary regulations, WHO has undertaken extensive research by sponsoring and coordinating epidemiological works. The problems of infectious diseases started to decline as experts have discovered capsules for controlling them. The reports were issued on tuberculosis, malaria, treponematosis, poliomyelitis, onchocerciasis, rheaumatic diseases, hepatitis, yellow fever, plague, cholera, smallpox, typhus and other rickety diseases bilharziasis, trachoma, leprosy, rabies, brucellosis, and other viral diseases. The role of epidemic intelligence covers giving information about pestilential diseases, quarantine restrictions imposed or withdrawn and details of current epidemics. Thus improved health facilities and the applications modern prophylaxis have greatly altered the modern health systems.

**International Standardization**

The organization from its inception starved to attain statistical perfection in causes of diseases and deaths. The first list released under the auspicious of WHO fused the codes of mortality and morbidity (Swaroop 1954:73-74). From then onwards every step has been initiated to establish national statistical committees on the pattern, which best suits to the country. Statistical countries were established in London, Paris, Caracas and Moscow (WHO 1958). The most important breakthrough in standardization has been the publication of the "Pharmacopoeia Internationalis" in 1950 (Simon 1958:27). This publication has been desired by number of countries because of proliferation of drugs from many quarters. The marking of drugs became very difficult, as each country's need is distinct.

In the biological products WHO has taken efforts to standarise vaccines. The nine such vaccinations have been achieved in 1954. For example, the cholera vaccination and the rabies vaccines were standaridisation in 1958 and 1953 respectively ( WHO 1958).

**Dissemination of Knowledge**

But these criticisms were generally neglected due to dozen other barriers to a common understanding of the problem. What is needed is a clearing house of medical and scientific information, a machine for weighing and sifting the experience of different countries.

In this the international committees of experts pioneered by the Geneva Office has been admirably accepted as the better for the wider purpose. During the first decade of operation the committee has produced reports on fifty different subjects (Sigerests 1961:236-237). Seminars, international conferences, working parties, study groups, study tours and research symposia which served the same purpose have also widely used.

**Applied Research**

The experience gained by the WHO during its first two decades has continually shown how much success in public health depend upon a better understanding of specific problems and of the local conditions under which work has to be done (Brockington 1966:87). Thus the enormous of work of WHO arises in the adventure with the field. A practical venture in public health meets with difficulties, which can be overcome by the adequate research undertaken by dedicated organization or laboratory (Brockington 1966:89). In 1970 WHO had more than 200 laboratories to carry out epidemiological research. The WHO had over 35 reference laboratories covering virus diseases, influenza and diptheria (Brockington 1970:131-132).

**Services to the Governments**

WHO has adopted the footsteps of the Rockefeller Foundation in delivering services to the domestic Governments. The services, which is distinct from advice, which is of two kinds expert guidance and practical guidance (Fraser 1975:149).

**Expert Guidance**

Expert guidance is the method of giving practical aid since it is concerned with administration and organization. In 1953 Burmese Governments sought advice on reorganization of central health department, Turkey about the sound system of health

statistics and Jordan asked the advice from the WHO for best means to advance its health systems (Fraser 1975:149). In 1966 the team of three consultants the USA, the UK and Egypt adviced Kuwait to establish a medical school (Fraser 1975:150). Thus the range of advice and consultant is very high. The unstinting, unprejudiced expert guidance is required to all governments.

**Practical Projects**

Practical projects are devised to establish fair public health services are undertaken with colloboration with other specialized agencies of United Nations notably FAO, UNESCO, ILO and UNICEF. UNICEF collaborates with the projects, which directly or indirectly affects children in schemes specifically aimed to benefit maternal and child health (UNICEF 1974). In campaign against individual diseases such as yaws and leprosy and project for water supplies, environmental hygiene, training staff and construction of training schools and hostels for students. In 1973 UNICEF spend more than eight million dollars assisting water schemes in sixty eitht countries. It collaborated a scheme to aid the Indian National Institute of Health Administration to make a study of district health administration and also it involved in providing refresher courses to medical professionals throughout the world (UNICEF 1974).

Practical projects can either have short time or long time objectives, i.e. they can seek to eradicate disease by blitz or mass campaign. They can also use the methods, which rely on the establishment of the permannt services or furtherance of desired social change. Thus it is clear that WHO's activities can be characterized as interventionist in communicable and noncommunicable diseases. The Alma Ata Declaration and HFA call for revolutionized its activities towards preventive and rather than curative activities.

## APPROACHES TO HEALTH

The advances made in responding to health challenges seem to be inadequate when considered against the exacerbated health risks and problems faced by large populations. As Gro Harlem Brundt has formulated the problem in her address to the World Health Assembly (WHA) in 1998, 'never have so many had such broad and advanced access to

health ". The crucial point to be noted is that of growing health disparities between the world's wealthy and the world's poor diminishes the rhetoric of advances in the global health. Poverty and inequality continue to provide the key context of terminal health problems, with immediate cause for most deaths among the poor being a disease for which there is a cure. The World Health Organization (WHO) suggests that 50-90 percent of drugs are paid from the developing and transitional economies. The inequality issue has been highlighted in the context of the recent debate over human immunodeficiency virus (HIV) by the controversial remarks on the causes of HIV related deaths by Thabo Mbeki and the ensuing campaign for broad-based access to antiretroviral (ARV) drugs. More than any other disease HIB-AIDS reflects entrenched growing global disparities, inequality and exclusion together with a salient retrenchment of north south divide. The most challenging problem for HFA agenda must engage with the implications of a health policy environment that has been shaped pervasively by inequalities reproduced through global economic policies. In this part the study briefly delineate the general approaches and technical approaches to the health.

## General Approaches

The general approaches characterized the notion of health in four discursive phases. This phase reflects its thematic shifts and changes in its evolution and application by the different Intergovernmental and International Nongovernmental Organizations. These phases are (a) health as an act of charity, (b) as a professional activity, (c) as a tool for development and (d) as a basic human right (Inoue and Drorie 2006:198).

### Health as a Charity

The first approach of the health conceives health as a charitable activity. The organizations whose goals and activities reflect this notion focus on benign care and treatment. They also make their commitment to health as charity as rather explicit in their activity. The activity of Ida Scudder in India in the late nineteenth century opines "Serving to Grow: Growing to Serve: Giving heeling touch to the sick and the marginalized" (Abel 2001:137-138). John also also describes its core goal as to encourage and promote all works of humanity and charity for the relief of the persons in

sicknesses. While most of these international organizations are indeed religious orders and while almost all religious orders are among the older organizations within the global health field (Mathew 1982:219). Even contemporary religious organizations also similar state, for example the Heal the World Foundation established in 1992 and headquartered in the US act as a charity organization for the disabled, orphans and underpreviliged children.

**Health as a Professional Activity**

The second approach considers health as professional activity and health related organizations that carry this discursive tone proliferated in the late nineteenth century. Most of these organizations are health related professional associations. These organizations serve as the liaisons in terms of organizing conferences, training sites offering workshops and courses, sources of technical support giving expert guidance on specialized issues and established professional standards. For example World Orthopedic Concern (WOC), established in 1979 head office in at Singapore, promotes orthopedic education and care, standards of orthopedic surgery in developing countries. The London based International Council of Nurses (ICN) established in 1899 vows to assist nurses in developing and improving the health services for the public (Subhashini 1993[a]:33). The organizations adopting these professionalised perceptions of health dominated the health field from the late nineteenth century until the late twentieth century. They also account for the most the contemporary health related international organizations. It is acknowledged that most of the professional health related international organizations were the primary users of the scientific language highlighting rational references to the procedures, criteria, evaluation, standards and ethics.

**Health as Tool for Economic Development**

The health related international organizations came into existence after Second World War considered the promotion of health as a tool for economic advancement. The focus of this phase is on fuller and better utilization of available resources. Healthy people are more productive people and more productive people are more prosperous and developed

(Abassi 1999:865). Thus health becomes social service with an intimate goal namely development. The best example is the World Bank established in 1944 headquartered in Washington intruded into health arena in 1980s in an controversial way but continues to dominant the discourse (Abassi 1999:868). The initial example would be that of Italy based Food and Agriculture Organization (FAO) established in 1945 vows to eliminate hunger and enhance nutrition standard in the universe.

**Health as a Human Right**

Most of the health related international organizations founded after 1990 considered health primarily as a basic human right (Ineua 2003:177-179). The emphasis laid on the health as a fundamental moral and universalistic claim that is the previlege of any human simply because he or she is human (E.g. Help Age is the classic case in point of such organizations)

Inspite of the late emergence of this theme in the international health field, the concepts of human rights and its applications as a prism for health related activities are not necessarily new. The human rights presently transforming into twin pillars as empowerment and rights.

In summary it is quite discernable transition in the various approaches reflected in the self proclaimed goals of the international health related organizations. While all international organizations address the same issues all offer health services, all are international and all regard health promotion and the delivery of health as their core mission. Thus this health related organizations identify themselves as one of the four types social approaches.

## Technical Approaches

Unlike the general approaches the technical approaches concentrates on the applications of the methods to overcome the problems. The health related international organizations adopted this techniques in their policies and projects. This approaches is not periodic

bound or it did not emerge with the advancement of technology. This approaches are quite explicit and best serves for the effectiveness of its tasks.

**Primary Health Care**

The importance of the primary health care is based on practical and scientifically sound metod to achieve minimum degree of health status. The community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Drummond 1982:1-62). It forms an integral part of country's health system which emphasis on overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with national health system where woes of the marginalised were cured with benign health care conditions. PHC addresses the main health problems, methods of preventing and controlling them, promotion of food supply and adequate supply of nutrition and basic sanitation.the extent of immunisation process has been intensified, communicable and non communicable epidemics have been considerably reduced. An acceptable level for all by the people of the world year 2000 can be attained through a fuller and better use of world" resources, a considerable part of which are spend on armamanets and military conflicts. This peace détente and disarmament should enable international community to devote their resources in social aspect with respect to health care should be provided its due share. The joint UNICEF/WHO report on PHC serves as the solid base further development and operationally the goal of the primary health care. The PHC can be divided into Selective Primary Health Care (SPHC) and Comprehensive Primary Health Care (CPHC)

**Needs Based Approach**

The needs based approach is gaining prominence in the recent health policy domain. The needs based approach acknowledges the existence of legitimate requirement of social, economic and cultural needs of the society. Such needs would include among others all goods and services mentioned in international document of social, economic and cultural rights (Osiatynski 2004:1). These needs can be fulfilled by the broad spectrum of means and instruments. However the individuals through their family, or

through community needs can fulfill individual. But the domain of health field is very vast and extensive it requires the intervention of State and international organization to regulate. The State can introduce policies that aim to maximize possible employment, protect the environment and public health (Ollila 1999:31). In the international domain WHO's shift in the 1970s is also based on the need-based approach. The need based approach would include the policy would take the confidence of the poorest and vulnerable groups. The special emphasis on women and children constitutes this approach.

**Horizontal/Vertical Approach**

In the field of international co-operation, vertical disease oriented programmes were the major form of co-operation in the initial stages. These programmes were targeted predominantly at communicable diseases such as malaria and schistosomiasis, but population questions and malnutrition were also emphasized (Ollila 1997:112). The improved medical technology paved the way for operations against the major scourges of mankind. International donors consistent emphasise on such programmes did not yield adequate results (Lambert 1994[b]: 725) During this period many of the countries concerned had no widespread health infrastructure. Although the vertical approach brought substantial advances in the control of number of diseases, it nevertheless gradually became evident that multiple vertical.

Programmes as a long-term approach entailed serious inefficiencies and redundancies (Lambert 1994[b]: 726). Some countries had more than ten separate largely vertical programmes while at the same time they had to combat many health problems. This mismatch of the various programmes created chaos and provoked international community to move towards integrated approach. An integrated approach was already being made in the 1950's and 1960's but integration gained momentum in the 1980's after the completion of several successful projects (Kavusola 1997:28-29). In addition to concern over the concrete problems associated with the implementation of the vertical approach, the policies of the Alma Ata declaration and health for all have their

background in an approach emphasizing social justice and universal access and inter sectoral action.

**Biomedical Approach**

The biomedical approach takes the trajectory of logical positivism, which believes truth is assumed that it is unchangeable and unrelated to human perception (Bryant 1989:549-551). In biomedical approaches health is defined by the scientists and quantative outputs rather than by people's experiences. It gives those who measure health outputs control over those who experience health and well-being. There is strong belief that science will find technological means to control the inadequacies in the medical system (Meyer 2003[a]: 101). It also assumes that health has a priority over other human needs. The biomedical approach gives priority to the individual over to the context rather than his experiences. Thus biomedical approach health as a commodity and market as the organizing principle. The classic case in point is the AIDS control mechanisms by various international organizations.

## CONCLUSION

The introductory chapter has outlined the historical evolution of health cooperation. It has also highlighted the functions of the WHO till the Alma Ata Declaration and various approaches to systematize the health and international relation. The subsequent chapters will elaborate the basic themes that emerged in the introduction. The second chapter *Institutional Arrangement for Health Cooperation* will analyze the structure and function of five Intergovernmental and two INGOs in the health field. After introducing the various organizational activities, the third chapter *Health for All: Origin and Development* traces the state of the health of world and discuss the origin of Health for All vision and presents the elaborate analyzes of the contents of the landmark Alma Ata Declaration. It also discusses the growth of HFA and contents of the follow up conferences after Alma Ata.The fourth chapter *Problems in Promoting Health* for All deals with systemic problems and specific organizational problems in pursuit of this goal. Finally the fifth chapter *Renewal of HFA: Prospects and Challenges* highlights some of

the reasons for not meeting the goal in 2000 and its subsequent target of 2020. This chapter will focus upon prospects and challenges to attain this vision in 2020.

# CHAPTER –II

# INSTITUTIONAL ARRANGEMENTS FOR INTERNATIONAL HEALTH COOPERATION

The profound changes have occurred in global health policies. The new problems such as AIDS pandemic have become major security threat to the international community. Rapid spread of communicable diseases in developing countries and emergence of new drugs regime have created tumultuous situation over many countries. New agencies and actors have become harbinger in the field of international health more notably the World Bank and International Monetary Fund (IMF). These economic institutions have engineered in squeezing State funding for global health. The emphasis is laid on private sector participation in health programmes. The International Non-Governmental Organizations (INGOs) continue to criticize pharmaceutical industries and impact of Structural Adjustment Programme (SAP). In this context, this chapter is divided into two broad sections viz., Intergovernmental organizations and International Nongovernmental Organizations. It will briefly outline their mandate, organizational structure, resources, policies, accountability and constraints and challenges of inter-governmental bodies such as World Health Organization, World Bank, United Nations Development Programme, United Nations Integrated Children's Emergency Fund and United Nations Population Fund and some of the international non-governmental organizations like Rockefeller Foundation, and World Vision International who are active in the field of health issue.

## INTERGOVERNMENTAL ORGANIZATIONS

The intergovernmental organizations in general played a vital role in international relations. The international health policy making as no exception to it. The international organizations generally play three primary roles in international sphere. They are instrument, arena, and actors (Archer 1990:135). As arena, international organizations provide space for discussions. It acts as the facilitator between big and small States. As an actor, organizations involve in various international issues brought to its notice. International organizations acts as the instrument to legitimise international actions. In health policy making international organizations works for reaching the unreached in the

expanded form of important commodity referred as health, they play a major role in biological standardisation and agenda setting in various meetings.

## Mandate and Objective

Mandate of the organization determines to adopt right trajectory to attain the specified objective. Mandates play a unique role in promoting and strengthening the policies, programmes and evaluation techniques. Hence in this section, the study will briefly analyze the mandate of WHO, UNDP, UNICEF, World Bank and UNPF.

### WHO

WHO is the specialized agency of United Nations family charged with health issues. Its mandate and objectives enshrined in its lengthy constitution signed on July 22 1946 at New York. It defines "Health is a complete physical and mental and social well being rather than absence of disease or infirmity". This definition is a potential breakthrough because it transcends medicalisation of health field and covers various such other issues of social and economic factors as major determinants in health conditions (Constitution of World Health Organization 1947:225). This expanded definition of health broadens its scale and sphere of activities. The WHO constitution also outlines the necessity of attaining of highest possibility of health as fundamental human rights without distinguishing race, religion, political belief and economic and social conditions. The WHO constitution recognizes that the highest level of health can be achieved only through the means of cooperation from the States, individuals and civil society organizations. It also calls for the protection and promotion of health of the children and other vulnerable sections. Taking the cautious note about the unprecedented havoc created by the horrors of the Second World War, this newborn health organization called on its member to relate peace and harmony to attain a degree of health development in order to march on the trajectory towards progress and prosperity.

The WHO constitution also outlined to eradicate epidemics and other endemic diseases, which plagued the entire universe. Infact the previous health related organizations left a strong legacy for WHO to incorporate these changes. It also emphasized to actively engage itself in ameliorating maternal and child health.

In order to pursue its objectives, the WHO recognizes the need for cooperation from the states, individuals and civil society; it also endeavors to establish strong collaboration with other UN specialized agencies such as UNICEF and UNDP.

**World Bank**

The World Bank and International Monetary Fund were established at the end of the Bretton Woods conference in 1944 (Mason and Asher 1973:9). The World Bank consists of five other agencies, which collectively referred as World Bank Group. They are International Bank for Reconstruction and Development (IBRD), International Development Agency (IDA), International Financial Corporation (IFC), Multilateral Investment Guarantee Agency (MIGA) and International Centre for Settlement of Investment Disputes (ICSID). The creation of IDA was a major progress in the issue of development aspects because it transformed Bank into a development agency. The main task assigned to IDA was to provide development assistance to the Least Developing Countries (LDCs) on lesser terms and conditions than IBRD (Mistry 1995:16). It operates within the World Bank's direction but decision-making component rests with the contributors.

Before the creation of IDA there was a proposal for a Special United Nations Fund for Economic and Social Development (SUNFED), which would be fundamentally different than World Bank in the sense, control will be shared equally between donors and the members. But this proposal did not materialize instead, what emerged was United Nations Special Fund (UNSF) which subsequently transformed as United Nations Development Programme (UNDP). The UNDP functions as the principal channel for technical assistance while IDA lends softer loans to the poorer countries (Childers 1994: 78-103).

**UNICEF**

The United Nations International Children's Emergency Fund (UNICEF) was established as a temporary body by the General Assembly in 1946 to meet the exigencies of the children in Europe. (UN Resolution 57/I, 1946) Since 1950, UNICEF shifted its concentration from Europe to Third World independent countries (Lafond 1994) (Black 1996:13-5). In 1953, it secured the permanent status and placed its emphasis on child health and welfare in developing countries. It was instrumental in the adoption of many conventions related to children such as Declaration of the Rights of the Child, 1989 Convention of Rights of Child. The World Summit on Children was organized with the efforts of UNICEF (Black 1996: 13-5). In all of these declarations and conventions, international community entrusted UNICEF to coordinate the implementation of the rights (Engber-Pedersen 1992:19-22). By specializing in the needs of children, UNICEF's work transcends many sectors and policy issues. But it is well recognized its active role in the health sector (Lafond 1994).

