Global Cooperation Newsletter

ICSW

International Council on Social Welfare

June 2016

This dedicated issue of Global Cooperation Newsletter deals with public health.

The feature article was written by Dr. Odile Frank and covers some of the most acute challenges in the public health area of today in the context of the 2030 Sustainable Development Agenda. Another theme addressed in this issue is related to the activities of the World Health Organization (WHO)—the preeminent international body established 68 years ago to promote health and ease the burden of disease worldwide. The WHO takes direction for its goals and priorities from 194 Member States that it is designed to serve. The World Health Assembly (WHA) is convened each year in Geneva, bringing together senior health officials from around the world, as well as representatives from many agencies, organizations, foundations and other groups that contribute to improving public health. Finally, this edition of the Newsletter presents the profiles of two civil-society organizations active in health-care advocacy, awareness-raising and other spheres.

The Editor

INSIDE

Social protection, universal health coverage and human dignity: The role of the workforce in social development

By Odile Frank
President, NGO Forum for Health

At the opening of 2016, we were gifted overnight with a new guiding vision for health. Our perspective and horizon swerved toward a broader, longer vista. No longer limited by the achievement of specific goals, we now see the possible reach of universal access to health, supported by social protection and guided by human rights and social justice.

The Sustainable Development Goals (SDGs)

The Sustainable Development Goals (SDGs) are not just a new agenda for development policies and their programmes and work plans; they represent values that raise the moral stakes for all societies. They inspire responsibility and accountability.

The consecration of health as a free-standing Goal[1] places health at the very highest priority level of the 2030 Agenda, reflecting a commitment of the international community to universal health coverage and to providing an adequate response to everyday health threats. At the same time, the very first goal of the Agenda[2] - to end poverty - underscores the critical role of social protection systems, one of whose pillars is universal access to essential health care[3].

Implementation gives us all pause. We will need political will and resource mobilization on a sustainable basis and, most of all, sufficient human skills at all levels. The health workforce is fundamental, and the availability of human capacity will be the most accurate translation of both political will and dedicated resources in order to achieve, finally, our longstanding ambition of Health for All.

Odile Frank has worked on health issues at the Organisation for Economic Cooperation and Development, the Population Council, the World Health Organization, the United Nations (as Chief, Social Integration in the Department of Economic and Social Affairs (DESA)), the International Labour Organization (as Senior Research and Policy Adviser & Chief, Research and Policy Analysis Unit in the Global Programme on HIV/AIDS and the World of Work) and most recently at Public Services International (as the Health and Social Services Officer). She holds a Doctorate of Science from Harvard University, where she specialized in public health and the medical and social sciences, and Master's degrees in Population Sciences and in Counselling Psychology. Dr. Frank has authored numerous papers and articles in technical areas of international development.

In 2016 Dr. Frank was appointed Special Representative of ICSW at the UN Office in Geneva and the Specialised Agencies in Geneva.

1 Sustainable Goal 3 aims to "Ensure healthy lives and promote well-being for all at all ages".

2 Sustainable Goal 1 aims to "End poverty in all its forms everywhere", and Goal 1.3 calls to "implement nationally appropriate social protection systems for all…"

3 "Recommendation Concerning National Floors of Social Protection" (N°202, International Labour Organization, 2012).

The health and social-care workforce

The health workforce as well as social and public welfare services are at a critical point, however, and not poised at all to take on the new vision. Health-care and social-work facilities are frequently under-staffed and their professionals are under-paid and experience abysmal working conditions in many parts of the world. In part because of the discouraging terms of employment and poor working conditions, and in part owing to the grievous limitations on recruitment, which are due to austerity budgets and the dictates of structural adjustment, such professionals are also grossly insufficient in number. And despite the shortages in their numbers, there is little or no pressure to increase their wages. But the most grievous consequence is the inevitable impairment in the range of services that they are able to provide to patients in all circumstances.

