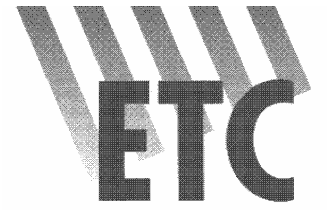

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The International People's Health Council and the Globalisation & Health project – Evaluation

Final report
January 2004

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Preface

As external evaluators we are grateful for having had the chance to acquaint ourselves with the work of the IPHC network and enter into discussions with its participants and those associated with it. Actually the discussions have been extremely lively, enjoyable and instrumental to achieving the purpose of the evaluation. IPHC, as this report tries to highlight, is a unique network, which has existed for more than a decade, largely because of the tremendous commitment of its participants – and not in the last place the global coordinator – and their dedication to fight for human rights and especially the right to health of under-privileged people. This transpired throughout the entire evaluation and we hope that the report reflects the same spirit.

This evaluation is the result of a collaborative effort of many. We are grateful to all those were willing to invest so much of their time – in most cases their own private time – to answer our questions and provide us with the information that we required.

We would like to emphasise that, in line with the overall purpose of the evaluation, this report should primarily be seen as a feedback to the IPHC network itself. The intention of the evaluation was to provide an opportunity for learning and to encourage dialogue and exploration on how the network could be further developed in the future. We hope the report does justice to this. While overall the evaluation portrays quite a positive picture of the results achieved so far and the potential for achieving results in the future, it also identifies some weaker areas that require attention. With a network as heterogeneous and diverse as the IPHC we do not expect that all those who associate themselves with the IPHC will subscribe to all the interpretations and suggestions made by the evaluation team. Yet, we do hope that the network will endorse and take up the overall conclusions, the main opportunities identified for the future development of the network and the more specific recommendations as presented in the final chapter.

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Leusden, January 2004

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Abbreviations

ACHAN	Asian Community Health Action Network
CAS	Country Assistance Strategy (World Bank)
CEDOC	Centro de Documentación
CI	Consumers International
CISAS	Centro de Información y Servicios de Asesoría en Salud (Managua)
DHF	Dag Hammarskjöld Foundation
FTAA	Free Trade Agreement for the Americas
GATS	General Agreement on Trade in Services
G&H	Globalisation and Health project
GK	Gonoshasthaya Kendra (Bangladesh)
HAI	Health Action International
IBFAN	International Baby Food Action Network
IMF	International Monetary Fund
IPHC	International People's Health Council
MSF	Médicos sin Fronteras / Médecins sans Frontières
PHA	People's Health Assembly
PHM	People's Health Movement
OPS / PAHO	Organización Panamericana de la Salud / Pan-American Health Organisation
PHC	Primary Health Care
PPP	Public-private partnership
PRS	Poverty Reduction Strategy
PRSP	Poverty Reductions Strategy Paper
ToR	Terms of Reference
TRIPS	Trade-Related Intellectual Property Rights
TWN	Third World Network
WGNRR	Women's Global Network for Reproductive Rights
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organisation
WSF	World Social Forum
WTO	World Trade Organisation

1. Introduction

1.1 The International People's Health Council

> IPHC is a worldwide coalition of people's health initiatives and socially progressive groups and movements committed to working for the health and rights of disadvantaged people – and ultimately of all people. The vision of the IPHC is to advance toward 'Health for All', viewing health in the broad sense of physical, mental, social, economic and environmental well-being.
>
> *(source:* www.iphcglobal.org).

The booklet 'Health care in societies in transition', published in 1992 by the Hesperian Foundation, was the first IPHC publication and gives a report of its international inaugural meeting held in early December 1991 in Managua, Nicaragua. In the early planning stages in the late 1980s, the planners of the meeting had considered 'transition' in the positive sense, in terms of change toward healthier, people empowering social structures. The participants were mostly from countries in socio-political turmoil, if not always transition. All were leaders in community health work among disadvantaged groups, many in the struggle for liberation or for far-reaching social and political (structural) change. They were from El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, the Dominican Republic, the USA, India, Bangladesh, the West Bank and South Africa.

At the end of the meeting a public statement was issued, announcing the name of the newly formed IPHC, its proposed structure and objectives. The text of this statement has basically remained unchanged and can nowadays be found on the IPHC website. The text in the above textbox has been taken from this first public statement with just a few minor modifications. Phrases such as 'collective grassroots power' and 'changing unfair and unhealthy social structures', which already featured in the 1991 statement, have been maintained in today's IPHC vocabulary. IPHC's vision to help promote Health for All through participatory democracy (decision making by the people), equity (in terms of equal rights and satisfaction of everyone's basic needs) and accountability (of governments and leaders towards the people of the world) has basically survived more than a decade.

At the December 1991 meeting, one overall network coordinator was chosen (from Nicaragua) and five provisional regional coordinators: from South Africa (for Africa), India (for the Far East), Jerusalem (for the Near East, including the Soviet Bloc), Mexico (for Latin America and the Caribbean) and the USA (for 'the North').

The overall network coordinator who was elected in 1991 is still in function. At the time she was director of CISAS, Centro de Información y Servicios de Asesoría en Salud (Information Centre and Advisory Services in Health), in Managua, Nicaragua. For several years she fulfilled the IPHC coordinator's role alongside her regular duties as director of CISAS, which served as the host organisation and legal umbrella of IPHC.

The IPHC network coordinator resigned from her position as CISAS director and since March 2002 the global coordination no longer resides in the CISAS central offices. However, CISAS has since continued to serve as the umbrella in terms of legal and financial responsibility.

> "The struggle for health is a struggle for liberation from poverty, hunger and unfair socio-economic structures"
>
> *(Phrase used on IPHC publications, brochures and business cards)*

In early 2003, IPHC commissioned a consultancy on the structure, internal management and organisational aspects of the network, as well monitoring and communication. In fact this consultancy was a requirement from Novib, the funding agency of the Globalisation & Health (G&H) project (see below), through which IPHC has been receiving external funding since late 1999. The consultant was Dr Andrew Chetley, from Healthlink Worldwide (a London based NGO), who had been associated with IPHC as a network advisor for almost two years. Some of the results of his work will be discussed in the present report. Amongst others, he produced a discussion paper on the legal structure of IPHC, and on the possibilities to become a foundation ('*stichting*') according to Dutch law. This should enable the network to become independent and raise its own resources. In fact it was one of the conditions of Novib to explore ways of setting up a legal framework for IPHC, when it approved funding of the G&H project.

1.2 The Health Counts coalition

The Health Counts coalition was founded in 1997. Originally, three European health-related NGOs took part: Wemos in the Netherlands, Medact in the UK, and Physicians for Social Responsibility[1] in Finland, with Wemos assuming the role of coordinator. Through joint campaigning, awareness raising and advocacy, they called for economic policies respecting equity and the right to health.

Over the years, both the composition and status of Health Counts have changed. Due to their relatively small size and resulting capacity constraints, the Finnish NGO no longer participates. Collaboration between Wemos and Medact is still visibly strong, but the name 'Health Counts' is said to be rarely used these days. Interviewees in the current evaluation described the coalition as "having faded out". Most of the present activities that Wemos and Medact jointly undertake concentrate on poverty and health issues.

Wemos is a Dutch NGO based in Amsterdam, the Netherlands, which aims to contribute to the progressive realisation of the right to health of men and women in developing countries through influencing international policies. Wemos' activities are concentrated on lobbying among national and international policy makers, collaboration with Southern partners, and campaigning among Dutch health

[1] Mostly in the person of Ms Meri Koivusalo from Stakes.

professionals. Presently, Wemos implements three distinct projects, which in fact comprise all or nearly all of the organisation's activities: (1) Health and Poverty, (2) Health and Trade, and (3) Health and the role of the Private Sector.

Medact is based in London, in the UK. It is a health professionals' organisation that 'challenges barriers to health'. It produces critical reflections on the health impacts of, among others, violence and war, global economic policies and environmental degradation, and together with others it undertakes efforts to counteract them.

1.3 The Globalisation & Health project

Collaboration between IPHC and the Health Counts coalition started in 1998 at a meeting at Novib, in The Hague, about the 20/20 Initiative. The collaboration was formalised with the start of the Globalisation & Health (G&H) project in late 1999. IPHC and Wemos had submitted a funding application (project proposal) to Novib for a period of 4 ½ years, from October 1999 to April 2004. There would be an inception phase of six months, meant for preparatory activities, such as: setting up an IPHC secretariat in Managua; establishing communication between the IPHC secretariat and the Health Counts coalition members; preparing for the first overall (joint) coordination meeting in Amsterdam; defining the final version of the G&H project proposal; and establishing a work plan for the first year of the project. Several parties involved considered the project proposal too ambitious, as a result of which the inception phase eventually lasted 18 months, from October 1999 to March 2001.

In early 2001, IPHC and Wemos (on behalf of the Health Counts coalition) prepared a new project proposal and submitted this to Novib (in June 2001). Novib approved the project in August 2001, with retroactive funding to April 1st 2001, for a period of three years, until March 2004.[2] The priorities of the IPHC and Health Counts coalition for the new project phase concentrated on the follow-up process of the People's Health Assembly (see below), in particular around the politics of health. There was consensus that this would require special emphasis on the following:[3]

- The right to health as enshrined in Article 12 of the International Covenant on economic, social and cultural rights. There was interest in how to hold the IMF/WB, WTO, WHO accountable, although they are not formal parties to the Covenant. It was considered necessary to encourage health organisations to develop a human rights approach and to help them in this task.
- Special emphasis should be given to questions on financing for health and privatisation of health services.
- The PRSPs and GATS were considered important international 'trends', which must be studied and monitored and on which IPHC and the Health Counts coalition would need to develop a position.
- Continued attention would be given to debt, health care reform and sector wide approaches.

[2] In late 2003, the current project phase was extended until … 2004.
[3] Funding application, June 2001 version.

The Globalisation & Health project proposal (June 2001 version) sets out a range of objectives and outcomes/results that were expected from the project. The proposal contains a logical framework with a series of indicators for measuring performance.

The *overall objective* of the project remained unchanged compared to the previous project proposal:

> To foster among local, national and international agencies the formulation of economic and health policies that respect equity and the right to health, with an emphasis on primary health care, community-based health and health as a broad crosscutting issue.

This would include promoting the adherence to international agreements on health and health care, especially with regard to vulnerable groups in developing countries, notably women and children.

The *project purpose* was to establish an effective South-North lobbying network on economic policies and health, and to link up with and feed into other networks.

Based on the prior experience during the first 18 months of the Globalisation & Health project, the original *specific objectives* were revised as follows:

1. To strengthen the IPHC and HC network:
   a) To strengthen the Southern secretariat,
   b) To strengthen the country and regional coordination in Asia, Africa, Latin America, the Middle East and in Europe,
   c) To build capacity in the regions,
   d) To establish a clearinghouse,
   e) To set up a network newsletter, and
   f) To relate to and feed into other networks.

2. To develop joint strategies and alternative solutions that promote health as a fundamental human right:
   a) To utilize the People' s Health Charter as a starting point and as an educational and advocacy tool,
   b) To ensure a critical input in the PRSP policy debates at all levels,
   c) To raise awareness among governments and the health sector on the impact of GATS on health care structure and financing; as well as to provide a health input in GATS negotiations, and
   d) To encourage PHA bottom-up follow-up activities in the regions.

The project was expected to generate *four main types of results*:

1. Network development: the formation and expansion of an effective international South-North advocacy network concerned with the impact of economic policies and processes such as globalisation on equity and the right to health, primary health care, community-based health and health as a broad cross-cutting issue.

This would require – as preconditions – a strong Southern secretariat and regional offices in different areas of the world. It would also require effective communications systems and a regular newsletter for the coordinators, as well as a functional clearinghouse.

2. Capacity building: the number of people and organisations within the network with lobbying skills, resources and materials would need to be increased. In addition, national public support for policy changes towards social and health goals would be mobilised, by raising the awareness of civil society, health NGOs and the medical profession of the impact and importance of economic policies for health, and by establishing and strengthening working relations with these groups. The concrete subjects to be considered included PRSPs, GATs and health as a human right (Art 12 of the ECS Covenant) as advocacy themes; and financing of health care, privatisation, and health care reforms as concrete issues to be dealt with at national regional and international levels.

3. Publications: the network would produce and disseminate publications targeted at a variety of groups, including policy makers, NGOs, journalists and the broader public. A periodic newsletter would be established for communication between IPHC/HC and other networks.

4. Advocacy and lobby: the network would lobby during World Bank and IMF meetings, WTO conferences and UN and WHO assemblies. National and EU delegates to these meetings would be approached by the participating NGOs in their respective home countries. These delegates would take up the issues brought forward by the participating NGOs, and publicly discuss these in the national and international press. Country specific policies would be influenced by targeting World Bank's Country Assistance Strategies (CAS) and Consultative Group meetings (CGs), the Poverty Reduction Strategy Papers (PRSP) and GATS.

1.4 The People's Health Assembly and the People's Health Movement

The People's Health Assembly (PHA) was held in December 2000 (Dec 4-8) in Savar, Bangladesh. A total of almost 1500 people from 92 countries participated in the PHA, which was the culmination of 18 months of preparatory action around the globe. The preparatory process elicited what has been described as "unprecedented enthusiasm and participation of a broad cross section of people who had been involved in thousands of village meetings, district level workshops and national gatherings".[4] At the Assembly they reviewed their problems and difficulties and shared their testimonies, experiences and plans.

The PHA culminated in the adoption of the People's Charter for Health, which emphasises health as a human right and calls for concerted action to combat the global health crisis. With equity, ecologically sustainable development and peace at the heart of its vision, the Charter lays out the broad determinants of health – including the economic, social & political and environmental factors and phenomena such as war, violence, conflict and natural disasters – and "calls on people of the world" to take 52 different points of action. The People's Charter for Health is now considered *the*

[4] Source: www.phmovement.org

common tool of the worldwide citizen's movement that is committed to making the Primary Health Care goal of Alma Ata a reality.

The People's Health Movement (PHM) emerged from the PHA. It describes itself as "a growing coalition of grassroots organisations dedicated to changing the prevailing health care delivery system". This system is considered to be failing to serve the deteriorating health of most of the poor worldwide. The goal of the PHM is to re-establish health and equitable development as top priorities in local, national and international policy-making, with primary health care being the strategy to achieve these priorities. The PHM aims to draw on and support people's movements in their struggles to build long-term and sustainable solutions to health problems. The steering committee of the PHM includes the eight organisations that were the organisers of the PHA:

- Asian Community Health Action Network (ACHAN),
- Consumers International (CI),
- Dag Hammarskjöld Foundation (DHF),
- Gonoshasthaya Kendra (GK, in Bangladesh),
- Health Action International – Asia Pacific (HAI-AP),
- Third World Network (TWN),
- Women's Global Network for Reproductive Rights (WGNRR), and
- IPHC.

The steering committee further includes representatives from some other civil society organisations that are involved as facilitators in their respective countries or regions.

