Main Identity

From: Mathura P Shrestha <mathura@healthnet.org.np>
To: <"Undisclosed-Recipient:;"@smtpin.touchtelindia.net>
Sent: Friday, March 12, 2004 8:46 PM
Subject: PHA-Exchange> Fw: March 20 : anti war protests

----- Original Message -----
From: Anant Bhan
To: mfriendcircle@yahoogroups.com
Cc: pha-exchange@kabissa.org
Sent: Wednesday, March 10, 2004 1:08 PM
Subject: PHA-Exchange> March 20 : anti war protests

SSP

Please click wherever is needed and register our solidarity in all the ways possible

RN 17/3/04

Hi all,

this is a message from Greenpeace

FYI

Rgds,
Anant

Greenpeace: We need you on March 20th

~~~~~~

"On February 17, 2003, a front page news analysis in the New York Times
described the global anti-war protests as the emergence of 'the second
superpower'." --The Register

PPan Lanka

Dear Friends,

We need a few minutes of your time and a few mouse clicks to build a
powerful message: the return of the second superpower.

On February 15th last year, 30 million people were on the streets to say
"No" to war. The centreless coalition of groups and individuals who
organised those activities want YOU and YOUR FAMILY AND FRIENDS back on the
street this Saturday, March 20th, to demonstrate that we STILL say "No" to
war.

In March 2003, George Bush told us that "Intelligence gathered by this and
~~~~~~

other governments leaves no doubt that the Iraq regime continues to possess
and conceal some of the most lethal weapons ever devised."

We now know this was untrue. And a war based on this untruth has cost over
10,000 civilian lives.

On March 18th, one year will have passed since the invasion of Iraq began.
We can't stand silent. The world's leaders need to know that the demonstration by 30 million people last year was a lasting expression of a
global democratic force.

Be a part of the second superpower. Stand up against future illegal,
preemptive wars and protest the continuing suppression of human rights and
free speech which have characterised this one. Help us get the word out that
we're making a second showing on Saturday, March 20th.

Click here to send an invitation to your friends to join you in a day of
peaceful protest for a world without war:

http://act.greenpeace.org/ecs/s2?i=1303&sk=fxd&la=en

Click here to leave a message of peace on our website as part of a "virtual
protest" to complement the peaceful demonstrations on the street:

http://act.greenpeace.org/col/get?i=1304&sk=std3

Click here to see where activities are being organised in your city:

http://www.unitedforpeace.org/calendar.php?caltype=17

Peace,

Greenpeace

P.S. Please forward this to your friends.

Community Health Cell

From: Community Health Cell <sochara@vsnl.com>
To: Claudio Schuftan <aviva@netnam.vn>; <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Thursday, February 27, 2003 3:03 PM
Subject: Draft: Dr.Lee's letter

Dear Claudio and PHM Steering group,

Greetings from People's Health Movement Secretariat at CHC, Bangalore!

Thanks (Claudio) for the draft of the letter to Dr.Lee. I am circulating it to the Steering committee with some small modifications for their okay before forwarding it to Dr.Lee. While I await everyone's endorsement and or suggestion, I would also request Allison or anyone in the PHM Geneva group to find out the coordinates of how one can reach Dr.Lee presently. Perhaps the PHM Geneva group can meet him personally and hand over the letter when it is finalized and also present him with a set of the Charter, the testimonies and the background paper. Since I shall be touring in USA along with Zafarullah and Thelma till mid March, I would request you to address all the suggestions and modify the letter if required incorporating as many ideas as possible without the letter becoming too long. Prasanna will send you the final letter on a PHM letterhead and this can be forwarded to Dr.Lee – or it will have to wait till the 1^{8th} when I return.

Best wishes,

Ravi Narayan

PHA - Embargo
09/03/03

[Draft not for wide circulation – to be finalized]

February 28, 2003

Dear Dr Lee

As the Coordinator of the People's Health Movement Secretariat I would like to add my voice to that of others to heartily congratulate you on your nomination by the EB.

I am sure you do not need me to at length explain to you who we are and what people-centered interests we represent worldwide. Our organization has grown continuously since the People's Health Assembly in Bangladesh in December 2000 and we now have a presence in every continent.

You should be familiar with our active role in getting Mrs Dr Brundtland to set up the CSI at HQs and with our work with them since.

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What is less likely, is that you have had a chance to read our historical People's Charter for Health which distills the core of that PHM stands for and commits itself to in the coming years. We are enclosing a copy for you and would be more than appreciative if you would find the time to give us a short feedback on it.

Your nomination comes in the auspicious year of the 25th anniversary of the Alma Ata Declaration. It should not surprise you that we have actively been advocating for a "Health For All Now" approach resurrecting the deep moral values of the Declaration. Time for your campaign was short so we did not have the chance to find out from you specifically about your views on this. We look forward to the chance of discussing this issue with you and the senior staff you will appoint.

Of particular interest to us, is to get to know your views on, among other, the Global Fund, the WTO and TRIPS, the role of transnational pharmaceutical houses, decentralization and democratization efforts in the WHO decision-making structure, your intentions vis-à-vis WHO's Civil Society Initiative (CSI), and so many other topics not appropriate to mention in this introductory letter.

A short note of the major developments last year would be helpful

We are the largest coalition of grassroots organizations working for people's health. As such, we are keenly interested in what WHO and its leadership does. We look forward to an open door dialogue with you and your close collaborators. Although we can only imagine the overwhelming number of priorities you have right now, we sincerely hope that during WHA -- where we are planning to have a large presence and an anniversary celebration of Alma Ata-- we will have the chance to meet you and your collaborators in person. We would be honored to have you come to the opening of our pre-WHA meeting May 16th in Geneva.

Looking forward to a long and mutually productive relationship with the Organization you are about to take the helm of, I remain yours truly,

Ravi Narayan

Coordinator, People's Health Movement Secretariat
CHC Bangalore
#367 "Srinivasa Nilaya"
I Block Jakkasandra, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

3/4/03

To Claudio
Steering Group

Dear Claudio + PHM Steering Group

Thanks, Claudio for the draft of the letter to Dr Lee.
I am circulating it to the Steering committee with some small modifications for their OKay before forwarding it to Dr Lee. While I await everyones endorsement and or suggestion I would also request Allison or anyone in the PHM Geneve group to find out the coordinates of how one can reach Dr Lee presently. Perhaps the PHM Geneve group can meet him personally and hand over the letter when it is finalised and also present him with a set of the Charter, the testimonies and the background paper. Since I shall be touring in USA along with Zaferullah and Thelma till mid March I would request you to address all the suggestions and modify the letter if required incorporating as many ideas as possible without the letter becoming too long. Rosanne will send you the final letter on a PHM letterhead and this can be forwarded to Dr Lee. — or it will have to wait till the 15th when I return.

Best wishes

letter revised - See overleaf.

Community Health Cell

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Friday, February 28, 2003 12:37 PM
Subject: PHA-Exchange> UN lowers world population projection, AIDS is one of 2 major causes

From: "jvnet" <jvnet@netnam.vn>

UN POPULATION DIVISION LOWERS WORLD POPULATION PROJECTIONS FOR 2050 BY 400
MILLIONS, DROP DUE TO DEATHS FROM AIDS, LOW BIRTHRATE

http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=16270

The United Nations Population Division on Wednesday lowered its estimated world population projections for 2050 by 400 million, largely due to the effects of the HIV/AIDS pandemic and "lower than expected" birthrates, the AP/Philadelphia Inquirer reports. The "World Population Prospects: The 2002 Revision" report attributes about half of the decrease to a rising number of deaths due to AIDS-related complications and the other half to the fact that three out of four countries in less-developed regions will have fertility rates below replacement levels by 2050 (Lederer, AP/Philadelphia Inquirer, 2/27). The world population is still expected to increase by 2.6 billion over the next 47 years, from 6.3 billion today to 8.9 billion in 2050 (United Nations release, 2/26). Eight countries -- India, Pakistan, Nigeria, the United States, China, Bangladesh, Ethiopia, and the Democratic Republic of Congo -- will account for 50% of the world's population increase, the Financial Times reports (Wolf, Financial Times, 2/27). "However, the realization of these projections is contingent on ensuring that couples have access to family planning and that efforts to arrest the current spread of the HIV/AIDS epidemic are successful in reducing growth momentum," the report states (Xinhua News, 2/26).

PHM Exchange→

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FERTILITY

The "key to the change" was a "surprise" drop in birth rates of the most populous developing countries, Reuters/New York Times reports. Joseph Chamie, director of the U.N. Population Division, said that the most important factor in declining fertility rates is that "men and women want smaller families, and now they have the means to do so" (Reuters/New York Times, 2/27). The report says that fertility levels in most developing countries will fall below 2.1 children per woman, the "level needed to ensure long term replacement of the population" (United Nations release, 2/26). Already, fertility rates in developing countries have fallen from six children per woman in 1950 to three children today. The populations of 33 countries -- including Japan, Italy, Bulgaria, Russia and Ukraine -- are

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expected to be smaller in 2050 than they are today (Financial Times, 2/27).

According to the report, if fertility in all countries were to remain at current levels, the world population would "more than double" to 12.8 billion by 2050 (AP/Philadelphia Inquirer, 2/27).

HIV/AIDS IMPACT

HIV/AIDS will have a "serious and prolonged effect" on the populations of the most-affected countries, where the number of HIV/AIDS cases will still be "substantial" in 2050, although models predict a decline in HIV prevalence levels after 2010 (United Nations release, 2/26). The number of AIDS-related deaths in the 53 worst-affected nations is estimated to reach 278 million by 2050 (Agence France-Presse, 2/26). Seven of the most affected countries -- Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe -- are located in Southern Africa, where HIV prevalence is greater than 20%, the Wall Street Journal reports. According to the estimates, the population of these countries in 12 years will be 19% lower than it would have been without AIDS. Chamie said that in some countries, including India, China, Russia and Nigeria, "even a small difference [in HIV prevalence] has a big effect on the number of excess deaths," compared with previous estimates. He said, "It's a catastrophe. We have to bring down mortality in these countries" (Naik, Wall Street Journal, 2/27). Chamie added, "The long-term impact of the epidemic remains dire. HIV/AIDS is a disease of mass destruction and we do not see a vaccine coming soon" (BBC News, 2/26).

