

Breaking the vicious circle

Wemos programme 2006-2010



May 2005

In memory of Hans Hartmann
1957-2005

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Executive summary

Wemos envisages a world in which every person can realize his or her right to the highest attainable standard of health. Advocacy is the means the organization has chosen to structurally improve the health of people in developing countries. Strengthening national health systems that are accessible, available and sustainable is of vital importance and will form the focus of the work of Wemos in the coming five years.

The themes for the coming five years are:

- Health care providers,
- Health budgets,
- Human resources for health,
- Nutrition,
- Medicines.

Advocacy is practised on behalf of all these themes and consists of the three parts of the Wemos strategy:

- Lobbying,
- Collaboration with Southern partners, including capacity strengthening,
- Campaigning and awareness raising among health workers in the Netherlands in order to support the lobby.

The Wemos strategy is pursued at three different levels: the South, the North and Global. Collaboration with Southern organizations is concentrated on four countries: Kenya, Zambia or Tanzania, Bolivia and Bangladesh. Long-term relationships are established with organizations in these countries, and capacity strengthening is an important aspect of the collaboration. Collaboration is sought with organizations in other countries based on specific themes and/or events.

In the coming five years, the knowledge acquired by Wemos and its partners concerning the effects of international policies and health will further be strengthened: case studies will be carried out and trends will be analysed. Lobbying activities are being pursued at all levels, by partners, by Wemos and by a combination of forces. Participation in international, regional and national networks is very important in strengthening the lobby. The choice of four countries will lead to a further deepening and intensification of the collaboration with Southern partners. Flexibility will be the key word in campaigning and awareness raising activities, which support the lobby and are carried out to increase the support for the work of Wemos and for development cooperation in the Netherlands.

A key issue in the coming five years is the further development of the Wemos strategy in the field of lobbying and the collaboration with Southern partners. By strengthening the strategy, the organization will be better able to effectively contribute to the structural improvement of people's health in developing countries.

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Prologue

Wemos was founded in 1981 by medical students who were of the opinion that too little attention was being paid in medical schools to the structural causes of ill health. Started by volunteers, Wemos has developed over the years into a professional organization with twenty paid members of staff in its office in Amsterdam. In the earlier days attention was focussed on awareness raising activities in the Netherlands, and campaigns were organized to stop the destructive behaviour of some of the multinational companies in developing countries.

In the course of the years, the focus has shifted towards influencing international policies so that they contribute to the structural improvement of people's health in developing countries. Lobbying the Dutch government for better policies and joining forces with civil society organization in other countries, including those in developing countries, became core activities for Wemos. Campaigning among health workers in the Netherlands has remained one of the main strategies for supporting the lobby.

In recent years, collaboration with organizations from developing countries has become more and more important. Influencing international policies can only be effective when the people concerned can raise their voices. Strengthening the capacity of civil society in Africa, Asia and Latin America has therefore become a very important part of the Wemos strategy, as reflected in this Wemos programme 2006-2010.

Focussing on the link between international policies, national policies and the health of people in developing countries puts Wemos in a rather unique position in the field of development cooperation. Its added value lies in its expert knowledge on international policies and health and its collaboration with advocacy organizations in developing countries.

In a recent evaluation of Wemos carried out by MDF, interviewees typified Wemos as a young, flexible, trustworthy, solid, knowledgeable, creative and energetic organization. The big challenge for the coming five years is to maintain these characteristics and at the same time to further improve the quality and effectiveness of the work.

1. Introduction

For millions of people in this world, living a healthy life remains a distant goal. Every day 30,000 children die from preventable diseases. In many parts of the world health care facilities are not available or not accessible, prevention programmes are often lacking and proper food and sanitation is in short supply. The main cause of ill health is poverty. Many people in developing countries lack the means to feed their families properly, to send their children to school and to generate sufficient income to lead a healthy life. Or as stated by the WHO (2000, page 5) 'Poverty is fundamentally a condition in which individuals lack the capacities required to satisfy their basic needs, fulfil their aspirations and participate fully in society'. Poor people are trapped in a vicious circle of poverty and ill health. Being poor makes it more difficult to stay healthy and being ill makes it more difficult to generate income.

The improvement of people's health has been recognized internationally as one of the most important development goals. Of the eight Millennium Development Goals of the United Nations, five are directly related to health: goal 1: Eradicate extreme poverty and hunger, goal 4: Reduce child mortality, goal 5: Improve maternal health, goal 6: Combat HIV/AIDS, malaria and other diseases, goal 7: Ensure environmental sustainability. Health as a key factor in people's lives is also reflected in the 'Right to the Highest Attainable Standard of Health' as included in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and in other human rights treaties and principles such as the Convention on the Elimination of All Forms of Discrimination Against Women.¹

The health of people in developing countries² is increasingly determined by international trends, treaties and agreements. To make a structural contribution to the improvement of people's health, Wemos therefore focuses its activities on international policies. The main players on the international stage influencing people's health are the World Bank, the International Monetary Fund, the World Trade Organization, the World Health Organization, UNAIDS, Western governments in their role as international donors, transnational cooperative efforts and philanthropists such as Bill Gates.

The Wemos vision is a world in which every person can realize his or her right to the highest attainable standard of health. The Wemos mission is to contribute to the structural improvement of people's health in developing countries through advocacy. The main focus of the work of Wemos in the coming five years is on international policies that support national health systems which contribute to the structural improvement of people's health in developing countries. The intervention strategies all fall under the umbrella of the term advocacy:³

- lobbying to ensure that the policies of international actors contribute to national health systems,

¹ This right does not imply the right to be healthy but the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health (see Chapter 2).

² Some prefer the term 'low- and middle-income countries'. For reasons of readability the term 'developing countries' is used throughout this document.

³ Advocacy involves direct lobbying, public campaigning and public education as well as strengthening capacity and creating alliances in order to achieve desired changes in people's lives (Roche 2002, p.192).

- collaboration with Southern civil society organizations including the strengthening of their capacity to influence policies, and
- campaigning and awareness raising among health workers in the Netherlands in order to support the lobby.

Following on these strategies are Wemos's main target groups: international and national policy makers in North and South,⁴ Southern civil society organizations and health workers in the Netherlands. Wemos considers itself part of the international civil society and joins others in the fight to improve people's health in developing countries.

Chapter 3 provides a description of the Wemos strategy and Chapter 4 introduces the programme for 2006-2010. In Chapter 5 more details of the organization are presented. But first an overview is given of what Wemos considers to be the most important trends in international health.

⁴ The term 'North' covers Europe and the United States, the term 'South' refers to developing countries.

2. International developments and health

2.1. Introduction

Joyce Wafula lives in a small village in Western Kenya. She is 50 years old and lives with her husband and four grandchildren. Her daughter and son-in-law died last year, presumably of AIDS. Of her six children two died when they were very young: Joseph died of malaria when he was two and Anna died of diarrhoea when she was only six months old. Her other two daughters are now 25 and 27 years old and live in the same village. Her son is 35 and moved to a big town some 20 years ago. Of her 20 grandchildren three have also died of malaria, which seems to have been on the increase again in recent years. And one died from dehydration because of diarrhoea and severe vomiting. Joyce had hoped that time would bring a change for her and her family, but she is still a poor woman struggling to survive. On the radio she heard that the government plans to spend more money in health care, but many people around her are dying and very little has been done to avoid it.⁵

Joyce is just one of the millions of people in this world trapped in a vicious circle of poverty and ill health. The structural improvement of people's health is absolutely vital in the fight against poverty. Healthy people are more able to live fulfilling lives, to generate income and to contribute to their societies.

The fact that Joyce and her children find themselves in this vicious circle of ill health and poverty is the result of a large number of factors, including economic factors such as low world market prices for crops grown in Kenya, national policies and international policies that have not been pro-poor, cultural issues such as taboos and social factors such as discrimination. So the structural improvement of people's health in developing countries is a complex task which requires not only the tackling of financial and logistical problems but also has to include a wide range of measures. One of these measures is the field in which Wemos is active: influencing international policies in such a way that they contribute to the structural improvement of the health of people like Joyce.

This chapter describes the context in which Wemos and its partners operate and serves as an introduction to the Wemos strategy and programme 2006-2010.

⁵ Joyce Wafula represents the story of many women in Africa. She is a fictive person based on reality.

2.2. The vicious circle of ill health and poverty

Here at the beginning of the 21st century, the health of millions of people in this world is a matter of great concern.⁶ 10.5 million children will not survive to their fifth birthday, dying mainly of preventable diseases. The large majority (98 percent) of these children are found in developing countries, half of them in Africa. More than 500,000 women die each year in pregnancy and childbirth. Tuberculosis (TB) kills 2 million people per year and malaria 1 million (WHO 2004). Over a third of the children under five are malnourished, and malnutrition is the main contributor to the burden of disease in the developing world (SCN 2004). More than one billion people struggle to survive from hunger and poor health on less than 1 US dollar a day and almost 40 percent of the people in developing countries do not have access to clean drinking water (UNICEF 2004).

The impact of HIV/AIDS is enormous. Over 42 million people are living with the disease and in many countries infection rates are still increasing. In some parts of East and Southern Africa, the AIDS epidemic has negatively affected economic development, has enormously increased the burden on the already weak health system, has resulted in thousands of orphans and decreased average life expectancy. In Zimbabwe, for example, life expectancy has plummeted from 56 in the period of 1970-75 to 33 in 2000-2005 (UNDP 2004). The overall deterioration in the health situation in the South is not only due to the devastating effects of the HIV/AIDS epidemic, however, but is a general decline reported for most of the developing countries (Weisbrot 2001).

Poverty is one of the most important factors contributing to the poor health situation in which so many people in this world find themselves. In recent decades the income gap between the top 20 percent of the world's richest people and the bottom 20 percent of the poorest has increased from 30 to 1 in 1960 to 74 to 1 by the end of the 20th century (UNDP 1999: 36 in Harris and Reid page 23). These increasing differences in income are found both between and within countries.

Differences in income are reflected in differences in health expenditures. In 2000, 20 percent of the world population lived in OECD countries which were responsible for 90 percent of the total expenditures in health. The African region accounts for only 2 percent of global health spending but carries 25 percent of the global burden of disease. In almost a fifth of the WHO member states health expenditure is still less than 15 US dollars per capita (WHO 2003). In 2001, Jeffrey Sachs and his Commission on Macroeconomics and Health calculated that at least 40 US dollars per capita per year are needed for the treatment and prevention of infectious diseases alone. The commission underlined that a worldwide scaling up of health investments in low-income countries would not only improve people's health but would also alleviate poverty since healthy people are better able to generate income (Commission on Macroeconomics and Health 2001).

⁶ The definition of health used in this document is the WHO definition which states that: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1948).

2.3. International commitments

The right to health

Health as a prerequisite for a fulfilling life has long been recognized by the international community. The right to health is one of the fundamental human rights and is included in the Universal Declaration of Human Rights and many other human right treaties. The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health (CESCR 2000) and not as the right to be healthy. This is reflected in the fact that the right to health should be realized progressively,⁷ taking into account the limits of available resources. For individuals this implies having access to a number of health-related services and freedoms that are related to health and to the underlying preconditions for health, such as healthy food and safe drinking water. States have to ensure that these services and preconditions are accessible for all; either by providing the services or by ensuring that other actors make them available for all (Toebe 1999). States not only have the obligation to provide services for their own citizens but should also support other states in fulfilling their obligations, provide the necessary aid when required and ensure that the right to health is 'given due attention in international agreements' (CESCR 2000). International institutions such as the World Bank, the International Monetary Fund (IMF) and the World Trade Organization (WTO) also have the obligation to respect the right to health in their policies. Sexual and reproductive health is an integral element in the right to health and deserves special attention because of the specific health needs of women (Commission on Human Rights 2004).

Millennium Development Goals

During the UN Millennium Summit in September 2000, 189 countries committed themselves to the achievement of the so-called Millennium Development Goals (MDGs) by the year 2015.

Since 2000, major multilateral institutions such as the World Bank and the WHO have also committed themselves to the achievement of these goals:

- MDG 1: Eradicate extreme poverty and hunger
- MDG 2: Achieve universal primary education
- MDG 3: Achieve gender equality and empowerment of women
- MDG 4: Reduce child mortality
- MDG 5: Improve maternal health
- MDG 6: Combat HIV/AIDS, malaria and other diseases
- MDG 7: Ensure environmental sustainability
- MDG 8: Build a global partnership for development, including an open, rule-based trading and financial system, more generous aid and debt relief (see annex 1 for the goals and related targets).

These goals lack the essential features of the right to health such as reproductive health, which is needed to achieve the MDGs, and by focusing on the average condition of a population they do not pay explicit attention to the situation of vulnerable groups. Despite these shortcomings, Wemos is of the opinion that these ambitious goals could make major

⁷ Progressive realization implies a step-by-step process in which governments take measures in line with available resources.

contributions to the improvement of people's health since they represent the first globally coordinated approach to poverty reduction and to the improvement of the circumstances in which millions of people find themselves.

A stock-taking exercise carried out in 2003 and 2004 by the UN Millennium Project revealed that while many countries will be able to achieve some of the goals by the year 2015, broad regions are lagging behind. Most countries in Sub-Saharan Africa will not achieve any of the goals by 2015 because of 'a downward spiral of AIDS, resurgent malaria, falling food output per person, deteriorating shelter conditions and environmental degradation' (UN Millennium Project 2005, page 2). According to the Millennium Project, however, it is possible to reach the goals by 2015. What is required is political will in both the developed and developing worlds and sufficient funds.

2.4. Health systems

Yesterday Joyce went to the district hospital where she waited for hours to see a doctor. When she was finally called to his room he excused himself for being late but he had to meet two foreign officials who came to see him to discuss one of the health programmes. The district hospital is now running five different programmes funded by foreign donors, each focussing on a different disease. The doctor said that he is now spending most of his time receiving the different delegations and has hardly any time left to treat patients. According to the guidelines of the programmes, however, he is not supposed to use the programme budgets for investments in health personnel. At the same time, some of his best staff members have left the hospital to work in a private clinic in town where they can earn much more money. Joyce and many others complained about the long waiting times but he said that there is nothing he can do about it.

