GLOBALIZATION

ASIAN COMMUNITY HEALTH ACTION NETWORK

ASIAN CONSULTATION

19 - 27 JANUARY, 1999
HOTEL GRANDE VILLE, BANGKOK, THAILAND

Objectives

ACHAN (Asian Community Health Action Network) held a series of consultations with their strategic partners, 19 - 27 January, 1999, to evaluate the current global trends in the light of the growing integration of national economies, the loss of sovereignty of national governments and their selective effects on the poor of the world ultimately reflecting on their health. The IMF-WB (International Monetary Fund - World Bank) combine has forced changes in national health policies, giving low priority to primary health care and advocating cuts in social spending. These Consultations were organised to evolve strategies to counter the threat of globalization on the poor.

Since globalization has been identified as the main threat to the health of the poor of Asia, ACHAN brought together strategic partners from ten Asian NGOs with the time, space and motivation to involve themselves in countering the effects of globalization with the objectives of:

- Helping NGOs (Non-Government Organisations) to understand the effects of globalization and to identify strategies to counter it.
- Evolving appropriate strategies to safeguard and promote the health of the poor
- To formulate a concrete agenda and a joint plan of action for ACHAN and its partners.

ACHAN has always believed and used training as a tool for social transformation. With new threats to the poor emerging, training must build capacities of NGOs and communities to cope with these changes. Training needs to be used as a strategy for enabling communities to understand the changes around and the reasons for them and to counter the factors that affect them adversely. The objectives of the *Asian Master Trainers Workshop*, 22-24 January were:

- to evolve training strategies appropriate to the context of globalization
- develop a training module on globalization for use by our partners.

The two workshops were followed by a consultation of Advocacy partners. The objectives of the Advocacy Workshop were:

- to determine the advocacy status of the partner NGOs
- identify needs and gaps in advocacy work,
- set up a system of coordination among advocacy partners of ACHAN and
- to develop an advocacy agenda at the country level.

Summary of Achievements

Strategic Partners Meet achieved:

- A clear understanding of the realities of globalization and its effects on the poor
- A commitment to a joint plan of action
- An affirmation to build coalitions at the national level
- Play an active advocacy role - with national governments

Asian Master Trainers Workshop helped:

- Develop training strategies to capacitate NGOs
- Develop a training module on globalization
- A commitment to train partners in all the countries under reference

Advocacy Consultation:

- Identified gaps in advocacy work, nationally and regionally
- Resulted in focusing on a single, fundamental and important issue

Synthesis of the three ACHAN Workshops

The first workshop resulted in a mutual reaffirmation of commitment between ACHAN and its strategic partners. It rekindled the spirit of unity in the struggle against ill-health, poverty and foreign oppression. It culminated with a vital document, **The Bangkok Declaration**, which embodies the analysis, perspectives and aspirations of representatives of 22 participating organizations. All agreed to counter the effects of globalization, to genuinely promote people's health and to work together based on the principles of people-centered development in health in the Asian region.

Specifically, we resolved the following:

On ***Networking***:

- To re-vision and re-mission our NGOs in order to better focus on countering the effects of globalization that are causing the deterioration of people's health
- To expand our network to others and possibly build coalitions united in our efforts in countering globalization.

On ***Training***:

- To incorporate the effects of globalization in all training designs
- To make training as a strategy to empower the people.

On ***Advocacy***:

- To launch a campaign on globalization and its ill effects on poor people's health
- To reaffirm that primary health care in state responsibility and to present state recognization this
- To continue strengthening networks through information systems
- To identify and embark on different methodologies that will put people's health issues in the public eye
- To come up with a joint program of action in pursuing our commitment
- To build an alternative development paradigm of health.

Tasks ahead

ACHAN needs to build a perspective for its constituent NGOs on issues concerning globalization. There is a need for training to create awareness and build competence of communities to counter globalization. People's organizations and movements must be involved in all actions. Promotion of alternatives in health, particularly indigenous knowledge is pertinent. The ultimate aim is to create people's resistance movements at all levels.

Note:

In order to better understand our plans for the future as well as to have clarity on the material at hand it is important to take an in depth look at some of the fundamental principles and stratergies of ACHAN. The following is from the ACHAN proposal for action for the period 1999-2001.

Focus

For ACHAN therefore, the focus would remain unambiguously on the poor of Asia and on their health.

Vision

We aspire for a society that is just, participatory, pluralistic and peaceful, where a dignified living sustainable within people's own resources and within the resources of their immediate environment can be secured for all people without fear or discrimination.

Mission

Our mission is to capacitate the NGO sector involved in health care of the poor in Asia in: i) the values and norms of an alternative society, ii) knowledge and skills in implementing people-based programs, iii) developing a cadre of informed, capable young people who will be involved with the poor, iv) developing organisational structures appropriate for the 'clientele' and the task ahead and v) building solidarity among them and among their national networks.

Strategies

Our strategies are aimed at two specific groups of people involved with the health of the poor: *first,* the NGO sector and the *second*, decision makers and policy makers such as international and regional health agencies, ministries of health and resource agencies.

In brief, these strategies focus on three specific thrust areas:

Training

Advocacy

Networking

These thrust areas emerged as a result of an extensive participatory reflection process that took place in the last eighteen months and involved various levels of what can be termed as other 'stake holders', a term currently in fashion, including and specially, communities of the poor in five Asian countries.