Although the PHM is far much bigger than the IPHC network, IPHC participants have undeniably played a prominent role in the preparations and organisation of the PHA and continue to do so in the PHM. *All* of the IPHC core group participants play a role in the PHM, either

(i) as steering committee members (the global IPHC coordinator, the representative from GK Bangladesh and one of the IPHC collaborators in India);
(ii) as regional facilitators/focal points (Europe/UK, Middle East & North Africa, Australia, Southern Africa, South America);
(iii) as country contact persons (Brazil, the Philippines, Zimbabwe); or
(iv) as coordinators of several so-called 'secretariat support circles' and 'working circles'.

IPHC participants are members of several *secretariat support circles*, including:

- the support circle for the People's Charter for Health (and its translation into various languages),
- the media support circle,
- the PHA Exchange support circle,
- the news briefs support circle,
- the PHM resource centre support circle, and
- the finance/resources support circle.

The PHM *working circles* deal with content related matters. Working circles for which IPHC participants (focal points or collaborators) serve as contact points are:

- Relationship between PHM and WHO
- Research and analysis

- Wars, conflicts, disasters, violence and humanitarian action
- Politics of health.

It is further worth noting that the two northern partners of IPHC in the G&H project play a role in two other PHM working circles: a Medact staff member serves as the contact point for the working circle on macro-economics & health and a Wemos staff member does so for the working circle on public-private partnerships. The evaluation team did not get insight into the extent to which these working circles are actually functioning and delivering concrete outputs as per their mandate. The nature of the relationship between IPHC and PHM will be highlighted and further discussed in Section 5.1.

2. Aim of the Globalisation & Health project evaluation

The current evaluation was seen as an opportunity to reflect on the work of IPHC, both in terms of the aims and objectives of the Globalisation and Health project itself – including the collaboration between IPHC and the Health Counts coalition – as well as in relation to the overall development, effectiveness and impact of IPHC. The evaluation should help to put in place effective processes for monitoring and assessment of future IPHC activities, and should enable IPHC to develop strategic plans for focusing its future work.

The two-fold aim of the evaluation was defined as follows:

a. What have been the results to date?
   Over the past four years, what role has IPHC played in influencing and encouraging changes in policies and practices related to people's right to health? What has been the contribution of the Globalisation and Health project in particular? What lessons can be drawn from this that could inform IPHC's future work?

b. What are the opportunities for achieving results in the future?
   What is the strategic position of IPHC within the arena of actors that deal with the right to health? What can realistically be expected from IPHC over the next three to five years in terms of influencing global policies and local practices in the domain of health? Based on IPHC's strategic position and diverse connections, is it appropriate to bring more focus into the content of its actions; and/or to bring more uniformity in its strategies, so as to maximise its future impact?

The Terms of Reference (ToR; a full copy is attached in Appendix 1) further suggested that the evaluation team bear in mind that:

- It is not always easy (or possible indeed) to attribute any change in policy or practice on the ground to a particular intervention or action;
- IPHC operates at a number of levels – from the grassroots level to the international policy arena – and uses a number of approaches – including research, policy analysis, communication, advocacy and social mobilisation; and
- IPHC is a network rather than an organisation, and it relies on the contributions from its participants and their various connections to achieve its goals. As the International Development Research Centre (IDRC) in Canada has noted: 'Networks are not institutions, they cannot be expected to do what institutions do'.[5]

At the same time, the ToR suggested that the issues and challenges in evaluating a networking activity be explored. Apart from examining the specific achievements and potential of IPHC as a network, a secondary purpose of the evaluation was to suggest approaches and tools that could be used by other network initiatives to review their work. It was considered relevant for the evaluation team to take note of some of the recent discussions about evaluating networks which can be found on the Monitoring

[5] Bernard, A.K. 1996. IDRC Networks: an ethnographic perspective. Ottawa: Evaluation Unit, IDRC

and Evaluation News (MandE News) website at http://www.mande.co.uk. A separate paper will be prepared for this purpose.

The timeframe for the current evaluation is from the start of the G&H project in October 1999 until November 2003.

3. Methodology

A team of three consultants, two from the Netherlands and one from Uruguay, has conducted this evaluation. Apart from extensive e-mail contacts to elaborate and agree on the methodology prior to the fieldwork, the team had the opportunity to meet once, in the Netherlands, to review the progress made (on November 1st, 2003).

The evaluation used a variety of resources to conduct the evaluation:

(a) Written documents:
- The funding application for the G&H project (original and revised versions),
- IPHC Planning documents and minutes/reports of planning meetings,
- Annual progress reports[6],
- Financial reports[7],
- Reports of events and meetings,
- Various booklets, articles and brochures, and
- Various internet sites and electronic mailings.

A list of the most important references is appended.

(b) Interviews with:
- The global IPHC coordinator and her staff in Managua,
- IPHC participants: focal points and 'collaborators',
- Representatives from partner organisations with which IPHC works, in particular those from the Health Counts coalition (Wemos and Medact),
- Representatives from the donor agency (Novib), and
- Some selected key informants, from research institutions and international agencies.

Unfortunately, and in spite of several attempts to set up an interview, it has not been possible for the evaluation team to speak to the IPHC advisor, who conducted the consultancy (mentioned in section 1.1) earlier in 2003.

Since the aim of the evaluation was strongly geared towards examining results – results to date and opportunities for achieving results in the future – it was logical to design the exercise in such a way that both people from within or closely associated with the IPHC network would be interviewed, as well as those outside IPHC, including people from agencies that IPHC tries to influence. Because of time constraints, only a few representatives from the latter category have been interviewed. This is the main limitation of the evaluation.

Based on the terms of reference and the background information made available to the evaluation team, several interview guides were developed, covering a variety of issues, to structure the interviews. Several group interviews have been held, along with a substantial number of individual in-depth interviews, either by phone or (where

[6] The progress reports utilised are for the following periods: 1st Oct 1999-31st March 2000 (6 months inception phase); 1st April-31st December 2000 (9 months); 1st January 2001-31st March 2002 (15 months) and 1st April 2002-31st March 2003 (12 months).
[7] The utilised financial reports are for the following periods: 1st April-30th September 2000 (6 months); 1st October 2000-31st March 2001 (6 months); 1st April 2001-31st March 2002 (12 months); and 1st April 2002-31st March 2003 (12 months).

this was possible) face-to-face. The full list of resource persons is appended (Appendix 3).

One of the evaluators (Ms Muxí) was able to visit Managua and meet the global coordinator and her staff as well as some of the other IPHC participants from Central America and some representatives from affiliated organisations. The field visit to Zimbabwe or Cyprus that had initially been foreseen could not be conducted and was substituted by telephone interviews with the respective focal points in Zimbabwe and Palestine. The two Netherlands based evaluators were able to meet and interview the global IPHC coordinator for a whole day when she happened to be in the Netherlands (on October 21st).

The expected outputs of the current evaluation were three-fold:
(a) An update summary of progress report: this report was submitted to Novib and the Global IPHC Secretariat on November 10th, 2003.[8]
(b) The evaluation report itself (the present report).
(c) A contribution to a short reflective assessment report outlining suggestions on how to evaluate networks. This will be a separate report, which is due on December 31st, 2003

When developing the methodology for the IPHC evaluation, the consultants made use of a recent article on the evaluation of international social change networks by Martha Nuñez and Ricardo Wilson-Grau (2003).[9] They distinguish four performance criteria: *democracy, diversity, dynamism and excellence*. In terms of the actual functioning of networks, the article suggests to explore the above four criteria along what is referred to as three 'operational dimensions'. These are: (a) political purpose and the strategies used, (b) organisation and management, and (c) communication.

We added a fifth criterion to the above four, suggested by Nuñez and Wilson-Grau, namely *identity*. The issue of identity, as we shall demonstrate below, is of particular relevance for the IPHC in view of the emergence of the People's Health Movement in the past three years. Key questions in this regard are: what holds the network together and what keeps it from spinning apart? And: does the IPHC have an added value (or a *raison d'être*) since the emergence of the PHM?

We further operationalised the above performance criteria and operational dimensions by translating them into several series of questions for discussion in the various group and individual interviews. Different questionnaires (or topics lists) were used for focal persons/collaborators and 'resource persons' (see Appendix 4; questionnaires A and B).

The next chapter (Chapter 4) first gives an account of the results of the G&H project in relation to the expected results as set out at the beginning of the project. Chapter 5 then discusses the functioning of the IPHC network in terms of the above five performance criteria. Chapter 6 draws conclusions, addresses the issue of the

[8] No comments were received on this progress report.
[9] They base their article on an earlier article by Madeline Church *et al.* (2002), under the title *"Participation, relationships and dynamic change: new thinking on evaluating the work of international networks"*.

sustainability of the IPHC network, and elaborates on some opportunities that the IPHC core group might want to take up to shape its own future.

To support and illustrate the observations and conclusions of the evaluation team, various relevant quotes from those interviewed are presented throughout the text. The reader may wonder to what extent some of the opinions forwarded by interviewees and some of the quotes presented in the next sections are representative of the network as a whole. In general they are not, since – as section 5.3 will demonstrate – the network is quite diverse and there are numerous issues on which opinions diverge. The methodology has been incremental to the extent that the evaluators have opted to confront interviewees with opinions – especially some of the stronger opinions, positive or negative – expressed by people interviewed early in the process. We have tried to clearly indicate which statements and opinions are and which ones are not unanimously shared among all interviewees.[10] In a qualitative evaluation like the present one, it is the prerogative of the (external) evaluators to decide which of the opinions and statements forwarded in relation to the topics raised are presented and which ones are not. Obviously a selection had to be made from the material gathered, again in relation to the topics at hand, but it would be inappropriate to then conclude that there is a bias in the presentation of findings. Bottom-line has been to present those statements/opinions that we believed to be interesting enough to help shape the future of the network.

In this same context, we reiterate here that, in line with the overall purpose of the evaluation, the current evaluation report should be seen as a feedback to the entire IPHC network with the intention to provide an opportunity for learning and to encourage dialogue and further exploration on how to take the evaluation findings forward.

[10] In cases where there was no consensus you may find that "some" or "a few" respondents held those particular views. We refrain from providing actual numbers or percentages because of the relatively small number of people interviewed.

4. Current status and results to date

'We need more people to mass power. That is how we can make an impact, by yelling louder.'

This chapter starts with a succinct description of the current global IPHC network and further presents the results of the G&H project to date in relation to the four main types of expected results, as defined in the project proposal (the June 2001 funding application) and as listed in section 1.3 of the present evaluation report.

4.1 Description of the current global network

'My connections help raise the profile of the issues that IPHC is struggling for.'

In order to better understand the roles of the various actors involved in the IPHC network it is appropriate to make a distinction between (a) the core group of participants in the IPHC network, (b) their respective local/regional networks and connections from which these participants draw their experiences and into which they feed IPHC analyses and experiences, and (c) the wider circle of global alliances, networks and organisations which IPHC participants are either part of or which they try to influence.

(a) The IPHC core group

'The output of IPHC enriches, broadens, strengthens, challenges my thoughts.'

The core group of the IPHC network consists of ten focal persons and six or seven collaborators, who collectively meet about once a year. During the lifetime of the G&H project, four such core group meetings have been held: in February 2000 in Amsterdam, in December 2000 in Dhaka, in February 2002 in Cape Town and May 2003 in Geneva. These are coordination meetings, which serve to review activities and achievements in the past year and plan for activities in the year to come.[11] Appendix 2-A summarises the involvement of the IPHC focal persons in past events. While five of the focal persons can be considered co-founders of IPHC (in late 1991), several others joined soon afterwards. The IPHC focal persons in South America and Brazil were the last ones to join the network (in 1998 and 2000, respectively). Efforts to involve a person from Nigeria so as to a have a better representation from the African continent, in particular West Africa, have failed. Similarly, efforts to involve somebody from Greece have not materialised either.

Most members of the IPHC core group have formal positions in their respective countries of residence, either as lecturer/researcher at a university or director or employee of an NGO, with one member who has retired and works as a freelance

[11] For practical purposes it has not always been possible to hold these meetings precisely at the end of each project year (in February-March), which explains why the progress reports do not always cover a 12 months period (see footnote 3).

consultant. While most of the focal persons participate in the IPHC core group in a personal capacity, some represent the institutions they are working for: the Council for Health Development (CHD) in the Philippines, the UPMRC in Palestine (focal point for the Middle East) and the Regional Committee for the Promotion of Community Health (RCPCH) in El Salvador (focal point for Central America). Two of these focal persons (the ones in Palestine and in El Salvador) do work with regional or national networks. The other focal persons have fulltime jobs and have various connections in local, regional or even global organisations, networks and movements, but their affiliation with the IPHC is purely on a private basis.

Observations

There are no clear definitions for an IPHC focal person/point or an IPHC collaborator, which at times causes confusion. The interviews with focal persons themselves revealed differences in expectations as to what one might expect from a focal person, either in terms of their contribution towards typical IPHC political analyses and towards IPHC representation and advocacy at international forums, or in terms of the nature of their relationship with their respective constituencies.

> Some of the IPHC focal persons expressed a certain degree of disappointment with the level of output of some other members and the shallowness of some of the political analyses. They were of the opinion that the tendency to emphasise personal testimonies went at the expense of sound political analysis. Two of the IPHC focal persons wrote a critical analysis of the 2000 People's Health Assembly.[12] While they perceived the building of international solidarity and the 'enabling of a process of catharsis' as two of the greatest strengths of the PHA, they elaborated extensively on what they saw as some serious shortcomings of the assembly, such as insufficiency in direction (both in content and in facilitation), the lack of balance between testimonies, and overviews of analytic work and exploration of workable solutions, insufficiency in contributions from sectors other than the health sector, and a general lack of dialectical debate. This critique was not supported by everyone and may have been perceived by some as undermining the whole purpose of the PHA. The lack of consensus on the issues raised appears to have left some marks of distrust within the IPHC network.

One of the recommendations of the consultancy conducted by Andrew Chetley in early 2003 was indeed to clarify and define the roles of the focal persons. It was suggested that in the design of future IPHC work plans and project proposals, focal points take on specific tasks and responsibilities for particular outputs and that they be given the necessary resources to help them carry out those tasks and achieve these outputs. The findings of the current evaluation support this.

Similarly, it would be worthwhile to define the roles and responsibilities of those referred to as 'collaborators' vis-à-vis the IPHC network and to specify what they can expect from the IPHC network in terms of resources (access to IPHC meetings, sponsoring of activities, sharing of materials, contacts or other information, …).

[12] David Werner and David Sanders: *Liberation from what? A critical reflection on the People's Health Assembly 2000*. Published in Newsletter 44 (March 2001) of Healthwrights, a US based working group for people's health rights.

This is not to say that everybody is confused about the role of an IPHC collaborator. One of the collaborators himself was very clear about this. Alongside the business card that he uses in his regular work and which has the logo of the organisation he is working for, he also carries an IPHC business card. He uses this in connection with his role as a facilitator of several worldwide campaigns. The best-known campaign is the Million Signature Campaign, which was jointly launched by the People's Health Movement and the IPHC at the World Social Forum held in January 2003. It aims at catching the attention of organisations such as WHO, Unicef and other UN bodies, social and political organisations, policy makers and national governments to make health for all a reality, reaffirm their commitment to the principles and strategies of the 1978 Alma Ata declaration and endorse the Peoples Charter for Health.