Health systems are a dominant feature in discussions about the improvement of people's health. A health system is defined as including all the activities whose primary purpose is to promote, restore or maintain health (WHO 2000, page5). This includes formal and informal health services, health promotion and disease prevention and other health enhancing interventions such as the development of national nutrition plans, education programmes on healthy diets, sanitation projects and ensuring access to safe drinking water. According to the WHO, the concept of Primary Health Care (PHC), adopted in Alma Ata in 1978, should still be the guiding principle in building health systems. This entails universal access to quality care and coverage on the basis of need, availability of health services and conditions for leading a healthy life, commitment to health equity as part of development that is oriented towards social justice, community participation in defining and implementing health agendas and intersectoral approaches to health.

Wemos strongly supports the view that a health system is essentially a core social institution and does not consist solely of providers of health care and other health enhancing activities. The way these systems are organized reflect the norms and values of society. Ensuring universal access to health systems is vital for development and democracy, and health systems that exclude certain segments of the population underline the position of the poorest

as marginal groups (Freedman et. al. 2004). The prime importance of health systems is increasingly recognized by international key players such as the UN Millennium Project.

Despite the central role ascribed to health systems in general, in many countries the national health systems do not function adequately. They are a far cry from the principles of quality care, accessibility, availability, equity and participation. Public health care facilities are chronically underfunded, and the introduction of user fees has limited the access to health services in many countries. For poor women the situation is even worse. They are usually the last in line when money is available for health expenses because men and boys are more highly valued in most societies. Women have special needs connected with reproductive health that are often not catered to, and violence against women, which increases in poor circumstances, also leads to ill health. Finally, women are increasingly being affected by the HIV/AIDS epidemic, not only because they are infected themselves (about half the infected people are women) but because they are the ones taking care of sick family members and orphans of people who died of AIDS (Doyal 2002).

The availability of quality care is also negatively affected by a lack of personnel. In East and Southern Africa this is exacerbated by the HIV/AIDS crisis which has resulted in a double burden for health workers: hospitals are overcrowded with dying patients and many of their fellow health workers are ill or have already died.

The proliferation of a large number of different providers is another factor influencing the accessibility of health systems. Because of the changing role of governments, among other things, reflected in cuts in public expenditures on health, profit and not-for-profit private institutions are increasingly catering to health needs. In order for this patch work of facilities to contribute to the structural improvement of people's health, Wemos is of the opinion that government regulation and leadership is required. Unregulated health care leads to discrimination of those who can't afford the services and creates a situation that is far removed from the PHC principle of universal access to quality care.

A final important issue in relation to well-functioning health systems is their sustainability. Because of a continuous lack of sufficient investments, shortage of personnel and lack of participation of people in the development of health policies and their implementation, many health systems are unable to contribute to sustainable health solutions.

There is a wide range of reasons why people such as Joyce have little or no access to health care and to the conditions for living a healthy life. Some of these reasons are location specific; others apply to many Joyces in this world. Among the latter are: lack of political will and commitment on the part of national governments to develop pro-poor health policies, lack of funds and a decrease in the power of governments to regulate the health sector and to set policies. This decrease in power is mirrored by the increasing influence of international actors such as the WTO, World Bank and IMF, and other donors and companies in shaping national health policies and national health systems. Below a brief overview is provided of the main influences of international policies on key aspects of national health policies and national health systems.

2.5. International policies and national health policies and systems

About a year ago the village had a visitor. He came from Nairobi and told them that he worked for an organization that wants to influence the government in order to improve the lives of poor people. He and 20 village women gathered around the biggest tree, and he asked them all sorts of questions about what and how much they ate, how often they went to see a doctor and what they had to pay. He told them there was some money available from an international health project and he wanted to advise the government on how to spend the money. So he asked them to come up with suggestions. The discussion was very lively and the man promised to pass on these ideas to the government. Joyce now wonders what happened with their suggestions.

International policies influence national health systems *directly* through the funding of health programmes by international donors such as Western governments, the World Bank and the IMF and through so-called Global Public-Private Partnerships, and *indirectly* by setting conditions for the development of national health policies by the World Bank/IMF and the WTO in particular. The policies of the relevant international actors are a reflection of the predominant neo-liberal ideology. The main feature of this ideology is a strong belief in the importance of further liberalization of economies for poverty reduction. Proponents of this ideology argue that in the long run everybody will benefit from an increase in trade in products and services -- the so-called trickle down approach. In order to increase trade, barriers such as national subsidies should be removed. Critics, such as Wemos, maintain that this principle might work in a world in which trading takes place among equals. In the present situation, however, trade openness actually increases poverty and inequality. The countries that have liberalized most rapidly have fared worst (Labonte 2004). Below is a description of the issues Wemos considers of major importance for the structural improvement of people's health and which are closely related to the themes on which the organization intends to work in the period 2006-2010 (see Chapter 4).⁸

Budgets for public health

Since the 1980s in many developing countries, government budgets for health and other social services have been reduced, the public health sector has been downsized and user fees for health services have been introduced. To a large extent, this is the result of the radical health sector reforms that were implemented under the leadership of the IMF and World Bank in the form of Structural Adjustment Programmes (SAPs). Since the 1970s, developing countries have become increasingly dependent on these institutions for obtaining financial assistance and debt relief to fund their national health systems. To date, the World Bank is the leading funder of the health sector in developing countries.

In 1999, the IMF and World Bank introduced a new framework for financial assistance and debt relief. In order to obtain funds, low-income countries are now required to formulate a

⁸ This is not to suggest that the influence of international policies on other issues such as access to safe drinking water, education or environmental health are regarded as less important for people's health. These issues, however, are not the expertise of Wemos and are covered by other organizations.

Poverty Reduction Strategy Paper (PRSP). PRSPs are supposed to be integrated policy plans, owned by the country itself and developed with the involvement of civil society. Health is supposed to be an integral part of the national PRSPs, but case studies carried out by Wemos and its partners in Bangladesh, Kenya, Bolivia Nicaragua, Ghana, Uganda and Ethiopia⁹ showed that health expenditures have not substantially increased since 1999, that there is little coherence between the proposed macroeconomic and social policies and that civil society was hardly involved in the PRSP formulation, implementation and monitoring process. Furthermore, there is limited attention being paid to formulating policies that are specifically geared to improving the health of the poor and there is convincing evidence that the IMF and World Bank continue to exercise strong influence over national governments through the conditions attached to their loans, credits and other financial agreements (Rowson and Verheul 2004).

An increasing number of Western governments have linked their assistance to the PRSPs. Some donors opt for providing direct support to the national health budget instead of -- or in addition to -- direct support to the macro budget. Many donor agencies, including the Netherlands, have adopted the so-called Sector Wide Approach (SWAp) as the guiding principle for their bilateral development cooperation. In health, a SWAp essentially means that national governments, international donor agencies and other stakeholders including civil society together shape the overall policy, institutional and financial framework in which health care is provided. This includes the implementation of joint health sector reviews. The available evidence suggests, however, that the inputs from stakeholders other than government and donors in SWAps and sector reviews are still rather limited.

Health personnel

A specific and highly topical issue in health budget discussions, which is of great interest to Wemos and its partners, is the allocation of funds for improving human resources and the related role of international actors. It is widely acknowledged that in order to attract and keep personnel for the health sector, unorthodox measures are required. A study estimates that between 1986 and 1996 about 60 percent of the medical doctors that graduated from the University of Ghana Medical School had emigrated to the West (Buchan and Dovlo 2004). In order to stop the exodus of health workers, some countries have increased their salaries. There are strong indications, however, that this was met by fierce resistance from the IMF and World Bank. Their argument is that increased salaries cause inflation and should therefore not be allowed.¹⁰ Furthermore, even within the same country, private health care providers offering better working terms and conditions have attracted personnel from the public sector. This negatively affects the services to the poor, who heavily rely on public health care.

At the same time, the general agreement on trade in services (GATS), currently negotiated within the WTO, makes it more difficult for governments to develop regulations to stop health workers from leaving the country. For countries that have opened up their markets to foreign

⁹ These case studies had three overarching purposes: (1) to analyse the process, content, implementation and health impact of PRSPs, (2) to strengthen civil society action and inputs in PRSP processes, and (3) to facilitate capacity building among participating organizations (Rowson and Verheul 2004).

¹⁰ Trying to keep and attract health personnel is not only a matter of salaries but is also related to secondary labour conditions such as training and education, infrastructure, pension schemes, retention schemes, etc.

providers, additional pressure on the public health system is expected as a result of staff and patients being attracted from the public sector.

The severe negative consequences resulting from a lack of health assistants, doctors and capable policy makers have long been overlooked by the international community (Chen 2004). According to Chen, who chaired the Joint Learning Initiative (JLI) on Human Resources for Health and Development, lack of funds, emigration to more developed countries (brain drain) and lack of an overarching global policy on human resources have resulted in malfunctioning health systems. Overcoming these shortages is absolutely vital for achieving the MDGs (Chen 2004).

Following the Abuja High-Level Forum on Health-related MDGs in December 2004 and the recently released report of the JLI, a consultation held in Oslo (24-25 February 2005) brought together key stakeholders to discuss the crisis in human resources and its impact on health in sub-Saharan Africa.¹¹ It was agreed that the key is country-led and country-based action, whereby processes within countries are to generate demand for regional and global reinforcement. It was acknowledged that country level interventions should not be hindered by international forces. According to Chen, Oslo will be remembered as a landmark event that turned the corner from consultation and consensus to a call-for-action.

Health insurance

Health insurance programmes that cover both poor and rich citizens are not common in developing countries because they are regarded as too costly when average incomes are so low. Insuring the population via Social Health Insurance programmes, for instance, is one of several important measures that can be taken to ensure access to basic health care services for all. Such programmes can function as social redistribution mechanisms that can contribute to the improvement of the quality of services. However, the financing of health systems can be undermined by liberalization, as competition may threaten the sustainability of programmes designed to spread costs across society and to provide affordable health care for all. Furthermore, insurance companies can place certain demands on health care providers because they represent a large number of clients. One of Wemos's partners is involved in discussions with the Kenyan government, as the Ministry of Health intends to develop a National Social Health Insurance Scheme in which all Kenyans, including HIV/AIDS positive people, are covered for basic health services. This plan has met with resistance from the private sector, who fear they might lose their market. There are indications that the World Bank is putting pressure on the Kenyan Ministry of Finance to withdraw the plan because of difficulties anticipated in adequately financing the Scheme.

Providers of health care and medicines

Health care services

As mentioned earlier, in many countries health systems are characterized by a large number of different providers, from the public and the private for-profit, including traditional medicine, to the not-for-profit sector. The proliferation of providers due to the liberalization in health services and the privatization of hospitals and clinics lead to the downsizing of the public sector. In many countries this has resulted in a severely underfunded public sector which

¹¹ These stakeholders include bilateral donors, multilateral agencies, World Bank/IMF, global funds and initiatives, CSOs, academia and professional councils.

offers just basic services for the poor. At the same time a more sophisticated private sector offers services for people who can afford them, including rich patients from the West who travel to poor countries for treatment. Because of better wages and working conditions, many health workers prefer to work in the private for-profit sector. As a consequence, in addition to the brain drain from the South to the North, a brain drain within countries is also taking place to the detriment of the poorest. For countries that have opened up the health sector under the GATS it will become even more difficult to ensure that health services are accessible to all citizens.

At the international level, different actors are joining forces in response to the major health problems in developing countries. UN agencies such as the WHO and UNICEF, governments, companies and philanthropists such as Bill Gates have set up so-called Global Public Private Partnerships (or initiatives) in health. Examples of these partnerships are The Global Fund to Fight AIDS, TB and Malaria, Roll Back Malaria and Stop TB. The good news is that these partnerships have increased funding for certain poverty-related diseases. However, from case studies carried out by partner organizations of Wemos it appeared that these good intentions have some negative side effects.¹² In some countries more than 25 of these partnerships are being implemented. They each have their own system of implementation and monitoring, and very little coordination is taking place between the different partnerships. As a result, the already overburdened health workers have to deal with many different guidelines and procedures. At the same time hardly any long-term investments are made for the provision of basic services (for e.g. broken legs) or for strengthening the overall national health system. While it is internationally recognized that investments in health systems that ensure universal access are of utmost importance in the achievement of the MDGs, many international actors prefer to invest in visible, short-term projects that are usually not part of an integrated approach to health.

The lack of coordination is not limited to partnerships. The coherence and coordination of the various donors involved in or supporting health programmes is still lacking or insufficient in many countries. Efforts are being made by some donors, such as the Dutch government, to come to a more coordinated approach to health, but in many countries specific disease-oriented programmes exist side by side with more integrated programmes and are sometimes contradictory in the demands they make on health personnel and civil servants (see Joyce's story on page 8).

Medicines

In addition to donor governments, pharmaceutical companies are also involved in many of the international partnerships described above. In recent years, under pressure of public opinion and generic competition, they have lowered their prices for HIV/AIDS medication and sometimes donate free medicines. Their involvement in development cooperation is often part of their strategy of corporate social responsibility, but it can also simply be a way to find new markets. In recent years, access to medicines has evoked fierce international debate. The WTO agreement on Trade Related Intellectual Property Rights agreement (TRIPS) grants 20 years of patent protection to companies that have made new inventions, which makes some life-saving medicines unaffordable for poor countries. Under pressure of

¹² Case studies were carried out of the Roll Back Malaria partnership in Tanzania, Zambia and Uganda, the Global Alliance to Eliminate Lymphatic Filariasis in India and Kenya, Polio Eradication Initiative in India and the Stop TB partnership in South Africa (Utrera forth.).

international civil society and some of the developing countries, the 'Doha declaration on TRIPS and public health' was signed in 2001 by the WTO member states. This declaration includes measures that make it possible to import cheaper versions of patented drugs in case of a public health crisis and to grant permission to local manufacturers to produce these cheaper drugs. However, under pressure of pharmaceutical companies the United States government has compelled governments of low-income countries to develop national patent laws that are far stricter than the TRIPS-agreement in exchange for trade benefits. Furthermore, the implementation of TRIPS in countries that produce generic drugs such as India and Brazil will most likely result in decreasing access to affordable drugs for people in these countries.

