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Annual Community Health Fellows Workshop, Bangalore
ROOM ALLOCATION

Date: March 6 – 8. 2006 **Venue:** Navspoorthi Kendra (NSK), Cookson Road. Off Davis Road

Theme: Health as a human right in the era of globalisation

Sl No	Name	Accomodatin Required	Room No.	Intercom No
1.	Dr. Anant Bhan	Y	R- 226	301
2..	Dr. Abraham Thomas	N		
3.	Dr. Mathew P Abraham	N		
4.	Mr. Naveen I Thomas	N		
5.	Dr. Sandhya Y A	N		
6.	Mr. Ameer Khan K	Y	R- 227	302
7.	Dr. Neeta S. Rao	Y	R- 228	303
8.	Dr. Jyoti Gupta	Y	R- 229	304
9.	Mr. Mathew Sunil George	Y	R- 003	111
10.	Dr. Vishwanatha Vinay	Y	R- 230	305
11.	Ms. Manjusha B. Dhiwar	Y	R- 231	306
12.	Ms. Madhumita Biswal	Y	R- 232	307
13.	Mr. Premdas Edward Pinto	Y	R- 233	308
14.	Ms. Sathyashree Goswami	Y	R- 234	309
15.	Dr. A. Arun Gupta	Y	R- 235	310
16.	Ms. Harriet Sathyavati	Y	R- 236	311
17.	Ms. Asha	Y	R- 237	312
18.	Dr. Vasundhara	N		
19.	Dr. Ravi Narayan	N		
20.	Dr. Thelma Narayan	N		
21.	Prof. Abdul Azeez	N		
22.	Prasanna Saligram	N		
23.	Sr. Tina, Hannur	N		
24.	Dr. Narendra Gupta, Prayas	Y	R- 239	314
25.	Mr. Victor Fernandes	N		

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COMMUNITY HEALTH CELL

Annual Community Health Fellow Workshop, Bangalore
Date: 6th to 8th March - 2006
Venue: Nava Spoorthi Kendra, Bangalore

REQUISITION FORM FOR TRAVEL SUPPORT

NAME :

ADDRESS :

DETAILS OF TRAVEL EXPENSES

Date	Mode	From	To	Amount
GRAND TOTAL (in figures)				
Rupees (in words):				

Approved by:

Signature of person receiving the amount

- Please attach supporting bills for the claims mentioned above

Com 11

AGENDA ITEM NO. 5

Suggesting a global 'Right to Health campaign' by PHM
which could be launched at PHA-2

We thus find ourselves at a crossroads: health care can be considered a commodity to be sold, or it can be considered a basic social right. It cannot comfortably be considered both of these at the same time. This, I believe is the great drama of medicine at the start of this century. And this is the choice before all people of faith and good will in these dangerous times.

- Paul Farmer

The context
The large scale weakening of public health systems, unchecked privatisation in various forms and erosion of universal healthcare access systems are phenomena seen across the globe in the current phase of liberalisation-hegemonic globalisation. The global health sector discourse seems to be dominated by vertical, selective, urban and technocratic approaches, as well as by 'public-private partnerships' of different kinds --at global, national and local levels-- as the preferred mode of implementation of services. Today there is an urgent need for a process that will replace this dominant discourse by a 'Right to health and health care' approach needed to achieve truly 'universal and comprehensive health care systems both in developing and developed countries. To counter and reverse the current trend that commoditizes health, there is thus a need to reach a strong global consensus on 'Health care as a right', as well as a need to begin using the existing international and national provisions that support this Right in an effective manner; we need to fight for strengthening public health in an accountable manner. It is in this context that the possibility of launching a global initiative to strengthen the 'Right to Health', with a focus on defending and operationalising the 'Right to Health Care', is presented here below.

The justification
The majority of countries around the world (over 150) are party to the International Covenant on Economic, Social and Cultural Rights. The General Comment 14 of CESCR, adopted in the year 2000, elaborates on and goes into the details of the Right to Health and clearly defines its broad characteristics, methods of operationalisation and current violations, and suggests the means to monitor the implementation of this Right. We are nearing five years of the launching of General Comment 14 --the most comprehensive internationally adopted instrument that rules the understanding we ought to have of the Right to Health. However, there is still a need to launch a global process that will raise the demands for the provisions of GC 14 to be seriously implemented in all signatory countries. This stresses the paramount importance of operationalising the 'Right to Health', and calls for reviewing, revisioning and remissioning all global and national health sector initiatives in the light of the overarching framework of health rights (such as, for example, MDGs).

A suggested content focus of the campaign
The 'Right to Health' framework provides us with an internationally agreed-upon consensus structure based on which a strong argument should be constructed. However, within this broad framework, we suggest that the campaign should, in its first phase, focus on the 'Right to health care'. This is a burning issue in the context of current weak and weakening health systems and it is amenable to actions from within the health sector. This, of course, involves arriving at a broadened vision of health care, one that includes not only the entire

range of preventive, promotive and curative health services, but also services like nutritional supplementation, ensuring drinking water quality, health related education and information -- all activities carried out with the primary and express purpose of improving health comprehensively. It need not be emphasised that specific important aspects of this Right, such as Women's right to health care, Children's health care rights, Mental health rights, Health care rights of HIV-AIDS affected persons, Worker's health rights, The right to essential drugs and other will be woven together, bringing diverse strands of the health movement into a broad coalition that will work to strengthen public health systems and a universal access to health care.
At the same time, some other key social determinants of health adversely affected by policy changes that are having negative impacts on the health of the poor --and where PHM members are in a position to document and push for policy changes-can and will be identified at the country level and taken up as part of the campaign. This focus could be broadened in the subsequent phase of the campaign.

Possible organisational collaboration (networking)
The United Nations Special Rapporteur on Right to Health is entrusted with the responsibility of reviewing the status of implementation of this Right the world over. There has been some communication with the present Rapporteur, Prof. Paul Hunt, who has shown interest in the idea of such a global process. WHO has a division dealing with Ethics and Human Rights, and there are persons in other divisions such as the Poverty and Health Policies Division who also seem to be willing to lend support to such a process. Given our aim to shift the focus of WHO towards a Rights-oriented approach, and given its global potential to influence national health systems, we see WHO as an important collaborator in such a process. Most countries have National human rights commissions or similar official bodies, which we hope to involved to varying extents in monitoring the Right to Health. Human rights groups have the potential to take interest in this issue, especially in issues like access to care for HIV-AIDS affected persons. Of course, present strategic allies of PHM will need to take a lead with us in the different countries helping us involve a broader range of civil society organisations in this campaign (including women's organisations and networks, coalitions of HIV-AIDS affected persons, trade unions of health sector personnel, people's movements).

Suggested process to advance this discussion
To move towards a concrete campaign start-up process, we suggest a possible sequence of activities as per below, which will be modified and refined based on suggestions from the PHM global steering group and PHM activists across the world.

a. During the upcoming PHM steering group meeting at Bangalore on 11-12 April, a discussion is planned on the various aspects and feasibility of such a campaign. This will provide the basis for concretising the next steps.

b. Sometime during the World Health Assembly in May, we plan a meeting co-organised by the Poverty and Health Policies Division of WHO, PHM and other strategic allies, on 'Global efforts for operationalising the Right to Health'. Paul Hunt will be invited to this meeting. In this meeting, we will brainstorm on the possibilities of a Global Right to Health initiative, and the possible roles of WHO, the Special Rapporteur on Health and of PHM and other partners. At this point we foresee working out an outline of a larger event during PHA-2 as suggested below. (Based on preliminary communications, it appears that both persons

from the Poverty and Health Policies Division of WHO and Paul Hunt are interested in such a meeting).
Also during WHA, a PHM group will meet Dr. Lee and, while inviting him for PHA-2, we will discuss this idea with him, since his endorsement is crucial for WHO co-sponsoring and supportinng Regional consultations on 'Operationalising the Right to Health' in various WHO regions and sponsoring the follow-up workshop on this during PHA-2 (as discussed below).

c. During PHA-2, we are thinking of having a well planned large workshop on 'Global action for the Right to Health', involving WHO and PHM delegates from various regions and all other partners who will have joined us by then.
Dr. Lee and Paul Hunt will be invited to co-chair this workshop, and there we will work out a concrete outline of a 'Global Right to Health Campaign' focussing on ensuring widespread social support, official recognition, delineation and operationalisation of the Right to Health Care and Right to key health determinants. By then we will try to crystallise an agreement among WHO, Paul Hunt and PHM to organise Regional events on the 'Right to Health' in various regions of the world, which will be fed into by PHM country level reports or papers and will be based on the stipulations in CESCR General Comment 14.

d. If such an agreement emerges, we plan to collaborate with WHO to organise a series of Regional assemblies on 'Right to Health - Universal Access to Health Care', say from end 2005 to end 2006. Each regional assembly will be preceded by country level workshops, wherever possible, involving national human rights bodies, to analyse the state of the 'Right to health' in their country (based on GC 14 and national constitutional and legal obligations) and to concretely delineate gaps in health rights, while raising the need for a mechanism to address violations. The Regional assemblies will be attended by senior country health officials, national human rights bodies and PHM delegations, and will discuss the operationalisation of health rights and developing redressal and monitoring mechanisms in each country.

e. This series of regional assemblies may culminate in some kind of resolution being adopted at WHA-2007, calling for time-bound complete implementation of the Right to Health, and putting in place mechanisms for monitoring and redressal of this right in all countries of the world, while appealing for an end to all forms of violations of this Right based on a content clearly defined by the CESCR general Comment 14. PHM partner organisations will use this as a concrete opportunity to draw in many more organisations into their network, to dialogue with their country governments, to engage with national human rights bodies and to build a consensus on the need to end violations of health rights in various forms and to reverse policies responsible for such violations.

The process will be used to try to shift the discourse from the preoccupation with globally directed vertical programmes and privatisation-oriented measures, by talking about widespread denial and violation of the Right to Health, by demanding a global consensus on implementing this Right, and asking that all programmes and measures must now be critically evaluated from a Health Rights perspective.

What can realistically be achieved in such a process?
There is no illusion that systematically raising the issue of 'Right to Health' itself will lead to actual complete implementation of this Right in countries across the globe. The universal provision of even basic health services involves major budgetary, operational and systemic changes; providing these in a definite Rights-based framework also involves major political

and legal reorientations; and such major changes cannot be expected in the near future, given the political economy of health care in most countries of the world today.
However, we can expect and work for certain more achievable objectives, which will take us towards the larger goal. Some such 'achievables' to be expected from a campaign may be - explicit recognition of the Right to health care at country level; formation of health rights monitoring bodies, with PHM and civil society participation in some countries; clearer delineation of health rights at both global and country levels; shifting the focus of WHO towards health rights / universal access systems and strengthening a group within WHO to continue working for the same; bringing Right to health care into the global agenda and making it a reference point in the global health discourse; and strengthening PHM networks in various countries around a common, broad rallying point.

PHM organisation - PHM campaign; an iterative process of building both
An obvious and valid response to this suggestion may be that the development of PHM is highly uneven in different countries, and that in many countries the PHM groups are not in a position to take up such an activity. While accepting this situation, we also need to reckon with the fact that PHM country circles, which were formed during or after PHA based on a shared concern and broad understanding about health and the health sector, need to move beyond communication and discussion to develop common advocacy activities, if they are to develop further and to draw in more groups. Moving forward from the basis created by the 'Million signature campaign' and the 'Health -Now! No to war, no to WTO' campaigns, there is a need to develop shared effective advocacy initiatives at the country level. These could directly engage with decision makers and could try to bring about certain changes in the ground level situation based on people's awareness and initiative. A 'Right to Health' campaign can be such a process, which can bring together existing and new PHM groups towards defined country level advocacy objectives, and hence can strengthen and expand the PHM organisation while developing a common activity. Of course, assessing the overall practicability, and ascertaining the existence of a minimum critical mass of PHM in a substantial number of countries which is necessary to develop the campaign, is something that would need to be done collectively by the People's Health Movement to concretely evaluate the feasibility of this approach. Our appeal is that such a process of discussion should be initiated, and that some first steps be planned to explore the potential of such a campaign. If there is a basic consensus on taking this forward, then given the approaching People's Health Assembly, we should make use of this major event to work out, crystallise and plan the further process.
We are concretely asking Steering Group members to react to this so that the Secretariat can give the green light to this exciting process. We ask you to respond before April 5th.

- Abhay Shukla and Claudio Schuftan

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Viewpoint

Pushing the international health research agenda towards equity and effectiveness

Lancet 2004; 364: 1630–31

David McCoy, David Sanders, Fran Baum, Thelma Narayan, David Legge

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Despite substantial sums of money being devoted to health research, most of it does not benefit the health of poor people living in developing countries—a matter of concern to civil society networks, such as the People's Health Movement.[1] Health research should play a more influential part in improving the health of poor people, not only through the distribution of knowledge, but also by answering questions, such as why health and health-care inequities continue to grow despite greatly increased global wealth, enhanced knowledge, and more effective technologies.

Previous Editorials in this journal, and other reports, have already highlighted three important issues.[2–4] First, that the 10:90 gap—whereby only 10% of worldwide health research funds are allocated to the problems responsible for 90% of the world's burden of disease, mainly in poor countries—needs to be reversed. Second, that greater emphasis should be placed on research in the social, economic, and political determinants of ill health, relative to clinical and biological research. Third, that the barriers to the transfer of knowledge from research into policy and practice need to be overcome.

The 10:90 gap largely represents a funding gap shaped by commercial interests, and inadequate funds being provided through the public budgets of poor countries, development assistance grants, charitable foundations, and non-government organisations who have an interest and a mandate to invest in public or non-commercial research activities that are orientated towards addressing the health needs of poor people.

Part of the solution to addressing this overall deficit in funding includes continuing with current efforts to increase development assistance, hasten the cancellation of unfair debt and reform unjust trade structures. But we also need creative thinking and bold action around new proposals, such as raising funds through an international authority that is able to effectively tax global corporate profits,[5] or applying levies against global financial transactions (eg, the Tobin tax).[6,7]

With respect to research on the social, political, and economic determinants of health, we draw attention to three points. The first is the need for more research into the effects of globalisation on poor health and growing health inequities, and on the development of proposals to reform the current global, political, and economic institutional order. In addition to research on more effective mechanisms for global resource redistribution, research should focus on how health equity can be protected from the market failures of economic globalisation and the operation of transnational commercial interests. Second, we want more research applied to the question of why the cancellation of the odious debt of many poor countries has not been forthcoming, why many rich countries' development assistance still falls short of the UN's 0·7% gross domestic product target,[8] and why bilateral and multilateral trade agreements continue to be unfavourable and even punitive towards the poorest and sickest people. Third, more research is needed into the design and financing of systems and basic services and into how these factors determine access to good quality care and other health inputs (eg, water and adequate nutrition). As health systems become increasingly inequitable and fragmented, research on the drivers and effects of the liberalisation, segmentation, and commercialisation of health-care systems is essential.

These three points complement the call for more research on why available and affordable technology and knowledge are not used, for example, to prevent millions of children from dying of diarrhoeal disease and acute respiratory infections. Appropriate research would indicate how the mainly social and political barriers to application of existing technologies might be overcome. This achievement could be aided by country case studies that combine an analysis of the political economy of poverty and ill health together with the health systems factors that help or obstruct access to effective health care. Such research would bring together political and social scientists, health economists, public health professionals, ethicists, and civil society organisations.

To promote the transfer of knowledge from research into policy and practice, several issues should be examined. Presently, there is a research culture and incentive system that encourages researchers to be more concerned with publishing their results in academic journals than with ensuring that their research leads to improved policy and practice. Furthermore, policy makers and programme implementers in developing countries are either sceptical about the value of research, or do not have the skills to appraise and use new information.[9] The scarcity of capacity in the public sector has been further aggravated by the steady brain drain of capable health professionals to richer countries or from the public sector to the domestic private or non-government sectors (including the health research sector).[10]

These difficulties could be overcome by changing the incentive system and allocating a greater share of health research funding to academic and non-government research institutions in poor countries that work closely with policy makers, health managers, service providers, and communities. This allocation of funding needs to

be complemented with more investment in developing research capacity within the health systems of poor countries.

Research geared towards practical health systems development is also often qualitatively different from research that is geared towards the imperatives of academia and the medical industry. For example, research on the efficacy of interventions in a controlled environment is different from that on the practicability of applying effective interventions in the real world. More action research that involves service providers can help to bridge the gap between research and implementation, and ensure that research is embedded within the day-to-day realities and constraints of under-resourced health-care systems. The use of participatory research methods can also help poor communities shape health systems to meet their needs.[11,12]

Research findings are also more successfully implemented when researchers include mobilised citizen constituencies.[13] Successful implementation is aided first by ensuring a vigorous community of civil society organisations with a mandate to keep a watch on health policy development and implementation; second, by use of research funds to actively foster the capacity of these organisations to change the commissioning and priority setting for research; and third, by including civil society organisations in research production and encouraging partnerships that link them with academic researchers.[14]

Finally, the imbalance in power between researchers in rich and poor countries must be bridged. Many academic and non-government institutions in more developed countries benefit disproportionately from the meagre research funds that are focused on poor health in developing countries. This imbalance is in a context where academic and research institutions in developing countries are struggling to gain their own funding and find it difficult to retain good staff. Practical ways of addressing the inequities within the health research community might include mapping out the distribution of research funds for health problems between research institutions in rich and poor countries, documenting the obstacles to the development of research capacity in developing countries and conducting in-depth case studies of the health-research funding policies and patterns of selected donor and international agencies.

Global conferences and summits on health research, such as the two that are due in Mexico this November, by themselves are unlikely to substantially affect the challenges we present. The current pattern and use of health research shows the balance of prevailing global power, perspectives, and interests. Redressing the imbalance will require consciousness-raising, mobilisation, and pressure at many different points in the global health research system and in health-care systems more broadly. Pressure for change will need to be exerted at all levels and by many different actors. The Peoples Health Movement is committed to being increasingly influential.

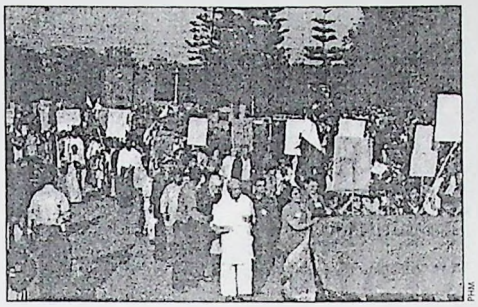

Figure: People's Health Assembly rally, Dhaka, Bangladesh, 2000

Conflict of interest statement

We declare that we have no conflict of interest.

Acknowledgments

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Peoples' Forum against ADB

Call for Action!

ADB and World Bank, Quit Asia! Quit India!

Mobilise against the Asian Development Bank Annual Governors' Meeting
3-6 May 2006 Hyderabad

The Asian Development Bank (ADB) is the third largest source of development finance in the Asia-Pacific region, next to the World Bank Group and the Japanese Government. Every year, ADB moves huge amounts of money across the Asia-Pacific region in a bid to foster rapid economic growth and market capitalism. In 2004, the ADB's total lending was US $ 5.3 billion which was used to promote 64 projects covering mostly road transport, communications, energy, law, economic management in the public policy sectors. Private sector assistance was to the tune of US $ 807.2 million. The ADB's largest borrowers in 2004 were China and India, each receiving US $ 1.3 billion, about 24 per cent of the total lending. India is the fourth largest shareholder in the ADB overall.

Despite its name, the management and operations of the ADB are greatly influenced by the USA and the non-Asian capitalist powers. Although, Japan enjoys the most powerful status in the ADB, at par with the USA, the non-Asians are powerful enough to manipulate the institution's directions to suit their own interests. In promoting privatisation and private sector investments, the ADB routinely dole out lucrative contracts to favour international firms and consultants.

Destructive and unaccountable

The ADB is an extremely secretive, non-transparent and unaccountable institution, despite its rhetoric on good governance. Its founding Charter of Principles provides the bank and its staff with immunity from local and national laws. The ADB is thus not legally liable to communities, governments or individuals for any wrongdoing, material harm or violation of rights.

Evaluation of ADB projects by independent researchers, citizen's groups, movements, NGOs and by its own Operations Evaluation Department indicate that most ADB supported projects are poorly designed implemented and managed. ADB does not facilitate public participation in development planning and access to information while weakening local and national governance through undemocratic, non-transparent and non-consultative methods of project implementation. ADB projects have continued to displace hundreds of thousands of people across the region with little or no compensation, have resulted in negative environmental and social impacts. The ADB, is therefore, charged with creating "development refugees" and "manufacturing poverty" by the civil society organisations and movements.

The ADB, like the World Bank, has become the custodian of private investment and the promoter and protector of corporate interests and profits. It follows the neo-liberal policy by imposing policy conditionalities – the reform agenda and privatisation – on borrowing countries, and facilitates foreign companies to grab contracts for research work, consultancy, project development, construction and management.

India Incorporated!

The ADB, in its Country Strategy and Programme (CSP) for India, 2003-2006, claims that the 10th Plan strategy is a sound one and is similar to its own poverty reduction strategy founded on pro-poor growth, social development and good governance. India's strategy seems to fit well with the Banks! The CSP further says that the most important role that India's development partners can play is in introducing international best practices to strengthen fiscal and other structural reforms in the 10th Plan. The Indian Government is playing second fiddle by indicating that it looks to ADB, to play a leading catalytic role in supporting the next generation of policy reforms. Since India can no longer access concessional loans from ADB, high risk loans at market rates are taken for sectors focusing on high growth, reforms and private sector development.

During current CSP period, the ADB loans, starting from US $ 1.67 billion in 2003 is slated to increase to US $ 2.05 billion in 2006, totaling US $ 7.5 billion. Projects financed by the ADB range from energy and power sector reform and restructuring to road transport, water, irrigation, flood control, tourism, urban development and administrative and fiscal reform. These projects are located across Jammu & Kashmir, Uttaranchal, West Bengal and the North East, to Madhya Pradesh, Chhattisgarh, Gujarat, Rajasthan, Karnataka and Kerala. The ADB's array of policy conditions include, a) adopting legislations and regulations that favour private sector involvement in key sectors, b) market-friendly restructuring, c) corporatisation and privatisation of public enterprises and utilities, d) creating a flexible labour force, e) commercialization of agriculture and f) trade and investment liberalization.

Mobilising against the Annual Governors' Meeting

The ADB is holding its 39th Annual Governors' Meeting (AGM) from 3-6 May 2006 in Hyderabad.in the State of Andhra Pradesh in southern India The Governors are the highest level of decision makers in the ADB. Appointed by the ADB member countries, they are high-ranking national officials such as Finance Ministers or Secretaries of National Treasuries. The current Chair of the AGM is Indian Finance Minister P Chidambaram. Since 2000, peoples' movements, communities affected by the ADB projects, progressive academics, intellectuals, labour unions, activists and NGOs have used this opportunity to successfully mobilise themselves at the AGM venues and protest against the institution and its development policies.

In 2000 and 2001, the ADB was shocked by the intensity of protests and strong messages sent to the ADB by peoples' movements in Thailand and the US. The last AGM was in Turkey in 2005 where local movements and organisations lent great support to the project affected and protest organisations that gathered for the AGM.

In 2006, the eyes of the movements and struggles in Asia will be on Hyderabad and India. Peoples' struggles against destructive development and oppressive economic and political structures are legendary in India and particularly in Andhra Pradesh. Andhra Pradesh does not have any ADB supported projects, but it is already a victim of the World Bank conditionalities – the power sector workers, the road transport workers, the displaced tribals and the rural poor. In the recent past, the people of Hyderabad and Andhra Pradesh gave a befitting reply to the Chandrababu Naidu Government that tried to foist a World Bank dictated reform agenda. Thousands have marched in the streets of the city calling for a rejection of the World Bank's AP economic restructuring loans. The Government that refused to listen to its people was comprehensively voted out of power. The present Government, unfortunately, continues on the same path, eager to bring in foreign investment at any cost.

The Hyderabad AGM offers us the opportunity to work with the groups in Andhra Pradesh; movements, communities, organisations and activists in India and across Asia should come together and raise a collective and unified voice against neo-liberalism. Whether through World Bank or ADB projects, the net impacts on communities and societies are the same, especially on the poor, vulnerable and the marginalised, the workers, dalits, tribals, women, peasants, the fishworkers or the urban poor, the hawkers and slum dwellers.

Come May 2006, let us give the ADB, the World Bank and all the other corporates who covet India's resources and wealth, encroach upon the sovereignty of countries across the globe and in Asia, a unified message:

Enough is Enough!

No to ADB, World Bank and the marauding corporates!
Governments listen to the voices of the peoples!

Peoples' Forum against ADB comprises of the following groups from India and Asia:

National Alliance of Peoples Movements, Narmada Bachao Andolan, Asia Pacific Movement on Debt and Development (APMMD), Freedom from Debt Coalition, Philippines Rural Reconstruction Movement (PRRM), Karnataka Rajya Raitha Sangha (KRRS), Equations, Nadi Ghati Morcha, River Basin Friends, Environment Support Group, ADB Quit Kerala Campaign, INSAF, CORE, Urban Research Centre, Focus on the Global South, Citizens Concern for Dams & Development, Delhi Forum, Samata, National Forum of Forest People & Forest Workers, mines minerals & People, Shaheen Centre, Consumer Protection Forum, Water Initiatives, Consumer Protection Forum, Civil Society Initiative on IFIs (NE), Intercultural Resources, NGO Task Force on ADB, Nagarika Hitharakshana Samithi, Balakedarara Hitharakshana Vedike, Anikethana Trust, India Centre for Human Rights and Law (ICHRL), Palni Hills Conservation Council, National Fishworkers Forum, Polavaram Project Andolana Samithi, Naga Peoples Movement for Human Rights, Movement Against Uranium Projects, Centre for Environment Concerns, Aman Vedika, ITDS, Peoples Alliance Central East India, Japan Centre for a Sustainable Environment and Society (JACSES), Center for Economic Justice, PAIRVI, Jharkhand Jangal Bachao Andolan, Bureau for Human Rights, Adivasi Mukthi Sangathan, Peoples Movement in Subansiri Valley, Krishak Mukti Sangram Samithi, Arunachal Citizens Rights, Indigenous/Tribal Peoples Development Center, Rural Volunteers Centre, Human Rights Tamil Nadu Initiative,Parisava Badokidara Vedika, Human Rights Law Network, SAKSHI Human Rights Watch, Chatri, Jharkand Labour Union, Dalit Women Forum, National Hawkers Federation, Net Work of Persons with Disabilities Organisation (NPDO), Lok Raj Sangathan, Consumer Protection Council, Manthan Adhyayan Kendra, South Asia Network of Dams, Rivers & People, Grassroot Options, FIMCOTN, Dwarf People's Organisation, Chatri, New Trade Union Initiative, SEVA, SABALA, National Campaign on Dalit Human Rights, Women's Collective, Bangla Praxis, Nagarik Udyog, Corporate Accountability Desk of The Other Media, Chasma Lok Sath, National Centre for Advocacy Studies, Open Space, Peoples Voice, Gangpur Adivasi Forum, Dalit Mukti Morcha, Plachimada Solidarity Committee, Pani Committee, Keselu Palu Group (PNG), Uttaran, AOSED, Save Chara River Campaign, Gono Udyog Forum, Green Movement of Sri Lanka

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People's Health Movement

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PEOPLE'S CHARTER ON HIV AND AIDS

Launched at the XV International AIDS Conference, Bangkok, Thailand, 16 July 2004

PREAMBLE

Health is a social, economic and political issue and, above all, a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill health. Achieving health for all means that powerful interests working against people's well-being have to be challenged, corporate globalisation has to be opposed and political and economic priorities have to be fundamentally changed.

HIV and AIDS are a development issue that calls for social and political action. It is also a public health issue that requires people centered health and medical interventions. Such responses require democracy, pro-people inter-sectoral policies, good governance, people's participation and effective communication. They should be rooted in internationally accepted human rights and humanitarian norms.

The special needs of women and children as infected persons, their dependents and caregivers should be addressed.

In the current context, People's Charter on HIV and AIDS recognises the devastating impact of war and conflict on health systems and how it amplifies the vulnerabilities of people to HIV and AIDS.

People's Charter on HIV and AIDS draws upon perspectives of communities affected and infected with HIV and AIDS and those vulnerable to the infection. It encourages people to develop their own solutions and hold accountable local authorities, national governments, international organisations and corporations to their promises and responsibilities.

VISION

As stated in the People's Charter for Health: 'Equity, ecologically sustainable development, social justice and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich one another; a world in which people's voices guide the decisions that shape our lives'.

PERSPECTIVES

The AIDS pandemic is one of the greatest humanitarian crises of all times. It has caused death and misery, destroyed families and communities, derailed development and reversed health gains achieved over decades in one stroke. HIV and AIDS is already wiping out a generation in Africa. Two decades after it began its onslaught, the disease is still spreading fast, gaining a firm foothold in all parts of the world.

HIV and AIDS spreads along migration routes charted out by globalised trade. Social and economic distress due to conflict, war, disasters, skewed international trade and unjust economic policies make more and more people vulnerable to the infection.

The landmark Alma Ata Declaration of 1978 promised Health for All by 2000 through primary health care. Verticalisation, changing economic priorities, invasion of private interests into political decision-making and a lack of political will led to a total breakdown of the public health and primary health care systems during the 1980s and 1990s. The spread of HIV and AIDS also contributed to the non-achievement of these goals.

Poverty, hunger and ill health are increasing because of neo-liberal economic policies. In this context, integrated, adequately-resourced health systems based on primary health care and public health are urgently required.

Lack of sensitisation and training of health personnel have created negative attitudes towards persons living with HIV and AIDS. Such attitudes and practices lead to stigma and discrimination that impede interventions.

It is essential to ensure that health care is safe and that people undergoing treatment at health care facilities are not exposed to HIV or other infections.

A CALL FOR ACTION

By People and Social Movements

- Mobilise and strengthen capacities of communities in health promotion, disease prevention and care.
- Empower women and youth as key players in HIV interventions.
- Build alliances among positive people's networks, women's movements, health and social activists, trade unions, student groups, academics and other progressive constituencies.
- Intensify the campaign for equitable and universal access to anti-retroviral (ARV) treatment through comprehensive primary health care.
- Facilitate legal measures and mass campaigns to change intellectual property rights regimes that escalate drug prices.
- Oppose policies dictated by multilateral financial and trade institutions that disregard people's right to health and health care.

- Expose links between the spread of HIV and AIDS and the underlying societal determinants such as poverty, war and displacement, and participate in efforts to redress these injustices.

By Health Professionals and Health Workers

- Provide responsible care and quality treatment to persons living with HIV and AIDS.
- Stop stigma and discrimination in institutions of care and treatment.
- Respect patients' right to dignity and privacy.
- Follow ethical and regulatory principles in drug trials.
- Provide adequate preventive measures to avoid transmission of infection in health care institutions.
- Support People's Health Movement initiatives that address the larger social, political and economic issues.

By Governments

- Develop and strengthen comprehensive approaches based on primary health care to include HIV and AIDS interventions.
- Enhance involvement of people and civil society in planning and implementation.
- Ensure greater involvement of persons living with HIV and AIDS at all levels.
- Ensure occupational safety of health workers.
- Increase access to basic services to people living with HIV and AIDS.
- Ensure easy, affordable and sustained availability of quality generic ARV and other essential drugs.
- Allocate adequate resources for public health.
- Implement guidelines for transparent, scientific and ethical clinical trials.
- Make nutritional inputs and psycho-social support part of HIV and AIDS care.
- Develop programmes for life skill education and women's health empowerment.
- Promote traditional systems of medicine with enough resources.
- Promote harm reduction policies and programmes for all vulnerable sections, including sex workers, drug users, sexual minorities and street children.

By Corporates

- Place people above profits.
- Make available diagnostic and prognostic tests that are affordable.
- Ensure the availability of ARV and essential medicines at affordable rates.

By WHO and UNAIDS

- Evolve a comprehensive approach that strengthens primary health care and health systems, with built-in indicators of progress.
- Stop narrowly-focused vertical programmes.
- Urge all governments to follow the UN's International Guidelines on HIV infection and AIDS and Human Rights.
- Include non-priority countries in the 3x5 initiative.
- Take appropriate action in 'low prevalence countries'.
- Start immediate action for sub-Saharan African countries.
- Monitor the impact of trade agreements on health.

By World Bank, International Monetary Fund and World Trade Organization

- Be accountable for social disasters caused by anti-poor macroeconomic policies.
- Cancel debts of all poor countries, especially those identified as vulnerable to HIV and AIDS.
- Stop free trade agreements, privatisation of essential services, and the commercialisation of health care.
- Finance HIV and AIDS interventions with grants instead of loans.
- Remove pharmaceutical patents that adversely affect availability of generic drugs.

We call upon all individuals and organisations to endorse and implement the People's Charter on HIV and AIDS and join the People's Health Movement (PHM).
PHM has an active presence in about 100 countries.

Largely based on the People's Charter for Health of the People's Health Movement.

Developed through an active participatory process involving people from various walks of life, including persons living with HIV and AIDS.

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People's Charter on HIV and AIDS

Designed by Books for Change, Bangalore, India

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The Rights Based Framework – Which Way To Go?

Anant Phadke

As a preparation for the discussion on 'right to health care' in the forthcoming MFC meet, in this note I would attempt three things –

I. To put the rights based framework in a larger, historical context so that there is more clarity on the meaning of the issue of rights and human rights

II. To argue that limiting ourselves purely in the rights based framework, without analysing the political economy of health and health-care would not take us forward.