(b) Local and regional networks and connections

'I have a life motto. Think globally, act locally.'

'The international lobby should be backed up by the local level.'

'Their combination of analysis and grassroots work is laudable.' *Key informant*

The participants in the IPHC core group (focal persons and collaborators) each have their own local/regional networks and connections from which they draw their experiences and into which they feed IPHC analyses and experiences. Appendix 2-B consists of a list of such local and regional connections for each of the IPHC focal persons. The intensity of such connections varies.

'Many of the grassroots groups are those working on anti-globalisation, health rights, traditional medicine, women issues, community health. (…) These connections are important to IPHC because the reports from the groups give us the true picture of what is going on in local situations.'

While the connection of IPHC grassroots organisations is often referred to as one of the strongest features of the network, which makes it rather unique, some of the interviewees expressed concern that this link was not always sufficiently maintained. Especially when representing IPHC at international meetings and advocating for the plight of 'the poor', it was not always clear on whose behalf IPHC participants were speaking.

Observations

Critics and outright opponents of the IPHC network may use the issue of representation by questioning the constituencies of the IPHC participants, although this does not seem to have happened very often. The issue of weak representation (or small constituencies) is being recognised by several movements and networks, including the IPHC, and has led to a strategy to invite representatives from oppressed groups (poor people, victims of war, physical or sexual exploitation, people with AIDS, etc) to give their personal testimonies. There is a general lack of consensus within the IPHC core group as to whether such a strategy is appropriate for IPHC. Earlier in this report (section 4.1) it has been highlighted that some of the more academically oriented people are of the opinion that there has been too much emphasis on personal testimonies, which is difficult to reconcile with IPHC's ambition to provide sound and in-depth political analyses. This was one of the

criticisms on the PHA of December 2000, and it would have set the tone in the post-PHA period.

(c) The wider circle of global organisations, alliances, networks and movements

> 'You may agree or disagree, but at least you need to listen.' *Key informant*
>
> 'A global network such as IPHC is of great importance in the current context'. *Key informant*

The circle of global organisations, alliances, networks and movements which IPHC participants are either part of or which they try to influence from outside is impressively large. It includes the People's Health Movement (PHM) and organisations such as WHO and PAHO, the International Monetary Fund (IMF) and the World Bank. Appendix 2-C contains a list of the international connections maintained by the various IPHC focal persons. Section 4.5 attempts to assess the actual extent to which IPHC manages to provide input into these various groups, organisations, movements and networks, and in particular to disseminate its typical political analyses.

> 'When they interact in different networks, you never know how the positions are taken and how the decisions are made.' *Key informant*

It is clear that the PHM has provided IPHC a vehicle to reach out to a much larger audience. The question is whether the enthusiasm and dynamics of the PHM will be sustained so that it can continue to serve as a vehicle for the IPHC to ventilate its ideas and calls for political action. To a large extent this will depend on the IPHC participants themselves, since they are among the driving forces behind the PHM. There are strong voices that call for the organisation of a second PHA in 2005 (in Ecuador).[13] IPHC will play an important role in the preparation of that event, which will provide an ideal forum for the network to bring its ideas and calls for political action to the attention of a large audience.

4.2 Network coordination and development

In terms of financial inputs, network coordination and development has been the largest component of the actual G&H project expenditure. It accounted for 74% of the total expenditure in project year 1 (1st April 2001 to 31st March 2002) and 42% in year 2 (1st April 2002 to 31st March 2003). Because of under-expenditure on other budget lines, the relative expenditure on network coordination and development was much higher than what was budgeted for in the first year (58% of the total budget), but in year 2 this has been redressed (42% actual expenditure versus 44% budgeted).

The annual budget and expenditure statements allow a breakdown of this component into three sub-components: the southern secretariat (in Managua), international network development (involving the various regional focal points), and the northern secretariat. In terms of budget, the southern secretariat takes up 42-47% of the available funds, leaving 31-35% for international network development and 21-22% for the northern secretariat. In terms of actual expenditure, the picture is slightly more

[13] A decision in this regard will be taken at the PHM Steering Committee meeting In January 2004.

biased towards the southern secretariat, which has absorbed almost half (49%) of the funds in each of the first two years of the project. This is mostly for salaries (of the general IPHC coordinator and office staff), with the remainder going to operational costs, website development and the purchase of equipment. Several IPHC core group participants expressed concern over the relatively high cost of the southern secretariat and would like to see more resources go into support to the regional focal points.

The G&H project has provided funds to enable several focal points to acquire computers, printers and internet/e-mail facilities and establish themselves more firmly as a focal point. This has happened in Zimbabwe and Tanzania, where the focal points were less endowed with resources.

The performance of IPHC itself in terms of actual functioning and further development as a network will be discussed in Chapter 5. This section will further concentrate on 'north-south' network coordination and development between IPHC and its two northern partners in the G&H project, Wemos and Medact, and between IPHC and Novib.

Surprisingly, none of the IPHC core group participants questioned the functioning and/or the cost of the northern secretariat. The latter secretariat has two main functions: coordination of activities with the southern secretariat (a task assigned to Wemos) and serving as a 'clearing house' (the task of Medact). The interviews with the relevant officers at Wemos and Medact revealed that these two functions are not well defined, and therefore not surprisingly, not well implemented either.

(a) Wemos

Although Wemos does work together with several of IPHC's partners – southern as well as northern partners – the original idea of forming a close partnership between Wemos and IPHC that would cut across the different projects has never been turned into a reality. The 2002/03 IPHC progress report mentions that the IPHC global coordinator participated in the internal reorganisation process, which Wemos undertook in 2002. As part of this process an attempt was made to define how IPHC could be involved in each of the three Wemos projects.[14] The interviews with IPHC participants and Wemos representatives revealed that at present the collaboration has still not been defined and appears to be mainly event driven. The actual sharing of information and analyses seems to be restricted to meetings and specific international events.

The reasons why the IPHC/Wemos partnership has not advanced much are not entirely clear. Wemos has high regard for IPHC's capacity to identify topical matters, articulate these and bring them to the attention of policy makers and press agencies. Wemos itself tries to build on this by incorporating IPHC's strong 'southern perspective' into its own 'northern' perspective and by linking its own activities to those of IPHC. However, in Wemos' perception, the respective strategic positions are not entirely compatible: IPHC is seen as leaning strongly towards the anti-globalisation movement, whereas Wemos considers it's own position more as intermediary between "the establishment" (of governments, policymakers and

[14] The three projects are listed in section 1.2.

international institutions such as World Bank, IMF, WTO and WHO) and the "voices from the south". That however, would not preclude cooperation, since IPHC relies even more than Wemos on experiences of people from 'the south'. It is in fact, one of the strengths of IPHC that it can be considered a truly southern network that has its own links with policymaking bodies in 'the north'. There does seem to be sufficient commonality between Wemos and IPHC in terms of vision and overall goals. A rival explanation for the lack of cooperation, which would be worth to explore further, is that the *complementary* roles of IPHC and Wemos have not been examined sufficiently, including areas in which the two organisations *compete* with each other. One could imagine competition in the domain of publicity, representation in meetings, access to funds and even intellectual property. While the current relationships between IPHC and Wemos are amicable and there are no concrete examples of competition that have created tensions – as far as the evaluation could determine – it might be worthwhile to better define each other's roles and positions so as to identify areas in which IPHC and Wemos can strengthen each other.

> One area in which IPHC and Wemos seem to be playing complementary roles is that of international trade relations and their impact on health systems and people's health. The Latin America wing of IPHC, including the global secretariat, is very much involved in analysing and critiquing the Free Trade Agreements for the Americas (FTAA), which involve trade relations between the United States and other countries in the Americas. Wemos engages more into analysing global international trade regulations that fall under the WTO umbrella – such as the general Agreement on Trade in Services (GATS) and the Trade-Related Intellectual Property Rights (TRIPS) – with a specific focus on the effects of these regulations on food and nutrition. Some IPHC participants outside the Americas consider the focus on FTAA as less relevant for them, and they might turn to Wemos (which has a Health and Trade project) rather than their IPHC counterparts in Latin America. Since there is no clear collaboration between the IPHC global secretariat and Wemos' Health and Trade project, the similarities between FTAA on the one hand and GATS/TRIPS on the other remain opaque. Hence there appears to be room for more exchange of information, articulation of complementary roles and joint strategy development between IPHC and Wemos in this particular domain of health and trade.

(b) Medact

IPHC has used some if its funds to obtain assistance from Medact in strengthening its internal and external communications and its strategic directions. The 'clearing house' function, which Medact would ensure within the framework of the G&H project, has not been put into operation, though. Medact developed a set of newsletters with the purpose of circulating information and fuel the debate on the core issues that are of IPHC's concern. However, these newsletters were never disseminated, partly because of busy schedules and other priorities of the officers concerned. In early 2003, Medact hired the services of a consultant to work on clearing house issues. At its May 2003 meeting in Geneva, the IPHC core group meeting did discuss the paper that result from this work, but no decisions were taken either on the Medact newsletter or on clearing house issues because of other pressing discussions at that time. While Medact did make these efforts to strengthen its resource function for IPHC, it is not quite clear how effective these efforts have been. Part of the problem is that there does not seem to be a common understanding (between IPHC, Medact and Wemos) of the 'clearing house' function that Medact could or should play. In the opinion of the global

coordinator, the clearing house function refers to the 'clearing' of information, which comprises activities like selecting and filtering information that is of particular relevance to IPHC, sharing this information within the network, 'translating' it into understandable language (as far as necessary) for specific target groups and disseminating it to others outside the network. The global secretariat already plays this role – to a large extent through the development of CEDOC (see section 4.4) and the IPHC website – but has so far benefited little from support in this domain from its northern partners.

(c) Novib

A relation that is not highlighted in any of the documents examined (funding applications, planning documents, progress reports) is the relation between IPHC and Novib. Novib, which is a member of Oxfam International, works towards diminishing the disparities between the rich and the poor in an environment of globalisation, integrated markets and advanced communication methods. Novib works with a wide variety of partners from the south and the north to fight for human rights. It does this by supporting local development projects, influencing the policy of national and international governments and organisations (including the EU, the World Bank, WTO and the UN) and by campaigning in the Netherlands. In line with the Oxfam policy, Novib focuses on the realisation of economic and social rights within the wider human rights continuum. It distinguishes five rights:

- the right to a sustainable livelihood,
- the right to basic social services (including education and health services),
- the right to life and security,
- the right to be heard (social and political participation), and
- the right to an identity (gender, diversity).

Novib is a member of Social Watch, a network of about 500 civil organisations from all over the world. It was present at the birth of the Social Watch initiative during the Social Summit in Copenhagen in 1995.

Within Novib, the G&H project falls under the Global Programmes desk, which deals with some 38 different partners worldwide. Many of these partners have similar goals and strategies to those of IPHC. An excerpt of Novib Network journal articles shows titles that are highly relevant to the work of IPHC:

- Hypocrisy wins the day in Cancún
- Women on farms in South Africa
- Vulnerability of mobile women workers to HIV/AIDS in Vietnam
- AIDS in the Ukraine
- The disastrous privatisation of public rights and goods and services
- Public health system collapses due to lack of financing
- Stop the WTO negotiations
- NGOs and social change in Morocco.

It is surprising that, so far, IPHC has never featured in the Novib Network and that the Novib Campaigns department, as far as the evaluation could detect, has never made use of any of the IPHC analyses or contacted any of the IPHC core group participants. Few of the Novib desk officers (apart from those in the Global Programmes desk) seem to be familiar or to even have heard of IPHC. Clearly, the opportunities to

collaborate and join forces, especially for lobby and advocacy towards governments and international agencies, are many but they have not been seized so far by either of the parties. This reflects deficiencies in internal communication between the various departments within Novib on the one hand, and in communication between Novib and the IPHC network on the other.

4.3 Capacity building

> 'The ability to see the links, to forward it without threatening people, and to show the urgency and the need for change.'

The capacity building activities that are being supported under the G&H project comprise mostly workshops and meetings. For instance, the 2002/03 IPHC progress report mentions workshops in:

- Guatemala about health care reform, FTAA and PPP.
- Nicaragua: CISAS' involvement in the Wemos sponsored PRS network.
- The Philippines: about privatisation of health services and the presence of US troops in the country; and about massive evacuations of Muslim people following Philippine military operations on the island of Mindanao.
- Brazil: community based meetings in the north-eastern state of Maranhao, with Christian communities, landless peasants and university groups.
- Ecuador: a congress for Health and Life to mark the centenary of PAHO; and the second forum to commemorate the humanistic and "medical thoughts" of Eugenio Espejo and Ernesto 'Che' Guevara, which at the same time was the first official meeting of the IPHC regional network in Latin America.
- Palestine: meeting of the Middle East and North Africa regional IPHC network.
- Zimbabwe: planning meetings for a Regional Southern African Conference, involving IPHC, PHM and other groups.

It is worth noting that not all meetings and workshop that are mentioned in the progress reports draw funding from the G&H project. The regional IPHC networks in Australia and to a lesser extent South America (focal person in Ecuador) seem to be able to raise domestic financial resources to organise their meetings. Earlier progress reports give a similar picture although the meetings and workshops were slightly less diverse in types and geographical scope. The creativity of IPHC focal persons and the global coordinator to capitalise on new or existing initiatives and to combine activities so as to promote the work of IPHC is commendable.

Observations

There does not appear to be much focus in the type of meetings and workshops that are being supported. While this is understandable given the prevailing diversity among the various regional and national networks – both in topics of interest and in their stage of development – there seems to be a very broad interpretation within IPHC of the term 'capacity building', under which heading these meetings and workshops are being held. Several interviewees, mostly IPHC focal points themselves, expressed concern in this regard. Some explicitly called for a better articulation of what should be understood by capacity building, which objectives

IPHC should pursue in relation to capacity building and what would be the target groups whose capacities need to be strengthened.

As regards the purpose or objectives of capacity building, the ideas seem to differ. Some argue that IPHC should invest more in building/strengthening analytical capacities, others would favour capacity building in the domain of advocacy and lobby or in the development of networks. One interviewee said it very thoughtfully as follows:

> 'The required capacities should be derived from the focus of the IPHC network'.

This underscores our general observation that IPHC could improve its performance by bringing its capacity building strategy and activities more in line with its overall political goal.

4.4 Publications

> 'The collective pool of experience and knowledge about political economy of health – e.g. David Werner's analytical material, PHA material brought out by IPHC – would need to be more widely available. The Charter has been translated in Hindi by us in IPHC, but not so many of the other relevant documents. Information is needed today as international trade regimes are being negotiated almost unilaterally with pressure from the super power.'