Conditions for living a healthy life

Joyce grows maize on a two-acre shamba (plot) next to her house. Last year's harvest is finished and she has no food to feed her husband and grandchildren. Last week she earned some money by brewing beer, so she can buy food on the market in the next village. The last time she attended the health post, the health assistant told her she has to eat more fish and meat because of a lack of iron in her blood. The problem is that meat and fish are very expensive and unaffordable for Joyce. Maize, however, has become much cheaper. Her cousin told her that this is because maize is imported from other countries, such as America. Her neighbours, who sell maize at the same market, are complaining about the cheap maize because they have lost almost all their customers. Joyce doesn't dare tell her neighbours that she is very happy with the cheaper maize. But she sometimes wonders why the government allows foreign maize on the market and does not support the local farmers.

Health systems are often equated with health care. For Wemos this is too narrow a focus because it ignores the importance of so many other factors involved in realizing the right to the highest attainable standard of health. Without clean drinking water people will get sick, even with the most sophisticated forms of health care. The same applies to proper sanitation, housing, education and food. Investing in nutrition is one of the most cost-effective means of improving health. Access to healthy food is increasingly determined by international policies. The heavily subsidized food production in the United States and Europe leads to overproduction, which is sometimes dumped on markets in developing countries. This food is sold below world market prices, and as a result local farmers are losing their markets and their income. This in turn has negative consequences for the food security of these small farmers. The WTO Agreement on Agriculture makes it very difficult for governments to stop these low-priced products from entering their markets since the use of import tariffs is not allowed under WTO rules. The dumping of food also takes place in the form of food aid. The European Union is of the opinion that food aid should be given in the form of money to buy food at local or nearby markets, in order to provide local farmers with income and not to disturb these markets. The United States and the World Food Programme are in favour of aid in the form of food. The Food Aid Convention in which guidelines for food aid are formulated is under discussion at the moment. The EU hopes to convince the United States to change its policy in this respect.

Two other important international actors are the WHO and the Codex Alimentarius. The WHO has advised its member states to write national nutrition plans. In most countries, however, these plans are not seen as a priority since nobody is requesting it: neither the World Bank and IMF as part of PRSPs, nor the EU as part of the bilateral trade agreements. As a consequence most countries pay very little attention to the development of nutritional plans and their implementation. Since nutrition is such a vital aspect of health, this situation is worrisome. The Codex Alimentarius (CA) is the international body that sets the rules for food safety. The CA can protect consumers from false information and unsafe food. However, the CA is increasingly being used not for the benefit of the consumers but as a forum to facilitate trade. Safety measures are set too high for developing countries to comply, thereby negatively affecting their chances of selling products on the world market. At the same time, labelling requirements are set at a lower level to make it easier for multinationals to sell their products.

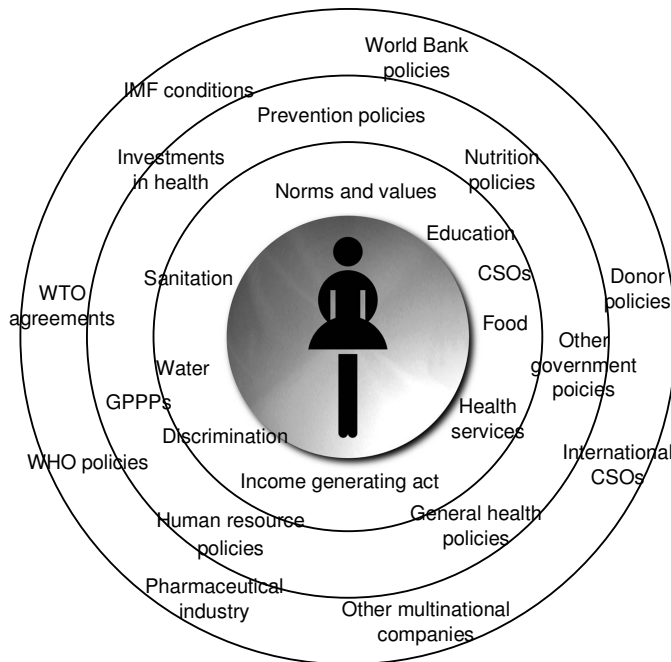


Figure 2.1: International policies and actors, national policies and factors influencing Joyce.

Wemos position

The link between the health situation of our fictive African woman Joyce and the international policies described in this chapter is influenced at different levels (see figure 1). Her health is directly influenced by the availability and quality of local health services and access to healthy food, drinking water, sanitation, income-generating opportunities and education. These factors are in turn determined by a range of national policies including investments in health, the regulation of different health service providers, human resource policies, prevention and nutrition policies and by the health programmes of the national government, of international CSOs (civil society organizations) such as Medicines Sans Frontiers (MSF), of the World Bank, of donor governments and of Global Public-Private Partnerships. As has been shown in this chapter, the policies of the national governments are in turn increasingly determined by international trade agreements, policies of the World Bank/IMF and of donor

governments. Joyce's health is thus both directly and indirectly affected by international actors.

In working on the improvement of people's health, many organizations provide infrastructural support by building hospitals or setting up of curative and/or preventive health programmes, including the sending out of medical personnel. Others provide support through the financing of local CSOs that run health services and work on the improvement of the conditions for leading a healthy life such as the development of pipe lines or the improvement of agricultural techniques. In recent years many people, both at the international and national level, have come to realize that in order to structurally improve the situation of people in developing countries, policy changes are required. Wemos occupies a rather unique position in the field of development cooperation because of its specific focus on the link between international policies, national policies and health. Wemos is not primarily a funder of CSOs in developing countries but joins forces to influence policies both on the national and the international level.

In the coming years Wemos will intensify its collaboration with CSOs in developing countries and strengthen its focus on realizing concrete results in developing countries in terms of improved policies that contribute to national health systems. In the following chapters the Wemos strategy and programme will be described in detail.

3. Vision, Mission, Objective and Strategy

The context described in the previous chapter and Wemos's focus on the impact of international policies on people's health in developing countries, has resulted in the following vision, mission and objective.

Vision

Wemos envisages a world in which every person can realize his or her right to the highest attainable standard of health.

To enable people such as Joyce to exercise her right to the highest attainable standard of health, policy changes are required.

Mission

*Wemos contributes to the structural improvement of people's health in developing countries through advocacy.*¹³

In order for people to exercise their right to the highest attainable standard of health, policies should contribute to the strengthening of national health systems.

Overall objective

The Wemos overall objective is to strengthen national health systems that contribute to the structural improvement of people's health in developing countries.

Health systems combine health care and the conditions for leading a healthy life and are therefore crucial in the Wemos vision and mission. Health systems should fulfil certain criteria, however, so they can contribute to the *structural* improvement of people's health.

First of all, health systems should be *available* to all, not only in urban areas but throughout each country. This implies that health systems should guarantee the availability of a wide range of services including reproductive health services, information, health education and vaccination programmes as well as healthy food, water, sanitation and other conditions for leading a healthy life.

Secondly, health systems have to be *accessible* to all. Men and women, old and young, poor and rich, disabled people and people from minority groups should all have access to health systems. This implies physical and economic accessibility and accessibility to information as well as non-discrimination.

Thirdly, health systems have to be *sustainable*. This implies that they have to be in line with local priorities, norms and values regarding health. The participation of the population in

¹³ The term advocacy includes lobbying, collaboration with Southern partners including capacity strengthening and campaigning and awareness raising (see page 3).

making decisions regarding health systems is also vital in ensuring sustainability. This participation implies the involvement of CSOs or other representatives of the population in policy formulation and implementation. Another aspect of sustainability is the importance of long-term investments in health systems. Short-term programmes that end within a year or two cannot contribute to the structural improvement of people's health.

Wemos calls upon governments to strengthen available, accessible and sustainable¹⁴ health systems by reminding them of their obligations to protect, respect and fulfil the internationally agreed upon right to the highest attainable standard of health (see Chapter 2 for more details about health as a human right).

3.1. Wemos strategy

As described in chapter 2, there is a strong link between ill health and poverty. In alleviating poverty three intervention strategies are often distinguished: 1) direct poverty alleviation of individuals and communities by such means as the creation of income generating activities and the building of hospitals, 2) building up civil society to enable people to work on their own poverty alleviation, and 3) lobbying and advocacy in order to change policies that directly and indirectly affect poor people (Ministry of Foreign Affairs 2001). It is increasingly recognised that national and international policy changes and the work of civil society in the North and the South to hold decision makers accountable are vital in ensuring structural and sustainable changes in the situation of poor people, including their health.

Wemos combines the second and third intervention strategy and its work includes:

- Lobbying to ensure that the policies of international actors contribute to national health systems,
- collaboration with Southern civil society organizations including the strengthening of their capacity to influence policies, and
- campaigning and awareness raising among health workers in the Netherlands in order to support the lobby.

Since its inception, Wemos has combined lobbying and campaigning. This has proved to be effective and has given Wemos a rather unique position in the field of development organizations. Over the past years Wemos has intensified and formalized its collaboration with CSOs in a number of developing countries. Building on this existing collaboration, Wemos now aims to strengthen its focus on realizing concrete results in developing countries in terms of improved policies that contribute to national health systems. To achieve these concrete results, the Wemos strategy is pursued at three different levels:

- in developing countries (**South**),
- in the Netherlands and the EU (**North**), and
- on the international level (**Global**).

¹⁴ These criteria are based on general comment no.14 of the Right to the Highest Attainable Standard of Health (CESCR 2000), which states that health-care facilities, goods and services have to be available, accessible, acceptable and of good quality. Wemos has decided to focus on availability and accessibility as the most important first steps to be taken to create health systems that are of good quality. Acceptability is included in the term sustainability, which has been added because of the importance of health systems that continue to contribute to the improvement of people's health over longer periods of time. The issue of sustainability is a highly topical one and deserves extra attention.

3.2. Lobby

The aim of the lobby is to promote policies that support national health systems contributing to the structural improvement of people's health. Lobbying has always been an important aspect of the work of Wemos. Over the years, the strategy has developed from undertaking ad hoc activities to a more structured approach to lobbying based on thorough analyses of international trends in health issues. In this new programme for 2006-2010, more attention will be paid to the strategic aspects of lobbying.¹⁵

South, North and Global

- The Southern partners focus their lobbying on national policy and decision makers that shape or influence health policies and on the representatives of their countries in the relevant international institutions.
- Wemos focuses its lobbying activities on Dutch and international policy and decision makers who play an important role in shaping or influencing the international policies of the most relevant international actors such as the World Bank, IMF, WTO, WHO, donor countries and companies.
- Jointly, Wemos and its partners target relevant international actors and forums. At all levels cooperation is sought with other CSOs, academics, international and regional coalitions and networks.

Joint lobby efforts

AIS, the Wemos partner in Bolivia, has been tracking the Highly Indebted Poor Countries (HIPC) resources in the health sector. With its local membership AIS actively participated in the local and national consultations for the new PRSP. This PRSP will be presented to the donors at a Consultative Group meeting. Wemos joined forces with ICCO and other Dutch NGOs as part of the PRSP partnership initiated by the Ministry of Foreign Affairs in order to facilitate a coordinated response to the donors by the different partners in Bolivia and to link lobbying efforts from the local to the international level. AIS is playing a central role in this coordination while Wemos is facilitating the process in the Netherlands. In addition, Wemos mobilized NGOs from like-minded donors in order to reach out to their governments. The coalition in Bolivia is an effective partner in the formalized relations between Dutch NGOs.

The three levels on which lobbying is carried out are mutually reinforcing. The research and policy analysis conducted by the Southern partners on the impact of international policies form an important input in the formulation of positions and policy alternatives. At the same time, Wemos's thorough analyses of international policies and their possible risks and consequences for health are a very important source of information for the Southern partners and inspire their lobby. Meetings during international conferences offer the opportunity to develop joint lobby strategies, target policy and decision makers together and exchange information. Successes and best practices in one country can inspire action in other countries.

¹⁵ As a first step in this process, a lobby expert has been working with the Wemos lobbyists since early 2005 to improve the effectiveness of the lobbying and advocacy activities. The description of the lobbying strategy below is a reflection of this work.

Different elements of lobbying

The key element in lobbying is policy dialogue. Policy dialogue can only be effective in combination with three key supporting strategies: research and policy analysis, network and coalition building and mobilizing public opinion. The latter is part of campaigning and awareness raising and activities are described below. The other three activities are all carried out at the three levels of intervention: in the South, the Netherlands and the EU and on the global level (see Figure 3.1).

| | South | North | Global |
|---------------------------------------|--|---|--|
| Policy dialogue | Meetings with policy and decision makers. Meetings with members of government delegations to international meetings such as WHA. Meetings with members of government advisory committees | Meetings with policy and decision makers. Meetings with EU officials Writing lobbying letters, organization of expert meetings and workshops. | Organization of joint seminars during international conferences of WTO, WHO, etc. where ministers and other officials are present. |
| Research and policy analysis | Case studies on effects of international policies on health. Collecting relevant information from Wemos and other sources. | Stakeholder analyses of actors involved in lobbying. Contacts with academic institutions to improve collaboration. | Collecting information from international networks such as Oxfam and Action Aid, through websites and other sources. |
| Network and coalition building | Participation in national and regional networks on health issues. | Coordination of lobbying with networks and in the Netherlands and EU. Member of Partos, MDG platform, Jubilee coalition, Share net and other networks on health. | Participation in international coalitions such as the Food Trade and Nutrition Coalition and the People's Health Movement. |

Figure 3.1: Lobby activities at different levels

3.3. Collaboration with Southern partners, including capacity strengthening

For Wemos, the collaboration with Southern organizations has become increasingly important in recent years because of the realization that joint efforts are required and that the empowerment of civil society organizations in developing countries is a prerequisite for sustainable policy changes and pro-poor development. As a result, contacts have been enhanced and structured and capacity strengthening has become an important part of the collaboration with organizations in Kenya, Bolivia, Bangladesh, Brazil, India, Zambia, Tanzania, Uganda and South Africa.

