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MUMBAI DECLARATION
Of the People's Health Movement
Released on the 25th Anniversary of Alma Ata
At the III International Forum for the Defense of the People's Health
Mumbai, India
14-15 January 2004

PREAMBLE: We, the 700 persons from 50 countries, gathered at the III International Forum for the Defense of the People's Health, hereby affirm the People's Health Charter. We celebrate and are inspired by testimonies we have heard in this forum. In the spirit of Health as a Human Right and Comprehensive Primary Health Care, participants have spoken about their actions to confront and change the tragic health reality threatening our lives and the future of our world. As signaled by the Million Signature Campaign, we demand Health for All, NOW.

ANALYSIS of Current Threats and Gains: We, the representatives of the People's Health Movement gathered for the III International Health Forum for the Defense of the People's Health, insist upon recognition of the social and political determinants of health, specifically:

- Health is a basic, fundamental human right. We welcome the pronouncement of the WHO to return to its original constitution and its commitment to the Alma Ata Declaration on Primary Health Care;
- The forces of corporate-led globalisation are violating our human right to health. The impositions on countries of the International Monetary Fund, the World Bank and the World Trade Organisation (through trade agreements such as the Trade Related aspects of Intellectual Property Rights, TRIPS and the General Agreement on Trade in Services, GATS) have contributed significantly to the current global health crisis.
- Privatization of basic needs and resources, from water to electricity to education, including healthcare through so-called Health Sector Reform, is having a highly negative impact on health;
- Poverty is a form of structural violence and is a public health issue;
- Poverty exists in developed countries (including Germany and the USA) as well as developing countries and is a major cause of poor health;
- Malnutrition remains a major killer throughout the developing world, and a problem within marginalized populations of the developed world;
- Poverty reduction strategies, such as those set forth in policy papers such as WHO's "PRSPs" fail to address corruption, gender-bias, and the rise of non-communicable diseases;
- Small farmers, fisherfolk and indigenous peoples are among those who suffer the most from corporate-led globalisation policies;
- War, occupation and militarism are devastating to health;
- Anti-war actions (against the occupation of Iraq and Palestine, against the Wall in Palestine, etc.) are pro-health;

- Currently the WTO often determines global health priorities through trade agreements, while the WHO has historically refrained from involving itself in trade-related health issues;
- The Doha Agreement of the WTO expressed the will of the world's countries to be able to put the health of their people as a higher priority than trade agreements. However, soon after its inception, the Doha agreement began to suffer multiple ongoing efforts to weaken health as a priority. The Doha Agreement has yet to be implemented;
- Tobacco kills, and yet transnational tobacco companies continue to directly target youth and marginalized in their tobacco marketing strategies, especially in the developing world and the inner-cities of the developed world;
- Liberation Medicine is the conscious, conscientious use of health to promote social justice and human dignity. Paradoxically, doctors and other health professionals often obstruct efforts toward comprehensive primary health care. Optimal health promotion emphasizes child-happiness and inclusive respect for elders and traditions;
- Public-private partnerships represent an insidious form of privatization that removes responsibility for health from the public sector, while treating health as a commodity rather than a human right. The WHO's initiatives on public-private partnerships lack transparency and public accountability;
- The Basic Human Needs Approach, as practiced in Iran through Health Houses and "Well-Being Promoters," represents an exemplary form of comprehensive primary care;
- Selective and vertical health programs have corrupted and weakened the concept of comprehensive primary health care as defined in the Alma Ata Declaration. They do not take into account the expressed needs and priorities of the community;
- Structural Adjustment Programs, SAPS, have adversely affected public sector services, especially health;
- Multi-disciplinary Health Teams are very effective in the practice of comprehensive primary health care;
- Community Health Workers, chosen by their own communities and given adequate training, back-up and referral mechanisms, have proven to be excellent at providing comprehensive primary health care;
- Health professionals educated in the developing world and migrating to the developed world represent a transfer of billions of dollars South to North, due to the investment in training. Their departure further burdens health systems already suffering from a precarious lack of human resources. This so called "brain drain" is not only from developing countries to developed countries, but also exists within developing countries from the public to the private sector;
- There is gross inadequacy of medical education on subjects such as gender, ethics, comprehensive primary health care, and the realities of poor and marginalized;
- Traditional and Alternative Systems of Medicine are a vibrant part of Comprehensive Primary Health Care.
- Traditional birth attendants form the first and often the only access to reproductive health in many areas of the world. They and their knowledge and traditions should be validated and their skills reinforced with continuing education, including women's

rights and prenatal care. They should also be provided with materials to do their jobs and given adequate back-up for difficult and emergency cases.