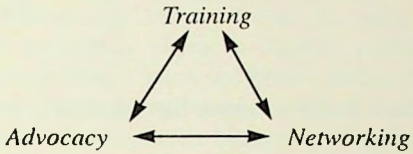
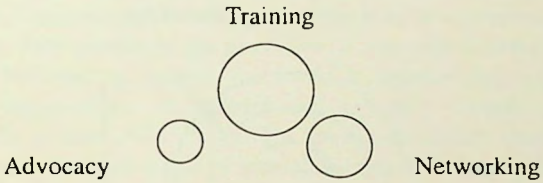
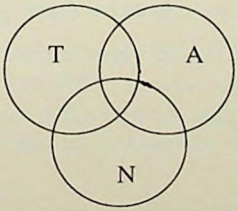


Figure II



In many other programs, these circles (*Figure II*) may not even converge. In fact, they may not be even of the same size denoting their priorities in terms of time, effort and resources. But in such a state, the left hand may not know what the right hand is doing and therefore finally be largely ineffectual. Therefore, ACHAN will strive to reach a stage where our activities will be of equal proportion and converge, like this (*Figure III*):

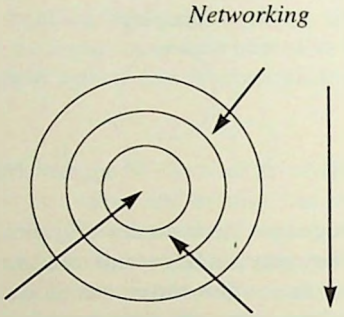
Figure III



Our aim will be to keep enlarging the central area of convergence (*shaded area here*). Our central or core activities will be those which emerge out of here. This is the *synergy* producing area. *Synergism* is defined as the interaction of elements that when combined produce a total effect that is *greater* than the sum of the individual elements. This is what we expect the *complementarity* of our three thrusts to do.

Ultimately, we hope that it will look like (*Figure IV*).

Figure IV



ASIAN COMMUNITY HEALTH ACTION NETWORK (ACHAN) BANGKOK DECLARATION 1999

It is the fundamental and basic right of every human being to live a dignified life without any sense of guilt or fear, without being oppressed, and experience physical, mental, social and spiritual wellbeing. Human health is central and both a determinant and product of the above tenet. Some key provisions in the constitution of WHO state that health of all peoples is fundamental to the attainment of peace and development; that the informed opinion and the active participation of the public are most important in the improvement of the health of the people; and that governments have a responsibility for the health of the people by the provision of adequate health and social services. However, at present, the world is experiencing a period of growing deprivations, inequalities and injustice towards the poor particularly women and children. The impact on human health of this has been enormous in terms of wasted human lives and setbacks for development.

With the above concern, we the participants in the meeting of the Asian Community Health Action Network (ACHAN) hereby solemnly commit to the following declarations:

1. We resolve to unite, act, and actively advocate to reject the current globalization trends, as they stand today because:

* Globalization is purposefully defined, glamorized and aggressively imposed to justify and even legitimize unequal relationships among peoples and nations.

* Globalization is a new and sophisticated form of colonialism with multinational corporations setting conditions for policies, decisions and choices. Socio-economic dominance has rapidly accelerated the process of making the rich richer and the poor poorer.

* The so-called liberal economy prescribed with globalization has increasingly made countries susceptible to imbalances of trade,

severe indebtedness, addiction or dependence on foreign aid, economic crisis or even near bankruptcy and economic collapse, mainly resulting from monopolistic marketing practices and unjust appropriation of resources. Similarly, globalization imposed, incapacitates people, making them lose their sovereignty, subservient with colonization of their minds. It also degraded quality of life and environment, increased risk of unemployment, ill-health and even suicide.

* Globalization is systematically shifting the ownership of natural resources from the people especially of indigenous/tribal populations, to corporations and from nation to regional or international conglomerates.

* Globalization is directly and indirectly eroding human value systems, people's and nation's freedom, sovereignty and dignity by minimizing the role and responsibility of the state towards the people by imposing export oriented trade, tariffs, capital flows and taxation.

* Globalization, now unjustly patronized by WTO, has seriously threatened food security with massive shifts in agriculture towards cash crops. This has resulted in massive increases in malnutrition and hunger.

2. We resolve to act to counteract and to correct the internal factors that are promoting such globalization in its current form by causing:

* An upsurge in professional irresponsibility with a shift towards profit motives, the commodification of health, unethical practices and indifference to threats affecting life and health of the people they serve.

* A rise in corruption,

* Government insensitivity in their political and social commitment towards the needs of the people, and social accountability, and

* Shifting the role of the public sector to the private sector.

3. In order to set things right, we resolve to counter globalization and totally replace with a new concept in a different perspective that puts people, social justice for poor people, equity and a people-oriented development first, so that:

* Knowledge, information systems, human rights and other gains of human civilization do not serve the vested interests and groups - nationally and internationally.

* Resources and development gains are more fairly distributed.

* Countries and people generate and develop the needed information to facilitate informed decision.

* All countries and people of the world have access to channels and means of communication needed for their development.

* Human development programs and processes are people-oriented and at the same time environmentally friendly.

* The identity and interests of minority and Indigenous People, their language and their socio-cultural setting are not overrun.

4. We will educate all concerned to foster development of a more wholistic health with a special focus on the health of the poor, women, children and those deprived for which we pledge to take health as:

* Wholistic and indivisible.

* A human right and a responsibility of all.

* A development issue to be taken beyond the biomedical and public health parameters and also related to the provision of basic minimum needs, empowerment of women throughout their life cycle, a stable and sustainable development of eco-system and environment, social justice, recreation and human rights (including civil, political, economic and cultural rights)

* An area to be safeguarded from aggressive national and international trade practices, unjustified and unethical advertisement and promotion of tobacco and alcohol products, non-essential drugs, and junk food items.

* An area also concerned with the development societies free of violence, torture, sexual assaults, human trafficking, bonded-labor systems and child-labor.

* An opportunity for the choice and development of alternative and traditional care systems including ethnomedicine.

* An enhancement of the quality of life (QOL) with provision of basic-needs of the people, and primary health care as defined by the Alma Ata Declaration.

5. We strongly affirm that equity and social justice are key to the health and well-being of the people, and we also believe that:

* Equity and social justice are based on the principle that those who need most should get most, thus justifying ACHAN's focus to the poor, women, and deprived populations.

* Health rights are to be taken up rather than bestowed or given to the people as charity. There is thus a need to conscientize the people to develop solidarity among them and enable them to assert their health rights. People are to actively participate in the socio-political and economic affairs and decision-making process starting from their family to the national and international levels.

* Politicians, legislators, judiciaries, policy-makers, decision-makers, health and related professionals, health providers and frontline health workers should be more socially and professionally responsible and accountable for the progressive development of more equitable health policies with active participation of the people.