III. To locate the need and importance of a detailed discussion on right to health care in the health-care movement in India.

I

Needs and rights

Let us begin with a simple, elementary question: why do we talk in terms of rights and not in terms of needs? Food, water, health-care, education etc. are human needs in the modern world. There are enough resources in the world to meet these basic needs of everyone. But this does not happen because there are -

- huge wastages on preparations for wars, nuclear or otherwise;
- massive inefficiency in use of resources (for example use of individualised transport instead of mass transport);
- mind-boggling creation of false needs like unnecessary medical interventions;

All this is basically a product of profit mongering and power mongering capitalist system. Add to this, the greatest ever inequality in human history fuelled by the shameless greed of a few in the new phase of globalization and complete sway of speculative finance capital. All this together makes it impossible to fulfill even the basic needs of the vast-majority of the people inhabiting this unique globe. ***Therefore, unless human needs are couched in the form of rights, these cannot be fulfilled in our today's society and there is a necessity to talk in terms of basic human rights, the fulfillment of which has to be ensured by the state. This conversion of basic human needs into rights is not exactly a very desirable thing. Our ultimate goal should be to build a society wherein basic human needs are fulfilled without involving the language of rights.***

Unlike animals, human needs change and expand. There is nothing like human rights, which are valid for all times. The content of human needs and of human rights would develop as society develops. For example, the content of 'Right to education' would change as society develops.

Professional Rights and Human Rights

Today's society is divided into various social groups whose interests are opposed to each other- employers versus employees; landlords' versus servants; people being benefited by developmental project versus those displaced by it or suffering from it; men versus women, one caste – group versus other etc. etc. Each of these social groups is competing with the other to gain more wealth and prestige. Since resources are limited and especially in view of huge wastages, inefficiencies, false needs mentioned above, they cannot suffice to meet all these competing needs, the specific interests and needs of each of these groups have to be protected from others by converting these needs into rights. In situations where interests of different groups are not opposed to each other, there is no need to involve the discourse on rights. Thus generally we do not talk about rights of mothers versus those of their infants. While rights of members of one foot ball teams are guarded against those of the rival team members by the match referee, there is no question of any rights of any team member within the team being pitted against those of others. The point being made here is that ***the discourse of rights in today's society is premised on opposed social groups and their interests.***

Human rights belong to a different category of rights. Out interest, needs as human beings, and not as members of a particular class with particular interests also need to be protected from

violations from the society in general. If I am old man, my interests, needs arise not out of belonging to any professional group but arise out of my being an old person. Similar is the case of not only groups like infants, pregnant mothers who have special needs but is also of many of our needs as human beings and not as part of a professional class. However, ***in today's society human interests take the form of interests of a professional class or are intrinsically bound by it.*** For example, my interest as tenant-farmer lies in reducing the rent. I have to pay my landlord and the fulfillment of my human interests as an old man partly depends on the protection of my interests as tenant farmer. If the latter are violated, the former gets threatened. But nevertheless theses two have different trajectories of development. My interests as tenant farmer are bound up with the existence of tenant-land lord relationship. With the dissolution of this relationship my interests as tenant – farmer will also disappear whereas, my human interests as an old man would continue in any society.

Our long-term aim should be to build a society not based on antagonistic or opposed professional interests but based on harmonious co-operative interests. In such a society, particular ***class interests*** and rights will gradually wither away. There will not be a need for a powerful class state to ensure that the rules of competition between opposed professional classes are observed. However, there will be some contradiction between human interests of individuals and those of the society as a whole. This is because ***the earlier Marxian vision of withering away of scarcity with the unfettered development of productive forces no more seems to be realistic; energy and other natural resources no longer seem to be limitless.*** Hence some amount of limited scarcity would continue, so also the need to ration resources. Even though complete plenty and hence a good bye to the rationing of resources will never be achieved, if exploitation, inequality, ecological-socially destructive use of resources is overcome, modern productive powers can reach a stage when there is less and less need to encroach on somebody else's needs in order to fulfill my needs.

To decide how much resources individuals would be entitled to from the common societal pool would require the presence of a state power to ration the resources. ***The rights framework and the state will be required to ensure the fulfillment of human needs of all.*** This state would not guard the interests of any particular class or social layer. It would not be a state in the classical sense of the word but will balance the human rights of individuals with those of the society as a whole. The point is - the rights framework would be needed even after the withering away of class interests.

II

Political economy and human rights

Protection of ***civil and political rights*** is in a sense one of the fundamental principles of the capitalist society. If the market is to function properly, each buyer or seller in the market has to be political independent and free. This political equality is no obstacle to the inequality generated by the logic of the market i.e. the logic of the purchase and sale of different commodities, including the sale of human labor power. Hence political equality has been guaranteed by constitution in all capitalist countries. A fair degree of observance of civil and political rights in advance countries has been quite compatible with great socio-economic inequalities in these countries. However, people's organizations/human rights organizations have to be vigilant and fight for consistent observance of civil and political equality. This is because, though the rulers as a whole have agreed to recognize political rights, some times individual money bags, blinded by short-term interests and profits, tend to violate these rights. The altitude of the rulers towards political rights is thus inconsistent, whereas that of the people's organizations, civil rights groups is of consistently upholding of these rights. The US government raises the issue of violation of political rights when it suits its interests, whereas for us, its a matter of basic principle.

As regards the ***socio-economic rights,*** the position of the rulers is much more inconsistent. Here, it is more of paying lip service to these rights. The rulers are wedded to the interests of propertied people and not to the interests of the vast majority of the laboring population. Hence they cannot afford to guarantee the socio-economic rights of the people - right to livelihood, water, health-care, etc. But there are different sections within the rulers. If health-care becomes very

costly and thereby leads to the demand for higher wages, many employers would like health-care to become a right to be fulfilled through public funds so that the their wage-bill would not rise an account of spiraling health care costs. They may thus support the demand for health-care as a right. But overall, taken together, the rulers are not in favor of granting socio-economic rights, whatever may be the international declarations. ***Unlike the civil-political rights, granting the socio-economic rights is not compatible with the existing social order, at least in the developing countries.*** When we talk of fulfillment of socio-economic rights, we have to keep this is mind.

Since some leading United Nation's organizations talk about economic, social rights also, we can use these declarations to put pressure on our governments, and we can make some progress in harnessing some of these rights. But we have to be clear that demand for complete fulfillment of all the socio-economic rights is actually a revolutionary demand. Just appealing the rulers or merely demanding from them the socio-economic rights is not going to make any substantial progress in achieving these rights. Neither is it adequate to keep merely monitoring the violations of these rights. We have to find out concretely, who would be opposed to our concrete demands like right to food, right to essential drugs and to health-care, etc. We will have to strategise how to overcome this opposition; to what extent the existing state can ensure fulfillment of which demand and why. ***If we keep away from the political economy of socio-economic rights, we would be merely indulging into a sterile repetition of nicely worded international declarations or making a list of various rights or would be kept busy with mere monitoring of their violations.*** We also need to go into the ***political economy*** of the concerned issue and reveal the forces, which would be in favor of or would be opposed to this demand, put forward an ***alternative policy*** of how things can be done differently if balance of power is changed. For example, in health care, we have to point out what are the sicio-political obstacles in achieving the right to health care and how to struggle against these forces. This point brings us to the third, last issue of my note- the need and importance of a detailed discussion on the right to health care in the ongoing health movement in India.

III
What is our alternative?

The new challenging situation

I would argue that today we are in a challenging, somewhat fluid socio-political situation and we have to make efforts to shape the changes in health-care policies. The rulers are restructuring the world. The post-war strategy of state capitalism or welfarism in which the state played a leading role in the economy, in which the provision of basic social services was considered the responsibility of the state, is now being abandoned. In India, the Nehruvian path of development is being left behind. Thanks to the Nehruvian model of state capitalism in India, there was a relatively very rapid development after independence. But this development has unleashed new problems, which cannot be solved by merely continuing the Nehruvian policies. The economy needs restructuring.

The rulers are trying to restructure the economy with their trinity formula of Globalisation, Liberalisation, Privatisation (GLP), which suits the rulers but spells disaster for the ordinary people. We need to formulate and press for an alternative strategy of restructuring in opposition to the GLP strategy. In the field of health–care it is not adequate to oppose the various elements of 'GLP in health care' in a piecemeal manner. Nor can we demand going back to the Nehruvian era. ***Our opposition should be based on an alternative plan for restructuring*** of the health care system in India. 'Right to health care' can be the rallying slogan, theme of this alternative framework. Thus the direct, indirect privatisation of public health services should be opposed on the basis of an alternative framework of Universal Health Insurance of which a very much reformed, efficient, accountable, expanded public health services would be a part. Our alternative policy could be 'reform the public sector and regulate the private sector.' (Instead of giving a call of 'Save the Public sector' it will be more appropriate to give a call – "reform and expand the public sector;

regulate the private sector".) In our plan for reforming the public health services, by way of example, on the issue of accessibility of Primary Health Care we can argue for -

- a much more important role for Community Health Workers and their much better integration into the public health services;
- much more accountability of the health services to the community and to the patients;
- a more rational use of the PHC staff by introducing multi-tasking wherever possible.

The point is, the current system is obsolete, the rulers are restructuring it with their GLP strategy and our opposition to it has to be based on an alternative policy, which goes beyond the Nehruvian model of development. Whether one is part of the system or want to reform it or revolutionise it, today, one needs to go into the debates about strategic, policy issues. MFC offers a broad platform for such debates.

The MFC debates

In the earlier MFC – annual meets, we have discussed in some detail various policy-issues ranging from medical education to drug policy to women's health. The People's Health Charter of the Jan Swasthya Abhiyan, of which MFC is a part, summarises our alternative on 20 crucial aspects of a comprehensive alternative policy. Amongst us there can be differences of opinion about some of these measures in this 'twenty point programme'. But this Charter is an indication that the Right to Health Care movement in India has not confined to a conventional 'rights based approach' but has also involved itself in formulating alternative policies and has time and again pointed out specific changes in the current policies. We have thus not confined ourselves to merely making a list of various health-rights of the people, but have argued for concrete policy-measures needed to make health-care accessible to all. Now what needs to be done is to show concretely that India has the resources to implement the various policy measures we have been arguing for. This is necessary because officials, politicians say that they agree with the measures we have been suggesting but say that "However, the state does not have the resources." We need to work out at least to a certain extant, how much funds would be required to institute the measures we are suggesting and how the state can raise the resources to meet these funding requirements. This is ***necessary to delegitimise the existing system and to move from a purely oppositional to a hegemonistic politics.*** People will come forward to fight for these rights and there will be broader support to such struggles if we are able to show that Indian economy has the resources, but the existing rulers are not ready to harness these resources as this would involve harming the interests of those sections to which they are wedded.

I hope that the MFC meet would recognize the need to overcome the "there is no alternative" (TINA) syndrome. Let us realise that policy-measures that we discussed in earlier meets have acquired new significance as we have entered the era of restructuring of the economy and society. In this new context let us revisit various policy measures we had debated. Let us decide, how as part of the JSA, in this new situation we can contribute to pushing forward measures which we had formulated earlier. MFC provides an open space for detailed discussions on the content of various policy measures. Let us use this space more productively in the new situation. The election results during the last few months have shown that people are expecting an improvement in their daily lines. Emotional issues have been pushed back. The rulers are under pressure to show results. In this fluid situation, policy – level interventions are likely to be much more productive than hitherto. Now is the more opportune time to put pressure on the system, to expose it. But we need to raise the quality and quantity of our efforts in this direction. Can MFC do this?

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A statement from the People's Health Movement prepared for presentation at *Making Partnerships Work for Health, a workshop at the* World Health Organization, Geneva, 26-28 October, 2005.*

PHM identifies exploitation and marginalization of the poor as root causes of preventable disease, malnutrition and death and in this and many other respects, women and children are particularly vulnerable. This awareness guides all of our work including our position on partnerships for health.

We start with **a simple observation. Partners in any endeavour must genuinely share a common goal.** If they do not, the interaction is not a partnership and its precise nature must be made clear for its real value and the real risks it may pose to public health, to be properly evaluated.

With that in mind, we look first at interactions that are called 'public private partnerships', because they are **increasingly portrayed not just as a possible arrangement – but as an innovative and unavoidable policy paradigm** – to address global health problems.

The Cuenca Declaration, issued at the Second People's Health Assembly in July 2005 in Ecuador, states: "We oppose public-private partnerships because **the private sector has no place in public health policy making".** We will elaborate on this here.

The extraordinary power of the private sector, and in particular of transnational corporations (TNCs) and pharmaceutical houses under the neoliberal, corporate-led globalization process, has been identified as **the major obstacle to achieving social and economic justice and therefore, also, Health for All.**

TNCs already exert enormous power over governments and International Financial Institutions (IFIs). **Through PPPs, they are becoming major players in many areas of public policy making**, including health.

Let us clarify some **fundamental democratic principles.** All citizens are involved and concerned in health matters *as individuals* (including employees and Chief Executive Officers of TNCs). However, until recently it has been considered an unacceptable **conflict of interest** to include TNCs as decision makers in public policy.

WHO has always interacted – and often collaborated - with private sector and other non-state actors. What is currently subsumed under the term partnerships with the private sector includes such diverse activities as corporate donation, sponsorship, research collaboration, negotiation or public tenders, and contracting out of selected health services. It also includes global health alliances, such as GAVI, GAIN and the Global Fund for AIDS, TB and Malaria which involve **high level policy interactions between UN agencies, corporations, and private foundations which propagate a business philosophy.**

Many of these interactions are not fundamentally new; others are social experiments. Some, such as the outsourcing of public health services, the funding of international public health and UN agencies through corporate charity and the GAVI style health alliances are highly problematic.

What is new – and of serious concern in most current PPPs - is that industry is invited as a 'full partner' in decision making processes on public issues.

Today, the UN Secretary-General's Report on Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector, states that it offers to the private sector through engagement in governmental processes "opportunities to have its voice heard."[1][1]

PHM argues that, in terms of both process and outcome, these developments are **incompatible with democratic decision making, economic justice, emancipatory development, human rights including the right to health – and therefore the achievement of Health for All.**

A second simple observation is that TNCs have a legal obligation to make a profit for shareholders. **The raison d'être of private companies is completely different from that of organizations and groups working for Health for All and the meeting of people's basic needs for health as a human right.**

We have only time to present the briefest summary of some of the risks to public health that this difference implies.

Public private partnerships:

- Allow private interests to set/influence the public health agenda.
- Sacrifice broad public health goals of prevention of disease, protection and promotion of health, and tackling of the underlying social and economic determinants of avoidable disease and death.
- Prioritize technological interventions, cosmetic and unsustainable, which generate profit for a minority.
- Favour short term, vertical approaches and privatization of essential public services rather than horizontal, comprehensive and sustainable public services.
- Provide legitimacy to corporations' activities through association with UN agencies (blue-washing); blur roles and real interests.
- Compromise public agencies, including UN agencies, and make them 'call the tune' for private interests of a tiny privileged minority rather than for 6 billion people.

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[1][1] UN (2005). Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector. Report of the Secretary-General, A/60/150, 10 August, para 20

As a policy paradigm, then, the PHM regards PPPs as fundamentally flawed. It thus follows that the actual evaluation of the effectiveness of particular PPPs in practice is of limited interest. PHM cautions that almost any project can demonstrate "effectiveness" within a narrow context using a specific set of indicators - if enough money is thrown at it by powerful actors, over a short space of time.

Evaluations of selected PPPs have been undertaken - though few of these have considered risks and harm in the widest sense - and the results have been variable. PHM's conclusion is that **PPPs are ideology-driven rather than evidence-based.** If one takes privatization of health services as an example (as this is prominently promoted through PPPs), no serious studies have yet shown that privatization of health services is either efficient or effective. A wealth of evidence exists, however, to show that national, universal, publicly run and funded health services are significantly cheaper and produce far better health outcomes.

So what kind of partnerships does PHM recommend? PHM promotes a broad based holistic approach to health which involves common struggles in a spirit of solidarity. **Individuals and groups with whom WHO could work as partners need to share goals and represent people's interests in terms of their right to health.**

This would include health workers, public service workers, trade unions, teachers, community workers, indigenous people's movements, landless peasants' movements, community groups, solidarity movements, public interest NGOs, civil society organizations, social justice political parties, professional associations and many more.

We support solidarity between groups and organizations serving the **public interest** within, across and beyond the health sector in order to address the major determinants of preventable disease, malnutrition and death **because it is through such arrangements that human rights and the right to health, which only some of us enjoy, have been won.**

We must never forget that these rights have been won painfully and slowly, with much suffering and loss of life for the poor – and against formidable obstacles in the form of powerful, private interests.

We cite as examples the efforts undertaken by various groups working in solidarity towards Health for All to address the lack of food and water, bearing in mind that:
a) these two factors together account for well over 60% of preventable disease and death,
b) mothers and children are always the primary victims in times of shortage, and
c) that women are largely responsible for the provision of these daily essentials.

- Access to water and to essential services has been won through partnerships between public sector workers, their unions, local community groups and health workers in countless places the world over, most notably in Cochabamba, Bolivia.
- The struggle for food sovereignty, critical to adequate consumption of high quality food, is the joint struggle of landless peasants' movements, opponents of

liberalization of the agricultural sector, and the tremendous worldwide movement for social and economic justice that has been meeting at the World Social Fora.

Such solidarity struggles involving collaboration between public interest groups confront the formidable and overwhelming power of TNCs that are behind the neoliberal restructuring of our world and increasing poverty and inequality – the first causes of poor health.

Referring now to this meeting at the World Health Organization:

Why are agencies and organizations with public responsibilities adopting these arrangements? For the simple reason that, today, **the private sector is considered the only untapped source of funds**. The term PPP encompasses essentially the hope to access funds of corporations and some hyper-rich. Under neoliberal economic regimes, public sector budgets have been slashed and tax bases destroyed. These developments are themselves the result of the influence of TNCs on governments and the international financial institutions.

The solution to this problem is not for public bodies to go knocking at the doors of the private sector, nor of the foundations of celebrity philanthropists from industry. The solution is economic justice, including an **adequate tax base, both nationally and internationally, to cover all public services,** as well as **proper funding of public institutions such as WHO** through regular budgets so that it may fulfill its international responsibilities unimpeded by corporate interests.

In relation to 'Making Partnerships Work for Health', we urge the World Health Organization to keep to the **founding principles set out in its Constitution.** In particular the following parts of the preamble:

"Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people."

"Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

The **PHM urges WHO to claim its rightful place as the international health authority** and to ensure, with governments, accountability to the people, not to private interests - in all matters of health. Our message is simple: **Work with the people, for the people!**

Together, we can achieve Health for All.

*: For reasons beyond PHM control, the statement was not read at this workshop.

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Policy lessons from comparing mortality from two global forces: international terrorism and tobacco

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Abstract

Background

The aim of this study was to compare the mortality burdens from two global impacts on mortality: international terrorism and the major cause of preventable death in developed countries – tobacco use. We also sought to examine the similarities and differences between these two causes of mortality so as to better inform the policy responses directed at prevention.

Methods

Data on deaths from international terrorism were obtained from a US State Department database for 1994–2003. Estimates for tobacco-attributable deaths were based on Peto et al 2003. The countries were 37 developed and East European countries.

Results and discussion

The collective annualized mortality burden from tobacco was approximately 5700 times that of international terrorism. The ratio of annual tobacco to international terrorism deaths was lowest for the United States at 1700 times, followed by Russia at 12,900 times. The tobacco death burden in all these countries was equivalent to the impact of an 11 September type terrorist attack every 14 hours.

Different perceptions of risk may contribute to the relative lack of a policy response to tobacco mortality, despite its relatively greater scale. The lack is also despite

tobacco control having a stronger evidence base for the prevention measures used.

Conclusion

This comparison highlights the way risk perception may determine different policy responses to global forces causing mortality. Nevertheless, the large mortality differential between international terrorism and tobacco use has policy implications for informing the rational use of resources to prevent premature death.

Background

International terrorism, or aspects of it, have been argued to be a reaction to globalization and/or to be aided by many of its features [1,2]. In the last twenty or more years, there has been a substantial focus on terrorism-related policies in many jurisdictions, particularly since the attacks of 11 September 2001 in the United States. This focus has included spending and legislation, and has included public health measures relating to bioterrorism protection [3,4]. The focus is understandable, considering the political significance of attacks by non-state organisations, and the economic and psychological effects on the societies which may consider themselves attacked [5-7]. However, it is important for policy makers to know of the opportunity costs of the response to international terrorism, relative to addressing other causes of premature death, and to better understand how differences in risk perception influence policy making. Therefore, we contrasted the mortality impacts of international terrorism with another major cause of preventable death – tobacco use [8] (which is also exacerbated by globalization [9,10]). This work is part of a wider attempt to put international terrorism into a public health context [11,12].

Methods

As part of a study to describe the epidemiology of international terrorism [11] we extracted data for 1994–2003 on international terrorist attacks involving any deaths among non-perpetrators from United States (US) Department of State reports. The definition of terrorism used by the Department is: 'Premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents', with international terrorism meant as 'terrorism involving citizens or the territory of more than one country'. These data were supplemented with findings from more detailed published studies (see: [11]). Countries included were 21 'established market economy' countries and 16 'former socialist economies of Europe' (as per the classification in an international mortality study) [13]. These two groups

of countries were selected because there was better quality data available for both terrorism and tobacco. From these data, an average annual mortality burden was calculated for each country.

Data on tobacco mortality was based on the updated estimates for the year 2000 by Peto et al [14]. This method involves country-specific rates of lung cancer mortality together with corresponding rates from the American Cancer Society's Cancer Prevention Study II to derive 'smoking impact ratios' by age and sex. The burden includes tobacco-related: respiratory diseases, vascular diseases and other tobacco-related cancers. This methodology has been shown to be a robust indicator of the accumulated hazards of smoking [15].

Rates were calculated using the most recent population data for each country from the World Health Organization website http://www.who.int/country/en/.

Results

For the selected countries collectively, the annual mortality burden from tobacco was approximately 5700 times that of the average annual mortality burden from international terrorism (Table 1). For 26 of the countries, there were no deaths from international terrorism. Within the other 11 countries, the ratio of annual tobacco to international terrorism deaths was lowest for the US at 1700 times, followed by Russia at 12,900 times.

The absolute annual burden from tobacco was highest for the US at 514,000 deaths per year in 2000 (Table 1). This is equivalent to the impact of an 11 September type terrorist attack every 2.1 days. For all of these 37 countries collectively, the tobacco mortality burden was equivalent to the impact of an 11 September type terrorist attack every 14 hours.

Discussion

Definitions of terrorism are highly contended [16-18]. Furthermore, we have identified some limitations with the US State Department dataset, including with the definition used [11]. Indeed, if a tighter definition of international terrorism was used, then this would substantially reduce the number of deaths categorised in this way (eg, relative to domestic terrorism or other types of homicide [11]). Therefore this analysis may over-represent the mortality burden from international terrorism to some degree.

In contrast, the tobacco mortality estimates may be underestimates of the true mortality burden. This is because the estimates by Peto et al ignore all deaths in those aged under 35 years (including neonatal deaths and deaths from sudden infant death syndrome attributable to smoking), and the methodology was one of 'conservative underestimation of tobacco hazards' [19]. More recent data also suggests that the long-term hazards of smoking on health are probably higher than previously thought [20]. Nevertheless, methodologies for assessing the tobacco-related mortality burden differ and for the US a more recent analysis [21] indicates a lower mortality burden attributable to tobacco (ie, 438,000 versus the 514,000 calculated by Peto et al and used in this analysis).

Despite these various limitations, the findings of this analysis suggest that the mortality burden from tobacco use is at present vastly greater than from international terrorism in all the selected countries studied. This is even the case for the US, which has suffered the worst mortality burden from international terrorism out of these countries in the last decade.

Why does tobacco mortality not receive a proportionate response? Some may find comparisons between 'catastrophic' and 'normal' deaths misplaced [22]. We recognise the subjectivity of risk perception [23,24], and the tendencies of populations to: (i) overestimate risks stemming from visible, well publicised sudden violence with collective results, particularly where the cause is not well understood, compared to risks with results dispersed over place and time; and (ii) to overestimate risks from causes were there is little apparent control by the individual, compared to risks from causes which appear to many to be voluntarily undertaken [25-27].

This tendency may be exacerbated by disproportionate media coverage of certain causes of mortality which involve low risk at the individual level [28,29]. There is also the political problem of giving priority to long-term issues, compared to dealing with emotive immediate concerns [30,31]. However, we have also demonstrated elsewhere that even for another cause of mortality which results in visible, well publicised sudden death (road crashes), policymaking does not appear to take into account the disproportionate mortality burden, compared to that from international terrorism [12].

International terrorism and the harm from tobacco use have similarities, in that they both involve discrete perpetrators – international terrorist groups and the globalized tobacco industry – against which governments can take action. Also, many tobacco deaths globally are due to the actions of foreigners – policymakers and company officials in tobacco manufacturing and exporting countries. Both international terrorism and tobacco use can substantially harm national economies and the international economic fabric in many ways [32,33]. Similarly, both can have widespread impacts on the way society functions and on its institutions eg, terrorism on security arrangements, and tobacco via the tobacco industry on the functioning of political processes [34,35]. The costs from both are largely or totally preventable, and investment in long-term prevention for both, as opposed to containment, may not necessarily be mutually exclusive (eg, if military budgets are diverted to terrorism prevention).

Despite these similarities, there are substantive differences. One is that the tobacco industry, unlike terrorists, is generally described as 'a legal industry' ie, an industry taking part in legal activity. This is despite the fact that the deliberate sale of a highly addictive, commonly lethal substance, and the routine denial of some harms (eg, of secondhand smoke) may be considered reckless criminal behaviour under the laws of some countries [36]. This presumed 'legality' contributes to the societal acceptance and political strength of the tobacco industry in developed countries, relative to international terrorist groups.

Secondly, there is considerable evidence about the preventability of tobacco-related harm using current methods, and of their cost-effectiveness [37-40], compared to the high uncertainty about the effectiveness of particular measures to prevent international terrorism or its health impacts [41,42]. From a public health perspective, anti-terrorism efforts tend to focus on immediate containment, rather than addressing the possible root causes of terrorism [43-46]. The cost-effectiveness of public health measures related to potential terrorism impacts has had little conclusive research [47,48].

A further difference, as this analysis indicates, is the vastly different *scale* of the consequent mortality burdens. The policy implications of this include the relative extent, effectiveness and cost-effectiveness of the resources used to address the two problems [49-52]. A public health and evidence-based approach may suggest a greater relative emphasis on tobacco control both nationally and internationally. While public health budgeting will always have to take into account public concerns that are not based on the evidence of relative risks, we argue that such policy moves should be as rigorously examined, as is the budgeting for tobacco control. A further possible implication is to learn from the response to international terrorism, so as to inform the way that tobacco marketing can be reframed as a serious threat to the social and economic well-being of individual countries and to international social and economic development.

Conclusion

This analysis suggests a very large mortality differential between these two problems exacerbated by globalization, international terrorism and tobacco use. Different perceptions of risk may contribute to the relative lack of a policy response to tobacco mortality, despite its greater scale. The lack of an appropriate response is also despite tobacco control having a stronger evidence base for the prevention measures used. National and international policy makers need to consider these issues if they are to make more rational use of resources to prevent premature mortality.

Competing interests

Both authors have undertaken contract work for tobacco control-related non-government agencies, and NW has undertaken contract work in tobacco control for the New Zealand Ministry of Health.

Authors' contributions

Both authors contributed to the design of the study, the data collection and the drafting and final write up of the manuscript. NW undertook the data analysis.

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Perspectives on Global Development and Technology

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Special Issue:

Globalization and Health

Guest Editors: Richard L. Harris and Melinda J. Seid

CONTENTS

Editors' Preface

This international collection of essays on globalization and health examines the global health issues associated with the economic, technological, political, social, cultural and environmental effects of globalization. These essays analyze the complex linkages between globalization and health, the health effects of globalization at all levels (global, national, and local), and the policy and institutional responses associated with the health consequences of globalization.

This collection combines essays that are global or broadly comparative in scope with those that focus on health issues in a single country or region. The contributors of these essays are international experts, officials, and scholars who are deeply concerned about the global health problems and issues addressed in this collection. They provide important information, insights, and conclusions about the linkages between globalization and health, the health effects of globalization, the major global health issues faced by humanity, and the responses that have been and need to be developed to these issues.

The health risks and challenges faced by humanity today are enormous. The global increase in chronic diseases as well as the spread of new and reemerging communicable diseases is unprecedented. The globalization of contemporary economic, technological, political, social and cultural forces and the health effects of these forces are increasing the risks to population health around the world. This collection of essays was organized to contribute to the global search for effective responses to the global health problems confronting humanity at the outset of the twenty-first century. Hopefully, it will contribute to increasing awareness about these problems and to the ongoing efforts to resolve them.

RICHARD L. HARRIS and MELINDA J. SEID

Perspectives on Global Development and Technology, Volume 3, issue 1-2

The People's Health Movement: A People's Campaign for "HEALTH FOR ALL—NOW!"

RAVI NARAYAN* AND CLAUDIO SCHUFTAN**

ABSTRACT

The People's Health Assembly and the People's Health Movement have been a civil society effort to counter the ill effects of globalization on health and health care. The Assembly, through an interactive dialogue, developed the People's Charter for Health as a tool for advocacy and a call for radical action. Consisting of a wide range of action initiatives, the People's Charter for Health, now translated into over forty languages, is helping to promote a movement that involves geographical circles of health professionals and activists that organize street-level rallies, policy debates and dialogues, and public education. The movement's advocacy efforts with the WHO and other major international health players and health campaigns are all focused on the goal of "Health for All—Now!"

Background

In 1978, an International Health Assembly at Alma-Ata in USSR, co-sponsored by the World Health Organization (WHO), United Nations' Children's Fund (UNICEF); and others, gave the World a slogan "Health for All by 2000" and endorsed the famous Alma-Ata Declaration, which brought people and communities to the center of health planning and health care strategies, and emphasized the role of community participation,

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appropriate technology, and intersectoral coordination. The declaration was endorsed by most of the governments of the world and symbolized a significant paradigm shift in the global understanding of health and health care (WHO—UNICEF 1978).

Twenty-two years later, after much policy rhetoric, some concerted but mostly ad hoc action, misplaced euphoria, assault and distortions by the growing market economy of medicine, and a lot of governmental and international health agency amnesia, this declaration remains unfulfilled and mostly forgotten. As the world comes to terms with the new economic forces of globalization, liberalization, and privatization, the dream of providing health for all is receding. The People's Health Assembly in Savar, Bangladesh, on December 4-8, 2000, and the People's Health Movement that evolved from it represent a civil society effort to counter this global amnesia and challenge health policymakers around the world with a people's health campaign for "Health for All—Now!"

The People's Health Assembly

The global People's Health Assembly held at Savar, Dhaka, from December 4-8, 2000, brought together 1453 people from 92 countries, in an unusual five-day event, sharing people's concerns about the unfulfilled Health for All initiative launched in Alma-Ata two decades earlier (Narayan 2000). The assembly included a variety of interactive dialogue opportunities for all the health professionals and activists who gathered for this significant event. These activities included the following:

- A march for health.
- Meetings at which testimonies on the health situation from many parts of the world and struggles of people were shared and commented upon by multidisciplinary resource persons (People's Health Movement 2002).
- Parallel workshops to discuss a range of health and health-related challenges.
- Cultural programs to symbolize the multiregional, multicultural, and multiethnic diversity of the peoples of the world; also exhibitions and video/film shows.
- Dialogue, in small and big groups, using formal and informal opportunities.

The assembly in Savar was preceded by a series of preassembly events all over the world. The most exceptional of these was the mobilization in India. For nearly nine months preceding the assembly, there were grassroots, local, and regional initiatives of people's health enquiries and audits; health songs and popular theater; subdistrict and district level seminars; policy dialogues and the translation of national consensus

documents on health into regional languages; and campaigns to challenge medical professionals and the health system to become more Health for All-oriented.

Finally, over 2000 delegates arrived in Kolkata, mostly by five people's health trains, bringing ideas and perspectives from 17 state conventions and 250 district conventions. At Kolkata, the assembly endorsed the Indian People's Health Charter, after two days of conferences, parallel workshops, exhibitions, a march for health, a public rally, and cultural programs. About 300 delegates from this assembly then traveled to Bangladesh, mostly by bus, to attend the global People's Health Assembly. Similar activities, though less intense, took place in Bangladesh, Nepal, Sri Lanka, Cambodia, the Philippines, Japan, and other parts of the world, including Latin America, Europe, Africa, and Australia.

The People's Charter for Health

Finally, at the end of a whole year of mobilization and five days of a very intense and interactive assembly at Savar, Bangladesh, a global people's health charter emerged, which was endorsed by all the participants (People's Health Assembly 2000a). This charter provides:

- an expression of common concerns;
- a vision of a better and healthier world;
- a call for radical action;
- a tool for advocating people's health; and
- a rallying point for global health movements, networks, and coalition building.

The global people's health charter is a significant development for many reasons. First, it endorses health as a social, economic, and political issue and a fundamental human right. Second, it identifies inequality, poverty, exploitation, violence, and injustice as the roots of ill health. Third, it underlines the imperative that Health for All means challenging powerful economic interests, opposing globalization in its existing iniquitous model, and drastically changing political and economic priorities. Fourth, it includes perspectives and voices of the poor and marginalized (rarely heard) people, and encourages them to develop their own local solutions. Finally, it encourages people to hold accountable their own local authorities, national governments, international organizations and corporations.