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Friday, March 07, 2003 CHC10 AM
Subject: PHA-Exchange> Medical journals: bias against diseases of the poor

From: <EQUIDAD@LISTSERV.PAHO.ORG>

> Medical journals: evidence of bias against the diseases of poverty
>
> Richard Horton
> The Lancet - Volume 361, Number 9359 - 01 March 2003
>
> Available online at:

<http://www.thelancet.com/journal/vol361/iss9359/full/llan.361.9359.editorial_and_review.24792.1>
>
> ".....A report from the WHO recently described under-representation of
> individuals from low-income and middle-income countries on the editorial
> boards of ten leading psychiatry journals. Shekhar Saxena and colleagues
> concluded that this "unsatisfactory situation" needed to be corrected, given
> the global importance of mental health. But this issue goes well beyond
> editorial boards and mental health. There is widespread systematic bias in
> medical journals against diseases that dominate the least-developed regions
> of the world. Is this an example of what some have described as the
> institutional racism that afflicts parts of medicine today?
>
> Some of the world's leading general medical journals include the Annals of
> Internal Medicine, BMJ, JAMA, New England Journal of Medicine, and The
> Lancet. These five titles lay claim to their global legitimacy for many
> reasons--weekly or biweekly publication, long-established histories, the
> credibility and power of their owners, large numbers of full-time editorial
> staff, membership of the International Committee of Medical Journal Editors,
> and influential joint statements. Their editorial boards matter because they
> help to shape the personalities and policies of these journals. The
> composition of editorial boards sends a signal to authors and readers about
> a journal's interests. General medical journals follow the same patterns as
> their psychiatry counterparts (panel). Most board members come from nations
> with a high human development index. ..."

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> Saxena S, Levav I, Maulik P, Saraceno B.
> How international are the editorial boards of leading psychiatry journals?
> Lancet - Vol. 361 February 15 2003 at:
>
http://pdf.thelancet.com/pdfdownload?uid=llan.361.9357.correspondence.24540.
> 1

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

3/12/03

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: Dolar Vasani <dolar.vasani@novib.nl>
Sent: Saturday, March 08, 2003 CHC9 AM
Subject: PHA-Exchange> Food for thought for the excluded

Human Rights Reader 39

Social Exclusion and Human Rights.

Who's in and who's out:
1.The process of social exclusion is closely linked to/with many current day economic and human rights (HR) problems.
Social groups are excluded, because they have no access to the opportunities afforded to others in society, including public health care services, adequate nutrition, public education, public housing and employment. The many barriers to access prevent people from reaching their full productive potential --in turn constraining equitable economic growth, as well as poor people's revenues and their HR. Lack of access makes the poor more likely to incur in health and social services expenditures they can ill afford. The exclusion process is exacerbated by prices of basic services out of reach for most of the poor.

The faces of social exclusion:
2.Social exclusion has many faces: among other, it includes residential segregation, exclusion from health care, barriers in access to legal services, inequalities in education, language barriers and schooling inequities for ethnic minorities...

The word 'excluded' has a double meaning:
3.More often, exclusion refers to the social classes and social groups (indigenous people, black people, women, etc) that are excluded
-from receiving social services,
-from the products and the income they generate, and
-from the political institutions that govern the country.
Less often are the excluded looked at as the victims of an array of HR violations. [As much as they should...].

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Who are the excluded?:
4 Many of the excluded play an important or even essential role in the production and distribution processes of the prevailing system: they are unemployed or they work as domestic workers, as agricultural wage laborers, as construction workers, as subsistence farmers, as factory workers with shoddy contracts, or they are the youth that never had a stable job, or the army of the underemployed vendors in the gray market... In a word, overwhelmingly, the excluded are the poor majority, or a greater than 50 % of the working-age population.

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production, but do not receive any of its benefits --mainly because they are excluded from the structures of power.

6.The main battle is, therefore, not for the poor to be 'incorporated' into the system --since they already are a part of it (but are basically subordinated, powerless, landless, 'rightsless', excluded from owning property, from receiving services...).

7.The real problem of the excluded is more the 'transformation' of the system of property, of power and of violation of HR so that they can get greater access to and control over the resources and services they need.

8.Today, the poor are not only excluded from employment; they do dirty work, hold unstable jobs; they are poorly paid; they resort to the informal (gray) sector of the economy to eke out a living; they receive no fringe benefits (retirement, paid vacations, health benefits).

Who excludes?:
9.States, corporations, banks, the globalization process, unfair trade, cheap/ subsidized imports destroying local industries and causing further unemployment, the WB, the IMF (as instruments of, for example, forced privatization that further pauperizes the poor) are all part of the culprits of exclusion.

10.The excluded and the excluders are essentially in dialectical conflict: the condition for domination of some is the exclusion and the violation of the HR of the many.

11.The first cry of the excluded erupts when they refuse to suffer in silence --when their poverty becomes intolerable. This then leads to organized social movements that demand justice, land, jobs, food, decent housing, schools....rights. Then, the cry of the latter is not a cry of desperation anymore, but a struggle cry; it is a cry that now goes beyond immediate concessions: it demands the socialization of the means of production and of state power; it demands the reversal of HR violations. In short, these movements demand a new society --one that no longer has excluded.
12.The cry of the excluded reflects a world:
of exploitation, of urban and rural hunger, of social decadence, of school desertion, of economic pilfering, of concentration of wealth in the hands of a few, of un-enforced labor legislation, of an agro-industry oriented towards export markets, of forced displacements, of a fall in real wages, of the progressive pauperization of retirees, of an end of staple food subsidies,
of a relentless loss in purchasing power (the cost of living has outstripped minimum wages often severalfold), of a massification of poverty.
In short, most of these are violations of HR.

13.All this has also led to a popular rejection of electoral processes that

are considered viciated, rigged and controlled by the media at the service of (or for sale to) the powerful.

14.Only identifying and acting upon the causes of exclusion will enable more people to lead productive lives, have their rights respected and enjoy access to all the benefits of society.

15.To eliminate exclusion, then, the struggle for rights has to go hand in hand with a struggle for power.

Claudio Schuftan, Ho Chi Minh City
aviva@netnam.vn

Mostly taken from J.R.Behrman et al, Social Exclusion in Latinamerica, IADB, 2003, www.iadb.org/exr/pub/pages/book.asp?id=141 and J.Petras, Grito de los Excluidos, 2003, http://attac.org/attacinfoes/attacinfo175.pdf

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Main Identity

From: Aviva <aviva@netnam.vn>
To: Dolar Vasani <dolar.vasani@novib.nl>
Sent: Saturday, March 08, 2003 CHC9 AM
Subject: PHA-Exchange> Food for thought for the excluded

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5.Not paradoxically, they are thus already integrated in the system of production, but do not receive any of its benefits --mainly because they are excluded from the structures of power.

6.The main battle is, therefore, not for the poor to be 'incorporated' into the system --since they already are a part of it (but are basically subordinated, powerless, landless, 'rightsless', excluded from owning property, from receiving services...).

7.The real problem of the excluded is more the 'transformation' of the system of property, of power and of violation of HR so that they can get greater access to and control over the resources and services they need.

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In short, most of these are violations of HR.

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Claudio Schuftan, Ho Chi Minh City
avlva@netnam.vn

Mostly taken from J.R.Behrman et al, Social Exclusion in Latinamerica, IADB, 2003, www.iadb.org/exr/pub/pages/book.asp?id+141 and J.Petras, Grito de los Excluidos, 2003, http://attac.org/attacinfoes/attacinfo175.pdf

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3/10/03

PHM Secretariat

From: UNNIKRISHNAN PV (Dr) <unnikru@yahoo.com>
To: PHA Global <pha-exchange@kabissa.org>; <pha-ncc@yahoogroups.com>; <PHA-Europe@egroups.com>
Sent: Tuesday, March 11, 2003 CHC12 AM
Subject: PHA-Exchange> Voice of the dark corners by Fidel Castro

Voice of the dark corners

Fidel Castro
Thursday March 6, 2003
The Guardian

These are hard times we are living in. In recent months, we have more than once heard chilling words and statements. In his speech to West Point graduating cadets on June 1 2002, the United States president declared: "Our security will require transforming the military you will lead, a military that must be ready to strike at a moment's notice in any dark corner of the world." That same day, he proclaimed the doctrine of the pre-emptive strike, something no one had ever done in the political history of the world. A few months later, referring to the unnecessary and almost certain military action against Iraq, he said: "And if war is forced upon us, we will fight with the full force and might of the United States army."

That statement was not made by the government of a small and weak nation, but by the leader of the richest and mightiest military power that has ever existed, which possesses thousands of nuclear weapons, enough to obliterate the world's population several times over - and other terrifying conventional military systems and weapons of mass destruction.

— PHM - US file →
— Also PHM Exchange →
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That is what we are: dark corners of the world. That is the perception some have of the third world nations. Never before had anyone offered a better definition; no one had shown such contempt. The former colonies of powers that divided the world among them and plundered it for centuries today make up the group of underdeveloped countries.

There is nothing like full independence, fair treatment on an equal footing or national security for any of us; none is a permanent member of the UN security council with a veto right; none has any possibility of being involved in the decisions of the international financial institutions; none can keep its best talents; none can protect itself from capital flight or the destruction of nature and the environment caused by the squandering, selfish and insatiable consumerism of the economically developed countries.

After the last global carnage in the 1940s, we were promised a world of peace, a reduction of the gap between the rich and poor and the assistance of the highly developed to the less developed countries. It was all a huge lie. We had imposed on us an unsustainable and unbearable world order.

The world is being driven into a dead end. Within hardly 150 years, the oil and gas it took the planet 300 million years to accumulate will have been depleted. In just 100 years, the world population has grown from 1.5 billion to over 6 billion people, who will have to depend on energy sources that are still to be researched and developed. Poverty

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continues to grow while old and new diseases threaten whole nations with

annihilation. The world's soil is being eroded and losing its fertility; the climate is changing; the air that we breathe, drinking water and the seas are increasingly contaminated.

Authority is being wrenched away from the United Nations, its established procedures are being obstructed and the organisation itself destroyed; development assistance is being reduced; there are continuous demands on the third world countries to pay a $2.5 trillion debt that cannot be paid under the present circumstances, while $1 trillion dollars are spent in ever more sophisticated and deadly weapons. Why and for what?

A similar amount is spent on commercial advertising, sowing consumerist longings that cannot be satisfied in the minds of billions of people. Why and for what? For the first time the human species is running a real risk of extinction due to the insane behaviour of the very same human beings, who are thus becoming the victims of this "civilisation".

However, no one will fight for us, that is, for the overwhelming majority, only we will do it. Only we can save humanity ourselves with the support of millions of manual and intellectual workers from the developed nations who are conscious of the catastrophes befalling their peoples. Only we can do it by sowing ideas, building awareness and mobilising global and North American public opinion. No one needs to be told this. You know it very well. Our most sacred duty is to fight, and fight we will.