* Existing pro-people movements need to be further developed and strengthened.

6. We resolve to work and contribute to redefine the development paradigm to make it encompass human development and have it incorporated elements of human values, equity and social justice. We also resolve to campaign actively to:

* To ban secret or non-transparent, and unethical research affecting human lives, environment and peace.

* To oppose the misuse and manipulation of statistics or information to justify conditions perpetuating disparity, segregation or deprivation of peoples.

In summary,

We advocate the promotion of a people-centered localized approach to develop and improve health, protect and develop existing and traditional knowledge and skills, and expose and counter the negative elements of globalization as experienced in Asia and the rest of the world.

Such localized approaches will build on the felt-needs and demands of the people giving them a lead role in shaping their own destinies.

As members of ACHAN, we pledge to work together and be committed to the principles of people-centered development in health in the Asian region.

January 21, 1999.
Bangkok

ACHAN Strategic Partners Meeting 19-21 Jan, '99

Introduction and welcome address - Dr. Kawahara

Dr. Kawahara welcomed the participants and expressed his happiness at seeing some familiar and many new faces.

Introduction of participants - Edelena del la Paz

The participants introduced themselves in a participatory manner facilitated by Edelena.

Introduction to ACHAN - Prem Chandran John

Health programs need to shift from a service delivery mode to an enabling one. Any worthwhile community health program must enable the community to be self reliant. The spread of community health has not been wide. Participatory training methodologies, participatory learning methods and participatory strategic planning need to be propagated

In India the health status of the poor has been threatened by external factors such as globalisation. In this context we need to see whether NGOs are upto the task of equipping communities to resist globalisation. The focus of NGOs should now be to protect indigenous knowledge, place special emphasis on vulnerable section like women and safeguarding common resources.

Objectives of the Workshop - Edelena de la Paz

- Identify appropriate strategies for Asian NGOs to promote the health of the poor in coordination with ACHAN.
- ACHAN has identified globalisation as the main threat to the health of the poor. The challenge before NGOs is to understand the effects of globalisation and identify strategies to counter it.
- A concrete action agenda on globalisation needs to be formulated for ACHAN and its partners.

Keynote Address - Dr. Debabar Banerji

With ACHAN, he shares a common commitment to the poor. He would like to be a doctor to doctors. Doctors are sick and we must find

a theological diagnosis to look at medicine as a whole. Health is a product of social, economic and political forces. In all our countries we had systems of coping with ill health. The colonisers utilized different mechanisms such as having English as the medium of communication, to suppress all other systems of knowledge. Cultural arrogance and ethnocentricism negated all other knowledge. Only 3% of Indians speak English and control 97% of the country.

Inspite of all difficulties, Asia has made valuable contribution to the world's health system. Three significant contributions made by India in the treatment of tuberculosis are:

In the 1950s, research revealed that home treatment is just as effective as hospitalization in the treatment of tuberculosis. Research from Chengleput proved that BCG has no protective value for adults. The National Tuberculosis Institute in Bangalore found, in the 1960s, that people believe in rational treatment for tuberculosis and they do not have to be chased for treatment as the DOTS program has contemptuously assumed.

Enlightenment and rationality are not important to the West when their economic and political interests are at stake. The English language has been used as an instrument to impose Western knowledge on Asians. In the pre tigerisation phase in South East Asia, there was a complex and workable indigenous health care system. This was completely lost in the tiger phase when stress was given to the development of tertiary health care. In the post tiger phase, people have no resources to spend in tertiary care and they have also lost their indigenous knowledge to take care of minor health problems.

The immunization programs are a fine example of how health programs are designed to suit the economic interests of the West. No serious evaluation has been done on the effectiveness of the programs and more of these are daily imposed on the developing countries. Programs are decided arbitarily, for example, the pulse polio program was decided by the Rotary International. Lack of information is a political tool. In India, there is no reliable data of births and deaths. Rulers do not want to be embarrassed by such information.

The responsibility of NGOs is more since governments are increasingly controlled by multilateral agencies. The myth of the

global village is propagated whereas in reality we are only asked to join it as bonded labour of 'cowboys, landowners and kulaks. Asking for globalisation on equal terms is like asking a tiger to be a vegetarian.

China had come out with excellent ideas in health care, like the barefoot doctors scheme in community health which incorporated the traditional systems of medicine. This was the essence of the Alma Ata declaration - start with the people, find out what people do when they are sick, and develop systems appropriate to them. But these systems were allowed to deteriorate over time. People are punished for determining their own health.

Globalisation is an old phenomenon and started with the Opium Wars and continues today under various guises. WHO, WTO, WB, UNAIDS, etc. are all agents of control. They took away decision making powers from the state. Immunization programs have received massive funds because of the biotechnology industry. It is the market which decides what the problem is and what the solution should be.

The structural adjustment programs in various developing countries have involved sharp cuts in budgets for the social sector. Privatisation has been promoted in an unregulated way. WTO decides on the health agenda. In the tigerisation phase, in Malaysia, there was a stupendous growth of curative services at the cost of plantation services. Now, 30% of the beds are unoccupied. Diseases are manufactured to suit the market.

WHO's vision for the 21st century is renewal of health for all, increasing involvement of the private sector, greater use of emerging technology and vertical programs on a global scale. But why renewal of health for all when this has been on their agenda for the past thirty years . How is it possible to have programs on a global scale when the globe is so diverse? This fits into Milan Kundera's picture, "Man's struggle against oppression is a struggle between memory and forgetfulness".

A survey on the utilization of medical care in India revealed that 90% of people use allopathic medicines and only 10% use traditional medicines. People's health systems are emasculated. They are resorting to quakes because of their helplessness - they have lost their

own mechanisms for coping. Expenditure on medicines is the most important reason for rural indebtedness in India.

Open Forum - Comments

In Asia, there are three concerns: As states we must either find a place in globalisation or follow an alternative model. This is the political agenda. Voluntary agencies must shift from a social paradigm to a political social paradigm. Voluntary agencies are dying because government are making regulations for them.