Thus its basic mandate is to protect and promote the rights of the children throughout the world. Its principles are derived from the conventions such as Rights of the Child. It aims to achieve sustainable human development based on the observance of the rights of the women and children. This organization, as part of the UN system works to protect and improve the lives of the children and adolescent throughout the world. Its mandate is to promote and protect the rights of the children, help to cover their basic requirements and increase the opportunities to fully develop their potential. Its work is orientated towards women responsible for guaranteeing the well-being and development of children, promoting equal rights and supporting their full participation in community development (UNICEF.org.).

**UNDP**

United Nations Development Programme (UNDP) was established in 1965 replacing United Nations Special Fund (UNSF) as the central funding agency for technical assistance to the developing countries (Ahlberg and Lovbraek, 1985, p.69). UNDP is a programme and hence it is sustained by voluntary contributions. All development projects are based on grants, made with the framework of Indicative Planning Figures (IPFs) designed as similar as country five year plans. The UNDP projects are carried out by tri-partheid cycles. Governments are responsible for the programming of UN resources. The UNDP will be in charge of approval and UN agencies will execute the programme. Thin funding base has undermined its active role in development assistance (Nordic Project 1991: 30-35).

UNDP is the UN's global development network, an organization advocating for change and connecting countries to knowledge, experiences and resources to help people to build a better life. It closely associated with Millennium Development Goals (MDGs) including the overarching goal of reducing poverty to half by 2015. UNDP's network links and coordinates global and national efforts to reach these goals. UNDP helps countries to build and share solutions to the challenges. It emphasizes on democratic governance, poverty reduction, crisis prevention and recovery, energy and environment and HIV AIDS.UNDP's objective to help developing countries to attract and use and effectively, including in health sector. Its main task include protection of human rights and the empowerment of women, these have significant hearing on health sector. Its health focus is quite obvious in all its operational areas.

**UNPF**

United Nation Population Fund (UNPF) is the subsidiary organ of the General Assembly. In 1993, General Assembly transformed the governing bodies of UNICEF and UNDP/UNPF into Executive Boards subject to the authority of ECOSOC (Goss and Gilloroy 1991).

In 1996, the Executive Board of UNPF endorsed a mission statement identified the three main areas of its operation as (Lee 1994:224)

(a) Help to ensure universal access to reproductive health including family planning.

(b) To support population and development strategies that enable capacity building in population programming.

To promote awareness of population and development issues and to advocate the mobilization of the resources. Political will be necessary to accomplish its areas of work. It is also noted in the mission statement that UNPF guides and promotes the principles of the International Conference on Population and Development (ICPD). UNPA affirms its commitments to reproductive rights, gender equality and empowerment of women all over the world (UNPF 1996).

## Organizational Structure

Behavioural theorists have argued that structure influences the organization's outcomes and hence they advocate that structure defines the organization's agenda. For behavioural theorists structure enables to understand norms, functions and organizational relations. Secondly, it enumerates complex bureaucratic mechanisms and the nature of organizational culture generated within the institution (Wilson 1989:45-8). The organizational structure should be of multidimensional approach and should reflect its goals and objectives. According to Peabody organizational theory tries to explain how coordination in a bureaucracy accomplishes its critical tasks (Peabody 1991:7-18). Various scholars popularly describe three-fold taxonomy of organizational structure. Firstly there is a Traditional or Rational System, which is characterized by a formalized structure independent of specific individual staff. The rational system envisions a proper organization as one could be able to maximize output by adopting scientifically managed techniques. A second type of system renounces this formal approach and considers both

the formal and the informal structure of an organization. "Natural Systems" are based on the personal characteristics of staff in the organization and on the behaviour of informal cooperatives. Unlike the rational system, the natural system concerns with the survival of organization rather than profit maximization. This system also stresses on set of culture and myths. Hence the staff heavily influences natural systems and much of its operation depends on the ability of the head or the leader of the organization. As a result of its over dependent on head or staff, it ignores the importance of the environment that organization interacts. The third system "Open System" remedies this problem. It is analogous to the biological process which relies on its environment for input, coordinates and interacts amongst its various officials and comes out with an end product suitable to milieu in which it exists (Freidson 1973:19-38) (Abbott 1991:7-18). Each of these models is relevant to our analysis. Using an organizational analysis this chapter explores various features of health organizations.

**WHO**

In 1946, International Health conference was held 51 members and 13 non-members of UN participated in the deliberations. The first World Health Assembly (WHA) was held in 1948 (Sidiqi 1958). WHO was given decentralized structure because of the past experiences with the erstwhile organizations. The centralized structure is rigid and complex and many members expressed their reservations in adopting the same. WHO from its inception adopted decentralized structure with regional centres at various zones. WHO has six such zones Europe (Copenhagen), Eastern Mediterranean (Alexandria), Africa (Brazzaville), South East Asia (New Delhi), Western Pacific (Manila) and Pan-American Health Organization (PAHO) for Americans which theoretically functions as a regional structure but it practically functions as a distinct inter-governmental organization with separate budgets and personal. This decentralized structure has been a heated debate over half a century (Sidiqi 1995).

The work of WHO is based on its lengthy constitution which assigns equal importance to the normative, coordinating and directing role on the one hand and its technical cooperation role on the other. WHO the principal governing body of WHO has adopted

the policy of One-State-One-Vote regardless of their financial contribution and demography (Constitution of WHO: 226). The assembly is charged with electing the 32 members Executive Board. The Board monitors operation of WHO, devices polices and programmes and nominates the Director General. However the nomination of Director General takes place behind close doors with utmost political maneuvering. For example in 1993 British delegates accused the election of Dr.H.Nakajima in a series of articles published in British Medical Journal. The World Health Assembly has elected every Director General thus nominated by Board. The DG's term is for five years and eligible for re-election.

Although all specialized agencies are supervised by the UN Economic and Social Council (ECOSOC) the executive heads are independent and free from any centralized control. The Director General delegate's responsibilities and assigns programmes to the WHO professional staff in the course of international health activities. Besides Director General WHO's structure is unique for a specialized agency as the structure helps to explain not only external interaction with member States, but also organization's policies and leadership in the internal milieu. The policies are framed in Geneva at the head quarters, allocates the budget and devices the strategies for implementation. The six regional offices supervise and coordinate the programme implementation. However regional offices are authorized to formulate and implement any policy, which demands the respective region. These activities are carried through a formal body of Regional Committees analogous to WHA at the apex. The Regional Committees are headed by the Regional Directors for the fixed five-year term with same power and responsibility as Director General. Thus the unique arrangement of electing DG and RDs which is done behind close doors is subject to political tampering and may not be based on sound public health development principles (WHO 1990). To sum up internal organizational structure is hierarchical structure at the top, resource utilization at the bottom and policy implementation and outcome at the member state level.

**World Bank**

The structure of WB has set in its Articles of Agreement, which established the institution. The Articles of Agreements vests ultimate control in the hands of Board of Governors. Each member country has one member in the board of Governors, which meets annually to approve the working manual of the organization. Further powers are delegated to the Executive Directors numbering twenty-four who are elected by the power of the contribution. The top five highest contributors have each one director and some countries jointly share the election of the Directors (Blough 1968:155).

The President appointed for the fixed tenure of five years with eligible to re-election heads the operating staffs of the Bank. The highest shareholder of the Bank nominates the nominee. By convention an American always gets nominate because of the understanding between the developed countries. Thus its structure is determined by the economic capability of the members. The World Bank is officially one of the United Nations agencies but it has maintained greater distance from its supervision. According to Bradlow and Grossman the relationship agreement between the Bretton Woods agencies and the UN, must acknowledge that WB/IMF are specialized agencies and must consider UN decisions and recommendations (Griesbarger and Gunter 1996:23-48). Adams has observed United Nations has never been allowed to play any significant role of supervision and coordination in relation to the World Bank and the IMF (Childers 1994: 91). In the World Bank the share of voting power is determined by the amount of contribution. The decisions are taken by the means of weighted voting system. The developing countries are completely marginalized even though policies are debated and deliberated for them.

**UNICEF**

36 members Executive Board elected by ECOSOC govern UNICEF for three-year term on rotational basis. In electing the members, geographical distribution and representation

of donors and recipients are considered. The Executive Board is responsible for providing inter-governmental support and vested with power to monitor the various activities of the organization (United Nations Hand book 1994a). UN Secretary General appoints the Executive Director after consulting Executive Board (UIA 1992).

The basic operational structure of UNICEF includes three levels. The headquarter level is situated in six centres, six regional offices and country level offices. Thus, we can see the fairly decentralized structure when compared to other UN specialized agencies. It consists of more than 200 field offices. For meeting the burgeoning range and scope of its field, the country offices have acquired substantial functional autonomy (Engberg 1992: 22). Major operational decisions are left to the discretion of country representatives and they coordinate directly field operations. (Lafond 1994)

**UNDP**

The UNDP has executive board it is made up of representatives from 36 countries around the world, which serve on a rotating basis. This board elect members of UNDP bureau consist of a president and four vice-presidents taking into account the need to ensure equitable geographical representation. Through its bureau the board overseas and supervise the activities of UNDP, ensuring that to organization remains representative to the evolving needs of programme countries.

The executive board secretariat facilitates the work of the board by remaining and editing all documentation for submission to the board. It provides information and other support services to board members, in each country office, the UNDP resident representative normally services as the resident coordination of development activities for the UN system as a whole. Through such coordination's, UNDP seeks to ensure the most effective use of UN international resources. (http://www.undp.org/about/accessed on 3 July2006).The developing countries had to run this in initial stages adopting one State one-vote principle.

But UNDP's vulnerability is underestimated as led agency for development because like other UN agencies the wishes of donors have prevailed in crucial issues.

The Executive Board has thirty-Six members with proper geographical representation elected by the member for three years. (UNDP 1994a) During 1990s it undertook over 6000 technical health related programmes employing over 12000 employees in developing countries. The bulk of its programmes are implemented by the Government agencies and remaining are by the partnership agencies. NGOs are actively involved in UNDP health activities.

**UNPF**

The Executive Board is composed of 36 members keeping in mind the wider geographical representation as possible. In 2004, it contained eight from States from Africa, seven from Asia, four from the Eastern European States, and five from Latin America and twelve from Western Europe.

UNPF is a subsidiary organ of the UN general assembly and base the same executive board as UNDP. It has executive director with the each of under-secretary general of the United Nations appointed by the UN secretary general.

In 1995, General Assembly endorsed an agreement between UNDP and UNPFA to designate UNPA resident country directors as UNPA representatives. The Executive Board members are elected for three fixed terms. It observes one-person-one-vote principle. The Executive Director is appointed by the UN Secretary General (Mendehlson 1993). Its headquarters is situated in New York and also has field offices in 140 countries (UNPF Annual Report 2004). It also consists of UNPA country representative's subsidiary and UNDP country representatives.

## Resources

Finance is the lifeblood of all monetized socio-economic formations ranging from simple nuclear families to complex national and international organizations. A system deals with inputs and outputs, as well as the mechanisms and processes behind the transformation of inputs into outputs. The financial system transforms financial resources into human resources. The essence and purpose of finance would differ under different social systems depending upon the particular mode of social production. International Organization's financial administration would include voluntary contributions, corporate donations and assessed membership contributions. The voluntary contributions are uncertain and unstable. The strength of the organization is determined by its merit of its funding base. The important issue like health is no exception in this category. Positive health output needs proper management of the resources. This section the chapter will analyze resource mobilization methods and challenges faced by important institutions dealing with health issues.

### WHO

The budget of WHO includes regular contributions by the national Governments and the extra budgetary funds, which are made up of voluntary contributions. The assessed contribution of WHO stood at 950 million dollar in 2004 -05 while in previous decade it stood around 822 million dollar. This represents decrease by 3% for the last decade. In real terms, WHO's budget has not grown substantially since 1980s. One scholar has remarked WHO's total effective working budget is less than that of New York national hospital. The major contributors are USA 25%, Japan 11% and Germany 9% (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995:86). The extra budgetary consists of voluntary donations from Governments (79%), World Bank (6 percent) and other UN agencies and NGOs. This extra budgetary has grown considerably for the past couple of decades, estimated to over half of the total budget (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995: 88-9) (Stenson, and Stiry 1993:134-9). Most of these funds are utilized for health promotion and disease control in developing countries ( Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995:89).

According to Walt, the structure of WHO financing with its significant amount of voluntary contributions tends to raise demands for transparent financial management and financial issues. He also criticizes WHO's staff and secretariat for the emergence of dominant tendencies to devote time and energy in discussing fiscal matters rather than policy formulation (Walt 1993:125-44). The three quarters of budget were allotted to Tropical Research Programme (TPR), Onchocerchiasis Control Programme OCP and Research on Human Reproduction Programme RHP. (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995:89). There seems to be incoherence within the donor countries on the allocation of extra budgetary funds and policies concerning its allocations for developmental projects. This contribution generally falls under the mandate of development cooperation while WHO's policies are directly dealt by Ministries of Health (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995:116) These inconsistencies may subject WHO into different position than other UN agencies as far as budget allocation. This has mammoth implication for WHO policy and bilateral collaboration. This marginalization would lead WHO to loose its premier policies to the priority of national ministries of health.

**World Bank**

The World Bank is financed through subscription. IBRD members finance the organization through capital stock. But private borrowing in capital markets raises the bulk of the resources. The IDA raises its resources through voluntary contributions by donor Governments. Thus mobilized resources may not last long because of long-term contributions. So it goes for additional funding which is referred as replenishments (Brown 1992:33). The IBRD loans are lent on market rates while IDA loans are lend in softer terms. This means there are multiple channels involved in the transaction. Again as same like the USA, Japan, Germany, France and the UK are the major subscribers and contributors to World Bank and IDA respectively.

Banks funding increased rapidly since late 1980s. In 1991 the Bank approved over 29 projects in the health sector with total estimation of 3.3 billion dollars (Buse 1996: 95-99). In 2004, the projects sanction was just near to double with fifty percent hike in the

total allotment. (Sacs 2001). Thus it is claimed that World Bank's policy takes it closer to the development approach and raises suspicion regarding its rational to fund health programmes.

**UNICEF**

UNICF relies on voluntary contributions unlike WHO and other agencies, which gets assessed contribution from Governments. The bulk of UNICEF resource is funded by a voluntary basis of government and also an individual. It does not have assessed contributions like WHO and other UN agencies. The annual income of UNCF is about $1000 millions per year. More than two quarters of budget are provided by North America, Western Europe and East Asia. The other quarter comes from NGOs and marginal 10 percent was raised by selling miscellaneous items (UNICEF Policy Review 2000: 27). The UNICEF income is allotted to two major categories, namely General Resources also referred as Voluntary Contributions and Supplementary and Emergency Fund intended for specific purposes. The General Resources are allotted to the fixed programmes while exigency funds are reserved to meet any disastrous.

**UNDP**

The financial contribution of UNDP is primarily derived from contributions from participating States (Gordenker and Wise: 543-55). However the native Governments have to bear the implementation cost, which is a unique feature than any other UN agency. In addition to the core programmes, the UNDP manages special purpose funds and it jointly co-finances with other agencies if the target exceeds beyond its limitations. (UNDP Human Development Report 1996:137) In 2000, the UNDP's income stood at 1.9 billion dollars. The share of the health programmes ranges from 10 – 15 percent (UNDP 2000). But its major player as technical assistance organization considerably weakened during 1980s, which reflected in the donor policies. In the 1980s Organization of Economic Cooperation and Development (OECD) provided more than 95 percent of extraordinary budgets. This oscillation in the voluntary contribution reduced UNDP's activities.

**UNPF**

The UNPF relies on the voluntary contribution from Governments. The major portion of the revenue is contributed to the General Budget, which is not earmarked because of uncertainties. The UNPA also administers funds on behalf of the donor governments for an agreed project or group of projects. The major donors include Japan, Sweden, Netherlands, the United States, the United Kingdom, Germany, Denmark, Norway and Canada. (UNPA 2006) Many European Governments channel funds through UNPA, (Green 1996) Once the major donor the USA ceased to fund after the enactment of Kemp Kasten Act in 1985 and resumed its funding in 1993. (United Nationals Population Fund 2002:963). During this period there is substantial hike in contribution from developing countries. Even though their contribution was nominal but served its symbolic purpose by demonstrating support for UNPA activities. (Lee 1994)

UNPF along with the USAID and World Bank is one of the three largest donors of population assistance. The share of UNPA was approximately US$300 million in 2000. About a quarter, of all population assistance flows through UNPA (Green 1996). The work of UNPA constitutes in developing countries. The major recipients such as India, Vietnam, China and Bangladesh generously have used the resources from UNPA.

## Policies

A policy is a statement or general understanding, which provides guidelines in decision making to members of an organization in respect to any course of action. Policy limits an area within which a decision will be consistent with and contributive to objectives. A policy tends to pre-decide issues, avoid repeated analysis, and give a unified structure to other types of plans. A policy is formulated in the context of organizational objectives. Therefore, it tries to contribute towards the achievement of these objectives. Health policies are framed with the view of both long term and short-term perspectives. Health for all is also such a policy cherished with specified, flexible strategies. Health policies cannot be homogeneous because of the prevailing inequalities among the countries.

Thus, any health policy should be clear, consistent, balanced and a planned one. This section will briefly survey the various policies of the health institutions.

**WHO**

The critical tasks of an organization are defined as the set of actions that allow organizations to cope with the problems it intends to overcome. WHO in its inception prescribed set of tasks and behaviour, which later became its operational mandate (Whoole 1976:76-84). In initial decade containing Yaws, a crippling disease of skin, which leads to disability, became the major agenda in the WHO policy (Whoole 1976:188). After this successful adventure, WHO defined three main critical tasks. (a) The coordinator, holding international symposium, (b) A trainer, offering fellowship to national staff and (c) A disseminator, prescribing rules and guidelines for future programmes (WHO 1998:35-9).

After the successful launch of Yaws approach, organization thrilled to introduce new tools and techniques. In recent days it consists of technical meetings, consultative visits, fellowships training and the provision of supplies. This approach is widely endorsed within the organization. In adopting the above prescriptions the WHO has gained substantial advances in expanded programme on immunization while suffering setback in malaria eradication ventures in the third world. This collection of tasks and behaviour depend on its strength of the culture.