3/13/03

Main identity

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Thursday, March 13, 2003 6:06 AM
Subject: PHA-Exchange> Water for People - Water for Life -

> Water for People - Water for Life -
> The United Nations World Water Development Report
>
> UNESCO website: <http://upo.unesco.org/bookdetails.asp?id=4042>
>
> ".....To what extent will population growth, rising levels of pollution,
> and climate change intensify the water crisis? Exactly how much water is
> available per person in countries around the world? How much will we need
> for food security in the next fifteen, twenty-five and fifty years?
>
> The international community has pledged to reduce by half the proportion
of
> people without access to water supply and sanitation by 2015. What regions
> are on track? How much will it cost to achieve these goals? What is the
> likelihood that countries will go to war over water in the near future?
>
> There questions and others are addressed in this Report, which offers the
> most comprehensive assessment to date of the state of the world's
freshwater
> resources, based on the collective inputs of 23 United Nations agencies
and
> convention secretariats. It is part of an on-going assessment process to
> measure progress towards achieving sustainable use of water resources, and
> to influence better formulation and implementation of water-related
> policies.
>
> The goal of sustainable development was first set at the Rio Earth Summit
of
> 1992 and has been restated or expanded in many forums since then. The UN
> Millennium Declaration of 2000 transformed general guidelines into
specific
> targets. The international community pledged ". . . to halve by 2015 the
> proportion of people who are unable to reach, or to afford, safe drinking
> water" and "... to stop the unsustainable exploitation of water
resources,
> by developing water management strategies at the regional, national and
> local levels, which promote both equitable access and adequate supplies."
> Thus, ten years after Rio it is time to take stock.
>
> The global overview is complemented by the presentation of seven pilot
case

PHM Exchange->

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> studies of river basins representing various social, economic and

> environmental settings: Lake Titicaca (Bolivia, Peru); Senegal river basin
> (Guinea, Mali, Mauritania, Senegal); Seine Normandy (France); Lake
> Peipsi/Chudskoe (Estonia, Russia); Rupuna basins (Sri Lanka); Greater
Tokyo
> (Japan); and Chao Phraya (Thailand).
>
> Please consult the World Water Assessment Program's website at:
> http://www.unesco.org/water/wwap/wwdr/ex_summary/
> <http://www.unesco.org/water/wwap/wwdr/ex_summary/> for Executive
Summaries
> of the UN World Water Development Report online in 7 languages (English,
> French, Spanish, Arabic, German, Japanese, and Russian). In addition to
> these languages, Chinese and Bahasa-Malay are expected soon.
>
> * * * *

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To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

Main Identity

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Thursday, March 13, 2003 CHC8 AM
Subject: PHA-Exchange> Poverty trap

From: <id21NewsAdmin@lyris.ids.ac.uk>
> ********
> Whose data? 'Stealing' from the poor
>
> There is growing evidence that researchers and their agencies 'capture'
> poverty data sets for years on end, without making them publicly
> available. While hanging on to data sets may enhance their reputations
> and help 'fast-stream' their careers, what long-term effect does this
> have on research into chronic poverty and ultimately, the poor
> themselves?
>
> http://www.id21.org/insights/insights46/insights-iss46-art08.html
>
> Email request: GET http://www.id21.org/getweb/Insights46art8.html
>
> Further Information:
> David Hulme, Chronic Poverty Research Centre, Institute for Development
> Policy and Management, Crawford House, Precinct Centre, Oxford Road,
> Manchester M13 9GH, UK
> T +44 (0)161 275 2825 F +44 (0)161 273 8829 Email
> david.hulme@man.ac.uk

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14/3/03

Main identity

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Friday, March 14, 2003 CHC10 AM
Subject: PHA-Exchange> "State of the World" reports

From: "Peter Burgess" <Profitinafrica@aol.com>

> Dear Colleagues
>
> I realise that it is now the mandate of every UN specialized agency
> to publish an Annual "State of ..... " report.
>
> Does anyone know how much money is spent compiling the information
> and getting it printed? And how much of this is offset by actual
> sales? Does anyone know how much notice is taken of the information
> by the media, and by the public at large?
>
> But perhaps more important does anyone notice that so much of what is
> in these reports shows that most of the critical problems have been
> with us now for decades and do not seem to be getting better very
> fast? In some cases, the data shows we are going backwards.
>
> So the question then comes down to what is being done wrong, or al-
> ternatively what needs to be done to make things right?
>

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22/3/03

RN
14/3/03

Main Identity

From: claudio <saviva@netnam.vn>
To: Dolar Vasani <dolar.vasani@novib.nl>
Sent: Friday, March 14, 2003 CHO3 PM
Subject: PHA-Exchange> Food for an active engagement beyond thoughts

Human Rights Reader 40

BEYOND CAPACITY ANALYSIS: ADDITIONAL ELEMENTS
OF A HUMAN RIGHTS-BASED DEVELOPMENT STRATEGY. (1)

[In this Human Rights Reader series, we have focused on quite a few elements called for in the implementation of the emerging human rights-based approach to development --mostly in health and nutrition. Additional conceptual and operational elements for its implementation are added at this time. As said once earlier, the repetition of some human rights concepts is both inevitable and also part of this Reader's intention to have them 'sink-in' into the readers' everyday parlance by looking at these concepts from different angles].

1.The 'chronic emergency' situation in the health, nutrition, education and other service sectors in an important number of the developing countries only sporadically , becomes a 'loud emergency'. However, if things stay their present course or worsen, such loud emergencies will increasingly become inevitable.

2.At the base of this is the fact that we are witnessing a failure of governments to sustain the provision of basic services, to pay the full cost of such public services and to respect, protect and fulfill people's human rights. Moreover, traditional sectoral approaches to development --aid-backed or not-- are not delivering expected results (or are not delivering them fast enough to reach the Millennium Goals).

PHM Exchange
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21/3/03

The need and the challenges:
3.There is thus an urgent need to accelerate the implementation of a human rights-based development strategy centered around this emerging development paradigm that incorporates the poor beneficiaries as protagonist actors. This paradigm also merges ethics and science, ideology and politics and theory and practice (i.e., what ought to be done and what can be done) into one consolidated development compact --one that effectively responds to the dire necessity here briefly sketched and one that is taken up as an active engagement or covenant with the people whose rights are being violated day-in, day-out.

4.A much wider participative and empowering Assessment-Analysis-and Action (AAA) process (2) --as an operational framework for the human rights-based

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3/17/03

approach-- has to be set in motion (or strengthened if elements of it are

already in place). To bring about change, people have to come from their very own experience (getting at their own realities). AAA processes are thus tools of social mobilization and of mobilization and progressive control of the resources needed. Such proactive AAA processes should be ultimately pursued in all areas and sectors of development. Social mobilization only succeeds if the repetitive/iterative character of the AAA operational framework begins to work. Positive AAA processes will then lead to the needed social mobilization at the community level. This mobilization envisions a key role for mobilizers/animators with three types of skills, namely:

-Moral Advocacy skills,
-Social Activism skills, and
-Political Advocacy skills.

These animators are the indispensable promoters of the needed mobilization process: they become the catalizers in the interaction between outsiders and the community -bridging the "them and us" schism between development organizations and the community.

All active concomitant development AAA processes have to be identified and assessed at national and sub-national level so as to select our strategic allies and mark and neutralize our strategic opponents in implementing this new human rights-based approach.

5.This rights-based approach will give equal importance to process and outcome achievements, carefully targeting the most vulnerable in ty --those whose rights are most flagrantly being violated-- so as to make the endeavor truly equitable.

6.Quite a bit can be learned from successful coping mechanisms already used by households. Poor people are already doing; we need to asses what they are doing and build from there. [Note that reinforcing coping mechanisms risks locking the poor into a 'low level of changes' trap; it may keep them away from pursuing a more radical reappraisal of their needs, one more related to the structural determinants of their present condition]. Be it as it may, these spontaneous (or project-related) success factors need to be documented and better understood to consider them for eventual replication. (Keep in mind that going for small gains first is OK provided the ultimate vision remains to fully reverse gross violations of human rights).

The strategy:

7.The new human rights-based strategy will focus-on/center-around the household and its members, i.e. around legitimate household members' rights and their respective entitlements/claims. This means first providing for the household members' basic entitlements, i.e., reaching a minimum level of family security. It is at the household level that we ultimately need to achieve significant changes, especially in health, nutrition and sanitation behaviors and status.

8.The needed community support mechanisms and structures to help identify and assist vulnerable households will have to be developed and/or strengthened. It is here where mobilizers (activists/advocates) become essential. We will not achieve our human rights goals unless we put in place a veritable "army" of such animators. (3)

9.The household entitlements/rights we are talking about here are in the realm of:
-food and nutrition (macro and micronutrients),
-cooking fuel,
-health (curative and preventive),
-the care of children an the support of women to do so,
-clean water supply and sanitation facilities and services,
-education (pre-primary and primary with a focus on girls and female literacy/numeracy),
-shelter and clothing,
-income (in kind and in cash including employment opportunities),
-women's own gender-related needs and entitlements,
-access to credit (especially by women) and to selected agricultural inputs subsidies,
-legal protection (especially of women's and children's rights),
-physical environmental safety,
-physical personal safety during armed conflicts, and
-women's personal safety from domestic violence.

10.Key, easily measurable, process and outcome indicators (or proxy indicators) for each of these entitlements will need to be agreed upon and monitored in our work with communities.

11.To make sense of these indicators, the human rights-based strategy will have to have its own Conceptual Framework (2) that will allow us to move up and down the causality chain to inquire about/find out what determines the findings represented by those indicators. Such a conceptual framework is crucial to help us create a consensus on the causes of family insecurity and the violation of its members' rights. When using the conceptual framework, interpretation of the analyses is inevitably value laden; therefore, the values have to be shared. (It is good to be reminded that, as social actors, we inescapably become technicians with an identifiable --even if hidden-- political agenda).
[My own preference is for this conceptual framework to be "upside-down" in relationship with the 1990 UNICEF conceptual framework of the causes of preventable ill-health, malnutrition and early deaths: i.e., the basic causes should be on top. If interested in one such tentative conceptual framework being prepared for wider discussion, you can request a copy from aviva@netnam.vn].

12.The role of an indispensable (and specially designed) Information/ Education/Communication (IEC) component in the human rights-based strategy

needs to be emphasized here.
(Part two to follow)

Claudio Schuftan, Ho Chi Minh City
aviva@netnam.vn

(1): Capacity Analysis takes what is being proposed to be done for each determinant of a human rights violation at each causal level and looks at what is already being done or not being done (and why) for that problem. It then looks at who should be doing something about it [individual(s) and/or institution(s) who is (are) the corresponding duty bearer(s)] and attaches the name of that (those) person(s) or institution(s) to each proposed solution. This results in a list of the most crucial persons/institutions that have to be approached to push them to get the major proposed solution(s) for each main problem implemented.