Our society has been eroded by the ruling classes for hundreds of years. Globalisation cannot be blamed for the lack of health, water and education in our villages. The brown man is the worst colonist. Let them not find excuses in globalisation. Our ruling classes are exploiting us. Our struggle is with our own people.

The linkage between health and education is ignored. There are is many indifferent people around us. NGOs have not reached that critical mass where they can lead mass movements.

People's struggle against oppression is to remind the oppressor. We need to have the intellectual capacity to confront the oppressor. The Independent Commission on Health in India and Citizens Report on Floods are some such efforts. Sacred cows need to be challenged. Oscar Wilde as sang, "The worst crime you can commit is to leave a person alone in his thinking."

Workshop I

Identify factors and processes responsible for the deteriorating health situation.

Key features of Globalisation are:

- Technology as an instrument of control
- Imposition of a particular knowledge system over all others. Indigenous knowledge is vandalized.
- Transfer of power from nation states to multilateral agencies and multinational corporations resulting in crisis in food security, detereoriating food security and decreasing space for the poor.
- The response of the NGOs has been inadequate.

Guide questions for small group dicussion:

Given this scenario, how have we as a collective force in Asia countered these dehumanising structures and decision making process?

- Identify issues based on country situation, trends during the past ten years with focus on women, children, environment, health, etc., what are the changes brought about by globalisation.
- What are the responses of NGOs to the changing situation, how have they repositioned themselves
- Where are the gaps in our actions

Groupings

Group I - India

GroupII - Sri Lanka, Bangladesh, Nepal

Group III - Philippines, Indonesia, Vietnam, Laos, Japan

Synthesis of Workshop I

I Country Situations: Issues

External Factors

- Imbalance of trade leading to economic crisis and widening the gaps between the rich and poor nations
- Colonization of the mind
- Loss of empowerment, sovereignty and independence
- Subversion of people's interests to multinational corporations

Internal Factors

- Subservience and colonial mentality
- Corruption
- Conservative societal structures
- Government insensitivity

Effects of these factors on the Poor

WOMEN - Triple burden of child rearing, household work and economic work increased, unemployment, lacking skills to cope with new technology, forced to work as migrant labour

CHILDREN - child labour, malnutrition, poor education

ENVIRONMENT - increased pollution, unsustainable exploitation of natural resources

AGRICULTURE - shift from food crops to cash crops affecting the food security of the poor, unsustainable practices in agriculture

SOCIAL - disintegration of the family caused by economic insecurity

HEALTH - deterioration of traditional health systems, privatisation, complete negation of Alma Ata

II NGO Responses to Globalisation

- Education/training - educating policy makers, conscientization, information dissemination, skills and capacity building, empowerment
- Networking and alliance building
- Policy advocacy
- Human resource development

NGOs have not addressed the actual issue of changing or controlling economic trends

NGOs have not questioned export led growth models - they have reacted but not acted

III Gaps in NGO Action Identified

There is a lack of clear vision among the NGO community. NGOs need to share information in order to be effective. NGOs have not networked due to insecurities and external factors. There is a lack of ideological commitment from most NGOs. Some are also lacking an assertive attitude. Less access to policy making and not playing an advocacy role with policy makers.

Organisational Change Processes

Presentation of case studies by CHAI, VHAI, IPHC, RECPHEC, ADAB which demostrates changes in organisational structures and policies in the light of globalisation.

Catholic Health Association of India - Fr. James Culas

Catholic Health Association of India (CHAI) is one of the largest actors in the health sector. The majority of the membership are small health posts run by a single nurse sister providing simple health care for mother and child. A shift in philosophy occured with communitty health being identified as the first priority. This was defined as 'a process of enabling the people, especially the poor and the marginalised, to be collectively responsible to attain and maintain their health and to demand health as a right.' The strategy to implement this involved, decentralisation, bottom up approach and networking with the government and voluntary agencies. Advocacy was perceived as an important tool and the concept of the District Health Action Forum was mooted.

Tamil Nadu Voluntary Health Association - Saulina Arnold

Tamil Nadu Voluntary Health Association (TNVHA) has been involved in issue based networking, capacity building of voluntary agencies and their staff, publications, networking and advocacy. They work in active cooperation with the government, critiquing it at the same time, and modifying government programs to suit local need. They have changed their earlier policy of being aloof from the government which they feel is a futile exercise.

Institute of Primary Health Care - Luz Canave-Anung

Insitute of Primary Health Care (IPHC) is engaged primarily engaged in training health workers, enhancing agricultural productivity and gender and reproductive health. In the late 1970s, with a view at promoting holistic development, they started the sustainable Integrated Area Development Program.

Resource Centre for Primary Health Care - Shanta Lall Mulmi

Resource Centre for Primary Health Care (RECPHEC) was part of the movement for establishing democracy, freedom and constitutional rights in Nepal. RECPHEC's main areas of interest are policy advocacy, sensitization and awareness raising activities, consumer rights and consumer movement and information dissemination through publications. With Nepal coming under the umbrella of globalisation,

RECPHEC has been campaigning against the tobacco industry and looking into aspects of globalisation and poor people's health.

Association of Development Agencies in Bangladesh - A B M Shamsul Huda

Association of Development Agencies in Bangladesh (ADAB) is a 900 member organisation started during Bangladesh's struggle for independence. After the participatory strategic planning process, all members endorsed certain programs for ADAB. These include programs to strengthen the democratic institutions in the country, create awareness on the impact of globalisation on women and children and evolve a stable relationship with the government.

Sarvodaya - Dr. Vinya Ariyaratne

Based on the Gandhian ideal of self help and self reliance, Sarvodaya stresses saving and credit programs and community organisation. The challenges they face are operating under conditions of civil war and in the light of globalisation protecting their programs from interference by the World Bank or the Asian Development Bank.

PERDHAKI - Dr. Felix Gunawan

PERDHAKI is the coordinating body of Catholic health organisations in Indonesia. Their programs include primary health care, medicine supply, pastoral care and training of volunteers. They also work towards religous harmony in areas of conflict. During Suharto's dictatorship, the government had a very hostile attitude towards NGOs but now they have opened up and NGOs will change course now.