Significantly, health and social-care workers represent a poorly remunerated workforce, even in countries with a generally high level of health-care provision and availability of social services. Very much like teachers, health and social-service workers are inadequately appreciated and are deemed as unproductive in the new neo-liberal economic calculus, just as education and health are considered consumer goods for which each consumer is responsible, not valued as public goods whose price is above rubies.

Political will is at a low ebb, with governments pitted against private-sector interests to ensure the needed increases in public revenues to enhance, strengthen and give sustainable buoyancy to health care and social services. The ultimate outcome of this contest of wills could be deemed a success if the resources dedicated to building the workforce of health professionals prove able to make the universality of access to health a reality.

A strengthened health-care and social-service workforce will be needed, in particular to ensure the quantity, quality and sustainability of the services, fulfilling a range of functions from serving as "gatekeepers" for access to services and the delivery of health care and social support, including, among others:

1. Access of all to the services to which people are entitled;
2. Accompanying entitled persons, ensuring that services are fully enjoyed by them;
3. Providing health and/or social-care services to persons directly, including those with particular needs, such as pregnant women, women with infants or small children, persons who are unemployed, ill, old or disabled, and all minor children and persons who have two or more simultaneous needs;
4. Ensuring monitoring and quality control of services against the agreed standards;
5. Ensuring the administration, management and sustainability of services;
6. Ensuring coherence between and across services, so as to enable an equitable approach and ensure that the situations of persons with multiple needs are addressed across services and over time.

The health and social-care workforce in resource-rich economies

In many resource-rich economies, the welfare state, as an institution rooted in the ideas of such people as Bismarck (in Germany) and Beveridge (in the United Kingdom), prevailed during the 1960s and 1970s[4] and then rapidly lost ground without being truly fulfilled. The welfare state was trampled on and then overcome by the forces

4 Costa Esping-Andersen. The three worlds of welfare capitalism. Princeton University Press, 1993

of global capitalism, which pushed for weak government and the deregulation of private enterprise on the belief that each individual would benefit directly - and more - from the fruits of his or her labour in alliance with capital, as long as government allowed both labour and capital more freedom. Left to deal more directly with capital, however, labour is no match, and the result of government withdrawal since the 1980s has been a sharp rise in the gap between money earned from work and money earned from money. Fortunes have accrued to the wealthy, and fortunes have been made in the global marketplace, whereas the purchasing power of workers has stayed stagnant, and declined in some cases. Left with increasingly restricted revenues and increasing limits on their authorization and creditworthiness to borrow, governments have not been able to compensate workers for the gap, and poverty has remained, immorally unalleviated in the midst of wealth. As a result, some of the greatest growth in poverty today is occurring in so-called "pockets of poverty" in resource-rich countries. At the same time, the tools to redress this state of affairs remain grossly underfunded, notably the elements that underpin social protection programmes – ***including their fundamental component of universal access to essential health care*** – and that are needed to provide the adequate quantity and quality of human resources to deliver those services.

In a sense, the new Sustainable Development Goals are very accurately addressed to all, including the resource-rich economies. Even if the 2030 Agenda for "*Transforming our world*"[5] has an important focus on developing countries, the language of the goals on social protection and on universal health coverage underscores their universal tenor and inclusive intent:

> "*1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable*"
>
> "*3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"*

Resource-rich countries are being held accountable now to complete what they had started, but have, as yet, failed to achieve. The 2030 Agenda calls for a renewed commitment to universal health, implying a redirection of resources to health care and social systems – including the reinforcement of the quantity and quality of health and social-care professionals – and creating new financing mechanisms to eradicate and reverse persistent poverty. This goal is ambitious, but it is well within the reach of these countries, with clear benefit to all their populations.

In all these areas, the resource-rich countries need to demonstrate their determination and the feasibility and achievability of the Goals, and they need to do so soon.