(2): Situation analyses have to be based on an Assessment and an Analysis of the existing situation that will then lead to decisions being made for Action; this has been called a triple A (AAA) process. But the assessment and the analysis cannot be done in a vacuum --without previously having worked on a Conceptual Framework of the causes of the problems that are to be solved. This means that one has to have an in depth understanding of how those problems come about --what their determinants are before one can, in a participatory way, decide what the best options are to do something about them, i.e., "one finds what one looks for". The essence of a good situation analysis, then, is to carry out a Causal Analysis based on a pre-existing Conceptual Framework and to base all decisions for action to be taken on this analysis. Therefore, appropriate interventions for the main causes at each causal level have to be found. Addressing each cause is necessary, but not sufficient to change the outcome (i.e. preventable ill-health, malnutrition and excess deaths). That is why communities need to act at all levels of determinants at the same time (and this is also why so many "selective PHC interventions" have failed in the past). AAA processes are happening all te time already (consciously or not) in all decision-making. >From the perspective of the outcomes we want to achieve, we can identify positive, negative and neutral AAA processes: it behooves us to start and strengthen positive and neutralize the negative AAA processes in the realm of human rights.

(3): A mobilizer has a complex set of roles. Among them, some of the following can apply:
she listens, observes and consults, she validates scientific information, she validates what is permissible/fair/possible/doable/right for the local context, she shares knowledge, she influences perceptions, she puts things/concepts in a local context, she fosters evidence-based decision-making, she catalyzes/facilitates, she mobilizes/inspires people in the community, she advocates/convinces/persuades, she influences actions, she builds people's capacities, she empowers them, she lobbies, she

3/17/03

networks/liaises, she negotiates and goes into strategic and tactical

partnerships, she carries out social and political mapping of resources, she mobilizes local and outside resources, she educates, she organizes, leads, manages, she sets an example, acts as a role model and is trustworthy, she assesses/re, analyzes/re, she coordinates/starts new actions, she creates space for such actions, she supervises, monitors and evaluates, she fosters and instills a vision and a hope, she raises political consciousness, she delegates, she makes decisions and solves problems, she is interested in learning from outside

****

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ago),
> and to ask if you could clarify what the process will be for setting up
the

11/22/03

PHM- Secretariat(Global)

From: Vandana Prasad <chaukhat@yahoo.com>
To: PHM-Secretariat(Global) <secretariat@phmovement.org>
Sent: Friday, November 21, 2003 6:21 PM
Subject: Re: Regarding JSA communication issues

dear prasanna,
this sounds good but will need a little training for
people like me.
what i really wanted was that different'circles' or
groups that got set up - like the 'sect group', like
the various sub committees should have their own e
groups with coordinator.
i had suggested this to abhay many times, specially
for the sect that we should have specific id and
group. had that been the case, i would have
automatically known, for example, that the bangalore
minutes have come in.

as far as the jsa website is concerned i think it
should be discussed at the next nwg.

because this type of issue comes up between national
and state secretariats just as it is with global and
currently india, i feel it is better to keep seperate.
that way responsibilites are better understood and
shared. also no one can accuse global sect of more
focus on the host country etc.

PHM - JSA

the whole issue of national sect needs to be
reaffirmed along with the responsibilities of the
people who volunteer to coordinate various specific
circles or activities. ideally their particular e
group should be in their hands.

however, i am no expert on e technology or its use and
just about manage to keep afloat with the e mail.
i know many state coordinators do not respond to e
amil at all - they need phone calls or letters.
national sect has been sending out snail mail to all
on its list as well as e mail and i make phone calls
if it is important.

vandana

PHM Secretariat

From: Empower India <tth_empowel@sancharnet.in>
To: <secretariat@phmovement.org>
Sent: Sunday, August 24, 2003 5:34 PM
Subject: Call for Action

Dear Sir / Madam
Greetings from EMPOWER.Kindly send more details about Call for Action and include our organisation in your mailing list .

Thanking You
Yours in Global Concern
MEERA SHANKAR
Programme Director
EMPOWER
107 J / 133 E, MILLERPURAM
TUTICORIN - 628 008
INDIA

RN
25/8/03

Action taken

SSP → Please send anything else or the usual form letter to PHM enthusiasts suitably specified for this particular request. Also get in touch with TNSF/AID chemical and others

RN
25/8/03

(Thanks

Secretariat

From: Mohib <mohib@gkbd.org>
To: 'PHM Secretariat' <phmsec@touchtelindia.net>
Sent: 28 January 2004 20:24
Subject: Thank you

Dear Ravi

Let me express sincerest gratitude to you personnaly and on behalf of GK and All PHM bangladesh circle participant.
We will never forget your help during our stay in Mumbai
Please also convey our sincerest gratitude to Prasanna, Xavier and all PHM global friends

Please make some time and visit us.

Dr. Mohib

RN
28/1/04

PHM - IHF / WSR
Bangladesh

RN
28/1/04

Main Identity

From: prayas <prayasct@sancharnet.in>
To: <forestrights@yahoogroups.com>; <pha-ncc@yahoogroups.com>; DNRM <dnrm@panchayats.org>
Sent: Wednesday, February 04, 2004 6:15 AM
Attach: Public Hearing.doc
Subject: [pha-ncc] Re: [forestrights] Fw: [andamanicobar] DRAFT NATIONAL POLICY ON TRIBALS

Dear friends:
Please find attached an invitation to participate in a public hearing on forest issues.

Best.

Jawahar & Narendra
Prayas,
B -8, Bapu Nagar, Senthi,
Chittorgarh 312 025 India
Tel : 91.1472.243788/250044
Fax : 91.1472.243788
Please sign for the campaign against coercive population control action plan of the Govt. of Rajasthan at http://www.petitiononline.com/jaipur/ & https://www.genderhealth.org

PHM-JSP
Rajasthan

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4/2/04

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4/2/04

2/4/04

Public Hearing

on

Forest Department Development Works

Date : 20th February 2004 from 11.00 A.M.
Venue : Village Dharani, Tehsil : Pratapgarh, Chittorgarh Dt.

Dear Friends

In our campaign towards transparency in public works and freedom of information, we have been holding public hearings on various vital livelihood issues. Public hearing on the issue of benefit sharing in Joint Forest Management was held in village Sadani of Pratapgarh tehsil of Chittorgarh district in the month of September 2001. The hearing highlighted the unfair distribution of benefit between the community and the department. The next hearing about the misappropriation of panchayat development funds was held in May 2003 in village Kanjeti of Kapasan tehsil in Chittorgarh Dt. The testimonies of the people and physical audit revealed embezzlement of Rs. 347,000/- out of total works of Rs. 1,23,000/-. The authorities tried to stall the hearing by enforcing section 144 and terrorising people in the village. Despite it there was a huge turn out. However, later the Government enquiry also validated the charges of embezzlement and issued orders for recovery of the money. The third hearing pertained to women's access to health care. This was held in September 2003 at Chhoti Sadari town of Chittorgarh Dt. 72 women of child bearing age shared their horrifying experiences of money extortion, bad behaviour and very little relief while trying to seek health care for their maternal health issues, treatment of reproductive tract and sexual health related problems, advice on fertility issues and availability of contraceptive devices.

The hearing next on line is on the development works executed by the forest department. As you perhaps know that the Forest Department gets large amount of funds to start development activities for the protection, promotion of forest and also of the communities living around forest so as to ease pressure on forest resources for livelihood. After a long and sustained hard work of thirty months, we could get the vouchers of development works carried out by the forest department in last seven years under the World Food Program assisted projects for village Dharani under Devgarh forest range of Pratapgarh forest division in Rajasthan. Physical appraisal and examination of vouchers have opened up a new panorama of how valuable funds meant for development are siphoned off.

A public hearing is being organised at village Dharani on 20th February 2004 from 11.00 A.M. wherein people of the village will testify about the wrongdoings.

Please join us in the hearing to strengthen our campaign.

In solidarity

Lok Van Vikas Parishad,
Village : Devgarh (Deoha),
Via : Pratapgarh, Chittorgarh Dt.

Secretariat

From: "cehat" <cehat@vsnl.com>
To: "Padma Deosthali" <padma72@yahoo.com>; "panchamu" <panchamu@sancharnet.in>
Cc: "PHM - Secretariat" <secretariat@phmovement.org>; "pitre" <pitrev@vsnl.net>; "Prasanna - PHM communications" <prasanna@phmovement.org>; "Parag" <lifestyleod1@indiatimes.com>; "Pasumai Thaayagam" <pasumaimail@yahoo.co.in>
Sent: 12 January 2004 18:03
Subject: WSF - Disability Panel

Disability is a global perspective: Nothing about us without us – A Panel Discussion
January 18, 2004.
Venue_Hall No.4,
1.-4 pm
World Social Forum, Goregaon, Mumbai

The World Social Forum is not an organisation, not a united front platform, but "…an open meeting place for reflective thinking, democratic debate of ideas, formulation of proposals, free exchange of experiences and inter-linking for effective action, by groups and movements of civil society that are opposed to neo- liberalism and to domination of the world by capital and any form of imperialism, and are committed to building a society centred on the human person". (From the WSF Charter of Principles).

Focus of panel
Disability activists from India, Kosovo, Fiji, Canada, Germany and USA will share their experiences and offer their perspectives on the social construction of disability. The panel will and the ensuing discussion will focus on

§ Medicalisation of social problems.
§ Denial of rights and access to services.
§ Disability and capitalism.
§ Disabled people as activists and shapers of their own fate.
§ Mainstreaming disability within the feminist discourse.
§ Devaluing of disabled lives – assisted suicide, euthanasia, selective abortion, disability and biodiversity, genetic engineering.

Objective
§ Better understanding of the social construction of disability and lesser likelihood of accepting medical and technological solutions for problems created by social and institutional structures.
§ More inclusive process of disabled people and their issues

Panellists
§ Anita Ghai, Reader of psychology, Jesus and Mary College, New Delhi. A disability activist and writer of (Dis) Embodies Form: Issues of disabled women. Anita would focus on the gender issues from the vantage point of a disabled woman living in a developing country.
§ Jean Stewart, Founder, Disabled Prisoner's Justice Fund, Founder, Disabled Prisoners' Justice Fund; writer, disability rights activist. Jean has several publications to her credit and looks at disability as an outcome of capitalist society
§ Anne Finger, who is currently the President, Society for Disability Studies, has been a disability activist all her life. Anne would talk about – assisted suicide, euthanasia, selective abortion, disability and biodiversity, genetic engineering.