Responses to the Case Studies

While organisations have changed over time, they have not taken the global changes into consideration. There is a need to balance actionism and activism. NGOs have become service delivery organisations. These policies of NGOs have not changed.

Is VHAI legitimizing government programs by participating in them?

VHAI as a nodal organisation inspite of all its shortcomings has taken up national issues which is a substantial contribution. VHAI took initiative to analyse programs like Tuberculosis. Voluntary agencies must pool their resources.

Working with the government is a dilemma. Some NGOs work with the government because it gives them stability and they feel they can change government policies this way. Taking money from the government makes NGOs accountable to them. Also, NGOs cannot ignore the existence of government. But relationship with the government must be well defined. Development is a political process. Hence NGOs need to have a political stand.

Roles that have Emerged

- Networking is the key factor to effectiveness
- Need for accessing information, interpretation and dissemination. Information to be used for advocacy
- Research role
- Influencing the media and creating public opinion
- Training and capacity building at the macro level

There is a good balance between what roles partners can play and what roles ACHAN can play.

Workshop II

Guide questions

1. Elaborate on the gaps in actions identified in the previous workshop and show how these gaps are to be bridged at the country and Asian level.
2. What will be the role of ACHAN and what is the expectation from ACHAN

Roles For ACHAN

- Counter legislation that affects the health of the poor such as the legislation in India which equates the voluntary sector with the private sector in health delivery
- Promote people's health forums to address local health issues
- Act as a health resource information centre: facilitate data generation, interpretation in the light of globalisation and disemmination of information, documentation of successful health care models

- Conduct research studies on: impact of the South East Asian crisis on the health of the poor, alternative systems of primary health care
- Capacity building through trainings
- Facilitate partnership among members
- Be an advocate among donors
- Act as a health resource information centre
- Work with interested national level NGOs
- Collect case studies of initiatives
- Advocacy role: promote the Asian perspective on health, policy making at the country and Asian level
- Build national alliances at the country level and a regional alliance at the Asian level in order as a mechanism to formalise the arrangement

Action Plan

What is expected of ACHAN -

- Be an aggressive network
- Shared idea of health
- Membership to only those sharing this vision
- Facilitating data generation and dissemination, eg, economic meltdown
- health research information system to mainstream successful alternatives
- Advocacy role among donors - bring them to a common understanding
- Facilitate partnership among members
- Capacity building, including funds for module development
- Network or secretariat for the network - What is the role at the country level and Asian level

Dilemma

- In terms of membership, to what extent do we represent the issues of our membership?
- While the network may have one philosophy, members can have their own concerns which ACHAN cannot address
- There is a need for a common minimum program for the membership and all other programs must comply with the spirit of these
- Pooling together common resources
- Need for a mechanism for coordination at the national and Asian level

Tasks Ahead

- Perspective building for NGOs in the light of globalisation
- Training to create awareness and competence to counter globalisation
- Providing information to different actors to equip them to counter globalisation
- Advocate a single issue
- Involve people's organisations in all actions
- Promote alternatives in health, particularly indigenous knowledge

Asian Master Trainers Workshop
22-24 Jan, '99

Welcome address - Prem John

The role of trainers is crucial to the transformation process. In the light of globalisation, the strategies adopted for trainings and the process itself will have to undergo changes. We hope to arrive at strategies to counter these trends in the course of this workshop

Objectives of the Workshop - Dr. Abigail Tauli

ACHAN has been involved in training for the last ten years. Now after a series of internal evaluations the focus is now on the issue of globalisation. We need to develop strategies to counter the trends that affect the health of the poor.

Expectations

- Develop training perspectives
- Training in the context of globalisation
- Needs assessment for training
- Community based alternative training methodologies
- Evolve action plan for training
- Define role of training in ACHAN as a network
- Discuss ACHAN's role as a support system for training
- Strategy for fund raising.

Strategies for Training

Organisational Strategy

Objectives:

Perspective building at the organisational level with regard to vision, mission and values and at the level of trainers with a view to develop leaders and alliances

To produce leaders and capacitate organisations for informed leadership to lead people's health movement

To develop alliances and networks for people's causes

Process

1. Critical analysis of existing conditions, programs, trends, relations
2. To develop combat strategies
3. To develop alternative paradigm
4. Internalising by the organisation
5. Participatory sensitization sessions
5. Creating conducive environment (need based)
6. Develop modalities for working with concerned people
6. Organisational effectiveness
7. Networking and sharing with other groups for further development
8. Effectivenesss of communities to counter globalisation
9. How to channge donors' perspective, resource mobilisation - internal and external
10. How to develop allies -

1. Inter and intra country - activate existing ones and make new ones
2. Critical study, exploration and policy making
3. Existing and emerging problems
4. Strategic partnership with people's movements
5. Create alliances to make health a public agenda

Workshop I

Content of Training

The contents of the training on globalisation should include the causes of the problems that affect the health of the poor, an indepth analysis of the effects on poor people, measures to counter these effects and alternative paradigms of development.

A Framework for contents of trainings:

To understand global problems, training should focus on

To understand its causes training is needed on

To understand the consequences, training is needed on

To understand the cost of not doing anything

To understand the mechanisms of how these causes result in such consequences and how they are linked to health, training is `needed on Understanding what it will take to counter the effects of globalisation and planning of alternative courses of action to effect needed internal and external changes

The problem

Health care system

Lack of facility

Causes

Indigenous systems destroyed

No food security

Land alienation

Shift to cash crops

Failure of public distribution systems

Drought and degradation of the environment

High cost of medicines

Lack of government priorities

Budget cuts due to structural adjustment programs

Emphasis on urban areas

Effects

No health service to the poor

Untrained health personnel

Example

Outcome : **Malnutrition**

Immediate Outcome: Low food intake
Incidence of preventable diseases
A combination of both

These factors together form a viscious spiral. International donors attacked the problem at this level and distributed food.