The vision and the principles of the charter, more than any other document preceding it, extricate health from the myopic biomedical-techno-managerialism of the last two decades, with its vertical, selective magic bullets approach to health, and centers squarely in the context of today's global social, economical, political, cultural, and environmental realities. However, the most significant gain of the People's Health

Assembly and the Charter is that, for the first time since the Alma-Ata Declaration (1978), a Health For All action plan unambiguously endorses a call for action that tackles the broader determinants of health. These include health as human right; economic challenges for health; social and political challenges for health; environmental challenges for health; tackling war, violence, conflict, and natural disasters; evolving a people-centered health sector; and encouraging people's participation in creating a healthy world.

In a nutshell, the People's Health Movement promotes a wide range of approaches and initiatives to combat the ill-effects on health, health systems, and health care initiatives of the triple assault by the forces of globalization, liberalization, and privatization. These approaches include the following:

- Combating the negative impacts of globalization as a worldwide economic and political ideology and process.
- Significantly reforming the international financial institutions and the WTO to make them more responsive to poverty alleviation and the Health for All Now movement.
- Forgiveness of the foreign debt of the least developed countries and the use of its equivalent for poverty reduction, health, and education activities.
- Greater checks, restraints, and mechanisms to ensure their compliance on the freewheeling powers of the transitional corporations, especially pharmaceutical firms.

In addition to these initiatives aimed at the existing institutional framework of the global economic system, the movement promotes a large number of more specific initiatives aimed at the following:

- Greater and more equitable household food security.
- Some type of a Tobin tax that will tax runaway international financial transfers.
- Unconditionally supporting the emancipation of women and respecting their full rights.
- Putting health higher in the development agenda of governments.
- Promoting the health (and other) rights of displaced people.
- Halting the privatization of public health facilities and working towards greater controls on the already installed private health sector.
- More equitable, just, and empowered people's participation in health and development matters.
- A greater focus on poverty alleviation in national and international development plans.
- Greater and unconditional access of the poor to health services and treatment regardless of their ability to pay.

- Strengthening public institutions, political parties, and trade unions involved in the struggles of the poor.
- Opposing restricted and dogmatic fundamentalist views of the development process.
- Greater vigilance and activism in matters of water and air pollution, the dumping of toxics, the disposal of waste, climate changes and CO2 emissions, soil erosion, and other attacks on the environment.
- Militant opposition to the unsustainable exploitation of natural resources and the destruction of forests.
- Protecting biodiversity and opposing biopiracy and the indiscriminate use of genetically modified seeds.
- Holding violators of environmental crimes accountable.
- Systematically applying environmental assessments of development projects and people-centered environmental audits.

Moreover, the movement has taken a position on a number of critical global political issues such as the following:

- Opposing war and the current USA-led, blind "anti-terrorist" campaigns.
- Categorically opposing the Israeli invasion of Palestinian towns, having, among others, a sizeable negative impact on the health of the Palestinian people.
- The democratization of the UN bodies and especially the Security Council.

Finally, the movement promotes a large number of initiatives aimed at transforming health in the most comprehensive manner possible. These include the following:

- Making a renewed call for a comprehensive, a more democratic people's health care that is given the resources needed and that holds governments accountable in this task.
- Independent national drug policies focused on essential, generic drugs.
- The transformation of WHO, supporting and actively working with its new Civil Society Initiative (CSI) and making sure it remains accountable to civil society.
- Assuring WHO stays staunchly independent from corporate interests.
- Sustaining and promoting the defense of effective patient's rights.
- Expanding and incorporating traditional medicine.
- Changing the training of health personnel to assure that it covers the great issues of our time as depicted in the People's Charter for Health.
- Public health-oriented (and not for-profit) health research worldwide.
- Strong people's organizations and a global movement working on health issues.

- More proactive countering of the media that are at the service of the globalization process.
- Promoting people's empowerment leading to their greater control of the health services they need and get.
- Creating the bases for more effective analysis and concerted actions by the PHM's members through their greater involvement in the PHM's website and listserve.
- Fostering a global solidarity network that can support and mobilize fellow members when facing disasters, emergencies, or acute repressive situations.
- Getting more actively involved in actions addressing the silent epidemic of violence against women.
- Assuring more prompt responses and preventive/rehabilitative measures in cases of natural disasters.

The decision to pursue this comprehensive combination of health initiatives, as we enter the new millennium, is probably the most significant achievement of the People's Health Assembly and the evolving People's Health Movement (Schuftan 2002).

Significant Gains of the People's Health Assembly and the PHM

The mobilization process at the global level, the assembly, and the development of the movement have already made many significant gains. For the first time in decades, health and non-health networks have come together to mobilize global solidarity and act collectivity for health. The main organizations that have taken the lead in this effort include the International People's Health Council (IPHC), Health Action International (HAI), Consumer International (CI), Asian Community Health Action Network (ACHAN), Third World Network (TWN), Women's Global Network for Reproductive Rights (WGNRR), Gonoshasthya Kendra (GK), and the Dag Hammaeskjold Foundation (DHF). More recently, new networks such as the Global Equity Gauge Alliance (GEGA) and the Social Forum Networks have joined the effort.

At the country level similar developments are beginning to happen. In India, for instance, the movement has gained the support of various scientific groups, women's movements, the alliance of people's movements, health networks and associations, research and policy networks, and some trade unions. Another significant development has been the development of solidarity between national movements. This solidarity has found symbolic expression in various collective documents at the global level (People's Health Assembly 2000b, 2000c). These documents have included themes such as Health in the Era of Globalization: From Victims to Protagonists;

the Political Economy of the Assault on Health; Equity and Inequity Today; the Medicalization of Health Care and the Challenge of Health for All; the Environmental Crisis: Threats to Health and Ways Forward; Communication as if People Mattered: and Adapting Health Promotion and Social Action to the Global Imbalances of the Twenty-First Century. Taken together, these documents represent an unprecedented, emerging, global consensus on a wide range of critical issues.

These kinds of "consensus documents" to support public education and policy advocacy have also been evolving at the country level. In India, for instance, five small booklets, now translated into most Indian languages are now being widely distributed on the following five issues: (1) what globalization means for people's health; (2) whatever happened to health for all by 2000 AD; (3) making life worth living by meeting basic needs of all; (4) a world where we all matter by focusing on the health care issues of women, children, street kids, the differently abled and the aged; and (5) confronting the commercialization of health care. These booklets have been published by 18 national networks that together form the national coordination committee in India and represent an unprecedented consensus on these issues, the first of its kind in five decades.

The People's Health Assembly itself was an unprecedented achievement. This international health gathering expresses and symbolizes an alternative health and development culture based on dialogue and the celebration of people's health. Another significant gain has been the translation of the People's Charter for Health into nearly 40 languages. These include Arabic, Bangla, Chinese, Danish, English, Farsi, Finnish, Flemish, French, German, Greek, Hindi, Indonesian, Italian, Japanese, Kannada, Malayalam, Ndebele, Nepalese, Philippine, Portuguese, Russian, Shona, Sinhala, Spanish, Swahili, Swedish, Tamil, Urdu, Ukrainian, and in the process are Tonga, Lithuanian, Norwegian, Welsh, Thai, Cambodian, Vietnamese, Pastun, Dhari, and Creole. An audio tape in English with Braille titles is also available. All these translations have been translated by volunteers who are committed to the People's Health Movement.

Audio visual aids, including videos for public education, exhibitions, slides, and other forms of communication, are being developed and distributed. There is a new BBC Life Series video on the Health Protesters, which focuses on the PHM movement. The movement itself has evolved a communication strategy, which includes a website (www.phmovement.org); an e-group exchange/discussion group (PHA-Exchange@kabissa.org); news briefs (nine since January 2001) and a host of press releases on a wide variety of themes, special events, and crises.

Presentations of the People's Health Charter have taken place at national, regional, and international fora. They have included the World

Health Organization, the Global Forum for Health Research (GFHR Forum 5 & 6), and the World Health Assembly. The relationship that has developed between the PHM and WHO is particularly interesting. In April 2001, a very effective and assertive lobbying effort by a visiting PHM consultant to a WHO research seminar resulted in the formation of the WHO Civil Society Initiative (WHO CSI) announced at the World Health Assembly in May 2001. Six PHM leaders were subsequently invited to meet and dialogue with the WHO Director General. In May 2002, WHO CSI invited PHM to present the People's Charter for Health as a Technical Briefing to the World Heath Assembly. Thirty-five PHM members participated in this event. In May 2003, over 80 PHM delegates from 30 countries attended the 2003 World Health Assembly and made statements on primary health care, TRIPS and other issues and were invited to meet the new Director General designate, who welcomed greater dialogue with PHM members at all levels of the WHO so that the organization can be in touch with the realities of the lives of the poor and the marginalized. The 2003 World Health Assembly was preceded by a PHM Geneva meeting on the Alma-Ata Anniversary, which was attended by some WHO staff, including the Pan-American Health Organization Regional Director. These developments represent small but incremental movements towards a critical collaboration between PHM and the WHO.

In many countries of the world, country-level PHM circles are beginning to organize public meetings and local campaigns that include taking health to the streets as a human rights issue. Discussions on the charter held with professional associations and public health schools, articles and editorials in medical/health journals are also beginning to increase. Policy dialogues and action research circles are also being developed on the WHO/WHA, Poverty and AIDS, Women's Access to Heath, Health Research, Access to Essential Drugs, Macroeconomics and Health, Public Private Partnerships, and Food and Nutrition Security issues. Everyday the list of actions increases.

Conclusion

The People's Health Assembly and the People's Health Movement that have emerged from it have been an unprecedented development in the journey towards the goal of Health for All. The PHM movement:

- is a multiregional, multicultural, and multidisciplinary mobilization effort;
- brings together the largest collection of activists and professionals, civil society representatives, and people's representatives themselves;
- develops global instruments of concern and action; and

- expresses solidarity with the health struggles of people around the world, especially the poor and the marginalized who are affected by the current global economic order.

Recognizing that we need a continous, sustained, collective effort, the People's Health Movement process reminds us, through the People's Health Charter, that a long road lies ahead in the campaign for Health for All.

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The Globalization of Health: Risks, Responses, and Alternatives

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ABSTRACT

This essay provides a summary and synthesis of the wealth of information, analysis, and conclusions provided by the other contributors to this collection of essays on globalization and health. The major themes addressed are the health risks and health effects of globalization, the responses to these risks and effects at the national and global levels, and the alternatives to the present patterns of globalization in which the health of billions of people around the world and the planet's ecological sustainability are threatened.

Introduction

In the introduction to this collection of essays on globalization and health, we pointed out that, according to the existing literature on globalization and health, it is generally accepted that certain aspects of globalization have "enhanced health and life expectancy in many populations," while other aspects of globalization "jeopardize population health via the erosion of social and environmental conditions, the global division of labor, the exacerbation of the rich-poor gap between and within countries, and the accelerating spread of consumerism" (McMichael and Beaglehole 2000). These threatening aspects of globalization present major challenges for

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health researchers, practitioners, and policymakers today, and they are the major focus of this collection of essays.

The contributors to this collection of essays on globalization and health provide a wealth of information, analyses and conclusions on many of the health risks and health effects of globalization, on the responses to these risks and effects, and on the search for alternatives to how the contemporary forces of globalization affect health around the world today. In the pages that follow, we provide a summary and synthesis of the major findings on these themes that the contributors to this collection of essays have reported in the preceding pages.

The Health Benefits and Risks Associated with Globalization

Most of the contributors to this collection of essays agree that there have been some significant health benefits from globalization. For example, Badawi, Labonte, McMurray, Smith, and Yach and Beaglehole acknowledge in their essays that the global diffusion of new health-related knowledge and technologies as a result of international trade and investments has contributed to disease surveillance, treatment and prevention around the world as well as the spread of sanitation and vaccines that have greatly reduced the threat of many deadly diseases.

McMurray states in her essay that "there is no doubt the spread of Western medicine through out the world and the implementation of global health programs has brought numerous benefits"; however, she also points out that "at the same time, globalization has promoted patterns of dependency, development, settlement and lifestyles that have been detrimental to health." Smith's essay reveals how new information and communication technologies (ICT) are being applied to healthcare in some of the more remote areas of the Pacific islands, and he argues that these technologies have the potential to provide "a remarkable expansion of the medical expertise available to act in a curative manner" and to advance preventative healthcare in these remote areas of the world. However, Smith's essay also reveals how these technologies, which are a central feature of globalization, are a "two-edged sword."

On the one side of the sword, the new information technologies and Internet connectivity enhance the provision of healthcare to people in remote and marginalized areas, but on the other side, they reinforce the neocolonial ties and unequal power relationship that exist between these areas and the developed core economies. They also transmit the more negative aspects of the consumerist life-styles associated with these economies.

The essay by Finau, Wainiqolo, and Cuboni focuses on how the "changes in health of Pacificans are about the power imbalances brought

about by globalization, imperialism and colonialism." They see "the continuance of colonialism and imperialism in different forms" in the present context of globalization. They also argue that many contemporary "technologies and ideologies contribute to the reproduction and the strengthening of the pattern of power relations that feed imperialism." In their essay on women's reproductive health in post-transition Mongolia, Rak and Janes provide an example of how this works. Their research shows how the global discourse on family planning and reproductive health as well as global reproductive health policies are based on assumptions that "fail to consider the local cultural context of reproductive decision-making, do not meet women's needs, and are therefore seriously flawed." Nevertheless, external donors and consultants who are in a very real sense the agents of globalization in this case are imposing these global norms and policies on women in Mongolia.

Most of the contributors to this collection of essays reveal either explicitly or implicitly that, in fact, what is generally referred to as "globalization" is none other than the global expansion and integration of contemporary forms of capitalist production, distribution, and consumption. Their essays reveal that the global expansion and integration of twenty-first century capitalism involves not only the global diffusion of certain technologies, products, and practices, it also involves the global dissemination of certain ideologies and cultural norms.

Together, these forces of capitalist globalization have inadvertently or purposively promoted the following types of global health risks:

- The global spread of various communicable and noncommunicable diseases.
- The global promotion of unhealthy products and practices.
- The global diffusion of a wide range of technologies and production processes that are hazardous both to human health and to the health of the natural environment.
- The global promotion of inequitable forms of private health care and the commercialization of health services and medicines that place them beyond the reach of large sectors of the world's population.
- The global diffusion of Western norms, practices, and ideological models/paradigms of health care that often conflict with local values and needs and that create/reinforce inequitable power relationships and social inequities.

As we learn more about these and other adverse health effects of the global expansion and integration of modern capitalism, it is clear that many of the contemporary effects of the globalization of twenty-first century capitalism are a serious threat to not only the health of billions of people around the world but also to the sustainability of the planet's entire biosphere.

As Labonte points out in his essay, we have now lived through more than twenty years in which the global diffusion of knowledge and technology has taken place under a neoliberal capitalist regime of trade liberalization and global economic integration; yet the health impacts of this process of liberalization and globalization have been largely negative, especially the effects of this process on what Labonte refers to as the two fundamental health-determining pathways of globalization: poverty/inequality and environmental sustainability.

The liberalization and globalization of the economies of many developing countries have been accompanied by a corresponding increase in the poverty, environmental degradation, and poor health of a large proportion of the population. Loewenson notes in her essay that the incomes of a quarter of the world's population declined at the end of the last millennium when globalization was going at top speed. Even many of the positive effects of the global expansion and integration of capitalism have adverse consequences. Labonte's essay gives the example of how the opening of the economies of many developing countries to international trade and investment has increased the access of women to wage-earning employment and contributed to their empowerment in gender relations. However, he points out that more often than not they are employed in low-paid, unhealthy and insecure jobs, frequently in so-called free trade export zones where labor organizations are prohibited and only single young women are employed under hazardous working conditions (and often exploited and sexually harassed). Loewenson reports in her essay that these young women have been documented to experience high levels of job stress and reproductive health problems, including miscarriages, problems with pregnancies, and poor fetal health.

McMurray's essay illustrates how the globalization of capitalism intensifies disparities in health between and within nations and also how it can create paradoxical health outcomes in the most peripheral areas of the global capitalist economy. Her essay reveals that in the smallest and most remote countries within the global system, such as the Pacific island countries, the negative health effects of capitalist globalization impact the population more in the globalized (Westernized) and urbanized core areas than in the thinly populated and more peripheral rural areas that have less access to modern health services but relatively better environmental health conditions. McMurray focuses on how globalization affects these societies through, "first, its impact on environmental quality, second, its impact on the quality and accessibility of health services, and third, its promotion of unhealthy lifestyles."

As Labonte's essay and our own introductory essay in this collection indicate, the extent to which the forces of globalization affect the health

of the population in individual countries depends upon the prevailing economic, social, and political conditions in these countries; their level of technological and economic development; and their natural endowments (Cornia 2001; Drager, Labonte, and Torgerson 2002; Woodward et al. 2001). These indigenous factors mediate most of the direct effects of globalization on the national/domestic level as well as many of the indirect effects of globalization on the community and household levels.

Labonte's essay reveals that the forces of capitalist globalization affect population health at the national level through various channels or pathways, such as externally imposed macroeconomic policies (e.g., IMF structural adjustment programs and monetary policies), the enforcement of trade agreements, the flows of trade associated with these agreements, official development assistance (from the United States and other major "donor" countries), the international transfer of health-related knowledge and information, and the influence of the global communications and entertainment media. There are also "environmental pathways" through which capitalist globalization affects health. These pathways include cross-border pollution, the depletion/contamination of natural resources (water, the soil, fish stocks, and forests), and the destruction of the biodiversity in local ecosystems. Many of the essays in this collection touch upon the health effects of these environmental pathways of globalization.

Globalization and Life Style Changes

Most of the essays in this collection support the thesis that certain contemporary patterns of death and disability are caused by the lifestyle changes promoted by globalization, particularly the increased consumption of unhealthy processed foods and products. These lifestyle changes and particularly the unhealthy consumption patterns they entail are, as Yach and Beaglehole demonstrate in their essay, contributing to an alarming global increase in chronic and noncommunicable diseases (NCDs)—the so-called diseases of affluence (although they are increasingly suffered by the poor). McMurray, Smith, and Finau and his colleagues all address the negative health impact of these lifestyle changes and the increased consumption of unhealthy foods, especially in the island nations of the Pacific.

All three essays on the Pacific call attention to the health effects of both the disruptive changes and the uneven pattern of economic and social development that have been promoted in the developing countries by contemporary forms of capitalist investment, trade and production. Finau, Wainiqolo and Cuboni emphasize the disruptive and destructive nature of many of these changes and attribute them to the Western capitalist

model of development that has been imposed on the Pacific peoples by colonialism, imperialism, and globalization.

According to Yach and Beaglehole, an unprecedented epidemiological or "health transition" is taking place in the world, and this transition is responsible for the global increase in NCDs and the "double burden of disease" (both communicable and noncommunicable diseases) suffered by the populations of most of the developing countries. They cite data, which indicate that NCDs have become the main cause of death and disability throughout the world. They attribute this development to both the positive aspects of globalization, which have contributed to the aging of the world's population through the diffusion of modern medicine and sanitation, and to the negative aspects of globalization, which have promoted the adoption of unhealthy lifestyles.

They also note that the uneven development and social inequalities associated with globalization are largely responsible for the fact that many communicable diseases continue to be a major cause of death and disability in the least developed areas (e.g., in sub-Saharan Africa and South Asia) and in the poorer sectors of the population throughout the developing countries. Thus, the poor in these areas suffer the so-called double burden of disease (both communicable and NCDs) caused by the uneven patterns of development and "poverty gaps" associated with the global expansion of capitalism.

However, Finau, Wainiqolo, and Cuboni question the validity of the "health transition" paradigm that Yach and Beaglehole and other global health researchers use in their work. They question how much of the so-called heath transition or what they call the "mortality transition" in the Pacific countries is really due to the spread of NCDs as opposed to underlying infectious risk factors, such as the emerging evidence that certain NCDs may be caused by *Heliocobacter pylori*, *Chlamydia pneumoniae*, and oral bacterial diseases. They also note that, for many Pacificans, the quality of life they are now living "due to various transitions, may as well mean that they are dead long before the certification of the expiry of life."

Finau and his colleagues argue that it is in fact a cluster of various types of transitions (religious, economic, environmental, political, social, etc.) and particularly inequitable power relationships established by colonialism and imperialism that are responsible for the poor health, dependency, and lack of control over their own socio-economic development suffered by the Pacific peoples. They blame the contemporary forces of globalization for reinforcing and masking these determinants of health in the Pacific.

McMurray's contribution to this collection of essays calls our attention to the fact that one of the effects of capitalist globalization in the developing countries is the migration of large numbers of people to the urban areas

in these countries, where they hope to find wage-earning employment and access to modern consumer goods. However, most urban migrants are exposed to poor nutrition, substandard housing, and unsanitary environments in these urban areas. As McMurray indicates in her essay, the limited employment and the low incomes that these migrants generally earn leave them "no choice but to purchase the cheapest food, which tends to be the least nutritious." Moreover, their consumption of unhealthy foods is generally combined with their exposure to unsanitary environmental conditions.

The problem is that there are very few employment opportunities in the urban areas and most jobs do not provide an adequate income. As a result, there is widespread unemployment, and most people who are employed do not earn enough income to maintain a nutritious dietary intake or healthy lifestyle. McMurray also reveals that under these circumstances of urbanization without adequate employment, young people generally have little incentive to maintain a healthy lifestyle and often engage in various types of substance abuse and other unhealthy forms of behavior. Based on her research in the Pacific, McMurray has found that "the negative impact of urban lifestyles on health is clearly evident in that the incidence of early onset NCDs" in the Pacific "is lower in the outer islands and remote areas ... where traditional foods are consumed and people are engaged in subsistence agriculture and food gathering." She contends that similar conditions "can be observed in peripheral areas everywhere, including remote and economically depressed areas within most industrialized countries."

According to McMurray, the rising incidence of early onset NCDs among the urban population in the Pacific is "a direct consequence of global forces that have led to urbanization without industrialization, idealization of Western lifestyles and imports of cheap food, alcohol and cigarettes." She argues that no real improvements in the population health of the Pacific island nations and other developing countries can be achieved under these conditions "until their people are empowered and have the means to choose healthy lifestyles."

As indicated, Yach and Beaglehole also hold globalization responsible for the lifestyle changes that have produced the rapid increases in chronic diseases (especially cardiovascular disease, coronary heart disease, stroke, cancer, chronic respiratory disease and diabetes) in the developing countries and the fact that these diseases are now the major components of the global burden of disease in all regions of the world. Moreover, they argue that "policy makers and the donor community have neglected the rapidly growing burden of chronic diseases" even though they are the

major cause of death and ill-health in most of the developing as well as the developed countries of the world.

Yach and Beaglehole contend that these diseases "predominate among poor populations largely because of inequalities in the distribution of major chronic disease risk factors." They claim these risk factors are "driven by the more fundamental causes of ill health in the socio-economic environment." They blame "global forces in trade and marketing" for promoting "the entrenchment of the causes of these chronic diseases in all regions." The health risks they identify are tobacco consumption, unhealthy diet/nutrition, physical inactivity and alcohol use, as well as the failure to invest in appropriate prevention and health promotion measures. They indicate that "most of these risk factors are common to the main categories of chronic diseases and all are modifiable, albeit with some difficulty."

According to Yach and Beaglehole, the aging of most populations due to declining fertility rates and increasing child survival rates (one of the health benefits of globalization), and the "nutrition transition" to diets that are high in saturated fats and sugars but low in fruits and vegetables, as well as smoking and alcohol usage, are being promoted by the forces of globalization. They also note that the nutrition transition to unhealthy diets is generally combined with lower levels of physical activity and regular tobacco and alcohol consumption. In fact, they cite WHO data that indicate tobacco and alcohol consumption, high blood pressure, and high cholesterol levels are the major contributors to the global burden of chronic diseases.

Yach and Beaglehole say that globalization has contributed to the rise in chronic diseases through a complex array of both direct and indirect factors. They focus on "the direct negative effects of globalization," which they claim are best "illustrated by the increasingly globalized production, promotion and marketing of tobacco, alcohol and other products with adverse effects on population health status." They blame major transnational corporations and the global communications media for "the marketing of tobacco, alcohol, sugary and fatty foods" in nearly all parts of the world. They indicate that "a significant portion of all global marketing is now targeted at children under the age of 14," since the companies that market high sugar and high fat fast foods, cigarettes and alcoholic beverages seek "to foster brand-loyalty among pre-teens, as young as six years, and teenagers."

They give particular emphasis to what they call the "globalization of the tobacco pandemic," and the "strong link between increased tobacco consumption and free trade and tobacco-related foreign direct investment." Based on their research for the WHO, they have found that "tobacco companies aggressively exploit the potential for growth in tobacco sales

in developing countries." They claim this practice is "not surprising since they are motivated only by their obligations to shareholders." According to Yach and Beaglehole, "the main targets of the industry and the associated marketing campaigns are now young people and women, most of whom do not smoke."

Having been closely associated with the WHO's tobacco control efforts and the international campaign on behalf of the Framework Convention on Tobacco Control, Yach and Beaglehole know a great deal about the tactics that have been used by the transnational tobacco corporations to subvert and oppose "any effective international regulatory regime" dealing with the marketing, sale, and consumption of tobacco products. Included among these tactics are the companies' frequent public refutation or denial of the evidence about the harmful effects of smoking and their practice of "paying scientists to carry out spurious research aimed at confusing the public and delaying action" to control tobacco marketing and consumption.

Yach and Beaglehole's research also leads them to conclude that the "alcohol industry is becoming as globally integrated and pervasive as the tobacco industry." They claim that there is a direct link between the consumption of alcohol and certain cancers, cirrhosis of the liver, and most injuries, especially motor vehicle-related injuries and injuries resulting from violence. For this reason, they argue that there is a pressing need for global action to control the marketing of alcohol to young people, "especially through its association with sporting events and with gender specific roles."

Trade Liberalization and the Privatization of Health Care

The essays by Labonte, Badawi and McIntyre, Thomas and Cleary as well as the contribution by Yach and Beaglehole reveal the adverse effects on health of multilateral agreements such as the General Agreement on Tariffs and Trade (GATT), the Technical Barriers to Trade (TBT) Agreement, the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS), the Agreement on Trade-Related Intellectual Property Rights (TRIPS), and the General Agreement on Trade in Services (GATS). The essay by McIntyre, Thomas, and Cleary reveals how the GATS contributes to the already existing problem of the migration of skilled health professionals from South Africa (and other developing countries) to the developed countries. Their essay also reveals the difficulties TRIPS imposes on poorer countries that try to import or produce affordable medicines to fight the disastrous effects of global diseases such as HIV/AIDS.

Badawi states that "access to low-cost, safe and effective essential drugs is largely threatened by the agreement on TRIPS." He argues that "technology transfer, production and global movement of health commodities are also threatened by the monopoly TRIPS gives to the

companies who hold patents protected by the TRIPS agreement." In fact, as Labonte indicates, agreements such as TRIPS do not promote "free trade"; rather they promote the protection and entrenchment of the so-called intellectual property rights and lucrative profits of companies and individuals in the wealthier developed countries.

Labonte points out that the global "brain drain" of trained health professionals from the developing to the developed countries has so far cost the developing countries at least an estimated 500 million US dollars in training costs. The GATS agreement is likely to accelerate this transfer of skilled health practitioners from the developing to the developed countries. Labonte notes that some 54 members of the WTO (including many developing countries) have so far agreed to liberalize/privatize their health care systems under the terms of the GATS agreement. The implementation of the GATS provisions on the "progressive liberalization" of services will contribute to the regressive privatization of health care systems, promote the brain drain of health practitioners, and benefit the health of the wealthier at the expense of the poorer sectors of the population.

The essays by Labonte, Yach and Beaglehole, Loewenson, and Badawi indicate that the trade liberalization measures and the neoliberal economic reforms associated with capitalist globalization have shifted a greater burden of the costs of health care to those who can least afford to assume these costs: low-paid workers in the export zones and industrialized urban areas within the developing countries; self-employed and casual workers in the growing "informal sector" of the economies of these countries; landless peasants and agricultural workers; and the large numbers of unemployed, disabled and indigenous/tribal peoples around the world. They generally do not have access to adequate health care and other forms of social protection.

The IMF, World Bank, WTO and the main donors of official development assistance have promoted the downsizing of the public sector and the privatization of health care and other social services around the world. Largely as a result of their influence, the governments of the developing countries and the former socialist countries ("emerging economies") have privatized their health services and/or imposed so-called user fees and/or other types of "cost recovery" measures that have raised the cost of such services above the capacity of large sectors of the population to pay for them.

Badawi, Loewenson, and McIntyre and her associates call attention to the fact that the poorer sectors of the population are not covered by health insurance in most of the developing countries where health care is being privatized. Moreover, the governments of these countries generally do not have sufficient funds to provide adequate social protection

to the population, especially under the "state shrinking" and fiscal restraints imposed on them by the IMF, the World Bank, and the other guardians and promoters of globalization. As Loewenson notes, under these circumstances job-related injuries and ill health generally lead to not only the loss of employment and household income, but to impoverishment and the breakdown of the overburdened informal mechanisms of social protection provided by the extended family and local community.

The privatization of health care has been particularly unkind to the poor and to low-income households. As Badawi notes in his essay, many people in the developing countries have been caught between the inability of their governments to continue providing free public health services and their own inability to pay the rising costs of basic health care. The forces of globalization have led governments to reduce their spending on health and other forms of social protection, to sell off many of their public health facilities, and to encourage the privatization and commercialization of health services and products. As a result, there has been a marked deterioration in the health services of many of these countries and restricted access to these services—both of which threaten the health of large sectors of the population.

In the present context of increasing privatization and the promotion of neoliberal policies at both global and the national levels by the IMF, World Bank, and the WTO, national government responsibility for providing basic health care for all members of the population has been replaced by so-called selective primary health care, public-private partnerships, and the privatization of health services and health care facilities. As the essay by Narayan and Schuftan indicates, this shift in responsibility for providing health care is considered by many critics of globalization and the current trends in health to be a betrayal of the international commitment made in the late seventies to provide primary health care for all by the year 2000. This was the official commitment made by most of the governments represented at the 1978 International Health Assembly held at Alma-Ata in the central Asian republic of what was then the Union of Soviet Socialist Republics (PHA 2000:1).

The Alma-Ata declaration set forth the goal of achieving "Health for All by the Year 2000" and charged the health ministries and health workers around the world with the responsibility for providing comprehensive primary health care to all the members of their societies by the beginning of the new millennium. As Narayan and Schuftan indicate in their essay, the global network of health activists and health advocacy organizations involved in the People's Health Movement (PHM) seek to halt the privatization and commercialization of health care. The PHM holds that health is a fundamental human right and that national governments have

an obligation to ensure universal access to quality health care, education, and other social services in accordance with people's needs, not their ability to pay. They are mobilizing broad-based popular movements around the world in a global campaign to achieve the goal of "Health for All—Now!" by pressuring governments to provide comprehensive primary health care to their populations and incorporate health and other human rights into their national constitutions and legal systems.

The Health Effects of Dependency, Neocolonialism, and Western Ideological Paradigms

The essays by McMurray, Narayan and Schuftan, Rak and Janes, and Finau and his colleagues reveal that Western medicine has been imposed as the universal standard around the world, and that the health systems of most developing countries are generally dependent upon the development assistance they receive from the governments and NGOs of the developed Western countries as well as international organizations such as the World Bank and the World Health Organization (WHO). McMurray contends that the health programs in the Pacific countries "are determined by global health policies, set by the World Health Organization and other health sector donors." Moreover, she argues that much of the assistance these programs receive "fosters dependency and imposes conditions" on the recipients that force them to accept donor policies, practices and medicines as well as consultants from the donor countries.

Narayan and Schuftan indicate that the People's Health Movement believes that it has extricated health and health systems around the world from the "myopic biomedical-techno-managerialism of the last two decades, with its selective magic bullets approach to health." The PHM's analysis of the political economy of health in the world today (PHA 2001) lead its advocates to conclude that the most significant determinants of health in the world today are economic and political factors that have colonial roots. Moreover, the movement's analysis indicates that people's health around the world is under a triple assault from globalization, liberalization, and privatization, which Narayan and Schuftan claim "have ensured that health for all is a receding dream." The PHM argues that "health services today are inaccessible, unaffordable, inequitably distributed and inappropriate in their emphasis and approach" (PHA 2001:3). The movement also claims that "health care is increasingly used as a subtle and widespread instrument of social control," and that the Western model or "ideology of medicine ... mystifies the real causes of illness, often attributing disease to faulty individual behavior or natural misfortune, rather than to social injustice, economic inequality and oppressive political systems" (PHA 2001:18).

The essay by Finau, Wainiqolo, and Cuboni as well as the essay by McMurray trace the current dependency and Western orientation of the health care systems in the developing countries to the imposition of the Western curative model of health care on these societies by their former Western colonial rulers. They attribute the continued dominance of Western health policies, standards and practices in these societies to the development assistance they receive from the developed countries, the globalizing influence of Western education and training, and the economic dependency of these countries on the developed Western countries (as well as "Westernized" Japan). In fact, as Finau and his colleagues assert in the case of the Pacific island societies, many developing countries "are still practically colonies," and as such they are still subjected to the racism, imperialist domination and exploitation they suffered under colonialism—in the health field as well as in other fields.