PHM - [illegible] PHM - JHF/WSF

SSP/NT
Can we be in touch with Kamayani and track the outcome of this meeting and then put it on PHM exchange as our support to the issue
RN
29/1/04

CMF/Mani/SJC will also be interested.

§ Jean Parker, An internationally renowned radio journalist specializing in coverage of disability issues . Visually impaired, Jean will talk about the international disability rights movement, from the perspective of a journalist who has traveled the globe interviewing people with disabilities from many countries.

§ Javed Abidi- Disability Movement in India

§ Sibaji Panda, Deaf Issue and Deaf Rights

For further information contact Kamayani- 9820749204

www.cehat.org

20/01/2004

Main Identity

From: UNNIKRISHNAN PV (Dr) <unnikru@yahoo.com>
To: PHA Global <pha-exchange@kabissa.org>
Cc: <pha-ncc@yahoogroups.com>
Sent: Tuesday, March 18, 2003 CHC10 AM
Subject: [pha-ncc] IRAQ- Fw: Running Out of Patience- Letter to the London "Observer" from Terry Jones (Monty Python)

Apologies for posting a non-health despatch !

If everyone starts using Bush's logic what the world will be like ? Just because he runs out of patience, he decides to bomb Iraq ?

Sent: Monday, March 17, 2003 3:12 AM
Subject: Running Out of Patience

> Letter to the London "Observer" from Terry Jones (Monty Python)
>
> I'm really excited by George Bush's latest reason for bombing Iraq: he's
> running out of patience. And so am I! For some time now I've been really
> pissed off with Mr. Johnson, who lives a couple of doors down the
> street.
>
> Well, him and Mr. Patel, who runs the health food shop. They both give
> me queer looks, and I'm sure Mr. Johnson is planning something nasty for
> me, but so far I haven't been able to discover what. I've been round to
> his place a few times to see what he's up to, but he's got everything
> well hidden. That's how devious he is. As for Mr Patel, don't ask me how
> I know, I just know - from very good sources - that he is, in reality, a
> Mass Murderer. I have leafleted the street telling them that if we don't
> act first, he'll pick us off one by one.
>
> Some of my neighbours say, if I've got proof, why don't I go to the
> police? But that's simply ridiculous. The police will say that they need
> evidence of a crime with which to charge my neighbours. They'll come up
> with endless red tape and quibbling about the rights and wrongs of a
> pre-emptive strike and all the while Mr Johnson will be finalising his
> plans to do terrible things to me, while Mr Patel will be secretly
> murdering people. Since I'm the only one in the street with a decent
> range of automatic firearms, I reckon it's up to me to keep the peace.
>
> But until recently that's been a little difficult. Now, however, George
> W. Bush has made it clear that all I need to do is run out of patience,
> and then I can wade in and do whatever I want! And let's face it, Mr
> Bush's carefully thought-out policy towards Iraq is the only way to
> bring about international peace and security. The one certain way to
> stop Muslim fundamentalist suicide bombers targeting the US or the UK is

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> I want to blow up Mr Johnson's garage and kill his wife and children.
>
> Strike first! That'll teach him a lesson. Then he'll leave us in peace
> and stop peering at me in that totally unacceptable way. Mr Bush makes
> it clear that all he needs to know before bombing Iraq is that Saddam is
> a really nasty man and that he has weapons of mass destruction - even if
> no one can find them. I'm certain I've just as much justification for
> killing Mr Johnson's wife and children as Mr Bush has for bombing Iraq.
>
> Mr Bush's long-term aim is to make the world a safer place by
> eliminating 'rogue states' and 'terrorism'. It's such a clever long-term
> aim because how can you ever know when you've achieved it? How will Mr.
> Bush know when he's wiped out all terrorists? When every single
> terrorist is dead?
>
> But then a terrorist is only a terrorist once he's committed an act of
> terror. What about would-be terrorists? These are the ones you really
> want to eliminate, since most of the known terrorists, being suicide
> bombers, have already eliminated themselves. Perhaps Mr. Bush needs to
> wipe out everyone who could possibly be a future terrorist?
>
> Maybe he can't be sure he's achieved his objective until every Muslim
> fundamentalist is dead? But then some moderate Muslims might convert to
> fundamentalism. Maybe the only really safe thing to do would be for Mr
> Bush to eliminate all Muslims?
>
> It's the same in my street. Mr Johnson and Mr Patel are just the tip of
> the iceberg. There are dozens of other people in the street who I don't
> like and who - quite frankly - look at me in odd ways. No one will be
> really safe until I've wiped them all out. My wife says I might be going
> too far but I tell her I'm simply using the same logic as the President
> of the United States. That shuts her up. Like Mr Bush, I've run out of
> patience, and if that's a good enough reason for the President, it's
> good enough for me.
>
> I'm going to give the whole street two weeks - no, 10 days - to come out
> in the open and hand over all aliens and interplanetary hijackers,
> galactic outlaws and interstellar terrorist masterminds, and if they
> don't hand them over nicely and say 'Thank you', I'm going to bomb the
> entire street to kingdom come. It's just as sane as what George W. Bush
> is proposing - and, in contrast to what he's intending, my policy will
> destroy only one street.
>
>
>
>
>

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CHC

From: George(s) Lessard <media@web.net>
To: <iCTs@yahoogroups.com>; <creative-radio@egroups.com>
Cc: <pha-exchange@kabissa.org>; <wuscnet@wusc.ca>
Sent: Wednesday, April 16, 2003 11:11 AM
Subject: PHA-Exchange> AFRICA Five radio plays available on CD highlighting rights issuesas they affect older people.

HIGHLIGHTING THE RIGHTS OF OLDER PEOPLE
HelpAge International Africa Regional Development Centre have produced five radio plays available on CD as parts of their Rights Programme highlighting rights issues as they affect older people. The titles are: The effects of HIV/AIDS on older people in Africa; Poverty and older people in Africa; Abandonment of Older people in Africa; Witchcraft accusations and violence against older people in Africa; Health care for older people. They also have a two-part documentary highlighting the abuse of older people's rights. The titles are: The rights of older people: the mark of a noble society; The rights of older people: possible solutions.
Contact
helpage@africaonline.co.ke
r copies.

[Via / From / Thanks to and / or excerpted from the following :]
PAMBAZUKA NEWS 105
http://www.pambazuka.org
/\/\/\/\/\/\/\/\/\/\/\/\/\/\/\/\

PHA- Exchange?
RN
17/4/03

THIS NEWSLETTER IS BROUGHT TO YOU BY FAHAMU, KABISSA, AND SANGONET
Fahamu - learning for change
Unit 14, Standingford House, Cave Street, Oxford OX4 1BA, UK
info@fahamu.org
http://www.fahamu.org

Kabissa - Space for change in Africa
4 Philadelphia Avenue, Takoma Park, MD 20912, USA
info@kabissa.org
http://www.kabissa.org

Southern African Non-Governmental Organisation Network (SANGONeT)
P O Box 31
Johannesburg, 2000
South Africa
info@sn.apc.org
http://www.sn.apc.org

RN
17/4/03

PHA - Africa

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:-) Message Ends; George(s) Lessard's Keywords Begin (-:
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CHC

From: claudic <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Friday, April 18, 2003 7:29 PM
Subject: PHA-Exchange> The Numbers: American War Machine & Other

> > Iraq Invasion By The Numbers
> >
> > by Jackson Thoreau
> >
> > April 03, 2003
> >
> > Percentage of the world's population living in the U.S.: 6.
> >
> > Percentage of the world's energy resources used in the U.S.: 30.
> >
> > Rank of Iraq among countries in the world for the largest oil
> > reserves: 2 [behind Saudi Arabia].
> >
> > Military spending, worldwide: $900 billion.
> >
> Percentage of worldwide military spending by U.S.: 50.
> >
> > Percentage of worldwide military spending by Iraq: 0.0015.
> >
> > Percentage of Iraq's military capacity U.S. claimed it destroyed in
> > 1991 Persian Gulf War: 80.
> >
> > Percentage of Iraq's post-1991 capacity to develop weapons of mass
> > destruction the UN claimed to have discovered and dismantled by
> > 1998: 90.
> >
> > Percentage of U.S. military spending that would ensure basic
> > necessities to everyone in the world: 10.
> >
> > Number of Americans who have died in wars since World War II:
> > 92,212.
> >
> > Number of people living outside U.S. who have died in wars since
> > World War II: 25 million.
> >
> > Years that Iraq has had chemical and biological weapons: 20.
> >
> Number of U.S. and European corporations that supplied Iraq with
> > materials and knowledge to make chemical and biological weapons
> > since the early 1980s: 150.
> >
> > Number of Western nations that condemned Saddam Hussein in 1988

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> > immediately after he used gas in the Kurdish town of Halabja in 1988
> > to kill an estimated 5,000 people: 0.
> >
> > Number of pounds of Agent Orange and other herbicides U.S. dropped
> > in the Vietnam War: 100 million.
> >
> > Value of worldwide weapons trade: $800 billion.
> >
> > Percentage of weapons dealt by U.S. companies worldwide: 50.
> >
> > Estimated number of Iraqi civilian deaths in the 1991 Persian Gulf
> > War: 35,000.
> >
> > Estimated number of retreating Iraqi soldiers buried alive by U.S.
> > tanks in 1991 War: 6,000.
> >
> > Estimated number of Iraqi civilian deaths Pentagon predicted in the
> > 2003 war: 10,000.
> >
> > Estimated number of Iraqi civilian casualties in the 2003 war so
> > far: 800.
> >
> > Percentage of Iraqi civilian deaths that are children: 50.
> >
> > Tons of depleted uranium left in Iraq and Kuwait after the 1991
> > Gulf War: 40.
> >
> > Percentage increase in cancer rates in Iraq between 1991 and 1994:
> > 700.
> >
> > Pounds of explosives U.S.-led coalition dropped on Iraq in 1991
> > Persian Gulf War: 177 million.
> >
> > Pounds of explosives U.S.-British pilots dropped on Iraq between
> > December 1998 and September 1999: 20 million.
> >
> > Estimated pounds of explosives U.S.-British pilots have dropped on
> > Iraq since the start of Operation Iraqi Invasion in March 2003: 200
> > million.
> >
> > Years Iraq has lived under economic sanctions imposed by the UN:
> > 12.
> >
> > Iraqi child death rate in 1989 [per 1,000 births]: 30.
> >
> > Iraqi child death rate in 1999 [per 1,000 births]: 131.
> >
> > Number of Iraqis estimated to have died through 1999 due to UN
> > sanctions: 1.5 million.
> >

> > Percentage of them children: 50.
> >
> > Number of UN inspections conducted in Iraq in November-December
> > 1998: 300.