- HIV/AIDS is spreading along the routes of migration and linked to the influx of capital related to globalization. HIV/AIDS is Africa's major health emergency. HIV/AIDS has been associated with the resurgence of other communicable diseases, such as tuberculosis. Millions of children, especially in Africa, have been orphaned by HIV/AIDS, representing a major public health problem. Women are the most affected culturally, socially and economically by the HIV/AIDS epidemic;
- HIV/AIDS in Latin America and the Caribbean, in an ambiance of machismo attitudes toward women's rights and taboo around speaking of same-sex coupling, is a ticking bomb. The window of opportunity for education and enlightened policy to prevent a major Latin American epidemic is closing if not already shut;
- Shaming of the pharmaceutical companies into dropping legal action against the South African government around anti-retroviral medications is a victory for Health as a Human Right.
- The WHO has made an official commitment to pursue its 3 X 5 (three million persons with AIDS receiving ARV treatment by the year 2005) through comprehensive primary health care. However, providing access to ARV's remains a complex and very difficult process requiring a stepwise approach. We are concerned that the 3 by 5 initiative address the following challenges:
  - A focus on treatment alone, can ignore the complexity of the epidemic
  - High costs and long-term dependency on donors
  - Inadequate involvement of NGOs and the patients themselves in planning and implementation
  - Failure to address the need for improved infrastructure to provide drugs and general health services.
- We emphasise that ARVs must be delivered through a comprehensive primary heath care model. Programs to address the HIV/AIDS epidemic require contextual solutions emphasising availability and effectiveness of drugs, and availability, effectiveness and efficiency of basic services, especially in areas where people continue to die of malaria and tuberculosis;
- Violence against women is a major public health issue;
- Past population policies have involved such reprehensible practices as forced sterilization of women. Population control policies including the use of disincentives violate human rights. Newer contraceptives and reproductive technologies often ignore women's health hazards, and ethical and moral issues, in their practice;
- Many women around the world lack access to basic health care, endangering them and their families. Women's right to health, including sexual and reproductive health, is violated not only by current socio-economic and political structures but also by religious and cultural fundamentalism;
- Trafficking of women and girls is a major public health problem, little addressed by governments where the trafficking is most rampant;
- Technology is misused to discriminate women as seen in sex selective abortion;
- Rights of sexual minorities, sex-workers and the mentally challenged and their access to health care are not being addressed adequately;

- The caste system and its vestiges in India have brought an atrocious health and human rights reality for the Dalit;
- Indigenous peoples around the world, including those who live within developed countries, suffer terribly poor health indices, often double or more those of the general population of the country in which they reside. Further, they are loosing their traditional knowledge and traditional systems of medicine. They are forced to follow the hegemonic cultural system;
- The health and other human rights of persons with disabilities are currently ignored or inadequately addressed throughout the world. Yet we are encouraged by the example of Palestine, where many persons with disabilities have organized to defend and promote their own health and human rights;
- Migrant workers around the world, including those living and working within the developed world, suffer poorer health indices than the general population. Migrants are deprived of their rights in both countries of origin and destination as they lack access to basic services such as health, education, etc. and suffer other violations of their human rights;
- Discrimination against children in difficult circumstances, such as the street children, increases with the rising poverty associated with globalization;
- Children in difficult circumstances dream of being self-reliant and of having livelihoods in the future;
- The health of all children and youth should be guarded carefully, with strategies emphasizing their happiness, celebrating their cultural traditions and including the prevention of disease;
- Privatisation of social sector services which should have continued under state responsibility also leads to uncontrolled accumulation of private wealth at the expense of people's health. Privatisation of health care services leads to weakening of health systems and resurgence of diseases. User fees further decrease people's access to health care services;
- Monitoring efficiency of health systems has become the essence of health sector reforms without considering issues of efficacy, effectiveness and equity;
- Mental health problems often result in stigma. The links between mental health problems, poverty, gender and human rights issues are not being properly addressed;
- Environment, livelihood, and people's health are interconnected;
- Environmental degradation and loss of livelihoods have a highly negative impact on health;
- Rivers around the world, like the Abra in the Philippines, like the Narmada in India, are in danger of being destroyed, as are lives and health of those persons and communities who depend on these rivers;
- Toxins, in the form of pesticides, fertilizers, defoliants (such as Agent Orange and those used in the Amazon as part of the so-called "Anti-Drug" war of Plan Colombia), waste from US Military Bases (such as those in the Philippines), dust from exploded depleted uranium ordinance (such as that used in Iraq and Vieques, Puerto Rico) and medical and nuclear waste as well as mining run-off and exploitation for petroleum are poisoning our environment and represent a critical hazard to the health of our lives and communities throughout the world;

CHALLENGES: We, representatives of the People's Health Movement gathered for the III International Health Forum for the Defense of the People's Health, call on:

Civil society to:

- Build solidarity to fight globalisation;
- Establish peace initiatives at various levels based on justice and equality;
- Take the anti-war forward with innovative actions such as:
  - The global campaign on "No to War, No to WTO, Fight for People's Health;
  - Setting up a global "Occupation Watch" to monitor the impact of war, occupation, militarization and conflicts;
  - "Boycott Bush" campaign targeting multinationals which benefited from the Iraq invasion, industries (i.e. pharmaceutical and food companies) that enrich themselves while contributing to ill-health;
- Support and promote campaigns on women's access to health care;
- Address the negative impact on women of current practices of polygamy;
- Campaign on No To Intellectual Property Rights (IPR), including medicines and seeds, which are our life and our future;
- Include Liberation Medicine in health professional education (emphasizing a value-based, holistic and multi-disciplinary approach) and practice (liberating ourselves from oppressive concepts and accompanying others in their own liberation);
- Doctors and other health professionals must be encouraged to be part of, rather than to obstruct, the struggle for health and social justice;
- Work towards Health for All Now, joining the Million Signature Campaign for Health as a Human Right;.
- Stop tobacco companies from targeting youth and minorities;
- Struggle to strengthen the concept that the health of the people is a higher priority than trade agreements;
- Pressure the World Bank and the International Monetary Fund to acknowledge their culpability in the current health care crisis, especially the damage caused by Structural Adjustment Programs (SAPs);
- Incorporate Comprehensive Primary Health Care promotion into the curriculum of all health professionals;
- Preserve health-related traditions, while preventing the patent-right robbery of health-related traditional medicines by pharmaceutical corporations;
- Demand for representation of people's organisations in policy-making processes such as the FCTC;
- Resist the efforts of the WTO and transnational corporations to own and trade in our traditional systems of medicine and to own and patent our seeds;
- Develop and strengthen efforts by communities to collect data on:
  - Processes of organizing and mobilizing media campaigns, advocacy for legal avenues and pressure for policy reforms
  - Monitoring environmental damages caused by local and transnational industries, such as pesticides, toxic waste products from military bases, etc.;