The health and social-care workforce in developing economies

In most developing economies, there is no history of a welfare state. Solidarity was a critical facet of life in the village and among new urban migrants, for example, but governments, faced with large rural populations living from subsistence agriculture, focused on economic growth based on primary commodities, extractive industries, the modernization of agriculture and the draw of industrialization. These economies often modernized economically at a pace that carried increasing proportions of

5 "*Transforming Our World: The 2030 Agenda For Sustainable Development*". New York: United Nations, 2015 [A/RES/70/1].

the population forward, while economic growth alone was for a long time deemed to be the sole source of relief from poverty. Today, many developing countries have established social-protection systems that include a range of support and benefits for disadvantaged groups. But in these countries too, the requirements of structural adjustment, the pressures of economic globalization and the budget austerity following the impact of the financial and economic crisis originating in 2007-2008 have hampered growth in state solidarity-based systems and stymied their development.

In fact, many of the countries in this group need to re-start and grow their health and social systems. Resources are often lacking, and special efforts are required in order to obtain them on a consistent basis. In this light, most developing countries will need to grapple with altering their sources of revenue from taxation so as to include new taxes, and altering their expenditure priorities, while assigning the health and social-system expenditures a higher priority and downgrading former priorities. This change includes, importantly, resourcing the means to improve the distribution of health professionals in medically underserved locations and communities.

The health and social-care workforce in the most disadvantaged economies

Low-income countries have been hardest hit and have often been totally overtaken by the forces of globalization, having been unable to negotiate any benefits in the globalization process from the global economic transformations taking place. They are bearing the brunt of the load in their enduring poverty. The wherewithal to develop health care and social systems has simply not yet materialized. The governments of these countries are still largely focussing on basic economic growth for its own sake and as a panacea for social development, often making decisions based on the donors' advice that accompanies conditional loans and development assistance. The global economic downturn hit these countries at a critical time, and many of them are just trying to keep afloat, with possibly even more uncertain prospects overall. This group of countries are vulnerable; they will need to obtain better policy advice as well as external aid directed particularly at social infrastructure development. They will need to direct limited resources to health care, education and social services rather than wait for the elusive "trickle-down" effect from limited numbers of growth sectors. There is some evidence that official development assistance (ODA) is growing for these least-developed low-income countries, as ODA gets redirected from better-off developing countries that have "graduated" from concessional financing and are benefitting more from foreign direct investment.

It has become abundantly clear that ODA must be earmarked for social infrastructure development, including health care and social services, and it is not sufficient for the donors, including financial institutions, to simply point to where the money should be invested. ODA should be tracked. A good case can be made when we look at the Ebola virus disease (EVD) outbreak of 2014.

The lack of investment in the health systems in the three West African countries hit by the Ebola outbreak of 2014 was the single most critical cause of the spread and persistence of those outbreaks. At the time, the three affected countries were investing largely in their extractive industries, overlooking health care and social sectors. In one case, the country was not meeting its own targets for minimal "priority sector spending", namely, investing in education, agriculture, energy, justice, social affairs and public works, as well as health and public hygiene, and was failing to meet those targets quarter after

quarter, in fact ignoring its prior agreements with the World Bank to use proceeds for those priority social sectors. In another case, the country was admonished by the World Bank for a small budgetary deficit resulting from overruns in public spending!
Even so, ODA is only a fraction of the resource base of the least-developed countries - about 12 per cent of gross national income on average at present - and so these countries too will need to address the implementation of the Sustainable Development Goals by reorienting their expenditures to new priorities. The distance they need to travel is significant, particularly in regard to the low priority they give to health expenditures. It even violates standing intergovernmental commitments-- for example, the Abuja Declaration of 2001 of the African Union[6] called on its members to increase their shares of national budgets spent on health to 15 per cent, yet barely a handful of the more than 50 countries in the Union have achieved that level to date, which is fewer than one in ten countries.