Country focus

In the coming years, Wemos will further intensify collaboration and will support CSOs that are advocating better health policies in four specific countries.¹⁶ This focus will improve the

¹⁶ The decision to focus on these countries does not imply that collaboration only includes organizations from these countries. When appropriate, room will be maintained within international networks to also include contacts with organizations from other countries (also see section on collaboration with other Southern organizations).

quality of the collaboration because Wemos will be better able to gain more in-depth knowledge of national health systems, national health policies, the national impact of international health policies and the regional context. Based on the following criteria -- 1) existing relations with partners, 2) the presence of strong advocacy CSOs (see below), 3) a government that allows room for advocacy, 4) the possibility to collaborate with other larger Dutch development organizations with partners in the countries and 5) in some cases the possibility to collaborate with the health expert at the Dutch Embassy -- the following countries have been selected:¹⁷

- Kenya
- Zambia or Tanzania¹⁸
- Bolivia
- Bangladesh

In early 2006 planning meetings in each of the four countries will take place with a number of CSOs to discuss themes and activities for the coming years, including advocacy in the countries and the region, joint international activities and capacity strengthening for advocacy. These meetings will be organised together with the Southern partners in these countries with whom Wemos has already established close working relations. In all countries activities will be pursued on the issue of the regulation of health care providers.¹⁹ Other themes and strategies will depend largely on the country context, the expertise of the organizations involved, the opportunities for advocacy and the added value Wemos can bring. The collaboration with organizations in these countries concerns long-term processes and will require long-term commitment on the part of Wemos.

Partnerships

To be effective in changing policies for better health, organizations with some experience in advocacy are needed -- the so-called 'stronger sisters':

- strong CSOs
- which are not directly linked to governments and the business sector and can operate rather independently
- with solid and extensive networks within their countries and geographical regions,
- with knowledge and experience on the effects of international policies on health,
- and with practical experience in advocacy.

The present partners of Wemos in Bolivia, Kenya, Bangladesh fulfil these criteria to a lesser or larger extent. In looking for other partners in these countries and in Tanzania or Zambia, these criteria will serve as a method of selection.

Wemos and its 'stronger sisters' share common goals and jointly strive for the structural improvement of people's health in developing countries. In this collaboration we fulfil different roles. Wemos depends on the input of Southern partners and Southern partners depend on Wemos for access to information and to international policy makers. This mutuality means that despite differences in capacity and financial resources, the relationships are based on partnership.

¹⁷ In the coming five years political or other developments may negatively affect the chance to work in any of these countries. If this situation occurs, Wemos might decide to work with organizations in other countries.

¹⁸ Wemos has contacts with CSOs in both countries. In the coming months, based on discussions with relevant stakeholders including CSOs in the two countries it will be decided which of the two countries will become the fourth focus country for Wemos. This selection is based on the five criteria mentioned here.

¹⁹ See specific objective 1 in the next section.

Capacity strengthening

In many countries, health organizations are not well organized and their capacity has to be strengthened to effectively articulate public interests in health and to come up with viable suggestions for improved health policies. In the four focus countries Wemos aims to fill some of the gaps, where possible in close collaboration with other Northern organizations such as Cordaid and ICCO, which have partner networks in some of these countries. This programme builds upon the experiences gained from the existing collaboration with CIN in Kenya, AIS in Bolivia and DORP in Bangladesh. The lobbying capacity of these organizations has increased in the framework of the Wemos programme 2003-2005 and they are expected to play an important role in the new programme.

Strengthening the capacity to influence policies includes:

- providing access to information and analysis about international health policy issues,
- facilitating access to tools, technical advice and training,
- exchange of experiences between countries,
- participation in networks, and
- participation in international events

What is included in capacity strengthening depends on the organization and its context, but all supported activities are related to the enhancement of the capacity to influence policies.

This means that capacity strengthening may concern:

- institutional development such as the strengthening of the ability of the organization to cooperate and the embedding of the organization in larger networks,
- organizational development such as the internal strengthening of the organization to carry out its activities, and
- human resource development such as skill training of individual staff members.

Wemos facilitates capacity strengthening by providing funds and offering access to relevant courses and training institutes.

Capacity strengthening is a two-way process in which Wemos and its partners learn from previous experiences and from each other, thereby developing tools and mechanisms for learning from experience.

Advocacy in the South

As part of the working plans developed in the four countries, Wemos will support country level advocacy activities and international activities including financial resources. Wemos's added value lies in the opportunity to build alliances and mobilize support among donors and to link up with European and American CSOs that can lobby their own government representatives in the specific country. Wemos will also support partners in the four countries in carrying out case studies²⁰ on the impact of international policies on health systems and in carrying out policy analyses.

Collaboration and capacity strengthening

²⁰ In recent years, research has become an important aspect of the collaboration with Southern organizations. In a number of countries case studies were carried out on the impact of international policies on people's health. Case studies were carried out within the framework of the project on Global Public Private Initiatives, PRSPs and health and trade. These case studies provided important input for the advocacy activities of the Southern partners and Wemos and also served as a method for capacity strengthening in research for advocacy (see box on p.23).

In the Global Public Private Initiatives (GPPIs) project, different activities were programmed to strengthen the capacities of organizations from five African countries and three Indian states. In 2003, two meetings were organized for joint discussion and analysis. After that, research guidelines and instruments to be used by the organizations in the implementation of case studies were designed with the help of an external consultant. In 2003 and 2004 the case studies were carried out. In a joint meeting in April 2004, the participant organizations were trained on concepts and tools related to research for advocacy, and they also exchanged experiences related to the implementation of their own case studies. The result of the project is: a case study report which forms a very valuable source of information for advocacy and has already received a lot of attention (Utrera forth.), and increased capacity of partners for lobbying. The last joint meeting will take place in June 2005. The programme for that meeting includes training sessions on linking national activities with international advocacy and an evaluation and discussion of lessons learned from the three-year process.

Wemos activities in the North

Wemos organizes events in the Netherlands and Europe in which Southern partners participate to present their views and experiences. Wemos also obtains funds and will increase its staff and budget for working with Southern partners from 2006 onwards (see Chapter 5).

Joint activities on the global level

Joint lobbying activities during international conferences and participation in international networks (see section about lobbying) provide the opportunity to organize training sessions and work on joint strategies and offer a platform for learning from each other in an organized way.

Collaboration with other Southern organizations

Ad hoc collaboration with CSOs in other countries is possible within the framework of specific themes, often in the context of collaboration with Cordaid and ICCO or other European CSOs. Wemos may finance specific activities such as international meetings or case studies. This will not be part of longer-term financial relationships, however.

3.4. Campaigning and awareness raising

Wemos strongly believes that to be effective in the kind of lobbying that leads to sustainable political solutions, it is necessary to mobilize public support. In its almost 25 years of existence, Wemos has organized a large number of campaigns in the Netherlands directed at health care workers and the wider public. The success of these campaigns lies in the combination of activities, ranging from the organization of public events and participation in fairs and conferences to the production and dissemination of materials such as leaflets, gadgets and background papers.²¹

²¹ Campaigning and awareness raising activities are pursued in the Netherlands Southern partners play an important role in these activities. The collaboration with partners in the South focuses on the three other aspects of lobby: policy dialogue, research and policy analysis, network and coalition building.

the Netherlands

Wemos attaches great value to face to face discussions and debates with the target groups during different events so that support for the work of Wemos can be gained. Wemos believes in the process of building up knowledge, changing attitudes and thus mobilizing support by means of signature campaigns, for example, or the sending of SMS messages. Over the years Wemos has collected tens of thousands declarations of support, which have more than once been helpful in convincing policy makers to develop policies for better health in developing countries. Wemos also works on awareness raising by participating in panel discussions on broader development issues and by publishing a bi-monthly newsletter and keeping its website up to date.

The main target groups for the campaigning and awareness raising activities in the coming years will be health workers and future health workers, i.e. medical students. Experience and studies show that health workers are interested in the subjects Wemos raises and are willing to support the campaigns because they can easily relate to their colleagues in developing countries and to health issues. Medical students are an interesting target group as they are eager to gather new knowledge and are in the process of forming their own opinions. Moreover, it is important to invest in contacts with an interested group of future health workers.

In supporting the campaigning and awareness raising activities, Southern partners, other CSOs and the media fulfil a crucial role because they provide information, offer opportunities for higher quality activities, enlarge the number of people reached and/or form an important intermediary medium for reaching the target groups.

Within the context of the Wemos programme 2006-2010 the following activities are envisaged.

Campaigns and actions of current relevance

In the past three years Wemos has organized one campaign each year. In order to be more flexible and able to react on topical issues, Wemos plans to invest more in short-term campaigns in the coming years and in actions directed at health workers, medicals students and the wider public. These campaigns and actions will be inspired by the current news in order to generate free publicity, to raise awareness and to support lobbying activities. The actions comprise political cafes, opinion polls, publication of information booklets, etc. In these ad hoc campaigns and actions collaboration with organizations such as hospitals, students organizations and other development organizations is crucial in reaching the target groups. The strategic partnership between Wemos and COS Nederland (Centres for International Cooperation), which is relatively new, makes it possible to extend the outreach of campaigns and other activities into the different regions of the Netherlands. The collaboration with dozens of hospitals in the Netherlands will be continued, as well as with branch organizations such as the KNMP (the Royal Dutch Pharmaceutical Society), KNMG (the Royal Dutch Medical Association) and the LHV (National Association of General Practitioners)

Lectures and workshops for medical students

Wemos also raises awareness of international health issues by giving lectures to medical and other students. Cooperation with students' organizations such as the International

Federation of Medical Students' Association (IFMSA) is another way of reaching them. Through participation in the Global Health Education Project, Wemos contributes to placing global health issues on the curricula of medical faculties of Dutch universities. Students are also practically involved in the work of Wemos as volunteers participating in campaigns and media actions, and in work placement.

Press-related activities

Wemos has good contacts with a number of professional health magazines and specialized journalists. In the coming years, Wemos plans to develop activities and products that are set up specifically to attract press attention and thus to reach a wider public. To improve our access to the media we will appoint one press spokesperson who is responsible for getting in touch and maintaining contacts with relevant journalists from the different media.

Campaigning

Wemos has initiated the Jubilee campaign in the Netherlands, mobilizing health workers and the Dutch government. Together with the international Jubilee 2000 coalition, debt relief was put high on the political agenda, and since 2000 funds have been made available within the framework of the Highly Indebted Poor Country Initiative. In 2003 and early 2004, Wemos organized a new campaign as member of the Jubilee coalition and collected 10,000 signatures of health workers and others. A total of 65,000 signatures, including those collected by other members of the coalition was handed over to Ministers Zalm and Van Ardenne in April 2005. At the international level the topic is still receiving a great deal of attention, and Prime Minister Blair has developed a new proposal for further debt relief. In the Netherlands, the ministers for finance and development cooperation recently announced their own plans. Lobbying efforts still need to continue to ensure that debts are actually cancelled and more money becomes available for investments in health.

Fundraising

Awareness raising, campaigning and communication are vital aspects of fundraising. Among the Wemos's main target group, the health care workers, there exists a lot of willingness to contribute to the improvement of the health situation of the people in the South. In past campaigns many health care workers have made financial contributions as well. In the coming years Wemos will address this specific group on a larger scale with requests for structural financial support for the work of Wemos. One of the communication advisors, along with the director, will more actively raise funds in the near future (see also Chapter 5).

Global and national networks

Long-term campaigns in collaboration with others

In the coming years, next to ad hoc actions, Wemos will continue its active participation in long-term campaigns organized by other organizations. Present examples are the NCDO 'Kans op Gezondheid' campaign, and the 'Maak het waar' campaign of the Dutch Platform Millennium Development Goals and the debt relief campaign of the Jubilee Nederland Coalition. In the last two campaigns Wemos is an active member of the steering committees. When possible Wemos will join forces with European and international coalitions. The Food, Trade and Nutrition Coalition is an example of a successful collaboration in which campaigns and other communication activities are incorporated.

Southern partners

Southern partners will continue to play an important role in campaigns and other awareness raising activities. They provide Wemos with useful topical information, participate in public events in the Netherlands and are interviewed by different media. In intensifying the contacts with the Southern partners, possibilities for learning from and feeding into each other's campaigning and awareness raising activities will be explored. To improve communication, the Wemos English website will be further developed and possibilities to develop an English newsletter will be explored. In 2006 discussions will be held to find out what the partners' needs and wishes are and whether a regular English newsletter is feasible.

4. Wemos Programme 2006-2010

This Wemos Programme is based on the analysis of international trends and policies and their relevance for the health of people such as Joyce, on the expertise and added value of Wemos and the Southern partners and on the possibility of seeking collaboration with other organizations.

The different parts of the Wemos strategy all contribute to this programme which covers a five-year period. In annual work plans, further details will be provided concerning the timing of the different specific objectives.

4.1. Overall objective and specific objectives

As described in Chapter 3, the overall objective is: *to strengthen national health systems that contribute to the structural improvement of people's health in developing countries.*

This overall objective reflects the broader development impact to which Wemos intends to contribute in order to fulfil its mission: to contribute to the structural improvement of people's health in developing countries through advocacy, thereby advancing its vision of a world in which every person can realize his or her right to the highest attainable standard of health.

The overall objective is delineated in five specific objectives:

| Specific objectives | |
|--------------------------------------|---|
| 1. Health care providers | <i>Civil society organizations in developing countries have developed concrete and feasible alternatives for the governmental or social regulation of private and public health care providers, in order to ensure access to health services by the poor and vulnerable groups.</i> |
| 2. Health budgets | <i>Policy and decision makers from developing countries and the Netherlands have taken affirmative steps to design and negotiate fiscal frameworks with the IMF that allow for health expenditures necessary to meet MDG commitments.</i> |
| 3. Human resources for health | <i>In developing countries civil society organizations have effectively advocated for the harmonization of national and international efforts in human resource development in health in order to contribute to a well-functioning health system.</i> |
| 4. Nutrition | <i>Nutrition security as one of the most important determinants of the health status of people in developing countries has been taken into account during WTO and regional trade negotiations and their implementation by policymakers from developing countries and Europe.</i> |
| 5. Medicines | <i>A significant increase has taken place in the public and political pressure being brought to bear on pharmaceutical industries to behave socially responsible, when operating in or producing for developing countries.</i> |

A large number of actors and factors influence the successful achievement of these objectives. The political situation in the Netherlands or developing countries may suddenly

change, capable staff from Southern organizations may decide to seek employment elsewhere and natural disasters may make it difficult to continue the work. At the same time, it is not always possible to attribute concrete results to the work of Wemos. A number of stakeholders are involved in advocacy work on health, and successes are often the result of joining forces but may also have to do with changes in the political climate in a country or in the international community which cannot directly be attributed to the work of civil society. This programme therefore includes specific objectives, expected results and activities which now seem achievable within the coming five years. In annual plans and reports possible adjustments will be introduced and described.