- Hold corporations and governments accountable for the damage they have done to the environment.
- Develop a comprehensive approach to address the HIV/AIDS epidemic by having a range of interventions, including:
  - promote peer education
  - decrease the stigma against people living with HIV/AIDS
  - increase access to basic services by people living with HIV/AIDS
  - make ARV drugs available now
  - rebuild the lives of those affected by the epidemic by strengthening and empowering them;
- Pressure media to play a more positive role in the promotion of good health;
- Promote access to essential drugs in various ways, including public pressure on individual governments as well as inter-governmental bodies such as the UN and the WTO.

Governments to:

- Incorporate and ensure women's access to health care in national health policies and programmes;
- Address health needs and rights of women who are victims of trafficking, especially in destination countries;
- Include sex-ratio at birth, infant mortality rate and gender differential as basic indicators of development;
- Have a national policy on traditional medical systems and include them in national health programmes;
- Regulate the corporate sector in the social services such as health, education, transportation, etc.;
- Involve the marginalised sectors in decision making regarding policies affecting them;
- Respect the people's right to ownership of natural resources;
- Strengthen health care systems to respond to health care needs
  -no to cost recovery
  -no to privatization
  -yes to solutions addressing the internal/external brain drain of health professionals and health care workers
  -yes to having a national policy on traditional medical systems and including them in national health programs;
- Include sexual and reproductive rights into all Primary Health Care Initiatives;
- Sign, ratify and implement the Framework Convention on Tobacco Control (FCTC);
- Desist if present coercive, women's-rights-unfriendly policies for population control
- Strengthen and expand community-based primary care programs.

The People's Health Movement to:

- Recognise and include in the People's Health Charter challenges and new developments;
- Include the following issues in the People's Health Charter:

- Ecological/environmental health
- Traditional medicines
- Rights of the disabled and of marginalized groups
- Tobacco control
  - ➢ Expose, shame and stop government officials, academic institutions, and civil society organisations from accepting money from the tobacco industry
  - ➢ Be vigilant over the tobacco industry's tactics to undermine public interest initiatives internationally and nationally
  - ➢ Regulate the tobacco product and the tobacco industry
  - ➢ Demand from governments to allocate resources for tobacco control
  - ➢ Include tobacco control in Primary Health Care programs
  - ➢ Demand for governments to ratify and implement the Framework Convention on Tobacco Control (FCTC)
  - ➢ Demand for active participation of people's organisations, health workers, farmers in the implementation of the FCTC

- Address gender inequities in all advocacy efforts for Health for All;
- Analyse the disease burden related to industrialisation;
- Resist "TRIPS-plus" through bilateral or regional agreements driven by the United States government;
- Link with other civil society organisations working on environmental justice at the grassroots, national and international levels. Join them in their struggles and invite them to join in our struggle for the People's Health;
- Consciously incorporate marginalized populations, the "unheard and unseen" groups, into the People's Health Movement and build a strong network with them facilitating their access to mainstream discourse.

CONCLUSION: Another World, which includes Health for All, is Possible. We must all join in the struggle to make that world of Health for All a reality, Now.