Finau, Wainiqolo, and Cuboni argue that "imperialists control all phases and determinants of the health transition" in the Pacific countries, and "the socialization of Pacificans, through foreign education, is another imperialist tool to enhance control" over the Pacific peoples. In fact, Finau and his colleagues take the position that "globalization is the latest label for capitalism, colonialism and imperialist expansion combined," and they regard the ideology of globalization as nothing more than an updated version of the classic imperialist justification for the Western domination of non-Western peoples formerly known as the "white man's burden." According to Finau, Wainiqolo, and Cuboni most Western-trained health personnel practice, reflect, and promote the Western emphasis on fighting disease at the individual level rather than promoting community health in a holistic manner. They argue most doctors and nurses are trained as disease fighters to save individuals rather than as health promoters to save communities. Imperialist ideologies and logics perpetuate and reproduce the power imbalance and inequities of the past as well as strengthen the pattern of inequitable power relations associated with contemporary forms of imperialism under the guise of globalization.

Rak and Janes' essay on reproductive health in Mongolia reveals how global reproductive health policies, promoted by international NGOs and the governments of developed countries such as the United States, impose family planning methods on women in countries such as Mongolia that often run counter to the beliefs, experiences, and needs of the local population. These imposed paternalistic and ethnocentric family planning methods have ignored local cultural values and devalued the alternatives that exist at the local level. Rak and Janes reveal the contradictions in this approach within the context of Mongolia's rapidly deteriorating health services caused by the adoption of market-based reforms, the reduction

of the public budget for health care and the privatization of the health sector.

The Health Effects of the Inequities Promoted by Globalization

At the outset of the new millennium, the WHO noted that "the greatest burden of health risks is borne by the poor countries, and by the disadvantaged in all societies" (WHO 2002:13). These sectors of the world's population have the misfortune of suffering the health effects of poverty as well as well as the other social and economic inequities that characterize the present era of capitalist global expansion and integration. Most of the essays in this collection reveal that globalization is associated with economic policies that create, reinforce, and intensify the inequities in health found throughout the world. Thus, Loewenson states in her essay that "within the current processes of globalization, inequality is not simply happening but is being constructed by powerful economic and political interests and public policies" that keep the benefits of globalization from reaching those who need them the most. Finau, Wainiqolo, and Cuboni contend that the economic and social inequities (including the health inequities) that the Pacific peoples have inherited from colonial rule are reinforced today by the contemporary forces of globalization, which they hold responsible for the continuation of Western imperialism.

McIntyre, Thomas, and Cleary reveal in their essay how the struggle to overcome the "legacy of massive inequalities in income, health status and access to health and other social services" resulting from South Africa's colonial, racist, and repressive past has been hindered by the contemporary forces of globalization. Moreover, they reveal that it is not just the obvious forms of global intervention such as IMF loan conditions, externally enforced compliance with the TRIPS Agreement on patented HIV/AIDS medicines, and the World Bank's privatization of health care programs that exacerbate the existing inequities in South Africa. It is also the more subtle and indirect influences of globalization that have led the post-apartheid government in South Africa to adopt "self-imposed" structural adjustments in order not to run afoul of the major forces in the global economy. These self-imposed policies and practices tend to reinforce the health inequities created by centuries of colonialism, racism, and European domination on the African continent.

The essay by McIntyre and her colleagues reveals the extent to which the global trend towards the privatization of health care and the indirect impact of global health actors on the health sector in South Africa have contributed to the "rapid and uncontrolled growth of the private sector," which in turn "has contributed to disparities in health service access and the health of South Africans." Today, less than 20 percent of the

population has access to more than 60 percent of the financial resources for health care, while the remaining 80 percent of the population have access to less than 40 percent of the financial resources devoted to health care in the country. Moreover, only one-fourth of the doctors in the country work in the public health sector, which serves the historically disadvantaged majority of the population.

Rak and Janes premise their analysis of the global discourse on reproductive health and its application to Mongolia on the assertion that poverty in its modern sense was created in the developing countries by the spread of the market economy and years of colonial rule, and they argue that the current policies to "develop" these countries "have exacerbated the divide between the rich and the poor." Since the country adopted market reforms, privatization, and the integration of its economy into the global capitalist economic system, Mongolia has experienced a rapid deterioration in its health services, increasing social inequality, and a high level of male unemployment. Rak and Janes conclude that "it has taken the transition from a socialist to a market economy, led by the intervention of the global financial and policy institutions of the developed world, to create Mongolia as a Third World country."

The PHM, as Narayan and Schuftan's essay explains, sees a direct relationship between existing health inequities and globalization. The members of this global movement consider inequality, poverty, exploitation, violence and injustice as the root causes of ill health in the world today. As Narayan and Schuftan make clear in their discussion of the People's Charter for Health, achievement of the PHM's goal of "Health for All—Now!" requires "challenging the powerful economic interests that dominant the existing global order, opposing globalization in its existing iniquitous form, and drastically changing the political and economic priorities at all levels of the global system."

The Environmental Health Effects of Globalization

The wide variety and scope of globalization's environmental effects make it difficult to provide a sufficiently comprehensive analysis of these effects in any single book or collection of essays. This collection of essays does little more than scratch the surface of the health impact of some of the more complex and far-reaching environmental effects of globalization, such as global climate change, the depletion of the ozone layer, and the contamination of oceans, lakes, and rivers around the world.

As we indicated in our introductory essay to this collection, there is mounting evidence that the global diffusion of capitalist patterns of production and consumption developed in the Western industrial societies has created a multitude of environmental problems. In a research study

undertaken by Diaz-Bonilla and his colleagues on the health risks of the poor in developing countries, they claim that "poor environmental quality has been calculated to be directly responsible for around 25 percent of all preventable ill-health in the world today" (Diaz-Bonilla et al. 2002:38). They attribute much of this "poor environmental quality" to the environmental "spill-over" effects of economic globalization.

Many of the essays in this collection recognize the threats to health posed by the environmental effects of globalization. For example, Badawi notes that environmental threats to health have resulted from the increasing international trade in technology, capital, goods, services and labor. He notes that many "environmentally unfriendly" industries have moved from the developed to the developing countries, where there is generally less concern about the health hazards caused by their technology and often a lack of environmental health safeguards. Badawi also states that the over exploitation of fishing licenses, deforestation, industrial waste, and the dumping of health-hazardous materials are part of a long list of environmental health threats confronting the populations of the developing countries. Moreover, he warns that the indigenous germ pool and medicinal plants in the developing countries are threatened by the "commercial exploitation" of giant transnational corporations and warns that "genetically modified organisms, microbiological pathogens and hazards in animal production represent a real health risk for the developing countries."

Finau, Wainiqolo, and Cuboni contend that the cultivation of cash crops, mining, and industrialization threaten the fragile environment of the Pacific islands, and they say the "green house effect and rising sea levels caused by metropolitan modern societies' efforts to maintain their consumption level are threatening the Pacificans' habitat." They also claim that the environments in these societies "have become obesogenic, toxic and insecure, due to crime and violence." As a result, the Pacific countries are undergoing what they refer to as an "environmental transition" that has brought about "not only physical and social changes, but also developed uncertainty and stress in the Pacific psyche."

McMurray's essay analyzes the effects of globalization on environmental health in the Pacific and other developing countries. She notes that "modernization" and globalization are responsible for the development of urban areas and the increasing concentration of the population in these areas. She cites United Nations data that indicate most developed countries now have 70 percent or more of their population concentrated in urban areas and that the number of these areas is increasing in most countries. One of the environmental health problems created by this increasing urbanization of the population and the globalization of these

societies is that they have adopted the costly portable water and sanitation systems of the most developed countries in most of their urban areas, as a result of their colonial legacy and/or the development assistance they have received in recent decades. McMurray indicates that they now have difficulty maintaining and extending these systems because they lack the resources and technology needed to do this. She gives various examples of the rising problems of pollution and contamination in the urban areas of the Pacific resulting from the breakdown of their sewage and piped water systems.

Loewenson's essay on the health and safety aspects of working conditions in Southern Africa reveals that most workers in this region of the world "continue to experience work related hazards that have long been controlled or even eliminated in high income countries." According to Loewenson, "the expansion of chemical, electronic and bio-technology industries and of the service and transport sectors ... widened the spread of work-related risks and their interaction with non work factors of ill health, including environmental pollution." Employment in the large informal economy exposes workers in this sector to the health risks associated with "poor access to clean water and sanitation, ergonomic hazards, hazardous hand-tools and exposure to dusts and chemicals." Loewenson also points out that work in the agriculture, mining, and manufacturing sectors within the southern African economies is associated with high rates of injury from the mechanical, electrical, and physical hazards in their work environment.

The essays by Badawi, Labonte, Loewenson, McMurray, and Finau and his colleagues acknowledge the fact that globalization and trade liberalization have promoted the deregulation of production, health, and the environment. These forces have seriously weakened the capacity of the public sector to respond to the environmental and occupational health risks posed by industry, mining, transportation/shipping, and commercialized agriculture; they also have undermined the already inadequate forms of worker protection and social protection (including health) in existence in these countries.

Labonte's essay argues that environmental issues are becoming "inherently global" and are no longer purely national or domestic issues. He notes that the "environmental impacts of human activities are planetary in scale and scope" and that "almost one-sixth of humanity is on the move to escape environmental or economic degradation and conflict." Labonte sees this situation as evidence of the need for global solutions to these problems.

Community Health Care, Grassroots Action, and Globalization from below

As Finau, Wainiqolo and Cuboni contend in their essay, community-based, grassroots, and ethnic-specific health care has improved the access, acceptability, availability, and affordability of the health care provided to the communities it serves. This model of health care has also improved the effectiveness, efficiency, efficacy, and equity of the health services provided to these populations through changing the power relationships between the health care providers and receivers. They argue that this model of health care addresses the oppression and assimilation implanted by Western colonialism and "borne by imperialism through globalization." According to Finau and his colleagues, community-based health care releases the participants from the oppression of the Western health care model imposed first by Western colonialism, and more recently by contemporary forms of imperialism under the guise of globalization (e.g., the globalization of Western medical education and training, the transfer of Western medical knowledge and technology, the bureaucratization and privatization of health care along Western lines).

Narayan and Schuftan's essay on the People's Health Movement (PHM) reveals the emphasis this new movement gives to community control of health care, grassroots action, and global action based on the use of international health advocacy networks. These are important elements in the movement's global campaign to combat the health inequities associated with globalization and to make sure that universal access to comprehensive primary health care is provided everywhere in the world. This movement is engaged in what amounts to "globalization from below" as it builds support for its global Health for All—Now strategy, lobbies at the global level, and mobilizes a grassroots-based campaign to realize the vision and achieve the goals of the People's Charter for Health.

The Charter, which is the PHM's visionary statement of goals and its main tool for advocacy, calls for "a people-centered health sector that is democratic and accountable" (PHA 2000:9). The Charter calls on the people of the world to: (1) build and strengthen people's organizations as a basis for analysis and action; (2) promote, support, and engage in actions that encourage people's involvement in decision-making in public services at all levels; (3) demand that people's organizations be represented in local, national and international fora that are relevant to health; and (4) support local initiatives towards participatory democracy through the establishment of people-centered solidarity networks across the world (PHA 2000:10). One of the primary principles of the Charter is the proposition that "the participation of people and people's organizations is essential to

the formulation, implementation and evaluation of all health and social policies and programs" (PHA 2000:4).

McIntyre, Thomas, and Cleary conclude in their essay that "the growth in number, size and power of civil society organizations combined with the increased networking of these organizations across national boundaries" is having a "countervailing effect" on the negative health impacts of globalization. They give the example of how civil society organizations in South Africa gained the support of civil society groups in the Untied States to pressure the US government into dropping its efforts to convince the South African government to change its policy relating to the importation of medicines so that it would not contravene the TRIPS agreement. They show how these groups in South Africa also teamed up with international groups such as Médecins sans Frontières and Health Action International to oppose the efforts of the transnational pharmaceutical corporations (with the support of their host governments) to pressure the South Africa government and the governments of other developing countries (such as Thailand) into restricting their use of certain provisions in the TRIPS agreement that permit governments to obtain urgently needed patented medicines at reduced prices.

The adverse effects of existing international trade agreements on health, human rights, and the environment have been subjected to increasing public criticism in recent years. As Labonte notes in his essay these agreements have "become the focus for progressive social movements." The global networking and collaboration that have developed among these social movements, such as the PHM, represent a form of "globalization from below" that is rising up to challenge the "globalization from above" imposed by the transnational corporations and their allies in the IMF, World Bank, WTO, the Group of 8 governments (led by the US government), and certain large international non-governmental organizations that are closely associated with these forces.

Labonte notes in his essay that the WTO has been besieged by a broad coalition of forces that are opposed to its global trade liberalization agenda. He argues that there are several reforms in the global trade regime that health activists in league with other progressive forces are promoting in their efforts to change the current effects of the WTO's trade liberalization efforts. These reforms would:

- Extend "special and differential" trade agreement exemptions for developing countries;
- Ban the patenting of life forms, exempt patent protection legislation for poor countries indefinitely, decrease the patent protection period and permit parallel importing under the TRIPS agreement;

- Impose a Tobin Tax (named after the Nobel economist who first proposed this idea) on international currency exchange transactions to raise about US $150 billion annually for an international development fund;
- Negotiate an overarching and enforceable rule in trade agreements that would require, when there is any conflict, for environmental and human rights agreements (including the right to health) to override the trade agreements; and
- Exclude health, education and other essential services (such as water and sanitation) from privatization since they are essential to human life and health.

In addition, Labonte argues that the WTO needs to be overhauled by making its decision-making more democratic and transparent. However, he disagrees with those activists and social movements who are calling for its abolition. He contends that this would be a mistake since "there is no other vehicle where the unequal balance of economic power globally might be subject to enforceable change." Labonte believes that the struggles of civil society organizations and the developing countries "to wrest reforms from the WTO are giving rise to a new system of global governance for the common good."

The Current State of Global Health Governance

As Labonte points out in his essay, social, economic, environmental and health issues are becoming "inherently global" rather than purely national or domestic. He argues that the evidence in favor of the need for global solutions to these issues is irrefutable, including the evidence about the rapid spread of infectious diseases, the increased adoption of unhealthy lifestyles, and the increasing international promotion of unhealthy foods and products such as tobacco and alcohol. Labonte concludes that "we live in the most important historical moment of our species, [since] the planet is dying, there is excessive affluence and poverty, [and] once far-away conflicts and diseases are imperiling global health and security." Faced with this unprecedented situation, he optimistically contends that "we are struggling forward to some system of global governance for our common good."

Yach and Beaglehole take a similar position. They conclude that the global diffusion of the major risks of chronic diseases is now almost complete and the prevalence of these diseases is increasing in most regions of the world. They contend, however, that the prevention and control of these diseases have not been able to keep pace with their globalization and growth. Therefore, they conclude that sustained progress against these diseases "will only occur when governments and influential international

bodies involved in health policy and funding acknowledge that the scope of global public health must be rapidly broadened to include chronic diseases and their risk factors."

Based on their experience in the ongoing struggle over the international control of tobacco, Yach and Beaglehole predict that "progress will continue to be slow unless the response to the epidemics [of chronic diseases] is scaled up in a manner commensurate with their burden on both families and societies" around the world. They believe that global solutions are needed to address the global health risks responsible for the epidemics of chronic disease that are taking place around the world.

However, Yach and Beaglehole argue that the global health agenda is currently dominated by what they call "the infectious disease paradigm." The main global health organizations and funding sources believe priority should be given to the prevention and treatment of infectious or communicable diseases before addressing chronic diseases. Because most institutional responses to disease prevention and control are based on this infectious disease paradigm, Yach and Beaglehole argue that the global and national responses to the spread of chronic diseases are "woefully inadequate and few countries have implemented comprehensive prevention and control policies."

They contend that a comprehensive response that combats all the health risks responsible for the global spread of chronic diseases is necessary, and they argue this response must overcome the "powerful countervailing forces" that presently stand in the way of changing the status quo. According to Yach and Beaglehole, a successful global response to the existing configuration of major health risks has to overcome the "many powerful and persuasive commercial entities involved in the production and promotion of unhealthy products." They claim these entities "exert an adverse influence on health policy developments" as well as on the development and implementation of environmental policies.

Yach and Beaglehole conclude that "stronger and broader alliances of major health professional bodies, consumer groups, enlightened industries and academics are now needed to effectively prioritize the prevention of the major risk factors" responsible for the global spread of chronic diseases. They suggest that the global campaign for tobacco control provides a successful model for how to organize a comprehensive response to the global spread of chronic diseases.

Yach and Beaglehole ultimately conclude that there is an increasing need to establish global norms on a wide range of global issues "to balance the otherwise unrestrained influences of powerful actors." They argue that, if the WHO is strengthened it can be used to establish these norms in the health sphere and then use the norms to resolve trade

disputes and other health-related global issues in a manner that promotes positive health outcomes. However, they do not think the WHO and national governments alone can address the challenges of chronic disease prevention and control. As in the case of tobacco control, they believe collaborative partnerships and interaction are needed with international consumer advocacy groups, international and national sports federations, sporting goods companies, transnational food corporations, retail food businesses, and insurance companies to improve the quality and access of people to healthy foods and increased physical activity. They advocate a consultative and "multi-stakeholder approach" with all interested parties as well as joint initiatives with the transnational food companies rather than an adversarial relationship. However, they recognize the dangers and difficulties that are involved in this approach.

Badawi's essay urges the developing countries to make more effective use of the provisions in the WTO agreements (the GATT, GATS, TBT, and Anti-Dumping agreement) that allow for "special and transitional arrangements." He contends that they can take the "compensatory actions" allowed under these agreements to limit the negative effects of globalization on their economies, environments, and protective social services. Badawi says that, unfortunately, these agreements are not well studied by policymakers and specialists in the developing countries. He recommends that they develop their national capacity and expertise for "expert reading" of the provisions of these agreements so that they can use their special exemptions to protect what he and the International Labor Organization refer to as the "social dimension" (social protection and social services such as health) as well as the environmental health of their populations.

Badawi also argues that the developing countries need to "cooperate and consult with other developing and developed countries to influence decision-making" at the WTO, the WHO, and other global institutions as well as to negotiate multilateral and bilateral agreements that confront the health hazards posed by globalization. Moreover, he argues that the governments of the developing countries, contrary to the prevailing feeling that [they] have lost control of their mandates, must, "adopt the measures necessary to protect the public interests in the environment, public health and nutrition."

Loewenson argues in her essay that "there is a growing understanding that global security and equity cannot be built on the significant burdens of deprivation borne by communities in the south," and that "globalization has produced powerful tools, new communications technologies, more widely connected social movements and an increasingly global recognition of universal rights as fundamental to policy." She contends that the full

potential of these tools can be used to create concerted global action to protect workers' health. The democratization and extension of the enforcement powers of international agencies such as the ILO and WHO would certainly help to improve the social protection of workers and the many other sectors of the world's population that are being harmed and disadvantaged by the global expansion and integration of twenty-first century capitalism.

Most global health advocates argue that a genuinely health-centered (and people-centered) process of globalization can be achieved only by ensuring that the interests of the developing countries and vulnerable populations are fully represented in all international decision-making on global health issues (Woodward et al. 2001:880). According to Badawi, Labonte, and Yach and Beaglehole, the democratization of decision-making in the existing international regulatory and financial organizations such as the WTO, IMF, and World Bank is needed to transform these institutions into global governance institutions that will advance the interests of the great majority of the world's population rather than the interests of the powerful economic elites they now represent.

Alternatives to the Globalization of Health from above

The People's Health Movement (PHM) is clear evidence that the existing linkages between globalization and health are contestable. In fact, most of the essays in this collection indicate that the adverse health effects of globalization are being challenged at the global, national, and local levels. The People's Health Movement and the People's Charter for Health provide a significant expression of alternatives "from below" to the present globalization, privatization and commercialization of health coming "from above." As Narayan and Schuftan state in their essay, this People's Charter for Health provides a vision of a better and healthier world, a call for radical action, a tool for advocacy for people's health, and a rallying point for building a global health movement based on international networks and coalition building.

The People's Charter for Health lays out a blue print for the transformation of the existing global order through democratization at all levels of the existing system and through what some people in the global social justice movement call "globalization from below" (Brecher, Costello, and Smith 2000). It is based on the fundamental, but radical, assumption that "to ensure health, people's basic needs for food, water, sanitation, housing, health services, education, employment and security must be met" in the present time frame (PHA 2001:1). In addition, it is based on the assumptions that global decisions must be democratized and that people's organizations and organized grassroots action can bring

about an "alternative vision of development—one that promotes human and environmental well-being" (PHA 2001:3). To achieve this vision, the PHM is pursing the democratization of health decisions and outcomes at all levels.

According to Narayan and Schuftan, the Charter for People's Health calls upon national governments and global institutions to recognize health as a fundamental human right and as a social, economic, and political issue deserving the highest priority. It also identifies inequality, poverty, exploitation, violence, and injustice as the roots of ill-health, and it makes clear that the achievement of universal access to primary health care requires challenging powerful economic interests; opposing privatization and globalization (in its present inequitable form); and drastically changing the prevailing political and economic priorities at all levels in the global order.

The Charter also makes it clear that the PHM wants the poor and marginalized (rarely heard) peoples throughout the world to participate in health decision-making and develop their own local solutions to their health problems. The movement encourages people to hold local authorities, national governments, and international organizations and corporations accountable for ensuring that the goal of Health for All is achieved now, not at some distant point in the future. However, even though the PHM firmly believes national governments have the primary responsibility for promoting an equitable approach to health and human rights, the movement knows that it will take pressure from people's organizations to force their governments to meet this responsibility. This statement reflects one of the most important strategic assumptions held by the PHM: that it will take organized grassroots action as well as concerted action at the global level to bring about the profound social changes that are needed to achieve the sweeping vision and radical goals of the movement.

All the essays in this collection provide suggestions and/or proposals for creating alternatives to the present conditions, in which the adverse effects of globalization threaten the health of people around the world and the planet's ecological sustainability. In their essay Finau, Wainiqolo, and Cuboni provide a series of models or strategies for thinking about the management of change in the field of health. They are all based on the assumption that change is inevitable and that the present power imbalances in the world must be changed in order for substantial progress to be achieved in the domain of health as well as in the other major domains of human existence.

These models/strategies provide useful conceptual tools for thinking about alternatives to the present global patterns and direction of change in health. We hope that this entire collection of essays serves the same

purpose as the models presented by Finau, Wainiqolo, and Cuboni—that it contributes not only to the ongoing discourse on globalization and health but also to the efforts that are being made around the world to find alternatives to the adverse effects of globalization on the health of the planet's human population as well as the sustainability of its biosphere.

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The Globalization of Health: Risks, Responses, and Alternatives

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ABSTRACT

This essay provides a summary and synthesis of the wealth of information, analysis, and conclusions provided by the other contributors to this collection of essays on globalization and health. The major themes addressed are the health risks and health effects of globalization, the responses to these risks and effects at the national and global levels, and the alternatives to the present patterns of globalization in which the health of billions of people around the world and the planet's ecological sustainability are threatened.

Introduction

In the introduction to this collection of essays on globalization and health, we pointed out that, according to the existing literature on globalization and health, it is generally accepted that certain aspects of globalization have "enhanced health and life expectancy in many populations," while other aspects of globalization "jeopardize population health via the erosion of social and environmental conditions, the global division of labor, the exacerbation of the rich-poor gap between and within countries, and the accelerating spread of consumerism" (McMichael and Beaglehole 2000). These threatening aspects of globalization present major challenges for

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health researchers, practitioners, and policymakers today, and they are the major focus of this collection of essays.

The contributors to this collection of essays on globalization and health provide a wealth of information, analyses and conclusions on many of the health risks and health effects of globalization, on the responses to these risks and effects, and on the search for alternatives to how the contemporary forces of globalization affect health around the world today. In the pages that follow, we provide a summary and synthesis of the major findings on these themes that the contributors to this collection of essays have reported in the preceding pages.

The Health Benefits and Risks Associated with Globalization

Most of the contributors to this collection of essays agree that there have been some significant health benefits from globalization. For example, Badawi, Labonte, McMurray, Smith, and Yach and Beaglehole acknowledge in their essays that the global diffusion of new health-related knowledge and technologies as a result of international trade and investments has contributed to disease surveillance, treatment and prevention around the world as well as the spread of sanitation and vaccines that have greatly reduced the threat of many deadly diseases.

McMurray states in her essay that "there is no doubt the spread of Western medicine through out the world and the implementation of global health programs has brought numerous benefits"; however, she also points out that "at the same time, globalization has promoted patterns of dependency, development, settlement and lifestyles that have been detrimental to health." Smith's essay reveals how new information and communication technologies (ICT) are being applied to healthcare in some of the more remote areas of the Pacific islands, and he argues that these technologies have the potential to provide "a remarkable expansion of the medical expertise available to act in a curative manner" and to advance preventative healthcare in these remote areas of the world. However, Smith's essay also reveals how these technologies, which are a central feature of globalization, are a "two-edged sword."

On the one side of the sword, the new information technologies and Internet connectivity enhance the provision of healthcare to people in remote and marginalized areas, but on the other side, they reinforce the neocolonial ties and unequal power relationship that exist between these areas and the developed core economies. They also transmit the more negative aspects of the consumerist life-styles associated with these economies.

The essay by Finau, Wainiqolo, and Cuboni focuses on how the "changes in health of Pacificans are about the power imbalances brought

about by globalization, imperialism and colonialism." They see "the continuance of colonialism and imperialism in different forms" in the present context of globalization. They also argue that many contemporary "technologies and ideologies contribute to the reproduction and the strengthening of the pattern of power relations that feed imperialism." In their essay on women's reproductive health in post-transition Mongolia, Rak and Janes provide an example of how this works. Their research shows how the global discourse on family planning and reproductive health as well as global reproductive health policies are based on assumptions that "fail to consider the local cultural context of reproductive decision-making, do not meet women's needs, and are therefore seriously flawed." Nevertheless, external donors and consultants who are in a very real sense the agents of globalization in this case are imposing these global norms and policies on women in Mongolia.

Most of the contributors to this collection of essays reveal either explicitly or implicitly that, in fact, what is generally referred to as "globalization" is none other than the global expansion and integration of contemporary forms of capitalist production, distribution, and consumption. Their essays reveal that the global expansion and integration of twenty-first century capitalism involves not only the global diffusion of certain technologies, products, and practices, it also involves the global dissemination of certain ideologies and cultural norms.

Together, these forces of capitalist globalization have inadvertently or purposively promoted the following types of global health risks:

- The global spread of various communicable and noncommunicable diseases.
- The global promotion of unhealthy products and practices.
- The global diffusion of a wide range of technologies and production processes that are hazardous both to human health and to the health of the natural environment.
- The global promotion of inequitable forms of private health care and the commercialization of health services and medicines that place them beyond the reach of large sectors of the world's population.
- The global diffusion of Western norms, practices, and ideological models/paradigms of health care that often conflict with local values and needs and that create/reinforce inequitable power relationships and social inequities.

As we learn more about these and other adverse health effects of the global expansion and integration of modern capitalism, it is clear that many of the contemporary effects of the globalization of twenty-first century capitalism are a serious threat to not only the health of billions of people around the world but also to the sustainability of the planet's entire biosphere.

As Labonte points out in his essay, we have now lived through more than twenty years in which the global diffusion of knowledge and technology has taken place under a neoliberal capitalist regime of trade liberalization and global economic integration; yet the health impacts of this process of liberalization and globalization have been largely negative, especially the effects of this process on what Labonte refers to as the two fundamental health-determining pathways of globalization: poverty/inequality and environmental sustainability.

The liberalization and globalization of the economies of many developing countries have been accompanied by a corresponding increase in the poverty, environmental degradation, and poor health of a large proportion of the population. Loewenson notes in her essay that the incomes of a quarter of the world's population declined at the end of the last millennium when globalization was going at top speed. Even many of the positive effects of the global expansion and integration of capitalism have adverse consequences. Labonte's essay gives the example of how the opening of the economies of many developing countries to international trade and investment has increased the access of women to wage-earning employment and contributed to their empowerment in gender relations. However, he points out that more often than not they are employed in low-paid, unhealthy and insecure jobs, frequently in so-called free trade export zones where labor organizations are prohibited and only single young women are employed under hazardous working conditions (and often exploited and sexually harassed). Loewenson reports in her essay that these young women have been documented to experience high levels of job stress and reproductive health problems, including miscarriages, problems with pregnancies, and poor fetal health.

McMurray's essay illustrates how the globalization of capitalism intensifies disparities in health between and within nations and also how it can create paradoxical health outcomes in the most peripheral areas of the global capitalist economy. Her essay reveals that in the smallest and most remote countries within the global system, such as the Pacific island countries, the negative health effects of capitalist globalization impact the population more in the globalized (Westernized) and urbanized core areas than in the thinly populated and more peripheral rural areas that have less access to modern health services but relatively better environmental health conditions. McMurray focuses on how globalization affects these societies through, "first, its impact on environmental quality, second, its impact on the quality and accessibility of health services, and third, its promotion of unhealthy lifestyles."

As Labonte's essay and our own introductory essay in this collection indicate, the extent to which the forces of globalization affect the health

of the population in individual countries depends upon the prevailing economic, social, and political conditions in these countries; their level of technological and economic development; and their natural endowments (Cornia 2001; Drager, Labonte, and Torgerson 2002; Woodward et al. 2001). These indigenous factors mediate most of the direct effects of globalization on the national/domestic level as well as many of the indirect effects of globalization on the community and household levels.

Labonte's essay reveals that the forces of capitalist globalization affect population health at the national level through various channels or pathways, such as externally imposed macroeconomic policies (e.g., IMF structural adjustment programs and monetary policies), the enforcement of trade agreements, the flows of trade associated with these agreements, official development assistance (from the United States and other major "donor" countries), the international transfer of health-related knowledge and information, and the influence of the global communications and entertainment media. There are also "environmental pathways" through which capitalist globalization affects health. These pathways include cross-border pollution, the depletion/contamination of natural resources (water, the soil, fish stocks, and forests), and the destruction of the biodiversity in local ecosystems. Many of the essays in this collection touch upon the health effects of these environmental pathways of globalization.

Globalization and Life Style Changes

Most of the essays in this collection support the thesis that certain contemporary patterns of death and disability are caused by the lifestyle changes promoted by globalization, particularly the increased consumption of unhealthy processed foods and products. These lifestyle changes and particularly the unhealthy consumption patterns they entail are, as Yach and Beaglehole demonstrate in their essay, contributing to an alarming global increase in chronic and noncommunicable diseases (NCDs)—the so-called diseases of affluence (although they are increasingly suffered by the poor). McMurray, Smith, and Finau and his colleagues all address the negative health impact of these lifestyle changes and the increased consumption of unhealthy foods, especially in the island nations of the Pacific.

All three essays on the Pacific call attention to the health effects of both the disruptive changes and the uneven pattern of economic and social development that have been promoted in the developing countries by contemporary forms of capitalist investment, trade and production. Finau, Wainiqolo and Cuboni emphasize the disruptive and destructive nature of many of these changes and attribute them to the Western capitalist

model of development that has been imposed on the Pacific peoples by colonialism, imperialism, and globalization.

According to Yach and Beaglehole, an unprecedented epidemiological or "health transition" is taking place in the world, and this transition is responsible for the global increase in NCDs and the "double burden of disease" (both communicable and noncommunicable diseases) suffered by the populations of most of the developing countries. They cite data, which indicate that NCDs have become the main cause of death and disability throughout the world. They attribute this development to both the positive aspects of globalization, which have contributed to the aging of the world's population through the diffusion of modern medicine and sanitation, and to the negative aspects of globalization, which have promoted the adoption of unhealthy lifestyles.

They also note that the uneven development and social inequalities associated with globalization are largely responsible for the fact that many communicable diseases continue to be a major cause of death and disability in the least developed areas (e.g., in sub-Saharan Africa and South Asia) and in the poorer sectors of the population throughout the developing countries. Thus, the poor in these areas suffer the so-called double burden of disease (both communicable and NCDs) caused by the uneven patterns of development and "poverty gaps" associated with the global expansion of capitalism.

However, Finau, Wainiqolo, and Cuboni question the validity of the "health transition" paradigm that Yach and Beaglehole and other global health researchers use in their work. They question how much of the so-called heath transition or what they call the "mortality transition" in the Pacific countries is really due to the spread of NCDs as opposed to underlying infectious risk factors, such as the emerging evidence that certain NCDs may be caused by *Heliocobacter pylori*, *Chlamydia pneumoniae*, and oral bacterial diseases. They also note that, for many Pacificans, the quality of life they are now living "due to various transitions, may as well mean that they are dead long before the certification of the expiry of life."

Finau and his colleagues argue that it is in fact a cluster of various types of transitions (religious, economic, environmental, political, social, etc.) and particularly inequitable power relationships established by colonialism and imperialism that are responsible for the poor health, dependency, and lack of control over their own socio-economic development suffered by the Pacific peoples. They blame the contemporary forces of globalization for reinforcing and masking these determinants of health in the Pacific.

McMurray's contribution to this collection of essays calls our attention to the fact that one of the effects of capitalist globalization in the developing countries is the migration of large numbers of people to the urban areas

in these countries, where they hope to find wage-earning employment and access to modern consumer goods. However, most urban migrants are exposed to poor nutrition, substandard housing, and unsanitary environments in these urban areas. As McMurray indicates in her essay, the limited employment and the low incomes that these migrants generally earn leave them "no choice but to purchase the cheapest food, which tends to be the least nutritious." Moreover, their consumption of unhealthy foods is generally combined with their exposure to unsanitary environmental conditions.