CHC

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Friday, April 18, 2003 5:29 PM
Subject: PHA-Exchange> Leadership and health equity

EL SALVADOR, 24 FEB. 2003. SOME REFLECTIONS BY DR HALFDAN MAHLER.

LEADERSHIP AND HEALTH EQUITY.

I believe that Milos Kundera had it right when he wrote in one of his books: »The struggle against human oppression is the struggle between memory and forgetfulness ». For instance, I believe that the many who over and over again ridicule WHO definition of health in its Constitution that these many have forgotten this Constitution and its Health Definition. So, let me remind all of us of the intrinsic beauty and pertinence of this definition: »Health is a state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity ». Let me also remind the forgetful about the link between the inspirational and the practical in that this Constitution has only one article defining « The Objective of The World Health Organization shall be the Attainment by All Peoples of the Highest Possible Level of Health ».For my personal enlightment one of the architects of this WHO definition, a partisan during the 2d World War, explained it to me in the following way : »I have experienced this complete physical, mental, spiritual and social wellbeing many times as a partisan when I decided to risk my life for something I thought was vitally important, namely freedom from occupation. Complete physical wellbeing, in that I as an individual could make a difference against a huge army of occupation. Complete mental and spiritual wellbeing, in that I fully realized my existential freedom by deciding to risk my life for something vitally important. Complete social wellbeing, in that I knew that should I not come back alive somebody from my partisan group would take care of my family. » And so, in facing death this partisan maintained that he had experienced the innate and transcendental meaning of WHOs Health Definition!

I am convinced that health is politics and that politics is health as if all people truly mattered. I am, therefore also convinced that political action for health-locally and globally-requires moral and intellectual stimulation. I am, furthermore morally and intellectually convinced that the Health for ALL Vision and the Primary Health Care Strategy provide significant starting forces and added impetus for health development all over the world. Such development is based on the principle that those who have little in health and wealth will generate much more for themselves, and those who have much will have no less, but will have it with a better social conscience.

I see startling patterns of inequities in the health scores throughout our miserable world. I'm not talking about a first, or second, or third, or fourth world-I'm talking about ONE WORLD-the only one we have got to share and care for. And I continue to support the resolve to provide levels of

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health that will allow all people of this ONE WORLD to lead socially and economically satisfying and productive lives.
I have always maintained that peoples own creativity and ingenuity are the keys to their and the world's progress. People's apathy can turn development dreams into stagnating nightmares. The transformation of social apathy into social and economic productivity is the point of embarkation of all sustainable and cumulatively growing human development. And an adequate level of health is a basic ingredient that fuels this transformation. What the billions of people throughout the developing world need and want is what everyone, everywhere need and wants: the wellbeing of those they love; a better future for their children ; an end to gross injustice ; and a beginning of hope. So, development is about the creation and expansion of opportunities for human beings to realize what they consider to be their positive destiny. It is a complex, often messy process involving the interplay of physical, social, economic and political variables. And, we are not talking about dealing with physical sciences and controlled environments where quantifiable elements can be introduced and results predicted. We are talking about human institutions and cultures, ways in which people organise themselves to effect change in their social environments. We are talking about human expectations, perceived rights, preference values, and people's emotions and attitudes about those rights and values.
Equity, especially in ensuring essential health and socio-economic needs, and particularly as it relates to vulnerable groups such as the poor, children, women, elderly, disabled remains for me a primordial objective of all development. Indeed, I consider equity a moral imperative to which all social and economic activities must be subsumed. I do believe that a greater degree of equity, to assure a more just and reasonable equality of health opportunity, is an absolute necessity for the preservation of a sane local and global humanity. Let us not forget that there are still thousands of millions of humans caught in the absolute poverty trap-a condition of life so characterized by malnutrition, illiteracy and ill health as to be beneath any definition of human decency.
How then, in to-day's largely amoral, if not immoral world is « social conscience » on the part of leaders generated? Rarely in human history has this kind of leadership been so essential-so vital ;leadership to propagate new values in society, particularly values that are concerned with social progress, leadership of involvement, of responsibility, of objectivity and of compassion.
It has been said that leaders have a significant role in creating the state of mind that is the society. They can express the values that hold the society together. They can bring to consciousness the society's sense of its own needs, values and purposes. And let us not forget that visionaries have always been the true realists of humankind's history.

It is my firm personal conviction that leadership is nothing if it is not linked to the collective purposes of the society. The effectiveness of the leaders must be gauged, not by their charisma, or their visibility, or the so-called power they hold, but by the actual social change they create, measured by the satisfaction of human needs and expectations. I do speak of

moral leadership, where values have a decisive place, where leaders assume consummate responsibility for their commitments, and thereby produce social change that is truly relevant to the needs, aspirations and values of the society.
And the vision of a commitment to remove social inequities cannot be

introduced as a one-shot piece of magic. It must be introduced time after time. It must be incorporated in the political system and supported through the strategy and decision making processes. It must be reinforced continuously through the diligent pursuit of facts and the fearless exposure of the facts that cry out for social justice.

A question often raised is , »Can health truly form a leading edge for social justice, especially when we are dealing with situations where the basic issue is survival ;where people are trapped in the vicious circle of extreme poverty, ignorance and apathy. ? ».

I can best answer this question by referring to the events that lead to the creation of the Health for All movement and to this movement, in my opinion becoming a leading edge in the promotion of equity and social justice.

The World Health Assembly decided in 1977 that the main social target of Governments and WHO in the coming decades should be the attainment of what is known locally and globally as « Health for All « . And the World Health Assembly described that as a level of health that will permit all the people of the world to lead socially and economically satisfying and productive lives. Please note that the World Health Assembly did not consider health as an end in itself, but rather as a means to an end. That end is human development as characterized by social and economic productivity and wellbeing. You will also note that the social aspect preceded the economic aspect. That is also as it should be. When people are mere pawns in an economic growth and profit game, that game is so often lost for the poor. But when people themselves can contribute actively and voluntarily to the social development of the society in which they live, whether in such fields as shaping public policies, providing social support to others, undertaking voluntary action for the health and education of society, or through all kinds of cultural activities, in other words when people are socially productive there is much hope for economic productivity too.

This morally binding contract of Health for All was the basis of The Primary Health Care Strategy which implied a commitment not only to a reorientation of the conventional health care systems- which rather should be called « medical repair systems »-but to a shift towards people `s own control over their health and wellbeing to the extent that they would be willing to handle in fact profound social reforms in health. This implies a continuous empowerment process whereby people acquire the skill and will to become the social carriers of their own health and wellbeing.

Therefore, I do believe that the fundamental values of social justice and equity are firmly embedded in the vision of Health for All and the strategy of Primary Health Care. And this vision and strategy can, indeed be a strong force and leading edge for achieving social justice and equity. Health may not be everything, but without health there is very little to wellbeing.

The question is often asked: »Can we afford the cost of social justice and equity? ». I would propose a counter question: »Can we afford the cost of social and economic destabilization inherent in to-day`s pursuit of profit-

maximization? ». The costs generated through the creation of a just and equitable health care system may indeed cause some economic turbulence. But equitable cost containment can be introduced and resources can be reallocated. Justice and fiscal responsibility do not have to be incompatible. They will be only so if there is a breakdown of political nerve. While there has been solid progress in a few countries towards Health for All, progress towards social justice and health equity remains strictly limited. A major reason-in my opinion- for this limited progress in the application of the HFA Vision through the PHC Strategy has been the lack of politically sensitive ammunition generated through epidemiological, sociological and operations research. Therefore, much more leadership must be generated as a collective force from all levels of the local and global society towards accelerating the abatement of to-days gross health inequities.

I believe it is obvious, if present inequity trends continue undimished, that our world will become more crowded, more polluted, less stable ecologically and much more vulnerable to socioeconomic and political devastation. I believe the most turbulent transition will be that associated with the establishment of equity between all earth citizens.

Health for All leadership-locally and globally- is moved by a vision which can not tolerate the unacceptable inequities of life, and which has faith in the potential of people, in their inherent ability to develop and to take responsibility for their own destiny.

I do believe that the leaders are there, who are willing to take up these challenges. They are those in leading political positions, who can emphasize social values and be politically sensitive to them, who feel strongly about equity issues, and who can find ways to motivate and mobilize others. They are the leaders in the communities-able to take up the cause of justice and equity more strongly, prepared to adjust their own traditional values and approaches and willing to take risks. They are the leaders of thousands of civil society organizations at local and global level already fighting for equity in health. They are the leaders in educational and scientific institutions-able to visualize the scope for improving human conditions and thus willing to focus their intellectual energies accordingly-and also willing to motivate future generations towards social values promoting equity. Last, but not least they are potentially among the leaders of all the world's religions willing to add the spiritual dimension in the fight for justice and equity.

Those who are fighting for social justice and equity must be even more than ready to look, to listen, to probe and to learn; must be brave enough to fearlessly evaluate progress or lack of progress in abating inequities. Only by highlighting inequities is it possible to re-dress them. This struggle for equity can often be frustrating, since development knows no limits. The more you move along its road the more you want to move. You cannot blame people if they strive to join up with those who are further along the road than they are. That is only human nature. Injustices however have to be seen through the eyes of those who are farthest behind on that road. But, we must not let the injustices take over. Indeed we must not!

I am convinced that this Centro de Investigación y Desarrollo en Salud which we are inaugurating to-day will provide essential ammunition in the fight

against the growing inequities in local and global health.

Thank you.

CHC

From: claudio <aviva@netnam.vn>
To: Dolar Vasani <dolar.vasani@novib.nl>
Sent: Saturday, April 19, 2003 5:08 PM
Subject: PHA-Exchange> Neutral food for non-neutral thoughts

Human Rights Reader 43

The ideological neutrality of human rights is its greatest strength, but its proponents should not be neutral in engaging to achieve them:

> There is no neutral territory in combating poverty and oppression.
> These who believe in such neutrality more often than not become prey to the agendas of dominant social forces.
> (F. Manji)
> The principle of neutrality --being indifferent-- is increasingly obsolete; it is immoral and short sighted.
> (J. Foster Dulles)

1. An undeniable contemporary fact is that, too often, our political leadership is dissociated from moral and ethical considerations. But essential for their legitimacy is precisely their ability to translate prevailing social and ethical values into politics (or 'ethical praxis', if you want): politics is the translation of all our scientific, ethical and historical knowledge into a fair management of society. (D. Najman, P--QLI Commission)

2. So, not trying to be facetious, if our leaders do not know how to equitably distribute wealth and justice, shouldn't they at least equitably distribute poverty and injustice...?