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PROGRAMME

Date/ Time/ Session	Programme
DAY ONE (IHF) **14th January 2004** **9.00 – 11.00** **Inaugural Plenary** **Part I**	**Overview on Confronting the Challenge of Globalisation through Health Work: Perspective, Struggles and Strategies** **Chair:** Zafrullah Chowdhury (Bangladesh) **Moderator:** Sarojini (India) 1) Opening with Campaign Songs (10 mins) 2) Welcome and Introduction – Amit Sengupta (India) (15 mins) 3) Two Keynote Presentations (60 mins) a) Globalization – A Macro Perspective - Walden Bello (Philippines) b) Linkages between Globalization and Health - David Legge (Australia) 4) Brief Overview of People's Health Movement and the Main Challenges before it in Response to the Threat of Globalization – Ravi Narayan (India) (15 mins) 5) Interactions from the floor
11.00 – 11.30	**Break**
14th January 2004 **11.30 – 13.30** **Inaugural Plenary** **Part II**	**Chair:** N. H. Antia, PHM (India) **Moderator:** Maria H. Zuniga, PHM /IPHC (Nicaragua) 1) Panel: Regional Challenges, Struggles and Role of PHM (75 mins) a) Asia – Edelina De La Paz (Phillipines) b) Africa - Mwajuma Masaiganah (Tanzania) c) Americas- Arturo Quizhpe (Ecuador) d) Europe – Pamela Margaret Zinkin (UK) e) India – Abhay Shukla (India) 2) Some brief Country Case Studies (30 mins) a. PHM Italy b. PHM Bangladesh c. Others 3) Interactions from the floor
13.30 – 14.30	**Lunch**
14.30 – 16.30	**Parallel Plenaries**
14th January 2004 **14.30 – 16.30** **Parallel Plenary 1A**	**A) Globalisation, Health Policies and Health Sector Reforms** **Chair:** **Moderator:** Sundararaman (India) 1) Testimonies: a) Privatisation and Healthcare – Evelyne Hong (Malaysia) b) Poverty and Health in USA –Tara Colon/ Jen Cox, KWRU (USA) c) Privatisation of Electricity: Impact on the Health of the Poor in Industrialised Countries – Fran Baum (Australia) 2) Keynote – a) "A World without World Bank and IMF – The Cuban experience of Health for All " – Aleida Guevara March (Cuba)

	b) Globalisation and Health – Issues and Alternatives – Antonio Tujan (Philippines) 3) Round Table – Globalisation and Health Imrana Qadeer (India) David Sanders (South Africa) Tissa Vitarana (Sri Lanka) Julie Ancian, MDM – GATS and access to health 4) Interactions from the floor
14th January 2004 **14.30 - 16.30** **Parallel Plenary 1B**	**B) <u>Health under War, Occupation and Militarization</u>** **Chair:** Babu Matthew, NLSIU / NAPM (India) **Moderators:** Unnikrishnan (India) / Ghassan Hamdan (Palestine) 1) Welcome, Introduction 2) Key note address: Edgar Isch Lopez (Ecuador) 3) Voices from the field: a) Palestine – Jihad Mashal b) Gujarat – Renu Khanna (India) c) Vietnam: Impact of agent Orange d) Iraq – Hanna Edwards e) Iraq – Clara Kim (South Korea) f) Afghanistan g) Mindanao – Reginald Pamugas (Philippines) h) Africa – Malachi Opule Orondo (Kenya) i) The Cambodian experience – Chiv Bunthy, CHC (Cambodia) 4) Interactions from the floor
16.30 – 17.00	**Break**
17.00 – 19.00	**Parallel Workshops**
14th January 2004 **17.00 – 19.00** **Parallel Workshop 1**	**<u>Globalisation and Health Policy</u>** **Chair:** **Moderator:** Anant Phadke (India) 1) Testimonies a. Gleevec campaign against Novartis – Clara Kim (South Korea) b. National Trust fund for Health and Community Mobilisation for Health For All – Jagdish Goburdhan / Ita Sohan (Mauritius) c. Trade Union campaign on Right to Health Care – Nicola Delussu (Italy) 2) Panelists: a. Securing the Right to Health – Julio Monsalvo (Argentina) b. WHO or WTO – who determines global health priorities?– Armando de Negri Filho (Brazil) c. TRIPS and Access to Essential Medicines- Olivier Brouant, MSF (India/ Belgium) d. Global Equity Gauge Alliance – Alexandra Bambas (GEGA) 3) Interactions from the floor
14th January 2004 **17.00 – 19.00**	**<u>Promoting Synergy: Towards joint Anti – war action</u>** **Chair:**

Parallel Workshop 2	**Moderators:** Unnikrishnan (India) / Ghassan Hamdan (Palestine) 1) Keynote: Bert Belder (Belgium) 2) Voices from the field: a) Stop the War Coalition UK b) Resistance in Palestine c) Anti War effort in South Asia – Sandeep Pandey (India) d) No money for War: Boycott Bush campaign – Pol d' Huyvetter, Mother Earth (Belgium) e) Sri Lanka Peace Initiative – Vinya Ariyaratne (Sarvodaya, Sri Lanka) f) Global SOS from a coalition of San Fransisco Bay Area Anti-War Groups – Jeff Conant (USA) 3) International Resistance and Local Actions – ILPS, Philippines 4) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 3**	**Learning from the Global Tobacco Control Campaign – including FCTC** **Chair:** Surendra Shastri (India) **Moderators:** Carmelita C. Canila (Philippines) & Shoba John (India) 1) Testimonies: a) Community in Health Promotion – Sehra Sajjadi (Iran) b) Youth in Tobacco Control Campaign – Bobby Ramakant (India) c) Fighting Transnational Tobacco Companies – Olufemi Akinbode (Nigeria) d) The Canadian Way to Innovative Tobacco Control Policies – Atul Kapur (Canada) 2) Round Table (FCA / PATH Canada / PHM and AFTC): a) Relevance of Tobacco Control within the context of Social Development – Prakash Gupta (India) b) FCTC – An international and legal perspective – Patricia Lambert (South Africa) c) FCTC –Entitlements and Lessons – Shoba John (India) d) People's Health Charter & Tobacco Control – Carmelita C. Canila (Philippines) 3) Interactions from the floor 4) Suggestions for the People's Health Charter
14th January 2004 **17.00 – 19.00** **Parallel Workshop 4**	**Liberation Medicine - Bringing together experiences of the conscious, conscientious use of health to promote social justice and human dignity** **Chair:** Fr. John Vattamattom **Moderator:** Lanny Smith 1) Panelists include: Sayeh Dashti (Iran), Roland Bani (Albania), Chris Fritsch (US) and Medico Friends Circle (India) 2) Interactions from the floor
14th January 2004 **17.00 – 19.00**	**Globalisation and Health Sector Reforms** **Chair:** Tej Walia, WHO SEARO **Moderators:** Ravi Duggal (India)