Recent key publications

The annual progress reports mention several publications that IPHC has brought out, or to which it has made contributions in terms of writing and/or funding. Different translations are available for many of these, at least in English and Spanish. IPHC has also invested in the publication of pamphlets, posters and videos (mainly in Spanish). Below follows a selection of what appear to be recent key publications:

- The *People's Health Charter*. Since its formulation at the PHA in 2000, the Charter has been translated into the impressive number of 26 languages, including vernacular languages (such as Shona and Ndebele, in Zimbabwe). The Charter is available both in print and in digital format, and can be easily downloaded from the PHM website.
- The *Struggle for Health: Problems and Solutions – Reflections from the South* was published in January 2003. This is a joint IPHC, Wemos and Medact publication in the context of the G&H project, for which funds also came from HIVOS. The booklet counts 21 pages and is available in English, Spanish and Portuguese. A total of 2000 copies were printed, and a digital version can be downloaded via internet from the IPHC website. Contributions came from Maria Zúniga, Mike Rowson, Unnikrishnan P.V., David Sanders, Julio Monsalvo and Arturo Quizphe. The case stories, such as the one from a peasant woman in the Philippines, and the poem from a young student in Zimbabwe who warns her friends for AIDS, clearly support the message of the book, which is to continue the struggle for "Health for All".
- *Health for all now! Revive Alma Ata!!* This is a joint publication of PHM, IPHC, Books for Change, Wemos and Medact, counting almost 85 pages, which came

out in 2003. The document starts off with an inventory of lessons learned, and reflections on 25 years of Alma Ata and Health for All, also including two case studies illustrating the present political health situation in Palestine and Iran. The second part of the book comprises the previous *Struggle for Health* publication. Furthermore, various press releases, the People's Health Charter, and suggestions for how to celebrate Alma Ata, are included. On the whole, it must be said that the latter two publications resemble each other to a large extent.

CEDOC

Since March 2002, the IPHC global coordination office has been building up its own documentation centre, Centro de Documentación (CEDOC), to electronically store information that is considered of "vital importance" for IPHC (books, magazines, bulletins, CD's and videos). The aim is to distribute materials so as to build capacity in different topics. There is also a practical reason: due to the climate, hard copies cannot be kept for long periods. The available information is being filed and classified in a database so as to allow users to enter search commands. At this moment, the database counts a total of 1171 classified and registered titles. One of the staff members at the global office is being trained as a documentalist by the head of the CISAS documentation centre, from which IPHC's CEDOC adopted its database structure. CISAS and the IPHC global office are also working together on developing a communications strategy. The primary target audience of IPHC's CEDOC is the Latin American region, but a worldwide function is being considered. The progress reports mention that "…the most ambitious project is to put the documentation centre on line (internet), so users will be able to consult our material directly." As previously mentioned, IPHC has a website which is still in a development stage. In November the documentalist at the global secretariat office became the webmaster, which should facilitate the further development of the website.

Observations

According to the project plan, "…the network would produce and disseminate publications targeted at a variety of groups, including policy makers, NGOs, journalists and the broader public. A periodic newsletter would be established for communication between IPHC&HC and other networks."

Generally speaking, the various contributions from different authors – academics, journalists, health professionals, NGO staff, 'ordinary people' – are quite accessible and serve the interests of a wide and diverse audience. Also, publications and international advocacy (see section 4.5) have often gone hand in hand, which indeed can be a very powerful combination. For example, the *Struggle for Health* document was launched and disseminated at two international events in 2003: the World Social Forum and the WHA. IPHC representation at the WHA also allowed for dissemination of IPHC publications among staff from ministries of health, WHO, World Bank and other agencies.

In addition to these achievements, there are some missed opportunities as well. Firstly, some of the claims of IPHC are not clear. For example, the 2001-02 Progress report mentions the Save the Children's Fund paper *The Bitterest pill of all, the collapse of Africa's Health Systems* as one of the publications that was produced. One

of the authors is a member of Health Counts, but how and to what extent IPHC has contributed to this publication remains unclear. The name of IPHC is not mentioned in the document. Doing this – when appropriate, of course – would not only give clarity, but also more visibility to the network. Secondly, some IPHC participants contribute a substantial amount of critical analyses to various platforms, but – although fully in line with the networks' ideology – not under the umbrella of IPHC. A good example is the IPHC collaborator in Vietnam, who has produced a vast number of articles and critical reflections – partly via electronic discussion forums – over the past few years. Again, this would be an opportunity to give more visibility to IPHC. The next quote suggests that the option of bringing out IPHC material independently might be an issue for further discussion within the network.

> 'As IPHC we should have done things less "adulteratedly" as IPHC with our own identity in mind. We did produce quite some material but in many cases they were contributions to PHM. We should bring out our own IPHC material independently.'

The evaluation team has tried to explore the extent to which IPHC has succeeded in having an influence on major publications of those organisations that IPHC targets, such as the World Bank and WHO. The team did not find any such evidence, although opportunities do arise from time to time. In July 2002, for instance, WHO published a booklet entitled *25 Questions and answers on health and human rights*. A brief conversation with the compiler, Ms. Helena Nygren-Krug, the Health and Human Rights Officer at the WHO's Director General's Office, learned that she is not familiar with IPHC nor its publications, although she has heard of the PHM. Ms. Nygren-Krug was eager to get in contact with IPHC and explore opportunities for collaboration.

The evaluation team is not aware of the establishment of a periodic newsletter for communication between IPHC&HC and other networks. As for internal communication with IPHC&HC, the global secretariat initiated "Herding Tigers" in April 2002. This bulletin goes out to the IPHC focal persons as well as collaborators in different countries. It is a fairly simple bulletin that contains brief reports, recent and upcoming events and suggestions, and plans for the future. So far there have been eight issues of Herding Tigers. While the global coordinator keeps inviting IPHC participants to provide feedback, the interviews made it clear that very few contributions have been made so far. Although the newsletter is appreciated, a point of critique was that it should appear more regularly. "Herding Tigers" is additional to the electronic list serve "IPHC Worldwide" that was established in January 2002, and to which about 30 people subscribe – the focal points, the collaborators, and with permission, other people (e.g. from Wemos and Medact). The IPHC global coordination office moderates the list serve, through which more than 350 messages have been exchanged so far. The list serve is used for organisational and planning matters (e.g. obtaining and sharing people's contributions to the IPHC planning matrix), to announce new publications (e.g. a new publication by Wemos on the Private Sector Development Strategy of the World Bank), and to discuss and comment on IPHC analysis (e.g. the speech that the global coordinator delivered in September 2003 at a PAHO conference on 25 years Alma Ata, in Washington, D.C.). The interviewees all expressed their satisfaction with the list serve.

4.5 International advocacy

> An important result of the WHA is the overt recognition by WHO of the PHA and the need to work together 'for the health of our countries'. It is a significant moment in the development of the IPHC and Health Counts relationship and in the future of the Globalisation and Health project.
>
> (Source: *Progress report 2001-2002)*

Global health events have been important lobby and advocacy podia for IPHC. The global coordinator, in particular, attends many of them and also regularly contributes to the programme. Below is a selection of recent key events.

- The annual *World Health Assembly* of governments and donors in Geneva. As a result of the PHA and the pressure of people's movements for health, WHO agreed to the participation of PHA representatives in activities at the WHA in May 2001. The former Director General of WHO, Dr. Gro Brundtland, articulated her intention to learn more on the People's Health Charter. Contacts with the present DG are also good, as illustrated by a speech of the PHM coordinator at a recent international conference in Geneva. Since 2001, members of IPHC, as part of the PHM delegation, have not only been present at the annual WHAs, but they have also been involved in organising workshops, lobbying among delegates, drafting and passing resolutions, bringing out press releases and advocating the People's Health Charter.
- The annual *World Social Forum,* in Porto Allegre, Brazil, January 2002. The PHM and IPHC had a strong representation at the WSF. IPHC sponsored the participation of two delegates: one from Argentina and one from Nicaragua. During the upcoming Social Forum in India, next January, IPHC plans to be more visibly present, by organising public discussions on health issues during the Forum's program.
- The annual conference of the *Canadian Society on International Health* in Ottawa. The 10th conference took place in 2003, and IPHC has participated since the 2nd meeting. Together with a staff member of Wemos, the global coordinator hosted a workshop on public-private partnerships. Some other IPHC members were present as well. During the conference, a human rights book by the IPHC collaborator for Vietnam that bundles about 50 short stories was launched. The foreword mentioned both the PHM and IPHC (again, this is an example of the strategic launch of an IPHC related document).
- The 2003 *PAHO Conference on Primary Health Care*, in Washington, D.C. The director of PAHO, Dr Mirta Roses, invited the IPHC global coordinator as a keynote speaker to a congress on Primary Health Care, in September 2003.
- The *annual meeting of the World Bank and the IMF*, in Dubai in September 2003. Two delegates, from UPMRC Palestine and CISAS Nicaragua, were invited to the meeting as part of the NGO delegation. They spoke about the work of IPHC at the global and regional levels.

Observations

All interviewees – IPHC and Health Counts members as well as the key informants – firmly agree that in terms of lobby and advocacy IPHC has been most successful at

the international level. Looking in more detail at the activities that were undertaken, and comparing them to those envisaged in the project plan, it can be observed that IPHC was predominantly successful in reaching WTO, UN and WHO, but less in reaching World Bank and IMF. The latter two agencies have been targeted more directly by Wemos and Medact. One interviewee said:

> 'We could have done more work on health policy issues related to the Bank. We have mainly covered thematic issues, but not something like pro-poor health policies. We could have done more things that really challenge the agenda.'

At the national and regional levels (at least in some regions), IPHC has been quite successful in lobbying national delegates and officials (see textbox below). Issues such as PRSP and GATS, as formulated in the project plan, have indeed been successfully taken up.

Press conference on Access to Medicines in Latin America in relation to the CAFTA (Central American Free Trade Agreement) and the ALCA (Free Trade Agreement for the Americas)

In Managua, Nicaragua, on 13 October 2003, the International People's Health Council was one of 30 national, regional and international organisations involved in a press conference denouncing the negative impact on health of two free trade agreements being negotiated in Latin America. IPHC for many years has been working to ensure that the issue of the free trade agreements and their impact on health – in particular, but not only, access to medicines and health services – is on the political agenda in Nicaragua (and in other parts of Central and South America). In particular, IPHC has been stressing that the rights of people's health have to take precedence over commercial interests. The press conference was convened by the Access to Essential Medicines Initiative, which dealt with the logistics for the event. IPHC was one of the main contributors to the documentation that analysed the situation and explained the impact of the trade agreements on people's health. It outlined the potential impact on:

- Citizens of the region – for example the likelihood that prices for essential medicines would increase as a result of the agreements
- Local pharmaceutical companies in the region – who would face new manufacturing standards that would involve additional investment that many local companies might not be able to make: the result could be the loss of many jobs
- Governments in the region – will be obliged to spend more on the national institutions controlling all aspects of the production of medicines, and will also face

Also noted were the likely loss of control over the knowledge and use of local biodiversity, which would pass into the hands of transnational corporations; and the likelihood that transnational companies would be permitted to increasingly exploit national resources. The press conference demanded that:

- The TRIPS (intellectual property) agreements of 1994 are respected because these agreements are the ceiling for any negotiations, not the starting point
- The DOHA Declaration of 2001 is the basis for the negotiation process.
- It is not necessary and dangerous to include intellectual property elements in CAFTA discussions since all these have been negotiated, approved and ratified by the World Trade Organisation.
- That the negotiations around CAFTA has to be carried out by a multisectoral team that includes representative not only from the Ministry of External Relations and Economics, but also the Ministry of Health and others.
- A regional position be determined to enable block negotiation to guarantee the transparency of the negotiations and increase the participation of the sectors that are affected.

The above press conference summary is a recent example of the lobby and advocacy work of IPHC in the Latin American region.[15] It had a good result among the stakeholders that were part of the Access to Essential Medicines Initiative, as well as the mass media (radio, TV, newspapers), which helped to raise this issue in public dialogue. In addition, it demonstrates how civil society organisations were able to strengthen the hand of the main governmental advisor on human rights in Nicaragua.

> At this same press conference the human rights advisor said: "The health of people is not negotiable. It has to be guaranteed." He asked the Initiative to work with him for a common solution for the country. He also said that it would be good to work with this group of organisations as they are recognised as having a clear understanding of the issues involved and a strong constituency of popular support. The advisor noted he would "take the joint statement to the international forums" – one in Madrid and the other in Panama – so that he could argue strongly for other governments to support the position that had been taken in Nicaragua, so that a clear regional strategy could be developed. It is likely that the topic will be more widely discussed in other arenas, so that 'common people' may become more aware of the problems related to the free trade agreements. The Initiative has opened up the possibility of more transparency and accountability within the negotiations, because a regional meeting was agreed at the press conference, so that civil society organisations would be able to receive draft versions and submit their comments.

This is an example of how IPHC works on advocacy – linking global developments to regional and local realities – through a number of local organisations and networks, and making use of the media. It demonstrates IPHC's ability to translate concepts that are difficult to understand – such as trade agreements and intellectual property issues – into something that everyone can understand – such as access to medicines and to health services. It also demonstrates that IPHC has the capacity to respond quickly to events that come up suddenly and that cannot easily be foreseen. The press conference was organised within two weeks and involved considerable communication between IPHC and other organisations within Nicaragua and throughout Central America to ensure a successful outcome.

[15] One of the evaluation team members had the opportunity to attend this press conference.

5. Performance of the IPHC as a network

This chapter analyses the performance of the IPHC network along the five criteria introduced in the methodology section (Chapter 3)

5.1 Identity

> 'I totally identify with the ideological position of IPHC. Since my relationship is with the coordinator and the focal points, I feel that amongst them there is clarity, in fact most of them are associated with IPHC because of the shared ideology. I may not be in a position to say so about some of them in different countries when I don't know, but I guess they would not be associated with IPHC if they did not share it.'

The importance of having a clear IPHC identity was first explicitly recognised at the February 2002 IPHC planning meeting in Cape Town. This was undoubtedly related to the emergence of the PHM, in which all IPHC focal points are involved in one way or the other.

The notes of the latest IPHC planning meeting, held in Geneva in May 2003, give a reflection about IPHC as a network. A network is defined as …

> *... a partnership between different institutions[16], based on identified goals/ headlines; the commonalities can be ideological and/or issues based.*

There does not appear any disagreement about the commonality of the participants in the IPHC network: without any exception all people interviewed indicated that the participants in the core group of focal persons and collaborators do share a set of political values.

> 'I feel a sense of belonging with IPHC.'

These values provide the group with a strong sense of political understanding, and an inquisitiveness to further improve its understanding of the political dimensions of worldwide events and trends, such as war, international trade relations, financial indebtedness, health reforms, HIV/AIDS and globalisation in general.

It seems appropriate, though, to further specify the character of the IPHC network. It is clear that the IPHC is a good example of an 'international social change network',[17] which typically aims to influence economic, political and cultural conditions in one or more societies. Through such networks, diverse social actors pursue a common purpose based on personal and institutional relations. Establishing and maintaining such a network is an eminently political act, since its fundamental function is to configure the power and action of its members into a collective force for social change. There is little doubt that anyone within the IPHC network, or at least within

[16] It is noted here that the term 'institutions' does not apply to most of the participants in the IPHC core group, since they participate as individuals rather than as representatives from their respective institutions.

[17] The term 'international social change network' is being used by Nuñez and Wilson-Grau (2003).