The problem is that there are very few employment opportunities in the urban areas and most jobs do not provide an adequate income. As a result, there is widespread unemployment, and most people who are employed do not earn enough income to maintain a nutritious dietary intake or healthy lifestyle. McMurray also reveals that under these circumstances of urbanization without adequate employment, young people generally have little incentive to maintain a healthy lifestyle and often engage in various types of substance abuse and other unhealthy forms of behavior. Based on her research in the Pacific, McMurray has found that "the negative impact of urban lifestyles on health is clearly evident in that the incidence of early onset NCDs" in the Pacific "is lower in the outer islands and remote areas ... where traditional foods are consumed and people are engaged in subsistence agriculture and food gathering." She contends that similar conditions "can be observed in peripheral areas everywhere, including remote and economically depressed areas within most industrialized countries."

According to McMurray, the rising incidence of early onset NCDs among the urban population in the Pacific is "a direct consequence of global forces that have led to urbanization without industrialization, idealization of Western lifestyles and imports of cheap food, alcohol and cigarettes." She argues that no real improvements in the population health of the Pacific island nations and other developing countries can be achieved under these conditions "until their people are empowered and have the means to choose healthy lifestyles."

As indicated, Yach and Beaglehole also hold globalization responsible for the lifestyle changes that have produced the rapid increases in chronic diseases (especially cardiovascular disease, coronary heart disease, stroke, cancer, chronic respiratory disease and diabetes) in the developing countries and the fact that these diseases are now the major components of the global burden of disease in all regions of the world. Moreover, they argue that "policy makers and the donor community have neglected the rapidly growing burden of chronic diseases" even though they are the

major cause of death and ill-health in most of the developing as well as the developed countries of the world.

Yach and Beaglehole contend that these diseases "predominate among poor populations largely because of inequalities in the distribution of major chronic disease risk factors." They claim these risk factors are "driven by the more fundamental causes of ill health in the socio-economic environment." They blame "global forces in trade and marketing" for promoting "the entrenchment of the causes of these chronic diseases in all regions." The health risks they identify are tobacco consumption, unhealthy diet/nutrition, physical inactivity and alcohol use, as well as the failure to invest in appropriate prevention and health promotion measures. They indicate that "most of these risk factors are common to the main categories of chronic diseases and all are modifiable, albeit with some difficulty."

According to Yach and Beaglehole, the aging of most populations due to declining fertility rates and increasing child survival rates (one of the health benefits of globalization), and the "nutrition transition" to diets that are high in saturated fats and sugars but low in fruits and vegetables, as well as smoking and alcohol usage, are being promoted by the forces of globalization. They also note that the nutrition transition to unhealthy diets is generally combined with lower levels of physical activity and regular tobacco and alcohol consumption. In fact, they cite WHO data that indicate tobacco and alcohol consumption, high blood pressure, and high cholesterol levels are the major contributors to the global burden of chronic diseases.

Yach and Beaglehole say that globalization has contributed to the rise in chronic diseases through a complex array of both direct and indirect factors. They focus on "the direct negative effects of globalization," which they claim are best "illustrated by the increasingly globalized production, promotion and marketing of tobacco, alcohol and other products with adverse effects on population health status." They blame major transnational corporations and the global communications media for "the marketing of tobacco, alcohol, sugary and fatty foods" in nearly all parts of the world. They indicate that "a significant portion of all global marketing is now targeted at children under the age of 14," since the companies that market high sugar and high fat fast foods, cigarettes and alcoholic beverages seek "to foster brand-loyalty among pre-teens, as young as six years, and teenagers."

They give particular emphasis to what they call the "globalization of the tobacco pandemic," and the "strong link between increased tobacco consumption and free trade and tobacco-related foreign direct investment." Based on their research for the WHO, they have found that "tobacco companies aggressively exploit the potential for growth in tobacco sales

in developing countries." They claim this practice is "not surprising since they are motivated only by their obligations to shareholders." According to Yach and Beaglehole, "the main targets of the industry and the associated marketing campaigns are now young people and women, most of whom do not smoke."

Having been closely associated with the WHO's tobacco control efforts and the international campaign on behalf of the Framework Convention on Tobacco Control, Yach and Beaglehole know a great deal about the tactics that have been used by the transnational tobacco corporations to subvert and oppose "any effective international regulatory regime" dealing with the marketing, sale, and consumption of tobacco products. Included among these tactics are the companies' frequent public refutation or denial of the evidence about the harmful effects of smoking and their practice of "paying scientists to carry out spurious research aimed at confusing the public and delaying action" to control tobacco marketing and consumption.

Yach and Beaglehole's research also leads them to conclude that the "alcohol industry is becoming as globally integrated and pervasive as the tobacco industry." They claim that there is a direct link between the consumption of alcohol and certain cancers, cirrhosis of the liver, and most injuries, especially motor vehicle-related injuries and injuries resulting from violence. For this reason, they argue that there is a pressing need for global action to control the marketing of alcohol to young people, "especially through its association with sporting events and with gender specific roles."

Trade Liberalization and the Privatization of Health Care

The essays by Labonte, Badawi and McIntyre, Thomas and Cleary as well as the contribution by Yach and Beaglehole reveal the adverse effects on health of multilateral agreements such as the General Agreement on Tariffs and Trade (GATT), the Technical Barriers to Trade (TBT) Agreement, the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS), the Agreement on Trade-Related Intellectual Property Rights (TRIPS), and the General Agreement on Trade in Services (GATS). The essay by McIntyre, Thomas, and Cleary reveals how the GATS contributes to the already existing problem of the migration of skilled health professionals from South Africa (and other developing countries) to the developed countries. Their essay also reveals the difficulties TRIPS imposes on poorer countries that try to import or produce affordable medicines to fight the disastrous effects of global diseases such as HIV/AIDS.

Badawi states that "access to low-cost, safe and effective essential drugs is largely threatened by the agreement on TRIPS." He argues that "technology transfer, production and global movement of health commodities are also threatened by the monopoly TRIPS gives to the

companies who hold patents protected by the TRIPS agreement." In fact, as Labonte indicates, agreements such as TRIPS do not promote "free trade"; rather they promote the protection and entrenchment of the so-called intellectual property rights and lucrative profits of companies and individuals in the wealthier developed countries.

Labonte points out that the global "brain drain" of trained health professionals from the developing to the developed countries has so far cost the developing countries at least an estimated 500 million US dollars in training costs. The GATS agreement is likely to accelerate this transfer of skilled health practitioners from the developing to the developed countries. Labonte notes that some 54 members of the WTO (including many developing countries) have so far agreed to liberalize/privatize their health care systems under the terms of the GATS agreement. The implementation of the GATS provisions on the "progressive liberalization" of services will contribute to the regressive privatization of health care systems, promote the brain drain of health practitioners, and benefit the health of the wealthier at the expense of the poorer sectors of the population.

The essays by Labonte, Yach and Beaglehole, Loewenson, and Badawi indicate that the trade liberalization measures and the neoliberal economic reforms associated with capitalist globalization have shifted a greater burden of the costs of health care to those who can least afford to assume these costs: low-paid workers in the export zones and industrialized urban areas within the developing countries; self-employed and casual workers in the growing "informal sector" of the economies of these countries; landless peasants and agricultural workers; and the large numbers of unemployed, disabled and indigenous/tribal peoples around the world. They generally do not have access to adequate health care and other forms of social protection.

The IMF, World Bank, WTO and the main donors of official development assistance have promoted the downsizing of the public sector and the privatization of health care and other social services around the world. Largely as a result of their influence, the governments of the developing countries and the former socialist countries ("emerging economies") have privatized their health services and/or imposed so-called user fees and/or other types of "cost recovery" measures that have raised the cost of such services above the capacity of large sectors of the population to pay for them.

Badawi, Loewenson, and McIntyre and her associates call attention to the fact that the poorer sectors of the population are not covered by health insurance in most of the developing countries where health care is being privatized. Moreover, the governments of these countries generally do not have sufficient funds to provide adequate social protection

to the population, especially under the "state shrinking" and fiscal restraints imposed on them by the IMF, the World Bank, and the other guardians and promoters of globalization. As Loewenson notes, under these circumstances job-related injuries and ill health generally lead to not only the loss of employment and household income, but to impoverishment and the breakdown of the overburdened informal mechanisms of social protection provided by the extended family and local community.

The privatization of health care has been particularly unkind to the poor and to low-income households. As Badawi notes in his essay, many people in the developing countries have been caught between the inability of their governments to continue providing free public health services and their own inability to pay the rising costs of basic health care. The forces of globalization have led governments to reduce their spending on health and other forms of social protection, to sell off many of their public health facilities, and to encourage the privatization and commercialization of health services and products. As a result, there has been a marked deterioration in the health services of many of these countries and restricted access to these services—both of which threaten the health of large sectors of the population.

In the present context of increasing privatization and the promotion of neoliberal policies at both global and the national levels by the IMF, World Bank, and the WTO, national government responsibility for providing basic health care for all members of the population has been replaced by so-called selective primary health care, public-private partnerships, and the privatization of health services and health care facilities. As the essay by Narayan and Schuftan indicates, this shift in responsibility for providing health care is considered by many critics of globalization and the current trends in health to be a betrayal of the international commitment made in the late seventies to provide primary health care for all by the year 2000. This was the official commitment made by most of the governments represented at the 1978 International Health Assembly held at Alma-Ata in the central Asian republic of what was then the Union of Soviet Socialist Republics (PHA 2000:1).

The Alma-Ata declaration set forth the goal of achieving "Health for All by the Year 2000" and charged the health ministries and health workers around the world with the responsibility for providing comprehensive primary health care to all the members of their societies by the beginning of the new millennium. As Narayan and Schuftan indicate in their essay, the global network of health activists and health advocacy organizations involved in the People's Health Movement (PHM) seek to halt the privatization and commercialization of health care. The PHM holds that health is a fundamental human right and that national governments have

an obligation to ensure universal access to quality health care, education, and other social services in accordance with people's needs, not their ability to pay. They are mobilizing broad-based popular movements around the world in a global campaign to achieve the goal of "Health for All—Now!" by pressuring governments to provide comprehensive primary health care to their populations and incorporate health and other human rights into their national constitutions and legal systems.

The Health Effects of Dependency, Neocolonialism, and Western Ideological Paradigms

The essays by McMurray, Narayan and Schuftan, Rak and James, and Finau and his colleagues reveal that Western medicine has been imposed as the universal standard around the world, and that the health systems of most developing countries are generally dependent upon the development assistance they receive from the governments and NGOs of the developed Western countries as well as international organizations such as the World Bank and the World Health Organization (WHO). McMurray contends that the health programs in the Pacific countries "are determined by global health policies, set by the World Health Organization and other health sector donors." Moreover, she argues that much of the assistance these programs receive "fosters dependency and imposes conditions" on the recipients that force them to accept donor policies, practices and medicines as well as consultants from the donor countries.

Narayan and Schuftan indicate that the People's Health Movement believes that it has extricated health and health systems around the world from the "myopic biomedical-techno-managerialism of the last two decades, with its selective magic bullets approach to health." The PHM's analysis of the political economy of health in the world today (PHA 2001) lead its advocates to conclude that the most significant determinants of health in the world today are economic and political factors that have colonial roots. Moreover, the movement's analysis indicates that people's health around the world is under a triple assault from globalization, liberalization, and privatization, which Narayan and Schuftan claim "have ensured that health for all is a receding dream." The PHM argues that "health services today are inaccessible, unaffordable, inequitably distributed and inappropriate in their emphasis and approach" (PHA 2001:3). The movement also claims that "health care is increasingly used as a subtle and widespread instrument of social control," and that the Western model or "ideology of medicine ... mystifies the real causes of illness, often attributing disease to faulty individual behavior or natural misfortune, rather than to social injustice, economic inequality and oppressive political systems" (PHA 2001:18).

The essay by Finau, Wainiqolo, and Cuboni as well as the essay by McMurray trace the current dependency and Western orientation of the health care systems in the developing countries to the imposition of the Western curative model of health care on these societies by their former Western colonial rulers. They attribute the continued dominance of Western health policies, standards and practices in these societies to the development assistance they receive from the developed countries, the globalizing influence of Western education and training, and the economic dependency of these countries on the developed Western countries (as well as "Westernized" Japan). In fact, as Finau and his colleagues assert in the case of the Pacific island societies, many developing countries "are still practically colonies," and as such they are still subjected to the racism, imperialist domination and exploitation they suffered under colonialism—in the health field as well as in other fields.

Finau, Wainiqolo, and Cuboni argue that "imperialists control all phases and determinants of the health transition" in the Pacific countries, and "the socialization of Pacificans, through foreign education, is another imperialist tool to enhance control" over the Pacific peoples. In fact, Finau and his colleagues take the position that "globalization is the latest label for capitalism, colonialism and imperialist expansion combined," and they regard the ideology of globalization as nothing more than an updated version of the classic imperialist justification for the Western domination of non-Western peoples formerly known as the "white man's burden." According to Finau, Wainiqolo, and Cuboni most Western-trained health personnel practice, reflect, and promote the Western emphasis on fighting disease at the individual level rather than promoting community health in a holistic manner. They argue most doctors and nurses are trained as disease fighters to save individuals rather than as health promoters to save communities. Imperialist ideologies and logics perpetuate and reproduce the power imbalance and inequities of the past as well as strengthen the pattern of inequitable power relations associated with contemporary forms of imperialism under the guise of globalization.

Rak and Janes' essay on reproductive health in Mongolia reveals how global reproductive health policies, promoted by international NGOs and the governments of developed countries such as the United States, impose family planning methods on women in countries such as Mongolia that often run counter to the beliefs, experiences, and needs of the local population. These imposed paternalistic and ethnocentric family planning methods have ignored local cultural values and devalued the alternatives that exist at the local level. Rak and Janes reveal the contradictions in this approach within the context of Mongolia's rapidly deteriorating health services caused by the adoption of market-based reforms, the reduction

of the public budget for health care and the privatization of the health sector.

The Health Effects of the Inequities Promoted by Globalization

At the outset of the new millennium, the WHO noted that "the greatest burden of health risks is borne by the poor countries, and by the disadvantaged in all societies" (WHO 2002:13). These sectors of the world's population have the misfortune of suffering the health effects of poverty as well as well as the other social and economic inequities that characterize the present era of capitalist global expansion and integration. Most of the essays in this collection reveal that globalization is associated with economic policies that create, reinforce, and intensify the inequities in health found throughout the world. Thus, Loewenson states in her essay that "within the current processes of globalization, inequality is not simply happening but is being constructed by powerful economic and political interests and public policies" that keep the benefits of globalization from reaching those who need them the most. Finau, Wainiqolo, and Cuboni contend that the economic and social inequities (including the health inequities) that the Pacific peoples have inherited from colonial rule are reinforced today by the contemporary forces of globalization, which they hold responsible for the continuation of Western imperialism.

McIntyre, Thomas, and Cleary reveal in their essay how the struggle to overcome the "legacy of massive inequalities in income, health status and access to health and other social services" resulting from South Africa's colonial, racist, and repressive past has been hindered by the contemporary forces of globalization. Moreover, they reveal that it is not just the obvious forms of global intervention such as IMF loan conditions, externally enforced compliance with the TRIPS Agreement on patented HIV/AIDS medicines, and the World Bank's privatization of health care programs that exacerbate the existing inequities in South Africa. It is also the more subtle and indirect influences of globalization that have led the post-apartheid government in South Africa to adopt "self-imposed" structural adjustments in order not to run afoul of the major forces in the global economy. These self-imposed policies and practices tend to reinforce the health inequities created by centuries of colonialism, racism, and European domination on the African continent.

The essay by McIntyre and her colleagues reveals the extent to which the global trend towards the privatization of health care and the indirect impact of global health actors on the health sector in South Africa have contributed to the "rapid and uncontrolled growth of the private sector," which in turn "has contributed to disparities in health service access and the health of South Africans." Today, less than 20 percent of the

population has access to more than 60 percent of the financial resources for health care, while the remaining 80 percent of the population have access to less than 40 percent of the financial resources devoted to health care in the country. Moreover, only one-fourth of the doctors in the country work in the public health sector, which serves the historically disadvantaged majority of the population.

Rak and Janes premise their analysis of the global discourse on reproductive health and its application to Mongolia on the assertion that poverty in its modern sense was created in the developing countries by the spread of the market economy and years of colonial rule, and they argue that the current policies to "develop" these countries "have exacerbated the divide between the rich and the poor." Since the country adopted market reforms, privatization, and the integration of its economy into the global capitalist economic system, Mongolia has experienced a rapid deterioration in its health services, increasing social inequality, and a high level of male unemployment. Rak and Janes conclude that "it has taken the transition from a socialist to a market economy, led by the intervention of the global financial and policy institutions of the developed world, to create Mongolia as a Third World country."

The PHM, as Narayan and Schuftan's essay explains, sees a direct relationship between existing health inequities and globalization. The members of this global movement consider inequality, poverty, exploitation, violence and injustice as the root causes of ill health in the world today. As Narayan and Schuftan make clear in their discussion of the People's Charter for Health, achievement of the PHM's goal of "Health for All—Now!" requires "challenging the powerful economic interests that dominant the existing global order, opposing globalization in its existing iniquitous form, and drastically changing the political and economic priorities at all levels of the global system."

The Environmental Health Effects of Globalization

The wide variety and scope of globalization's environmental effects make it difficult to provide a sufficiently comprehensive analysis of these effects in any single book or collection of essays. This collection of essays does little more than scratch the surface of the health impact of some of the more complex and far-reaching environmental effects of globalization, such as global climate change, the depletion of the ozone layer, and the contamination of oceans, lakes, and rivers around the world.

As we indicated in our introductory essay to this collection, there is mounting evidence that the global diffusion of capitalist patterns of production and consumption developed in the Western industrial societies has created a multitude of environmental problems. In a research study

undertaken by Diaz-Bonilla and his colleagues on the health risks of the poor in developing countries, they claim that "poor environmental quality has been calculated to be directly responsible for around 25 percent of all preventable ill-health in the world today" (Diaz-Bonilla et al. 2002:38). They attribute much of this "poor environmental quality" to the environmental "spill-over" effects of economic globalization.

Many of the essays in this collection recognize the threats to health posed by the environmental effects of globalization. For example, Badawi notes that environmental threats to health have resulted from the increasing international trade in technology, capital, goods, services and labor. He notes that many "environmentally unfriendly" industries have moved from the developed to the developing countries, where there is generally less concern about the health hazards caused by their technology and often a lack of environmental health safeguards. Badawi also states that the over exploitation of fishing licenses, deforestation, industrial waste, and the dumping of health-hazardous materials are part of a long list of environmental health threats confronting the populations of the developing countries. Moreover, he warns that the indigenous germ pool and medicinal plants in the developing countries are threatened by the "commercial exploitation" of giant transnational corporations and warns that "genetically modified organisms, microbiological pathogens and hazards in animal production represent a real health risk for the developing countries."

Finau, Wainiqolo, and Cuboni contend that the cultivation of cash crops, mining, and industrialization threaten the fragile environment of the Pacific islands, and they say the "green house effect and rising sea levels caused by metropolitan modern societies' efforts to maintain their consumption level are threatening the Pacificans' habitat." They also claim that the environments in these societies "have become obesogenic, toxic and insecure, due to crime and violence." As a result, the Pacific countries are undergoing what they refer to as an "environmental transition" that has brought about "not only physical and social changes, but also developed uncertainty and stress in the Pacific psyche."

McMurray's essay analyzes the effects of globalization on environmental health in the Pacific and other developing countries. She notes that "modernization" and globalization are responsible for the development of urban areas and the increasing concentration of the population in these areas. She cites United Nations data that indicate most developed countries now have 70 percent or more of their population concentrated in urban areas and that the number of these areas is increasing in most countries. One of the environmental health problems created by this increasing urbanization of the population and the globalization of these

societies is that they have adopted the costly portable water and sanitation systems of the most developed countries in most of their urban areas, as a result of their colonial legacy and/or the development assistance they have received in recent decades. McMurray indicates that they now have difficulty maintaining and extending these systems because they lack the resources and technology needed to do this. She gives various examples of the rising problems of pollution and contamination in the urban areas of the Pacific resulting from the breakdown of their sewage and piped water systems.

Loewenson's essay on the health and safety aspects of working conditions in Southern Africa reveals that most workers in this region of the world "continue to experience work related hazards that have long been controlled or even eliminated in high income countries." According to Loewenson, "the expansion of chemical, electronic and bio-technology industries and of the service and transport sectors ... widened the spread of work-related risks and their interaction with non work factors of ill health, including environmental pollution." Employment in the large informal economy exposes workers in this sector to the health risks associated with "poor access to clean water and sanitation, ergonomic hazards, hazardous hand-tools and exposure to dusts and chemicals." Loewenson also points out that work in the agriculture, mining, and manufacturing sectors within the southern African economies is associated with high rates of injury from the mechanical, electrical, and physical hazards in their work environment.

The essays by Badawi, Labonte, Loewenson, McMurray, and Finau and his colleagues acknowledge the fact that globalization and trade liberalization have promoted the deregulation of production, health, and the environment. These forces have seriously weakened the capacity of the public sector to respond to the environmental and occupational health risks posed by industry, mining, transportation/shipping, and commercialized agriculture; they also have undermined the already inadequate forms of worker protection and social protection (including health) in existence in these countries.

Labonte's essay argues that environmental issues are becoming "inherently global" and are no longer purely national or domestic issues. He notes that the "environmental impacts of human activities are planetary in scale and scope" and that "almost one-sixth of humanity is on the move to escape environmental or economic degradation and conflict." Labonte sees this situation as evidence of the need for global solutions to these problems.

Community Health Care, Grassroots Action, and Globalization from below

As Finau, Wainiqolo and Cuboni contend in their essay, community-based, grassroots, and ethnic-specific health care has improved the access, acceptability, availability, and affordability of the health care provided to the communities it serves. This model of health care has also improved the effectiveness, efficiency, efficacy, and equity of the health services provided to these populations through changing the power relationships between the health care providers and receivers. They argue that this model of health care addresses the oppression and assimilation implanted by Western colonialism and "borne by imperialism through globalization." According to Finau and his colleagues, community-based health care releases the participants from the oppression of the Western health care model imposed first by Western colonialism, and more recently by contemporary forms of imperialism under the guise of globalization (e.g., the globalization of Western medical education and training, the transfer of Western medical knowledge and technology, the bureaucratization and privatization of health care along Western lines).

Narayan and Schuftan's essay on the People's Health Movement (PHM) reveals the emphasis this new movement gives to community control of health care, grassroots action, and global action based on the use of international health advocacy networks. These are important elements in the movement's global campaign to combat the health inequities associated with globalization and to make sure that universal access to comprehensive primary health care is provided everywhere in the world. This movement is engaged in what amounts to "globalization from below" as it builds support for its global Health for All—Now strategy, lobbies at the global level, and mobilizes a grassroots-based campaign to realize the vision and achieve the goals of the People's Charter for Health.

The Charter, which is the PHM's visionary statement of goals and its main tool for advocacy, calls for "a people-centered health sector that is democratic and accountable" (PHA 2000:9). The Charter calls on the people of the world to: (1) build and strengthen people's organizations as a basis for analysis and action; (2) promote, support, and engage in actions that encourage people's involvement in decision-making in public services at all levels; (3) demand that people's organizations be represented in local, national and international fora that are relevant to health; and (4) support local initiatives towards participatory democracy through the establishment of people-centered solidarity networks across the world (PHA 2000:10). One of the primary principles of the Charter is the proposition that "the participation of people and people's organizations is essential to

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the formulation, implementation and evaluation of all health and social policies and programs" (PHA 2000:4).

McIntyre, Thomas, and Cleary conclude in their essay that "the growth in number, size and power of civil society organizations combined with the increased networking of these organizations across national boundaries" is having a "countervailing effect" on the negative health impacts of globalization. They give the example of how civil society organizations in South Africa gained the support of civil society groups in the United States to pressure the US government into dropping its efforts to convince the South African government to change its policy relating to the importation of medicines so that it would not contravene the TRIPS agreement. They show how these groups in South Africa also teamed up with international groups such as Médecins sans Frontières and Health Action International to oppose the efforts of the transnational pharmaceutical corporations (with the support of their host governments) to pressure the South Africa government and the governments of other developing countries (such as Thailand) into restricting their use of certain provisions in the TRIPS agreement that permit governments to obtain urgently needed patented medicines at reduced prices.

The adverse effects of existing international trade agreements on health, human rights, and the environment have been subjected to increasing public criticism in recent years. As Labonte notes in his essay these agreements have "become the focus for progressive social movements." The global networking and collaboration that have developed among these social movements, such as the PHM, represent a form of "globalization from below" that is rising up to challenge the "globalization from above" imposed by the transnational corporations and their allies in the IMF, World Bank, WTO, the Group of 8 governments (led by the US government), and certain large international non-governmental organizations that are closely associated with these forces.

Labonte notes in his essay that the WTO has been besieged by a broad coalition of forces that are opposed to its global trade liberalization agenda. He argues that there are several reforms in the global trade regime that health activists in league with other progressive forces are promoting in their efforts to change the current effects of the WTO's trade liberalization efforts. These reforms would:

- Extend "special and differential" trade agreement exemptions for developing countries;
- Ban the patenting of life forms, exempt patent protection legislation for poor countries indefinitely, decrease the patent protection period and permit parallel importing under the TRIPS agreement;

- Impose a Tobin Tax (named after the Nobel economist who first proposed this idea) on international currency exchange transactions to raise about US $150 billion annually for an international development fund;
- Negotiate an overarching and enforceable rule in trade agreements that would require, when there is any conflict, for environmental and human rights agreements (including the right to health) to override the trade agreements; and
- Exclude health, education and other essential services (such as water and sanitation) from privatization since they are essential to human life and health.

In addition, Labonte argues that the WTO needs to be overhauled by making its decision-making more democratic and transparent. However, he disagrees with those activists and social movements who are calling for its abolition. He contends that this would be a mistake since "there is no other vehicle where the unequal balance of economic power globally might be subject to enforceable change." Labonte believes that the struggles of civil society organizations and the developing countries "to wrest reforms from the WTO are giving rise to a new system of global governance for the common good."

The Current State of Global Health Governance

As Labonte points out in his essay, social, economic, environmental and health issues are becoming "inherently global" rather than purely national or domestic. He argues that the evidence in favor of the need for global solutions to these issues is irrefutable, including the evidence about the rapid spread of infectious diseases, the increased adoption of unhealthy lifestyles, and the increasing international promotion of unhealthy foods and products such as tobacco and alcohol. Labonte concludes that "we live in the most important historical moment of our species, [since] the planet is dying, there is excessive affluence and poverty, [and] once far-away conflicts and diseases are imperiling global health and security." Faced with this unprecedented situation, he optimistically contends that "we are struggling forward to some system of global governance for our common good."

Yach and Beaglehole take a similar position. They conclude that the global diffusion of the major risks of chronic diseases is now almost complete and the prevalence of these diseases is increasing in most regions of the world. They contend, however, that the prevention and control of these diseases have not been able to keep pace with their globalization and growth. Therefore, they conclude that sustained progress against these diseases "will only occur when governments and influential international

bodies involved in health policy and funding acknowledge that the scope of global public health must be rapidly broadened to include chronic diseases and their risk factors."

Based on their experience in the ongoing struggle over the international control of tobacco, Yach and Beaglehole predict that "progress will continue to be slow unless the response to the epidemics [of chronic diseases] is scaled up in a manner commensurate with their burden on both families and societies" around the world. They believe that global solutions are needed to address the global health risks responsible for the epidemics of chronic disease that are taking place around the world.

However, Yach and Beaglehole argue that the global health agenda is currently dominated by what they call "the infectious disease paradigm." The main global health organizations and funding sources believe priority should be given to the prevention and treatment of infectious or communicable diseases before addressing chronic diseases. Because most institutional responses to disease prevention and control are based on this infectious disease paradigm, Yach and Beaglehole argue that the global and national responses to the spread of chronic diseases are "woefully inadequate and few countries have implemented comprehensive prevention and control policies."

They contend that a comprehensive response that combats all the health risks responsible for the global spread of chronic diseases is necessary, and they argue this response must overcome the "powerful countervailing forces" that presently stand in the way of changing the status quo. According to Yach and Beaglehole, a successful global response to the existing configuration of major health risks has to overcome the "many powerful and persuasive commercial entities involved in the production and promotion of unhealthy products." They claim these entities "exert an adverse influence on health policy developments" as well as on the development and implementation of environmental policies.

Yach and Beaglehole conclude that "stronger and broader alliances of major health professional bodies, consumer groups, enlightened industries and academics are now needed to effectively prioritize the prevention of the major risk factors" responsible for the global spread of chronic diseases. They suggest that the global campaign for tobacco control provides a successful model for how to organize a comprehensive response to the global spread of chronic diseases.

Yach and Beaglehole ultimately conclude that there is an increasing need to establish global norms on a wide range of global issues "to balance the otherwise unrestrained influences of powerful actors." They argue that, if the WHO is strengthened it can be used to establish these norms in the health sphere and then use the norms to resolve trade

disputes and other health-related global issues in a manner that promotes positive health outcomes. However, they do not think the WHO and national governments alone can address the challenges of chronic disease prevention and control. As in the case of tobacco control, they believe collaborative partnerships and interaction are needed with international consumer advocacy groups, international and national sports federations, sporting goods companies, transnational food corporations, retail food businesses, and insurance companies to improve the quality and access of people to healthy foods and increased physical activity. They advocate a consultative and "multi-stakeholder approach" with all interested parties as well as joint initiatives with the transnational food companies rather than an adversarial relationship. However, they recognize the dangers and difficulties that are involved in this approach.

Badawi's essay urges the developing countries to make more effective use of the provisions in the WTO agreements (the GATT, GATS, TBT, and Anti-Dumping agreement) that allow for "special and transitional arrangements." He contends that they can take the "compensatory actions" allowed under these agreements to limit the negative effects of globalization on their economies, environments, and protective social services. Badawi says that, unfortunately, these agreements are not well studied by policymakers and specialists in the developing countries. He recommends that they develop their national capacity and expertise for "expert reading" of the provisions of these agreements so that they can use their special exemptions to protect what he and the International Labor Organization refer to as the "social dimension" (social protection and social services such as health) as well as the environmental health of their populations.

Badawi also argues that the developing countries need to "cooperate and consult with other developing and developed countries to influence decision-making" at the WTO, the WHO, and other global institutions as well as to negotiate multilateral and bilateral agreements that confront the health hazards posed by globalization. Moreover, he argues that the governments of the developing countries, contrary to the prevailing feeling that [they] have lost control of their mandates, must, "adopt the measures necessary to protect the public interests in the environment, public health and nutrition."

Loewenson argues in her essay that "there is a growing understanding that global security and equity cannot be built on the significant burdens of deprivation borne by communities in the south," and that "globalization has produced powerful tools, new communications technologies, more widely connected social movements and an increasingly global recognition of universal rights as fundamental to policy." She contends that the full

potential of these tools can be used to create concerted global action to protect workers' health. The democratization and extension of the enforcement powers of international agencies such as the ILO and WHO would certainly help to improve the social protection of workers and the many other sectors of the world's population that are being harmed and disadvantaged by the global expansion and integration of twenty-first century capitalism.

Most global health advocates argue that a genuinely health-centered (and people-centered) process of globalization can be achieved only by ensuring that the interests of the developing countries and vulnerable populations are fully represented in all international decision-making on global health issues (Woodward et al. 2001:880). According to Badawi, Labonte, and Yach and Beaglehole, the democratization of decision-making in the existing international regulatory and financial organizations such as the WTO, IMF, and World Bank is needed to transform these institutions into global governance institutions that will advance the interests of the great majority of the world's population rather than the interests of the powerful economic elites they now represent.

Alternatives to the Globalization of Health from above

The People's Health Movement (PHM) is clear evidence that the existing linkages between globalization and health are contestable. In fact, most of the essays in this collection indicate that the adverse health effects of globalization are being challenged at the global, national, and local levels. The People's Health Movement and the People's Charter for Health provide a significant expression of alternatives "from below" to the present globalization, privatization and commercialization of health coming "from above." As Narayan and Schuftan state in their essay, this People's Charter for Health provides a vision of a better and healthier world, a call for radical action, a tool for advocacy for people's health, and a rallying point for building a global health movement based on international networks and coalition building.

The People's Charter for Health lays out a blue print for the transformation of the existing global order through democratization at all levels of the existing system and through what some people in the global social justice movement call "globalization from below" (Brecher, Costello, and Smith 2000). It is based on the fundamental, but radical, assumption that "to ensure health, people's basic needs for food, water, sanitation, housing, health services, education, employment and security must be met" in the present time frame (PHA 2001:1). In addition, it is based on the assumptions that global decisions must be democratized and that people's organizations and organized grassroots action can bring

about an "alternative vision of development—one that promotes human and environmental well-being" (PHA 2001:3). To achieve this vision, the PHM is pursing the democratization of health decisions and outcomes at all levels.

According to Narayan and Schuftan, the Charter for People's Health calls upon national governments and global institutions to recognize health as a fundamental human right and as a social, economic, and political issue deserving the highest priority. It also identifies inequality, poverty, exploitation, violence, and injustice as the roots of ill-health, and it makes clear that the achievement of universal access to primary health care requires challenging powerful economic interests; opposing privatization and globalization (in its present inequitable form); and drastically changing the prevailing political and economic priorities at all levels in the global order.