3. Consequently, in human rights (HR), stepping from the 'ethics of principles' to the 'ethics of responsibilities' means that our leaders must be made to stand by their signatures and made to keep their promises, basically because they made them...of their own free accord (or convenience at the time...).

4. In today's world, the life of a person who lives by her ethics is not easy: it is rather a crusade. For her, certain principles are non-negotiable.

5. In the human rights-based approach, rights are not negotiable. Therefore, we have to pin down the HR-expected outcomes --100% of them-- as non-negotiable (in a way, a zero tolerance stance). It is this, then, that has to become our point of reference to judge which Assessment, Analysis and Action (AAA) processes in society are positive and needed in our endeavor,

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PHA - Exchange

and which of them we have to challenge, because they do not lead to such outcomes (i.e., are negative and or neutral AAA processes for the achievement of HR).

6. In the same way, by now, we know that Respect, Protect and Fulfill all represent HR obligations of states: they thus have the connotation of a social contract! Carrying it a bit further, some people consider Respect to be a passive obligation, Protect to be an active one, and Fulfill to be a proactive obligation. So, for instance, when governments only respect and protect, but do not fulfill state obligations towards, say, the entitlement to food, to care and or to Health For All, they should be actively denounced and confronted by us; neutrality is not an ethical option.

7. One can ask: is it not commensurate with cowardice to live an uncommitted life in a world of growing polarization? We need to critically examine our commitments of all sorts. Uninformed innocence in a ravaged world amounts to pain and suffering that can be counted as dead bodies and children handicapped for life. We cannot be fundamentally unengaged on HR issues. Detachment has to be challenged. Detachment can come from our early training, disappointing experiences or mere indifference. We simply cannot selfishly shun commitment. A world of choice and action opens before us. We have to make choices. We have to take sides to remain human.... (A.A. de Vitis).

8. In troubled times, a vocal identification with ethical principles needs to be forged. Silence is a strategy to avoid commitment, in our case in HR work. Silence compromises the future of what we stand for. Silence is speech; it is a willed act in the furtherance of one's objectives. (Is it self-deception?)

9. We cannot attempt to disengage; political involvement in HR matters and, in final instance, is humanizing. Of course, the choice can be made to act as a 'sympathetic outsider'; from such a position, reality-out-there remains but a picture on the canvas. (Z. Pathak)
[I recognize that people exist as dismembered bodies; we are constructed as complex, fragmented subjects, in part because there is a dialectical relationship between the personal and the political...].

Can Human Rights advocacy be overdone?

10. All people have equal rights, but are indeed very different --and want to be different... (J.Rau, German Federal President, 13/5/02)

11. Because HR pertain to all people, everywhere, one danger is that the term "human rights" be used for many disparate things, if not for everything under sun. The fear is that, eventually, the term be abused so that it gets diluted to the extent that it loses all its original meaning and becomes empty rhetoric --like so many other 'big words' we have seen abused --from democracy to freedom to equity...

12. Human rights has actually become a 'convenient' moral term, so useful and effective in advocacy that, to be on the safe side, everyone (friend and foe of HR) throws it in...just in case. And that is where the danger of abuse and dilution lies.

13. While I am aware of the efforts to expand the traditional HR concept and expect that HR will play some role in areas such as the environment, I am wary that if everyone keeps stretching HR into everything under the sun, within ten years, we risk seeing a huge backlash in the HR arena: whoever mentions the term "human rights" will be suspected of being a dinosaur or a fanatic. In the next five years we will see expansion, but what in ten...? This, of course, does not mean that linking HR to environment issues should not be pursued... (Tran Dinh Hoang, personal communication).

14. The caveat here is that we ought to advocate for a faithful adherence to the established and already sanctioned international legal human rights concept and principles; expansion from there should be cautious, well justified and long-term.
If something is good, use it carefully, consistently and with care...

Claudio Schuftan, Ho Chi Minh City
aviva@netnam.vn

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Sent: Saturday, April 19, 2003 5:08 PM
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From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Saturday, April 19, 2003 8:22 AM
Subject: PHA-Exchange> MTCT meeting - PHM participant report

From: "Mwajuma S. Masaiganah" <masaigana@africaonline.co.tz>
RE: Mother to child transmission (MTCT) plus Meeting report by People's Health Movement Participant.

Firstly, I have the honour to introduce myself to you. My name is Mwajuma Saiddy Masaiganah. I belong to the Peoples Health Movement which is a global movement based in India (for more infor please go to our website www.phmovement.org). PHM is a result of the Peoples Health Assembly which was held in Bangladesh in December 2000, and which came up with the Peoples Charter for Health now available from the website in more that twenty seven (27) languages including Swahili. I am the facilitator for the movement for Eastern and Central Africa.
>From the website you can also get the following information and more: -
1. Health in the Era of Globalization
2. Voices of the unheaard
3. People's Health Assembly - Discussion paper
4. What Globalisation Does to Peoples Health - A PHA booklet (1)
5. Whatever Happened to Health for All by 2000 AD - A PHA booklet (2)
6. Making Life Worth Living - A PHA booklet (3)
7. A war Where We Matter - A PHA booklet (4)
8. Confronting Commercialization of Health care - A PHA booklet (5)

You will get to know more on PHM as we continue collaborating.

Secondly, on 22 February 2003, MTCT plus Secretariat organised a meeting in Johannesburg for a group of African women and Mama Graca Machel launched it as an advisory and advocacy group to share, advice and give leadership to the programme. The MTCT of HIV/AIDS initiative has been started due to the high spread of HIV/AIDS and the effects to mothers and families.

I understand that no one can live or work in isolation, and that is why I am taking this opportunity to introduce myself to you now and share with you the important things that happened and which were shared during this important meeting. This is my personal report as a participant wanting to get the information across as soon as things happen. I understand that MTCT plus will soon circulate the official report of the proceedings of the meeting which will give more details. I can also share that with you as soon as I receive it.

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Mwajuma S. Masaiganah Ms.

Join the "Health for all, NOW" campaign in the 25th anniversary year of the

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Alma Ata declaration visit www.TheMillionSignatureCampaign.org

THANK YOU FOR YOUR ACTIVE PARTICIPATION!

Reports on this meeting can be gotten from Mwajuma directly at his address above.
Claudio

CHC

From: CHC <sochara@vsnl.com>
To: aviva <aviva@netnam.vn>
Sent: Monday, April 21, 2003 12:36 PM
Subject: Re: PHA-Exchange> PHM PRESS RELEASE

Dear Claudio,

Greetings from People's Health Movement Secretariat at CHC, Bangalore!

Thanks for putting the 'let the Children of Iraq Live' press release on the exchange promptly. It seems to have come interspersed with =20. Please clarify if there's any way we should send it to you to avoid this artifact. Unni who does these releases can send it to you in other formats if that will help. Are you going to make it to PHM Geneva?

Best wishes

Ravi Narayan
Coordiantor
PHM Secretariat (Global)
----- Original Message -----
From: aviva <aviva@netnam.vn>
To: <PHA-exchange@KABISSA.org>
Sent: Wednesday, April 09, 2003 10:05 PM
Subject: PHA-Exchange> PHM PRESS RELEASE

> People's Health Movement
> URGENT
> PRESS RELEASE
> Bangalore (India) ; 8th April 2003:
>
> STOP THE WAR ! LET THE CHILDREN OF IRAQ LIVE.
>
> As the World Health Organisation celebrated World Health Day (April
> 7th) =
> on the theme "Healthy Environment for Children" and called everyone to
> =
> join WHO in 'promoting healthy environment for children and make a =
> difference for the future', the Peoples Health Movement (PHM), a global
> =
> coalition. calls for an immediate stop to the war on Iraq and demands "
> =
> Let the Children of Iraq Live!". PHM also expresses concern over the =
> failure of the WHO and UNICEF to take the leadership to campaign
> against =
> the unjust and immoral war on Iraq.

From: aviva <aviva@netnam.vn>
To: <PHA-exchange@KABISSA.org>
Sent: Wednesday, April 09, 2003 10:05 PM
Subject: PHA-Exchange> PHM PRESS RELEASE

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the unjust and immoral war on Iraq.
=20
PHM is a people-oriented global initiative that evolved out of the = People's Health Assembly, a historic summit that was held in December = 2000 in Bangladesh. Over 1453 participants from 92 countries met for the =
People's Health Assembly that was the culmination of 18 months of = preparatory action around the globe.=20
=20
As over 22 million Iraqi civilians especially children are going through =
a traumatising experience as all aspects of their environment - air, = water, land and their homes, schools and local community are being = subjected to the worst form of bombing in world history -PHM exhorts = all UN agencies especially WHO and UNICEF to take the moral leadership =
to campaign to stop the war on Iraq.
=20
The children of Iraq have been subjected to sanctions resulting in a = whole generation of malnourished children.UN agencies estimate that = there has been a 72%increase in the incidence of malnourishment among = children in Iraq since the sanctions. Sanctions also killed over 750,000 =
children. Shortage of medicines has affected children's health more than =
any other sector of the population.
=20

cc Unni
17/4/03
Dear Claudio
Thanks for putting the let the Children of Iraq Live' Press release on the exchange promptly. It seems to have come interspersed with =20. Please clarify if there any way we should send it to you to avoid this artefact Unni who does these releases can send it to you in other formats if that will help Are you going to make it to PHM Best Wishes Ram
RN Ram
17/4/03

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RN
10/4/03

PHan. Ag. Iraq (Anti-war Campaign)

Environmental hazards caused by the presence of depleted uranium and = other chemical hazards from the armaments used in the war will produce

a =
range of health problems including leukemia and hepatic,respiratory and
=
cardio toxic effects. The dropping of ammunition wrapped in yellow =
packing (similar to the food packages dropped by the invading forces) =
will increase the danger to the children as they will access unexploded
=
bombs accidentally thinking them to be food parcels.
=20
Mines and other explosives will continue to maim young children in the
=
years to come. In addition, with the health of their parents at greater
=
risk due to the ravages of war, child care, child health and child =
security will be the biggest casualty.
=20
PHM is particularly surprised at the insensitivity of the recent WHO =
briefing for Iraq dated 4th April 2003, three days before world health
=
day. There is no mention of the risks to children as their environment
=
is ruined by the war on Iraq. In a typical preoccupation with bio =
medical magic bullets the document talks about measles immunizations
r =
6 to 15 year olds which today is not the only hazard the Iraqi children
=
face with their homes, schools, streets,and their communities destroyed
=
by an unjust, illegal and immoral war.
=20
PHM calls upon all health and human rights activists all over the world
=
and agencies like WHO and UNICEF to recognise the gross human rights =
violation of child rights by the invading forces and to join the =
millions of anti war and pro peace protesters round the world in =
demanding an immediate stop to the war. "Give the children of Iraq a =
chance!".=20
People's Charter for Health, the guiding spirit of the PHM, is the =
largest consensus document on health. "Wars, violence, conflict and =
atural disasters devastate communities and destroy human dignity. They

have a severe impact on the physical and mental health of their
members, =
especially women and children. Increased arms procurement and an =
aggressive and corrupt international arms trade undermine social, =
political and economic stability and the allocation of resources to the
=
social sector," says the People's Charter for Health.=20

For the People's Health Movement=20

Dr. Ravi Narayan, Co-ordinator, PHM Secretariat=20

For media enquiries :

PHM Secretariat

From: Adrienne Potter <apotter@csih.org>
To: 'PHA Global' <pha-exchange@kabissa.org>; <PHA-Europe@yahoogroups.com>; <PHA-Europe@yahoogroups.com>; <pha-ncc@yahoogroups.com>
Sent: Wednesday, April 23, 2003 1:22 AM
Subject: PHA-Exchange> [PHA-Europe] 10th Canadian Conference on International Health / 10e Conférence canadienne sur la santé internationale

MARK YOUR CALENDARS!!!
ABSTRACT SUBMISSION DEADLINE IS APRIL 30th!!!