Underlying causes:
1. Decreasing household food security
2. Shifting from food crops to cash crops
3. Landlessness
4. Inadequate women and child care
5. Low access and utilization of health services - shortage of essential drugs and poor environmental sanitation

Intervention at this level is necessary but not sufficient

Intermediate cause: Lack of access to education especially for girls

Basic causes:
1. Poor have no control over resources
2. Inequalities in societies
3. Structural adjustment programs
4. Globalisation
5. Human rights violations
6. Oppressive political systems
7. Deteriorating terms of trade
8. Unemployment

For sustainable development, these issues have to be attacked.

Training Strategies

- Discuss forms of a new modified training strategy
- Convert existing training programs into training strategies
- Engage in a sector analysis to identify resources and major issues
- Set tentative objectives and desired outcomes for training
- Critically evaluate your present trainings in the light of globalisation
- Ask how open is your constituency to this new training
- Special needs of network NGOs, support NGOs and service NGOs to carry out new training
- Strategies to face donors is needed - to start countering effects of globalisation

- Put training at the service of advocacy
- Empower trainers to get involved in actions beyond mere training
- Seek links with existing national or local people's movements
- List resources - material, didactic, human, financial - needed for new training
- Share with colleagues the nature of the problems we are trying to address - globalisation and its effects on health
- Explicit training to be for whom to achieve
- Convene a meeting with strategic allies and set priorities
- Develop simple materials on globalisation and its effects
- Seek funds for grassroots training on these issues.
- Set criteria for / selection of participants

  \ impact analysis of our actions
- Identify other complementary strategies needed to achieve goals of better health for the people

What a training strategy assessment entails:

1. What are training objectives?
2. What are components of training strategy?
3. What are training contents?
4. Have training materials been developed?
5. What training methodology has been chosen?
6. Who are the target groups?
7. What is the scale of your training operation?
8. Follow-up of training to study its impact?
9. Have the experiences been documented and shared?

Synthesis:

1. We recognise the current globalisation processes that directly and selectively affect the lives of the poor
   * the lack of adequate mechanisms to counter these processes

2. Therefore, there is a necessity to play a proactive role in:
   * NGO structures and NGO network structures through appropriate training
   * Enlarging the alliances and network among NGOs and strategic partners outside
   * Working and building upon people's movements so that health becomes a people's movement

Strategy for Training

- Training as a strategy
- training as an activity

Contents:
- trainers as doers
- trainers as decision makers
- how to secure a commitment to a new strategy on global issues
- general guidelines for such a strategy
- Recommend if new structures will be needed internal and outside

Workshop III

Training objectives, strategies and content for decision makers, mid level workers and grassroots

Training for Decision Makers

Target: Decision-makers of the organizations/NGOs, managers and directors

Selection criteria: involved in Health and Development (NGOs, People's organization)

Objectives:

To sentisitize decision makers on the effects of "G" on health.

To critically analyze their own organizations in the context of "G"

To enable them to respond to "G" with concrete actions.

Contents:

Concept of Globalization:
-meaning
-players (WB, IMF, WTO, ADB)
-mechanisms
G in the context of the country
-health, economic, agricultural, social-policies
Impact of "G" on the life of the people
Impact of "G" on health

Content include tools for:
Analysis of the objectives, VMGSP and activities
Identification of gaps
Planning for changes
-info access
-networking/communication skills
-advocacy
Resource mobilization
Action plan

Methods:

Three phases: background materials
Lecture discusiion
Brainstorming

Comments:

- The feedback of the decision makers should be incorporated
- There is a need to incorporate case studies
- These training must have follow - ups.

Training for Middle Management

Objectives:

At the end of 6 days, the participants will be able to:

Internalize and articulate the underlying basic causes of malnutrition in relation to "G".

Describe various developmental approaches and models and empowerement processes

Integrate in their respective programs and that projects this new understanding about malnutrition and its causes.

Number of participants: maximum of 20

Training for the Grassroots

Target: Grassroots, the actors in the community

Criteria selection:

analytical capacity
committed to the cause
living in the community
can make decisions/influence
work towards implementation
preference: can read and write

Specific Objectives:

To develop a broader understanding on the causes and effects of ill health and nutritional problems and issues.

Expectation and Commitment at the Country Level:

We are looking for partners who believe in what we believe in. The partners in the country has the time, resources, space and will help convene and work out the inputs from these workshops. They will convene organizations in their country for action. This is a shared objective.

Country Convenors/Facilitators:

India	:	Dr. Arole, CHAI, CINI
Bangladesh	:	GK
Indonesia	:	FKPKMI
Philippines	:	South – IPHC, North - IIRR
Sri Lanka	:	SARVODAYA

Planning at the Convenors Level:

- Have a consultation at the country level
- Convenors will convene partner NGOs or network and follow-up this training
- Have an open line of communications – each organization can have or develop their partners.

Synthesis

What is the cost of not doing anything?

- Increase IMR, morbidity to the levels of 1960's
- Increase malnutrition
- Increase AIDS/TB/STDs
- Increase number of orphans
- Decrease utilization of facilities
- Overloaded hospitals rejecting non-paying patients
- Increase in self-medications, overuse of antibiotics
- Food shortages, riots, looting
- Street violence, gangs
- Increase unemployement
- Increase drug addiction
- Further default in health care financing
- Universalization of fee for service system with full costs
- Increase donor funding, increase donor influence on health policy
- Increase dependency
- Increase homelessness
- Increase mental illness, suicide
- Growing destitution of the elderly
- Break-up family unit
- Increase sex commerce, sex tourism
- Increase pollution, environmental degradation
- Increase fundamentalism
- Increase child labour

And so on and so forth....

But we are not trying to make the people feel guilty. We are asking for commitment for action. NGOs are not the ones who will make the change for this – but the creation of the critical mass. We shall foster unity with them and we want ourselves to be catalysts and validators of these realities. We hope we can be active members or be part of the movement who are the coalescing forces of change.

We started with Training and if this training will make the activist is us, something some changes will surely come up.

ACHAN Advocacy Workshop

25-27 January 1999
Grande Ville Hotel, Bangkok, Thailand

Welcome Address

Prem John gave a warm welcome to the participants of this Advocacy Consultation-Workshop. This is the last of a series of meetings (previous to this were the ACHAN *Strategic Partners Meeting* and the *Asian Master Trainers' Meeting*). He hoped that this will be another productive session bringing in new and bright ideas.