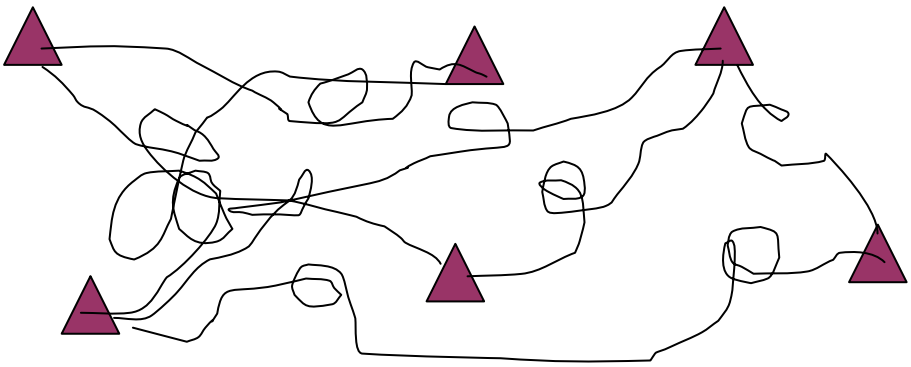
the core group of focal persons and collaborators, would contest this. It is a different issue whether or not it would be appropriate, especially from a strategic point of view, for IPHC to articulate this ambition toward the outside world. It might have implications for the ease with which IPHC gains access to national and international forums to promote its analyses and calls for social change. The evaluation team did not pursue this issue thoroughly enough in the interviews, but the IPHC network could easily take it up during one its coordination meetings, if found appropriate.

'The relationship between IPHC and PHM should be clarified. Otherwise IPHC will loose its identity, it will be absorbed by a greater network.'

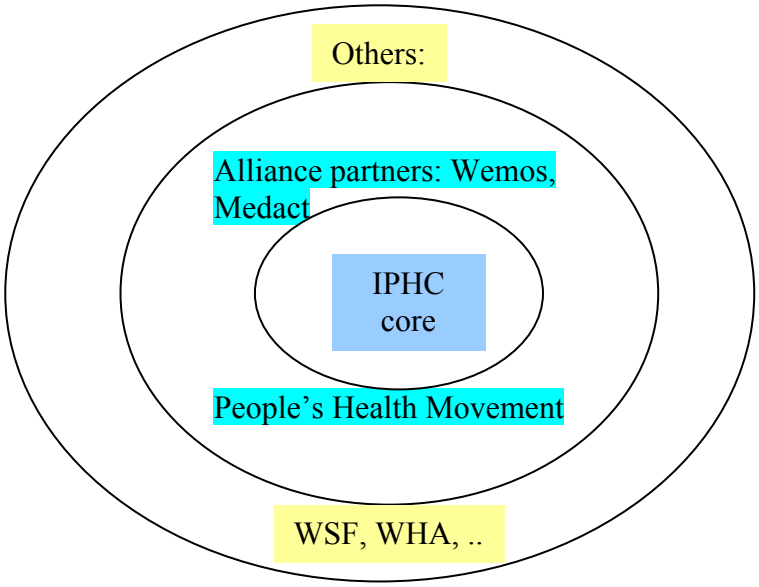
In view of the above it is worth looking a little closer at the relationship between IPHC and the PHM. Although there is no clear distinction between a network and a movement, the IPHC is generally referred to as a network, while the PHM refers to itself as a movement. According to the notes of the May 2003 IPHC planning meeting, movements are *"... perhaps more fluid and a little less structured than networks"*. Some key characteristics that would help sustain networks are:

- Tolerance
- Mutual understanding
- A certain degree of 'chemistry' and balance between the participants.

It was further acknowledged that networks require energy and time from their participants and are the best way to deal with complexity and diversity. Networks are believed to develop their strength through the interactions between the various parts of the network *"... in a messy combination of possible exchanges"*. This was depicted as follows:



The image of the IPHC network with its various linkages entertained by members of the core group is best depicted as follows: the core network of focal points and collaborators is situated inside several 'circles' of other networks, movements, organisations and events, of which some are less and others more distant from the core.



Another important identity issue relates to the visibility of the network and its participants. It is noted that most IPHC members distribute the brochure of IPHC within their respective networks, but only a few of them carry their own IPHC business cards.

> 'Yes, I have an IPHC letterhead and an IPHC business card. I use it in meetings where I am representing IPHC.'
>
> 'Whether I introduce myself as a representative of my organisation, or as an IPHC person, or both, depends on how much that would benefit IPHC, how much the occasion is related to the mission and objectives of IPHC.'

As far as could be assessed, nobody deliberately chooses not to carry an IPHC business card. But the fact that not everyone has such a card reflects that some people attach more value to their IPHC identity – or are more conscious of the importance of that identity – than others. Some IPHC participants find it difficult to choose whether to introduce themselves as an IPHC person or a PHM person.

In spite of the many documents that IPHC has produced so far, there seem to be several missed opportunities to articulate IPHC's values and objectives. The *Health for all now!* booklet, for instance, which IPHC published jointly with PHM, Wemos, Medact and Books for Change, does have a page that explains what the PHM is and tries to promote, but it merely presents IPHC as one of eight networks that are part of the PHM.

> 'As IPHC we should have done things less "adulteratedly" as IPHC with our own identity in mind. We did produce quite some material but in many cases they were contributions to PHM. We should bring out our own IPHC material independently.'

The possible amalgamation of IPHC into PHM was unanimously rejected. All interviewees saw a need for IPHC to maintain itself as a network because of its clear political purpose. The PHM is much more a broad movement, which does not articulate its political position the way IPHC does.

'You cannot separate IPHC and PHM.'

The evaluation team did not explore the issue of dual loyalty (towards IPHC and PHM) sufficiently enough to determine whether some of the IPHC participants would feel more comfortable being associated with PHM than with IPHC. For those with multiple international connections – in fact the majority of IPHC core group participants – it would be relevant to look into their loyalty towards each of these connections ('multiple loyalty') and examine the added value of being a member or participant in so many networks, groups and movements. This would require a critical assessment of what one *contributes* to each of these networks, groups and movements, rather than what one gets out of them.

It could be argued that IPHC participants should reflect and be more explicit about the specific roles they have taken upon themselves (or wish to do so), for instance analyst/writer, resource person, health practitioner, educator, media coordinator, campaign organiser, public relations person, networker, motivator/inspirator, challenger of ideas, etc. This would not only help strengthen people's individual identity as an IPHC participant, but also preserve confidence and mutual trust. Some IPHC participants have very high expectations of themselves and their peers, but it should be clear that one person can not realistically play all these roles at the same time.

5.2 Democracy

'In our kind of work, processes that are democratic but which fail to take the urgency of the situation into account may not always be appropriate; nor is the centralised top-down decision making, since it conflicts with our basic principles and creates resentment. A balance has to be ensured, which is what IPHC tries to do.'

The response to questions in relation to the democratic proof of IPHC as an international social change network was largely unanimous with just a few issues on which the viewpoints diverged.

Both the focal persons and the IPHC collaborators unanimously share the vision and mission of IPHC and they have a strong sense of belonging. The previous section has highlighted that the emergence of the PHM has evoked some doubts among certain members about the loyalty of some of their peers towards IPHC's vision and mission. But the fact that all participants were adamant in their opinion that IPHC had a '*raison de co-existence'* alongside the PHM shows their general commitment to the network. In terms of practical organisation and management of the network and its activities, there is a general feeling that the network does focus on fulfilling its political purpose. Given the nature and diversity of the network it is impossible for all members to collaborate in all the activities supported by the network and everybody recognises that choices have to be made as to who will represent IPHC at which forum. There are some doubts, though, as to who makes such choices. Several IPHC participants suggested that it is not automatically the global coordinator who decides, nor should she always be the one who represents IPHC at global meetings and events.

'The network is sufficiently democratic, everybody has a say, but there is no clarity on who makes the decisions.'

'We need to disperse the leadership a bit more.'

To the extent that participation in such meetings and events can be planned in advance – which is not always the case – it is good to be entirely open about the opportunities at hand and the arguments to delegate responsibilities. While concrete examples of missed opportunities or contested choices at the international level are very few, this does not seem to the case for the local level.

'There are missed opportunities at the local level because IPHC does not sufficiently build on what is already locally available. IPHC should acknowledge more the strength of others.'
Key informant

IPHC participants expressed a strong desire to be informed about activities that are being supported by or conducted on behalf of IPHC. It is typically the role of the global secretariat to inform the network participants of the agendas and relevant activities in the various parts of the world. The secretariat has been getting signals to this effect for several years and it did take it up to improve internal communications within the core group by starting to bring out 'Herding Tigers' (see Section 4.4).

'The global coordinator should be more bitchy, and say for instance: "If I haven't heard from you in ten days I will assume that you agree." '

Much effort of the global secretariat therefore goes into improving communication so as to keep the IPHC participants informed and maintain their sense of co-ownership of the network. The global coordinator and her team in Managua rightfully pointed out, though, that the global secretariat largely depends on the contributions of each and everyone.

'We could and should also improve horizontal communication about preliminary work, planning and review; this applies to myself as well.'

'I try to support our coordinator by keeping her informed and by sending her views and analyses in areas for which I have taken responsibility.'

Gathering information about relevant events and activities from the various 'corners' of the world has not always been easy. This does not seem so much due to a lack of commitment or transparency on the side of IPHC participants, but rather of busy work schedules, frequent travelling and the fact that IPHC work is generally not part of people's official duties.

The installation of communication facilities in some of the regional focal persons' offices (with financial resources from the G&H project; see section 4.2) has improved matters but has not been sufficient to solve the communication problem. The global coordinators further pointed out that the global secretariat has little control over the use of information that it sends out, either internally among the network participants or externally to other agencies, networks and movements. This remains people's own responsibility.

Opinions vary on whether IPHC participants contribute and have equitable access to the resources and reputation of the network. While participation is purely voluntary, some are of the opinion that the volume of output in terms of analytical work has fallen in the past two to three years. This is related again to the emergence of the PHM and the work that IPHC participants invest in advancing this worldwide movement. It has raised doubts about people's allegiance to IPHC and it poses what some perceive as a strategic dilemma: is it better to invest in quality and accept a smaller coverage or should the strategy be to go for broad publicity and reach out to the 'entire world', while putting less emphasis on thorough analyses and carefully designed strategies for social change? As far as the evaluation team could assess, this dilemma lies at the base of some of the concerns that emerged at the May 2003 IPHC coordination meeting in Geneva, but it does not seem to have been discussed in an open manner. A possible entry point to address this is to clarify the respective positions and roles of IPHC participants, as suggested in section 5.1.

There is general appreciation for the fact that some IPHC participants require more financial and/or material support than others, since the circumstances in which they operate vary greatly. There is no resentment that focal persons in Zimbabwe, Ecuador, El Salvador and Brazil receive more support than those in Europe, Australia or South Africa. However, IPHC participants do perceive a bias within IPHC as a whole towards activities (and funding of activities) in Central and South America. Whether or not this is related to the fact that the global secretariat is located in Central America is difficult to assess. It is a fact, recognised by most, if not all IPHC participants that typical IPHC issues are taken up more readily in Latin America than in Africa. It does warrant special attention to support IPHC activities in Africa where the network seems weaker than elsewhere in the world.

'There is a difference between the "what" and the "how". As for the latter, there should be more coherence, participation, democracy, and less exclusivity.' *Key informant*

Perceptions as to whether the IPHC structure is sufficiently democratic differ. Some call it too hierarchical while others call it too democratic. Some are of the opinion that there is too much influence of the global coordinator, others argue that firm decisions are at times delayed because there is no general consensus within the core group of IPHC focal persons and collaborators. From this, it appears that there is insufficient clarity as to which type of decisions can be taken by the global coordinator or any of the regional focal persons and which ones require consultation and joint decision making.

There do not seem to have been any particular major contested decisions within the IPHC network, except for one case, which was brought up by several respondents. It concerns the expulsion of one of the founders of IPHC from the core group of the network for disciplinary reasons. All agree that this has been an "extremely painful" incident, more so because it concerned somebody with a great international merit and a highly regarded contribution towards IPHC. Although some consultation did take place within the IPHC core group prior to the actual expulsion, some perceive the decision as unjust and/or the decision making process as undemocratic. With some this has left a sentiment of resentment.

At the May 2003 IPHC planning meeting, a decision was taken to establish an interim IPHC steering group to assist the global coordinator. The group would be composed of five people and the following terms of reference were suggested:

- To follow-up on the structure / governance of IPHC
- To take decisions on new participants
- To approve activity plans and budgets
- To respond promptly to requests for the global coordinator, including the endorsement of new strategic directions
- To agree on the delegation of certain responsibilities to the coordinator.

So far, the steering committee has not met, nor has it taken any initiative to enact its duties. With half a year gone since the meeting, it seems appropriate so suggest that the committee takes the current evaluation report, once adopted, as a reference for its future action.

> 'There is a need for the steering group to have a genuine working session to really sort things out and get things done.'

Membership is an important issue. Some people suggest that the term 'membership' does not apply since the IPHC is a network in which many people can participate.[18] Yet, in reality the core group of IPHC focal persons and collaborators is a rather closed entity, to which newcomers do not have easy access. Some of the key informants interviewed look at the IPHC core group as an 'exclusive' entity of which some of the members have the tendency to dominate contacts and be busy with their own personal profiling rather than pursue a common agenda. It cannot be denied that the IPHC core group has seen very few new participants join over the years. The majority if not all of the participants do recognise that the group is ageing and that there is a need to "open up" and bring in "fresh blood". However, for some this may be a matter of lip service: upon a question (asked as part of the interviews) whether they had thought of taking a step back from IPHC and handing over to somebody else, most IPHC core group participants said they had not done so.

The IPHC website states that the IPHC is …

> *"… an informal coalition of persons, groups and networks who identify with its vision, who endorse the People's Health Charter and wish to participate."*

This description has proven not adequate enough. The following criteria for membership were proposed at the May 2003 IPHC planning meeting:

- Individuals or groups should have demonstrated a particular political position in relation to economic globalisation.
- They should have an unambiguous position on military aggression.
- They should have a clear stand on privatisation of public health services and work to promote and defend publicly funded health services and other services that are essential to health such as water and electricity.
- They should demonstrate continuing activity in progressive health political work.
- They should be involved in analysis and political activity.

[18] These people therefore prefer to use the term 'participant', a term that is as much as possible used throughout this evaluation report.

These criteria still need to be endorsed. In addition, the benefits of membership would need to be specified further. For the moment they have been phrased as follows: to attend meetings, have access to resources and to related networks. It has not been made clear which resources are referred to.

> 'There isn't any way of joining. It's also the impression you give towards the outside world. It is a very uncomfortable position.'
>
> 'There is an enormous potential for IPHC but they should work in a more horizontal way. It is not at all that clear how new people can join.' *Key informant*

Also with regard to membership, some of the interviewees, including IPHC focal persons themselves, suggested that some people with good credentials were denied membership, or at least discouraged from assuming the position of a focal person. Whether or not this is actually a matter of denial, or of differences in perceptions in the respective roles of focal persons, collaborators and other sympathisers is not quite clear. Some IPHC collaborators, of whom others said they should become focal persons, explicitly stated they rather preferred to be a collaborator than assume any coordinating role in the country of their residence or their region. This underscores the need to clarify the roles (terms of reference) of focal persons and collaborators. It further appears that there is a need to clarify the issue of membership and agree on the terms of duty and any constituency requirements, if considered appropriate.