The health workforce and the Sustainable Development Goals

In addition, the Sustainable Development Goal for the health and social-care workforce has special relevance for this group of countries. Unlike the goals for social protection and universal health coverage mentioned earlier, the intent of the goal for the workforce is not universal, but focuses on developing countries, giving special emphasis to least-developed countries and small island developing states among all developing countries:

> *"3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States"*

In practical terms, it means that in the determination of priorities in spending, the most disadvantaged developing countries will need to ensure that the health and social care workforce figures prominently. This priority must also be an essential element of the ODA tracking.

Acknowledging the affordability of health and social care

But for all groups of countries, political will in allocating funds is paramount, and that often calls for persuading the key players responsible for the preparation and adoption of the national budget. For example, all countries must be persuaded or become firm in their conviction that social protection floors are affordable. That has been already amply demonstrated in studies by the ILO; moreover, the World Bank has calculated that 70 per cent of countries would gain economic efficiency with social protection, and that the remaining 30 per cent can be assisted in the endeavour.

This has also been amply demonstrated in existing social-protection programmes: In Brazil, for example, the well-known *Bolsa Familia*, which transfers income to families as long as they keep their children in school, has cost 0.4 per cent of gross national income, whereas the programme has shown a return that nearly doubles the national investment.

Aside from changes in tax revenues and in the priorities for national expenditures, as well as in access to ODA and loans, countries can expect to increase the revenues dedicated to health care and social services by contributing to the global efforts to fight illicit financial flows. This international undertaking is critically important; it envisions that multinational corporations can no longer engage in tax avoidance through base erosion and profit shifting and must

6 See http://www.who.int/healthsystems/publications/Abuja10.pdf. Geneva: World Health Organization, 2011.

become "grounded" for fiscal purposes. Both the international financial institutions and countries need to see the advantages of some deficit-spending and tolerance for inflation as well. The resource-rich countries and not a few developing countries could use the resources that they already have on hand, triggered by a renewed desire to achieve not only the letter, but the full spirit and intent, of the new Sustainable Development Goals. All of this will be money well spent.

The challenges of addressing the supply of health and the trap of two-tiered health care systems

The challenges that governments face when resolving to meet their responsibilities and commitments to health and social support systems are substantial. There is ample evidence that the demand for healthcare is inelastic to both income and price changes, outside of some services such as elective surgery. Demand for health is inelastic, except in terms of growth: demand for better health appears then to be limitless. Persons who are poor, whatever the economy in which they live, are willing to divest themselves for the sake of the health of a loved one, including through the distress sale of valuable assets. Wealthy people will buy the health that their assets allow. We do not behave as so-called rational consumers when it comes to our health. Patients don't "shop health" objectively like they shop for goods and services, seeking the optimal combination of delivery, price and quality. This is because we have incomplete information and there are other factors that count and that are purely subjective; our experience of physical well-being is vital and intimate, in a class apart from our material welfare. We do not *own* our health, as we would a commodity. Our state of health is part of who we are and of the daily experience of our lives.

Investment is sensitive to the need for health, and it responds accordingly. At present, global health expenditure, which is estimated to be on the order of $6.3 to 10 trillion, exceeds global defence expenditure by a factor of five or more. There is money to be made in health, and free-floating equity in search of a sure investment can find substantial and virtually guaranteed returns in the health sector. Compared to this need for unconditional returns on unqualified equity, the health industry, which directly and purposefully invests in health, including in pharmaceutical health technology and equipment sectors, stands to gain from maintaining standards and from a collective corporate social responsibility. Negotiation with the health industry is within the reach of governments, which can develop, expand, apply and enforce regulation. Free-floating equity is elusive, and is indifferent to the domain in which it is invested. The pressure from the availability of those resources is tremendous and pushes up the price of health, while forcing down costs to the barebones to ensure the returns that capture this capital. It is due to this financial squeeze that the health and social care workforce is under-gratified. It is as a result of this squeeze that governments find that they are left with the charge of caring for the sickest and poorest patients, whereas patients who can pay and who are less ill purchase health and other services from service providers, who charge far higher prices and benefit from high returns.