Parallel Workshop 5	1) Testimonies: a) Privatisation and Health – Eleanor A. Jara (Philippines) b) A grassroots perspective – GK Health Worker (Bangladesh) c) Insurance and Healthcare – Santanu Bhattacharjee and team, BRWS (India) 2) Panelists: a) Barriers to accessing health care in Africa - Harry Jeene (Kenya) b) Public Private Interactions and Implications – Jose Utrera (Netherlands) c) The SACHS report: Increasing the size of the crumbs from the rich man's table – Allison Katz (PHM Geneva) by Maria Zuniga (Nicaragua) d) Health Policy Reform for "Health for All"- Basic Human Needs Approach (Iran) – Md. Ali Barzgar 3) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 6**	**Health Teams for 'Health for All' (including CHWs)** **Chair:** Qasem Chowdhury, Gono Biswbidyalay, Bangladesh **Moderator:** Prem John, ACHAN (India) 1) Testimonies: a) CHW's in Albania – Roland Bani (Albania) b) Nurses and Migration – Edelina P. de la Paz (Philippines) c) The Great Brain Robbery – Vikram Patel (India) d) CHW experience in Palestine (Palestine) 2) Panelists: a) CHW's an overview – Shyam Ashtekar (India) b) Health teams for HFA – R.K. Boodhun (Mauritius) c) Engendering Medical Education – Mira Shiva (India) d) Health teams for HFA- Fran Baum (Australia) 3) Interactions from the floor
14th January 2004 **17.00 – 19.00** **Parallel Workshop 7**	**Traditional / Alternative Systems of Medicine and Primary Health Care** **Chair:** Zafrullah Chowdhury, PHM (Bangladesh) **Moderator:** Vijayan, GK (Bangladesh) 1) Testimonies: a) Perspective of a TBA from Rajasthan – CHETNA (India) b) Parinchay Health Worker, FRCH (India) 2) Panelists: a) Integrating ASMs for Primary Health Care – The GK experience – Vijayan, GK (Bangladesh) b) Revitalisation of local health traditions – Darshan Shankar, FRLHT(India) c) Training of TBAs – Smita Bajpai, CHETNA (India) d) Integrated health policy including TSM – D. Bauhadoor (Mauritius) e) Promoting herbal medicines and ASMs – Fr. Sebastian, CHAI (India) f) Integrating ASMs: The GBB course – Vinod, GK (Bangladesh) 3) Responses from other countries – Niranjan Udumalagala (Sri Lanka), Hugo Icu Peren (Guatemala) and others 4) Interactions from the floor 5) Suggestions for the People's Health Charter
19.00 –19.15	**Break**

19.15 – 20.15	**Cultural Programme**
15th January 2004	**DAY TWO**
8.00 – 9.00	**Interaction/ Fellowship**
15th January 2004 **09.00 – 11.00** **Plenary 2**	**HIV/AIDS: Confronting the Crisis** **Chair:** Olle Nordberg (Sweden) **Moderators:** Thelma Narayan (India) 1) Testimonies and Regional Reflections a) Ida Makuka (Zambia) b) Chiranuch Premchaipon (Thailand) c) Oblesh (India) d) Richard Stern, Agua Buena Human Rights Association (Costa Rica) 2) Panelists a) HIV/ AIDS: Africa's Health Emergency- Malach Orondo (Kenya) b) HIV/ AIDS and Access to Drugs – Lawan Sarovat – MSF (Thailand) c) Health Systems approach to the AIDS challenge – David Sanders, EQUINET/IPHC (South Africa) d) HIV/ AIDS & resurgence of communicable disease- T. Sundararaman, JSA (India) e) WHO: Evolving Strategy and Overview of 3 X 5 Initiative– Craig McClure / Ian Grubb (WHO) 3) Interactions from the floor
11.00 – 11.30	**Break**
15th January 2004 **11.30 – 13.30** **Parallel Plenary 3 A**	**Women, Population policies and Violence** **Chair:** Mwajuma S. Masiagana (Tanzania) **Moderator:** Mira Shiva (India) 1) Testimonies a) Population Policies of M.P. – SAMA (India) b) Population Policies of Rajasthan – Narendra Gupta - (India) 2) Keynote Presentations a) Population Policies: Mohan Rao (India) b) Violence against women as a Public Health issue – Manisha Gupte.(India) 3) Round Table 1) Farida Akhtar (Bangladesh) 2) Nadia (Netherlands) 3) Other country representatives 4) Interactions from the floor
15th January 2004 **11.30 --13.30** **Parallel Plenary 3 B** **(Access)**	**Health Care and the Marginalised** **Chair:** Medha Patkar, NAPM (India) **Moderator:** Enrico Pupulin, AIFO / PHM (Italy) 1) Testimonies a) Adivasis and Health – C. R. Bijoy (India) 2) Panelists: a) Dalit issues and Health - Ruth Manorama (India)