Culture simplifies the number of option and reduces uncertainties. It provides WHO a consistent way of addressing health problems. Culture also makes visible to the international community that WHO, like other international organization possess set of tools and tasks which it utilizes to solve any problem (Ouchi, Williams and Wilkens 1985:461). When culture is widely shared and warmly endorsed, theorists referred it as a mission. Selznick refers this concept as "distinctive competence" illustrated by pragmatic vision. This idea is reflected in the WHO's spectacular work of polio and small-pox

eradication. Earlier to above programmes, WHO has gained maximum success in children for immunization in developing countries (Ouchi, Williams and Wilkens 1985:482). But on the other extreme if this paradigm is wrongly applied the programmes may appear distinctively incompetent. AIDS programme is the classic case of illustration.

**World Bank**

World Bank initially had no clear mandate or any policies in the field of health. But its recent intrusion into health issues is legitimized by its dominant role in economics (Buse: 98). The World Bank gained prominence in the health sector funding in late 1980s and early 1990s. In its famous publication "Investment in Health" in 1993 outlined Bank's vision in this field. (World Bank Report 1993) At the turn of millennium Bank's contribution escalated over one billion dollars ranging around forty projects in various countries (World Bank Report 2000) (Brighton and Reinner 1986:1-27) The underlying twin principles of World Bank enhanced role of private partnership and selective care interventions. The private public combine would reduce public expenditure and entrust people to pay for their health needs (Buse and Walt 1996:185) The strategic of selective care enables to gain shorter results in brief period without envisaging the long-term goals. These twin principles proved to be detrimental to the needy and vulnerable section of the developing societies (Ansari 245-6).

**UNICEF**

UNICEF is engaged in every facet of child health from birth through adolescence. UNICEF became active in health sector in mid 1980s during the organizational inactivity (Williams 1987: 67). The UNICEF advocates comprehensive health care and prevention of child mortality. UNICEF gives generous financial and technical support to national governments, community based education and intervention program on health and nutrition (Wisner 1988:965) (963-969). Priority area would include immunization, preventing and controlling malaria, checking respiratory diseases, eradicating guinea worm and tackling anaemia. UNICEF commenced special programme of antenatal care in massive scale in Africa and Asia due to rising infant mortality (ibid: 968). advocacy, bilization and research in health fields. It has committed to provide forty percent of

vaccines for children in developing countries, which helps to ameliorate measles and diphtheria. Along with WHO, UNICEF supports water and sanitation programmes which in turn is important for health (UNICEF 2000).

**UNDP**

The UNDP's inception is focused on increasing the GDP of developing countries so as to remedy the lopsided balance between the economic development of developed and developing nations. In 1979 it adopted the "Basic Needs Approach", that was first proposed by the ILO. In 1980s, human resources development emerged as the main concern for policy formulation in the organization. This voluntarily funded agency provide expert advice, training and limited equipment to developing countries with increasing emphasis on assistance to the least developed countries. The UNDP, in joint sponsorship with World Health Organization, promoted research work to control tropical diseases involving a large army of scientists in many countries. They are working in multinational and multi-disciplinary team conducting research on six major diseases endemic in tropical countries. These diseases are malaria, schistosomiasis, filariasis, animal trypanosomiasis, chagas'disease, leishmaniasis, and leprosy. It also provides help for diarrhoeal diseases control.

**UNPF**

WHO and UNICEF vehemently opposed the creation of UNFPA because of the mandate and over loping policy interests. Initially UNFPA was intended to be an executive agency, but simply a funding body. It was also expected to act as a coordinator of activities carried out by the specialized agencies such as UNICEF, FAO, and ILO UNESCO. But its scope widened in the later days, as there were more and more complex problems in the existing international organizations. The UNFPA's dependency on voluntary contribution means that along with the Executive Board, the major donors have their say in its policies, programmes and projects. The mandate of UNFPA allows broad spectrum of population related activities but the main emphasis traditionally has been on funding family planning programmes (Hartmann 1987). UNFPA had a programming target Maternal Child Health (MCH) and Family planning (FP) MCH/FP of four percent

in Asia and Africa. However in Latin America, it emphasises on MCH rather than FP because of high MCH percentage (Mendehlson 1993).

Population programming at country level has two aspects, viz., demand creation and supply development. Most of the projects covered by the evaluation of UNFPA are commissioned by the German, Canadian, and Finish development agencies ignoring the gender component. Its scope further widened after the ICPD, which enunciated reproductive health, training and evaluation of its staff. The Cairo plan of action set a target to reduce coercive family planning projects and imbalances in allocation of resources in its projects.

## Accountability

Once the health policies are formulated by the International Organizations, it is the responsibility of the member countries to implement those policies in their countries. Accountability plays a vital role in measuring the performance of the policy implementation by the member countries. Accountability establishes reliability for the proper discharge of the duties. This section will briefly analyse the mode in which the International Organizations are accountable to their policy outcomes.

### WHO

As per principle most inter-governmental organizations are accountable to national governments. As a convention, WHA voting mechanism makes WHO accountable to member States (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995). Extra funding base also commits organization to be responsible to individual WHO programmes (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde 1995). In its early days WHO was dominated by medical professionals and followed disease oriented approach. The members are able to muster political consensus in WHA with the emphasis being on major disease burdens to which new technologies seem to provide possible solutions. Until mid 1970s, WHO was able to avoid conflict largely by taking specific technical approach (Smith: 765). A case to point out was the failure of WHO in malaria eradication programme (Walt 1993). The set back in malaria led to the complete

evaluation of WHO's policies and it was recommended by high level committee that more PHC approach would turn this programme's fortunes.

With the broader interpretation of relationship between health, development and community participation, the comprehensive integrated approach was framed in the late 1970s. But the resources mobilization for comprehensive approach was very modest while vertical programmes yielded substantial support from donor agencies (Allen: 64-7). The extent to which this has been due to the undermining the PHC policies by bilateral donors supporting these programmes remains clear. Nevertheless the division entrusted to implement PHC was never given required leadership and attention in order to systematize across the organization (Walt 1993). Thus the period between 1970 and 1980 is referred as the period of transformation of WHO into political body. This trend resulted in stagnation in its activities and it was sidelined in its specialized field. Thus better accountability is associated with organizations that explicitly define their objectives and use palpable means to attain the defined objectives. But this may not be possible in WHO because WHO's Director General lacks organizational incentives.

**World Bank**

The accountability of the WORLD BANK is reflected in the fact that it mobilizes its resources from borrowings from capital marketing (Gibbon 1992:193-220). The Bank's practices largely accountable to economics and efficiency rather than terms like long duration development results or equity. The Governments are also considered as accountable for the outcome of World Bank projects and loans. But in reality, national Governments are forced to modify the economy according to the guidelines prescribed by the Bank. The World Bank's tough conditions and major role in implementation of the projects are poised to hold accountable to the outcome.

According to Ayres, the dominant ideology widely shared throughout the Bank may be identified as that of neoliberalism (Ayres 1983:16). Further Ayres argues the norms such as removal obstacles for free market determination, sound currency, reduction of public expenditures so on and so forth constitutes basic ingredients of Bank's policy. Deviation

from any of those norms forms the mode of dialogue between the Bank and the deviation country. But Bank officials renounce this as an ideology, instead they argue that it is a neutral policies of sound economic management, technocratically orchestrated mechanism applicable to any system capitalism or socialism or third world way or model. Ayres refers this way of economic neutralism as "technocratic neoliberalism" which detrimental to the developing countries (Ayres 1983:47-51).

Even though World Bank is a political institution they are not directly but indirectly accountable to the peoples of the world through their representatives of their governments. Infact the Central Bank of the member country started to gain much influence in the recent decades. Thus democratic accountability has been further weakened due to the central bank's successful intrusion into the World Bank's activities.

**UNICEF**

UNICEF is accountable to four important players. The Executive Board which allocates country programmes and resources, the sponsors, who provide resources to the organization, the Governments of third world countries as its primary partners and the target group of women and children (Engberg-Pedersen 1992). Whose income is directly derived from the donors, the direct accountability to donors rather than efficiency and target achievement in clearly tangible. UNICEF's situation is thus similar to that of many other organizations (Lafond 1994). The influence of donors on health programmes can be strong since a substantial proportion of funds come from earmarked Supplementary Emergency Funds. The donors, the multiple sources of income, the decentralized structure of UNICEF and its programme activities are integrated with partners, which limit the transparency of the organization.

In the field of health policies, UNICEF was one of the first international agencies to shift its focus from sectoral analysis to comprehensive analysis (Wisner 1988). The comprehensive analysis comprises of action plan for special needs of the children, in which other UN agencies such as Food and Agriculture Organization (FAO), United Nations Scientific and Cultural Organization (UNESCO), International Labour

Organization (ILO) actively cooperated with UNICEF. (Black 1996) But in the later part of UNICEF's emphasis considerably shifted comprehensive intervention to the selective intervention concentrating on specific issue of children rather than development as a whole. The turn of UNICF towards SPHC shortly after the Alma Ata conference caused irritation in WHO's leadership (Walt 1993) (Killingsworth 1986:1000-1013). comprehensive to selective to target specific creates confusion in the health cooperation.

**UNDP**

In principle UNDP should be accountable to both donors and partners in development efforts. According to Jackson Report, UNDP is to be the core organization for UN development efforts because of its large share in funding and large country network. Thus centre-coordinated role was proposed for UNDP. But a firm disapproval from UN-specialized agencies, made this proposal to remain in paper. However, the concept of country programming provided some respect to the organization (Ahlberg, and Lovbreak 1986).

**UNPF**

Since UNFPA assistance is given through partnership with receiving Governments, UNFPA is directly accountable to the Governments receiving aid and assistance. It is quite obvious that UNPFA has to maintain delicate balance between the wishes of its donor and recipients as represented on its apex decision-making body (Finkle 1994). The involvement of the assisted population has been limited largely to there being targets in demand creation, study objects in the knowledge attitudes, practices recipients of the programme services. Thus UNPFA is accountable to member countries and also it should reflect the interests of donors and the programme implementing countries.

## Constraints And Challenges

The confusion over mandates was succinctly brought out in many studies (Lee and Walt 1992: 387-390) about development agencies. These studies conclude that the normative and informative roles of specialized agencies have been reduced while their technical cooperation activities with developing countries have increased. But funding base of this

programme considerably declined and relies on voluntary contributions. Thus the functions of the organization are to be termed as normative role and technical assistance functions.

**WHO**

The normative functions were referred in the constitution as directing and coordinating international health work (WHO Constitution, Jstor). The normative activities are described as the activities that are carried out at the regional and headquarter level, which defines the scientific and technical base of the organization. The programmes also provide necessary leadership, information, organization promotion and coordination. They deal with ideas, values goals and advocacy, which potentially influence the health programme (Sterky, Forss and Stenson 1996:185). Research capacity and relationship with research institution are important for knowledge-based organization like WHO. The concerns were raised against the WHO's capacity as a research agency (Frenk, Sepulveda, Gomez-eantes, McGuinnes and Knaul: 404-7). Attention has been drawn to study the WHO's possible role as a multidisciplinary research into health, health services and health policies at global and national level (Sterky, Bidwai, Trung, Childers, Chumharas and Dan 1996[b]: 331) (Seventh Consultative Committee 1997:1404-7) (Brown, 1997: 12-13). It will be problematic if research and capacity building would become the integral part of the other actors. There is clearly a demand of WHO to provide research synthesis and normative guidance for health policies.

Some donors believe that WHO has shifted too far towards implementing the programmes and in the process it has become irrelevant to their interests. Nevertheless the normative and technical assistance roles to remain as important function of the organization (Walt 1992: 389). There has been pressure to construct a country-based role analogous to development agencies. Many LDCs expressed concerns over such move because they felt that it would dwindle the quality of the assistance (Lee and Walt 1992:390). It has been argued that WHO should undertake fundamental review of regional centres is dot should strengthen non-medical resources at domestic level (Peabody 1995). According to a Danish study, despite WHO's advocacy of a health

policy approach the organization in practice has failed to take up the lead on the country level at the field level, Who's role has been limited to selected global health programme and it suffers from inadequate analytical capacity that has prevented it from influencing critical role in health sector. Thus it was suggested that WHO should limit its technical assistance and should increase its research-oriented role. It was argued that WHO should better use of conventions, regulations, recommendations and reporting mechanism for timely guidance and prompt solutions.

There is a growing concern in the decline of Extra Budgetary Funds (EBFs) on the scope of organization's works. According to several studies EBFs have played essential role in policy formulation and development both for common global needs and in support of technical cooperation. The study reiterates there should not be any reduction in EBFs instead the donors should increase their EBFs for effective technical cooperation. It was further emphasized that the organization has not taken the necessary corrective action to achieve sufficient integration between programmes. Leadership also plays an important role in an organization. In 1990s WHO's leadership came into severe criticisms by the vested interests. However be the merit of the criticism the DG Nagajima's tenure is marked by several allegations including corruption and misappropriation of resources. Thus the important challenge before WHO is to strengthen its research capability, preserve its normative and technical roles and dynamic leadership to exercise its influence. The functions of the WHO have tremendously increased since its inception. However, its financial resource has not been increased in commensurate with its functions.

**World Bank**

As a development institution the World Bank has been severely criticized for nature of its projects and their failure to reach the poor (Payer 1982:17) (Paul 1995:697-726) (Rich 1989:44-52) (Rich 1994:75-9) (Caufield 1996:246) (Oxfam 1995[a]: 54-58 and 1995[b]: 23-5). The World Bank has been blamed for continuing projects, which ignore environmental and social issues, and concerns were raised over its project's impact on resettlement schemes. (Rich 1994:176)

Another line of criticism has emphasized on the effects of SAPs and policy based lending loan conditionality aiming at policy changes (Mosely 1991) (Sparr 1994:38-41) (Loewenson 1993:717-30) (Logie, and Woodroofe 1993:41-4) (Costello, Watson and Woodward 1994:29). The WB has continued to be the target for global campaign and networks whose aim is to change Bank's policies and structures (Anon 1994[a]: 28-31) (Anon 1994[b]: 32-6) (Rich 1995:15) (Barnes, Grossmann and Reid 1994). To overcome such constraints some specific measures have been suggested by various studies. The measures relate to the controlling the administrative cost and proposed decentralization changing the staff mixing with various disciplines etc (Mistry 1995:176-180).

The Bank's report on World Development Report (WDR) stresses on the strategies for poverty alleviation and increased funding for social and health sectors is a positive move (Mosely 1991) (De Vries 1996). However the real contents and consequences of this initiative came under severe criticism. (Ugalde, and Jackson 1995:525-41) (Laurell and Lopez 1996:261-18). According to Ugalde and Jackson, the World Bank's well documented history of secrecy, lack of legal and political accountability emphasizes on free market strategies and its record as an institution actually fosters wealth transfers from south to north does not bode well for those who wish for improvements in third world public health. The recommendations contained in Presenting the Health correspond closely to neoliberal economic principles and promote the Bank's own ideology minimizing the role of Governments in public health interventions. The report places most responsibility for health on individuals minimizes corporate responsibilities on health risks caused by industries and contributes indirectly to the unleashing of market forces in order to maximize profits for large pharmaceutical corporations (Ugalde and Jackson 1995). Laurell and Lopez have concluded Investing in Health is primarily a blueprint for a new health policy within the context of structural adjustment and while it includes broad range of arguments, its implicit premises are neoliberal (Laurell and Lopez 1996). Werner has argued that the World Bank has turned health into investment taking a dehumanising mechanistic market place (Werner 1995:147-51). Despite its all

rhetoric about its poverty eradication, strengthening of households and more equitable and efficient health care, the central function of World Bank remains the same.

The neoliberal discourse has lead to increasing emphasis on non-state health care financing and service delivery as suitable alternatives (Lee and Zwi 1996:355-73). If the World Bank's prescriptions on health have been criticized chiefly on the basis of the contents of strategies, other critical insights have highlighted the role of health and social sector reforms and their linkages to broader policies and aims. Shiva has emphasized on the antisocial nature of World Bank lending claiming that the organization's commitment to privatisation of the social sectors is basically a prescription to take away from the poor all rights and entitlements to health, education and survival itself (Shiva 1994[a]: 22-4). Hutchful has drawn attention to the poverty alleviation strategy of the World Bank which relies heavily on the restructuring the public expenditure rather than on new funding programmes has come from Bank's own resources.

The centralized decision making structures and the policy of restricting information within World Bank have caused irritation. There is also a call to increase transparency and access to information. According to Clements the WB is not well structured to promote the interest of the poor. (Clements 1993:1633-46).

**UNICEF**

UNICEF has practiced a country programming that covers a wide range of activities in health issues (Taylor and Jolly 1988). In the country programming UNICEF's programmes were integrated into national plans. According to Basta, the quality of the country programming process has been well received by developing countries. Despite the merit of the quality of the report some concerns have raised that third world Governments have not taken into UNICEF's confidence while framing the policy. It also reiterates that UNICEF has not taken any survey prior to framing or implementing such policies. There is also risk involved in integration of UNICEF's programmes into national institutions, which may lead to distortions of their priorities (Edberg and Pederson 1992).

Over the past decade UNICEF has placed increasing emphasis on support for public service delivery with the aim to achieve global goals. This work has been done through vertical structures and in the course of implementation parallel structures are also created for service delivery. Support for implementation has been the primary concern and it is aimed in ensuring effective management of UNICEF supported programmes, despite reduction in health budgets and other health activities the coverage of medical components (Taylor and Jolly 1988).

According to Jolly and Taylor, the most urgent questions have to do with achieving the long-term sustainability of accelerated programmes. These programmes would include sustainable primary health care infrastructure, maintaining inter-sectoral cooperation sustained motivation and commitment of policy makers and financial sustainability (Taylor and Jolly 1988). The other important challenge in the policy of structural adjustment. The other emerging trend is that of building alliances with other international organizations.

**UNDP**

The clearest constraining factor effecting the organization has been its declining budgets. According to Williams, agency rivalry over funds is only one factor. The UNDP's philosophy is that it should rely on the recipient Governments decision about its economic and social priorities in deciding on the allocation of the technical assistance funds to the individual countries. This means UNDP is not interested to give preference to external interest like financial organizations. Donor Governments have admitted that although they have total confidence in UNDP's functioning as a channel for multilateral assistance funds, they were not interested in seeing their resources they provide lost in the general pool of multilateral funds were donors can have little say in how the resources are used and get little credit for their contributions (Williams 1987:223-31). During 1980, contributions from OECD countries declined sharply while funding for World Bank increased. There have been calls to revitalize and reaffirm the role of the UNDP as the major and potentially most effective instrument of multilateral development cooperation

and to reverse the relative decline in the UN family in order to avoid the surrender the global development issues to the financial institutions (Nordic 1991). Many developing countries refer UNDP as their major partner and view it as the relevant UN body for cooperation.