5.3 Diversity

> 'The diversity is good and it's bad at the same time.'

In itself, diversity is a strength and considered a prerequisite of a social change network.[19] The IPHC network, including the core group and the wider circle of organisations, networks and movements, which they are associated with, is very diverse indeed. Respondents were unanimous in their opinion that health practitioners, academics/ researchers, tutors/lecturers and NGO representatives are sufficiently represented in the network. Most IPHC focal persons and collaborators have more than a single background. One of the earliest established focal persons (in Japan) has even gone into politics, as a result of which he can unfortunately no longer dedicate time to the IPHC.

> 'The analysis has to come from the people, not from the academics. They think they've got the answers but they don't.'

Differences between individual IPHC participants in their preference to focus on specific events and trends do exist, but this is not considered a fundamental problem. Differences between academics and practitioners form a threat to the network. Academics find it difficult to accept the more practical, and perhaps more superficial approach of health practitioners who work more directly with grass roots organisations, while the latter group suggests that some of the academicians seem to be out of touch with the reality of 'ordinary people'. This has lead to tensions, which keep cropping up every now and again and which – partly because of the language

[19] See the definition used by Nuñez and Grau-Wilson (section 5.1).

that is being used – do affect mutual trust. This is something the IPHC core group would need to watch closely and discuss openly, so as to prevent the gap from widening.

> 'In Africa, there are very few focal points. There need to be more of them so that the politics of health can be better understood.'

There is wide appreciation for regional differences in terms of the issues that IPHC would need to focus on.

> For instance, the IPHC participants in Latin America (Central and South America) are keen to give publicity to the implications of the CAFTA – the Central America Free Trade Agreement – for people's health, while the participants from Africa and Asia wish to draw the spotlight on WTO negotiations, GATS and TRIPS.

There is also a great diversity in the stage of development of national and regional networks. Although the evaluation team did not explore this issue in great depth, it appears as though the opportunities to learn from each other's experiences in building networks have not been fully capitalised upon. This would typically qualify as a capacity building issue.

However, the weak representation of IPHC on the African continent is in sharp contrast with the immenseness of health problems in this part of the world. This is a point of common concern and readily recognised by all. It is associated with the general weakness of grassroots organisations and networks in Africa. It has triggered IPHC to invest extra energy into identifying new focal points in East and West Africa. In Tanzania there is now an IPHC collaborator who might take up the role of regional coordination and become an IPHC focal person. Initial contacts with people in Nigeria have dried up. The absence of francophone Africa from the network is striking and a strategy to address this missing link has so far been lacking. Language undeniably plays a role in this.

> 'IPHC is democratic, it leaves you room to be autonomous because it does not prescribe. You are free to apply the solution that is good for your country, it is your own choice.'

So far, the human base of the IPHC network, especially of the core group, has been sufficiently broad to avoid the dependence of many on just a few. IPHC strives for balance and diversity in terms of geography, size, gender and age. If there is any gender imbalance at all in the numerical sense, one should say that men are in the minority. This is not considered a weakness, though. But there are some other threats.

> 'IPHC is quite diverse but it could be more open. Not just the old buddies.'

The fact that hardly any young people are part of the network has been highlighted already as cause of common concern. Some focal persons – like the ones in Ecuador and South Africa – try to address this by involving university students in community health activities with grassroots movements. The evaluation team would encourage more critical self-reflection among IPHC participants, since it involves more than replacing relatively old participants by younger ones. The tendency of some of the IPHC participants to herald the ideology of fighters for freedom and social justice

from the past indicates that there may be an emerging generation gap between IPHC and young people, who may be equally concerned with social injustice and committed towards structural change.

> This became clear at a recent international gathering in Geneva, where an IPHC representative referred to the exemplary role of Ché Guevara in the struggle for better health and social justice. It caused some irritation among people in the audience. One young man took the floor and – after having identified himself as member of the PHM and supportive of most of what the IPHC representative had said – suggested that it would be more appropriate to refer to contemporary leaders, who might have more worldwide charisma – including Africa and Asia – and who are less associated with the use of violence, such Ghandi and Mandela. He also suggested that a different *discours* or language be developed to voice the message of civil society organisations.

A final observation in relation to diversity is that more should be done to broaden the financial base of the network. This is in spite of the fact that the IPHC global secretariat is quite creative in raising resources to complement the funds received from Novib through the G&H project, and in spite of the fact that some of the regional focal points themselves are able to generate resources for typical IPHC activities.

5.4 Dynamism

'Because of the lack of focus, it is difficult to renew ideas. WHAT ideas?'

Action features high on the list of IPHC priorities and this has contributed to the dynamic profile of the network. Goals are being pursued by seizing a broad spectrum of opportunities and adjusting to obstacles without losing sight of the political purpose. With health as the common entry point, the political purpose of IPHC is to advance toward 'Health for All'. The strategy along which this would be achieved, however, has been formulated in very broad terms as "a struggle for liberation, from poverty, hunger and unfair socio-economic structures".

'In a way, things have become easier because people are now actually beginning to experience the consequences of, for example, privatisation. The privatisation of the railways has turned out to be a failure. People can nowadays better imagine what privatisation can do and why there is a need to lobby against it.'

This explains the wide variety in types of activities that IPHC undertakes and support. It is also the main reason why many people are of the opinion that the network lacks a particular focus. It is not so much the ultimate purpose, but the strategies that lack focus. This is not to say that the network participants do not learn from past experience. They do reconsider and reformulate strategies, but it does not sufficiently result in a more focus.

'We could have done more work on health policy issues related to the World Bank. We have mainly covered thematic issues, but not something like pro-poor health policies. We could have done more things that really challenge the agenda.'

Some interviewees claim that the global secretariat has become a heavy and expensive structure. However, if one relates it to the wide spread of the network, the variety of issues at hand and the volume of activities undertaken, one must conclude that the secretariat and the annual coordination meetings actually form quite a light structure, which tries to be facilitate and be supportive to activities in the various regions. The allocation of human and financial resources does seem to expand and contract,[20] although this sometimes seems to happen more according to opportunities that arise rather than to strategic choices based on identified needs.

The extent to which IPHC core group participants take initiative and influence the development of the network varies. Communication and coordination between the various participants is not a continuous phenomenon, with most of the exchanges taking place prior to and during the annual meetings. Effective follow-up of annual plans is generally considered one of the weakest aspects of co-ordination. Some participants expressed their disappointment in the level of contributions – both in terms of quality and quantity – of some of their colleagues. One interviewee suggested that the network cannot afford to have focal persons "who are complacent with their past achievements or who mainly rely on others". Although few core group participants would concur with this, the person concerned was probably right in suggested that "the ultimate effect and impact of IPHC activities is more than the sum of the activities of individual participants".

The evaluation team further asked itself the question whether the G&H project and the institutionalisation of the IPHC global secretariat as an independent body has been instrumental in strengthening the network in terms of facilitation of activities and mutual co-operation. There is general consensus among those interviewed that in the 1990s – i.e. prior to the start of the G&H project – the IPHC network was largely event driven, and struggled to survive in between the various events. With the advent of the project, the IPHC has become more formal, since it brought along the obligation to plan activities and align them with project funding, meet deadlines, report on activities undertaken and achieved results, and account for project expenditure. This is being experienced as a burden on the network, to some extent, especially on the coordinator, and it calls for more delegation of responsibilities. The project and its associated funds also created opportunities for the network to invest in strategic development. According to most interviewees, these opportunities have not sufficiently been capitalised upon and the required focus is yet to be determined. More focus would inevitably imply less flexibility to respond to events and developments that cannot easily be foreseen beforehand. It appears as though more focus is a requirement so as to achieve more coherence between the IPHC goals, strategies and activities. It may ultimately be a decisive factor for the longevity of the network.

[20] In the first project year (2001/02) the largest part of G&H project funds went into network development, while the second year (2002/03) showed a shift towards capacity building and publications.

5.5 Excellence

Several of the IPHC core group participants are highly recognised internationally for their analytic work, not just in IPHC circles. There is a general consensus among the interviewees that to a large extent IPHC derives its credibility from these individuals and their work, even if it is not all published in the name of IPHC. There is also wide recognition for the fact that IPHC is successful in 'breaking a leg' and manages to draw attention to political issues and put these on the agenda of national policy makers and international agencies. Some of the academicians involved in the IPHC core group, however, regret what they perceive as a decline in productivity of the network in the past two or three years.

'IPHC's combination of analysis and grassroots work is laudable.' *Key informant*

Another source of international recognition is the link that IPHC is able to make between analysis and grassroots work, although again the practitioners who entertain such links would like them strengthened. This, and the fact that the IPHC core group has a very strong 'southern' representation, makes the network quite unique.

'The global update is easy, but national and regional updates require national and regional processes. Not a lot is taking place at these levels yet.'

Previous sections have pointed out already that the strategies and lines of action that IPHC pursues are not sufficiently coherent with the social changes that the network is seeking. But even the desired social changes themselves are not clearly defined. This is not something everybody recognises, but it would appear that this applies at all levels: local, national, regional and global.

While IPHC thus seems to have very high standards of performance when it comes to analysis and linkages with grassroots work, this is much less the case for strategy development and communication. From the interviews held it transpires that people interpret commonly used terms in different manners, for instance for terms such as 'liberation', 'socio-economic structures', 'capacity building', 'advocacy', 'lobby', 'clearing house'. This is partly a matter of language barriers and cultural differences, partly of deficiencies in articulating what these terms really mean.

Some of the key informants interviewed for the present evaluation outside the IPHC core group itself indicated they had difficulty in appreciating IPHC's tendency of victimization. Globalisation and other worldwide phenomena and trends tend to be portrayed as having turned poor people into 'victims', while the opportunities for empowerment that come along with globalisation would be underestimated or disregarded all together. By doing so, the IPHC would not achieve as much as it possibly could.

A final comment with regard to excellence relates to the 'north-south' distinction that characterises the debate about globalisation and international development cooperation. The G&H project has gone as far as making a distinction between a 'southern secretariat' (IPHC) and a 'northern secretariat' (Wemos and Medact). The project has assigned the latter specific roles in relation to lobby and advocacy – towards 'northern' organisations – and to serving as a 'clearing house'. Capacity

building seems to be considered the prerogative of the southern secretariat, which suggests that on the northern side it does not apply. This is questionable. Clearly there is overlap in functions, and there should be recognition for the fact that the southern secretariat is very much involved in lobby activities towards both southern and northern institutions and agencies. To the evaluation team, the distinction between the northern secretariat and the southern secretariat seems artificial since it has no practical function. While the term 'IPHC global secretariat' (for the small office in Managua) seems more appropriate, the complementary roles of the IPHC network on the one hand, and its partner organisations Wemos and Medact (and possibly Novib) on the other, would need to be clarified if the G&H project were to be extended.

6. Conclusion

From the findings and analysis presented in chapters 4 and 5, several conclusions can be derived about IPHC's current status and performance to date as a global network:

- ✓ Overall, the Globalisation & Health project document (funding application) has served as a useful guide to further develop the IPHC network. Although the original project plan was too ambitious, the project has been instrumental in strengthening the network in terms of facilitation of activities and mutual co-operation between the network participants. However, the exact nature of the desired relation between IPHC and its northern partners (Wemos and Medact) was not well defined, and as a result, the G&H project has not succeeded very well in strengthening the partnership between IPHC on the one hand, and Wemos and Medact on the other. While a possible partnership between IPHC and Novib is not imaginary, it has never been explored.
- ✓ The list of local/regional networks and connections from which IPHC core group participants draw their experiences and into which, in turn, they feed IPHC analyses and experiences is impressive. It suggests a strong link between analysis and grassroots work and a wide reach of the network's efforts to promote the political understanding of health as a global issue. Nevertheless, it remains necessary for IPHC participants to critically examine their 'constituencies' and as much as possible make explicit on whose behalf they present their findings and express their ideas when writing analytical papers or speaking at public forums.
- ✓ As regards the IPHC network, there is a need to clarify the roles of participants in the IPHC core group, i.e. the focal persons and collaborators, and to further define criteria for membership.
- ✓ IPHC could improve its performance by bringing its capacity building strategy and activities more in line with its overall political goal. There is a need to articulate much better what IPHC understands by capacity building, whose capacity needs to be strengthened and what activities will be undertaken.
- ✓ International advocacy has been very high on IPHC's agenda and some important successes have been achieved, most notably the joint organisation of the People's Health Assembly in December 2000.
- ✓ The emergence of the People's Health Movement should be considered as a significant achievement to which the IPHC has had a crucial contribution. The PHM has provided the IPHC a near perfect vehicle to ventilate its ideas and calls for political action among a broad international public. At the same time, however, the PHM constitutes a threat to the IPHC since it may dilute – and has already done so, to some extent – IPHC's profile as an analytical group and its lobby towards more political pressure for real social change.
- ✓ IPHC collaborators unanimously share the vision and mission of IPHC and they have a strong sense of belonging. Nevertheless, the IPHC core group should do more to increase the visibility of the network, so as to strengthen its unique identity as a social change network that has an added value to other networks and movements, in particular the PHM.

- ✓ Democratic decision making within the IPHC network is being challenged almost on a continuous basis, and at times even contested (see section 4.2). There is now need for the IPHC group participants to provide the newly formed interim steering committee to give it the mandate it deserves and endorse its terms of reference. IPHC 'membership' (or the right to participate) is an issue that is not sufficiently clear and gives the network an image of exclusivity, at least to those who are not directly involved in the IPHC core group.
- ✓ While the large diversity within the IPHC network is one of the strengths – and probably prerequisites – for its existence, it also forms a threat. This applies in particular to the difference between academicians and practitioners, and the associated difficulty for the network as a whole to strike the right balance between producing sound analyses and facilitating voices from 'the field' (e.g. through testimonies) and to connect the two in an appropriate manner.
- ✓ The IPHC is a highly dynamic network to the extent that, as a whole, it manages to pursue its goals by seizing a broad spectrum of opportunities and adjusting to obstacles without losing sight of the political purpose. However, more focus is required so as to achieve more coherence between the IPHC goals, strategies and activities. It may ultimately be a decisive factor for the longevity of the network.
- ✓ IPHC enjoys a great deal of international credibility which it derives from a combination of three factors: its strong representation of 'the south'; the high quality of the analytical work of some of its core group participants; and the combination of analysis and grass roots work. At the same time, however, more thought should be put into strategy development and appropriate external communication to put the messages across.

Three main opportunities arise for strengthening IPHC as a global network in the next few years.

1. The international climate: the current world of changing international relationships is characterised by sharp divisions between powerful and powerless people and between rich and poor, and by armed conflicts, ecological degradation and new epidemics that have an impact – directly or indirectly – on people's health and well-being. On the one hand this constitutes an opportunity for IPHC to expand its activities in relation to these new developments, but at the same time it implies an obligation for the network to review its focus and strategic directions. The international scene has changed over the past 10-15 years and there is now a multitude of organisations, networks and movements, some of which represent new generations of people: this in itself provides an opportunity for IPHC to develop a new *discours,* with possibly new paradigms and a new language. In order for IPHC to be more effective, there is a particular scope for the network to be more articulate about:
   a) the nature of the social changes that IPHC pursues;
   b) the strategies through which it tries to achieve this change; and
   c) the position IPHC occupies *vis-à-vis* these other organisations, networks and movements.