	b) Health of indigenous people- Hugo Icu Peren (Guatemala) c) Health and people with disabilities -Anita Ghai (India) d) Health care of indigenous people – Fran Baum (Australia) e) Health care of migrant workers – Sajida Ally (Asian Migrants Organisation) 3) Interactions from the Floor
13.30 – 14.30:	**Lunch**
15th January 2004 14.30 – 16.30 Parallel Workshop 8	**Key Issues in Women's Health** **Chair:** Farida Akhtar (Bangladesh) **Moderator:** Jaya Velankar (India) 1) Testimonies a) Mary Sandasi (Zimbabwe) b) Elvire Beleoken (Cameroon) 2) Panelists a) Women's Access to Health Care – Nadia (Netherlands) b) Reproductive Technologies: Mayhem on women's bodies–Sarojini / Manjeer, SAMA (India) c) Trafficking, migration & labour rights – Ishrat Shamim (Bangladesh) d) Sex Selective Abortion – Pavalam and others, CASSA, T.N. (India) 3) Interactions from the floor 4) Suggestions for the People's Health Charter
15th January 2004 14.30 – 16.30 Parallel Workshop 9	**Voices of the Unheard – Children, adolescents and people with disability** **Chair :** Pam Zinkin (UK) **Moderator:** ~~Vandana Prasad (India)~~ Hari Sarap. 1) Testimonies a) Children's dreams through paintings and testimonies by Radio – Child to child Arturo Peralta Quizhpe (Ecuador) b) Mama Huaca– Dibujos Animados (Latin America) – Video c) Disability Movement in Palestine – (Palestine) 2) Panelists: ~~a) CBR-Disability and Primary Health Care – Enrico Pupulin (Italy)~~ b) Youth and Healthy Living – Ghassan Issa (Palestine) c Child Health - Key Issues (PHM Srilanka) 3) Interactions from the floor
15th January 2004 14.30 – 16.30 Parallel Workshop 10	**HIV/AIDS and the Resurgence of Communicable Diseases** **Chair :** David Sanders, IPHC, PHM (South Africa) **Moderator:** Andreas Wulf, Medico International (Germany) 1) Testimonies: a) HIV/ AIDS and Orphans – Jennifer Atieno (Kenya) b) Perspectives of PLWA – CHIN (India) 2) HIV/ AIDS in Latin America and the Caribbean – Rebeca Zuniga (Central America) 3) Panelists: a) HIV/AIDS: Confronting the Crisis - WHO Team b) Access to ARVs – Some issues – Vivek Diwan, HIV / AIDS Unit, Lawyers

	Collective (India) c) Lessons for HIV / AIDS from MCH, TB and Malaria programmes – Rajarathnam Abel, CHIN (India) 4) Interactions from the floor particularly focused on civil society feedback on the WHO proposed initiatives
15th January 2004 **14.30 – 16.30** **Parallel Workshop 11**	**<u>Globalisation, Poverty, Hunger and Health</u>** **Chair:** Thomas Kocherry, World Forum of Fisherpeople, (India) **Moderator:** Abhay Shukla, (India) 1) Testimonies: a) Poverty in Germany: Gopal Dabade, BUKO Pharma – Kampagne b) Tackling Malnutrition: Arogya Iyakkam – Shanti, JSA Tamil Nadu (India) 2) Panelists: a) Veena Shatrugna (India) b) P. Sainath (India) c) Eugenio Villar (Peru) / Alaka Singh (WHO) d) PRSP and Health – Atiur Rehman (Bangladesh) 3) Interactions from the floor
15th January 2004 **14.30 – 17.00** **Parallel Workshop 12**	**<u>New Economics and its Impact on Medical Practice in India</u>** **Chair:** Sunil Pandya (India) **Co-Chair:** R. K. Anand (India) **Moderator:** Sanjay Nagral (India) 1) Testimony: a) Lessons from my crusade – P.C. Singhi (India) 2) Panelists: a) Collapse of Public Health and rise of private medicine-B. Ekbal (India) b) New players in the medical market – Ravi Duggal (India) c) Struggle for regulation of private sector –Arun Bal (India) d) Market, medicine, negligence and ethics – Sanjay Nagral (India) 3) Responses from around the world – Pakistan, Bangladesh, Philippines, Iran, UK, Germany, Egypt, South Africa and others 4) Interactions from the floor
15th January 2004 **14.30 – 16.30** **Parallel Workshop 13**	**<u>Social determinants of Mental Health and PHM</u>** "Exploring Poverty, Gender, Stigma, Globalisation and Human Rights issues in Mental Health – Linking them to the People's Charter for Health" **Chair:** **Moderators:** Vikram Patel (India) & Bhargavi Daver (India) 1) Panelists: a) Mani Kalliath – Basic Needs (India) b) Sehra Sajjadi – Iran c) Other country representatives 2) Interactions from the floor 3) Suggestions for the People's Health Charter