The five specific objectives contribute to the overall objective in different ways. In some cases the focus is on advocacy in the South, in others policy influencing in the North is at least as important. To enhance the readability and overview, each specific objective is illustrated with a figure in which the importance of the different strategies and the level where they are being carried out is highlighted.²²

Cross-cutting activities

In the framework of this programme, campaigning and awareness raising activities are pursued to gain support for our work among health workers in the Netherlands. When and how *campaigning* activities are carried out depends on the urgency of the matter and the possibility of attracting the attention of the press and health workers. Therefore, with the exception of specific objective 5, no specific campaigning activities are planned at the moment. In the yearly work plans specific activities will be elaborated. The *awareness raising* activities do not directly contribute to the achievement of the specific objectives but are important for the support Wemos is able to generate and for the imbedding of Wemos in Dutch society. They are therefore included as cross-cutting activities under each specific objective. Funds and FTEs for campaigning and awareness raising activities are included in the budget (see page 43).

4.2. Health care providers

Specific objective 1

Civil society organizations in developing countries have developed concrete and feasible alternatives for the governmental or social regulation of private and public health care providers, in order to ensure access to health services by the poor and vulnerable groups.

As described in Chapter 2, in many developing countries cuts in public expenditures have led to a deterioration of public health services and a growth in the number of private providers. User fees have been introduced and people now have to pay for many basic public health services, both public and private. The effect is that many people, especially the poor and vulnerable (women and children, HIV/AIDS patients), have less access to basic health care because they are not able to pay. At the same time, in many countries the quality of the services has deteriorated. In order for public and private care providers to produce quality

²² Information about the expected results, activities and planning is provided here. The planning gives a rough indication of when activities will be carried out. In the yearly work plans more specific time tables will be included, based on discussions with the Southern partners. For indicators and a description of the assumptions the reader is referred to the logical framework in Annex 2.

services also accessible to poor and vulnerable groups, government rules and regulations, including their implementation, are required. In countries where the government is unable or unwilling to regulate and control these services, civil society formulates proposals for forms of social regulation.²³ This requires the active engagement of CSOs in policy dialogues which is vital in ensuring policies that lead to sustainable improvements in people's health. This specific objective is a first step that should ultimately lead to the implementation of regulations resulting in accessible, available and sustainable health systems. Whether, where and when this will be achieved lies beyond the scope of this project.

Background

Since 2002 Wemos and a group of partners have been working on the consequences of Global Public-Private Partnerships (GPPPs) and of the increase in the number of private health care providers for the health of people in the South. The role of health insurance companies and the consequences of GATS for access to health care are also part of the 2003-2005 programme. The planned activities for the period 2006-2010 follow from these earlier activities.

Because of its expertise in strengthening advocacy activities related to international health issues and its network of advocacy organizations in developing countries, Wemos is in a good position to carry out capacity strengthening activities that will contribute to the development of concrete and feasible proposals for the regulation of health care providers.

| Health care providers | South | North | Global |
|--|-------|-------|--------|
| Lobby | | | |
| Collaboration with Southern partners, including capacity strengthening | | | |
| Campaigning and awareness raising among health workers | | | |

Figure 4.1: Intensity of activities per strategy and level of intervention

South

It is anticipated that partners in Kenya, Bolivia, Bangladesh and Zambia or Tanzania will be included in this project. Partners in the first three countries are already actively involved in discussions with their governments around health issues.²⁴ As mentioned in Chapter 3 possibilities for further collaboration in either Tanzania or Zambia need to be explored.

Wemos will support partners in strengthening their lobbying skills and in obtaining more knowledge about the possibilities and constraints in regulating health care providers. The partners will further develop their contacts with policy makers and will build coalitions with like-minded CSOs in the country and the region and link up with academic institutions for the collection of information. Wemos will assist the partners in obtaining, analysing and using

²³ These could be ad-hoc or systematic arrangements at local, regional and national level with the participation of (local) authorities, CSOs and other relevant stakeholders aimed to regulate the function and the quality of services delivered by health care providers.

²⁴ CIN in Kenya and AIS in Bolivia have actively participated in the development of this programme. DORP in Bangladesh is part of the PRSP monitoring project, and discussions about their involvement in this project will take place in the course of 2005. If they are not interested, contacts with other CSOs in Bangladesh will be explored.

information, knowledge and skills and will provide funds for conducting activities in the countries and on the international level.

North

Wemos will actively participate in discussions on the Dutch and European level in order to complement the advocacy work of the Southern partners. In the Netherlands, Wemos will continue to participate in the GATS platform, in which it is the only organization focussing specifically on health.

Global

On the international level contacts are being established with Public Services International and the European Trade Network. In these networks very little attention is being paid to health services and Wemos sees it as its role to put health higher on these agendas. By connecting with these networks Wemos obtains information which supports the advocacy work of the Southern partners. During international meetings Wemos and its partners will exchange experiences, evaluate progress and organize seminars about the importance of regulation and will contact policy makers.

Expected results

- A group of at least three CSOs in each of the four countries has produced a concrete and feasible proposal for government or social regulation of health care providers.
- At least five policy and decision makers in each of the four countries are aware of the proposals developed by CSOs.
- The advocacy capacity of at least three CSOs in each of the four countries has been strengthened.

Activities

- Collect information on health systems, health providers and the existing rules and regulations in the four countries.
- Support the conducting of four case studies by the partners on the effects of the large number of different types of health service providers on the access to health care of the poor.
- Assist in forming alliances of CSOs in the four countries and, where possible, regions where information is exchanged and proposals are being discussed.
- Support exchange of information, suggestions and recommendations among CSOs from the four different countries in order to increase knowledge and strengthen capacity of each of the CSOs during international meetings and via email.
- Facilitate the attending of meetings by partners where policies of World Bank/IMF and WTO in relation to the regulation of health care providers are being discussed.
- Participate in discussions in the Netherlands and Europe about GATS and the regulation of health service providers in general.
- Participate in policy dialogue with Dutch policy makers on the issue of regulation of health care providers in developing countries.
- Assist partners in organising meetings with policy makers to discuss regulation of health care providers.
- Assist partners in the formulation of position papers based on their proposals.
- Organize planning meetings with partners in the four countries for the development of work plans on advocacy activities, on research and policy analysis and capacity strengthening.
- Facilitate and/or organize capacity strengthening training and workshops by Wemos and its partners based on the work plans.

- Organize evaluation meeting in 2009 with partners from the four countries to evaluate collaboration and activities.
- **Cross-cutting activities**
- Give five lectures to medical students about the role of different health care providers and the importance of regulation.
- Publish five articles in newsletters and medical journals about the role of different health care providers and the importance of regulation.
- Contribute to Wemos publications: leaflets, newsletter and websites (Dutch and English)
- Explore possibilities for development of English newsletter for partners and other contacts.

Planning

In the first year of this project, Wemos and its partners will identify other CSOs interested in participating. During the planning meetings, which will take place in the first half of 2006 in the four countries, some of these organizations will already be included. 2006 will also be devoted to supporting the building of alliances, collecting and analysing information and beginning the development of a Terms of Reference for the case studies. In 2007 training workshops will be facilitated on research for advocacy and the setting up of the case studies will be finalized. The case studies will be conducted in 2007 and 2008. Based on the case studies and the information gathered from other sources, work will begin in 2008 on formulating the proposals for regulation. These initial proposals will be discussed with different stakeholders, including national and international policy and decision makers, and will be finalized in 2009. In that year the evaluation meeting with partners from all four countries will also be held. In 2009 and 2010 national and international advocacy activities based on the proposals will be carried out. Throughout the entire five years, meetings with Southern partners will take place, information will be collected, training workshops will be organized and international meetings will be attended.

4.3. Health budgets

Specific objective 2

Policy and decision makers from developing countries and the Netherlands have taken affirmative steps to design and negotiate fiscal frameworks with the IMF that allow for health expenditures necessary to meet MDG commitments.

As described in Chapter 2 health systems in developing countries suffer from structural and severe underfunding. Larger investments in health are seen as a vital precondition for the achievement of the MDGs by key players in the international community, and donor governments are called upon to allocate higher budgets for health. It is therefore expected that in the near future more funds will become available for health. The IMF also acknowledges the need to increase health investments but at the same time argues against increases in health budgets out of fear of inflation and macroeconomic instability. This has met with widespread and increasing criticism by CSOs and health donors. The AIDS epidemic and the crisis in human resources both require huge additional expenditure, which is often not possible under IMF programmes. Wemos and its partners, in the framework of three specific country programmes, aim to influence the fiscal conditions of the IMF by articulating health spending needs and helping to mobilize national and international public and political pressure to increase health budgets.

Background

Wemos has been working on the impact of economic policies on health since 1997. Wemos was one of the initiators of the Jubilee 2000 campaign in the Netherlands. Since 1999 Wemos has closely monitored the PRSP process together with partners in Bolivia, Kenya and Bangladesh. The PRSP monitoring experiences made Wemos and its partners realize that unless the conditions and working methods of the IMF change fundamentally, the PRSP approach will never lead to genuine country-owned strategies to beat poverty.

Very few organizations at both the national and the international level focus specifically on the negative aspects of the IMF conditionality on health. The knowledge and expertise of Wemos concerning international policies and their effect on national health budgets put the organization in a good position to further develop activities around this theme.

Figure 4.2: Intensity of activities per strategy and level of intervention

| Health budgets | South | North | Global |
|--|-------|-------|--------|
| Lobby | | | |
| Collaboration with Southern partners, including capacity strengthening | | | |
| Campaigning and awareness raising among health workers | | | |

South

Within the framework of the current PRSP project, partners in Kenya, Bolivia and Bangladesh have already developed work plans on the issue of health budgets. During the planning meetings scheduled for 2006, further collaboration on the issue of conditionality will be explored. Wemos will also seek collaboration with a number of organizations in other countries that meet unnecessary fiscal restrictions imposed by the IMF. Preferably, these will be countries with Dutch bilateral support for the health sector. Possibilities for collaboration with Cordaid and its partners are currently being explored in a number of African countries.

The Southern partners involved in this project will organize discussions with ministries of health and finance, representatives of donors and international agencies and IMF country representatives. Wemos will actively support building national alliances with academics, UN offices and like-minded bilateral donors and will facilitate efforts to mobilize public opinion. Where necessary, Wemos will support training to strengthen the capacity to participate in policy dialogue.

North

Wemos is part of the PRSP-partnership initiative, initiated by DGIS in 2004. The initiative aims to bring together Dutch civil society, partners, embassies and the ministry to strengthen national PRSP processes and link the local level to the policies at IMF/World Bank level. Six countries have been selected for this partnership: Bangladesh, Zambia, Bolivia, Nicaragua, Mozambique and Mali. Within this partnership, Wemos will focus on health budget issues.

Wemos will also remain an active participant in policy dialogue on broader issues such as harmonization, conditionality and MDGs and is an active member of the MDG platform and other coalitions such as Share-net and Jubilee Nederland.

Global

Wemos will feed broader policy debates at the global level such as debates on MDGs, IMF conditionality and donor harmonization. Positions will be formulated with input from partners. Whenever relevant, Wemos and its partners will organize seminars and participate in discussions at international forums such as the WHA and the World Bank and IMF annual and spring meetings and OECD meetings. Wemos will also actively share its experiences and coordinate lobby positions with CSO networks such as Eurodad.

Expected results

- CSOs in at least four countries have brought their opinions about the fiscal frameworks of the IMF to the attention of at least five relevant policy and decision makers, i.e. IMF and World Bank representatives and officials from the Ministry of Health and Finance.
- In two countries the Dutch embassy has supported Ministries of Health and Ministries of Finance in their negotiations with the IMF for more flexible fiscal frameworks.
- CSOs in three EU countries have lobbied their governments to ensure that in negotiations with the IMF the importance of fiscal frameworks that allow for increased health budgets have been taken into account.

Activities

- Support the conducting of case studies on the impact of fiscal target on health budgets in four countries.
- Monitor relevant policy developments in partner countries.
- Formulate position papers for country level advocacy together with partners.
- Support capacity strengthening activities on IMF policies and advocacy such as training and workshops for Southern partners.
- Support advocacy in Kenya, Bolivia and Bangladesh and Tanzania/Zambia and potentially other countries.
- Join in planning meetings in Kenya, Bolivia and Bangladesh and Tanzania/Zambia to discuss possibilities for joint activities (see objective 1).
- Organize joint meetings (Wemos and partners) during international conferences.
- Organize evaluation meeting in 2009 with all partners involved.
- Establish contacts with health experts at the embassies.
- Monitor Dutch contribution to relevant policy issues (conditionality, PRSPs, donor harmonisation and alignment).
- Formulate position statements for dialogue with policy makers in the Netherlands and health experts of embassies.
- Mobilise support from Dutch and international experts in health and development.
- Participate in policy dialogue with Dutch policy makers, eg PRSP initiative of the ministry of Foreign Affairs, Dutch embassies.
- Coordinate advocacy with Dutch CSOs and coalitions.
- Monitor international policy developments (conditionality, PRSPs, donor harmonisation and alignment).
- Formulate positions with other European CSOs for international policy actors/for a
- Participate in international policy dialogue and meetings at relevant global fora to contact EU CSOs and collect information (WB, IMF, WHA, DAC)
- Coordinate advocacy with European CSOs and international networks

Cross-cutting activities

- Give five lectures to medical students about the conditionality and health budgets.
- Publish five articles in newsletters and medical journals about IMF conditionality and health budgets.

- Contribute to Wemos publications: leaflets, newsletter and websites (Dutch and English)
- Explore possibilities for development of English newsletter for partners and other contacts.