UNDP's technical assistance is considered to be well targeted and has the comparative advantage over other development agencies. Its action plan is flexible which can adopt multicultural approach and capable of mobilizing global support for its activities (Nordic 1991). But UNDPs broad mandate and relatively small share of persons with expertise in health indicate a limited capacity as far as substantive issues at country level are concerned. UNDP involves in health through co-sponsored programme emergency action and the funding of research. The Human Development Reports (HDRs) are considered as a welcome contribution in general even though HDRs are dismissed as just another redundant composite development indicator (Mcgillivray 1991:1561-8). Nevertheless HDRs should be applauded for highlighting equity issues and social development.

The future challenges are closely linked with UNDP's process of reform and changes in the nature of technical cooperation. According to Singer, attention is now focused on enhancing the role of UNDP resident representatives in such a way as to make hem equivalent to UN coordinators in an effort to restore the role of the UNDP (Singer 1995:79-94). The organization has undertaken several evaluations to assess the efficacy of technical assistance programme. According to Fukuda-Parr, the problems associated with technical cooperation have been under discussion and the problems related to the expatriate expert component, costliness substitution rather than capacity transfer.(Fukuda-Parr 1995:64-7). The UNDP is also actively engaged in developing and employing new mechanism for sustainable human development (Banuri 1994) (Parnell 1996).

**UNFP**

According to Vaughan, UNFPA is seen as a leader in its field with limited technical capability and implementation capacity, but an effective procurement service. It has been

valued for its achievements in setting up and maintaining networks at regional level. Some scholars see UNFPA across the UNDP and UNICEF with an funding body with advocacy role (Vaughan 1995). On the other hand some scholars have de Facto coordinating agency in the field of population in some countries (Mendehlson 1993). Lee has argued UNPFA has limited role rather than USAID and World Bank (Lee 1994). Some argued that UNFPA has contributed substantially to advancing awareness and support for population activities worldwide, but others believed UNFPA has contributed minimum role within the countries concerned (Lee 1994).

Ensuring universal access to reproductive health services has been defined as one of UNFPA's three main areas of operation. In the Cairo document, RH has defined with terms resembling those of the WHO's definition of health within the UN system (Green 1996) UNFPA tries to provide overall framework to define policies, identify research priorities and give technical guidance for the full spectrum of RH services (UNFPA 1995). Thus overlapping mandate of the WHO and UNFPA gives potential gap for clash between two organizations. The UNFPA decisions are made in HQ at New York and give little opportunity to explore the best possible policies at the regional level. Thus UNPFA should strengthen its field and activities, research and priorities areas if it desires to provide leading role in this field.

## INTERNATIONALNONGOVERNMENTAL ORGANIZATIONS

INGOs participation in health is wide. Their degree of contribution and access and is able to reach wider masses. In general terms INGOs affect national governments, multilateral institutions, MNCs in four different ways. They are setting agendas, negotiating outcomes, conferring legitimacy and implementing solutions. INGOs active in health affairs engage themselves actively in above said four ways. Thus their role cannot be ignored in the HFA vision. This section will briefly delineate two important INGOs namely Rockefeller Foundation and World Vision International emphasizing on their mandate, structure, resources and policies and limitations.

## Rockefeller Foundation

In 1909 the Rockefeller Foundation began to show interests in health problems through support of a programme for the control of hookworm disease in our southern States under the dynamic leadership of Wickliffe Rose. In 1913 this programme was broadened to envisage a worldwide application of similar principles by the creation of an International Health Commission now referred as International Health Division of the Foundation. In the past nine decades it has accomplished extraordinary tasks. The Foundation's council has endorsed Health for All goals and devised mechanisms to attain this target.

### Mandate And Objective

The Foundation's activity was initially a philanthropic activity. It adopted a strong Christianity as the base to carry out its work. But sooner in the mid 1930 its approach has been changed and it incorporated other factors such as economic and social needs of the society in the grant making strategy. As a charitable Foundation its initial mandate were establishing medical institution and suggesting policies to the colonial governments. But when most of the countries became free from the colonial rule it widened its mandate and directly involved in health activities by establishing its offices in the respective countries (Gordon 1997:105). As it is clear that from a recommendatory or grant making body Rockefeller Foundation expanded its mandate to direct involvement.

### Organizational Structure

Rockefeller Foundation as an International Nongovernmental Organization maintains its presence in over fifty countries. Its President who is appointed by a designated body serves as the Managing Director and Executive Authority (www.rockfound.org) Apart form the head the Foundation also appoints divisional heads in New York. The country Director coordinates each country programme. The country director has independent role to function as demanded by the requirements.

**Resources**

Rockefeller Foundation as a non-profit institutions that make grants for public purposes depend for their existence on the private accumulation of great wealth and on fiscal wealth and moral incentives for its philanthropic activities (Bell 1969:465). Rockefeller Foundation utilizes the accumulated private wealth of John. D. Rockefeller for its international activities. Apart from this wealth it also invites donations, contributions from other corporate and business enterprises for its mission.

**Policy**

From the beginning since its inception the Foundation adopted a basic policies, which was consistently guided its activities. Their first principle was that public health was a function of Governments and that long ranged results could be accomplished only by building up national and local health administrations. This end has been pursued along three lines. Firstly, participation in joint demonstrations of suitable practical programmes and provision on a temporary basis of a personal and funds to establish sound public health services. Secondly, development of training centres for public health personal in various countries and provision of scholarships, aid. Thirdly, support of basic research in both governmental and non-governmental laboratories as well as in its own laboratories established for special purposes (Gordon 1997:104).

These techniques have been applied in many specific fields. The hookworm control programme was early extended to the West Indies, South America and the Far East. A campaign against tuberculosis was initiated in France after the World War II and massive campaign for eradication of yellow fever was underway. These programmes intensified with the establishment of research laboratories in Pasteur Institute in Paris and demonstration of practical control measures in Brazil. The developments, which lead to eradication of yellow fever from large center of population throughout the world the preparation of effective vaccines against this diseases and the understanding of the complex problems of jungle fever in Latin America, have been largely the result of activities of the Health Division (Gordon 1997: 105).

In malaria the accomplishments of the Foundation have been equally outstanding since the first mission was sent to Italy in early 1920. The Foundation engaged itself in extensive research to explore the various types of mosquitoes involved, their breeding habits and practical methods of control. This exploration yielded positive outcomes as four decades later the most effected regions like Sardinia has been completely free from malaria. The North America and Western Europe are almost freed from the surge of malaria. Underlying these attacks on such specific enemies of the human race, the need for establishment of administrative health authorities on a permanent basis and equipped with well-organized laboratories is the need of the hour. The Foundation has strongly advocated for establishing Schools of Public Health, which has been partially successful, as many countries has established such schools. The Foundation has realized that health is a positive not a negative thing that it involves hygiene as well as sanitation.

**Accountability**

The Unlike other IGOs, NGOs or foundations like RF's activities are responsible to the community of the participating territory. RF's grants are diluted to local NGOs to carry out its mission and community believes it is the NGOs at the grass-root level, which coordinates and facilitates the programme. The local NGOs gradually becoming redundant and engages themselves as profit making body. Thus RF's programmes are marginal and host nations should take accountable to its programmes.

**Constrains And Challenges**

The three important challenges of RF are organizational sustainability, programme sustainability and financial sustainability (Abel 2004:15). As century old organizations RF has undergone many organizational changes. From the group of family ownership and the recent days of involving other actors like agencies RF has undertaken massive organizational structure. The President's power gradually taken over by the select individuals. It faces constraints in meeting financial sustainability to act over hundred countries. It also faces challenges from growing issues such as AIDS. The concentration on AIDS will undermine its activities in non-communicable diseases. Thus in the new

millennium RF has indicated to withdraw its sustainable health services in some countries in Asia due to above constraints.

## World Vision International

The World Vision International (WVI) is a religious humanitarian international Nongovernmental organization devoted for the upliftment of the poor and suffering people with special emphasis on children. It operates in 96 countries throughout the world and its headquarters is situated in USA. 2.7 million children were benefited through child sponsorship and other welfare measures of World Vision International.

### Mandate And Objective

World Vision serves vulnerable population throughout the world. The WVI works hand in hand with local communities providing community based rehabilitation services. It also joins the global campaign against poverty working with other international agencies raise worldwide support for government policies that benefit the marginalized section. The WVI provides micro finance loans for 365 poor entrepreneurs to create sustainable self-employment in developing countries. HIV/AIDS Hope Initiative, which focuses on orphans and vulnerable children, continue to mobilize, strengthen community-based responses to the epidemic.

### Organizational Structure

The WVI has a unique organizational structure distinct from other INGOs. President heads it at the central apparatus and country directors at the country level. The President is always an American and serves for five years in office eligible for extension. The country directors functions at the pleasure of the central authority and has no fixed tenure. Although it may be an authoritative in centralising structure but the country directors are granted functional autonomy.

### Resources

WVI raises its own resources from its charitable activity. WVI jointly collaborates with private donors, foundations, corporations, child sponsors, government grants, annuity and

investment income, gifts in kind include food, clothing, medicines and other goods received through private and government agencies. It raised more than 1.7 billion US Dollars during 2005 for its health activities (WVI 2005:8-11).

**Policy**

WVI committed over 470 million dollars during 2005 for various programmes (WVI 2005). The programme includes investment in health care, education, water, sanitation, peace building, environmental protection and human rights. WVI delivered about seven hundred metric tones of food to the abject poverty bound regions of Africa. The transformational Development in which WVI programmes leading to sustainable development transforming the society form the ignorance to the livelihood accounted for two third of expenditures during the past two years. It seeks to provide expertise and the temporary resources to help children and communities to move towards lives of dignity and security in developing countries.

**Accountability**

WVI is accountable to donors and other religious organizations. Unlike RF, WVI maintains field level offices and directly accountable to its projects. Its Area Development Programme runs fof long duration of twenty five years through Participatory Rural Appraisal (PRA) technique they are closely linked with the promotion of sustainable health. Thus WVI are directly accountable to the community.

**Constraints And Challenges**

Amidst the growth of the power of WVI the failure in several fields is also discernable. The WVI played a bewildering range of beliefs, interests and agendas they have the potential to do as much harm as good- hailed as exemplars of the promoters of grass-roots democracy and action. But WVI is undemocratic and unaccountable to the people. It claims to represent, dedicated to promote more openness and participation in decision-making. Instead of acting as development agencies WVI transformed as old-fashioned interests group politics that produces gridlock on global scale. Its holistic health care packages faced setbacks due to financial constraints and lack of trained man power in the

field offices. Infact, WVI has withdrawn number of immunization programmes against polio programmes in South Tamil Nadu when community is fully depending on them. It also faces the challenges of narrow focus in operation and to revamp the centralised structure of the organizations.

## CONCLUSION

The organizational goals and objectives designed after some scholars period refer the Second World War as rational system. This model assumes that by organizational nature, which is equipped to analyse, tasks scientifically manage goals and maximize outcomes. The dominant health paradigm of that period is disease eradication, which is seen as a technical problem. The bureaucratic actions were purposeful and well coordinated, procedures were formalized and it was appropriately disseminated in right atmosphere and specialized tasks and policies were framed independently without external influences.

This circumstance became ideal for international health cooperation. Even after five decades of existence of WHO, World Bank signifies this model. But UNFPA implies distinct approach due its organizational features. Thus theorist believes and expanded rational approach so that general rules that govern hierarchical pattern of offices. Therefore all action emanates from its line staff effective technical assistance programme. The UNICEF and UNDP though functions as the development organization but due to its mode of activities it can be placed under open system model.

As the health field is not restricted to single organization it is bound to be overlapping mandate and range of engagement. The new intruders like World Bank were not stable in their process. Its consisting initiative towards to SPHC indicates that it was interested in short-term gain narrowly defined health objectives.

Health cooperation has expanded considerably from disease eradication disease prevention. This change has been brought due to the credible prudent policies of the health institutions. However there are cases of stagnation particularly in AIDS control

and setbacks in malaria control programme in Asia and Africa respectively. To avoid such debacles and March towards the target the international organizations should bring following modifications. Perverse incentives exist for leadership and member States should be eliminated. The organization needs to develop incentives that align staff and leaderships individual goals closer to the organizational goals. Secondly, employing staff with inadequate knowledge of public health limits the organizational capacity to its possibility. Thirdly, the organizations should be adaptable to the external milieu and interact better over their 180 member countries. Fourthly, the organizations should delegate more authority to the regional representatives to suit the local needs. The rational behind such arrangement is that successful completion of projects requires better utilization and application of resources, which can be provided on the basis of local needs and aspirations. Fifthly, in the open system context, professional staff must be given specific outcome objectives and assign distinct tasks such as budget constraints and policy boundaries. They should be granted total autonomy to carry out their mission without excessive supervision. Evaluation of staff should focus on these outcomes and avoid the deleterious effects of procedural evaluation. Finally, the organizations should reduce its rule bound bureaucracy. This will reduce cost and increase efficiency. These transformations would enable international community to attain positive outcomes in international health cooperation.

# CHAPTER –III

# HEALTH FOR ALL:ORIGIN AND DEVELOPMENT

The détente between the United States and the Soviet Union in the 1970s gave time and energy for the international community to shift their focus from security to the social issues providing adequate health care to their people has been the goal of all governments in the world. A fresh momentum was provided in 1977 when the World Health Assembly adopted the historic resolution calling for *Health For All* (HFA) by the year 2000. The following year, at the International Conference on Primary Health Care held in Alma Ata, the quest for *Health For All* was set in motion. Since then, the need for equity and social justice in health, and the fundamental right of every human being to health, have been increasingly recognized. This recognition culminated in the World Health Assembly's declaration in 1998, which underscored the interdependence of all nations, communities, families, and individuals in working towards *Health For All.* The Assembly also stressed that the community of nations must act together to meet common threats to health and to promote universal well-being. Thus, *Health For All* has continued to be a principal health development goal and primary health care the main approach to attain it. This chapter is divided into three parts. First part deals with over all view of the state of health in worldwide on the eve of the declaration of HFA and trace the idea of HFA vision. The second part will deal in depth the content of the declaration and the targets set forth to put into practice this vision. Third part will analyze the growth of Health For All vision.

## THE STATE OF HEALTH IN THE WORLD

It is the beginning of 1970s the health and the socio economic situation unsatisfactory and future trends are not encouraging. In addition tremendous disparities existed among countries and these are growing also within countries. Nearly one thousand million people are trapped in the vicious circle of survival and in poverty, malnutrition and disease (Pimental, Tort, Anna and Lee 1998: 817). This despair situation saps their energy, reduces their work capacity and limits their ability to take part in the

development. The depth of their deprivation can be expressed in a few statistics whereas the average life expectancy at birth is about 72 and 55 years in developed and developing countries respectively, while in Africa it is only 50 years. Only 10-20 out of every one thousand infants born in developed countries die during their first year while the Infant Mortality Rate (IMR) is more than 200 in developing countries. The death rate for children between 1 and 5 years old is only about one per thousand in most developed countries whereas it averages about 20 in many developing countries. In Sub-Saharan Africa alone 200 children die within year another one hundred die before the age of 5 years and only five hundred survive to the age of forty (WHO 1981:18).

These deaths in developing countries result from infectious and parasitic diseases. These are closely related to prevailing social and economic conditions and impede social and economic development (Prockington 1975:64-6). Diseases seriously disrupt about a tenth of the life of an average person in developing countries. The parasitic diseases in particular are chronic and debilitating and they endemic cause death and diseases in most poverty driven areas. The common infectious diseases are rampant in the developing countries while such diseases have been reduced to considerable extent in developed countries (Prockington, 1975: 66). The developing countries are facing serious deficiencies in meeting the cost of immunization to prevent these epidemics. Diarrhoeal diseases are widespread in Third World countries. They are transmitted by human faucal contaminated food and water. Only about a third of the people in Least Developed Countries (LDCs) have dependable access to safe supply of water and adequate sanitary facilities.

Diseases transmitted by the insects and vectors are highly contiguous in developing countries and continue to infect millions. Malaria remains the most prevalent despite of the fact that in theory it can be prevented by the routine ministration of inexpensive drugs or by insecticides by spraying mosquito tackler and its larvae. Some 850 million people live in the place where malaria has only been partially controlled and another 350 million areas that still lack active control measures (Steal 1971: 24). In tropical Africa at least one million children die each year from malaria. (Cohen, 1996, pp.518-9) Schistosomiasis caused by a snail-borne parasite is controlled in some fifty countries

where an estimated 200 million people is affected. Onchocerciasisor river blindness causes more than 2 million adult populations in some of the hyper endemic region in Africa (Cohen 1996:519). The development projects have increased the incidents of diseases of schistosomiasisowing to drainage and irrigation canals providing a habitat for the snails and the onchocerciasisowing to spillways of dams providing a habitat for the black fly larvae (Steal 1971:29).

In the developed countries about half of the deaths are due to cardiovascular diseases a fifth to the cancer and tenth to accidents. These problems are increasing in the developing countries in recent decades. Environmental health problems due to industrialization and urbanization are assuming growing importance (Bath 1982:379). These same problems could effect developing countries as they buildup their industries (Steal 1971:29). Chronic diseases increase, as people grow older. In recent years there has been a steady increase in mental disorders and in social pathology such as alcohol and drug abuse. Lung cancer as well as other lung diseases due to smoking and obesity due to overeating are becoming as common phenomena.

In contrast the developing countries experiences different picture altogether. Under nutrition afflicts hundreds of millions of people reducing their energy and motivation undermining their performances in people and at work and reducing their resistance to disease. In these countries as many as a forth of the population have a food intake is below the critical minimum level. The average per capita daily energy calories in the developed countries is about 3400 kilocalories, a figure far in excess of standard requirements. It is 2400 kilocalories in foremost developing countries and only 2000 kilocalories for least developed (WHO 1981:36). This is catastrophic for the underprivileged in many developing countries.

Literacy is of major importance for health. It enables people to understand their health problems and ways of solving them and facilitates their active involvement in community health activities (Lawrence 1956:544-6). The adult literacy rate is almost seventy per cent in industrialized countries while it is only 28 per cent in LDCs and only 13 per cent of women population in those countries was literate. But 900 million

adults in developing countries can neither read nor write and four out of every ten of their children complete not more than of primary education. This low level of literacy also enhances health risks and unawareness.

The economic situation also has direct bearing on health. While the Gross National Product (GNP) is far from being an ideal economic indicator particularly in relation to health since it does not reflect the degree of equity in the distribution of resources and factor tending to increase the GNP might actually detrimental to health. Nevertheless it is still the most powerful economic indicator common in use. The nations with under nutrition, less literacy rates result in further detritions of their living standard and basic requirements (Winakoff 1978:895). High GNP have low IMR and life expectancy and opposite being the case in developing countries. Many of the latter in plunged with the economic problems of inflations, balance of payments crisis and high unemployment. These problems spill over to the developing countries with the further decline in GNP.