15th January 2004 **14.30 – 16.30** **Parallel Workshops 14**	**Environmental Justice and People's Health – Confronting Toxics in our Communities** **Chair :** **Moderators:** Jeff Conant, Hesperian (USA) & Sarah Shannon (USA) 1) Testimonies a) Save the Abra River Movement - Ana Leung (Philippines) b) Eloor Community Study – Bidan Chandra Singh, Sanjiv Gopal, Greenpeace (India) c) Arsenic poisoning in water – Hilal Uddin (Bangladesh) 2) Panelists: a) Environmental Justice in South Africa – Ferrial Adam (South Africa) b) Mining and Human Rights Abuse – Sofia Bordanave (Argentina) c) Citizen's Action for Pesticides Elimination – Jayan, CHESS (India) d) Health Impacts of Oil impact in the Amazon Rain Forests - Edgar Isch Lopez (Ecuador) e) Action on Medical Waste – Deepika D'Souza, Mumbai Medwaste Action Network (India) 3) Interactions from the floor 4) Suggestions for the People's Health Charter
16.30 –17.00	**Break**
15th January 2004 **17.00 – 19.00** **Closing Plenary**	**Reviving the Spirit of Alma Ata... the challenges before us** **Chair :** D. Banerjee (India) **Moderator:** Pam Zinkin (UK) 1) Short inputs from six plenaries and fourteen workshops– from different regions – to lead to the Mumbai Declaration 2) Additional responses from the floor 3) Releases a) Charters in different languages, b) Language editions of the Million Signature Campaign website c) Some Alma Ata Anniversary publications 4) An overview – B. Ekbal, Convener PHM India 5) Concluding Remarks 6) Campaign Songs

Programme updated as of 8th January 2004. Some of the speakers in the above programme are yet to be confirmed. The programme schedule may be subject to some modifications, additions, and deletions.

Main identity

Com H-79.

From: <thanal@md4.vsnl.net.in>
To: "PHM-Secretariat(Global)" <secretariat@phmovement.org>; <ananth@dialb.greenpeace.org>; "Kavitha Kuruganti" <kavitha_kuruganti@yahoo.com>; "'Jayan'" <thanal@vsnl.com>; "Manu Gopalan" <mgopalan@dialb.greenpeace.org>; "Centre for Resource Education" <creind@hd2.dot.net.in>; "Nityanand Jayaraman" <nity68@vsnl.com>; "Madhumita Dutta" <mdutta@vsnl.net>; <Bharatich@hotmail.com>
Cc: <pss@narmada.net.in>; "Michael Mazgaonkar" <mozda@softhome.net>; <rajanpatil@yahoo.com>; <ejl@vsnl.net>; <tlchennai@vsnl.net>; <dcc_damodarp@yahoo.com>; <sochara@vsnl.com>; <cag@xlweb.com>; <fordisha@cal2.vsnl.net.in>; <nidhi@cseindia.org>; <umendradutt@rediffmail.com>; <shai.yashwant@dialb.gl3>; <ruchita@toxicslink.org>; <deepikadsouza@hotmail.com>; <sambavna@sancharnet.in>
Sent: Monday, January 26, 2004 3:48 PM
Attach: Presentation of the CAPE.doc
Subject: Presentation of CAPE at IHF, Mumbai

Dear all,

Attached is the presentation of CAPE in the panel at the International Helath Forum on 15th January 2004 at Mumbai. CAPE got an oppurtunity to present at the parallel workshop on Environmental Health and Justice moderated by the Hesperian Foundation.

For the CAPE-Secretariat (c/o Thanal)
sridhar

The following section of this message contains a file attachment prepared for transmission using the Internet MIME message format. If you are using Pegasus Mail, or any other MIME-compliant system, you should be able to save it or view it from within your mailer. If you cannot, please ask your system administrator for assistance.

---- File information ----------
File: Presentation of the CAPE.doc
Date: 26 Jan 2004, 15:06
Size: 33792 bytes.
Type: Unknown

Presentation of the
CAPE – Position, Intentions and Direction
at the Parallel Workshop on Environmental Health and Justice
at the International Health Forum on the 15th January 2004, Mumbai.

Pesticides and its impact on the system have become too ominous and threatening and yet little considered when matters of health and environment are discussed. In the last two or three years we have seen that many communities all over the country have realised that they have been enslaved by pesticide use and driven to suicides or have been living contaminated lives and our children and grandchildren are being affected.

The Endosulfan affected villagers in Kasaragod came together under the banner of the Endosulfan Spray Protest Action Committee (ESPAC) and together with Thanal have fought the pesticide and the government sponsoring the pesticide and the industry as well. The villagers of Warangal have reported heavy death tolls due to pesticide use, especially in cotton farms and led by Sarvodaya and Centre for Resource Education (CRE) have done a fact finding mission and released the book "The Killing Fields" with the support of other organisations like Toxics Link, Community Health Cell. Groups from Punjab, Maharashtra and Gujarat have also been fighting Pesticide poisoning issues. There has been substantial work done by the Centre for Science and Environment in NewDelhi by supporting this community needs as well as hitting out hard at the pesticide contamination in drinking water and beverages.

Even while the food safety, the life of the villages and the future of soil and water in the country is being affected, possibly irreversibly, as evidence points out, it is quite an irony that the health planning or even studies to that effect do not consider pesticides and its impact – both short and long term and subtle - as a factor of importance. Here we feel that a realistic and better understanding of the impact of pesticides on the health of the public and the environment need to be researched as well as considered in both planning and implementation.