Orientation to the Workshop
Edelina P. de la Paz

The objectives of the Advocacy - Workshop were presented to and agreed upon by the participants. These are the following:

1. Determine advocacy status of partner NGOs
2. Identify needs and gaps in advocacy work
3. Set-up a system of coordination among advocacy partners of ACHAN
4. Develop advocacy agenda at country level and for ACHAN
5. Formulate program of action on advocacy.

Challenges in doing advocacy Work (Speech by **Jaime Galvez-Tan**, Moderator)

Dr. Jimmy Tan related his recent visit to Maripipi, Leyte in the Philippines. This is where he had his post-internship rural health practice in 1975. He found out that after more than two decades, the place almost remained the same: no substantial change has happened in this village. The roads are still narrow, bumpy and dusty. The health center has only one volunteer health worker rendering health services.

He also visited a slum community in Pasay, where he is currently a consultant of an Italian health project. The situation in Pasay has worsened: more crowded housing and an increase in all kinds of pollution (air, noise and water). There are still many community health workers (CHWs) trying to help out. But though accessible, people do

not go to the government health centre because of the long queue, no free medicines and the arrogant personnel.

These are realities which advocates must see in order to be effective as advocates. We must be in constant touch with realities of those we want to advocate for - the ordinary people.

According to him, the challenges that lie ahead for advocates, in pursuing serious advocacy role are the following:

1. **Be constantly in touch with the poor.** To effectively advocate, one must experience life with the poor. This will lead to a better understanding of their conditions and needs.
2. **Our attitude must be bold and daring.** We must not remain silent amidst the sufferings we see.
3. **Be aware of the changing milieu.** There is increasing democratization, devolution and decentralization that we should take advantage of.
4. **Have a working knowledge of society.** There are three major social forces in society affecting change: State, civil society and business. Each one of them interplay with one another. We must be conscious of the dynamism of the three and put into good use such dynamism for the good of the people we advocate for.
5. **Identify new audience in advocacy.** Based on the changing milieu, advocacy for what and whom to target? Policy makers should be greatly considered. As we forge solidarity with the poor, we must inform them to know that others are speaking in their behalf.
6. **Make use of existing technology.** Look for short, quick and effective means of communication to reach the poor. Be creative and innovative. Use the language that is also being used by our target.
7. **Link with the poor.** For performing advocacy role, there is no substitute to linking with the poor who actually feel the brunt of the situation as they face all the sufferings.

Workshop I - Level of Advocacy Work

guide questions

1. Define advocacy
2. What is the status of advocacy work in the context of your country situation?
   - issues addressed
   - target audience
   - actions/activities
   - organizational support
3. What are the problems/constraints that are involved in doing advocacy work

Groupings:

Group I:	Shresta, Hariyato, Phoebe, Saulina, Prakash, Suranjan
Group II:	Sharad, Bala, Arman, Sirimal, Apol, Dat
Group III:	James, Hazel, Gaya, Sita, Vanh, Hang

Synthesis

Definitions of Advocacy

- There are three levels to advocacy:

1. advocates level - organise campaigns, sensitize groups, make a case, mobilize resources, influence the government.
2. People's level - empower the people, collective action, ensuring continuity
3. Macro level - look at global forces.

- Avocacy is the process of taking a stand on an issue, mobilising people and participate in the struggle to help the oppressed
- A process by which those believing in the people's cause, act in a shared leadership to empower the people, to influence the State and other policies on behalf of the people through combined efforts of training, networking, information sharing and sensitization.

Advocacy Status - Country Situation

Nepal

Issues - Human rights, development, globalisation, health policies, ecology, rational drug use, women's health, tobacco, alcohol, illicit drugs.

Target - Policy makers midlevel decision makers, consumers, politicians

Actions - seminars, talk programs, media, publication, alliance building, demonstration

Philippines

Issues - Health, livlihood, education, governance, community managed health care, essential drugs, AIDS

Target - community, people's organisations, policy makers

Actions - Training, demonstration, publication, operation research, seminars

Indonesia

Issues - health, religious harmony, socio-economic development

Actions - internal advocacy within the organisation, training, research, publications, networking.

India

Issues - Ecology, women and child rights, panchayati raj, globalisation, primary health care, AIDS,

Target - people's organisation, trainers, networks, policy makers, communities

Actions - research, training, publications and networking, rallies, dialogue, NGOs

Sri Lanka

Issues - promotion of traditional medicine, globalisation, child rights, rational drug use

Actions - Lobbying, campaigns, marches, training, pickets

Targets - Activists, communities

Vietnam

Issues - health care system, unregulated health practise

Actions - Training, education

Target - Teachers, community

Bangladesh

Issues - formulation of national health policies, reproductive health rights, substance abuse, environmental concerns

Actions - Education, training, rallies, seminars, dialogue with policy makers

Target - policy makers, communities

Sharing of Advocacy Experiences: International Baby Food Action Network (IBFAN)

Sita Letchmi

IBFAN works on the theme: "***Think globally, act locally.***"

History of IBFAN:

1950's-60s	Increase in the promotion of bottle-feeding, many mothers are rejecting breastfeeding
1960s'-70s	Growing public concern, alarming Infant Mortality Rates with 1.5 million deaths attributed to bottle-feeding
early 70's	Public interest peaked, founding members(IBFAN) were whistleblowers, all groups rallied in support. Nestle sued the group because of the campaign title "Baby Killers"
1977	Nestle boycott started, triggered a US Senate Cause Inquiry by Senator Edward Kennedy
1979	WHO and UNICEF International Meeting on Infant and Young Children Feeding, IBFAN was formed
1981	International Code of Marketing Breast-milk Substitutes was adopted by the World Health Assembly
1984	Nestle boycott ended, Nestle publicly announced its agreement to comply with the code