Health systems are poorly organized in most countries of the world. Tremendous inequalities exist between the developed and developing countries (Steal 1971:1). In the latter approximately 2/3 of the population do not have reasonable access to any permanent form of health care The overwhelming proportion of resources for the delivery of health care is concentrated in the large cities. In addition to these resources is devoted to expensive highly sophisticated technology serving a small minority of the population to the neglect of the primary health care for the majority. Even in the most highly developed countries the explosive costs of health care is making it impossible to provide the complete range of health technology to the whole population (WHO 1981b :23-24). Deficient planning and management including inadequate cooperation with other social and economic sectors are another affliction of health care delivery systems in many countries. Often multiple delivery systems act in parallel to serve the same population group in an uncoordinated manner. Inadequate training in health management and the insufficient use of good managerial practices led to the inefficiency in the health delivery system. In most of the countries health personals is not adequately trained for the tasks they are expected to perform and also they is not provided with the equipment and supplies required to fulfill the tasks. Health manpower varies greatly from country to

country and includes a wide variety of different categories of people fulfilling different functions in different societies depending on their social and economic conditions and their cultural patterns. To illustrate the widespread disparities one-health worker of all categories including traditional practitioners has to serve on the average 2400 people in LDCs. In other developing countries 500 people and in the developed countries 130 people one-health worker renders the service. In LDCs there is one doctor for an average of 20000 people, in the other developing countries one doctor for 2500 people and in the developed countries one doctor for 500 people. The corresponding figures for nurses one for an average of 7000 people in LDCs one for 15000 people and in the other developing countries one for 2200 people. Thus this figure indicates extremely high degree of disproportion and potential to hamper health services (WHO 1981:38).

The proportion of GNP spent on health ranges from far less than one per cent in many developing countries. This implies an average of few dollars percentage in most developing countries in comparison to hundred dollars in developed countries (Morley 1993 :55). Even LDCs increases the health expenditure by ten per cent per annum still they end up not more than five per cent by year 2000. Thus it is the urgent need of the hour that LDCs should increase there by two fold to meet their basic health needs. Demographic trends paint a disturbing picture. The trends population distribution presents more serious malady for developing countries. During 1970s the world population has grown at 1.9 per cent. If it continues to grow at this rate the world population would reach more than six billion by the year 2000. Over 75 per cent of population resides in Third World out of which Asia accounts for over fifty percent (Ramachandran 1990: 143). If the present trends towards urbanization continue by the year 2000 half of the world's population will live in cities. Eight out of ten in developed countries will live in urban while four out of ten in developing countries will reside in cities (Ramachandran 1990:144). The trend towards urbanization will result in a concentration of population in relatively few large metropolitan areas. It is estimated that by the year 2000 out of fifteen largest metropolitan areas twelve will be in developing countries. In spite of this trend the proportion of the population residing in rural areas will decline significantly in actual numbers the rural population in the world will increase by

approximately 400 million and increase of about 500 million in developing countries. The substantial increase in absolute numbers and the age and geographic distribution foreseen in different groups of countries as well as migration from rural to urban areas have important socioeconomic and health implications. They will influence and place additional burden on physical and social infrastructures increases the dangers of unemployment and underemployment. They will alter the production and distributional systems. It also has quantative and qualitative implications on education, sanitation and housing.

The pervasive problem in the third world is lack of proper immunization coverage, inadequate resources allocated to the health sector, shortage of trained health professionals. The health services are merely curative oriented and hospital based (Tort and Lee 1998:818). Thus public health and community medicine were not given the due share in third world (Lambo 1990:30-3).

Thus, by mid 1970s, the global health situation is of growing differential among and within the countries cause of deaths and diseases are rampant hunger and malnutrition, non-availability of safe drinking water, illiteracy, economic deprivation and burgeoning population. In developing countries, only 20 percent of population enjoyed access to health services and health services are biased towards urban elite. Technological mismatch, low coverage, costly solutions are the hallmark of the health services in the developing countries. It is against this situation of health services that the global strategies for Health For All evolved.

**Idea of Health for All**

The idea of Health For All developed largely due to new public health movements in second half of the twentieth century. Health education and health promotion are the two awareness generating process, which accelerated the health policies (Adams 1985:11-4) (Anderson 1980:79). Public health in general has gone through a profound reorganization in the twentieth century. The nineteenth century public health interventions emphasized

individual health became the focus of concern with the development of comprehensive vaccination and immunization programmes. It is only in the second half of the twentieth century that we have witnessed the transformation of public health approaches with concerns about structure, environment and ecology. A broader focus has become apparent within clinical medicine where the focus has been on the individual within his or her psychosocial context (Armey and Bergman 1984:35). Life styles and health behaviour have become concerns of public health and clinical medicine. Patients have drawn into the diagnosis and treatment of diseases. They have become not only consumers of health services but also quasi-producers of their health status. These shifts reflecting these changes can be identified which undermines more traditional oppositions between health and illness (Armstrong 1977:244-8).

Under the leadership of Canadian Minister for National Health and Welfare Mark Lalonde, a new perspective on the health of Canadians was outlined in 1974 (Lalonde 1975:32-9) Lalonde report introduced into public policy the idea that all causes of death and diseases could be attributed to four discrete and distinct elements. Inadequacies in current health care provisions, life style or behavioural factors, environmental pollutions and biophysical characteristics. The basic message was that critical improvements within the environment a structuralists approach and in behaviour life style approach could lead to a significant reduction in morbidity and premature death. As a result of this report Canadian Government shifted its emphasis in public policy away from treatment to prevention of illness and ultimately to the promotion of health. The Lalonde report echoed the concerns of many who had become critical of narrow view of health associated with the medical model. Basaglia has expressed such sentiments arguing that the medical model somehow separates the soma from the psyche, the disease from the patient and the patients from the society in which he or she lives (basaglia 1986:1-5) are said to lie in scientific explanations, ideologies, clinical diagnosis and prognoses which ignore the far more complex social issues facing individuals in the world such as employment, unemployment, housing or homelessness, and low income or cultures engendering behaviour harmful to health.

## HEALTH FOR ALL: OBJECTIVES, STRATEGIES AND TARGET

The Lalonde Report prompted a series of initiatives principally by the World Health Organization (WHO) covering the next decade beginning with the WHA Resolution in 1977 (WHO resolution 30:34). By this resolution the representatives of the Member Governments agreed that their main social goal and that of WHO should be the all citizens of the world reach a level of health by year 2000 that allow them to leave a socially ad economically productive life. In September 1978 an international conference was organized in Alma Ata expressing principal thrust on Primary Health Care to achieve this goal. It issued a declaration, twenty-two recommendations and a full report on primary health care. This Report emphasized that the health development is essential for social and economic development that the means for the attaining them are intimately linked and that actions to improve the health and socioeconomic situations should be regarded as mutually supportive rather than competitive. The Report went on to outline the feature of primary health care and of health system based on it and indicated how to organize primary health care in communities as part of comprehensive health systems. The Declaration of Alma Ata urged all Government to formulate national policies, strategies and plans of actions to launch and sustain primary health care as part of a comprehensive national health system and cooperation with other sectors. Although the principle thrust of the declaration was Primary Health Care (PHC) it did incorporate a commitment to community participation and intersectional action, which has been, accepted elements within any serious health promotion programme. Implicit in the HFA strategy was the new vision of health promotion combining both life style and structuralist's approaches (Buchanan 1987:164).

In 1979 the Executive Board of WHO issued document entitled "formulating strategies for Health For All" in which it put forwarded guiding principles and essential issues for formulating such strategies. In November 1979 UN General Assembly endorsed HFA goals and Alma Ata Declaration by adopting resolution 34/58. It commanded WHO and UNCF for their innovative strategies and policies. The WHA resolution, Executive Board

guiding principles and the UNGA endorsement are the similar in nature and the important inspiration is that HFA policy has received support from the global body. In 1981 WHA endorsed the strategies formulated by the WHO and other regional centers towards this vision. The national governments are directed to formulate their national strategies and objectives, establishing precise goals in terms of mortality and life expectancy at birth as well as total coverage of immunization, drinking of water, disposal of excreta and provision of medical services for all population groups.

**Objectives of the Alma Ata Declaration**

The international conference on Primary Health Care held at Alma Ata on 12th September 1978 expressed the need for urgent action by all Governments, all health and development workers and the world community to protect and promote the health of all the people of the world, the conference issued a declaration which is subscribed by 134 countries pledged to work towards attaining the minimum degree of health, which could lead to productive life and well-being. They endorsed the WHO's broad definition of health as complete mental and physical well being rather than defining in terms of medical conservatism (Mahler 1981:5). these countries along with International organizations such as WHO, UNICEF and other major funding organizations pledged together to work towards achieving basic health needs through the comprehensive primary health care.

(i) The conference strongly reaffirms that health which is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (WHO 1978:3).

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

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

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

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

**Need for Primary Health Care**

The Alma Ata conference highlighted that primary health care system would be the main mechanism to achieve the goal of HFA. The conference called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a NIEO. It urges Governments, WHO and UNICEF and other international organizations as well as multilateral and bilateral agencies, NGOs, funding agencies, health workers and whole world community to support national and international commitments to primary health care and to channel increase technical and financial support to it particularly in developing countries. The conference calls on all the above mentioned to collaborate in introducing developing and maintaining primary health care in accordance with the spirit and content of this declaration.

Primary Health Care includes-

(i) Reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social biomedical and health services.

(ii) Addresses the main health problems in the community providing promotive preventive, curative and rehabilitative services accordingly.

(iii) It includes at least education concerning prevailing health problems and the methods of preventing and controlling them. Promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation, maternal and child health, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases, and provision of essential drugs.

(iv) Involves in addition to health sector all related sectors and aspects of natural and community development, in particular agriculture, food processing industry, education, housing, public works, communications and other sectors and demands the coordinated efforts of all those sectors.

(v) Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care. Making fullest use of local natural and other available resources and to this end develops through appropriate education the ability of communities to participate.

(vi) It should be sustained by integrated functional and mutually supported referral systems leading to the progressive improvement of comprehensive health care for all and giving priority to those most in need.

(vii) It relies at local and referral level on health workers including physician's nurses, auxiliaries and community workers as applicable as well as traditional practitioners as needed suitably.

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

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

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

The most politically charged aspect of PHC as proposed at Alma Ata was its all inclusive equity oriented approach (Bryant 1998:121). The declaration stresses the need for a comprehensive strategy that that not only provides basic health services for all but also addresses the pervasive underlying social and political causes of poor health. It links health to a strongly participatory strategy that has since become known as people centre development. The support document for the declaration states that resistance to the primary health care should be thwarted and more aggressive strategies should be devised to pursue PHC. The Alma Ata declaration not only emphasizes Health For All requires structural change in the direction of greater socioeconomic equity but also anticipate opposition to this revolutionary strategy within the existing power structure. It can be seen that the proper application of primary health care will have far reaching consequences not only in health sector but for other social and economic sectors at the community level. Moreover it will greatly influence community organization in general

resistance to change and to overcome such opposition and to give people stronger voice the declaration calls for strong popular participation. Primary Health Care is an essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms and integral part both of country's health system of which it is the central function and main focus and of the overall social and economic development of the community. It is the first level of contact between individuals and national health systems in the continuing health care process.

**Strategies for Achieving Health for All**

In the Alma Ata Conference the member countries expressed their reservation to frame any global strategy to meet HFA vision. As the traditional world politics battle between supranational and sate sovereignty resisted them to concluding any meaning full strategy. However in the subsequent international deliberations and the preparatory committees a potential break through was made. As a result in 1979 the Executive Board of the WHO issued guidelines to the respect national governments and the regional headquarters of the World Health Organization. This relaxation was due to the diversity of the health problems. For example chronic diseases face Americas, Southeast Asia was the problem of infectious diseases and Africa is plagued by HIV AIDS. Due to such diverse and complexities the framing of strategies for HFA was delegated to the prerogative of the national governments.

The Executive Board's strategies recognize HFA is the call for social justice and equity. This suggested broad strategies to the domestic governments incorporates increase in life expectancy and in the quality of life improving equity between and within countries and access to all sustainable health systems. Thus it thrown wider concerns individual, government, national, international responsibilities Thus it can be said that the global strategy is a collective action involving people and civil society in planning and implementing the policies.

In 1979 the thirty-second World health Assembly (WHA) launched a global strategy for Health For All by the year 2000 by adopting resolution WHA32/30. In this resolution Health Assembly endorsed the Report and Declaration of the International Conference on Primary Health Care held un Alma Ata USSR. In the same declaration the Health Assembly invited the member States of WHO to act individually in formulating national policies, strategies and plans of action for attaining this goal and collectively in formulating regional and global strategies on the basis of guiding principles issued by WHO's Executive Board in the document entitled "Formulating Strategies for Health For All by the Year 2000". A large number of countries in all regions have since formulated national strategies and all regions have drafted regional strategies.

The first principle and strategy of HFA is to reduce inequalities in health between and within countries should be reduced because the HFA's core foundation is equality. Secondly the health promotion and disease prevention should be the strategy to help people to reach their full physical, mental and social capacity. Thirdly, it is to ensure people have accessible to all vaccines and medicines prerequisite for better health. Fourthly, creating awareness about health issues and community involvement in health services are considered to be important strategy in HFA vision. Fifthly, international collaboration should be used to address the health problems that transcend national boundaries. Sixthly, Primary Health Care (PHC) is recognized as the key strategy to attain HFA (WHO 1979:1-6).

The global strategies is based on the Alma Ata Report and Declaration and the WHO's Executive Board guiding principles. It reflects the national and regional strategies as seen from global perspective. It also responds to the resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development, which was adopted in November 1979.

**Targets Set in HFA Policy**

The global target reflects the major components to guide its implementation. These targets are evolutionary in nature, as the WHO members in various conferences and deliberations have developed it. The domestic or national governments will frame its own targets depend on their needs and priorities. HFA targets can be divided into three groups. First targets relate to the health outcomes. Second set of targets has emphasized that HFA can be achieved if the broader determinants of health are addressed. The third group of targets reflect the tool to build sustainable health systems.

The first target deals with the equity as the core principle without the compromising the merit. Equity is necessary for comprehensive and consistent preservation of inequities for the analysis of the determinants of disparities. This also helps in assessing the impact of health policies. The target two advocates the need for improvement in Maternal Mortality Rate (MMR), Child Mortality Rate (CMR) and life expectancy (simeant and visschedijk,1998:56). HFA policies set a target to reduce hundred casualties per thousand in MMR while forty-five per one thousand in CMR. It also envisioned increasing life expectancy by seventy years in all countries. The target three emphasis to mitigate the spread of five pandemics such as Malaria, Tuberculosis, HIV AIDS, violence and trauma. The five diseases constitute the world's maximum of cause of death and disability The HFA policy envisaged to reduce these diseases by comprehensive vaccination and substantial immunization. Target four specifies the non-communicable diseases such as measles, lymphatic filariasis, transmission of chagas; leprosy will be eliminated and eradicated completely by the year 2000. It also highlighted the grim picture of iodine and vitamin deficiencies and vowed to increase resources for preventing these maladies.

The target five emphasized the need for basic amenities such as sanitation, safe drinking water, food and shelter. This target advocates for intersectoral action between community participation and decision making authorities. Moving with the fixed health related targets, the seventh target stressed for the need for establishing operational mechanism for developing, implementing and monitoring policies that are consistent with HFA policies. The eighth target emphasized on research policies and institutional mechanism

will be operational at global, regional and country level. (Simeant and visschedijk 1998:56). Thus it is clear that the targets are quite ambitious and Comprehensive. To make this target realize, requires a strategic alliance between WHO, WB, and other UN organizations, NGOs.

## GROWTH OF HEALTH FOR ALL

The HFA vision did not remain dormant after its adoption. The adherence to the vision engaged themselves in number of midpoint meetings. The regional centers established evaluation teams to monitor the progress of the targets.

### Ottawa Charter

WHO in Europe launched its formal programme on health promotion using the above twin supporting themes of healthy cities project and health environment in 1984 (WHO 1984:1-16).1 This intrinsic programme gave rise to the international conference on health promotion held in Ottawa in November 1986. The Ottawa Conference concluded with the production of a charter, which outlined five principal areas for health promotion. These areas are action building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services. These five action areas provide a useful framework for the delivery of health promotion programme. Ottawa Charter on Health Promotion, an International Conference on Health Promotion, Organized by WHO, Health and Welfare in Canada, Canadian Public Health Association (Ottawa 1986:1-3). The Ottawa Charter also included three process methodologies or mediation, enablement and advocacy through which people could begin to take control over their own health. A health promotion activity requires the identification of obstacles to the adoption of the healthy public policies. The societies are complex and interlinked. The health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for emergence of socio ecological approaches to health. It is thus necessary to maintain reciprocal balance between the health and conservation of natural resources.

**Adelaide Conference On Health Promotion**

As a follow up to the Ottawa Charter another health promotion conference was held in Adelaide in April 1988. Adelaide Charter concentrated more on healthy public policy as an arm of health promotion and delineated certain policy priorities. These were policies supporting the health of women, nutritional standards, and tobacco policies concerned with environment. Underpinning these priority areas were the twin concepts of health equity and policy accountability. However policy makers mistakenly believed that only national Governments policy had any real effect on measures for health promotion (WHO 1993[b]: 6-11).

**Sandsvall Meeting**

In 1991, review conference in Sandsvall focused on supportive environments for health specifically it attempted to find practical ways to create physical, social, economic, environments for health compatible with sustainable development. It produced a handbook on action to improve public health and the environment. The conference points out that millions of people are living in extreme poverty and deprivation increasingly harsh environment, which threatens the goal of Health for All to achieve. The conference recognized that every individual has a role in creating supportive environment for health. Health, environment and social justice are became the integral part of broad alliances between the countries to achieve HFA.

**Jakarta Conference**

In July 1997, Jakarta Conference is the first such conferences to be held in a developing country and also it is the first conference where for the first time to involve private sector in health matters. It provides an opportunity to reflect on what has been learned in effective health promotion, to re-examine determinants of health, to identify the directions and strategies which are required to address the challenges in promoting health in developing countries.

The Jakarta Declaration calls for firm commitments to draw upon the widest resources to tackle health challenges in developing countries. The conferences also recognizes the pre-requisites to health are peace, shelter, education, social security, social relations, food, income, empowerment of women, a stable economic system, social justice and respect for human rights and equity. The conference also identified poverty is the greatest threat of health. Demographic trends paints disturbing picture. The burgeoning population in the Third World and ageing and prevalence of chronic diseases are some of the major problems in the health filed in the threshold of new millennium. Thus Jakarta declaration offers new focus and vision to carry forward the HFA movement (WHO 1993[b]: 16).

## GLOBAL INDICATORS FOR MONITORING HFA

The studies will also emphasis on global indicators to calculate the degree of achievement. The global indicators serve as the engine for the HFA vision. It helps in monitoring, evaluation and assessing the progress of HFA policies (WHO 1993[b]: 19). They are as follows.