The two-tier health systems, which can now be found in many economies, are one of the largest challenges to health and social systems. Governments globally will need to take stock of what has been achieved and determine strategies to safeguard the true universality of health care and social systems, based on fiscal solidarity, equity and social justice.

The opinions expressed in this article are those of the author and may not necessarily reflect the position of the ICSW Management Committee

World Health Assembly addresses major gaps and concerns in public health

By Sergei Zelenev

The sixty-ninth World Health Assembly (WHA) convened in Geneva this year covered a record number of agenda items (76 items in 6 days, from 23 to 28 May), and adopted several important resolutions addressing vital public health issues. The work of the World Health Organization (WHO) got a thorough review at the WHA, with the setting of new goals and the updating of existing priorities.

Discussions at the WHA highlighted the issue of health emergencies—this theme was one of the first to be considered, in part as a response to many critics and the global media outcry due to the initially slow multilateral response to Zika virus, as well as the difficulties in containing the Ebola outbreak in West Africa. The recently initiated programme of the World Health Organization on health emergencies, which is seen as a direct result of this major problem, got substantial support from the delegates; the WHO was asked to lead and coordinate the response to health emergencies so as to ensure that the response to global health threats is much swifter and more robust. The programme was adopted as part of the wide-ranging reforms implemented within the organization after reviews by different independent committees discovered weaknesses in the agency's current processes.

Global Strategy for Women's, Children's and Adolescents' Health

Delegates emphasized importance of taking forward the implementation of Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). The resolution adopted called on the WHO Secretariat to provide technical support to Member States in updating and implementing their national plans and to report regularly to the World Health Assembly on progress towards the health of women, children and adolescents health. The strategy sets out a very ambitious goal, namely, to ensure that every woman, child and adolescent, in any setting, anywhere in the world, is able to both survive and thrive by 2030. The document, including its new operational framework, envisions country ownership and strengthened accountability on the part of national authorities at all levels. It was underscored that the monitoring of national progress is hardly possible without the collection of high-quality detailed data and the appropriate capacity for its analysis.

Childhood overweight and obesity draw a lot of attention from the delegates as undeniable risk factors that require early intervention so as to promote the life chances of all children. In many countries childhood obesity has reached alarming proportions, paving the way for the development of diseases later in life. Many delegates -- and they were strongly supported here by the civil-society groups -- agreed that Governments should endorse the new WHO Guidance to end the inappropriate promotion of commercially produced foods and beverages targeted towards infants and young children. The implementation plans for the comprehensive, integrated package of policy actions recommended in the report of the Commission on Ending Childhood Obesity should be developed at the national level without a delay.

Healthy ageing today and tomorrow.

Delegates also approved a resolution on the Global Strategy and Action Plan on Ageing and Health 2016-2020. While countries vary in the timing and speed of

the ageing process, the proportion of older persons—namely, the population aged 60 years and over— is growing in all regions and in the large majority of countries. It is estimated that by 2050 the proportion of older persons will rise to 22 per cent in both the more-developed and the less-developed regions. The share of the "oldest old"—those aged 80 and over—is also rising within the group of older adults, creating additional needs.

In itself, ageing is a manifestation of human progress and tremendous achievement; the increase in longevity, particularly if it is coupled with ability to stay healthy well into "oldest-old" age, signifies impressive breakthroughs of modern medicine, including the use of more effective methods in geriatrics and gerontology. The growing share of older persons without a doubt presents numerous opportunities to societies—from using the experiences and skills of older workers at the marketplace to helping families to cope with raising children and grandchildren. But ageing is also a major societal challenge in terms of the additional demand it puts on health-care systems and long-term care at an age when disability or disease are difficult to avoid. In the light of the existing demographic trends, policy makers in all countries have to find answers to such fundamental questions concerning the opportunities and challenges found in ageing societies. Good health in old age reflects a combination of factors, but many chronic conditions can be prevented by healthy behaviors across the life-course. The WHO encourages countries to elaborate and support coherent action on healthy ageing, to develop age-friendly environments and make sure that health policies are inclusive and older persons are not left behind.