1985	IBFAN started series of Lactation Management Course IBFAN published 1st edition of Health Workers Guide to the Code which is now on its eighth edition Coordinated monitoring, launched publications - Feeding Fiasco, a report from Pakistan about Breaking the Rules, State of the Code which showed companies violating the Code.
1987	IFM formed - granted NGO status, regular meetings with WHA
1988	Second Nestle boycott starts and remains
1999	Innocenti Declaration, by 1995 a National breastfeeding Coordinator was assigned and established breastfeeding committees
1991	WABA was formed to follow-up Innocenti Declaration, Baby Friendly Hospital was initiated by WHO-UNICEF
1992	IBFAN/ICDC, Regional and Annual Code Implementation training for government officials
1996	8th edition of Health Workers Guide with 740,000 copies printed in 71 languages
1998	IBFAN honored by RCA "Alternative Nobel Prize", for its untiring work on the issue and launched its new publication - Guide for Manufacturers
Present	The struggle of 20 years is very much alive and requires constant work and vigilance"

Open Forum

The many lessons we have to keep in mind are:

1. IBFAN has succeeded because of its staying power. The MNCs and milk companies underestimated IBFAN's strength. IBFAN has been threatened, but did not yield. IBFAN is unrelenting. It pushed through with networking and initiated militant activities.
2. The advantage IBFAN has is the emotional connotation which was channeled into a militant political action.

3. With regards to the issue of globalization, the challenge for us is to make the issue as emotional as possible. If the people will really get angry, they will support the issue and channel their anger to militant actions. Then, we can really pin down these MNCs and those in power.

Advocacy is political action. Advocacy should be seen in the context of the country situation. It must be progressive and voice out people's concerns.

Sharing of Advocacy Experiences: Action for Rational Drug Use in Asia (ARDA)
By **Dr. Kumariah Balasubramaniam**

ARDA is an Asian Branch of Health Action International(HAI), founded in 1981. All activists who went to support IBFAN stayed in Geneva and formed HAI. The ultimate goal of advocacy is to change the world from A to B because there is no social justice in A. But the people don't know there's A and you want to go to B. A large number of those affected don't know that they are affected.

In health, one great concern is the pharmaceutical issue. In 1970, in Sri-Lanka, copies of national drug policies were given to various political powers for comments. The Communist Party, which was then in power, made some health policies:

- limit the number of drugs
- use of generic names
- entire drug industry should be under the control of the government

The task was then given to the Ministry of Health and then to the medical establishment which junked the policy saying that this is detrimental to the health of the people. The government set up a drug procurement system run by the Department of Trade. But now, big businesses dictates the development of free enterprise. World bodies such as UNCTAD, UNIDO, WHO, UNDP and UNIPEC formulated pharmaceutical policies for the Third World. UN APED (Action Program for Economic Development) situated in Guyana set up regional pharmaceutical centers all over the world.

In 1986. ARDA was formed and its first meeting in 1987 identified the following tasks and priorities:

- educate people about health
- look at the prescribing practices of doctors, look at the undergraduate curriculum of medical and pharmacy students
- involve policy makers
- do country case studies, e.g., diarrheal diseases, how mothers view the problem, etc.
- have health ministries meeting, also involve students and especially the media in doing advocacy work

Workshop II: Problems, Constraints, Needs and Gaps in Advocacy Work

Guide Questions:

Identify problems, constraints, needs and gaps in carrying out advocacy role.

Synthesis

- Problems /Constraints in Doing Advocacy Work
- Lack of appropriate and timely information
- Rapid turnover of staff, no continuity
- Lack of solidarity and networks
- Beliefs and tradition (culture of silence)
- Advocacy not priority in organizations
- Non-conducive political environment (autocratic government)
- Lack of skills and creativity among advocates (political smartness, politically naive)
- Fake NGOs, infiltration by industry implants
- Donor dominated agenda
- Marginalization of NGOs by government and policy makers (WHO, UN Bodies)
- NGO dynamics (bureaucracy, non-transparency)
- Legal hurdles
- Strength of the opposition/ "enemies" are efficient
- Lack of human power, resources
- Capacity building/skills

1. **Needs**

- Accessibility (management information system)
- Human Resource Management
- Networking, solidarity building
- Continuing conscientization/internalization
- Skills training
- Developing screening criteria (on-going)
- Developing alternative resources

Guide Questions

In the context of globalization,

- What are the priority issues that your organizations should be addressing at the following levels:

a. Local
b. National
c. Pan-Asia

- What concrete participation can your organization provide?
- What do you expect from ACHAN?

Discussion of Advocacy Agenda - Edelena Dela Paz

1. ISSUE:

The effects of "Globalization" on the poor people's health, particularly in Asia

- effects of the economic crisis on the implementation of PHC
- access to quality health care for the poor
- rising prices of health care
- decreased ability to pay
- privatization of health services
- inappropriate modern health technology
- transition to an alternative people-centered development paradigm for health

1. ACTIONS

a. **Local:**

- re-rision and re-mission of NGOs to support integration of Globalization" into the existing programs bearing in mind the basic orientation of the organizations
- do action research

b. **National:**

- continuous advocacy work targeting policy makers, decision makers, academe, general population and media
- lobby work for national policy on alternative health system
- have research info. management and training systems
- national people's forum.

c. **Pan-Asia**

Strengthen network:

- regular and timely exchange of relevant information with ragard to: health situation in each country and impact of "Globalization" health policies other related data
- evolution of an alternative people-centered development paradigm for health
- monitoring/documentation (India - CHAI, development of indigenous knowledge)
- administrative and logistic support to each other
- sponsor regional people's forum (VHSS)
- training support to ACHAN (SARVODAYA)
- continue building alliances

Our Pledge

We hereby pledge as individuals and organizations to unrelentlessly study, expose and publicize the effects of Globalization

on the health of the poor of Asia, in order to actively bring about an alternate concept and reality of a more equitable and people-controlled system of health for all.

We make this pledge ourselves, to each other and to the peoples of our countries in sincerity and the hope of a transformed society in which every man, woman and child counts.

This pledge is based on our most basic values; and we are bound spiritually to execute this pledge to the best of our abilities. May we find strength in our unity of purpose and our deep belief in the power of the human spirit.

Strategic Partners Meeting

19 - 21 January 1999
Grande Ville Hotel, Bangkok, Thailand

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22-24 January, 1999
Grande Ville Hotel, Bangkok, Thailand

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