Planning

The first year of this project will be used to explore possibilities for collaboration with organizations in Kenya, Tanzania or Zambia, Bangladesh and Bolivia. Contacts with organizations working on this issue in other countries will also be established. In 2006 the initial plans for the case studies will be developed with the partners who are to conduct these case studies in 2007. During the first two years, contacts will also be established with relevant policy and decision makers, experts, health advisers at the Dutch embassies and European and Dutch CSOs, and relevant information will be collected. In 2008, the data from the case studies will become available and partners will be supported in carrying out advocacy activities and learning from each other's experiences. In 2009, follow-up case studies will be set up; these will be carried out in 2010. During this period lobbying will continue in the South and the North. In 2009 the project will be evaluated with all partners involved. Throughout the five-year period meetings with Southern partners, participation in international meetings, policy analysis and policy dialogue will be pursued.

4.4. Human resources for health

Specific objective 3

In developing countries civil society organizations have effectively advocated for the harmonization of national and international efforts in human resource development in health in order to contribute to a well-functioning health system.

As described in Chapter 2, the lack of health personnel is one of the biggest problems in providing people with access to health care. For the achievement of the MDGs and in relation to the HIV/AIDS crisis, human resource development for health is an absolutely crucial aspect of available, accessible and sustainable health systems. Fortunately, bilateral donors, multilateral agencies, international financial institutions, leaders from Africa and members of the boards of Global Public-Private Partnerships (GPPPs) have all publicly recognized the importance of human resource development for health and have recently made a joint call for action which includes the establishment of a global platform coordinated by the WHO. The implementation of the commitments requires strong CSO participation at country level in order to remind governments of their obligations and of the importance of coherent national and international policies in relation to human resource development in health. National cooperation is required beyond the ministries of health and should include the ministries of finance, education, trade and foreign affairs.

Background

Wemos and its partners have been working on the issue of health personnel since 2002 within the framework of the work on health care privatization/commercialization, GATS and GPPPs. In these projects clear evidence has been collected concerning the heavy burden on

health personnel in developing countries. This project builds upon these experiences and is expected to be carried in two African countries.²⁵

Attention paid to human resource development in health has strongly increased during the last year at both the international and national level. In the Netherlands, KIT has collected valuable information about human resources in health and Cordaid is also working on the issue. There is an active network of NGOs in Europe and Africa working in this area and the Dutch embassy in Zambia supports a programme which aims to send out and retain national health workers in rural areas by increasing their salary and secondary working conditions. Wemos's added value consists in its in-depth knowledge on international (trade) policies and its international network, in which human resource development in health is a key issue.

| Human resources for health | South | North | Global |
|--|-------|-------|--------|
| Lobby | | | |
| Collaboration with Southern partners, including capacity strengthening | | | |
| Campaigning and awareness raising among health workers | | | |

Figure 4.3: Intensity of activities per strategy and level of intervention

South

The Southern partners will establish and maintain contacts with policy makers in the Ministries of Health, Trade and Finance to achieve coherence in initiatives on human resource development in health during negotiations with bilateral donors, IFIs and negotiations with Global Initiatives. Wemos will keep in touch with the health experts at the relevant Dutch embassies in order to cooperate where possible on human resource development for health.

North

In the Netherlands and at EU level, Wemos will actively participate in discussions and lobbying activities, with the main goal to complement the advocacy work of the Southern partners. Policy makers will be reminded of inefficiencies and inflexibilities in donor support and of the importance of refraining from measures which may undermine the commitments made in relation to human resource development in health in developing countries.

Global

During international meetings such as the WHA, Wemos and its partners will lobby WHO and representatives of donor governments to ensure harmonization of the implementation of international commitments on human resource development for health. With respect to the potential impact of the national and international migration of health personnel, Wemos will inform policy makers on its implications for the health sector.

²⁵ During the planning meetings scheduled for early 2006 (see objective 1), the question of which partners are interested and able to participate in this project will be explored. CIN from Kenya has already shown interest in continuing their work on this issue. Contacts have been established with the Dutch embassy in Zambia and will be further explored, and health personnel is an important topic within the framework of the collaboration with Cordaid. Based on all these factors, the partners with whom these activities will be carried out will be decided in early 2006. This collaboration is not necessarily limited to the four countries on which Wemos focuses its work.

Expected results

- Three CSOs in each of the two countries have built an effective alliance to lobby for harmonization of national and international initiatives for human resource development for health.
- Four policy and decision makers in each of the two countries are aware of the importance of greater coherence within and between national and international policies in human resource development for health.

Activities

- Collect information about the health personnel crisis in developing countries, and compile and disseminate best practices in human resource development for health.
- Explore emerging international policies (trade, health, migration) that may have a negative impact on or that aim to contribute to sustainable human resource development.
- Join in planning meetings in Kenya and Tanzania/Zambia in order to discuss possible collaboration on the issue of human resources for health (see objective 1)
- Explore possibilities in other African countries and set up collaboration with organizations in two countries.
- Organize meetings in the two countries to assist Southern partners in building alliances to lobby jointly.
- Share information within international networks (PHM, KIT, Medact, Save the Children, Sharenet, Equinet Africa etc) and organize discussions with these networks
- Establish regular contacts with embassy health advisers in two countries.
- Facilitate exchange of information from other countries via Southern partners on effective harmonisation of human resource development policies to enhance advocacy.
- Facilitate meetings with Southern partners and where necessary with experts and policy makers.
- Organize evaluation meeting with partners in 2009.

Cross-cutting activities

- Give five lectures to medical students about human resource development in health.
- Publish five articles in newsletters and medical journals human resource development in health.
- Contribute to Wemos publications: leaflets, newsletter and websites (Dutch and English)
- Explore possibilities for development of English newsletter for partners and other contacts.

Planning

In 2006, discussions with organizations in several African countries will result in the development of a plan with partner organizations concerning the two countries in which the activities will be carried out. During the first two years of this project the focus will be on the compilation of information and the sharing of best practices and policy analyses in order to broaden the knowledge and expertise of Wemos and its partners. Contacts with embassy health advisers, international networks and experts will be established and partners will be supported in building alliances with other CSOs in their countries or regions. From 2008 onwards the focus will be on the advocacy activities of the partners who will be supported in organizing meetings with policy and decision makers. At the same time, the possibility of exchanging information with organizations in other developing countries will be explored in order to learn from each other and, where feasible, to join forces. In 2009 an evaluation meeting will take place with the partners involved in the project. Throughout the five-year period international meetings will be held, articles will be published and contacts with policy makers in the Netherlands will be maintained.

4.5. Nutrition

Specific objective 4

Nutrition security as one of the most important determinants of the health status of people in developing countries has been taken into account during WTO and regional trade negotiations and their implementation by policymakers from developing countries and Europe.

Nutrition security is a key aspect of people's health and is absolutely vital for the achievement of the MDGs, not only in the fight against hunger (MDG 1) but also in relation to child mortality (MDG 4), maternal health (MDG 5) and the reduction in the number of people infected with HIV/AIDS, malaria and other diseases (MDG 6). In international trade negotiations the importance of nutrition is often overlooked, and many of these trade agreements have a negative impact on nutrition security, such as by making it more difficult for governments to develop and implement sovereign nutrition plans.

In the first phase, policy and decision makers involved in these negotiations will be targeted. In the course of 2006 and 2007 negotiations on the WTO Agreement on Agriculture and Economic Partnership Agreements between developing countries and the EU are expected to be finalized. In the second phase, activities will therefore focus on the national consequences of these agreements for nutrition security.

Background

Wemos has been working on nutrition for a large number of years. Until 2002 the focus was on the importance of breast feeding for children's health, and from 2002 onwards the focus has been on the impact of trade agreements on nutrition. Together with the Food, Trade and Nutrition (FTN) coalition in which ICCO, BBO, KerkinActie and 12 Southern organizations participate, lobbying activities have been carried out in conjunction with various WTO, UNCTAD and WSF meetings since 2003. This project is a continuation of the present work in the framework of this FTN coalition.

The impact of international policies on food security is an issue on which many national and international CSOs, including farmers unions, are working. Their focus is mainly on the production of food, including the issue of the impact of EU agricultural subsidies on local farmers. The consumption side of food security is often overlooked, and internationally far less attention is being paid to the impact of trade agreements and policies on nutrition security and health. Wemos and its partners operate in this niche and wherever possible support the lobbying of those focussing on food security.

| Nutrition | South | North | Global |
|--|-------|-------|--------|
| Lobby | | | |
| Collaboration with Southern partners, including capacity strengthening | | | |
| Campaigning and awareness raising among health workers | | | |

Figure 4.4: Intensity of activities per strategy and level of intervention

South

To raise awareness among policy makers, sound data are required. In the first year of this programme indicators²⁶ will be developed and in the second phase at least three case studies will be conducted by Southern organizations on the effects of international trade policies on food and nutrition security. In which countries these studies will take place will be decided during the planning meetings with partners (see specific objective 1) and meetings of the FTN coalition in 2006.

Southern partners will contact policy and decision makers for lobbying activities and will raise awareness among the wider public on issues related to international trade and nutrition. They will also join other national and regional CSOs working on this issue. Wemos will support the partners in conducting these activities and in strengthening of their capacity for advocacy work.

North

Wemos will establish regular contact with policy makers in the Netherlands and the EU to convince them of the importance of taking into account health and nutrition in international trade agreements. Alliances of other CSOs working on the issue will be formed and joint activities will be organized.

Global

Wemos and its partners will follow developments in relevant international forums such as the WTO conferences, the Standing Committee on Nutrition, the WHO and Codex Alimentarius in order to be fully informed about the international debates concerning trade, nutrition and health.

The collaboration with ICCO, KerkinActie and 12 Southern partner organizations will continue in the coming years and the capacity of this international Food, Trade and Nutrition (FTN) coalition will be strengthened.²⁷ Within the framework of the FTN coalition, seminars will be organized and policy makers approached during WTO and other relevant international conferences .

²⁶ Indicators for nutrition security have been developed by research institutes. To measure the effect of trade agreements on nutrition security does, however, require a new set of indicators. Wemos has established relationships with academic institutions that will develop these indicators.

²⁷ The current cooperative agreement between ICCO and Wemos ends at the end of 2006, but ICCO has already made it clear that they greatly value the joint work within the framework of the FTN coalition and intend to continue the collaboration with Wemos beyond 2006.

Expected results

- At least ten policy makers in the Netherlands have shown their awareness of the opinion of the CSOs involved in this project, on nutrition effects of trade agreements.
- Five European decision makers have publicly expressed their concern about the consequences of international trade agreements on nutrition security in the South.
- In total ten policy makers from four developing countries have publicly expressed their concern about the consequences of international trade agreements on nutrition security in the South
- The members of the FTN coalition have gained increased knowledge on nutrition effects of international trade agreements.

Activities

- Develop a set of indicators to study the effects of international trade policies on food and nutrition security.
- Support the conducting of studies in at least three Southern countries on the effects of international trade policies on food and nutrition security.
- Collect information about trade agreements and nutrition, including information on relevant topics such as the role of food industries in nutrition security, via networks, web sites and other sources.
- Publish the results of studies, position papers, letters and lobby papers on the issue of international trade, nutrition and health.
- Maintain regular contact with policy makers in the Netherlands to discuss the outcomes of the studies and other relevant issues in relation to international trade, nutrition and health.
- Obtain insight into other organizations' involvement in the issue of nutrition security and health.
- Organize and participate in meetings of alliances of CSOs in the EU and in the Netherlands working on food and nutrition security (such as the European Food Security Group).
- Attend other relevant international meetings to collect information and meet relevant policy makers (SCN, WHO, Codex and EU).
- Maintain regular contact with European policy makers to discuss the outcomes of the studies and other relevant issues in relation to international trade, nutrition and health.
- Develop a joint working plan with the FTN coalition including lobbying strategies research and capacity strengthening.
- Organize regular meetings with the FTN coalition to discuss plans, activities and strategies and work on capacity strengthening.
- Organize joint activities (seminars, discussions) with Southern partners during WTO conferences and other relevant international meetings (WHA, EU).
- Join in planning meetings in Kenya, Bolivia and Bangladesh and Tanzania/Zambia to relate FTN activities to other activities of the partners (see objective 1).
- Organize evaluation meeting with FTN coalition in 2009.

Cross-cutting activities

- Give five lectures to medical students about the effects of international trade agreements on nutrition and health.
- Publish five articles in newsletters and medical journals effects of international trade agreements on nutrition and health.
- Contribute to Wemos publications: leaflets, newsletter and websites (Dutch and English)
- Explore possibilities for development of English newsletter for partners and other contacts.

Planning

In 2006 the joint working plan of the FTN coalition will be formulated. Food indicators will be developed and decisions will be made as to where the case studies will be carried out. A

Terms of Reference for the case studies will be developed and the case studies are scheduled to be carried out in 2006 and 2007. In the same period, policy and decision makers in developing countries and Europe will be approached and asked to take the importance of nutrition security for health into account during international trade negotiations. This process will continue as long as the negotiations last. Based on the outcomes of the case studies, from 2007 onwards policy makers in developing countries responsible for the implementation of the trade agreements will be targeted to ensure that nutrition security does not become jeopardized by the new rules and regulations. The outcomes of the studies will also be discussed with policy makers in Europe and the Netherlands. In the last three years of the project this lobbying will continue, results of the studies will be published, the advocacy capacity of the Southern partners will be further strengthened, national experiences will be exchanged among the FTN coalition members and joint lobbying will be carried out. In 2009 the project will be evaluated.

4.6. Medicines

Specific objective 5

A significant increase has taken place in the public and political pressure being brought to bear on pharmaceutical industries to behave socially responsible, when operating in or producing for developing countries.

As described in Chapter 2, an important aspect of health systems is the access to medicines. The strengthening of health systems therefore means enlarging this access for people in developing countries. Multinational companies play a vital role in ensuring this access. In recent years the corporate social responsibility of these multinationals has become a very topical issue. Some pharmaceutical companies have lowered the prices of anti-retrovirals for the treatment of AIDS by more than 80 percent. Others are actively engaged in so-called Global Public Private Partnerships for health and have donated free medicines for the treatment of all sorts of diseases. At the same time, pharmaceutical companies try to influence the international policies that protect patients and consumers in the South and have lobbied their governments to ensure that the TRIPS agreement favours the protection of patent rights over the access to medicines for poor people.