   This would imply some kind of a 'central agenda' for the network.
2. Both internally and externally, in particular in relation to the PHM and the various global social forums, there seem to be ample opportunities to further clarify and define the role of *individual* IPHC participants, based on their

respective capacities and interests, in line with the overall IPHC mandate. The organisation of the second PHA (in 2005), for instance, should be seized as an opportunity to firmly pursue typical IPHC issues, in the full acknowledgement that the assembly will attract a large audience among which not all are equally sensitive to political analyses.

3. Planning and follow-up: the expiry of the G&H project funding (from Novib) in the course of 2004 creates the opportunity to develop a new 3-4 years plan, which would need to take into account the findings and conclusions of the present evaluation. When starting a new planning cycle, due consideration should be given to the institutionalisation of a better framework (or mechanisms) to ensure:
   a) participatory and effective decision making and strategic planning;
   b) adequate follow-up of annual plans; and
   c) the future institutional and financial sustainability of the network.

Some further reflections that arise from the analysis and which may be taken into consideration by the IPHC network are the following:

- ✓ IPHC focal points and collaborators should explore not only what they can get out of the network but also on what they actually contribute (or are able to contribute) to it (see section 5.1). This would comprise sharing of experiences in the form of reports, publications/articles or contributions towards Herding Tigers or the list serve, as well as local efforts towards strengthening focal points (including local fund raising) and linking them to the global network. It is suggested that there be more sharing within the network of opportunities to raise funds at the national/regional level for the development of focal points.
- ✓ The effectiveness of an international network such as IPHC, which has a relatively small group of core participants who meet each other occasionally though not only in IPHC driven meetings and activities, may be threatened by a 'personalisation' of viewpoints and positions, which can easily affect mutual trust and lead to conflict. Efforts are required from all concerned not to shy away from debates – even if they are critical about IPHC itself – and to keep discussing on the basis of arguments, rather than look at who says what. The distinction made in the present report between academicians and practitioners is meant to help understand people's thinking and reasoning, not to create a divide within the network. We reiterate that it would be worth capitalising more on the different skills and capacities of IPHC participants and on further articulating the various roles that many seem to have taken upon themselves already (see section 5.1: the roles of analyst, resource person, educator, media coordinator, 'inspirator', challenger, etc).
- ✓ The distinction between the southern secretariat and the northern secretariat should be reconsidered, keeping in mind the complementary roles and areas of overlap, and taking into account the mandates and strengths of the organisations involved (Wemos, Medact, Novib; see sections 4.2 and 5.5 of this report). The actual role of the latter three organisations within the next phase of the G&H project would need to be redefined.
- ✓ More time should be taken for actual reflection, e.g. on the focus and strategic direction of IPHC. The annual meetings have proven too short and hectic and tend to be dominated by short-term planning and practical issues. Such reflection

requires better preparation, for instance in the form of one or two discussion papers, which would be disseminated prior to the annual meeting.

- ✓ And finally, it is suggested that the interim steering group that was formed in May 2003 meets as soon as possible to enact upon its duties. It could take the current evaluation report, once adopted, as a reference for its future action.

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Nunez, Martha, and Ricardo Wilson-Grau (2003), Towards a conceptual framework for evaluating international social change networks.

Websites:

www.iphcglobal.org
www.medact.org
www.novib.nl
www.phmovement.org
www.wemos.nl

Appendices

Appendix 1: Terms of Reference

Evaluating IPHC

Since its inception in 1991, the International People's Health Council (IPHC) has been an active force in the global struggle to improve people's health. During that time, it has built many partnerships and links with people, organisations and networks around the world. Since 1999, it has been particularly involved with in a partnership with the Health Counts coalition (Wemos, Medact and previously a Finnish NGO) in a project to address globalisation and health.
This project provides an opportunity to evaluate the work of IPHC, both in terms of the aims and objectives of the project itself including the collaboration between IPHC and Health Counts, but also in relation to the overall development, effectiveness and impact of IPHC. The evaluation should be seen as an opportunity for learning within IPHC, should help to set in place effective processes for ongoing monitoring and assessment of future IPHC activity, and should enable IPHC to develop strategic plans for focusing future work.

A suggested evaluation plan is set out below.

Aim of the evaluation

Two broad areas of investigation need to be explored:

1. Results to date:
   Over the past four years, what role has IPHC played in influencing and encouraging changes in policies and practices related to people's (especially the poor) right to health? In particular (but not exclusively), what contribution has the work of the Globalisation and Health project made? What lessons can be drawn from this that could inform IPHC's future work?
2. What are the opportunities for positive results into the future?
   What is the strategic position of IPHC within the overall right to health issue? What is IPHC particularly well-placed over the next three to five years to achieve in terms of possible influence over policies and practices in this field? From its strategic advantage, its network and connections, and its strengths, what areas of focus would be most appropriate and most likely to achieve impact?

   We would be interested for each one of these major policy and practice changes if the evaluators could give us their opinion about:
   - The **consequences** if IPHC is successful in making the contribution: What are the potential direct and indirect benefits of success?
   - And, the **probability** that IPHC would be successful. What are IPHC's strengths and advantages that suggest it will make a contribution to the policy or practice change? For example, let us say that to contribute to a policy and practice change, IPHC must mobilise and strengthen grass roots organizations and enhance the global networking between them? Then, has IPHC demonstrated the capacity to build a global network between these organisations.

The evaluation team should also try to assess within the above mentioned two areas:

3. **What are the principal risks to success in achieving those policy and practice changes?** For each instance of a significant potential to contribute to policy and practice changes, what are the greatest dangers or threats, internal or external, to IPHC's being successful?

* **Negative consequences**: What would be the downside or losses if these dangers materialise into problems?
* **Probability**: What is the probability that the big threats or dangers would become problems that would undermine the success of IPHC?

In considering these, the evaluation team should bear in mind that:

- It is not always easy (or indeed, possible) to trace direct impact in the area of policy and practice change to a particular intervention or action
- IPHC operates at a number of levels – from the grassroots field level to the international policy arenas – and uses a number of approaches – from research and analysis to communication, advocacy and social mobilisation
- IPHC is a network rather than an organisation, and relies on contributions from and connections of network participants to be able to achieve its goals. As the International Development Research Centre (IDRC) in Canada has noted: 'Networks are not institutions, they cannot be expected to do what institutions do'.[21]

At the same time, it would be useful to explore the issues and challenges in evaluating a networking activity. Part of the function of the evaluation process should be not only to examine the specific achievements and potential of IPHC, but also to suggest approaches and tools that could be used by other networking initiatives to review their work. It would be relevant for the evaluation team to draw upon some of the recent discussion on evaluating networks to be found on the Monitoring and Evaluation News (MandE News) website at http://www.mande.co.uk)

Resources to draw upon

Monitoring data that can be used for the review and evaluation includes:

- Planning documents
- Reports of progress, events and meetings
- Minutes of IPHC planning meetings
- Feedback from participants in IPHC and partners with which it works, including the Health Counts coalition

Key stakeholders that should be consulted include:

- Donors to the programme
- Collaborators within the IPHC
- Members of the Interim Steering Group
- Staff
- Representatives from organisations with which IPHC has collaborated, including Health Counts
- Specific attention should be given to include stakeholders at grassroot level (including People's Health Movement).

Process

The detailed process for how to undertake the review and evaluation should be determined by the evaluation team, in consultation with IPHC staff. However, it is expected to include a review of available documentation, interviews with IPHC staff, some form of a reflective review process with the coordinating group of IPHC (probably done virtually), and a survey or set of interviews with key informants/stakeholders. Opportunities exist for the evaluators to interact with IPHC participants at a workshop in Cuenca, Ecuador from 13-17 October. It is also

[21] Bernard, A.K. 1996. IDRC Networks: an ethnographic perspective. Ottawa: Evaluation Unit, IDRC

suggested that the grassroots level work of IPHC's focal point in Zimbabwe be explored in some depth.

The Globalisation and Health project proposal sets out a range of objectives and outcomes that were expected, and a series of milestones that could be checked against. The degree to which these have been achieved could be a useful initial measure of results. These include:

Objectives:

a) To strengthen the IPHC and HC network
b) To develop joint strategies and alternative solutions that promote health as a fundamental human right.

In attempting to meet these objectives it was expected that:

- the Southern secretariat would be strengthened
- country and regional coordination in Asia, Africa, Latin America, the Middle East and Europe would be strengthened
- capacity would be built in the regions
- a clearing house would be established
- a network newsletter would be set up
- relationships would be developed with other networks along with an active engagement in each other's work
- the People' s Health Charter would be used as an educational and advocacy tool
- critical input in PRSP policy debates would be made at all levels
- awareness would be raised among governments and the health sector on the impact of GATS on health care structure and financing, and a health input would be made in GATS negotiations
- bottom-up PHA follow-up activities would be encouraged in the regions.

More generally, issues such as the degree of diversity, dynamism, democracy and decentralisation (see Chambers, 1997) within IPHC could be explored. This might include looking at issues such as:

- The degree to which local autonomy of network participants enables them to contribute in different ways to meeting the overall network objectives
- The degree to which initiatives for action, suggestions for new participants, and development of new ideas, approaches and materials are put forward by participants, rather than relying on the network secretariat
- The degree to which horizontal dialogue and linkages are occurring.

The evaluation needs to consider what brings this network together and what keeps it from spinning apart. An exploration of the contributions made to the network by participants would also be useful.

Feedback of the evaluation findings to the coordinating group of IPHC in a way that encourages dialogue and analysis about how to take the findings forward is an essential part of the process.

Evaluation team

Because of the multilingual nature of IPHC, a team of three evaluators is suggested: one to focus particularly on the work in Latin America and the other two from ETC working together to explore work in other parts of the world. The evaluators would need to work closely together on the final report that should be produced in both English and Spanish. It is expected that the first version of the report will be produced in English with translation into Spanish organised by IPHC.

Timing
The review and evaluation should be carried out during October and November 2003. An opportunity exists in early November for the evaluation team to meet in Europe. Some of the field work will have been done by that time. The final draft of the report needs to be completed by 15 December 2003.

Financing
Novib has earmarked the sum of $10,000 for the evaluation exercise. The Exchange programme on health communication is able to provide a further $12,500 towards the process, to ensure that the wider issue of how to evaluate networking activities is effectively explored.

Evaluation budget

Evaluators fees	
• ETC 14days @ $600 per day	$8,400
• C. Muxi 12days @ $400 per day	$4,800
Travel and subsistence	
• To Nicaragua (C. Muxi)	$2000
• To Zimbabwe (ETC)	$2000
• Within Europe (ETC/C.Muxi)	$800
Communications (ETC/C.Muxi)	$2,000
Copying, office materials (ETC)	$500
Report publication (ETC)	$500
Translation (IPHC)	$1,000
Distribution (IPHC)	$500
Total	$22,500

Appendix 2-A: IPHC focal points and their involvement in the global IPHC network and the G&H project

	IPHC Focal Persons											
	a Europe	b. Austral.	c Japan	d Philipp.	e Palest.	f C. Am.	g Zimb.	h India	i S. Am.	j S. Africa	k Brazil	Bangla.
IPHC Founder	-	-	X	X[22]	X	X	-	X		X	-	X
Active since	1992	1992	No longer	1991	1991	1991	1995	1991	1998	1991	2000	1991
Function: Reg/Nat	Nat. /Reg	Nat.	Nat.	Nat.	Reg.	Reg.	Nat.	Nat.	Reg.	Nat.	Nat.	Nat.
Repre-senting	Indiv.	Indiv.	Indiv	CHD	UPMRC	RCPCH	Indiv	Indiv.	Inform. Netw.	Indiv.	Indiv	GK
Involved in PHM	X	X	X	X	X	X	X	X	X	X	X	X
Attendance at IPHC coordination meetings (review and planning)												
Amst'dam Feb/00	X	-	X	X	X	X	-	X	X	X	-	-
Dhaka Dec/00	X	X	X	X	X		X	X	-	X	-	X
Cape Twn Feb/02	X	X	X	-	X		X	X	X	X	-	-
Geneva May/03	X	X		(X)	X	X	-	X	X	X	-	X
Inclusion of separate regional/country reports into IPHC progress reports												
2001/02	-	-	-	-	-	-	-	-	-	-	-	-
2002/03	-	X	-	-	-	-	X	X	X	X	X	-
Financial contribution received from G&H project												
2000/01	X	-	-	X	-	-	-	-	X	X	-	-
2001/02	-	-	-	-	-	X	X	-	X	-	-	-
2002/03	-	-	-	-	-	-	X	X	X	-	X	-

[22] CHD was to have been present at the founding meeting, but the delegate could not be present because of an emergency situation in the Philippines.

Appendix 2-B: Local and regional connections of each of the IPHC focal persons

Focal persons	**National and regional networks and connections**
a. Europe: Pam Zinkin in London	* PHM Europe * British Medical Association (local branch) * NHS Consultants Association * NHS Federation * LSHTM * Institute for Child Health * Over-sixties groups in Islington
b. Australia: Fran Baum in Adelaide	* Public Health Association, Research Advisory Group * PHM Australia * Global Equity Project * Australian Health Promotion Organisation * Community Health Association of South Australia * Flinders University Adelaide * Various academic linkages
c. Japan: Yoshinori Ikezumi in Nisshin City, Aichi	*Inactive*
d. East Asia/Philippines: Eleanor Jara (focal point) in Manila Delen de la Paz (collaborator) in Manila	* Council for Health and Development * PHM Philippines * Health Alliance for Democracy * Linkages to academic institutions * Asian Health Institute, Japan * College for Medicine, University of the Philippines * Various academic linkages * Council for Health and Development * PHM * HAIN * Linkages to various small and larger NGOs

Focal persons	National and regional networks and connections
	* Asian Committee Health Action Network * Asian Health Institute, Japan * HAI Asia Pacific, Sri Lanka
e. Middle East: Jihad Mashal in Ramallah, Palestine, with Ghassan Hamdan (collaborator)[23]	* National Committee for Human Resource Development and Education in Health * Preparatory board for the National Committee for promotion of Breastfeeding * Women's Health Committee * National Secretariat for Palestinian Children * National School Health Committee * Central National Committee for Rehabilitation * Palestinian NGO Network * Arab NGO Network * Arab Forum for Social Sciences and Health * MENA regional group of PHM
f. Central America: Margarita Posada in El Salvador	* Acción para la Salud en El Salvador * Alianza Ciudadana contra las Privatizaciones * Centro para la Defensa del Consumidor * Asociación de Ayuda Humanitaria-PROSALUD * Red Nacional de Comercio Justo El Salvador
g. Zimbabwe: Mary Sandasi in Harare	* Women and AIDS Support Network * Community Working Group on Health * Zimbabwe Women's Resource Center Network * Zimbabwe AIDS Network * Zimbabwe Development Education Network * The Center * Pan African Treatment Access Movement
h. India: Mira Shiva in Delhi	* Voluntary Health Association of India * All India Drug Action Network * Women and Health * Medico Friends Circle

[23] Mr. Hamdan was not interviewed.