We understand that "Self Reliance in Food" is a glorified campaign – a campaign that enslaved the farmers into technology, chemicals and hybrid seeds that failed the farmer and eventually led to suicides. And there has been no study, no facts that prove that chemical input – especially pesticide has helped increase food production. Ironically, in India, more that 50% of the pesticides are used only in one crop – Cotton – which is not a food crop. Officials of the IRRI and the FAO have no qualms in revealing that pesticides have not helped increase food production. So, we need to question the hype and look at the whole fashion of "Food Security" from the Sovereignty and the Safety angle. Food Sovereignty is a fundamental issue and cannot be achieved with policies that make more and more farmers slaves of MNC's and Pesticide Corporates. Food Safety (from chemicals and manipulated seeds) cannot also be achieved by continuing the policy of poison production and use.

We also need to ask a number of questions and answer them with hard, researched facts – questions such as who benefited from the fifty years of chemical agriculture? – the country, the farmers or the big corporate pesticide companies ? We also need to find and expose what the pesticide companies have inflicted on the workers, the nearby communities and the farmers communities. We need to come together in fighting the pesticide industry all the more strongly because today the pesticide manufacturers are threatening people who have complained against pesticide use with legal measures. We have been able to fight back these threats but the industry and the agriculture scientists in unholy liaison with them cannot be allowed to continue poisoning people and the environment.

The Endosulfan Tragedy has shown clearly that the Government of India – its agriculture Ministry has built itself a big wall against the people's voices and put its army of agriculture experts – officials of the Department and scientists of the ICAR – on this side to protect the wall. This army has repeatedly lied to the people. Even when health studies clearly pointed to the effects of Endosulfan, the

Government asked the agric-scientists to review the health reports and they candidly liasoned with the pesticide industry to sabotage the findings. Finally the Agriculture minister sent a one liner- Nothing was wrong and Endosulfan is safe for use. In Kasaragod, when qualified medical practitioners in the community pointed out to the pesticide endosulfan for poisoning their community, the Government preferred to accept the agric-scientists version that Endosulfan was safe. When the High-level ICMR doctors confirmed in their studies that endosulfan caused the health problems in Kasaragod, again the Ministry of Agriculture intervened and installed a committee under the Agriculture department which looked at the health study. This Dr. Dubey committee has rejected the study and recommended that another health study be done under the auspices of the Plant Protection and Quarantine Department. Adding insult to injury the head of the committee Dr Dubey has been officially patted on the back for the "commendable" work he has done. In this counuy, it is evident that Environmental health will not find listeners until the health professionals and activists do not respond to this hijacking of health sciences by vested non-experts. Now the same pattern of sabotage, the same drama is probably going to be repeated in the "Pesticides in Bottled water" issue as well.

This being the miserable state of affairs in the country, the farmers, activist groups, public health professionals, researchers and voluntary organisations came together and formed themselves a platform – the Community Action for Pesticide Elimination (CAPE) to take forward the joint struggle to keep our fields, food and lives free from pesticides.

In the Global scene, we see that some very positive steps are being taken. The Rotterdam Convention, the Stockholm Convention, the Code of Conduct of the FAO and the WHO are some to be named. The Fourth Inter-governmental Forum for Chemical Safety (IFCS) held in November 2003 have gone ahead to recognise the need for a special programmes on Children and Chemical safety, Acutely Toxic pesticides which not only includes pesticides in the Ia and Ib classification of WHO but also pesticides associated with frequent and severe poisoning incidents like Endosulfan and Paraquat. In such forums we see that the NGO's, and Voluntary Agencies and Independent Research findings are getting more and better spaces and consideration, and we also see that the Government of India is mute and poorly represented and performing pitiably in the discussions and negotiations. And in India, these global efforts are not reflected in the policies and decisions and the wall stands masking these global changes and efforts.

So, in this situation the Community Action for Pesticide Elimination (CAPE) believes that much work is needed to achieve the aim of pesticide elimination by taking the following direction -

1. **Consolidate** the experiences of the farmers, the affected communities as well as the work done in the pesticide contamination and death or effect related cases and also consolidate whatever information is available from the States regarding pesticide manufacture, use and impacts.
2. **Share** the information on the public domain and **Gather together** to fight the policy of poisoning – Farming is a creative activity and there should be no space for poisoning.
3. **The Fundamentals** that we stand on needs to be clear – that we advocate no pesticide use, because pesticides have basically only been a negative technology and have been harmful rather that useful. Moreover, we have no belief on the "corporate sponsored science" of Maximum Residue Levels (MRL's) and Admissible Daily Intake (ADI's).
4. And finally Expose at the Community level, the National level and the International level the vested science and corporate-profit driven planning that has resulted in contaminating ourselves and our environment with chemical pesticides. We also need to expose with the intention of informing and taking positive action the unholy nexuses between the poison industries, the agric-scientists and the government agencies that have together taken us for this toxic ride.

This was presented by Sridhar R, CAPE-Secretariat, c/o Thanal, L-14 Jawahar Nagar, Kowdiar,. Thiruvananthapuram – 695 003. thanal@vsnl.com