The Charter also makes it clear that the PHM wants the poor and marginalized (rarely heard) peoples throughout the world to participate in health decision-making and develop their own local solutions to their health problems. The movement encourages people to hold local authorities, national governments, and international organizations and corporations accountable for ensuring that the goal of Health for All is achieved now, not at some distant point in the future. However, even though the PHM firmly believes national governments have the primary responsibility for promoting an equitable approach to health and human rights, the movement knows that it will take pressure from people's organizations to force their governments to meet this responsibility. This statement reflects one of the most important strategic assumptions held by the PHM: that it will take organized grassroots action as well as concerted action at the global level to bring about the profound social changes that are needed to achieve the sweeping vision and radical goals of the movement.

All the essays in this collection provide suggestions and/or proposals for creating alternatives to the present conditions, in which the adverse effects of globalization threaten the health of people around the world and the planet's ecological sustainability. In their essay Finau, Wainiqolo, and Cuboni provide a series of models or strategies for thinking about the management of change in the field of health. They are all based on the assumption that change is inevitable and that the present power imbalances in the world must be changed in order for substantial progress to be achieved in the domain of health as well as in the other major domains of human existence.

These models/strategies provide useful conceptual tools for thinking about alternatives to the present global patterns and direction of change in health. We hope that this entire collection of essays serves the same

purpose as the models presented by Finau, Wainiqolo, and Cuboni—that it contributes not only to the ongoing discourse on globalization and health but also to the efforts that are being made around the world to find alternatives to the adverse effects of globalization on the health of the planet's human population as well as the sustainability of its biosphere.

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KARNATAKA

TOWARDS EQUITY, INTEGRITY AND QUALITY IN HEALTH

Focus on
Primary Health Care
and
Public Health

SUPPLEMENT TO THE FINAL REPORT
VOLUME - I

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A Commissioned Research Study

REVIEW OF EXTERNALLY AIDED PROJECTS IN THE CONTEXT OF THEIR INTEGRATION INTO THE HEALTH SERVICE DELIVERY IN KARNATAKA

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G : Some Policy Imperatives Including Integration and Sustainability

The previous chapters provide an overall framework of the 10 EAP's in Karnataka and some of the quantifiable or qualitatively describable indicators and features of these projects to help the project overview. As indicated in the project protocol this exercise was primarily a critical policy review and not an evaluation exercise of each of the EAP's per se. Some of the finding in the previous chapters and tables have addressed some of the questions that were included in our original list. In this chapter we try to address those which have not been adequately covered by the earlier one as well as provide some additional critical comments even on those that have been covered, drawing primarily from the very candid and frank interactive discussions we had with a wide variety of project directors. These policy issues and imperatives are as follows:

1. Scope of Projects

All the projects focus on Health System Development with varying degrees of emphasis on Primary Health care. While some focus on secondary level (e.g. KHSDP) there is a built in assumption that the secondary care support is with a view to support through efficient referral systems – the primary health care network. While in practice the links may not be so well established the conceptual framework is well directed to this issue. It is at the 'Public Health' context level however that the projects show a general weakness inspite of the fact that unlike other states in the country 'public health expertise' is available even among the senior leadership of the state. One can only surmise that in the changing financial situation perhaps financial management contingencies and bio-medically defined management framework are inadvertently distorting public health concepts and priorities. The focus on basic determinants of health is weak (nutrition, water supply, sanitation, environment) both at content level, emphasis and linkages; key public health components like surveillance and health promotion are inadequate; and the 'new public health' emphasis on empowerment of the community and public at large in health decision making is totally overshadowed by top down provision of specific packages euphemistically called social marketing. This lacunae / weakness needs to be seriously addressed.

2. Project Planning

In the absence of a strong Strategic Planning Cell in the Directorate (inspite of a provision in KHSDP for this) problems of project flexibility, design, long lead times and delays, in preparation, complications in procedures and various ongoing management and operational problems, all of which have been experienced in one EAP or another – are a symptom of lack of adequate attention to building in-house capacity for more realistic project planning and management. This has led to compartmentalized planning, inadequate collection of field based data or evidence, and adhocism in decision making further compounding the problem. Lessons are not learnt from positive and negative experiences of a particular EAP or its success

at some form of system development so the 'wheel is reinvented' each time by each project and the system is not enriched by the collective experience. E.g. Different EAP's have had different experiences of dealing with the 'NGO sector' or the private sector – some positive; some not so positive; some even disastrous in terms of unreliable partners or even 'fly by night' operators but the whole system does not learn from this to evolve a Directorates policy for NGO or Private sector partnership. This situation may change with the Task Force recommendation on state policy directives but for the present this is a lacunae to be urgently addressed.

3. **Who drives the projects?**

This was a very difficult policy issue to address. On the face of it, the State Government / State Health Directorate drives the project not the funding partners or their external consultants and all sorts of mutual consultations / reviews are organised. However two factors do affect the 'driving' of the project.

- **Absence of local homework**

In the absence of rigorous 'policy' and evidence based homework on the governments / directorate side due to a lack of strategic planning capacity as mentioned earlier, external consultants of funding partners are often able to drive the decision by just providing more options, more evidence based on data marshalled from experience elsewhere and the state policy makers are then more easily influenced or ready to accept them. e.g. During the study period an external funding agency resource person provided more data and perspective on private sector in Karnataka, than could be marshalled by local expertise thus inadvertently pushing the private sector agenda. The reliability of this data or whether it was extrapolated from quite different sources could not be commented upon, adequately without local homework.

- **Conditionalities of funding partners**

World Bank loans more than other agencies are also usually supported by some conditionalities that are clearly stated in their documents.

i. The need for economic reforms.
ii. The need to engage the private sector.
iii. The need to promote user fees as a means of cost recovery.
iv. The need to follow certain forms of 'tender' or 'consultancy 'laid down by bank' etc.

There does not seem to be adequate home work in-house on these and their implications especially long term options, before loan agreements are signed.

Some World Bank conditions

"The Country Approach Strategy (CAS) recommends focussing Bank-group financed investments on states that are undertaking economic restructuring programmes and supporting sectoral policy reforms. Karnataka is one of the state that has initiated important fiscal, sectoral and governance reforms. Further more it supports the CAS objectives by strengthening institutional capacity ....., engaging the private sector .....,

"Each project state ..... shall levy user charges in district and subdivisional hospitals in accordance with a program and time schedule acceptable to the Association(IDA)".

"Goods and works shall be procured in accordance with provisions of section I of the guidelines for procurement under IBRD loans and IDA credits" (International competitive bidding, bid packages etc).

"Consultants services shall be procured under contracts awarded in accordance with the provision of the Guidelines for the use of consultants by World Bank borrowers and by the World Bank as executing agency – published by the Bank in August 1981".

Source : Various reports of the Bank and Project Agreements

Both these factors lead to the continuing perception and the fact that indeed the 'external agent' does drive the project intentionally through general conditionalities or 'inadvertently through inadequate borrowers homework'. This needs to be addressed urgently.

Even where conditionalities are inevitable, these should be closely monitored and either reviewed if they have negative consequences or internalised into the system if they have positive implications.

4. **Are there areas of overlap / duplication ?**

- Compartmentalized projects by the very fact of being developed independently as 'stand alone' projects and not as components of a larger wholistic integrated project are bound to produce overlap and duplication.

- Not surprisingly the chairperson of the Task Force during one of his recent inspection visits found 'three operation theatres in a PHC compound' built by different EAP's with no evidence from the MIS of local needs that warranted such investment. In HMIS, IEC, and Training there are many overlaps and duplications .

- So different projects produce manuals and teaching aids or audio visual aids for Health Education which are quite similar in content;
- Health functionaries are expected to maintain a wide variety of registers that cater to the needs of different HMIS of different EAP's ; and
- Doctors go for different training programmes organised by a wide variety of EAP's that add to variety but not to a coordinated training plan at district or PHC level (see **case study A**)

- An overall integrated planning and training exercise is therefore urgently required. At the directorate / state level there are efforts to prevent this duplication of input and efforts but systematic change to streamline this process and prevent even accidental or inadvertent duplication is required since the health sector functions under a constant financial resource constraint and any effort to ensure more efficient deployment of available resources is welcome. A good example of adhoc integration is the utilization of KHSDP Resources for KfW project needs.

5. **Ownership and Leadership**

- In most projects the state level ownership is strong except perhaps in those projects which are 'package deals' decided at the centre.

- Because some of the EAP's have established independent structural identities e.g. KHSDP, IPP VIII, IPP IX, the links and feeling of shared ownership by the parent directorate (in the case of KHSDP and IPP IX) and the parent Municipal Corporation (in the case of IPP VIII) is weak. E.g. no serious consideration regarding sustainability issues and integration challenges relevant to KHSDP or IPP IX projects have been addressed at the directorate or Health secretariat. Nor is the Municipal Corporation adequately concerned about the very same issues vis a vis IPP VIII project.

- Another significant lacunae seen in the EAP's as they are presently structured, is that ownership at District level – at the point of implementation is quite weak vis a vis District Health Officers and PHC MOs; and perhaps non-existent vis a vis PRI institutions. All these three groups are crucial to ensure the integration and long term sustainability of all these projects. Ownership can be enhanced by involving all of them from the very inception and conceptual planning stage of such projects.

- Leadership of the project directors has been good as long as there have not been frequent changes of leadership or the burdening of project directors by multiple and additional responsibilities.

- However the leadership and ownership are particularly crucial if EAP's have to become more complementary or supplementary to each other and the whole

health care delivery system. Leadership that coordinates, networks and promotes linkages is crucial.

- Public Health orientation and socio-epidemiological orientation of the leadership - whether generalist administrator or medical / technical leadership is an important necessity to prevent inadvertent distortions due to extraneous lobbies or market forces. This will also enhance capacity to negotiate with external consultants and others as well.

6. **Intersectorality**

While in many EAP's the importance of this factor is mentioned, the intersectoral coordination between departments and programme managers and decision makers of different concerned ministries is still not given adequate priority. At the heart of good 'public health strategies' is the emphasis on intersectoral coordination and while EAP's may have not seized the opportunity in this aspect so far, the evolving Integrated Health, Nutrition and Population project (HNP) must focus on this aspect urgently and significantly. Even at the grassroots level a better coordination between PHC, ICDS centre, local schools, women credit cooperatives and development workers would strongly strengthen programme performance and outreach.

7. **Integration**

There is urgent need to integrate Health with Family welfare; public health , primary health care and the population agenda with each other to avoid not only duplication by compartmentalization but also to reach the community and tackle the health problems of people especially the poor in a more integrated way. Much lip service has been paid to the issue of integration but the stand alone EAP's have not tackled this issue adequately. In fact different EAP's focussed on different problems even further disintegrate the work of the directorate.

DHO's and MO's are constantly preoccupied or distracted at ground level by frequent visits of consultants, review teams, project teams asking for this and that data or feed back; the more EAP's the more such distraction from the normal planning and management routine.

At the directorate level different EAP's require different protocols to be filled, (different MIS mechanisms) so quite a bit of directorate staff time is spent in filling up questionnaires, schedules enhancing paper work but not necessarily enhancing efficiency of planning and management.

Consultants for each EAP provide their own framework of ideas and decision making. These do not allow for any inter-EAP consultant communication. One EAP may appoint a consultant that suggests one type of ideas, another EAP another type and all these have to function at the same PHC level or the same district level

or have to be operationalised by the same health functionary. This situation necessarily leads to adhocism and anarchy especially in the absence of state policy guidelines. Integration and coordinated communication is urgently required.

Another urgent area for integration to avoid wasteful duplication of time and procedure is the need for integrating all the single project related district level and state level societies into one Health society at both levels to receive and disburse the funds. Serious policy reflection also needs to be done to ensure that the District society's work under the purview of the Zilla Parishad and PRI.

8. **Equity**

While overall the EAP's do not have a well planned Equity focus some emphasis on Northern disadvantaged districts and on women and SC/ST have been identified and noted. HMIS of all EAP's as well as the Directorate must begin to focus on Equity in a more concerted way in the years to come. This 'equity imperative' must include

i. Geographical – Within districts and between districts.
ii. Gender – between male and female sections of the population and especially focus on girl child.
iii. Class / Caste – Between rich, middle class and poor or the so called haves and have – nots or 'landed' and 'landless' etc.
iv. Marginalisation – SC / ST or special groups such as child labour or rural migrants to urban areas, street child, elderly, people with disabilities etc.

Unless the HMIS focusses on disaggregated data the equity principle cannot be furthered by active policy or programmatic intervention. EAP's could build this in to their framework more concretely so that they go beyond policy rhetoric.

9. **Partnerships**

All EAP's have built some form of partnerships with the voluntary sector, NGO's, private sector, academic institutions or research institutions. But these do not build on a larger policy framework of the state since guidelines on such partnerships are not available. They tend to be some what adhoc. The directorate should actively move towards some form of Resource Directory; Accreditation system; or reviewing and registering system for such partners so that EAP's and different health departments can draw from pooled experience and pooled resource lists. A partnership cell in the Directorate like the erstwhile Society for Coordination of Voluntary Agencies (SCOVA) idea could build such directories, framework of guidelines and linkages, of use to all departments and projects.

10. **Community Partnership and Empowerment**

The resistance of the Health department to work with Panchayati Raj Institutions is well known and though some of the reservations of the health leadership may be

very genuine and based on difficult or awkward situations of 'interference' or extraneous push / pull factors in decision making – there is urgent need to review this and get over the problem rather than ignore it. With increasing political decentralization, PRIs will play an important part in local planning and administration in the future and EAPs should promote this process and not distort it.

The district level societies which leave decision making in the hands of the bureaucracy may be good for efficient disbursement of EAP funds but they definitely mitigate against active community participation. EAP's in particular must begin to focus on human development more than infrastructure; and in this human development component strengthening of community based organizations like PRI institutions to contribute to local planning and ensure accountability and transparency through capacity building will become as crucial as building health teams to deliver the programmes efficiently and effectively.

11. **Accountability / Transparency**

EAP's may develop their own monitoring system and evaluation systems, even audit systems but they are not accountable to the people, the political system, the legal system in the same way as the directorate and its regular programmes. While bureaucrats and technocrats may be closely involved with the development of these projects and the evolution of their frameworks of action there is still the danger of creation of a parallel system of decision making and programme management which may be seen as relevant in the short term but could become problematic in the long term.

However it was noted that overall some of the guidelines and procedures of the projects were able to immunize the project from the corruption and political interference which affect the larger system all the time since it does prevent the influence of extraneous 'push' and 'pull' factors due to clear cut guidelines that are not easy to circumvent.

In the short term review we were not able to make clear cut judgement whether extraneous interference's were making any sort of affect on programme formulation or implementation. The use of retired government personnel as consultants was common (a sort of 'old boy' network) which affected the dynamics of the programme and subsequently its performance in some cases but not necessarily to integrity. On the whole it may be surmised that EAP's are as subject to outside interference as the rest of the system not necessarily more.

However in the matter of construction costs and delays and whether some contractors were favoured rather than others – These areas were difficult to explore in the time constraint. There was hearsay evidence of this type all the time including architects inflating designs / and enhancing profit margins in other ways, etc.

12. **Sustainability**

This was one area on which there was very little real focus or policy discussion or planning in the projects at any level – project plans, project dialogue, project implementation mechanisms and so on. It is important to emphasizes that sustainability is often seen as being financial only. It is actually more than this and includes staff and other policies as well.

The overall assumptions which ignored this imperative and the trends seen were as follows:

i. The projects were seen as filling lacunae in the existing system and not creating additional structures or functions.

ii. The parent unit or department like the BMP in the case of IPP VIII and Health Directorate in the case of IPP IX, KHSDP etc were expected to take over the project when the period of the project was over. There seemed to be no contingency plans being evolved for this inevitable reality.

iii. In some project documents there was mention of cost recovery usually through user fees mechanism; or sustainability was to be made possible by NGO – or private sector partnership or take over but this was not followed up by serious operational guidelines or planning with the concerned parties.

iv. Sustainability as an issue seemed to be considered in the last year of the project as a knee-jerk reaction rather than as a serious plan evolved from the very beginning.

v. Unless the directorate estimates recurrent costs, running costs, maintenance costs and other such definable entities seriously as the time for phasing out of the project nears and unless these costs are budgeted for or recovery planned in some sort of methodical way – Sustainability like cost recovery will remain rhetorical and ultimately ignored or considered as someone else's problem at a later date.

vi. In some cases there seemed to be a confidence that some project donor would always step in to fill the lacunae if one donor phased out – so again this complacency led to a fatalistic non-planning situation which was not at all uncommon.

Sustainability of these relatively large EAP's is a very serious policy issue that needs urgent attention at the highest level and the active involvement of the finance ministry as well.

II. Some Reflections on the Financial / Economic implications of EAP's

Understanding the financial / economic implications of the increasing reliance on EAP's to support the health care delivery system in the state and the gradual shift from grant giving funding partners to becoming 'borrowers' of loans, was not an easy policy issue to review due to atleast two constraints.

- The financial management of the EAP's are separate systems not easily listed to the states own health budgeting / accounting system.
- The loan implications and the debt burden and debt servicing implications are not easy to explore in a short time constraint under which the project functioned.

The reviewers studied some earlier analysis particularly the review document (Analysis of Expenditure Medical and Public Health, Family welfare by S.Subramanya) and the more recent study of Dr.Vinod Vyasulu and group and also studied the credit agreements of various projects and the budget and account statements as well as status of project tables from World Bank and other sources. From a review of all these secondary sources of data the following conclusions and policy concerns are listed out: (See also box items which are extracts from authentic source and support our conclusions)

1. While the overall expenditure on health and family welfare is gradually decreasing and hovering between 1.1 and 1.4 of net state domestic product which is itself an overall low investment (ICSSR / ICMR recommend 8%), the reliance on EAP's is increasing which means Non-plan expenditure is coming down and Plan allocations are increasing. This is not a very healthy trend.

2. Most of the expenditure in non-plan is now directed to salaries with less and less available for programme / action components. EAP's are tending to take over more and more of this programme component – again not a healthy trend.

3. Considering that EAP's are now more and more loans rather than grants or long term soft loans this is a worrisome development. If these loans are not utilized with efficiency then we have the double burden of continuing ill health and a 'debt burden'.

4. Though all the projects talk about sustainability and cost recovery and user fees mechanism is often mentioned as a long – term option there is no indication that this mechanism is effective in reality. While some recovery has been demonstrated; and some efforts to identify those who cannot pay etc is being experimented; and the decision to let the amount / revenue collected be kept at the institutional level for local use rather than transferred to the general account or treasury – none of the mid-term reviews show that this could be a major option for sustainability even though in the short term they may help to improve quality by enhancing consumer participation. Researchers and programme evaluators are not unjustified in their concern that 'user fees' may ultimately

Health Financing – An Analysis

1. "State Finances, Health Finances and Efficiency: Three key issues, with regard to public sector finances at the state level need to be addressed. First the overall fiscal situation in many states has deteriorated sharply since the early 1990s, with a rise in the fiscal deficit, an increase in interest payments as a share of total revenues, and an increase in debt outstanding as a share of state domestic product. The deterioration in the overall financial situation faced by the states has had a deleterious effect on the health sector. The share of health and family welfare in the total state revenue budget has declined since the early 1990s suggesting that past declining trends of health sector's share in the budget has been exacerbated, rather than reversed. The decline in the health sector's share occurred despite a rise in real per capita expenditures in all states up to 1991, indicating that total government expenditures rose faster than health expenditures. Total government spending is about US$ 2-3 per capita for health services and is inadequate to meet the government's stated objectives. To achieve the government's objective of funding a basic package of health services, substantially more resources for health care are required, but the overall state finances noted above pose a serious problem. Second, within the health sector in most states, resource allocation in the public sector is skewed in favour of tertiary care services relative to needs at the primary and secondary levels, particularly rural and community hospitals. Third, much of the resources are absorbed by salary costs. The recurrent budget for operations and maintenance is chronically under-funded and the programs are not fully effective".

2. "Alternative Methods of Health Care Financing : The resource constraints faced in the health sector will required alternative methods of health care financing to supplement budgetary allocations. Alternative methods of financing health care, such as cost recovery, social and private insurance, and participatory schemes, are limited. Reported revenue data indicate that cost recovery in the health sector is about 3% on an average in India, although there are problems in estimating the level. Some of the problems faced with cost recovery include:
   a. Lack of an appropriate mechanism within the government to review user charges;
   b. Weak administrative mechanism for collecting user fees;
   c. Difficulty in targeting the poor for exemption from user fees; and
   d. Constraints to greater retention of funds generated through user charges at the point of collection.

   Based on international experience it should be noted, however, that a cost recovery rate of 15-20% in the health sector is about the most that can be expected in the public sector. In the long run, issues such as private insurance and managed health care will need to be addressed, as the industrial and urban sectors in India expand, and cost containment becomes increasingly important".

Source : Analysis of Expenditure on Medical & Public Health, Family Welfare

State Health Finances

"Non Plan expenditure, which is met from resources raised internally by the state, accounted for 63-69 percent of the total expenditure on health and family welfare between 1990-91 and 1994-95; this came down to 57 percent in 1995-96. Reduction in the proportion of non-Plan expenditure in 1995-96 is because of increase in Plan allocations and capital outlays. One reason for this increase could be the availability of funds from externally assisted population and health projects and Central government aided projects such as the AIDS control programme".

"With expenditure on health and family welfare accounting for only 1.21 percent of the net State Domestic Product down to 1.14 percent in 1991-92, but up to 1.24 percent in 1992-93, decreasing again to 1.22 percent in 1993-94 before increasing to 1.37 percent in 1994-95. It is clear that fluctuations of this nature are undesirable for the growth of the health sector as also that expenditure on health and family welfare is, by any reckoning, inadequate. A study group on Health for All, set up jointly by the Indian Council of Social Science Research and Indian Council of Medical Research, recommended 'a substantial increase in public expenditure on health at about 8 or 9 percent per year (at constant prices) over the next 20 years".

Source : Human Development in Karnataka – 1999

de-emphasize the need to focus on the marginalised. Other problems with this mechanism are highlighted in the box items as well.

5. There is a danger that increasing reliance on EAP's will ensure that programme costs in the regular non-plan health budgets will be ignored with a long – term distortion in budgeting creeping in. (This will perpetuate long standing budgetary imbalances with long term implications for health budgets).

6. There seems also a tendency to be more extravagant with issues like constructions, consultancies, equipment, vehicles, etc because EAP's promote unwittingly a more 'private sector' ethos so thrift, careful planning, basic simplicity and other such values that would ensure 'quality' at low cost or a more judicious use of resources so that more is available for grassroot needs is being affected.

7. Finally it may be important to caution that reliance on EAP's should only be a short term plan. Ultimately health budgets like the investment on education and welfare (social sector) should be increased as a long term investment in quality human development. Enough economic analysis and theory – including the more recent endorsement by the work of economists like Amartya Sen and others show this direction as the way ahead. This needs political will and commitment and some courageous state development policy planning. Let short term solutions like EAP's not come in the way of concerted, action for sustained development and higher investment in health.

J. General Policy Concerns : Are we reinventing the wheel?

The key researcher for this study and some of his colleagues had reviewed the World Bank activities in the Health Sector in India based on a case study on "The World Bank's role in the Health system in India" facilitated by the Sector and Thematics Evaluation Group of the Operations Evaluation Department of World Bank in August 1999.

That review had raised seven sets of questions / findings for a policy meeting organised by the Bank with Planning Commission, Ministry of Health and Family Welfare and others. The review of EAP's in Karnataka was a good opportunity to look at these propositions in a wider variety of project initiatives and with partnerships beyond the one with the bank. Our findings suggest that many of these concerns are very real ones even in the context of the current EAP's in the state and need to be given serious consideration by policy makers and project directors within the state before these distortions and concerns become too systemic. They are equally important for the funding partners. These concerns are enumerated as a set of policy questions that project directors and partners should reflect upon as they review their projects for long-term sustainability and integration within the larger system.

1. **Is Public Health not being adequately emphasised in problem analysis project planning and formulation?**

   - Is there a confusion in understanding public health?
   - Is economic or techno-managerial context taking precedence over socio-epidemiological analysis?
   - Are the wider determinants of health like nutrition, water supply, sanitation, and pollution not adequately addressed?
   - Is the focus on poor, indigent, marginalised not central?
   - Are regional diversities and differentials not central to decisions on focus of programme?

2. **Is Primary Health Care being given adequate emphasis and priority ?**

   - Is there focus on selective 'cost effective treatment strategies' rather than enabling / empowering processes?
   - Is there focus on first referral units rather than primary health centres, subcentres and home based care?
   - Is community involvement in planning and organisation mostly rhetorical with community capacity building made subservient to exigencies of top down management systems.
   - Are Panchayati Raj institutions generally ignored and registered societies promoted as an instrument of decentralization but under bureaucratic control?

3. **Are these partnerships adequately transparent and accountable ?**

- Are the partners willing to share the costs of failure and distortions due to poor programme design or planning which ultimately affects the poor?
- Is long term sustainability or integration into existing health care system being adequately addressed or followed up as an end of project after thought?
- Is there unhealthy competition between projects rather then collaboration and sharing of expertise and experience?
- Are accountability and transparency systems not clearly defined and hence not actively monitored?

4. **Some ethical issues and dilemmas ?**

- What is the ethics of promoting NGO-private sector partnership in the absence of solid evidence that these are more efficient operational options?
- What is the ethics of taking credit when an initiative is successful and yield positive results while pointing a finger to the directorate or ministry when the initiative is problematic?
- What is the ethics of expanding quality at the cost of or absence of adequate and operational quality control?
- What is the ethics of promoting infrastructure and 'hardware' at the cost of 'software ' that can more easily focus and reach the poor?

5. **Some management issues and dilemmas?**

In spite of marshalling lots of expertise both local and foreign is there a tendency to:

- Develop 'hardware' rather than 'software'?
- Expect 'training' to get over needs for serious management reforms?
- Little thought to social accountability and transparency?
- Inadequate attention to building ownership among different stake holders particularly district level players?
- Focussing on 'user fees' as the only primary fund enhancing option rather than looking at diverse options?
- Overall neglect of health human power issues like continuity, skill development and promoting team concept?

6 **Is the political economy adequately addressed?**

- Are the health projects adequately located in a broader, political, social, institutional analysis and adequately based on evidence of how projects run or do not run?

- Are issues such as political will; corruption and influence of lobbies political interference; market economy; being given adequate emphasis in the strategic planning exercises?
- Without developing a strong 'public health policy resource group' within the directorate is the free lancing, free floating, adhoc Consultancies and commissioned studies not allowing the means of change to become systemic?

7. **Is cultural context being disregarded?**

- Inspite of a rich and diverse tradition of Indian and alternative systems of medicine, including promotion and investment in health humanpower development in these systems by government and private initiative; are the EAP's ignoring the local cultural context and these alternatives in their formulation?

All these issues are relevant today and it was surprising to find that most of them were applicable to all the EAPs in the state and not only for those supported by World Bank. However it must be noted that the current health leadership both bureaucratic and technocratic seemed much more alive to these policy issues. That was a positive finding, symbolizing future potential. However as was brought out again and again in the interactive discussions **local holistic problem analysis and policy homework was inadequate in all these aspects. Strengthening of strategic policy analysis and development was an urgent action imperative. Policy makers and project managers need urgent orientation to Public Health aspects of decision making and socio-economic politico - cultural aspects of health situation analysis.** Any strategic planning exercise in the future for the continuation of the existing projects or the evolution of newer one must take these crucial questions into account so that the projects can be implemented more effectively and in a more realistic context with reduction in the implementation gaps.

J. Final Conclusion and Recommendations from a future Policy point of view.

The previous sections highlight the key findings and trends that emerged from the review process. However taken as a whole set of project experiences the key issues and conclusions that have emerged as significant for a concerted policy response are the following :-

1. While the EAP's do focus on a large number of health problems and health sector development issues, addressing various lacunae in the existing Health care delivery system in the state at both primary and secondary level, **they do evolve, exist and function in relatively compartmentalized ways without fitting cogently into a comprehensive, integrated strategic larger state health policy / plan evidenced by -**

- The absence of any state health policy document that includes serious reviews or details of all of them.

- Any coordinating mechanism at directorate level that addresses them in a collective context.

- Any consistent and rigorous strategic planning exercise / document that was used by programme designers when these EAPs were evolved. Some congruence / complementarity between / across projects has evolved since the members of the project committees overlap with senior policy makers common to all, but this is 'adhoc' and not always intentional.

  [Probably the HDR Report, Karnataka Task Force in Health and the recently evolving HNP project are fore-runners for this much needed paradigm shift from selective compartmentalized programme planning to more comprehensive integrated Health sector planning processes].

2. On the other hand while **compartmentalized evolution** may have lead to some problems of duplication and integration, especially in IEC and training, but also sometimes in infrastructure development, the very feature of compartmentalization has also lead to a certain degree of project autonomy that has lead to many interesting initiatives and innovations in structure, framework, operational mechanisms, evaluation and monitoring, some of which have been identified by this short-term review. These need to be rigorously documented, objectively evaluated further and adopted / adapted by the whole system as the projects phase out and get taken over and integrated by the ongoing larger systems.

3. Overall the **Directorate / EAP's have shown**

- An ability to evolve laudable objectives for each EAP.
- General lack of competence in the evidence based homework required to translate objectives into implementable strategies leading to delays in starting up times.
- Diffidence in guidelines and systems development leading to operational and execution delays.
- While ability to handle the hardware (infrastructure construction - civil works, equipment and transport) has been established, effective software development (training, IEC and Quality Assurance) has remained a weak skill / capacity. Also cost over runs have been many compounded with poor utilisation in other areas showing in-different financial management capacity as well.

4. Like the general health care services development, the projects have not shown any **evidence-based focus on equity, gender, regional disparity or other policy imperatives like impact assessment, community partnership and ownership, partnership building and decentralization** and hence though there are some successes and some failures as well, in none of these areas can EAP's be shown to have used their own programme / project autonomy to enhance the **health sector** experience in these areas. This is partly a reflection also that at the Ministry level there are no clearly circulated policies or programme guidelines on these policy imperatives and hence project managers have had to explore these dimensions if at all with diffidence rather than confidence and clarity. Similarly the issues of corruption, political interference, transparency and accountability seem to effect them just as much as they affect the larger public health system- no less, no more though perhaps in the tendering / purchase policies sometimes as conditionalities of the funding agencies, there seems to be an overall feeling among programme managers that outside or local interference is less!

5. **Lack of continuity of key personnel** has been an important handicap and lack of systems to monitor quality of care and responsiveness to local needs had handicapped the establishing or the enhancement of effectiveness. In addition selection of consultants and senior project consultant need to be critically reviewed and made more competence based and transparent. Apart from an old-boy network phenomena selection is not always focussed on skills for the job.

6. While the general impression of the programme managers seemed to be that these EAPs were not consciously **donor driven** and there was space and opportunity for local technical opinion to evolve project formulation, the impression of donor driven agenda was often attributed to lack of local homework and evidence generation and hence a tendency to accept the suggestions / frame work / ideas of working external consultants as an easy option. This aspect again underlines the urgent need to develop and enhance the strategic planning capacities of the Ministry / Directorate and making it multi-disciplinary as well [The KfW and OPEC experiences have however been good examples of the need 'to look at gift horses in the mouth' seriously which could have avoided all the problems that have followed. They have also shown the absence of long term planning capacities especially in **human resource development** for the hospitals being upgraded].

7. **Integration** as an issue does not seem to have been seriously considered by any of the projects since many projects were seen as stand alone or focusing on infrastructure not process. [The absence of clarity in development of a **referral system** complex between primary and secondary care (for example: IPP VIII, IPP IX and KHSDP) is a case in point. Similarly IPP VIII, IPP IX and RCH could have been more complementary, etc.] This leads to wasteful duplication at the ground - level.

8. **Sustainability** is another policy imperative that does not seem to have been taken seriously by the whole system since in many ways this should be a long term concern of the Directorate and not just of the EAPs. KfW project had some serious options outlined in the project part which were not adequately experimented with. [Efforts to evolve systems of user fees; efforts to identify and hand-over (contract) out services to NGO's and or private sector etc. are being experimented with in KHSDP, IPP VIII, RCH but these experiments seem adhoc and not within a clear-cut policy framework. Nor are they being evaluated objectively to establish relevance or effectivity]. Overall the human power development experience that is crucial for sustainability has often been ignored or inadequately addressed.

9. Overall EAPs do not seem to be adequately drawing upon the **Public Health / Community Medicine capacities** of the state in any concerted or formal way nor for that matter on the phenomenal inter-disciplinary capacities of institutions such as IIM, ISEC, NLSUI and other resource centers of health, social development or strategic planning expertise- many of which are also available in other districts and regions. In fact there seems to be an **overall lack of public health / sociological orientation in problem identification, situation analysis or programme planning** in the EAPs evidenced by a sense the researchers got of the dominance of :

   - Infrastructure over human resource development.
   - Bio medicine over socio-epidemiology.

- Secondary care over primary health care (especially preventive public health).
- Centralization over decentralization.
- Provision of services over enabling / empowerment strategies.