Background

Wemos has been involved in the debate on CSR in the Netherlands for a number of years. In the 1990s and first years of this millennium, Wemos carried out a large number of activities having to do with access to medicines. Wemos was member of the government delegation during the WTO ministerial conference in Doha in 2001 and ran a campaign among health workers, collecting 7,000 signatures which were presented to the Dutch government. Because of the large number of organizations active in this field it was decided to stop working on access to medicines in 2002.²⁸

In the past two years policy makers and other organizations have kept approaching Wemos for information and advice on TRIPS and other issues related to the CSR of pharmaceutical companies. On the international level a large number of organizations are active in the field

²⁸ With the exception of the discussions with representatives of some of the multinational pharmaceutical companies in the Netherlands.

of TRIPS and CSR. In the Netherlands, however, very few have specific knowledge of the issue. Because of the importance of these matters for the structural improvement of people's health, the earlier work and the continued demand for information and action, Wemos has decided to restart some of its work on the CSR of pharmaceutical companies with a specific focus on lobbying and campaigning in the Netherlands.

| Medicines | South | North | Global |
|--|-------|-------|--------|
| Lobby | | | |
| Collaboration with Southern partners, including capacity strengthening | | | |
| Campaigning and awareness raising among health workers | | | |

Figure 4.5: Intensity of activities per strategy and level of intervention

South

Apart from contacts with Southern organizations looking for information about this issue and contacts with other organizations with networks in developing countries pertaining to access to medicines, no activities are envisaged in the South.

North

Information will be collected through desk studies, conferences and others working in this field. Wemos will target policy and decision makers and will spread information about the CSR of pharmaceutical companies. The discussions about benchmarks with the branch organization of research-based pharmaceutical industries will continue, and where possible Wemos will support the work of others in this field: for example in collaborating with SOMO, which intends to carry out case studies on pharmaceutical companies.

Global

Contacts will be established (and re-established) with international networks active in this field in order to exchange information. Where possible, their lobbying will be supported.

Expected results

- At least ten policy and decision makers are informed of the CSR of pharmaceutical companies and will be prepared to discuss appropriate measures (regulations, sanctions).
- 20,000 health workers and members of the wider public support Wemos lobbying concerning the CSR of multinationals.

Activities

- Collect information about the CSR of pharmaceutical companies through contacts with other CSOs, websites and other sources of information.
- Facilitate and promote case studies conducted by other organizations (SOMO)
- Organize discussions with policy makers and decision makers about the CSR behaviour of pharmaceutical companies.
- Publish results of the study, write lobby letters.
- Continue discussions with pharmaceutical companies about draft guidelines for CSR.
- Follow the discussion about TRIPs in national and international networks and forums and discuss issue with policy makers when appropriate.

- Support Southern partners that intend to work on the CSR of pharmaceuticals companies.
- Organize meetings/discussions to exchange information and generate support among other CSOs working on CSR issues and health institutions in the Netherlands.
- Continue input on CSR performance of pharmaceutical companies as member of the MVO platform (CSR platform).
- Develop, produce and distribute campaigning material about the CSR of pharmaceuticals companies.
- Organize publicity events on the subject and attract media attention.
- Publish articles in Dutch medical magazines and other journals on the issue of the CSR of pharmaceutical companies.
- Give lectures to medical students and others on the CSR of pharmaceuticals companies.

Cross cutting activities

- Contribute to Wemos publications: leaflets, newsletter and websites (Dutch and English)
- Explore possibilities for development of English newsletter for partners and other contacts.

Planning

In 2006 the first case studies will be carried out and contacts with other networks and organizations working on this issue will be explored and intensified. Information will be exchanged and support for the Wemos lobby will be generated. In 2007 results of the case studies will be analysed and published. In the same year campaigning activities will start with the publication of articles and the organization of seminars and other publicity events. In the same period meetings with policy makers will take place, and position papers and lobby letters will be formulated. In 2008 a new series of case studies will be conducted, the results of which will be made available in 2009. In 2009 and 2010, based on these studies and other information collected, new campaigning activities will be developed and lobbying will continue. Throughout the five-year period the discussions with Nefarma will continue, information will be collected and analysed and Southern partners will frequently be contacted to obtain insight into their views and experiences and, where possible, to support their activities on this issue. In 2008 and 2010 the campaigning activities will be evaluated.

4.7. Means per objective

| | 1 | 2 | Specific objective 3 Human Resources for Health | 4 Nutrition | 5 Medicines | total |
|---|----------------|----------------|---|----------------|----------------|----------------|
| Activity costs per strategy: | | | | | | |
| <i>Lobby</i> | 5.000 | 26.000 | 15.000 | 26.000 | 20.000 | 92.000 |
| <i>Collaboration with Southern partners, including capacity strengthening</i> | 173.000 | 102.000 | 54.000 | 102.000 | 11.000 | 442.000 |
| <i>Campaigning and awareness raising</i> | 20.000 | 20.000 | 20.000 | 20.000 | 61.000 | 141.000 |
| Average activity costs in Euros per year in the period 2006-2010 | 198.000 | 148.000 | 89.000 | 148.000 | 92.000 | 675.000 |
| Personnel: | | | | | | |
| Average number of fte per year in the period 2006-2010 | 2,4 | 2,0 | 1,6 | 2,0 | 1,8 | 9,8 |

The above table gives a rough indication of the costs and fte necessary for the realization of this plan. Detailed budgets will be included in the annual work plans.

5. Organization

Wemos was founded by medical students who were of the opinion that too little attention was being paid in medical schools to structural causes of ill health. In November 1981 they organized a conference on international health issues that attracted over 1000 participants and formed the start of what became WEMOS, an acronym for *Werkgroep Medische Ontwikkelingssamenwerking* (working group on medical development cooperation). The students created a foundation under Dutch law and started activities to inform medical students and others about structural causes of ill health in developing countries. One of the main activities was the organization of discussions about whether 'to go or not to go' to developing countries to work as a medical doctor. Wemos also organized campaigns against Organon, which was selling anabolic steroids for malnutrition, and against Nutricia because it was selling substitutes for breast feeding for children younger than six months, which is not allowed under the WHO code on the marketing of breast milk substitutes. At first the organization depended largely on volunteers who worked together with conscientious objectors in developing lessons for medical students, writing articles and organizing campaigns. Over the course of the years WEMOS stopped using the abbreviation, changed its name to Wemos and developed into a professional organization with 20 paid members of staff and an advisory board. Whereas in earlier days the board was the most important decision making body, this power is now delegated to the director.

5.1. Organizational structure

Since 2003, Wemos's activities have been carried out by three project teams: Health and Trade, Health and Poverty and Health and the Private Sector. These teams consist of two or three project officers, one of which is the project manager and a communications officer. The supporting staff includes administrative and secretarial staff, a documentalist, ICT support, a communication advisor and a coordinator who was made responsible for monitoring and evaluation, writing of reports for funders and assisting the director in fundraising.

This structure has been very helpful in the development of expertise on the three themes. An evaluation carried out by MDF in the autumn of 2004 indicated that the strong emphasis on content, however, has resulted in less attention for strategic issues. In order to become more effective in influencing policies, Wemos will put a stronger emphasis in the coming five years on the development of its lobbying capacity and the capacity to collaborate with Southern partners. The latter strategy deserves special attention because of the decision to increase the focus of the work concerning the South (see Chapter 3).

The stronger emphasis on strategy is reflected in the way in which the organization will be structured (see Annex 3). The activities related to the five specific objectives will be carried out by two teams, supported by the supporting staff. The lobby team consists of lobbying experts with extensive knowledge of policies of the different international actors (World Bank/IMF, WTO, WHO, pharmaceutical companies and donor governments). This team also includes two communication officers who work on the campaigning and awareness raising activities related to the specific objectives. The Southern partner team consists of country

experts for Bolivia, Bangladesh, Kenya and Zambia or Tanzania and a communication officer. These experts have insight into the five objectives on which Wemos and its partners are working but are not experts in all these fields. Their expertise lies in the collaboration with partners, including capacity strengthening.

Within these teams, the further strengthening of the strategies on lobbying and collaboration with Southern partners is facilitated by the team leader, who has been allocated extra time for strategy development. He/she is also in charge of budgets and planning and personnel management issues.

Work on the five specific objectives, i.e. the projects, is carried out by staff members from the two teams. Responsibility for each specific objective is delegated to a specific project officer. Every year, in preparation for the yearly work plans, decisions are made concerning who is to participate in which project and for how much of his or her time. The number and type of staff depends on the specific objective. In some cases more lobbying expertise is required, in other cases the major efforts are coming from one or more of the country experts or communication officers.²⁹

The two communication advisors who share one position will remain staff members. Tasks to be divided among them are campaign coordination, general communication activities such as website and newsletters, press spokesperson, fundraising, supporting and advising the communication officers in the lobbying and Southern partner teams and general PR for the organization. These communication advisors will also participate in the projects for part of their time.

The director remains in charge of fundraising, personnel management, policy development and the representation of the organization in the outside world. To further improve the monitoring and learning capacity of the organization, the planning & reporting officer (formerly called coordinator) who has left Wemos in early 2005 will be replaced. This planning & reporting officer is responsible for monitoring and evaluation, planning and reporting and is in charge of the administrative work on the contracts with Southern partners. The Management Team consists of the director, communication advisor, planning & reporting officer and the team leaders.

This new structure has been developed with the present staff in mind. In order to effectively implement the new structure, carry out the planned activities and increase the focus on working in the South, it is necessary, however, to appoint one new staff member in the Southern partner team.³⁰

5.2. Personnel management

The Wemos personnel policy aims to create conditions which help staff members to function optimally and to continue with their own development. As part of the further professionalization of Wemos, new job descriptions were formulated for all staff members in

²⁹ See the table on page 43 for average FTEs per objective for the period 2006-2010.

³⁰ Because of the financial situation, other new appointments are not foreseen in the near future. If more funds become available, a further strengthening of the capacity of the Southern partners team will be considered.

2003 and 2004, and in 2004 a new structure of job evaluation conversations was set up based on the management of competencies. For each function specific competencies were defined by means of a participatory process. Managers were trained in how to conduct job evaluation conversations and the first experiences with competency management are now being evaluated. Next to job evaluation conversations, which take place once a year and are conducted by the director, the team leaders, communication advisors³¹ and the office manager, the director holds so-called 'personal development plan' (POP) conversations with all staff members yearly. These discussions focus on the longer term ambitions and expectations of Wemos staff members and often result in specific training or coaching which support the further professionalization of the staff. The outcomes of these personal development plan meetings are shared with the managers³² and are referred to during job evaluation conversations.

Based on the evaluation of experiences with competency management, adjustments will be made in the procedure for job evaluation conversations and in some of the competencies. In 2006-2008 the job evaluation conversations and the POP conversations will be held according to the new procedure, and in 2009 the procedures and competencies will again be evaluated. The training the managers and communication advisors received in 2004 and 2005 will be followed up in 2006.

For the period 2006-2010, about 2 per cent of the total salary costs will be budgeted for individual training and coaching. This amount will be allocated based on the job evaluation conversations, the POP conversations and needs expressed by managers, communication advisors and staff members. If several people express interest in a similar relevant topic, in-house training will be organized. Special attention will be paid to further improvements in the Wemos strategy. In 2005, experts on lobbying and working with Southern partners were consulted as part of the development of this Wemos programme. The results of these meetings are reflected in Chapter 3 and 4. In 2006 and the years thereafter, funds will be made available for the further development of these strategies in ways that contribute to the effectiveness of the activities of Wemos. Another major area of attention is the improvement of skills of staff members related to planning, monitoring, evaluation and knowledge management (see below).

5.3. Planning, monitoring and evaluation

Planning

The Wemos planning cycle consists of a strategic plan for three or more years based on the log frame method (2003-2005, 2006-2010) and annual work plans which include descriptions of the expected results, activities, assumptions, means and costs for that particular year, including their contribution to the specific objectives and the overall objective of the programme. From these plans a more detailed work schedule is developed including a calendar, staff hours allocated to each budget item and specified budgets. Each year before the first of April, a report including a description of all activities and results, and an overview

³¹ Job evaluation conversations with communication officers are conducted by a team leader together with communication advisor.

³² Managers include the team leaders and the office manager.

of the budget and expenditures, is compiled and sent to the various Wemos donors.³³ An annual report and financial statements (including an auditor's report) are also published every year.

Wemos's Southern partners develop their working plans based on discussions with Wemos and other stake holders. Based on these working plans contracts were drawn up which included guidelines on reporting and payments. Project officers were put in charge of the implementation of the contract and the contacts with the partners, but there was no formal procedure for imposing a division of labour and responsibilities. With the increase in the number of partners over the last few years and the expected further growth in the coming years, a streamlining of procedures is required. As a start, in 2005 a draft procedure was developed concerning the division of tasks and responsibilities among all personnel involved in working with Southern partners. This procedure will be tested and implemented in the course of 2005. At the same time, a computer format was developed that must be followed by partners with which Wemos has a financial relationship. This format has been tested by the institutional partners in the development of the work plan for 2005 and will be used in writing the first progress report for 2005. In the course of 2005 some adjustments will be made based on their feedback. From 2006 onwards this format will be used in all financial relationships with Southern partners.

Monitoring

The aim of the Wemos monitoring system is:

- to check project performance,
- to collect and analyse management information,
- to be able to report to donors, and
- to learn from previous experiences.

Since 2003, Wemos has had a monitoring system in place which is based on the principle of plan, do, check and act. For each project, activities, hours spent and expenditures made are registered. Every three months, a progress report is made by the planning & reporting officer in which an overview is presented of the planned activities and budgets, the actual activities carried out, the expenditures made and hours spent. The outcomes of these progress reports are discussed with the managers and the communication advisor who is responsible for general communication costs. After six months stock is taken of the activities in relation to the expected results and managers and the communication advisor are asked to adjust their plans if needed. The reasons for adjustments and the way in which they are made are included in the progress report. Based on these progress reports, the yearly reports are written for the different donors to Wemos's activities. These progress reports are also used in writing the new work plan for the next year. They are analysed in order to learn from previous experiences and to determine what should be changed in next year's plans.