(a) The number of countries in which HFA is continuing to receive endorsement as policy at the official level. allocation of adequate resources equitably distributed, high degree of community involvement and establishment of suitable organizational framework to implement the policies.

(b) The number of countries in which mechanisms for involving people in the implementation of strategies are fully functioning or are being further developed. The health policymaking should be decentralized to involve the social activists, women groups, and farmers, Trade Unions etc

(c) The percentage of Gross National Product (GNP) spent on health. It is agreed by the developing countries to spend at least five per cent of their GNP should be spend on health sector.

(d) The percentage of the national health expenditure devoted to local services. The domestic governments should invest more on primary health care, dispensary care; first level contacts and more importantly hospitals should be excluded from these expenditures.

(e) The number of countries in which resources for PHC are more equitably distributed.

(f) The amount of international aid received or given for health. The number of developed countries with well defined strategies for HFA accompanied by explicit resource allocations.

(g) The percentage of the population covered by the PHC with at least the following. Immunization against diphtheria, access to safe drinking water, availability of essential drugs, etc.

(h) The Infant Mortality Rate (IMR) among vulnerable groups should be reduced to fifty per thousand births. (I) Literacy rate of the country

(j) The per capita GNP exceeds US Dollar five hundred.

## CONCLUSION

This chapter has outlined the growth of HFA and elaborated its growth. It also discussed the state of the world health on the eve of declaration. As it is clear from the above discussion that the Third World and the developed world was facing distinct problems. The HFA emerged to address those core set of problems by collective means. As it has been clearly demonstrated the framing of strategies for implementing these policies are left to the prerogative of the participating governments for the smooth progress. The international efforts did not stop with the conception of idea of HFA instead there has been constant periodic review conferences and fixed targets and indicators were set to asses the progress made in this direction.

# CHAPTER –IV

# PROBLEMS IN PROMOTING HEALTH FOR ALL: GOALS AND STRATEGIES

In a landmark global conference in Alma Ata a revolutionary strategy based on Primary Health Care (PHC) was conceived as the central fulcrum to achieve "Health for All" by the year 2000. It is a global strategy initiated from above, but shaped by the 1970s worldwide challenge from below and defends it as a positive attempt to promote health, social justice and equality. It can be claimed that HFA goal has been partially successful. The global indicators reveal that in many countries health status have improved, mortality rate has been declined, and life expectancy has increased. However it is clear that grand aims facing new challenges from new pressing problem such as AIDS and health inequalities have widened as a result of economic globalization driven by powerful capitalists interests. This chapter probes into a fundamental question whether HFA 2000 was hopeless utopian dream or whether there were specific problems, which retarded its realization. It highlights some of the systemic problems, which come in the way of effective implementation of the goal of HFA. It attempts to evaluate the performs of various international organizations, agencies and International Non-Governmental Organizations dealing with health matters and probe into the problems and challenges faced by them in the process of implementing the HFA goals and strategies. To analyze these prepositions the chapter is divided into two parts. The first section will elaborate the systemic problems of deregulation, structural adjustments, and globalization and WTO regulations. The second part deals with attempts made by select international organizations and agencies and some of the INOGs in implementing the goals and strategies of the HFA and the problems they encountered in the process.

## THE SYSTEMIC PROBLEM

In this section, the study will briefly analyze the systemic problems that hindered the implementation of HFA policies. The deregulation, structural adjustment, globalization and more recently the new regulations introduced by WTO will be looked into as the systemic or global crisis factors that stunned the progress for achieving the HFA goals by 2000.

**Deregulating Health**

Research by Lundberg and Squire (1999) into trends in thirty-eight countries between 1965 and 1992, found that open to trade was correlated negatively with income growth among the poorest forty per cent of the population and positive for the remainder (Carpenter 2000:338). While poor people are particularly concentrated in areas of high stress notably Sub-Saharan Africa, which goes unnoticed in this process. The Asian financial crisis of 1997-1998 also throws millions into poverty. These are all the areas of the world most at risks from the AIDS, the worst pandemic the world has seen which in years to come will dramatic economic as well as human costs. There is incontrovertible evidence that general inequality and inequalities in health march in hand in hand, both between regions and countries and within countries (Navarro 1999:215).

In 1978, at the time of Alma Ata, there was a growing trend towards social regulation, and emphasis on equality and expansion of health and welfare provision, operated by agencies with a Keynesian or reformist bias like the WHO, over whom developing countries were exercising a growing influence. However since then there has been a shift in power from these organizations to ones which are primarily accountable to the USA, notably the World Bank, the IMF, and the WTO, who have insisted that they shift from Keynesian to neoliberal and monetarist methods. It could be argued that recession in the 1980s dictated this course of action, but there is also evidence that this was used by elites as a pretext for clawing back some of the power that was threatened by initiatives such as

HFA2000 and NIEO. This trend was accelerated by the Thatcher Reagan regimes of 1980s, which brought in new discourse of free market mantra, and caused severe reversal in health policies. These regimes were guided by neoliberal individualism, which made serious inroads against all forms of collectivism, fostering the expansion of the market and erosion of State regulation of social life. These changes caused considerable cost for the losers in global competitive processes.

The debt crisis in the Third World was due, among other things, to recession and the decline in prices for primary products, the failure of big prestige development projects and, corruption among national elites. International agencies such as the IMF and World Bank have offered help, but in the process have undermined national sovereignty through the imposition of policies of 'structural adjustment' on debtor countries (George 1988:7-8). These have forced governments to follow strict monetarist policies, public expenditure cuts and 'de-regulation' to open up countries to the influence of multinationals.

The world health could be improved by two means (Navarro 1999:215). The first is to speed up the rate at which disadvantaged people are able to embark on the health transition. The second is to try to minimize the extent to which people then become prey to chronic illness and disability associated with western 'civilization' (Navarro 1999:216). Both of these strategies are essentially political issues, dependent on securing greater social justice for the poor while curtailing the power of multinational companies and prevent them from environment damaging forms of production and consumption. Unfortunately the ability to act on both fronts has been seriously undermined since the 1980s by changes in international governance that enhance the power of financial markets and multinationals to force national government to deregulate health sector and cut each public expenditure (Navarro 1999:222).

**The Health Effects of Structural Adjustment**

The WHO in the early 1980s was advocating the expansion of primary health care facilities in rural areas, the World Bank, and the IMF were insisting that indebted countries should cut these public expenditure along with other public services, and would at most support specific campaigns targeted on vulnerable groups. They also insisted on currency devaluation, denationalization, the ending of food subsidies, wage restraint, and introduction of user-fees for health and education. Debt servicing policies also encouraged the production of cash crops rather than food for subsistence, even though one of the most significant causes of debt was the fall in the price of primary products, which was accelerated further by increased production. As well as the direct effects on health, such policies had indirect destabilizing effects, which exacerbated social tensions, intensified communal strife, and in extreme situations led to genocide in the countries like Rwanda (Wakhweya 1995:71-2).

An analysis by the World Bank found that spending in the social sector in all fifty-three countries undergoing adjustment declined typically from 5.9 per cent of the budget to 5.3 per cent. Health expenditure fell from 1.3 to only 1.1 per cent. The theory was that health charges would generate the resources to finance primary health care, but in practice this has not happened .The aim of agencies in developing special programme such as the 1996 joint IMF-World Bank Heavily Indebted Poor Countries Initiative (HIPC) was primarily to conserve Neoliberalism policies in the face of intense criticism. This measure only applied to uncollectable debt, and to qualify for relief countries initially had to agree to three further years of strict structural adjustment, which often increased poverty levels. Africa now spends twice as much on debt repayments as health care. Programme of adjustment are now supposed to have safety nets but governments often cannot afford to fund them (Logie and Haines 1995:544-5). Having failed in Africa, the West then sought to impose similar market ideologies and policies on the Soviet Union and Eastern Europe, with similarly disastrous effects on health. The disintegration of the social fabric in the former Soviet Union has particularly impacted on men whose life expectancy has fallen from sixty-two to fifty-eight years since 1980 (Walberg, McKee,

Shkolnikov, Chenet, and Leon 1998:315). In other words, the health transition has gone into reverse gear. The destructive tendencies of Neoliberalism also spread to the Tiger economies of Asia in the wake of the 1997-1998 crisis, threatening the health gains they have made, and illustrating that these are not secure in a volatile world financial system (Rowson 1998/99:18-9).

**Globalization and Health Transition**

The latest phase of globalization appears to have brought about economic growth in the developing countries. However, behind the appearance of economic growth in the developing countries are features like transfer of dirty industries such as nuclear reprocessing and regime shopping by the multinational in search of tax breaks, lower wages, weak health and safety regulations. This involves frequent resort to exploitative forms of labour such as the estimated 250 million child labourers who are denied schooling and often work in hazardous circumstances (UNICEF 1997:10).

Alongside production, multinational companies are also exporting hazardous consumer products that are falling in demand in the West to countries where regulation or consumer awareness is weaker. This include well publicized examples such as the promotion of powdered baby milk which UNICEF estimates may be responsible for 1.5 million infant deaths a year. Although WHO International Code of Marketing of Breast milk Substitutes was introduced in 1981 to prevent this happening, but its provisions are still being flouted (UNICEF 2000). The promotion of tobacco by multinational companies has increased rates of smoking in developing countries, which is detrimental to health. In some instances whole economies like Zimbabwe is becoming dependant through the growing, consuming and taxing of tobacco. The most damage to the health was the increase in the consumption of alcohol. A 1996 report by World Bank, WHO and Harvard School of Public Health estimated that the alcohol causes more illness, injuries, and violent crimes than tobacco. Alcohol is the forth-leading causes of disability in the world after depression, anemia and Tuberculosis (McGinn 1997:9). Thus the globalization has damaging effects of normal patterns of work, consumption and the lifestyle on the health of the people across the world. This absorption of the people in the developing world into

western industrial and consumer capitalism is widely causing the toll from western diseases such as cancer, strokes, heart diseases and diabetes. This health transition of the developing countries to western diseases is likely to follow the pattern followed earlier in northern capitalist countries. One of the most important changes is the shift to the western mode of diet. McDonalds, Coca Cola and Nestle promoted it. These MNCs along with the GATT and its successor WTO with its mandate of global free trade policies further accelerated the process (Sherry and McPherson 1997:86-7). Thus it is explicit that HFA vision has been hampered by the shifts in the production and consumption due to the effect of globalization. It can be said that the globalization brought prosperity to meager and mystery to millions.

**The World Trade Organization (WTO) and Health Implication**

A global tension then emerged between pressures to further 'liberalize' trade by the WTO and the IMF and the desire of international agencies like WHO and UNICEF to encourage governments to promote health through controls over multinational companies, Example, in 1983 Guatemala enshrined the WHO's Code on Breast milk Substitutes into law, and infant mortality rates subsequently fell. However the US Company Gerber threatened to go to the WTO to challenge a law, which made its trademark -a fat baby, which allegedly encourages dangerous overfeeding -illegal as a restriction on its freedom to trade, and in 1995, the Guatemalan government duly amended its law (Finch 2000:2-3). The WTO, which came into being in 1995, is a step further on from GATT, which was mainly concerned to regulate trade in goods at borders. The WTO seeks to dismantle all border restrictions hindering the operation of multinationals, and also has greater powers to decide in disputes between nations and impose solutions. Two recent agreements also significantly widen the definitions of 'trade' with potentially profound implications for health policy, the 1996 agreement on Trade Related Aspects of International Property Rights (TRIPS), and the 1995 revision of the General Agreement on Trade in Services (GATS). TRIPS institutes a system of 'free' trade that in reality guarantees multinationals a return on patented products, preventing Third World countries from developing cheaper alternatives. In the field of pharmaceuticals this means they must buy expensive brands rather than produce their

own cheaper generics. Although in theory governments may license the latter, the US government has made clear it regards TRIPS as merely a minimum. It has threatened trade sanctions against South Africa and Thailand to prevent them developing local cheaper versions of prohibitively expensive AIDS drugs (Drager 1999:2-4). TRIPS seeks to open up services, including health and welfare, to international competition in ways that would benefit US medical insurance multinationals who could then bid for contracted-out, state funded health care in any country (Price, Pollock and Shaoul 999:1890-1). It is also claimed that the agreement on food safety places obstacles on governments and consumers to prove risk (rather than placing the onus on producers to prove safety), undermining the EU's attempt to ban imports of hormone-fed beef.

## ACTIVISM BY INTERNATIONAL ORGANIZATIONS AND AGENCIES

The recession in 1980s culminated in organizational inactivism. As Martin Rochester argues not only decline in organizational scholarship but also its original mandate and activity (Rochester 1986:778-9). This section will briefly sketch the problems encountered by the selected international organizations agencies in the process of implementing health for all policies.

### WHO and the Stagnation of Health For All

In the initial stages of the HFA programme WHO executed its health mandate in larger political context with respect to advocacy and promotion. In the late 1980s, WHO deviated its original goals and moved towards narrower approach concentrating on technical and biomedical aspects rather than health policy as in larger picture. In spite of the past lessons from disease eradication and the proven necessity of a sufficient institutional basis for carrying out sustainable activities in vertical programmes, pressures continue to engage more in focused disease oriented activities (Kavusolo 1997:208).

In the later decades especially 1980s and 1990s the WHO's policy making capacity was completely marginalized. This role was captured by the financial organizations. Thus the role of WHO declined considerably but the roles of international financial institutions

continue to expand drastically during this period (Peabody 1995:9). Its scope has been unnecessary delimited by its involvement in global player to ministry of health has undermined its range of its activities. The WHO should be in fore front in the international agreements negotiated by WTO and other economic institutions and should strongly narrate the health implications of such treaties. The WHO mandate on health is broad and demands broader analytical capacity and knowledge basis.

Since the endorsement of health for all and PHC policies, the WHO approach has emphasized formally the comprehensive PHC approach including the social rights and equity aspects of primary health care in line with the Alma Ata Declaration. It has been noted however that in spite of the major role of WHO in the promotion of comprehensive health care, the organization itself has not changed (Backett, and Petros-Earvazian 1984: 1-11) (Walt 1993:36-8.) The vertical programme of the WHO remained during the 1980s and the resources used to support the aims were modest and as a whole decreasing in this period (Walt 1993:38). WHO policies were hampered by the selective approach, which gained prominent during this time. It has been described as a modification of the selective resource allocation strategy using markers to predict future morbidity and aimed at making the delivery of health services more efficient (Hayes 1991:6).

The monitoring efforts and choice of indicators had significant impact in terms of interpretation and emphasis of HFA policies. The global indicators gave further fillip to WHO'S assessment of disease burden and the development of DALYs (Disability Adjusted Life Years) with collaboration with World Bank (Green, and Barker: 79). (Murray and Lopez 1994:85-7). (World Bank 1993[a]: 2). It time WHO strengthened its emphasis on the development of health systems and broader policies in health. It emphasized intersectoral action on health as well as the role of the district health systems for the primary health care (Gunarilleke 1984:25-8) (WHO 1986:1-8) (WHO 1988[a]: 12) The midpoint meeting in Riga in 1988 highlighted the need for social and political action, intersectoral collaboration and the strengthening of the district health systems based on PHC (WHO, 1988[a]: 12)

The problems involving economic support for the HFA policies and PHC became crucial in Africa and Asian regions. Since Europe and other Western countries successful in their endeavors while Asia and Africa experienced discernable inequalities in theory and practice of HFA policies (WHO 1987[b]: 44-52). According to WHO document on economic support for the HFA strategies the discussions on economic support for HFA should not be clouded with narrow vision of financing health care or medical care by the public or private sectors (WHO 1987[b]: 42). In developing countries of intersectoral action had difficulties, as these were not easily integrated into a view of PHC with an inherent bias towards medical care. According to Baum and Sanders countries in the first world have used PHC to describe what is more accurately termed general medical practice whereas the rhetoric of the goal of HFA has been used more often in relation to health promotion policies and strategies (Baum and Sanders 1995:159.) The concerns over the socioeconomic trends between countries and within countries have been emphasized in several WHO documents (WHO 1987[b]:52), (1993[b]:114-121). The WHO profile remained low and consensual with respect to advocacy concerning international development policies and health. A review of economic policies and health was made together with the World Bank in 1990 (Weil, Alibusan, Wilson, Reich and Bradley 1990:14-7). The review concluded technical supportive approaches to the PHC and Health for All policies seem to have predominated in the 1990s. WHO is also under pressure to maintain and to promote the vertical programme. This is due to the authority given by the disease eradication programme and the perceived efficacy and short-term tangible benefits of the vertical programme.

Thus it is clear that to the large extent the health policies are determined by the policies and actions outside the health sector. At the global level health is defined within the framework of complex global economic policies and international organizations such as WTO, IMF, World Bank will gain more share in defining economic framework. In this competitive market environment the socially oriented international organizations like WHO without strengthening its broad analytical capacities in both tangible and intangible aspects. If HFA policies should be on the domain of WHO, it should extend beyond clinical or experimental medicine and thus it is clear that without further strengthening of

its capacity in these fields WHO will be unable to fulfill its mandate and goals effectively.

**World Bank's Intrusion and Hindrance of HFA**

The World Bank has entered into health domain in late 1980s and 1990s. The World Bank agenda has been focused on financing and adherence to market mechanisms in public sector reforms. World Bank advocates competition, privatization and regressive health systems and introduction of user charges (Stiglitz 1999:577). As WHO has been marginalized failing to discharge its mandate, WB has assumed leadership in international health policy formulation. According to Berkley since WHO waives out from the health policy formulation and coordination as envisaged by its constitution, other influential parties contemplate the possibility of handing this mandate to World Bank The WB has no clear mandate on health, and even its focus of its activities reveal that it lacks global perspective on health.

The most crucial aspect with WB funding of health is not the length and breadth of its lending, but its role in agenda setting. There has been huge controversy generated in WB financing in health through its lending practices, debt services, and policy prescriptions. The funding for health is not the does not hamper the health policies but its lending practices are not compatible with the policy prescriptions and need of the country. The WHA should intervene in WB financing and should assess the impact of WB Group of IBRD, MIGA, IFC, IDA funding in health sector. This is very necessary in the world of unequal to ensure that the public health systems are universally accessible and affordable.

The selective approaches gained momentum after WB's intrusion into health affairs. In 1982 WB President A. W. Clausen stated in his first health related pronouncement that child mortality in the world could be half reduced through the implementation of the new technological breakthroughs of oral rehydration therapy and vaccinations by means of a selective PHC (Unger and Killigsworth 1986:1001). The former World Bank Presidents Robert McNamara and Jonas Salk persuaded James Grant Executive Director of UNICEF to adopt immunization should be the spearhead of the UNICEF initiative and the WB

actively involved in the organization of the task force for child survival (Warren 1988:90). The selective health care approach has put a major emphasis on community health workers with short training to perform the selective interventions (Unger and Killigsworth 1986:1008). The cost effectiveness of the training of community health workers has been appreciated by the WB which funded and promoted schemes with community health workers because of low cost (World Bank 1980:25). The WB's rhetoric of promoting essential clinical services or basic health services falls on the same selective health care. However these basic services are well integrated and covers different level of interventions (World Bank 1993[a]:61-69), (Walsh and simonet1995:302).