Universal health coverage

Achieving universal health coverage and access to quality health care when needed is seen by WHO as a pivotal goal in the context of promoting physical and mental health and well-being and extending life expectancy. Resilient national health systems, which are based on strong primary care, provide essential support on this road and are widely regarded as the best defense that countries can establish against outbreaks of infectious diseases such as Ebola and Zika, as well the burgeoning burden and costs of non-communicable diseases such as cancer and diabetes. Universal health coverage is equitable and in many ways cost-effective. Many delegations expressed a strong commitment to such coverage, noting that it is inclusive, feasible and measurable. At the same time the discussions revealed that the gap in universal health coverage, taking into consideration the existing circumstances on the ground, cannot be covered overnight, and in the case of low-income countries may require decades. There is a need to expedite the quest for the more effective use of private-sector instruments as an important addition to national health-care system, making them more inclusive, without diminishing the importance of the public provision. As noted by WHO Director-General Dr. Margaret Chen in her statement to WHA, universal health coverage goes beyond purely medical aspects—it is "good for health and good for the cohesion and stability of societies".

Health in 2030 Agenda

Universal health coverage as a goal and policy approach is closely connected with the issue of health as addressed in the 2030 Agenda for Sustainable Development. The Sustainable Development Goals (SDGs), in the words of the Declaration, are "integrated and

indivisible, global in nature and universally applicable"[1]. Unlike their predecessor, the Millennium Development Goals (MDGs), the SDGs are intended for all countries, not just for developing countries. One of the critical dimensions of the SDGs is their emphasis on interlinkages, and they are designed to be cross-cutting. As noted in the Report of the Secretariat submitted to the WHA, several health targets in the SDGs follow on from "the unfinished agenda" of the MDGs, while many other health targets are derived from WHA resolutions and related action plans. "At the same time, it is important to recognize the breadth of the new Agenda: it does not only see health as a goal in itself; it also views health and its determinants as influencing, and being influenced by, other goals and targets as an integral part of sustainable development"[2].

Delegates agreed that strengthening national health systems is key to progress towards universal health coverage, which in its turn is crucial for achieving the health-related Sustainable Development Goals. The links between climate change and health, including those related to the spread of vector-borne diseases, were also noted. The discussions, as well as the resolutions adopted, highlighted the need to improve a range of essential public-health functions: investing adequate, sustainable resources in the strengthening of health systems; enhancing the education, recruitment and retention of health workers; tackling the social, environmental and economic determinants of health; and improving the monitoring and analysis of health outcomes.

The health-related targets are concentrated in, but not limited to, Goal 3: "Ensure healthy lives and promote well-being for all at all ages." They include a target of achieving universal health coverage, including financial-risk protection, access to quality essential health-care services and access to safe, effective, high-quality and affordable essential medicines and vaccines for all. Of course, the achievement of this Goal, as well as other SDGs, implies progressive realization—countries need to take into consideration the availability of domestic and other resources and move forward at their own pace.

Health and the environment

Improving the quality of the air we all breathe is one of the preoccupations of the WHO. The indoor and outdoor air pollution are both among the leading avoidable causes of disease and death globally. Air pollution does not respect national boundaries and interventions to address it often require urgent action, not only domestically, but also internationally. The 69th World Health Assembly considered and adopted a road map for an enhanced global response to the adverse effects of air pollution. In order to make monitoring specific, the adopted reporting framework has indicators and objectives to track progress.