Focal persons	National and regional networks and connections
	* Jan Swasthya Abhiyan (PHM) * National PHA * Health Action International Asia Pacific
i. South America: Arturo Quizhpe in Cuenca, Ecuador	* Frente Nacional por la Salud de los Pueblos * Dir. Relaciones Internacionales Fac. de Ciencias Medicas, Cuenca * Dir. Fund. Niño-a-Niño (Child-to-Child Foundation)
j. South Africa: David Sanders in Cape Town	* Public Health Assoc South Africa * Alternative Information and Development Center * Treatment Action Campaign * Not in my name * Equinet / Equity and Health Network in Southern Africa * WHO AFRO Continental Task force on Human Resource Development
k. Brazil: Ani Caroline Wihbey in Sao Luis	* National Association of Human Rights * Conference of the Religious of Brazil * MST, a movement of landless workers * SASE, a foundation working with poor farmers * Linkages to different congregations * Linkages to Indian community in Brazil * Cultural Centre of the Coloured People
l. Bangladesh: Zafrullah Chowdhurry in Dhaka	* Gonoshasthaya Kendra * PHM
m. Tanzania: Mwajuma Masaiganah (collaborator) in Bagamoyo, Coast Region	* PHM * Tanzania Public Health Association * National Policy Forum * Christian Council of Churches in Tanzania * Linkages to various Tanzanian NGOs * African Women Leadership Network * HAI Uganda * Consumers International Network Kenya

Appendix 2-C: International connections of each of the IPHC focal persons

Focal persons	**Global organisations, alliances, networks and movements**
a. Europe: Pam Zinkin in London	* IPHC * PHM * Medact * Healthlink * One World Action * IBFAN * World Development Forum * Medical Aid for Palestine * Public Services International Research Unit * Various grass roots organisations in Zimbabwe
b. Australia: Fran Baum in Adelaide	* IPHC * PHM * Editorial Board of the Journal of Epidemics & Community Health * Healthy Cities Network * International Union of Health Promotion and Education
c. Japan: Yoshinori Ikezumi in Nisshin City, Aichi	*Inactive. Used to be the PHA regional contact person*
d. East Asia/Philippines: Eleanor Jara (focal point) in Manila Delen de la Paz (collaborator) in Manila	* IPHC * PHM * International League of People's Struggles * Medical Aid for the Third World * Linkages through individual people working abroad * IPHC * HAI * PHM * International League of People's Struggles
e. Middle East:	* IPHC

Focal persons	Global organisations, alliances, networks and movements
Jihad Mashal in Ramallah, Palestine, with Ghassan Hamdan (collaborator)	* PHM * Children's Rights Network * MENA Regional Group of NGO Working Group on World Bank
f. Central America: Margarita Posada in El Salvador	* IPHC * PHM
g. Zimbabwe: Mary Sandasi in Harare	* IPHC * PHM * International Community of Women Living with AIDS
h. India: Mira Shiva in Delhi	* IPHC * PHM * HAI * Diverse Women for Diversity * IBFAN
i. South America: Arturo Quizhpe in Cuenca, Ecuador	* IPHC * PHM
j. South Africa: David Sanders in Cape Town	* IPHC * PHM * Global Equity Gauge Alliance * International Association for Health Policy * International Society for Equity in Health * Scandinavian Africa Institute Research Network on Structural Adjustment
k. Brazil: Ani Caroline Wihbey in Sao Luis	* IPHC * PHM * Congregation of Sisters of Notre Dame de Namur * UN NGO accreditation
l. Bangladesh: Zafrullah Chowdhurry in Dhaka	* IPHC * PHM
m. Tanzania: Mwajuma Masaiganah (collaborator)	* Columbia University, USA * Women's Global Network for Reproductive Health * Exchange * One World Action

Appendix 3: List of people interviewed

Name	*Designation*	*Method used*
IPHC		
Ms. Maria Hamlin Zúniga	IPHC Coordinator, Global secretariat in Managua, Nicaragua	Face-to-face interviews in Managua and the Netherlands
Ms. Olimpia Morales	Office manager of the IPHC Global secretariat	Face-to-face interview
Mr. Vergilio Medina	Documentation officer, IPHC Global secretariat	Face-to-face interview
Dr. Fran Baum	IPHC focal point for Australia	Telephone interview
Ms. Eleanor Jara	IPHC focal point for the Philippines	Telephone interview
Dr. Jihad Mashal	IPHC focal point for the Middle East (based in Palestine)	Telephone interview
Dr. Arturo Quizhpe	IPHC focal point for South America (based in Ecuador)	Telephone interview + written answers
Ms. Margarita Posada	IPHC focal point for Central America (in El Salvador)	Face-to-face interview
Ms. Mary Sandasi	IPHC focal point for Zimbabwe	Telephone interview
Dr. David Sanders	IPHC focal point for South Africa	Telephone interview
Dr. Mira Shiva	IPHC focal point for South Asia	Written response to questions
Sr. Any Whibey	IPHC focal point in Brazil	Telephone interview
Dr. Pam Zinkin	IPHC focal point for Europe (based in the UK)	Telephone interview
Dr. Julio Monsalvo	IPHC collaborator in Argentine	Telephone interview
Ms. Mwajuma Saiddy Masaiganah	IPHC collaborator in Tanzania	Telephone interview
Dr. Delen de la Paz	IPHC collaborator in the Philippines	Telephone interview
Ms. Ana Quirós	IPHC collaborator in Nicaragua	Face-to-face interview
Dr. Claudio Schuftan	IPHC collaborator in Vietnam	Telephone interview
Dr. Unnikrishnan P.V.	IPHC collaborator in Thailand/India	Face-to-face interview

Key informants

Dr. Francoise Barten	The Netherlands	Telephone interview
Mr. James Campbell	Nicaragua	In a group discussion with IPHC global secretariat staff
Ms. Martha Cranshaw	Nicaragua	Face-to-face interview
Dr. Carlos Hernandez	Nicaragua	In a group discussion with IPHC global secretariat staff
Dr. Eugenio Villar	WHO, Geneva	Telephone interview
Mr. Mike Rowson	Medact, UK	Telephone interview
Dr. Nina Tellegen, Ms Marjan Stoffers, Dr José Utrera, Ms Ellen Verheul	Wemos, the Netherlands	Group interview, face-to-face
Ms. Anne Kooistra and Ms. Heleen van den Hombergh	Novib, the Netherlands	Group interview, face-to-face

Appendix 4: Questionnaires

IPHC's G&H Project evaluation

Questionnaire A: Topic list for interview of IPHC focal points and IPHC collaborators (final version; 29 Oct 2003)

a. Identity

Mention the information we already have on organisations/networks, which the focal points are related to. Check if this list is complete and whether they want to make any additions.
(Keep the relevant matrix with background information at hand to refer to and complete/correct where necessary)

1. In what capacity are you a member of IPHC (as an individual or do you represent a group)? Since when? What has been your role?

2. What position and/or role do you have at the institution you work for?

3. In what way are you working on health issues (e.g. medical doctor, public health specialist, project officer)?

4. Which other institutions/organisations are you formally engaged with in your country of residence? Please characterise them. What position and/or role do you have?

5. Which institutions/organisations are you formally engaged with in your region? Please characterise them. What positions and/or role do you have?

6. Which global institutions/organisations are you formally engaged with? Please characterise them. What position and/or role do you have?

7. Do you consider your work for IPHC as part of your regular work, or do you conduct it alongside your regular duties?
   What does your work for IPHC imply in practical terms (e.g. workload, frequency of travelling)?
   Do you have an IPHC 'business card'? Where do you use it?

8. We would like to obtain information on your connections with grass roots organisations. Which grass root organisations are you connected with, formally or informally? (disregard connections that are no longer there since 2000). Please characterise them.
   What role do you have?
   Are those connections relevant for IPHC? How?

9. Are there any <u>other</u> important networks that you are part of (local, national, regional or worldwide; e.g. PHM)? Please specify.
   What role do you have?

Are those connections relevant for IPHC? How?

b. The following set of questions pertains to the above formal or informal connections.
As much as possible, try to clarify which of the connections the information provided relates to.

10. Where do you see most of your inputs? Which of the above connections?
    What typical IPHC inputs have you been able to provide as part of this connection?
    Where do you feel you have been able to make a contribution?
    Is your input valued and supported by the organisation/network that you are connected with?
    Do you meet any resistance?
    How do you see you can make an input to realising health as a basic human right?
    Do you have any evidence that your input has contributed to any desired change? Please specify.

11. Out of this connection, have you been able to feed some of your experience back into the IPHC network?
    Has this been useful in any way? How?

12. Are there any missed opportunities where you could have given a typical IPHC input?

13. Have you encountered any obstacles for giving IPHC input? Specify.

14. Do you think IPHC was there when it was most needed (mention here the example of Cancun)?

III. Questions about a different type of connections: between global policies and local events

15. *(in as far as the examples given as a response to Questions 10-14 do not already cover this:)*
    Are there any examples of connections that you have been able to make (or contribute to) between global policies and local events? How do you relate the local and global issues?
    Give examples and describe.
    Any evidence of a desired change?

16. Has your being part of the IPHC network been instrumental in making this connection? How?

17. Have you been able to feed this connection back into the IPHC network? How? With what result?

IV. The functioning of the IPHC as a network

18. In your view what is the major strength of the IPHC network? *(brief answer)*

19. What is its major weakness? *(brief answer)*

20. Are you familiar with the report and recommendations by Andrew Chetley? Do you have any particular opinion about his recommendations (on Legal structure, Focus, Decision making, Involvement and representation, Communication, Learning, M&E, Roles of focal points)?

21. How would you describe the ideological position of IPHC and what it tries to achieve? Do you think that there is sufficient clarity within the IPHC network on this?
    If not, what is not clear? Why is that so?

22. Do you think the overall goal of IPHC is shared among all IPHC focal points and collaborators?
    Reminder: the overall goal of IPHC is …
    If not, why?

23. Are the three general strategies that IPHC pursues (a. strengthening the network and feeding into other networks, b. advocacy & lobbying, c. capacity building) sufficiently shared among all IPHC focal points and collaborators?
    If not, why?
    Do you feel each strategy receives sufficient attention? Would you like to see any shifts?

24. Is the internal communication process effective and efficient? Do you think your IPHC 'colleagues' have a good picture of what you are doing? Do you have a good picture of their activities? Do you think this is important?
    Do you communicate on both organisational and content-related issues?
    How do you communicate with the IPHC Coordinator, and on what issues?
    How do you think the fact that you are in different continents, and speak different languages, plays a role (e.g. no problem, obstacle)?
    Would you like to see any improvements?

25. Are you satisfied with the current procedures for review and planning (with annual meetings)? What could be improved?

26. Are you sufficiently clear about the expectations of your role as an IPHC national/regional focal point (or an IPHC collaborator)?
    Suggestions.

27. What do you expect from your coordinator? Suggestions. How do you support your coordinator?

28. In your view, is the IPHC network sufficiently democratic? Any examples of decisions that were not taken in a democratic manner?
    Some say IPHC is overly democratic and that everything is being discussed. What is your opinion on this?

29. Is the network sufficiently diverse? Is it sufficiently open to new 'members'?

What qualifications and/or characteristics would a new member need to have?
Do you see a role for yourself in inviting new members?

30. Is the IPHC network sufficiently dynamic?
    Is there sufficient mutual sharing of experiences (even outside the meetings)?
    Within the network, do you sufficiently learn from previous experience?
    Is there sufficient renewal of ideas within the IPHC network?

31. Does the network and its 'members' keep itself sufficiently up to date with national, regional and global developments?
    Are the analyses made sufficiently sound?
    Are the strategies and lines of action pursued sufficiently coherent with the social changes that IPHC is seeking?
    Are the strategies and activities sufficiently practical?
    Is there sufficient strategic focus?
    What should the focus be?

32. Some people would say: "IPHC members are mainly busy convincing themselves". What is your reaction to such a statement?
    As a network, whom do you try to convince?
    Do you manage to convince them?
    Any evidence?

33. All IPHC members are busy within their own regional and local networks. Would such activities continue if there was no global IPHC network?
    What is the added value of having a global network?

34. At what level would you say the IPHC achieves most of its results: at the local level, at the national level, or at the international level?

35. Does the IPHC achieve any structural, long-term changes? Please specify. If not, why?

You may have heard about the G&H project, through which IPHC receives most of its funding (from Novib). There are basically two types of results that the project pursues: advocacy & lobby and capacity building.

36. Do you think IPHC is successful in advocacy & lobby? What are the major success stories (examples 1-2-3)?
    What are the major failures (examples 1-2-3)?
    Are there any potential advocacy & lobby issues that IPHC did not exploit or not fully exploit? Specify.

37. Do you think IPHC is successful in building capacity? Which type of capacity does IPHC try to build/strengthen?
    Among whom, at what level?
    Which skills in particular does IPHC try to build/strengthen?
    What are the major success stories (examples: 1-2-3)?
    What are the major failures (examples 1-2-3)?
    Is there any potential to do more in the area of capacity building?

38. Do you have any concerns about the viability of the network? What are the major threats?

39. Have you thought of taking a step back from IPHC and handing over your role to somebody else? Is there any candidate who could take over? What keeps you going?

40. How would you see IPHC in ten years from now (e.g. bigger size of the network, more connections to grass roots organisations, …)?

GRACIAS/OBRIGADO/MERCI/THANK YOU/DANK U WEL/DANKIE

Questionnaire B: topic list for 'informante calificado'/'key informants'

Examples of key informants:
a. Representatives from similar (and to a certain extent like-minded) networks such as HAI, IBFAN, PHM etc.
b. Representatives from 'grass root organisations'
c. Representatives from organisations that IPHC tries to influence.
NB: Obtain names of such persons and networks from each IPHC focal point/ collaborator

0. Please describe your network/organisation.

1. What has been the input from IPHC into your own network/organisation?

2. What input have you from your own network/organisation been able to give into IPHC?
   With these two questions people can think of the following types of input:
   a. Technical knowledge (e.g. analyses of the relation between macro-economic policies and health)
   b. Learning from each others experience (e.g. experience in operating as a network, in linking up with grass root organisations, in building local capacity, in advocacy and lobbying)
   c. Making use of each other's network (e.g. exchanging names and addresses) and/or sharing of human resources (e.g. people representing both networks at the same time).

3. Do the ideology and the strategies of IPHC match with those of your own network/organisation?

4. Are there any opportunities for mutually reinforcing each other that so far have not been capitalised upon?

5. Is there any conflict of interest between your respective networks (i.e. IPHC and your own network/organisation)? Would that hinder further collaboration? How can that be solved (if necessary)?

On the effectiveness of the IPHC network (in line with the long questionnaire):

6. At what level would you say the IPHC achieves most of its results?

7. Does the IPHC achieve any structural, long-term changes? Examples. If not, why?

8. Do you consider it successful in lobby and advocacy? Examples.

9. Do you consider it successful in capacity building? Examples.

10. Concerns, if any.