The WB choice of packages and interventions is based essentially on the evaluation of the cost efficiency of the interventions and becomes the criterion of highest priority in the evaluation of choices in health policies (World Bank 1993[a]:36). The WB promoted concepts of social safety nets, public health services and essential clinical services extended to district level have similarities with PHC approach, but nevertheless they originate in different contexts and framework. The WB also relates health to intersectoral action larger development questions and donor policies. The results of these considerations and WB activities do not reflect the spirit of the Alma Ata declaration as advocated by the public health activists (Werner 1995:147) (Green 1995:26).

David Werner has claimed that the WB's involvement in health has meant the death of the Alma Ata Declaration. In his opinion the three major components in the demise of PHC was introduction of selective health care policies, the introduction of the changes in health care financing of health services and the entry of the WB into the health domain (Werner 1994:10-4) (World Bank 1987:2-9) (World Bank 1993[a]:77-89). The WB policies have also indicated a shift from the Alma Ata perspective on health as a social right to the public and private spheres of health services and to emphasis on the outcomes of the different health interventions and on individual responsibilities (world bank 1993[a]:9),(paul 1987:15-17),(clark 1995:400). While the WB has set an aim of universal access to the basic health care package and has promoted the primary level in contrast to

tertiary care, the context in which the changes are made renders these efforts problematic in relation to the aims of the Alma Ata Declaration.

Thus it is clear that WB financing is essential and it has been welcomed by the countries. But HFA suffers because of its overwhelming conditionality. This harsh conditions and the lack of coordination between premier health related organizations and the World Bank stagnates the progress towards Health for All.

**UNICEF and Deviation from HFA**

To its part UNICEF played an active role in HFA policies. Although UNICEF was the joint host of the landmark Alma Ata declaration, its approaches considerably deviated from its original mandate. In 1970s UNICEF was advocating a multi-sectoral approach in health but it considerably deviated during 1980s. The policies have emphasized selective approaches to primary health care. It has moved closer to World Bank by its insistent on cost containment in health services. In comparision to WHO, UNICEF was more effective in making alliances with other actors. However UNICEF's emphasis on project implementation rather than policy formulation undermines its autonomy in its activities. Its explicit emphasis of Selective PHC is discernable after it declared Children's revolution in 1982-83. This declaration encouraged oral rehydration; universal childhood immunization and growth monitoring hampered its vision (Warren 1988:88). The practical aspect in terms of has explained the UNICEF selective approach promised health gains and the potential for mobilizing support from national and international sources. It was also argued that the official Alma Ata publication acknowledged that the national programme could start with only a limited number of the components of PHC provided that the others could be included in the course of time (Taylor and Jolly 1988:973). Wisner has argued that the belief that UNICEF's present emphasis on selective health care is a precursor or leading edge of comprehensive PHC is seriously mistaken and that the approach of UNICEF's diffusion of packages of technologies by means of campaigns organized from the top is more likely to undermine the social basis for comprehensive care (Wisner 1988[a]:967-8).

The UNICEF was an active partner in the development of the goals and targets for the world summit for children held in 1990 resulting in broad Governmental acceptance of the explicit targets set at the summit. Since then UNICEF has been actively monitoring target achievements. UNICEF's promotion of selective policies emphasis à small number of medical activities has been considered as contradictory to the assembling cross-sectoral information relevant to the well being of the children (de kadt 1989:506). The selective PHC approach promoted by UNICEF has been closer to the health policy of the World Bank. The vital UNICEF's strategies such as the prioritization of selective interventions with high cost, efficient social marketing and the Bamako Initiative funding mechanism have enjoyed the approval and promotion by the World Bank (World Bank 1993[a]:2-3). However UNICEF has not claimed that there is a need to halt structural adjustment programme, but rather called for structural adjustment with a human face in order to seek protection for the vulnerable sections. Thus UNICEF's deviation in its policies hampered the progress of HFA (UNICEF 1990:83-85).

**UNDP and Health for All**

The role of UNDP in development work is very complex. The UNDP has a broad mandate and the number of staffs dealing specifically with health field is very limited. Hence it collaborates with other organizations and at any circumstances the UNDP's interagency role has been changed from that of its original mandate. According to Nordic UN project the role of the UNDP has the central funding and coordinated agency has been substantial reduced and marginalized in the filed of development cooperation (Nordic Council 1995). According to Childers and Euquhart despite the emphasis on cooperation and coordination they have been very limited in practice. As UNDP is marginalized in both funding and policy initiatives its development activities declined drastically (Childers and Euquhart 1994). The UNDP's broad mandate and relatively small share of persons with expertise in health indicate a limited capacity as far as substantive issues of health concerned. UNDP's health programme includes cosponsored programme, emergency actions and the funding of research. The Human Development Index (HDI) is considered to be welcome contribution but the statistics presented in the report are highly unreliable for any conclusive policy.

The role of UNDP's president represents in such a way to make them to par with UN coordinators or UN ambassadors. There is also an effort to strengthen the technical assistance of UN agencies into a comprehensive country-programming framework framed and concluded by the organization. The UNDP representative's role should be enhanced to participate in stabilization process and structural adjustment programme (Singer 1995).

The UNDP, in joint sponsorship with World Health Organization, promoted research work to control tropical diseases involving 3,000 scientists in 125 countries. They were working in multinational and multi-disciplinary team conducting research on six major diseases endemic in tropical countries. These diseases were malaria, schistosomiasis, filariasis, animal trypanosomiasis, chagas'disease, leishmaniasis, and leprosy. It also provided help for diarrhoeal diseases control. The UNDP provide support to more than 300 projects in 105 countries at a total cost of $ 205 million over 15 years of time span. During this period developing countries moved up their production to 47 per cent of total world production.

In 1980s UNDP met with several changes in the realm of policies as well as theoretical understanding. Though the number of projects increased and resources also increased in absolute terms, but the burden sharing also increased which effected the low-income countries. Number of international experts continued to rise from developed countries that consumed substantial amount of developing fund. At policy, formulation, and project identification, developing countries were advised to allow UNDPs greater involvement that is clearly a major shift in the earlier UNDP mandate. As 1980s is known as lost decade for United Nations development cooperation because of two successive oil price hike in 1970s, global economic recession, and increased debt burden over developing countries gave rise a new economic policy of structural adjustment and financial stabilization propagated by the International Monetary Organisation. The structural adjustment policy echoed also in the annual report of administrator of the UNDP (Kamal 2003:188-194).

In 1994 the UNDP administrator James Gustave Speth categorised UNDP's criticisms into three dimensions. First, its week substantive capacity as a "mailbox" and processing agency. Secondly, its lack of clear mission and focus spreading its resources too thinly and thirdly its coordination role is not fully acceptable to the UN system as a whole and its central funding role has not been achieved (Speth 1994).

**UNPF and Isolation from HFA**

The mandate of UNPF relates to the population and family planning activities in the developing countries. In the International conference held at Cairo on the broad theme of Population and Development connected these two terms intrinsingly moving away from the demographically oriented policies to the policies concerned with human beings at the center of development and from family planning service provision to approach towards reproductive health services. In the post Cairo period the confusion arose between the UNPF and UNDP in their respective mandate concerning the development and the differences of activities between WHO and UNPF in reproductive health. Both UNPF and WHO offer different interpretations to reproductive health. UNDP sees development as more broader and complex framework while sees slower population growth as an important prerequisite for development. The UNPF's reliance on UNDP is further weakened as statistics demonstrates IDA's contributions exceed UNDP's contributions to UNPF (WB 1998).

The emphasis on individual well-being rather on demographic goals and on development as intrinsically linked with population issues. This tendency poses direct challenge to UNPFA mandate and to the division of labour between WHO and UNPFA and UNFPA UNDP (Lee 1996). It should also be noted that the World Bank has been very active in the field of population since1960s and its power in formulating population policies at country level should left to the discretion of UNFPA. Thus isolating the UNPFA from the original vision of HFA is a major stack of the policies.

**Criticisms and Social Implication of HFA Policy**

In response, the WHO and other more socially oriented international organizations like UNICEF very quickly abandoned broader programme of social change and empowerment. They too have shifted from policies of 'comprehensive' to 'selective' primary health care, especially focusing energies on child health campaigns such as Oral Replacement Therapy (ORT) and vaccination, and sanctioning the introduction of user charges for essential drugs. They have done this to prevent themselves being sidelined altogether(Koivusalo and Ollila 1997:209-10). The reality is that the World Bank has had more resources than UNICEF and WHO to dispense on health care programme, enabling it to enforce its policy preferences. Debate continues about how successful these strategies have been. Critics claim campaigns such as ORT have been commercialized through the sale of special plastic packs to poor parents rather than education in how to mix drinks, impoverishing them further and failing to address root problems of under nutrition (Werner 1994:10-3).

Navarro argues that Alma Ata declaration sees primary health care as a technical problem than as part of a larger development strategy while not minimizing the importance of an expansion of medical services. Navarro notes that most improvements in health have been due to changes in economic, social and political structures rather than in the health sector (Navarro 1984:472). Ugalde further argues that community participation within WHO sponsored programmes legitimized the low quality health services for poor while it generated massive support for regimes that do not seek equity as the basic principle (Ugalde 1985). Heggenhougen agrees that support by WHO of community participation does not by itself alter asymmetrical power relations in States and he points to the fact that community organizing may lead to State repression as in Guatemala (Heggenhogen 1984). Donahueand Green has observed that community once organized for health can make demands that Governments may not otherwise have anticipated or desired. International health organizations therefore have turned of late to the promotion of quality health services.

According to Bryant there is no doubt that WHO has been highly successful in eliciting formal statements from all member States in support of the meaning and perfectly targeted towards to Health For All. The troublesome question has to do with the extent and effectiveness of commitment and implementation of the policies (Bryant 1988). According to Tarimo and Webster the global solidarity in general and the PHC movement has depended almost exclusively on goodwill. The proposal to establishing Global Advisory Council as a means of exerting pressure on various HFA partners to comply with their commitments has not been successful and the need for such mechanism remains (Tarimo and Webster 1995). de Kadt has emphasized the nebulous phraseology and doctrine of HFA strategy and warned that the more a fuzzy ideology born from compromise is allowed to substitute for a practical assessment of the possibilities the less will be achieved (De Kadt 1982). According to Peabody the unrealistic goals of the Health For All strategy have been counter active and unattainable goal is demoralizing sand reorganization may be held accountable to the goals (Peabody 1995). Patel has argued even several years after the initiation of the global strategy essential cost of activities proposed by the strategy as well as their probable effects on health were lacking. Thus hampering the transformation of the policy into plan (Patel 1986). Thus Alma Ata declaration suffered setback from its inception. Nevertheless it was the first document, which generated radical modification in the existing health systems.

According to Baum and Sanders, while the social and other environmental factors influenced health may be recognized in the process of health promotion, most targets set relate to disease biological or behavioral risk factors which parallels the rapid shifts from comprehensive to selective health care (Baum and Sanders 1995 :154). Healthy cities initiatives builds to a large extent on a background similar to that of health promotion and may be seen as an initiative intended to lend support to city based health promotion (Baum 1989:34). (Ashton, Grey and Barnard 1986:320). In 1985 the project on health in cities emerged in the WHO regional office for Europe (Kickbush 1989:77). The first formal activity of the healthy cities project took place in Lisbon in 1986 Healthy cities project has been seen as a local application of health promotion

policies (Kickbush 1986:323). The project has brought forward a broader spectrum of social and environmental concerns resembling those of the Alma Ata declaration. But placing more emphasis on the environment and reaching the local level has caused major irritant among the organization. The healthy cities programme has been called as a success story and a growing movement (Tsouros 1995:133-6), (Kickbush 1989:82). On the other hand according to Baum, healthy cities projects around the world appear to be using the language of radical social movements with emphasis on change through conflict, but to be operating within a bureaucratic logic that stresses consensual and incremental change (Baum 1993:31). The term healthy public policy refers to all general Government policy that has an impact on health. Healthy public policy may be seen as the part of health promotion policy, which in turn belongs to the HFA goal (Hetzel 1989:60).

The existing tendency to 'realism' within reformist organizations has been reinforced since the appointment of Ms Gro Brudtland, former Prime Minister of Norway, as WHO Director General in 1998. The shift in policy has not, however, been in entirely one direction. Stung by critiques of the effects of structural adjustment on the health and well being, particularly in Africa, the World Bank has sought to incorporate 'safety net' measures in programme to protect the most vulnerable. It has also begun to grudgingly acknowledge the positive role of the state and the benefits of investment in health and education, while still of course strictly adhering to a model which equates development with economic growth, privatization and minimal state interference (e.g. World Bank 1993). Thus there has been a growing convergence in approach between international agencies, which is likely to be reinforced by the development of common campaigns around malaria and tobacco (WHO 1999). Unfortunately, then, Health for All emerged as a global strategy in 1981 just at the point when there was a pronounced turn towards Neoliberalism in the world economy. This involved the final rejection by Reagan and Thatcher in the same year at the world economic summit in Cancun, Mexico, of Third World demands for a NIEO (Bello 1994). This shift in global capitalism has been conceptualized by Ruggie (1994), as from and embedded' and constrained, to a 'disembodied' and unconstrained liberalism (Ruggie 1994:3-5). Preiswick and others

argued with some prescience that the rejection of demands for a NIEO was leading instead to the emergence of a 'New International Economic Disorder (NIED). (Abddo 1984:40).

## NGOs and Promotion of Health for All

The role of Non-Governmental Organizations (NGOs) or Civil Society Organizations (CSOs) or Community Based Organizations (CBOs) has received increasing importance in health policy over the decade. As health policies are becoming complex and diverse the Governments and IGOs invested due resources to this sector. Different agencies define NGOs differently. For e.g. World Bank defines it as private organizations that pursue activities to relive suffering, promote the interests of the poor, protect the environment, provide basic social services or undertake community development (Green 1987:40). However there is need for clarity in understanding the heterogeneity of this sector and to recognize the unique roles of different constituents for global health promotion. NGOs in 1960s and 1970s were largely not for profit making rather it was voluntary organization working for integral development. In health affairs they rendered medical services through establishing hospitals, health centers and mobile clinics. This group developed a community based understanding of the dynamics of health, health care and health development in different sociocultural situations. It is quite discernable that NGOs networks developed at national and global levels with a specific focus on health. During the past decade a global people's health movement emerged with a strong emphasis on health determinants and a right's based approach to health care. The potential for partnerships are emerging at global scale.

### Creating Enabling Environments for NGO Coalition In HFA

DR. Mahler, Director General of WHO at the time of Alma Ata publicly stated that it was NGOs who pressurized WHO strongly to move beyond a disease focused, expert dependent, techno-managerial approach based on the dominant system of medicine (Green 1978:711). The community participation, inter-sectoral coordination and appropriate technology became the underlying driving principles of primary health care strategy (Starfield 2005:467). The HFA policies provide a greater impetus for

partnerships between Governmental and Non-Governmental organizations to create an environment conducive to development and elimination of health hindrances. Investment in health is critical for development and achievement of HFA goal. Through advocacy for healthy public policies NGOs increase community health literacy and knowledge. NGO with diverse structures and functions enables them to grassroots presence and closeness with communities. This helps them to address effectively the health needs, concerns and aspirations. One of the corner stones of solidarity is sharing and defining common health and common strategies to attain HFA (Lopez, Arelano and Petras 1994:556). NGOs understand that individuals and families do not produce by hospitals and health professionals, but health by influencing their socio cultural conditions. NGOs are the positive force through direct health empowerment and action with people as well as by working on the deeper issues. They apply the principles of health promotion including capacity development, knowledge transfer, community participation, empowerment, intersectoral collaboration, equity and advocacy for sustainable development. In this part the study will briefly analyze the intervention of World Vision, Rockefeller Foundation, etc in the attainment of health for all.

**NGOs and Key Roles in HFA Policy**

Inequities in health are caused by a number of determinants including access of health care facilities. To ameliorate this gap requires integrated approach involving diverse elements and innovative ideas. Any activity carried outside the Government may be a solid and sustainable strategy. Understanding and engaging the broader community on these issues comes naturally to communities unrestricted by bureaucratic boundaries (Collier 1996:244-9). This is where NGOs excel governmental mechanisms. Hence some of its key roles are highlighted briefly as follows.

The INGO Rockefeller Foundation (RF), world Vision International lead the health policy discourse from its commencement. RF during 1950s acted as a pioneer foundation possessing wider coverage and resources. Its activity in South Asia began after the independence of India in 1947. Soon it began its operation and established a office in New Delhi to oversee its activities. The medical programme is extensive and has deepest

routes in renewed interests in the existing problem in the subcontinent. Even in Latin America it expanded its activities to overcome gross health problems. As we have already stated RF and WVI are the participants to the Alma Ata Declaration and agreed to adhere its core principles. But in the later RF and WVI shifted its mandate to tertiary care and lost its stewardship to progress (Gordon 1997: 554).

The mobilizing of resources became very crucial for HFA policies. The Rf from 1977granted over 2500 projects in the first decade but its decline is visible in the later decade. The one major reason is due to the renewed Cold War between USA and USSR and the policy differences in the host nation. For e.g. RF has ceased to fund health activities since 1973 because of India moving towards Socialistic rhetoric. In WVI turned its emphasis religion as its criteria for sanctioning the project. Thus the downsizing the resources in health activities lead to the retardation in HFA vision.

The RF was the first foundation to established a chair in School of Tropical Medicine in Calcutta in 1916.Dr.Victor Heiser visited India in 1916to evaluate the medical colleges in India. He recommended that India needed a School of Hygiene and Public Health, which till date remains in dead letter (Gordon 1997:108). The Ford Foundation also sends its medical officers to study the major causes of malaria in India and technical assistance team to Latin America. But the discernable problem in their activities is that of showing American values. It can be argued that knowledge and technical activities of these Foundations can be summarized as to bring a professional to the needy country and indicate them to we from America and this is what technical assistance (Gordon 1997:10) Thus many of the developing countries distanced from the large foundations. The stagnation of knowledge generation and mutual exchanges during 1980s and early 1990s hampered the progress of HFA.