Measures to prevent air pollution fit well within the package of measures considered in conjunction with the implementation of the Paris Agreement adopted at the Conference of the Parties to the UN Framework Convention on Climate Change adopted in December 2015. There are obvious opportunities for synergy in this context. Drastic reversal of the current trend in the generation of gases affecting climate change, envisioned by the Paris Agreement, depends to a large extent on the implementation of a series of policies aimed at mitigating climate change, including clean combustion technologies and demand management

1 United Nations General Assembly resolution 70/1, para. 5

2 World Health Organization. Sixty-ninth World Health Assembly. Health in the 2030 Agenda for Sustainable Development" Report of the Secretariat. A69/15, dated 8 April 2016, para.19

mechanisms.
Many of those policies also reduce health-damaging air pollutants (such as black carbon) that directly affect human health and climate. The adopted road map "identifies and harnesses opportunities for synergies and efficiencies linked to those policies that focus on reducing climate change and on monitoring progress with the relevant Sustainable Development Goals".[3] One of the beneficial impacts of the policies aimed at climate-change mitigation is that the allocation of resources in this case will have a dual purpose, and will also serve to improve air quality and prevent millions of deaths associated with air pollution. As observed by the drafters of the above mentioned report of the WHO Secretariat, "the increase in public awareness stimulates the demand for policies that reduce air pollution, prevent diseases and improve health and well-being… To obtain such efficiency gains, it is crucial to identify co-benefits from different measures that are outlined in the road map—to health and air pollution, and to climate change and sustainable development."[4]

The implementation of the measures outlined in the above road map requires effective interactions with relevant stakeholders, including those in the private sector. Collaborating with civil-society organizations (CSOs) has numerous potential benefits as CSOs could provide independent monitoring and accountability in assessing and accelerating progress on the indicators outlined in the road map. Those joint efforts are also essential in prioritizing good-practice sharing for effective multispectral collaboration, not only in fighting air pollution, but also with regard to the role of the health sector in the sound management of chemicals – one of the priority areas for discussion at the next WHA in 2017.

Dr. Sergei Zelenev is Executive Director of ICSW.

For more details:

http://www.who.int/mediacentre/events/2016/wha69/en/

http://www.who.int/mediacentre/news/releases/2016/wha69-25-may-2016/en/

http://www.who.int/mediacentre/news/releases/2016/WHA69-importance-of-multisectoral-action/en/

3 World Health Organization. Sixty-ninth World Health Assembly. Health and the Environment. Draft road map for an enhanced global response to the adverse health effects of air pollution. Report by the Secretariat, Doc. A69/18, dated 6 May 2016, para.7

4 Ibid.

Promoting health agenda: profiles of two civil society organizations

The NGO Forum For Health

A consortium of health organizations founded in 1978, the **NGO Forum for Health** is committed to the rights-based design and implementation of global health policy. International in its membership, the NGO Forum for Health is a registered non-profit association based in Geneva, Switzerland (http://www.ngo-forum-health.ch). The Forum is led by a Steering Committee, which meets at least four times a year and is composed of ten representatives of member organisations, elected at the governing Annual General Meeting for a two-year term. The Forum's activities and its Secretariat are principally financed by membership subscriptions complemented by a small amount of donor support, which must meet standards of sourcing and absence of conflict of interest. The Forum offers its members an information exchange and serves as a platform for advocacy and concerted action. The consortium works with the UN system and in partnership with other organizations of civil society; the Forum is notably a Core Group Member of the *Global Coalition for Social Protection Floors*.

The NGO Forum for Health began as a network in the 1970s that sought to promote the concept of primary health care (PHC). Over the years, the group expanded its activities beyond PHC: in the wake of the International Conference on Primary Health Care, held in Alma Ata in 1978, the tools and means needed by civil society to make PHC a reality were identified and promoted, notably:

1. The promotion of people's participation,
2. Strengthened means of communication at all levels,
3. Cooperation between NGOs within countries,
4. Coordination at local, regional and international level.