10. Finally a **review of EAPs** undertaken by us, inspite of the time and methodological constraints, lead us to suggest that there is urgent need to:-

a) ***Develop strategic planning capacities in the Health sector of the State to handle the complexities of Health sector development as well as the challenges of negotiating sustainable projects with external agencies and funding partners that develop not distort / enhance capacities all round / and integrate not disintegrate.***

This capacity should be multi-disciplinary, directorate-based and as an immediate starting point should also become the integrated evidence based monitoring unit for all the health programmes of the state including EAPs.

b) ***Develop mechanisms of integrated planning that would start as a first step of all programme managers and programme implementers being networked into a coordinated planning mechanism that from time to time focuses on integration and sustainability issues*** beyond the dynamics of compartmentalized projects / program. [The project preparatory committee of the current HNP project could well become the starting point of such a mechanism].

c) ***Both these mechanisms should draw on multidisciplinary professional expertise in the state especially public health and the behavioral sciences*** from all the resource centres both public, NGO, private and the professional colleges. (The HNP project is trying to do this by involving a multi disciplinary group like Community Health Cell (an NGO) but this needs to be done with greater clarity and flexibility.

c) ***A more detailed internal review and analysis of current EAPs should be undertaken as an in-house exercise by both (a) and (b) supported by (c) so that the positive lessons from EAP experience is integrated into health sector development in the state and distortions / problems handled by a more decentralized programme implementation mechanism or countered through more effective evidence based long term strategic programme planning.***

K. Limitations of the Review Exercise

- The task of reviewing ten Externally aided projects in Health in the state in a short term framework of 4-5 months was a very stupendous and exhaustive task and perhaps quite unrealistic as well.

- Hundreds of pages of reports, reviews and other documents had to be perused and interactive interviews had to be arranged with a large number of very busy government officials and project managers within this short term framework by researchers who also had to work within a framework of complementary demand and deadlines.

- In two cases RNTCP and KSAPS interactive discussions with programme directors could not be completed so we used reported information monthly - both presentations at KTFH meetings and documents and one other programme due to time constraint. NLEP (Leprosy control) was not included. Since this review was trying to identify the broader policy issues relevant to Externally aided projects in general all the nitty gritty's of all the projects were not focussed upon.

- The study was also focussing on many issues that are neither easy to measure nor always easy to elicit because qualitative judgements on qualitative issues are often not easy to collect especially if the judgements are negative or critical. We must record however that most of the people interviewed showed a phenomenal degree of openness, frankness and willingness to discuss even 'sensitive' areas and this candidness is really appreciated.

- We have tried to do our best integrating the rich, response and feedback that was received in the interactive discussions supported by background notes and papers and our own reading and critical analysis of all the documents that we were able to access. The effort has been made to make this review a learning experience as a partner not as a critical external reviewer.

- We hope we have been able to collate and highlight the salient features – both strengths and weaknesses of EAP's when taken collectively. Much more needs to be done to address all the questions originally listed out, some have been answered, others only just considered. More time would definitely have helped. However the experience has shown that full justification can only be done if this review, both in-house and external becomes part of the ongoing Strategic Planning Cell of the Directorate / Ministry. If our study has helped to get this message across we would have felt fully complimented by our efforts.

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Comments on "Case Study of World Bank activities in the Health Sector in India"

Presented at the Consultative Meeting on "World Bank Activities in the Health Sector in India" at World Bank Office, New Delhi, on 9th August 1999

The Sector and Thematic Evaluations Group and the Operations Evaluation Department of the World Bank (India) prepared a case study on the World Bank's Health - Nutrition - Population program in India based on review of literature, sector and project documents and the proceedings of the workshop on "The World Bank's Role in the Health System in India" which included 9 papers commissioned by OED.

This note by some of us from the Society for Community Health Awareness, Research and Action, Bangalore, a multi-disciplinary professional resource group working for the last 15 years supporting community level health action and community oriented health policies by the voluntary sector and government, brings to bear comments on this case study from a Public Health, socio-epidemiological; management; ethical; and public policy perspective - which are the disciplines represented among the four member group of the society, who studied the document.

We had a little over a week to study this document and in spite of a request were able to get copy of only one of the nine commissioned papers! So our comments are based on a rather rushed analysis of the document handicapped by the absence of access to the background papers from which much of the perspectives and conclusions included in the case study, are drawn. Notwithstanding this constraint we hope the concerns we raise will be taken seriously by the Ministry of Health and Family Welfare and the World Bank India operations team. We believe these are concerns that we along with so many other public health / community health / health policy resource groups have been raising for over two decades now, but we are emboldened once again to do so -because for once the findings of this case study so strongly endorse and support them. These comments are also based on insights that we have with involvement with World Bank projects at Karnataka State levels in various ways.

We believe it is time that the Ministry of Health and Family Welfare at the Centre and State and the International funding partners, particularly the World Bank ('who is now the largest lender in health, nutrition and population with the largest programme in India') - who jointly conceive, conceptualize, operationalise and monitor such large collaborative projects on behalf of the people of this country - (emphasizing "poor and undeserved and concentrating on children and mothers") took these concerns seriously.

This significant, rather short, but important Consultative Meeting could be a serious step in that direction. However, a more detailed dialogue is required if these concerns must get translated into constructive policy change.

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Comments

The Case Study of World Bank Activities in the Health Sector in India brings together findings from a variety of sources (mostly World Bank commissioned) and attempts a comprehensive, critical, historical view of 23 projects undertaken by the Bank in partnership with the Ministry of Health and Family Welfare at Central and State levels and to which the Bank "contributed over $2.6 billion plus studies and policy dialogue"

The case study is frank, introspective and 'as objective as possible under the circumstances'. Though inadequately referrenced even from the commissioned studies, and perhaps representing sets of opinions rather than 'evidence based analysis' it is still a sobering indictment of what the Bank claims to be the "largest Health Nutrition and Population programme" funded by it.

Appendix 1 of this note lists out in the report's words key findings and conclusions producing a rather disturbing, disconcerting scenario and **a rather frank admission of failure, and distortion. If a SWOT analysis were to be done on the case study -then weaknesses would far outweigh the strengths; and threats / distortions far outweigh the opportunities!**

In the absence of access to all the commissioned studies and reports / documents quoted in the report, it would be unfair to attempt a comprehensive review of the document, but we raise the following comments, reflections and questions from a Public Health; Epidemiological; Management; Political Economy; Public Policy and Ethical perspective, keeping an overview of the overall partnership between MOHFW and the World Bank in mind and not addressing just the nitty gritty. Some of these are endorsed in the case study. Others are derived from the findings presented.

1. Public Health devalued

The whole partnership suffers from a disturbingly lack of 'public health' competence and perspective and this chronic lacunae does not seem to have been overcome even when the claim "the Bank is now on the right track" is made.

Throughout problem analysis, project planning and formulation, there is a confusion between

- public health system and public health care system
- between socio-epidemiological context of a problem and its economic or techno-managerial context, the latter taking precedence over the former every time
- the wider determinants of health status that need to be addressed by good public health is totally ignored (devaluation of nutrition is admitted but other aspects like water supply and sanitation, transport and communication, environment pollution have not been addressed and even health education in this report is put outside the confines of the health sector.
- The focus on the poor, the indigent and the marginalised which should be the central focus of an equitous public health system is ignored or if present in programme focus is ignored in programme implementation
- In fact both 'epidemiology' which is the sheet anchor of public health and 'political economy' which should be a important part of problem analysis is totally ignored.
- The regional diversities and differentials -now known for a long term are ignored.

Between the generalist administrators who now manage India's Health System and the 'economists and programme managers' that advise them from among the Bank's staff and Consultants Public Health has been totally devalued and distorted both due to a lack of public health orientation and public health competence among the policy makers concerned.

2. Primary Health Care sidelined

The World Bank projects evolved and developed when the country began to take the Srivastava (1974) and Kartar Singh report (1973) seriously; commissioned the ICSSR/ICMR Health for All : An alternative strategy document (1981) after becoming an enthusiastic signatory of the Alma Ata declaration; enunciated the National Health Policy guidelines of 1982; the National Education Policy of 1986 and the National Education Policy for Health Sciences in 1989. In addition, the ICMR initiated its review of Alternative Approaches in Health Care (1976) and the Evaluation of Alternative Primary Health Care (1980). Preceding these documents but supplementing / complementing them, there was a spate of micro-level and collective initiatives in Alternative Health Care in the 1970s and 1980s which are now well documented and a host of very incisive, evidence based, thought provoking analysis of India's health care systems from social, economic, cultural, political, epidemiological and public policy perspectives from the mid 1980s to date. The World Bank project partnerships seem to be totally 'uninformed' about all this and has not only ignored the Primary Health Care mandate but has actively distorted the Primary Health Care agenda by focussing on

- *'selective, cost effective treatment schedules' rather than enabling / empowering health care processes*
- *relying only on the now well debated and well established inadequacies of the GBD study based on DALYS (WDR - 93 and the documents that followed)*
- *focussing now on secondary hospitals rather than primary health care*
- *on first referral units rather than the Primary Health Centres*
- *totally neglecting the people and community, whose involvement at all levels was envisaged by the Alma Ata commitment and 'whose needs / capacities / aspirations were to be emphasised' and not made subservient to needs of technology or the exigencies of top down management systems.*
- *Finally, it ignores Panchayatraj, which has to be the focus of Public Health and Primary Health Care in the 1990s (even cautions against it) and then creates Registered Societies as a decentralization initiative without clarifying how they will be made accountable, transparent, responsive to public need or the country's democratic political system.*

3. Unconstitutional partnership

The World Bank seeks to influence / health policy in India by (a) virtue of being the largest lender to the sector, even though there is enough evidence that this forms a small part of the entire country's budget; (b) by various conditionalities that overrule local expertise and project formulations, (c) by thrusting on the country ideas from rather different countries with different social, economic, cultural, political, ecological and epidemiological context. (An example from Malaria Control will be given to substantiate this)

What is the 'Constitutional validity' of this leverage which is greatly enhanced by use of 'funding muscle'? and which was established during a period of economic vulnerability of the country (The big break' mentioned in page 18).

Considering that many of these are loans and not grants, is the World Bank willing to bear the costs of failure and distortions due to poor programme planning that ultimately affect the poor the most?

What is the long-term sustainability of such a leveraged process - often arrogant, top down and externally inspired. What is the effect on local health system capacity development?

Is it not leading to coercion? Distortion? Competition? Who will bear the responsibility? What is the accountability and transparency especially to civic society?

The MOHFW must seriously dialogue on these issues before the PAC, the legal system, the political system and civic society begin to question and initiate informed citizens' action against it. In Karnataka this process is already starting up.

4. Ethical issues

The case study raises some major ethical issues

(a) What are the **ethics** of promoting so enthusiastically the 'private sector' when there is no evidence even from Bank sources that the private sector either has the capacity to provide 'low cost effective quality care' or has any commitment to 'public health' or to the goal of equity (giving only the example of Apollo, Chennai, which is not even among the best examples of corporate social responsibility is a case in point).

(b) What is the 'ethics' of undertaking a partnership taking the credit when there is success and then pointing a finger at the MOHFW when problems are identified and not solved (the report calls the World Bank position 'cautious' but 'incompetence' is what the report establishes). Does this make World Bank an unreliable partner?

(c) What is the **ethics** of continuing to fund even after 1990 - a programme, when the Bank is well aware of the flaws and distortions?

(d) What is the 'ethics' of expanding 'quantity' at the cost of 'quality' or 'infrastructure' at the cost of 'services focussing on the poor'.

Is it at all surprising that ever since the World Bank has become a lender of large amounts of money -that the medical scams in the country have also gone up? There may be no cause-effect relations but why does the report ignore corruption which is endemic in the country; is now well documented by civic society; and is well accepted in problem analysis, by serious policy researchers.

Has the World Bank ignored it by oversight? Is it aware that it may be inadvertently supporting it or even facilitating it - international tenders and guidelines not withstanding?

5. Management issues

In terms of 'Management' perspectives, it is rather surprising that a partnership that claims to be able to marshall international expertise has continued to:

i. *develop infrastructure quantity rather than quality;*

ii. *expected 'training' inputs to get over needs of management reforms;*

iii. *given so little thought to accountability and transparency;*

iv. *relied on internal monitoring / evaluation by in-house staff and consultants rather than independent credible external evaluation;*

v. *ignored health human power management issues;*

vi. *focussed only on 'userfee' rather than diverse fund enhancing options including health budget increase;*

vii. *given so little thought to ownership*

Directorate of Health Service staff at all levels often feel coerced by the conditionalities /guidelines and lack of flexibility, and do not identify with it. There is also nil ownership at the community / civic society level.

(This is probably the greatest failure of the World Bank projects and both MOHFW and World Bank partnership cannot overlook this any longer).

All this may be changing now - the case study claims - but is this real change understood at core policy level?

6. Political Economy

The case study does not look adequately at the larger 'political economy' issues against which the analysis and the successes and failures should be contextualised. These include *the financial situation in the country and globally; the reduction / stagnation of public sector budgets; the impact of rise in prices on drugs / diagnostics; the contraction of public sector; the expansion of private sector under LPG (Liberalization, Privatization and Globalization) and its impact on public health and access by poor to medical care, the potential impact of WTO and changes in Patent laws; the increasing corruption and scams, etc.*, and thereby the policy researchers involved in the partnership constantly under-estimate the political, social, institutional and other dimensions of the problem analysis and hence offer recommendations that are general and not focussed on 'how and why things run' or 'do not run'. The report admits this and hope the next phase will address it. While this may be changing, of late is it still on the sidelines of the partnerships planning and problem solving efforts and depends very much on the quality and experience of consultancies and in-house expertise that is facilitated both inside the MOHFW and the WB-India office.

Unless there is a strong 'public health policy resource group within the MOHFW' in the next phase and this free-lancing, free floating, adhoc consultancies and commissioned studies are institutionalised a real change in competence may not take place. The report establishes rather well the inadequacies of the last two decades but its chapter on implication for the future or how to develop an effective programme fails to grasp the complexity of the situation. One does not know whether this naievity is intentional or inadvertent?

7. Building on strengths and new insights

While the above 6 comments may seem to focus mainly on weaknesses and distortions that have plagued the framework of the World Bank Project partnerships, we do also recognise some strengths and especially some of the new insights in the report which we hope will find increasingly higher place on the agenda of problem analysis, project formulation and project management in the future.

Some Strengths

i. By focussing on 'private sector' even though on the 'profit' rather than 'non-profit' and 'corporate' rather than 'general practice', the Bank has brought into policy focus the engagement with the private sector which has long been a 'blind spot' in Indian health planning. It is time the GOI / MOHFW studied this sector recognized, monitored, involved, regulated, evaluated and 'quality assured' in this sector.

ii. It has more recently supported the target free approach and the shift from Family Planning, especially sterilization, to Mother and Child Health (RCH) but still has a long way to go towards women's health and development.

Some New insights

iii. It has also identified the following new thrusts in its section on policy implications which are welcome

- *"need to focus on staff policies and practices regarding compensation, assignment, transfer, promotion and demotion work rules and supervision"*
- *"need to take more account of field conditions and to find solutions to implementation problems"*
- *"need to ensure that basic, simple services for the poor are not neglected in the wake of attention paid to secondary hospitals"*

All these are definitely steps in the right direction. In addition, we believe that if the points 1-7 are considered not as negative judgements but as stimulus to change track and be rooted in local social reality than these will add to important policy change as well.

8. Some of blind spots continue even after two decades of work in India. (a) One is especially striking and that is the total disregard of Indian and alternative systems of medicine and folk health traditions, in spite of the country having such a large network of institutions, health centres and human resources in these systems. (b) Is the total lack of understanding of people from a social / community point of view. Reducing everyone to a potential patient, client or stakeholder and taking about social marketing through IEC rather than community involvement in planning, organising, monitoring and evaluation continues and is another major lacunae.

9. Our comments do not attempt a response to all the nitty gritty. In Appendix 2, we list out an alternative framework of reference -a paradigm shift that is seriously required if the World Bank and MOHFW want really to be on the right track. The Bhore Committee recognised it in 1946; the WHO through Alma Ata in 1978, GOI in 1982 through the NHP; and the ICSSR / ICMR earlier in their Health for All report in 1981;

How long can the poor and marginalised in our country wait for this shift to take place in World Bank thinking. In the 1999, there is a some possibility - as seen in this report. Will 'peoples health' needs finally prevail over the 'market economy of health'? Will ethical concern for health of the poor prevail over neo-liberal economics? Will the World Bank partnership with MOHFW be willing to make this paradigm shift?

SOME FINDINGS OF THE CASE STUDY

1. Bank Project 1972 - 1988
   a. "the projects did not make significant differential improvement in project districts compared to non-project districts" (page v)
   b. "Outputs other than infrastructure were largely neglected" (page v)
   c. "No attempt was made to apply different delivery models in project districts"
   d. "project districts continued to operate under the same personnel and recurrent budget constraints.

2. TINP
   a. "less successful in reducing moderate malnutrition"
   b. "Programme experience seems to have been lost on India and with it the clear emphasis on malnutrition as a leading risk for ill health".

3. ICDS
   a. "Only modest positive effects" (page vi)
   b. "targetting essentially by self selection" rather than as originally envisaged "targetting of the poor"
   c. "no Bank support for revision or structural change". (page 11)

4. Primary services
   a. "efforts to improve quality have not accomplished much and it has devoted inadequate attention to content, monitoring and evaluation, and feedback of results".

5. Before 1988
   a. "Bank ill prepared to make practical, constructive suggestion for systems improvements an alternative approach"

6. Sector Studies 1988-98
   a. "Tendency to make policy recommendation that are too general" (page 8)
   b. "Tendency to draw judgements about facts without adequate comparisons to experiences elsewhere" (page 5)
   c. "Inadequate analysis of underlying political, institutional and sociological factors that explain why things work the way they do" (page 8)
   d. "Earlier studies tended to be designed and executed by Bank staff with limited consultation" (Page 8)

7. IPP - VI & IPP -VII
   a. "More success in expanding the delivery and training systems than in improving their functioning"
   b. "quality and performance of the training programme remained weak" (page 9)
   c. "Efforts to strengthen MCH & IEC not very productive" (page 9)
   d. "Little progress in shifting contraceptive mix" (page 9)
   e. "failure to involve stakeholders in significant ways in design of project"

8. IPP -VIII (1992-97)
   a. "The goals and design are appropriate and relevant but they are too new and disbursing too slowly to judge their effectiveness or impact".

Com H --

GLOBALISATION: EFFECT ON HEALTH

Globalization is defined as the process of increasing economic, political and social interdependence and integration. The spectacular break-through in 'Information Technology' has made the process of globalization significantly different, quantitatively and qualitatively.

Globalization also means / or seems to be occurring:

a) When multinational corporations locate themselves anywhere they wish;
b) Western Financial Institutions influence and guide patterns of 'development' everywhere; and

If:

c) National Governments cannot match the power of Transnational capital
d) The Labour of all regions is to be set in a competitive race with each other;

Then:

It is not through any existing forms of International Organizations that the poor are going to be able to defend themselves
(Adapted from Jeremy Seabook's article in Third World Network Features)

Positive implications

- Information sharing: There is the possibility that more and varied information will be available, which can be put to use by other countries. Such information will be useful in improving.
  - Services, standards and quality of care;
  - Policies;
  - Legislation;
  - Exchange of ideas;
  - Appropriate technology
- Increased awareness among people of issues and activities elsewhere;
- Better practices by health care professionals and workers.

Negative Implications

While there can be some such positive influences, the possibility of harmful effects on health and health is much greater.

Products patents

These patents give the holder the exclusive right to use the patented invention for a specified period of time. GATT allows a product patent for 20 years from the date of filing the patent application.

Process patents

These patents grant the holder the right s to use the process and product obtained by that process.

Indian Patents Act, 1970, recognized only process patents. IPA states that the patent should not be used as an important monopoly. It required making available the process for manufacture of the product within the country recognizing the patent. TRIPS agreement confers the right to import and does not require the production of the patented invention in India.

TRIPS provisions

Inventions in all field s of technology, including drugs, chemicals, foods, agricultural products, animals, plants, and micro-organisms are entitled to product and process patents. We have witnessed the patenting of 'basmati'.

The Indian Patent Act provided a duration of 14 years for patent protection. A patent for process of manufacturing substances used or capable of being used as food, medicine or drugs has a duration of seven years from the date of filing and five years from the date of sealing of the patent, whichever is shorter.

GATT requires 20 years patent protection for all inventions in the field of technology, 17-20 years for pharmaceuticals, which can be further increased as process patent when the product patent expires.

There is an obligation to set up production facilities in the country granting the patent. Article 29 dilutes this provision. Patentee would be allowed to import the product in the countries granting the patent; this is to be taken as on par with the obligation for production in the country that grants the patent. This would make Third World Countries merely markets for Transnational Corporations with no obligations.

According to all **legal norms,** when there is alleged violation, the accused is considered to be innocent until proved otherwise. But in the new Patent rules, the burden of proof is shifted to the accused. If a company files a suit against another of violation of copyright, the accused will have to prove his / her innocence.

Patenting plant varieties

There are many herbs which have been traditionally used in India and other tropical countries as medicines. Now, these are being taken by the affluent countries. When genetic resources are taken from the tropical countries to the affluent countries, they are treated as freely usable and knowledge of their characteristics is seen as belonging to all. When the same is processed by mixing the traits, they are treated as private intellectual property attached to them.

The same thing happens to food crops seeds. This has resulted in a few companies in the North controlling the whole of the world seed markets and genetic resources. This can affect food security.

Farmers' exemption had allowed them to keep seeds form the harvest for the next sowing. In the revised system, the farmers' exemption has been removed. If a farmer is found using a patented variety of seeds, which he does not buy, all that the agent of the patent holder has to do is to file a complaint with the concerned authority.

Farmers will be forced to buy new seeds for every sowing. The local plant breeders will have to pay royalty for using the patented variety.

TRIPS and pharmaceuticals

According to Article 70.8, pharmaceuticals and agro-chemical firms can file applications for product patents within one year of signing the GATT accord. The applicants will be given monopoly of marketing rights for five years from the date of application.

Drug prices in India were among the highest in the world before the Indian Patent Act, 1970. IPA reversed the trend. Indian companies have now become major bulk drug producers. There are about 10,000 units engaged in the production of bulk drugs and formulations. The producers could bring down the price drastically. But this situation will change drastically with the new legislation.

COMH-
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Globalisation: Effect on Health

Globalisation provides threats and opportunities to the health of the people. As it is practised today, globalisation has more threats than opportunities. This is because the competition far outstrips collaboration. The impact on health and health care systems is broad and profound. Globalisation is the process of increasing economic, political and social interdependence and global integration. Capital, goods, persons, concepts, ideas and values diffuse across the boundaries of the countries.

Positive implications

◊ Information sharing : There is the possibility that more and varied information will be available, which can be put to use by other countries. Such information will be useful in improving

* services, standards and quality of care
* policies
* legislation
* exchange of ideas
* appropriate technology

◊ Increased awareness among people

◊ Better practices by health care professionals and workers

While there can be many positive influences, the possibility of harm to health and health is much greater.

Health technologies

Competition among health care providers will induce the spread of newer and not fully tested technologies. This will lead to increasing investments in expensive, sophisticated technologies, which may not be appropriate for the developing country.

Public sector:

To remain competitive in global markets, public expenditure has to minimized. World bank and IMF insist that there should be a contraction of the public sector in the health care services.

Dr.C.M.Francis and Dr.V.Benjamin

To be Published in forthcoming issues of People's Reporter

Global factor and their consequences

- 'Downsizing' and structural adjustment policies, leading to unemployment.
  Marginalization, increased poverty, decreased social safety nets leading to higher morbidity and mortality rates.
- Increased promotion of tobacco, alcohol and psycho-active drugs, dumping of unsafe pharmaceuticals.
  Increased addition, ineffective and harmful treatment
- Promotion of cash crops at the expense of food crops.
  Food security threatened; malnutrition increased
- Environmental degradation and unsustainable consumption by the rich: resource depletion; water and air pollution; ozone depletion; accumulation of greenhouse gases and global warming.
  Epidemics; respiratory disorders; immunosuppression, skin cancers; cataracts; effects of floods and storms; food shortages and malnutrition.
- Patents

Patents

The GATT agreement on Trade Related Intellectual Property Rights (TRIPS) is meant to protect intellectual property rights (IPR). It concerns mainly patents, which have serious implications on health care.

There are two types of patents:

Product patents

These patents give the holder the exclusive right to use the patented invention for a specified period of time. GATT allows a product patent for 20 years from the date of filing the patent application.

Process patents

These patents grant the holder the exclusive rights to use the process and product obtained by that process.

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TRIPS agreement confers the exclusive right to import and does not require commercial production of the patented invention in India.

TRIPS' provisions

Inventions in all fields of technology, including drugs, chemicals, foods, agricultural products, animals, plants, and micro-organisms are entitled to product and process patents.

Duration of patent protection : Industrialized countries: 17-20 years
Indian Patent Act: 14 years.

According to IPA, a patent for process of manufacturing substances used or capable of being used as food, medicine or drugs has a duration of seven years from the date of filing and five years from the date of sealing of the patent, whichever is shorter.

GATT requires 20 years patent protection for all inventions in the field of technology, 17-20 years for pharmaceuticals, which can be further increased as process patent when the product patent expires.

There is an obligation to set up production facilities in the country granting the patent. Article 29 dilutes this provision. Patentee would be allowed to import the product in the countries granting the patent; this is to be taken as on par with the obligation for production in the country that grants the patent. This would make Third World countries merely markets for Transnational Corporations with no obligations.

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drug prices in India were among the highest in the world before the Indian Patent Act, 1970. IPA reversed the trend. Indian companies have now become major bulk drug producers. There are about 10,000 units engaged in the production of bulk drugs and formulations. The producers could bring down the price drastically.

According to the new rules, the products need not be produced here. They can be imported and sold at very high prices; the Government will not have any control over its price.

Values

Globalisation brings about changes In values. Profit-at-any-cost becomes the guiding mantra (free market economy replacing the mixed economy). Consumerism spreads itself, bringing on the newer fashions and technology. Craving for them depletes the purchasing power. The amount available for the purchase of food materials becomes reduced substantially.

Junk foods

A craze for junk foods is created, reducing the intake of wholesome food. This affects the nutrition which is even otherwise poor.

Commercial crops

Cash crops are replacing food crops. Farmers in Punjab are growing tomato and potato for Pepsi. Karnataka shifted to sunflower cultivation to satisfy the requirements of Cargill. Andhra Pradesh shifted to prawn and shrimp cultivation. Kerala has been using its land more and more for the production of rubber, whose price has come down. All these affect cereal production and food security.

Public Distribution System

The millions of the poor in India were being helped through the Public Distribution System. GATT demands slashing down of the subsidies to the PDS. This would result in the prices of food and other essential commodities going up beyond the purchasing power of the poor.

Industries

Trade liberalisation is often accompanied by "decentralisation" in the less industrialised countries.

> "In India which has only in recent years opened up fully to the global economy, international competition has already led some sectors if industry to seek an advantage by recruiting cheap child labour-----
> Increased child labour is reported in sericulture, fish processing and genetic engineering of seeds (UNICEF, 1996)"

With the competition due to globalization, many industries and business houses are reducing their staff. Unemployment is staring at these people and the number of people below poverty line is increasing.

Dumping 'duty' industries

Hazardous industries and poor technologies will be relocated in the developing countries, leading to health hazards.

India has become a dumping ground for hazardous waste. The Supreme Court, on February 6, 1998, directed the Customs and other authorities in charge of the Tughlaqabad Container Depot and the Bombay Port Trust to neither auction nor release till further orders several containers of hazardous waste (Indian Express, February 7, 1998).

Supportive environment for health

The physical, social and economic environment must be supportive to health. Globalisation threatens to damage the environment. The inequities are increasing

The 'have' resort to wasteful consumption of the world resources. There is need for a more equitable distribution and utilization of the earth's limited resources.

Globalisation has provided an important new argument in favour of off-loading public funding as well as publicly operated provider institutions on to private sector and household budgets.

Earlier efforts of multinationals to establish production operations in different local markets - contemporary decisions to base production on exports from wherever manufacturing can be done most cheaply.

Globalisation is the growing integration of the world economy, linked together by large and increasing private sector financial and trade flows.

Desire of developing countries to attract multinational corporations and new jobs for their people - increasingly fierce effects of developed countries to retain a larger share of available investment capital and thereby to increase their own share of both jobs and international trade - invest less in developing countries, provide fewer jobs in the developing world but help developed countries fund jobs for their own unemployed.

> "When barriers between advanced and backward economics are destroyed, a new form of human exploitation can follow, resembling that of colonialisom in the 19th and early 20th centuries, complete with new forms of indentured labour"
>
> - Plaff, 25 September, 1997

Equity

Equity will be absent when there are unequal players : the rich and the poor in the country and the rich and poor nations. Action is needful for

* equity in health and health care services;
* access for all to essential health care;
* reduction in the burden of diseases and suffering.

Lifestyles

Health requires healthy life styles. Globalisation often promotes harmful lifestyles through advertisements and trade. One such is the promotion of tobacco.

Cost of health care

Globalization tends to bring costly,'sophisticated hospitals, beyond the capacity of the people; so also the cost of diagnostic tests. Yet, by advertisements through various media, people are made to go for these costly procedures, which may be standard in affluent countries, whose per capita income is 100 or more times that of India.

People

The transnational movement of people is restricted by Visor regulations. There is selection. Well-trained personnel of the developing countries are attracted by better remuneration and working conditions in the affluent countries. This causes a drain of qualified health personnel, who have been trained at great expense.

Many of the health personnel go to the richer countries to get better training but do not return. Further the training there may not match the needs of the home country. If they do return, they derm and a duplication of the health care facilities found in the affluent country.

Com H-

ORIGIN OF HIV*

Three of the earliest known instances of HIV infection are as follows:

1. A plasma sample taken in 1959 from an adult male living in what is now the Democratic Republic of Congo.
2. HIV found in tissue samples from an American teenager who died in St. Louis in 1969.
3. HIV found in tissue samples from a Norwegian sailor who died around 1976.

A 1998 analysis of the plasma sample from 1959 has suggested that HIV-1 was introduced into humans around the 1940s or the early 1950s; much earlier than previously thought. Other scientists have dated the sample to an even earlier period - perhaps as far back as the end of the 19th century.

In January 2000 however, the results of a new study presented at the 7th Conference on Retroviruses and Opportunistic Infections, suggested that the first case of HIV-1 infection occurred around 1930 in West Africa . The study was carried out by Dr Bette Korber of the Los Alamos National Laboratory. The estimate of 1930 (which does have a 15 year margin of error) was based on a complicated computer model of HIV's evolution. If accurate, it means that HIV was in existence before many scenarios (such as the OPV and conspiracy theories) suggest.

Theories for the Origin of HIV

It has been known for a long time that certain viruses can pass between species. Indeed, the very fact that chimpanzees obtained SIV from two other species of ape shows just how easily this crossover can occur. As animals ourselves, we are just as susceptible. When a viral transfer between animals and humans takes place, it is known as ***zoonosis***. Below are some of the most common theories about how this ***'zoonosis'*** took place, and how SIV became HIV in humans:

The 'Hunter' Theory

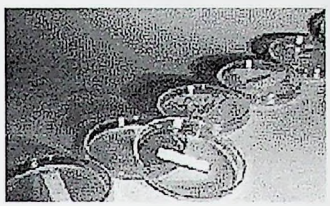
The most commonly accepted theory is that of the 'hunter'. In this scenario, SIVcpz was transferred to humans as a result of chimps being killed and eaten or their blood getting into cuts or wounds on the hunter. Normally the hunter's body would have fought off SIV, but on a few occasions it adapted itself within its new human host and become HIV-1. The fact that there were several different early strains of HIV, each with a slightly different genetic make-up (the most common of which was HIV-1 group M), would support this theory: every time it passed from a chimpanzee to a man, it would have developed in a slightly different way within his body, and thus produced a slightly different strain.

An article published in The Lancet in 2004 also shows how retroviral transfer from primates to hunters is still occurring even today. In a sample of 1099 individuals in

*A Background Note for session at Snehadan by Sunil George

Cameroon, they discovered to ten (1%) were infected with SFV (Simian Foamy Virus), an illness which, like SIV, was previously thought only to infect primates. All these infections were believed to have been acquired through the butchering and consumption of monkey and ape meat. Discoveries such as this have lead to calls for an outright ban on bushmeat hunting to prevent simian viruses being passed to humans.

The Oral Polio Vaccine (OPV) theory



Could production of the oral polio vaccine have contributed to the spread of HIV? Some other rather controversial theories have contended that HIV was transferred iatrogenically (i.e. via medical experiments). One particularly well-publicised idea is that polio vaccines played a role in the transfer.
In his book, The River, the journalist Edward Hooper suggested that HIV could be traced to the testing of an oral polio vaccine called Chat, given to about a million people in the Belgian Congo, Rwanda and Burundi in the late 1950s. To be reproduced, live polio vaccine needs to be cultivated in living tissue, and Hooper's belief is that Chat was grown in kidney cells taken from local chimps infected with SIVcmz. This, he claims, would have resulted in the contamination of the vaccine with chimp SIV, and a large number of people subsequently becoming infected with HIV-1.

However, in February 2000 the Wistar Institute in Philadelphia (one of the original places that developed the Chat vaccine) announced that it had discovered in its stores a phial of polio vaccine that had been used as part of the program. The vaccine was subsequently analysed and in April 2001 it was announced that no trace had been found of either HIV or chimpanzee SIV. A second analysis confirmed that only macaque monkey kidney cells, which cannot be infected with SIV or HIV, were used to make Chat. While this is just one phial of many, most have taken its existence to mean that the OPV vaccine theory is not possible.

The fact that the OPV theory accounts for just one (group M) of several different groups of HIV also suggests that transferral must have happened in other ways too. The final element that suggests that the OPV theory is not credible as the sole method of transmission is the argument that HIV existed in humans before the vaccine trials were ever carried out. More about when HIV came into being can be found below.