The RF in 1929 established Indian School of Public Health, which functioned till 1945. But it cannot carry out its activities because of differences arose during the end of British rule in India. In this way, these INGOs establish institutional mechanisms and do not care for its progress. They strongly advocate it is the responsible of the State to maintain

health institutions through the partnership with private combine. But the Third World Countries could not muster the resources to fund health activities. The RF and WVI has established close link with domestic governments. For e.g.WVI effective

Working of the government project in Ballia, U.P. in India. WVI spends money on training government personnel both in India and abroad, providing for capital inputs to supporting the government infrastructure. Then they make the government staff to work. It worked in U.P (Abel 2004:9). But gradually this partnership suffered due to differences between WVI and the Governments. Thus these INGOs could not fulfill their commitments made in Alma Ata Declaration.

**Public Health Movements and the Promotion of Health For All**

The Public Health Movements (PHMs) grew out of the increasing concerns between Governments and international bodies to work towards the goal of health for all. Unlike the past health groups and NGOs are joined by women's movements, the science and literacy movement, the environment movement, trade unions, development groups and enormous community based organizations which all recognize achieving better health is common concern. These groups should initiate collective analysis, planning, action and reflections with communities built around diverse cultural groups. This awakening culminated into a first People's Health Assembly (PHA) in December 1000, Savar, Bangladesh. Over 1400 delegates from 75 countries participated in health related deliberations, which was documented as people's Charter. Thus wider movements generate unprecedented support and very fruitful for HFA goal. NGO coalitions with communities, Governments and other organizations can mobilize human, political, financial and scientific resources to make HFA a reality. There is a need for the health professional to develop and sustain working links with native communities, groups and movements working beyond traditionally defined health sector in order to influence health determinants.

## CONCLUSION

This chapter has demonstrated that there have been real gains in health since the 1970s, but poverty and health inequalities have increased in an era of advancing globalization. The gains are not secure because of the negative health implications of the activities of multinational enterprises, and a system of international governance that widens inequalities and which is in some way responsible for, and certainly inhibits effective responses to global health threats such as the resurgence of tuberculosis and new diseases such as AIDS and BSE. These health threats are also associated with emerging threats to environmental sustainability through reduced biodiversity and climate change. As two key scientific investigators of the health implications of climate change put it.

The economic structures, social inequities, industrial practices and consumer behavior that underlie many of today's public health problems also underlie the growing pressures on the world's natural, life supporting systems. The advent of global environmental health hazards further underlines the continuing vulnerability of poorer, economically underdeveloped populations (McMichael 1997:809).

As a model for dealing with these problems, the original vision of the Declaration of Alma Ata, and its assertion of the need for comprehensive primary care, seems remarkably robust. It is important to assert this at a time when the organization and its approach have come under attack from both left and right.

The WHO is behind the Parts of the organization seem to be stuck in a public-sector warp. They regard government as automatically well, profit automatically as evil, and intellectual property as theft and harmful. But the age of medicine as pure public service is over. On the left however the WHO and UNICEF are seen as having increasingly abandoned their equity goals for Neoliberalism inspired and not very globalization or rechanneling it in more 'socially responsible' directions? Is it a effective selective care

which, while claiming to be in keeping with Alma Ata, is in fact in profound contradiction with it (Banerji 1999:227-8).

There are, however, dangers in posing broader and more 'targeted' strategies against each other, when they can in fact be complementary. Many illnesses could be prevented with a few extra resources such as vaccines, drugs, health education, and sanitation. Yet it is also the case that health and illness are embedded in deeper structures of causation, which must also be addressed for, as Navarro (1999) insists, the problem is also one of power. This requires 'top down' measures such as real rather than cosmetic action to 'forgive' debt, and a 'Tobin tax' on international financial transactions to slow down and stabilize the world economy and release resources for ameliorative measures.

Beyond these measures, there are bound to be debates about the best way forward. Is the issue one of combating question of a radical curtailment of the powers of the WTO or a widening of its remit to embrace social and health considerations? Is it a question of mounting rational arguments to influence public policies, or taking to the streets in Seattle and elsewhere to force the issue? The above two questions has no simple answer. Yet the fact that we can now pose them is itself an indication that the world is beginning to turn again, just as it did in the early 1980s, this time away from 'market universalism'.

The notion that 'globalization' is an autonomous force that cannot be resisted is being openly challenged, though it will not be easy to change course as the interests promoting it are deeply entrenched. The rational argument based on evidence that the 'social dimension' is positively important to health: that equality and community empowerment builds 'social capital' and a socially cohesive society conducive to health (Wilkinson, 1996). The negative 'risk society' argument (e.g. Beck, 1992) also has purchase in that what is currently a health risk for the poor cannot ultimately be 'contained' either at the local, national or global levels. There are, in Susan George's (1992) memorable phrase 'boomerang effects' that ultimately threaten health and environmental sustainability for all. Yet protest and action are also necessary to force change. While opposing current moves to globalization from above through a 'Lilliputian' strategy of containment, these

also contain the seeds of an alternative 'globalization from below'. (Brecher and Costello, 1994) Alternative policies for global governance and development based on 'community development' principles are thus emerging from the specific campaigns of the increasing powerful GSMs which seek to unite forces in the North and the South. 'Health For All' therefore seems as relevant and achievable as it did back in 1978, and as good a rallying cry for the new millennium as any, showing how global strategies from above and below can work together.

# CONCLUSION

## RENEWAL OF HFA: PROBLEMS AND PROSPECTS

International organizations are understood as an instrument to satisfy the self-interests of Nation-states. The economic and military powers used the international organizations as the institutional means to legitimize its interventions in international affairs. But this study has demonstrated a different perspective emphasizing on their collaborative actions on health. It is quite obvious that all international organizations are not homogenous entities and hence every organization has distinct mandates, structures, policies and objectives. There are also contradictions between agencies as illustrated in the case of meaning of reproductive health by WHO and UNPF. But these distinctions and contradictions are the unique features of the organizations, which in turn interconnect them. To illustrate this interconnectivities and collaborations, the study has analyzed the four distinct parts. In chapter one, the study has classified the origin of international policy making into four general approaches. These four approaches are period specific and HFA policies can be clubbed under the third phase of economic development. It also identified few technical approaches, which is curative arguing the need for comprehensive approaches. The second chapter has been divided into two sections which respectively deal with the organizational dynamics of Intergovernmental organizations and the International Nongovernmental Organizations. The state of the health conditions in the world on the eve of Alma Ata Declaration and the origin and growth of HFA policies are clearly discussed in the third chapter. The fourth chapter has enlisted the problems in the implementation of HFA policies. It is in this juncture, a question arises whether HFA goal has really been achieved. The answer is simply no. Even before the year 2000, the HFA target has been revised and extended to 2020. In this conclusion various reasons for its unsuccessful and its subsequent renewal to 2020 will be discussed.

### REASONS FOR THE FAILURE

Since the HFA initiatives there has been progress in health status. But this progress is not based on uniformity and equity as envisaged by the Alma Ata Declaration. Instead what emerged is the disparities and depravations between and within countries. The developed and developing countries have to encounter different set of problems. The affluent North

has to grapple with the high prevalence of chronic diseases while developing nations are engaged themselves in tackling infectious diseases (Murray and Lopez 1996:30). The HIV AIDS has become new global threat in the last decade and it eludes the scientific community to device a medicine for cure. It provides us the opportunity to analyze what went wrong with HFA policy.

The biggest assault on HFA is undermining the strategy of comprehensive primary health care. The selective primary health care became the philosophy of International organizations and the policy makers. The Alma Ata Declaration envisaged comprehensive primary health care based on equity and socioeconomic development as its core principle has been abandoned in the policy circle claiming CPHC is too costly and complex (Morley 1990:502) Instead what emerged as the selective PHC focused on few cost-effective policies targeting few high-risk groups. UNICEF was the international organizations to switch over to this policy and other organizations like WHO, UNDP followed later (Basta 1989:54-55). UNICEF's selective approach is quite determental because it focused on oral rehydration and selective immunization. This shift reduced immunization cost and spending on children's health came down drastically. The vertical programmes of WHO caused confusion among the public health professionals because of simultaneously exist of horizontal policies and drowning of resources. The cost recovery mechanisms such user fees kept many of the marginalized sections out of the public health services. As a result the child mortality and spread of communicable diseases have intensified drastically.

The World Bank's take over of Third World's health policy in 1990 started the new era in the health policy making. In reality World Bank does not have any clear mandate in the health policy domain. The World Bank realized that by stepping in health field it could explore the possibility of private collaboration (Claeson 1996:266). Thus it gradually increased its badly needed loans to the developed countries and dictated terms according to its wishes to acquire loans. The Bank document titled Investment in health in 1993 outlined its vision primarily free market mechanisms and reducing public expenditures (World Bank 1993:202-204). Thus it relegated WHO to the secondary position only

because of Bank's greater resources clubbed with requests from the developing countries for the highly desired loans.

The free market version of Bank brought large profits to the foreign investors and massive joblessness and increased poverty for millions. When developing countries failed to repay the loans the World Bank and IMF stepped into the domestic affairs with their bail out strategies. The strategies were primarily the ultimate intensions of Bretton Wood institutions of Structural Adjustment Programmes (SAPS) privatization and liberalization of the market. This is the step backward as the Alma Ata Declaration called for the increased public expenditure the Bretton Wood institutions free market mantra greatly hindered the progress.

The partnerships with Trans-National Corporations (TNCs) by WHO and UNICEF is the giant backward from the HFA vision. In last few years both UNICEF and WHO entered into an increasing number of partnerships with TNCs such as McDonalds, Coca Cola, injurious drug and junk food companies(Hamrell and Nordberg 1995:1-4). The classic case is UNICEF's collaboration with McDonalds while McDonalds recognized UNICEF's part of public health programme into its domain. Such compromises with industries that act as the catalysts to the chronic diseases such as obesity, heart diseases and diabetes are goes against the spirit of the Alma Ata Declaration.

The pre-packaged costly food's nutritional contents, the poor families could not afford to buy these nutrients. The rational for this collaboration with these TNCs is to raise resources for the health activities at the cost of structural constraints. The Alma Ata called for the combating structural causes of ill health while these partnerships legitimizes the actions of the actors which involve in enhancing structural health problems.

The next important assault of HFA is corporate rules of free market paradigm. In the late 1980s the large corporate shifted their focus on health field because of its potential to generate huge wealth. Their activities are undemocratic and unsustainable; they promoted

economic growth of the rich regardless of the human and environmental costs. The current model of economic development driven by a deregulated market system is dangerous to health.

The three biggest industries are Arms, illicit drugs and oil. All these colossal industries pose far-reaching dangers to the sustainable well being of humanity and the planet. But wealth generated by these industries strongly influences elections to the public offices, the democratic process gets undermined. It impedes humanity from taking decisive steps to tackle the biggest emerging global threats to human health such as global warming, the impending world war III, and the deepening poverty of one-third of humanity, the global pandemic of crime and violence, and the disempowerment leading to terrorism. Rather than confront underlying causes of these globalize threats to health, the world's chief tens engage themselves in greater ties with armaments, drugs and oil use the current crisis as the pretext to systematically role back civil rights, public services and boost corporate greed.

As the third chapter of the study outlined in detail about the state of the health on the eve of Alma Ata Declaration, it is also important to study the state of the world's health on the new millennium. As we confront the new emerging pandemics, the situation is becoming much complex. Further some of our old diseases are now becoming new ones. For example tuberculosis (TB) one of the major's killers in the past in the developed world and still an important killer in the developing world was declared by WHO as a global emergency. The reason for its resurgence is two fold. Firstly complacency towards TB control in developed world has led to the resurgence of the disease. Secondly the TB germ Mycobacterium tuberculosis is getting transformed easily due to free trade and travel. The migration of people for seeking economic opportunities led to the movement of the persons infected by TB are easily crossing borders. Moreover the TB germ is resisted by the treatment of insufficient drug regiments. The current global trend shows 1.8 billion people about thirty per cent of world's population are infected by TB. If it is unchecked it is estimated that seventy million people will loose their lives between 2000

and 2020. In order to raise awareness of this global emergency WHO has launched a global stop TB initiative to combat this disease (CDCP 1994:3)

Malaria is one among of the oldest diseases of mankind but re-emerging as a major problem in the Asia, Africa and the Eastern Mediterranean. Malaria is also transforming in new ways such as malarial parasite is resistant to preventive and curative treatment and the mosquito vector is increasingly resistant to the insecticide generally used to control it. WHO estimates that over 300 million clinical cases of malaria occur worldwide every year and over one million persons die every year of this disease(CDCP 1999:5) In the recent decade WHO has drawn attention to this epidemic and launched roll back malaria initiative. These are the two long lists of examples. New strains of cholera, resistant strains of bacteria causing pneumonia are widely spreading causing irritation in HFA policy.

The infectious disease such as HIV AIDS showed awesome potential to spread as global epidemic with devastating effects for health. It is estimated that thirty million persons have been infected with virus and over twelve million have fallen prey to the deadly disease. Tackling this virus in the scene of no proven cure becomes the serious challenge for HFA policy. The HIV AIDS has manifested wider disparities between developed and developing countries in combating this menace. For example access to the expensive drugs needed to ameliorate the disease and its progress is out of reach of the vast majorities of its sufferers in the developing world. The several UN agencies such as WHO recognized that the fight against AIDS require a worldwide coordinated effort formed the co-sponsored UN joint programme on AIDS.

The diseases can spread more easily in the highly mobile global village with high intensity of trade and travel. Most of these infections are due to changing life patterns and devoid of any natural immune to these epidemics. The chronic infections such as heart diseases, cancer and stroke has captured its attention in developed countries but it is far from well understood in developing countries. The most of the diseases are caused by insidious nature of addictive substance nicotine with twenty to thirty year delay in impact

on health. As we increase our longevity of smoking emerges as the high risk for death and disability. It is estimated that around five hundred million persons alive today will die due to tobacco related causes if we continue with current smoking patterns. In realizing the urgency, WHO has launched Tobacco Free Initiative has raised the call fro action to draft internationally accepted global health legal instrument the Framework Convention on Tobacco Control.

The other worrisome problems as we move into the next stage of HFA vision are the diseases caused by the deterioting environment, examples include acute and chronic disorders, asthma and allergies from pollutions of the air that we exhale, the toxic poisoning from the water that we drink and food we eat due to contamination and hazardous wastes, skin cancer and catarat from increased ultraviolet radiation caused by the depletion of the ozone layer in our atmosphere and increases in vector borne diseases as the phenomena of global warming changes the diseases depend upon the climatic factors form the new challenges that should be responded in order to achieve HFA.

The Rockefeller Foundation and World Vision International have moved away from awareness generating organization to involvement in internal political map of the host State. These two INGOs merely transformed as another redundant pressure groups arguing to maximize their self-interests. Moreover INGOs are driven by free market ideology and RF canceled its grants to India because of its social fabrics. Since the decisions are not on democratic principles the developing countries have no say in their grant making strategies. The INGOs in general and RF and WVI policies clearly shows they did not show much enthusiasm after the adoption of HFA. Thus the above deviations in the HFA really had a cascading impact in its implementation. As we stand in the threshold of the new millennium there is debate surrounding how to get back into the HFA track. It has been argued Primary Health Care (PHC) has been tried but failed. But in reality it has been never tried, certainly not on the spirit of the Alma Ata Declaration. It is much clear today than twenty years ago that the main determinants of health are social, economic and political resources. The resources have been drowned drastically denying the adequate food and basic health services to the needy and the vulnerable sections. A

fraction of what is spending on arms could provide the necessary health care and food for everyone, which currently lacks them. What is lacking in this concern is political will, rational allocation of resources and spirit of the international organizations. If the people of the world had clear understanding of the looming dangers to their health and the way in which world's top decision-makers have sold out to the interests to the corporations, people of the globe would have united and raised their voice against these groups. In reality some sort of awakening is happening in the Third World which is the positive development such as protest marches against the WTO meetings. As David Werner's memorable phrase goes HFA has to become reality the world should see the leaders and decision-makers who could place human need before corporate greed.

**RENEWAL OF HFA STRATEGIES AND TARGETS**

The HFA 2000 was renewed and further extended to 2020. Recognizing the unattainable target at 2000, WHO has renewed its goal further by twenty years. The resolution in 1995 set the tone for renewal and framing of new set of strategies. The newly framed strategies by reviewed by World Health Assembly (WHA) in 1998 and subsequently it was endorsed by it. The new global strategies aimed to build on global change and the increasing importance of international level activities for the determinants of health. The renewal strategy also included the partnership from private sectors and thus limiting the role of Governments. The 1981 strategy called for promotion of public expenditure while the renewed strategy prescribe to limit the responsibility of the government, thus shifting the focus from social right of access to the health services towards support for public health measures for all.

The document on HFA renewal strategy also acknowledges HFA values. (WHO 1995[d]: 56-57) But if one evaluates it cautiously, the resolution on the new global health policies emphasize only at individual, family, and community levels. But the role of government's agencies, International organizations, and NGOs has not been adequately highlighted. These various organizations have also played vital role in defining the conditions and responsibilities in health sector. The Global Health Policy document emphasizes on stay-health may be welcome at this moment, but in long run it may lead

to disparities. Moreover it dilutes the equity and solidarity requirements of the HFA vision.

**RENEWAL OF STRATEGIES AND TARGETS**

The renewed strategies acknowledged the need for integrating the means of planning, production, policy formulation and health delivery services. Secondly the preparation and use of human resource must be enhanced through better training and improved facilities. It was considered that medical conservatism is also one of the important reasons for failure HFA 2000. To overcome this difficulty HFA 2020 recognized for better coordination between medical and non-medical professionals. Thirdly HFA 2020 recognized the public private path to prosperity. Recognizing the inadequate resources to meet the public health expenditure and the failure by 2000 by this strategy made to envisage new strategy to attain HFA in 2020.Fourthly HFA 2020 acknowledged the intensification of international collaboration in the health field.

The new targets reflected the continuity in the earlier HFA policy. It called for increasing the dissemination of health information about the prevailing diseases and methods of controlling them. Secondly it sets reducing of health problems related to malnutrition by 2015. Thirdly it called on the international community to ensure safe drinking water for all by the year 2015.Fourthly HFA 2020 envisaged to reduce infectious diseases through enhanced immunization coverage. Fifthly it called for prevention and control of endemic diseases. And finally, it advocates for measures to reduce Infant Mortality Rate (IMR) by 5 per one thousands births and Maternal Mortality Rate (MMR) by ten per one thousand by the year 2020.

The study has highlighted the impressive accomplishments in the health such as eradication of small-pox as well as the outstanding problems that retard the progress of HFA. It is for our kind reality that the world is at critical stage of our collective global effort to achieve health for all and argues the need for partnerships from every entity to be part of the solutions. This study has outlined the directions we are heading in the health field in the twentieth century as we confront the challenge of both new and old

problems. HFA 2000 may not be reality but it precipitated number of initiatives probably by WHO, and other UN agencies in order to pursue it. It is in this circumstances we call upon the individuals, governments, NGOs, taking more responsibilities to improve the health, upliftment of the health of our neighbors in our global village in order to make the twentieth century a century of health for all.

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