In 1997, the organization decided to expand further and became the present NGO Forum for Health so as to encourage multi-sectoral presence and cooperation. A fundamental tenet of the Forum is the application of human rights in the health sector and all sectors related to health, including in the conduct of the Forum's business.

The Alliance for Health Promotion

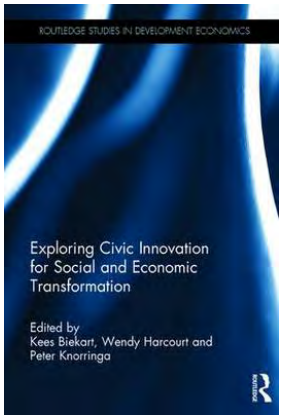
Started as an informal ad hoc group of several international NGOs concerned with translating ambitious international agendas to the grass-roots and community levels during the WHO 4th Global Conference on Health Promotion held in Bangkok in 1997, the Group became an independent Alliance under Swiss law, registered in 2008 and based in Geneva. The 11-member Board meets regularly in Geneva to chart and carry out the work. The annual WHO World Health Assembly (WHA) gives the Alliance a platform to invite other stakeholders to focus on the NGO response to WHO conferences, their follow-up, various themes and existing challenges. The members participate actively in the WHA and WHO Executive Board meetings, meet and network with government delegates, deliver joint statements and organise side events. The Alliance organizes four main events a year, in conjunction with the presence of its members at the WHO Executive Board and the World Health Assembly meetings. The *November Forums* convened by the Alliance began in 2010 to offer a specific platform to the civil-society organizations represented in Geneva and elsewhere working around the WHO/UN world, with the aim of learning, informing, participating and networking with others involved in health, health promotion and related issues. The Alliance works actively with student member organizations, striving to tap the enthusiasm of future professionals

to carry on the vital messages of health promotion. Partners include other international NGOs, health institutions, and members of academia.

In February 2015 WHO awarded Official Relations (OR) status to the Alliance as a result of its ongoing work with, and support for, the Social Determinants of Health Unit. The Alliance has now established a three-year programme of work with the Unit. The members of the Alliance are in regular contact and discussions with several WHO units dealing with health promotion, non-communicable diseases, gender & women's health and other issues. The Alliance has organised several workshops in Kenya and India, which have empowered local communities and associations to seek their own answers to local health challenges, contributing greatly to the Alliance vision "to bring the global declarations down to the grass roots".

Additional information is available at http://www.alliance4healthpromotion.org/

The useful resources and links – the find of the month



Exploring Civil Innovation for Social and Economic Transformation

Edited by Kees Biekart, Wendy Harcourt, Peter Knorringa, Routledge, London 2016

Reflecting the increasingly holistic approach to development, this edited collection illustrates how civic innovation happens at the global and institutional level, as well as in communities and for individuals. The book explores the new practices emerging from varying economies, transformative empowerment strategies in global value chains, the local politics of social movements and the struggles for rights with regard to race, gender and sexuality.

For more details: https://books.google.com/books?id=itQmDAAAQBAJ&pg=PT70&lpg=PT70&dq

World Employment and Social Outlook 2016: Transforming jobs to end poverty, ILO, Geneva, 2016

This edition of the World Employment and Social Outlook report prepared by the International Labour Organization is devoted to the issue of poverty, and examines how decent work can contribute to the goal of ending poverty—a goal relevant to all regions.

For additional details: http://www.ilo.org/global/research/global-reports/weso/2016-transforming-jobs/WCMS_481534/lang--en/index.htm

Newsletter Editor:
Sergei Zelenev, Executive Director
E-mail: szelenev@icsw.org,

Address:
ICSW, 5700 Arlington Ave.,
Bronx, New York, 10471 (US Office)

icsw@icsw.org
Website www.icsw.org