The Contaminated Needle Theory

This is an extension of the original 'hunter' theory. In the 1950s, the use of disposable plastic syringes became commonplace around the world as a cheap, sterile way to administer medicines. However, to African healthcare professionals working on inoculation and other medical programmes, the huge quantities of syringes needed would have been very costly. It is therefore likely that one single syringe would have been used to inject multiple patients without any sterilisation in between. This would rapidly have

transferred any viral particles (within a hunter's blood for example) from one person to another, creating huge potential for the virus to mutate and replicate in each new individual it entered, even if the SIV within the original person infected had not yet converted to HIV.

The Colonialism Theory

The colonialism or 'Heart of Darkness' theory, is one of the more recent theories to have entered into the debate. It is again based on the basic 'hunter' premise, but more thoroughly explains how this original infection could have lead to an epidemic. It was first proposed in 2000 by Jim Moore, an American specialist in primate behaviour, who published his findings in the journal AIDS Research and Human Retroviruses. During the late 19th and early 20 th century, much of Africa was ruled by colonial forces. In areas such as French Equatorial Africa and the Belgian Congo, colonial rule was particularly harsh and many Africans were forced into labour camps where sanitation was poor, food was scare and physical demands were extreme. These factors alone would have been sufficient to create poor health in anyone, so SIV could easily have infiltrated the labour force and taken advantage of their weakened immune systems to become HIV. A stray and perhaps sick chimpanzee with SIV would have made a welcome extra source of food for the workers.

Moore also believes that many of the labourers would have been inoculated with unsterile needles against diseases such as smallpox (to keep them alive and working), and that many of the camps actively employed prostitutes to keep the workers happy, creating numerous possibilities for onward transmission. A large number of labourers would have died before they even developed the first symptoms of AIDS, and those that did get sick would not have stood out as any different in an already disease-ridden population. Even if they had been identified, all evidence (including medical records) that the camps existed was destroyed to cover up the fact that a staggering 50% of the local population were wiped out there.

One final factor Moore uses to support his theory, is the fact that the labour camps were set up around the time that HIV was first believed to have passed into humans - the early part of the 20th century.

The Conspiracy Theory

Some say that HIV is a 'conspiracy theory' or that it is 'man-made'. A recent survey carried out in the US for example, identified a significant number of African Americans who believe HIV was manufactured as part of a biological warfare programme, designed to wipe out large numbers of black and homosexual people. Many say this was done under the auspices of the US federal 'Special Cancer Virus Program' (SCVP), possibly with the help of the CIA. Some even believe that the virus was spread (either deliberately or inadvertently) to thousands of people all over the world through the smallpox inoculation programme, or to gay men through Hepatitis B vaccine trials. While none of these theories can be definitively disproved, the evidence they are based on is tenuous at

best, and often ignores the clear link between SIV and HIV, or the fact that the virus has been identified in people as far back as 1959. They also fail to take into consideration the lack of genetic-engineering technology available to 'create' the virus at the time that AIDS first appeared.

WHERE?

The question of exactly where the transfer took place, and where the 'epidemic' officially first developed has always been controversial. Given the evidence we have already looked at, it is likely that Africa was indeed the continent where the transfer of HIV to humans first occurred (monkeys from Asia and South America have never been found to have SIVs that could cause HIV in humans). However, who exactly spread the virus from Africa, to America and beyond remains a mystery. It is quite possible that separate 'pockets' of the virus could have been developing in a number of different countries years before the first cases were ever officially identified, making it virtually impossible to trace one single source.

What did cause the epidemic to spread so suddenly then?

There are a number of factors that may have contributed to the sudden spread of HIV, most of which occurred in the latter half of the twentieth century.

Travel

Both national and international travel undoubtedly had a major role in the initial spread of HIV. In the US, international travel by young men making the most of the gay sexual revolution of the late 70s and early 80s would certainly have played a large part in taking the virus worldwide. In Africa, the virus would probably have been spread along truck routes and between towns and cities within the continent itself. However, it is quite conceivable that some of the early outbreaks in African nations were not started by Africans infected with the 'original' virus at all, but by people visiting from overseas where the epidemic had been growing too. The process of transmission in a global pandemic is simply too complex to blame on any one group or individual.

The Blood Industry

As blood transfusions became a routine part of medical practice, an industry to meet this increased demand for blood began to develop rapidly. In some countries such as the USA, donors were paid to give blood, a policy that often attracted those most desperate for cash; among them intravenous drug users. In the early stages of the epidemic, doctors were unaware of how easily HIV could be spread and blood donations remained unscreened. This blood was then sent worldwide, and unfortunately most people who received infected donations went on to become HIV positive themselves. In the late 1960's haemophiliacs also began to benefit from the blood clotting properties of a product called Factor VIII. However, to produce this coagulant, blood from hundreds of individual donors had to be pooled. This meant that a single donation of HIV+ blood

could contaminate a huge batch of Factor VIII. This put thousands of haemophiliacs all over the world at risk of HIV, and many subsequently contracted the virus.

Drug Use

The 1970s saw an increase in the availability of heroin following the Vietnam War and other conflicts in the Middle East , which helped stimulate a growth in intravenous drug use. This increased availability and together with the development of disposable plastic syringes and the establishment of ***'shooting galleries'*** where people could buy drugs and rent equipment, provided another route through which the virus could be passed on.

Structure and types of the virus

HIV belongs to the family of retroviruses. There are two types of HIV viruses: Type 1 and Type 2. Both Types are prevalent in India, Type 1 is more frequently reported. HIV Type 1 is a more virulent pathogen than Type 2 HIV Type 2 is generally milder, slower to progress and poorly transmitted vertically. The virus is found in almost all body fluids and organs, but they are present in large numbers in the semen, vaginal and cervical secretions and blood. The highest concentration of HIV among body fluids is found in the cerebrospinal fluid.

HIV attacks the white blood cells, in particular a group of cells know as the CD4 cells. Cd4 cells coordinate the response of our immune system to any foreign agent in our body such as bacteria or viruses by enabling the production of antibodies that neutralise and eliminate them from our body. When the CD4 cells are infected then our body's defence mechanism begins to crumble and we become prone to infections that a healthy person is able to ward off.

Modes of Transmission

S.No.	Modes of Transmission	Efficiency	Source of infection
1	Sexual Intercourse	0.1-1.0%	80-86%
2	Blood transfusion	90-95%	3-5%
3	Perinatal (Parent to Child)	20-40%	2-3%
4	Injecting Drug use	0.5-1.0%	3-5%
5	Needle stick injury	Less than 0.1%	

Stages of HIV Infection

Generally we can divide the stages of HIV infection in an individual as follows

1. Window Period
   It usually lasts from 6 weeks to 12 weeks. Routine tests like ELISA, Western Blot, RAPID will turn to be negative during this period. Few people develop what is

known as ***'seroconversion illness'.*** Most people are unaware that they have been infected. The person continues to be healthy and do all types of normal work. The person is a carrier of the virus and can transmit it to others by all the routes that have been mentioned.

2. Period of Latency
   This can last from anywhere between 3 months to 10 years and more. The person who is infected is a carried of the virus. He/She has no symptoms of the disease at this stage. The person is considered HIV positive as revealed by a positive test. A person can be in this stage for several years before the virus has destroyed much of the immune system and he/she falls ill.

3. AIDS Case
   This can be from anywhere between two years from the time of infection to ten years or more. As immunesuppression develops, the CD4 count falls and viral load increases. Signs and symptoms of the disease begin to manifest itself. These diseases are classified as minor (wasting, minor skin and oral problems, recurrent sinusitis etc.) and major (TB, bacterial pneumonia, chronic diarrhoea, prolonged unexplained fever). Multiple diseases and clinical problems are common in AIDS patients and in the absence of specific therapy death occurs.

Current rates/statistics
The following statistics taken from the latest UNAIDS report show us our current state with regard to our fight against HIV &AIDS.

People with HIV/AIDS in 2004

Total	39.4 million (35.9 – 44.3 million)
Adults	37.2 million (33.8-41.7 million)
Women	17.6 million (16.3-19.5 million)
Children	2.2 million (2.0-2.6 million)

People newly infected with HIV in 2004

Total	4.9 million (4.3 – 6.4 million)
Adults	4.3 million (3.7 – 5.7 million)
Children under 15 years	640,000 (570,000-750,000)

AIDS Deaths in 2004

Total	3.1 million (2.8-3.5 million)
Adults	2.6 million (2.3-2.9 million)
Children under 15 years	510,000 (460,000-600,000)

Diagnosis
HIV infection is diagnosed by blood tests that detect the HIV antibodies.
HIV antibody tests usually done are
- ELISA Test
- RAPID Test

- Western Blot

All the above tests turn positive only three months after the HIV infection has occurred. The following tests detect the virus directly instead of the antibodies

- Polymerase Chain Reaction (PCR) test
- NASBA (Viral Load assessment) test
- P24 antigen test

Both PCR and NASBA turn positive after 72 hours of infection while P24 turns positive after 2 weeks of infection. While these tests have shrunk the window period they are extremely expensive and available only in few places.

Treatment regimes and positive living

A person infected with HIV does not require any special treatment for a long period depending upon the progression of the illness in the body. Once someone comes to know that he/she is infected with HIV, it is more important to take care of basic hygiene and nutrition. Of great importance is the psychological support that a HIV +ve person receives from the community.

While HIV was not treatable a few years ago today HIV is a treatable manageable illness though a complete cure has not yet been found.

The drugs that are used to treat HIV infection are know as Anti retroviral drugs or ARVS. These are required only after a certain stage of progression, prolong the life, and improve the quality of life of the infected person.

Anti retroviral drugs are of different types. The common clinical criterion that is used to start Antiretroviral Therapy (ART) is the level of the CD4 count in an infected person. The current guideline is when the CD4 count falls below 200 or the viral load increases above 50,000-100,000 copies/ml. The assessment whether Antiretroviral therapy should be started is to be done only by a qualified medical practitioner.

Common Interventions

1. Prevention and Awareness Building
   This is one of the common interventions that is done. It focuses primarily on people indulging in high-risk behaviour and how they can be helped not to contract the virus.

2. Care and Support
   Interventions under care and support focus on People already infected or affected by HIV&AIDS.

3. Campaigns against Stigma and Discrimination
   This refers to all efforts aimed at removing the stigma and discrimination faced by People Living with HIV&AIDS.

Social and Ethical issues in HIV/AIDS

1. HIV and its consequences
   Acquired Immune Deficiency syndrome (AIDS), which is a consequence of HIV infection is not merely a disease as its impact on the general population goes far

beyond health. It involves social and developmental issues. People with HIV & AIDS often fail to get timely and appropriate medial care because of the social stigma and reluctance among a large number of doctors to treat such patients. Its association with sexuality, illness and death often produces strong feelings in the community. As a result, HIV positive people often fail to get their due rights, both as a patient and as a human being.

2. Social issues in relation to HIV infected persons
   - Society has overreacted to the epidemic, mainly because HIV is transmitted primarily through a behaviour which is private, secret, often hidden and in many places illegal, i.e. through sexual intercourse and through needle sharing for intravenous drug use.
   - Worldwide, many people infected with HIV &AIDS are denied of their human rights.
   - Stigma and Discrimination are major obstacles to effective HIV & AIDS prevention and care.
   - Fear of discrimination may prevent people from seeking treatment for HIV & AIDS or from acknowledging their HIV status publicly. Some are put into quarantine, imprisoned or forcibly tested.
   - The details of HIV positive individuals have found prominent media coverage exposing them to social identification and subsequent abuses.
   - People with or suspected of having HIV may be turned away from health care service, denied housing and employment, , shunned by their friends and collegues, turned down for insurance coverage and refused entry into foreign countries. In some cases they are evicted from home by their families, divorced by their spouses and suffer physical violence or even murder.

It is, therefore, important that respecting, promoting and protecting human rights are as important as providing care to HIV positive persons.

3. General emotional problems of the infected
   People living with HIV & AIDS go through a myriad of human emotions, such as
   - Fear of dying particularly alone
   - Loss of livelihood and ambitions and physical distress
   - Grief, losses they have experienced or anticipating
   - Guilt of having infected others, sadness of family
   - Depression –absence of a cure
   - Denial of status and social responsibility
   - Anxiety-prognosis, rejection and concern about confidentiality
   - Anger- unlucky to catch the infection
   - Suicidal activity- as a way to avoid pain

- Loss of self-esteem- rejection by colleagues, family members
- Spiritual concerns about impending death, loneliness etc

4. Important ethical issues

The most important are in relation to ethical issues has been in terms of testing for HIV status. Testing for HIV infection involves a simple test but the results have a profound significance for both the individual and the community. The development of a test in 1985 to detect HIV infection in individuals has had two aspects

1. It has opened the way to protect blood supply and allowed the identification of people, who while apparently healthy could transmit the infection.

2. It also exposed HIV positive people to stigmatization, discrimination and even loss of freedom.

There are three ethical aspects in testing for HIV infection

- Mandatory testing- should not be done, with exceptions like blood donation
- Voluntary testing – can be done after obtaining informed consent from the person to be tested.
- Pre and post test counseling- must be done to ensure that the person being tested, has the knowledge of the significance of the test results and options available in case of a positive status.

Note:

Screening for safety purposes is not allowed.

It is important to remember that professional misconduct and negligence can lead to legal liability.

Judgment of the Supreme Court of India

"Without permission of the patient, a doctor shall not inform the details of the treatment to anybody, except the doctor to whom the patient is being referred to for further opinion or management. However a doctor may consider it a duty to ensure that the sexual partner of a known HIV +ve patient is informed of the risk, regardless of the patients own wishes".

Com H-

Proposal for a global 'Right to Health and Health Care Campaign' to be launched by the People's Health Movement.

[Short Version, December 2005]

The context

1. There is an urgent need to replace the dominant discourse in health by a process aimed at universally achieving the 'right to health and to health care' as the main objective to achieve more equitable health care systems in both developing and developed countries.
2. The People's Health Movement (PHM) is launching a global initiative to strengthen the 'Right to Health' (RTH) with a focus on defending and operationalising the 'Right to Health Care'.
3. Since it is predictable socio-political forces at work that determine the risk of most forms of human rights violations, this Campaign looks at what additional measures have to be taken now. 8. It grounds our understanding of human rights violations in the broader analyses of power and social inequality. Knowing carries obligations --thus the proposed Campaign.
4. Poverty is the world's greatest killer. It is thus not enough to improve the situation of the poor within the existing social relationships. Structures and not just individuals must be changed if the RTH of the marginalized in the world is to be achieved.
5. Rights are realised by changing the prevailing power relations. Rights cannot be advanced but through the organised efforts of the state and of civil society.
6. Public health must be linked to a return to social justice and equity; this is the central challenge for the future of public health. The Campaign here proposed by PHM thus seeks the social transformations indispensable to resolve the inequities found in health.

The justification

7. There is now a need to launch a global process of mobilization to actually implement the provisions of General Comment 14* in all countries. The 'Right to Health' will be operationalized by changing global and national health sector reform initiatives.

*: Nearly 150 countries around the world are parties to the International Covenant on Economic, Social and Cultural Rights. General Comment 14 (GC 14) of the Committee on Economic, Social and Cultural Rights (CESCR) adopted in the year 2000 elaborates on and clarifies the Right to Health by defining the content, the methods of operationalization, the violations and the suggested means to monitor the implementation of this right. GC14 is the most authoritative interpretation of international law relating to the right to health. (http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument)

8. But why do we need a ***global*** campaign on the Right to Health? Much is wrong with the neo-liberal model of global restructuring in the world. This process is unchecked either by national or global mechanisms. It is in this context that there is growing recognition of the need for a ***global initiative*** to address health systems issues in a rights-based framework. What will this entail?:

A. Neo-liberal policies restrict the revenue of the state for use for welfare purposes so that governments find themselves unable to finance health security systems. To put in place mechanisms of effective redistribution of resources is only possible through a globally coordinated effort, thus the Global Campaign.
B. We need to establish universal norms regarding a basic standard of essential health care services that must be ensured. Further, health care workers distribution must be based on need rather than on the ability of richer countries to pay more for human resources from poorer countries.
C. There is also a need to challenge the dominant global discourse of *'Health care as a commodity'* and *'safety nets for those left outside the benefits'* wherein health services

are increasingly marketized and governments retreat from the provision of health care. We need to counter this with a *'Health care as a human right'* discourse.

A Campaign focusing on the Right to Health Care

9. PHM struggles for and demands the respect of all aspects of health rights.
10. This right includes both the *Right to health determinants* such as water, food security, housing, sanitation, education, a safe and healthy working and living environment, etc., and the *Right to health care* (the right to the entire spectrum of preventive, curative and rehabilitative services plus health education and selected promotive activities).
11. Naturally, the global health movement has an important role to play regarding both of the above components of the Right to Health. However, in practice, this suggests two types of tasks for the global health movement:

I. **Tackling the right to health determinants**

12. Supporting campaigns on water, food security, housing, etc. There are existing initiatives already working for these rights. This recognition places the obligation on PHM activists to actively support such initiatives though not necessarily to take up the responsibility of primary leadership of such groups.
13. A specific role that has to be played by PHM activists is to document violations of the Right to Health and its underlying determinants. Health-based arguments can indeed significantly strengthen the demands to tackle these determinants.

II. **Strengthening the right to health care**

14. This is a task for which the global health movement has an unquestionable responsibility to take the lead on.

We suggest the following overall strategy for PHM:

15. Regarding the strengthening the Right to health determinants, PHM country circles would continue to expand their involvement in these initiatives in their countries and regions. PHM may even co-initiate specific international campaigns on a particular health determinant (e.g., the Right to Water). However, it is not strategically possible for a global health movement like PHM to launch a single campaign encompassing all health determinants on a global scale.
16. We suggest launching a **Global Right to Health and Health Care Campaign**. PHM has a primary responsibility regarding this issue. However, during this campaign, the documenting of violations will not be restricted to those in the sphere of health care, but will encompass denouncing violations of health rights related to the various determinants of health.
17. These two types of activities should be combined as part of a comprehensive approach to the Right to Health. This differentiated strategy does not reflect any judgement on the relative importance of health care vs. the underlying and basic determinants of people's health; it is rather a question of the strategic approach chosen.

What is the added value of adopting this focus?

18. A RTH Campaign has a big social mobilization potential; the HR approach is backed by international legislation; the RTH approach demands that decision-makers take responsibility; HR imply correlative duties that are universal and indivisible; and (Unlike the MDGs) the HR approach is focused on processes that lead to concrete outcomes.

What does the RTH imply?

19. In every development process there are two types of actors: **claim holders and duty bearers**. When the State does not respect human rights, claim holders have to demand their rights from the duty bearers in government.
20. The marginalized are being denied their rights, in part because, as claim holders, they do not have the capacity to effectively demand (claim) their rights; rights are also violated because duty bearers do not have the capacity or the will to fulfil their obligations (called 'correlative duties').
21. Therefore, in the HR-based approach (HRBAP) one has to carry out two types of analyses: a) **situation analyses** in which one determines the causes of the problems placing them in a hierarchical causality chain of immediate, underlying and basic determinants, and b) **capacity analyses** in which one determines who are the individuals/institutions that bear the duty to do something about the above causes calling on them to fulfil their duties as per their country's obligations as signatory of the United Nations HR covenants.
22. These two types of analyses have to be carried out with the community and the beneficiaries of the health system so that the rights being violated can be identified jointly and those responsible can be confronted --for them to do something about the problems identified.
23. As a PHM ultimate goal, we do NOT look for health policies that favour the poor... We seek significant poverty reduction policies that directly address the social determinants of the inequitable distribution of resources, as much as we seek to end the exiting violations to the RTH. The Campaign gives us the possibility of advancing PHM's political agenda that strives for equity and for the structural changes that will do away with the social, economic and political determinants of health.
24. We are no longer going to go to beg for changes to be implemented; we are now going to demand them based on existing international law already in force in most of the countries where we work. Disseminating this concept is in itself empowering and is part and parcel of this Campaign.
25. We have to overcome the culture of silence and apathy about the HR violations in health we all know are happening. This, because HR and the RTH will never be given to poor, marginalized, discriminated and indigenous persons. Repeat: **rights are never given, they have to be fought for!** And this is what the RTH Campaign will attempt to do.

Suggested focus of the Campaign

26. It does not need to be emphasised that specific important aspects of this Right, such as women's and children's right to health care, mental health rights, HIV and AIDS-affected persons health care rights, workers' health rights, the right to essential drugs, etc. need to (and will) be woven into the Campaign, bringing diverse branches of the global health movement into a broad coalition working for public health systems that strengthen universal access to health care.
27. PHM will document violations, which can help push for changes in the key wider determinants of health; they will also denounce and act upon adverse existing and new policies that are having negative impacts on the Right to Health (such as the privatisation of services, the weakening of universal access systems, vertical programmes that fragment health systems, the current 90/10 gap in research funding, the unjust international trade regimes --to name just but a few).

Possible organizational collaboration

28. The United Nations Special Rapporteur on the Right to Health has already shown interest in the idea of this global Campaign. WHO will need to be strongly influenced, and could be a

potential collaborator. PHM has been a key actor in the launching of the Commission on the Social Determints of Health (CSDH) of WHO which we see having a real potential in the fight for the RTH care. Most countries have National Human Rights Commissions or official bodies that can be involved in monitoring the Right to Health. Present PHM-member organizations will also involve a broader range of civil society organizations in our network including women's organizations, coalitions of HIV and AIDS-affected persons, trade unions of health sector personnel, people's movements, etc.; in this sense the campaign would be led by PHM-and-partners.

Suggested process to launch the Campaign

29. To move towards implementing the Campaign process, we here propose a sequence of activities.

I. **Preparatory phase** (early to mid 2006)

1. Creation of a broad consensus on the Campaign idea. Formation of a 'Core Campaign Steering Group' of about 6-8 organizations who are willing to help coordinate the Campaign globally. This team will actively support a host of regional organizers and will lead the international networking work, plus the fund-raising and advocacy work for the Campaign. To support this team, a global campaign secretariat (of about three to four .persons) will need to be formed to coordinate the campaign.
2. Identification of specific (existing PHM or newly associated) groups that will take ***regional responsibilities.*** If possible, at least one consultation within each region to discuss the campaign will have to be held.
3. Identification of short and long-term sources of funding.
4. Ensure local campaign ownership and active involvement throughout the process. A mechanism for regular consultation with allies will be set up.
5. Completion of guidelines for the preparation of status papers on 'The State of the Right to Health' in each country (early 2006).
6. Contribution to the next (2007) edition of the Global Health Watch.

30.This phase will culminate in a restricted consultation of the Steering Group in the first quarter of 2006 in which the developments so far will be reviewed and plans made for the next phase of the Campaign.

II. **Documentation and analysis phase** (the last three quarters of 2006).

31. During this period, country, regional and global reports will be prepared as follows:

1. Country papers or reports on the Status of the Right to Health Care will be completed in the countries of at least two regions; in the other regions, the process will be started and brought to as an advanced stage as possible. Options are as follows:
   - **Full blown Country Reports**: These will be the most extensive and will analyse all or most aspects of the health care system in the country and report on their current status with facts and figures, documenting why and how General Comment 14 has (not) been fulfilled five years after its adoption (within the framework of a 'progressive realization of the right to health').
   - **Country Status Papers**: These will be less detailed and may not cover all components of the health sector, but will be based on country level information and statistics that bring out major health care system gaps.

- **Country Overviews**: These will only contain a listing of major issues of concern from the Right to Health perspective (e.g., declining health budgets, unregulated privatization, imposition of user fees, dismantling of the social security system).

32. The aim is that about 40-50 countries will prepare these country reports or status papers – aiming at a minimum of 5 in each region.

2. A **Global Health Watch Report chapter on the Right to Health** could be drafted focused on how the various global agencies and actors are infringing the Right to Health in different ways. It will also focus on the minimum obligations developed countries have to contribute to health care development in poorer countries and to stop the northward migration of health professionals.

33. This phase will culminate with the concrete planning of Regional Assemblies on the Right to Health in the seven or eight regions (to be determined) of the world: Dates, venues, financial arrangements, major agenda contents and organising agencies will be identified and given concrete mandates. For this, a pre-planning meeting to finalise the program of these regional assemblies may be held at the end of 2006.

III. **Regional Assemblies and subsequent action phase** (after the World Health Assembly of May 2007)

34: Plans are as follows:

1. Sequential **Regional assemblies on the Right to Health** will be held in all regions of the world: one assembly in each of the seven or eight regions, spaced about 2 months apart. These would be called by PHM, with involvement of the UN Special Rapporteur on the Right to Health and WHO, and will be attended by national health officials, national human rights committees and PHM, as well as other health and human rights activists. Available country reports/country performance report cards on the Right to Health will be presented and discussed. These assemblies will attract wide media coverage. Action plans to implement the Right to Health will be drawn, discussed and presented in the second half of the assemblies.
2. This series of regional assemblies may culminate in some kind of a resolution being proposed for adoption at, say, the World Health Assembly in Geneva in 2008. Such a resolution will call for the time-bound implementation of the Right to Health. This will include demanding governments progressively incorporate RTH principles and standards into their national laws. Further, the resolution will put in place mechanisms for monitoring and redressal of this right in all countries of the world. PHM partner organizations will also use this as a concrete opportunity to draw-in many more organizations into the network, to dialogue with their country governments, and to engage with national NGOs and human rights bodies.
3. Finalisation of the Global Health Watch report on the Right to Health is envisioned for April 2007. The same could include summaries of all the regional analysis papers and a one-page standardized abstract of the available country Right to Health reports.
4. Preparation of a **'Global Action Plan on the Right to Health Care'.** Such a document will convincingly show how quality essential health care services could be made available NOW to every human being on earth, provided certain key reallocation of priorities and resources are enacted. This Global assessment will be accompanied by practical recommendations for the

countries in each region; the latter will form the basis of a Concrete Agenda to achieve the goals set out in the People's Charter for Health.

5. The 2008 World Health Assembly will be asked to adopt a **'Declaration on the Right to Health for All'** for implementation by member countries, The same will have time-bound, specific and monitorable goals and contain the basic principles of a bottom-up health sector reform. The aim will be to sponsor effective community involvement and monitoring in health thus operationalizing the Right to Health. A shift in policies of all the international agencies working in the health sector will be demanded so that they progressively move towards a human rights-based approach to health planning.

35. Some shift in the focus of WHO towards the Human Rights-based Approach to Health will be needed: a shift that puts universal access systems at the center and that strengthens a group inside WHO that will continue to work and provide leadership on this work.

36. The strengthening and broadening of the PHM network in various countries across the globe will be both an outcome, and also an imperative to take the Movement forward around this rallying point.

A few conceptual and strategic points

37. i- The Campaign will challenge the commoditization of health, asserting the inalienable role of the state in public health systems with the public at the center.

ii- The Campaign makes health rights operational, and thus requires demanding specific commitments and norms that provide measurable parameters for monitoring and for the enforcement of redressal mechanisms.

iii- The Campaign builds a broad strategic alliance involving various special health rights movements that already (or not yet) claim the Right to Health as a key human right.

iv- The Campaign is deeply rooted in national initiatives, yet also addresses key global processes and counters powerful strategic opponents.

v- The Campaign vies for putting the RTH more at the center of attention in the health discourse, and engages major actors making them take an explicit stand on the Right to Health.

vi- For today, the Campaign represents a strategy of resistance (i.e., preventing a further weakening of public health systems) and, for tomorrow, it offers a whole new alternative vision (i,e., universal access to comprehensive health care plus the tackling of the key negative determinants of health).

vii- The Campaign will be used to shift the discourse from the preoccupation with vertical programmes and privatisation-oriented measures to focusing more on widespread denial and violations of the Right to Health, on demanding a global consensus on the implementation of this right, and on asking that all programmes and measures now be critically evaluated according to the tenets of health as a right.

What may be realistically achieved through the proposed process?

38. We have no illusion that systematically raising the issue of the 'Right to Health' will by itself lead to an actual complete implementation of this right in countries across the globe. The universal provision of even basic health care services involves major budgetary, operational and systemic changes; in addition to shifting to a rights-based framework, major political and legal reorientations are thus needed --and such major changes cannot be expected to happen in full in the near future.

39. However, we can expect and can work on a number of more achievable objectives that can take us towards the larger Human Rights goal. Some of these 'achievables' to be considered in our Campaign are: the explicit recognition of the Right to Health Care at country level; the formation, in some countries, of health rights monitoring bodies with PHM and civil society participation; a clearer delineation of health rights at both global and country level; the shifting of the focus of WHO towards health rights/universal access systems and the strengthening of groups within WHO that will work along these lines; and, finally, the strengthening of the PHM network in as many countries as possible so all its members work around a common and broad rallying point.

Organization of PHM and of partners and the Campaign

40. Recognizing that PHM country circles --which were formed during or after the first People's Health Assembly (PHA1) need to move beyond discussions to develop forceful, shared advocacy activities; this is crucial if they are to develop further and to draw-in more groups into our movement. There is now a need to develop and carry out shared and more effective advocacy actions at country level. These are to be directed at engaging both claim-holder groups and decision-makers (duty-bearers) in an effort to bring about needed changes in the existing (and often deteriorating) situation. A 'Right to Health and Health Care' Campaign can be such a catalyst and unifying process bringing together existing and new PHM circles, as well as involving new partner groups and networks. The campaign has the potential to give space to new organizations and networks, which have so far not been active in PHM. Assessing the campaign's viability will start by ascertaining the existence of a minimum critical mass of PHM-and-partners strength and power in a substantial number of countries. Our appeal is for such a process to start as early as possible. As a first step, we plan to explore the potential of this global Right to Health and Health Care Campaign. We have to make use of the momentum achieved at PHA2 to crystallise and plan the future courses of action of the Campaign --understanding that each country will move at its best (individual) pace.

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COMH-

Community Health Cell
Community Health Fellowship Scheme
Annual Community Health Fellows' Workshop 2006

Dates : March 6 – 8, 2006 **Venue: Navaspoorthi Kendra, Bangalore.**

Health as a Human Right in the Era of Globalisation

6th March 2006 (Monday)

9.00 - 10.00a.m - Informal Fellowship

10.00 - 10.30 a.m - Tea Break

10.30 - 11.30 a.m - Introductions
- Objectives/ Schedule of Workshop
- Expectation Inventory

11.30 - 12.00 noon - Demystifying Globalisation
- Pooling ideas and perspectives – Premdas and Naveen

12.00 - 1.00 p.m - Session I - Facilitator: Thelma Narayan & CHC Team
- Reflections on Field realities of Globalization effects on Health and Health Care at local level.
  a. Did I observe any trends/ changes in my area of field work that could be attributed to new economic policies or forces of globalization
  b. Were there any impacts of these on Health and Health Care of local people.

1.00 - 2.00 p.m _ Lunch

2.00 - 3.30 p.m - Session II - Reflections (continued)

3.30 - 4.00 p.m - Tea Break

4.00 - 5.30 p.m - Session III
- Reflections (continued)
- Synthesis (Anant, Sathyashree)
  a. Forces of Globalization visible at Community level
  b. Effects of these on Peoples Health and Access to Health Care

5.30 - 7.00 p.m - Free time

7.00 - 8.00 p.m - Group Discussion : i) CHFS Bulletin
ii) MFC meeting and Dec 2006 request

(Post Dinner Sing – song)

7th March (Tuesday)

9.30 - 11.00 a.m	- Impact of globalization on social and economic life of people Resource Person: Prof. Abdul Aziz (ISEC) (45 minutes presentation, 45 minutes interactive discussion)
11.00 - 11.30 a.m	- Tea Break
11.30 - 1.00 p.m	- Health Human Resource Development in the era of globalization (challenges and response) Resource person: Thelma Narayan
1.00 - 2.00 p.m	- Lunch
2.00 - 3.00 p.m	- Travel to Snehadhan or other agencies
3.00 - 6.00 p.m	- Observation/ Interaction visit followed by Reflection session at Snehadan • The realities of HIV/ AIDS • Globalisation and the challenge of Access to ARVs for patients as a Human Right Resource Persons : Sunil George/ Sr. Sylvia/ Ms. Manjula
7.00 - 10.00 p.m	- Informal dialogue - Preparation of Presentations

8th March 2006 (Wednesday): Women's Day

9.00 - 11.00 a.m - Health Rights : What are they/ What are the obstacles/ What can be done
Chair person: Narendra Gupta (Prayas, JSA/ NAPM)

- Women's Health (Facilitators: Madhumita, Sathyashree)
  - Activity
  - Study on ANC (Sr. Tina/ Vinay)
- Dalits, Adivasis, Children, Disaster situations, Workers, Street children, etc.

(Fellows should choose subgroups and prepare 5-7 minutes presentation on Rights of socially excluded groups and the challenges to meet them. Not more than 9 – 10 groups of 2 fellows each)

11.30 - 1.00 p.m - International Health Financing and Health Systems – Issues and Challenges

Resource person: Ravi Narayan, PHM Global Secretariat

(Will cover study on External funded projects in Karnataka for Task Force and WB Evaluation, and PHM critique of report of Commission on Macroeconomics and Health)

1.00 - 2.00 p.m - Lunch

2.00 - 4.00 p.m - Informal Discussion with External Review team conducting end review of the CHFS – Exclusively for interns/ fellows (Dr. Vasundhara / Dr. Narendra Gupta)

4.00 – 4.30 p.m - Tea

4.30 - 5.30 p.m - CHFS – Next Steps and the Way Ahead
Facilitator : Dr. Thelma Narayan & CHC team

Additional

i) Display of books, documents and other materials
ii) Bulletin Board
iii) Cultural programs – to be organized by fellows

9th to 15th March

Will evolve in discussion with the present batch on 6th March

Will include

i) Session with Dr. Shekar Seshadri on life skills education
ii) Time for discussion with Mentors
iii) Time for Reports
iv) Informal Group discussion
v) Visits