This monitoring system is functioning but requires further improvements. To be more effective and efficient, the monitoring system should provide insight into: 1) the relevance of our work, 2) whether the organizational structure in place is the optimal structure to carry out the planned activities, 3) the overall performance of the organization and, 4) the effectiveness of the relationships with other organizations and networks. This requires

³³ In the last three years the largest part of the Wemos budget was funded by institutional donors. For project subsidies other reporting mechanisms are in place which do not necessarily follow the same time frame.

strengthening the learning capacity of the organization (aim 4 of the monitoring system). Discussing activities, expenses and results is important, but reflecting on the chosen strategy and critically examining activities, relationships and working methods in relation to the results achieved requires extra effort. Questions such as: Have these been the best activities to carry out or would others have been more effective and/or more relevant? Could efficiency gains be made if other activities had been pursued or if other coalitions had been formed? Could improvements in the internal division of labour lead to better outputs? Were these appropriate organizations to carry out activities with? have to be asked in discussing the progress reports with the managers, in developing annual plans, in meetings with project and communication officers and in discussions with Southern partners and other organizations. Moments of reflection are thus not confined to the quarterly meetings with the managers and the planning & reporting officer but will be given a place in formal and informal settings throughout the year. The results of these reflections form the input for Wemos's annual plans and policy papers.

The monitoring of the work of the Southern partners is based on progress reports they submit and discussions during field visits and other meetings. The integration of the monitoring of the partners into the Wemos monitoring system is a high priority. The fact that specific staff members are made responsible for the work of partners in each of the four countries will improve the monitoring of the partners' work. These staff members will be supported by the planning & reporting officer, who will be made responsible for the administrative work concerning contracts with Southern partners, assisted by the secretarial staff.³⁴ The results of the monitoring of the partners will be integrated into the quarterly discussions held with the managers on the progress of the work.

Quality management: CBF, ISO, INK

Related to the implementation of the monitoring system is the question which system of quality management Wemos intends to implement. In 2003 Wemos was awarded the 'Verklaring van geen bezwaar'.³⁵ This means the organization fulfils a number of criteria related to transparency and accountability. In 2006 Wemos will seek advice from experts on the different systems and will decide whether to implement either ISO or INK or another system as a way to further improve the quality of the work, accountability and transparency. According to people familiar with ISO, the large number of procedures already in place, including the monitoring system described above, suggest that Wemos should not have a problem obtaining ISO certification. Others argue that INK is a much better system for organizations the size of Wemos since it means less administrative overload. Finally, Partos, the branch organization for international cooperation, is in the process of developing a quality system for the sector. Wemos will follow these developments closely and will take a decision about the implementation of a quality system before the end of 2006.

Evaluation

In 2001 a major evaluation of Wemos was carried out, commissioned by the Ministry of Foreign Affairs. The overall conclusion was that Wemos's unique selling point was the

³⁴ The division of labour between the project officers, the planning & reporting officer and the secretarial staff in relation to the management of the contracts with Southern partners is laid down in the draft procedure described on page 48.

³⁵ The CBF 'verklaring van geen bezwaar' was developed for organizations that obtain only a small part of their funding through public fundraising. Organizations for which such fundraising forms a large share of their income can apply for the CBF quality mark.

combination of capacity development and networking in the field of policy formulation in health issues. One of the main recommendations was that Wemos had to increase its focus on working with Southern partners in order to increase its knowledge and legitimacy. The outcomes of this evaluation were integrated into the Wemos programme 2003-2005 'People's Right to Health as a Global Concern', in which the collaboration with Southern organizations became more important than in earlier programmes. In 2004, a smaller evaluation was carried out by MDF. The main recommendations were that Wemos should enlarge its partner portfolio, increase its budget for working with Southern partners, continue the collaboration with bigger development organizations in the Netherlands (so-called MFOs) because of the added value of their partner networks and should improve its strategic capacities (see above). These recommendations have been included in this programme.

In the framework of the collaboration with the two institutional partners CIN from Kenya and AIS from Bolivia, a yearly evaluation session has been organized in 2003 and 2004 and will be organized in 2005.³⁶ In the coming five years the collaboration and the yearly evaluation meetings with the institutional partners will be continued based on the memorandum of understanding that has been developed in 2004. CIN from Kenya and AIS from Bolivia will also participate in several of the projects planned for the coming five years (see Chapter 4). As was the case in the previous years, in the framework of the projects, evaluations will also be made of all training sessions and workshops that are organized with and for the Southern partners. The outcomes of these evaluations are used in the planning of new meetings and workshops. Evaluation and planning of other project activities takes place during regular meetings with partners. In 2009, evaluations about all activities with Southern partners are planned as part of the work on the specific objectives on health care providers, health budgets, human resources for health and nutrition (see lists of activities in Chapter 4 and logical framework in Annex 2).

Campaigning and awareness raising activities are evaluated by students and outcomes are used in the development of new plans. In 2009, an evaluation will be carried out by external consultants of the total Wemos programme. Next to these evaluations, as part of the improvement of the organization's learning ability, a more structured approach to evaluation, reflection and implementation of changes will be developed in the coming years.

Knowledge management

To effectively influence policies and their implementation, Wemos relies to a considerable extent on information and knowledge. The organization has a documentation centre where relevant documents are collected and made available for staff members by the documentalist, who also screens list serves, websites and all sorts of documents and distributes the relevant information among all or specific staff members by means of e-mail or hard copies. Every two months a so-called 'knowledge meeting' is organized where experts from outside the organization such as academics, staff members of the UN or other CSOs give presentations about international health issues.

Despite the frequent contacts between staff members, the informal culture and the willingness to exchange information, improvements in the flow of information in the

³⁶ During these meetings the previous year's activities and collaboration are evaluated, and new plans are developed based on these experiences. These meetings were facilitated by consultants from INTRAC (2003) and MDF Arusha (2004).

organization are a priority for the coming years. Apart from the weekly lunch briefings, in which every staff member briefly explains which meetings he or she has attended and where other relevant information has been exchanged, extra efforts are needed to enhance knowledge management. Further improvements in the ICT aspects of information sharing will also be explored.

Financial matters

Wemos's expenditures amounted to € 962,000 in 2000 and increased to € 1,712,000 in 2003, the projected expenditures for 2004 and 2005 are at the same level as the expenditures in 2003. This is a deliberate strategy. Being relatively small makes the organization flexible and able to respond quickly to outside changes. In the coming years, a slight increase in the budget is foreseen so that more funds can be allocated to Southern organizations and one extra member of staff can be appointed in the Southern partner team (see page 46). Further increases in the budget will be limited to adjustments for inflation and the yearly increases in salary costs.

Fundraising

Apart from the wish to remain flexible, there are also financial reasons for limiting the growth of the Wemos budget. Public fundraising for activities related to influencing international policies is a rather difficult task. Wemos is therefore mostly dependent on government funding and funding from other CSOs and foundations such as Stichting Doen, the Liberty Fund and other trust funds. As part of the development of this Wemos programme for 2006-2010, and taking into account the plans for new financial regulations for CSOs issued by the Minister for Development Cooperation, Wemos has sought expert advice on fundraising.

The fundraising strategy, which will be further developed in the course of 2005, includes the following aspects:

- For private donations, Wemos will intensify its focus on health workers, including the branch organizations, as people who can easily relate to international health problems.
- At the international level Wemos will focus on institutional donors such as the World Bank, UNDP and the EU, possibly in collaboration with other CSOs.
- A committee will be set up of volunteers who are part of an interesting network and can raise funds among trust funds, lotteries and rich individuals on behalf of Wemos.
- Criteria for approaching private companies will be developed and stock will be taken concerning potential sponsors and donors.
- The opportunities for funding from American foundations will be investigated via the contacts with like-minded American CSOs and other sources.

The further development and implementation of this strategy is part of the tasks of one of the communication advisors. This strategy is expected to result in a strong increase in non-government sources of funding. In 2009, at least a quarter of the budget of Wemos will be covered by these sources.

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Abbreviations

| | |
|---------------|---|
| AIS | Acción Internacional por la Salud |
| BBO | Bureau Beleidsvorming Ontwikkelingssamenwerking (Ecumenical Institute for Advocacy on International Cooperation) |
| CA | Codex Alimentarius |
| CBF | Centraal Bureau Fondsenwerving (Central Agency for Fundraising) |
| CIN | Consumer Information Network |
| CSOs | Civil Society Organizations |
| CSR | Corporate Social Responsibility |
| DORP | Development Organization of the Rural Poor |
| FTE | Full Time Equivalent |
| FTN coalition | Food Trade and Nutrition coalition |
| GATS | General Agreement on Trade in Services |
| GPPPs | Global Public-Private Partnerships |
| HIPC | Heavily Indebted Poor Countries |
| ICCO | Interkerkelijke organisatie voor ontwikkelingssamenwerking (Interchurch Organization for Development cooperation) |
| IFIs | International Financial Institutions |
| IFMSA | International Federation of Medical Students' Association |
| IMF | International Monetary Fund |
| INK | Instituut Nederlandse Kwaliteit (Institute Dutch Quality) |
| INTRAC | International NGO Training and Research Centre |
| ISO | International Standards Organization |
| JLI | Joint Learning Initiative |
| KIT | Koninklijk Instituut voor de Tropen (Royal Tropical Institute) |
| KNMG | Koninklijke Nederlandse Maatschappij ter Bevordering der Geneeskunst (the Royal Dutch Medical Association) |
| KNMP | Koninklijke Nederlandse Maatschappij ter Bevordering der Pharmacie (the Royal Dutch Pharmaceutical Society) |
| LHV | Landelijke Huisartsenvereniging (National Association of General Practitioners) |
| MDF | Management for Development Foundation Group |
| MDGs | Millennium Development Goals |
| MFOs | Medefinancieringsorganisaties (Co-financing organizations) |
| MSF | Médecins Sans Frontières |
| MVO platform | Maatschappelijk Verantwoord Ondernemen platform (CSR platform) |
| PHC | Primary Health Care |
| PHM | People's Health Movement |
| POP | Persoonlijk Ontwikkelingsplan (Personal Development Plan) |
| PRSP | Poverty Reduction Strategy Paper |
| SAPs | Structural Adjustment Programmes |
| SCN | Standing Committee on Nutrition |
| SOMO | Stichting Onderzoek Multinationale Ondernemingen (Centre for Research on Multinational Corporations) |
| SWAp | Sector Wide Approach |
| TB | Tuberculosis |
| TRIPS | Trade Related Intellectual Property Rights |
| UNCTAD | United Nations Conference on Trade and Development |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations Children's Fund |
| WHA | World Health Assembly |
| WHO | World Health Organization |

WSF World Social Forum
WTO World Trade Organization

Annex 1. Millennium Development Goals

Goal 1: Eradicate extreme poverty and hunger

Target 1 Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day

Target 2 Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Goal 2: Achieve universal primary education

Target 3 Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3: Gender equality and empower women

Target 4 Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Goal 4: Reduce child mortality

Target 5 Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Goal 5: Improve maternal health

Target 6 Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6: Combat HIV/AIDS, malaria, and other diseases

Target 7 Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8 Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Goal 7: Ensure environmental sustainability

Target 9 Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources

Target 10 Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Target 11 Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers

Goal 8: Develop a global partnership for development

Target 12 Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction-both nationally and internationally)

Target 13 Address the special needs of the Least Developed Countries (includes tariff- and quota-free access for Least Developed Countries exports, enhanced program of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction)

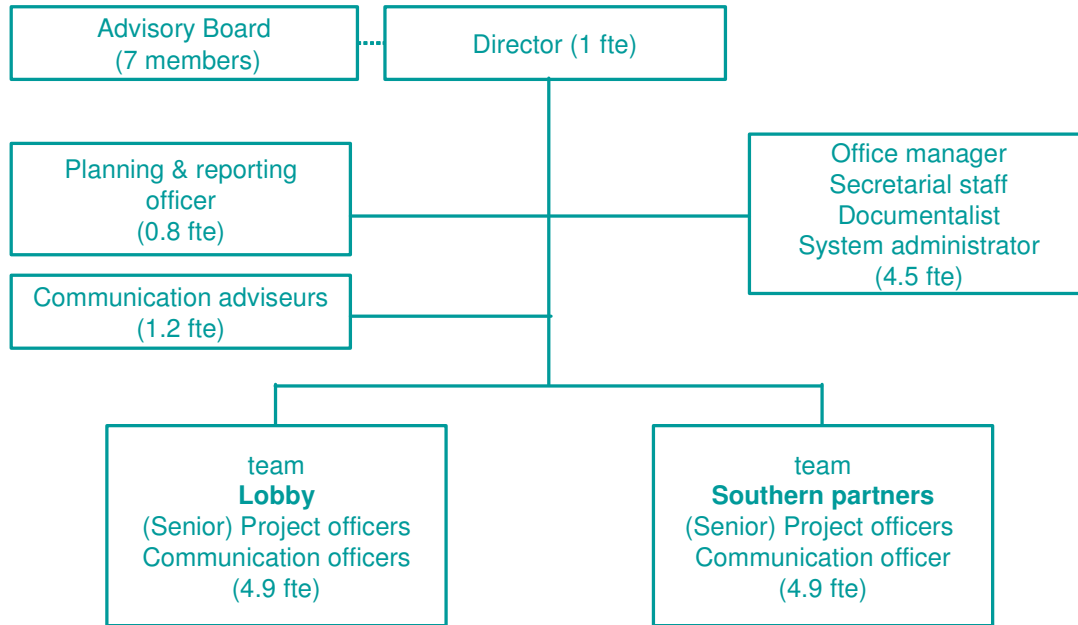
Target 14 Address the special needs of landlocked developing countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)

Target 15 Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Target 16 In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

Annex 2. Logical frameworks

Annex 3. Organizational structure



Colophon

Title: Breaking the vicious circle
Wemos programme 2006-2010
Document number: 0102RAP05001
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Date: 0102RAP05001

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