10th Canadian Conference on International Health

The Right to Health: Influencing the Global Agenda
How Research, Advocacy and Action can shape our future

Mark your calendars!

October 26-29, 2003
Ottawa, Canada

Conference Goal: To provide a forum for practitioners, researchers, educators, policy makers and community mobilizers, interested in health and development issues, to share knowledge, experience and promote innovation and collaborative action.

For more information, contact the Conference Secretariat at:
Toll free in Canada: 1-877-722-4140
Phone: 613-722-4140
Email: conference@csih.org

PHM Exchange →
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24/4

****

10e Conférence canadienne sur la santé internationale

Le droit à la santé : influer sur l'agenda mondial
Comment la recherche, la promotion et l'action peuvent influer sur notre avenir

À noter dans votre agenda !

26-29 octobre 2003
Ottawa, Canada

But de la conférence : Offrir une tribune aux practiciens, chercheurs, éducateurs, décideurs et organisateurs communautaires qui s'intéressent

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PHM - Exchange

4/24/03

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Wednesday, April 23, 2003 5:10 PM
Subject: PHA-Exchange> Nestle Supports Right to Food ? (2)

From: <w.b.eide@basalmed.uio.no>

There could hardly be a better illustration to Claudio's concerns in his recent "Neutral food for non-neutral thoughts" than this Nestle-Nigeria appropriation of the right to food.

I think we have feared that this would happen. It is however the first I hear about of the sort. What to do? Can we think of some concerted expression of concern? Or just leave it in order not to awaken sleeping dogs - but how long will they sleep?
I'd be interested in the readers' opinions.
W.

Also from: w.b.eide@basalmed.uio.no
Re: Neutral food for non-neutral thoughts

I just read through this piece ('The ideological neutrality of human rights is its greatest strength, but its proponents should not be neutral in engaging to achieve them' *) and could not agree more with Claudio about the risk that everybody now will join what could become a bandwagon, without bothering to go through the tedious requirements of learning and understanding what it is really about. We should discuss this more. There is a real danger for "inflation" indeed, and one cannot help asking "...where were they (= those who now easily join!) at the time when the work was really so hard and uphill in the beginning .... the lack of support for years will be remembered while one must indeed welcome those who really now are trying, simply because they now do understand more!
>

My personal encouragement that it is possible lies in some of the very successful outcomes of the recent national human rights seminars, notably in Uganda and Mali in particular. Some material from these will soon be posted on our website
W.

*: Human Rights Reader 43

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24/4

PHA-Exchange is hosted on Kabissa - Space for change in Africa

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PHM. Exchange

To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

4/23/03

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Wednesday, April 23, 2003 6:07 PM
Subject: PHA-Exchange> Paradox of wealth transfer from poor to rich nations throughmanpower (4)

From: "Selassi Amah d'Almeida"
> Paradox of wealth transfer from poor to rich nations through manpower
> ---
>
> This is nothing but the truth, and I believe this will continue for a
> long time till poor countries do something about their economies to
> retain labour. This issue goes beyond health professionals, because
> all cadres of trained professionals and untrained citizens are leav-
> ing Africa and other poor countries (I guess) to seek greener pas-
> tures where labour is better rewarded.
>
> At the 52nd Session of WHO Africa Regional Office (AFRO) Regional
> Committee Meeting, Health Ministers echoed their concern about the
> mass exodus of skilled health personnel from developing countries in-
> cluding Ghana mainly to the more advanced countries. The health sec-
> tor is deemed probably to be the hardest hit by this phenomenon.
>
> In view of this, Member States requested WHO and the International
> Organisation for Migration (IOM) to assess the situation in the coun-
> tries as objectively as possible, to determine the magnitude of the
> problem and report back to the 53rd Session of the Regional Commit-
> tee.
>
> Furthermore WHO was requested to assist the countries in defining ap-
> propriated evidence-based strategies for retention of skilled health
> personnel by defining evidence-based appropriated solutions and share
> with countries. To do that calls for an accurate data on migration of
> health professional. A number of countries including Ghana were cho-
> sen to pilot the studies, and since November 2002, questionnaires
> were sent to over one thousand potential respondents (Ghanaian Health
> Professional in diaspora). As at date less than 0.02% have responded,
> but we have lost hope. We will do our best to generate enough evi-
> dence to inform policy to at least enable our brothers and sisters to
> contribute one way or the other in the health care delivery of their
> various countries.
>
> By the time, you have finished reading this mail, at least 2 health
> professionals may be on their way out of their countries to seek
> greener pastures elsewhere.
>
> Selassi Amah d'Almeida
> Health Economics Advisor

DH

RN 24/4

RN 24/4/03 for

PHM. Exchange →

4/24/03

> World Health Organisation
>> Accra, Ghana
> mailto:sadalmeida@whoghana.org

PHM Secretariat

From: Adrienne Potter <apotter@csih.org>
To: 'PHA Global' <pha-exchange@kabissa.org>; <PHA-Europe@yahoogroups.com>; <PHA-Europe@yahoogroups.com>; <pha-ncc@yahoogroups.com>
Sent: Monday, April 28, 2003 8:10 PM
Subject: PHA-Exchange> [PHA-Europe] 10th Canadian Conference on International Health / 10e Conférence canadienne sur la santé internationale

IMPORTANT NOTICE!

10th CANADIAN CONFERENCE ON INTERNATIONAL HEALTH: ABSTRACT SUBMISSION DEADLINE EXTENDED TO MAY 30, DUE TO GLOBAL HEALTH EVENTS

Due to the extraordinary demands of the global health environment, we are extending the deadline for abstract submission to May 30, 2003. The theme for the 10th Canadian Conference on International Health is: "The Right to Health: Influencing the Global Agenda. How Research, Advocacy and Action can shape our future." For more information or to download a copy of the Call for Abstracts, visit the conference website: http://www.csih.org/what/conferences2003.html.

To discuss in PHM Geneva
↓
Canadian Coalition to organise PHM-Canada meetings
RN
7/5/03

10e CONFÉRENCE CANADIENNE SUR LA SANTÉ INTERNATIONALE : LA DATE D'ÉCHÉANCE POUR SOUMETTRE VOS ABRÉGÉS A ÉTÉ PROLONGÉE À CAUSE DE LA CONJONCTURE MONDIALE DANS LE DOMAINE DE LA SANTÉ

Dû aux contraintes extraordinaires qui affectent la santé mondiale, nous avons prolongé la date limite pour la soumission des abrégés au vendredi 30 mai 2003. Cette année, le thème de la conférence est : « Le droit à la santé : influencer l'agenda mondial - Comment la recherche, la promotion et l'action peuvent influencer notre avenir ». Pour plus d'information ou pour le formulaire de soumission d'abrégé, visitez le site Web de la conférence : http://www.csih.org/what/conferences_f2003.html.

10th Canadian Conference on International Health

The Right to Health: Influencing the Global Agenda
How Research, Advocacy and Action can shape our future

Loseyet pravoui

Mark your calendars!

October 26-29, 2003
Ottawa, Canada

PHM-Exchange

Conference Goal: To provide a forum for practitioners, researchers, educators, policy makers and community mobilizers, interested in health and development issues, to share knowledge, experience and promote

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innovation and collaborative action.

For more information, contact the Conference Secretariat at:
Toll free in Canada: 1-877-722-4140
Phone: 613-722-4140
Email: conference@csih.org

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19e Conférence canadienne sur la santé internationale

Le droit à la santé : influer sur l'agenda mondial
Comment la recherche, la promotion et l'action peuvent influer sur notre avenir

À noter dans votre agenda !

26-29 octobre 2003
Ottawa, Canada

But de la conférence : Offrir une tribune aux praticiens, chercheurs, éducateurs, décideurs et organisateurs communautaires qui s'intéressent aux questions relatives à la santé et au développement, pour qu'ils puissent échanger leurs savoirs et leurs expériences afin de promouvoir des solutions novatrices et concertées.

Pour tout renseignement, prière de s'adresser au secrétariat de la conférence :
Numéro sans frais (au Canada) : 1-877-722-4140
Téléphone : 613-722-4140
Courriel : conference@csih.org

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Cc: <community-health-l@mail.msh.org>
Sent: Friday, April 18, 2003 5:10 PM
Subject: PHA-Exchange> PAHO launches virtual public health campus

From: "Dieter Neuvians MD" <neuvians@mweb.co.za>
> PAHO launches virtual public health campus
> ----------
> Washington, DC, April 10, 2003 (PAHO) - The Pan American Health Or-
> ganization (PAHO), in association with 14 academic institutions in
> the Americas and Spain, launched a Virtual Public Health Campus as a
> tool to provide continuing education to public health personnel in
> the Americas, offering a variety of distance education courses to
> contribute to public health policy-making and to the performance of
> health systems in the Region.
>
> The Virtual Campus of Public Health is a virtual community offering
> communication exchanges to generate useful knowledge, training and
> debate between individuals and institutions on priority issues re-
> lated to health sector reform processes and the management of essen-
> tial public health functions, as well as health management and the
> institutional development of schools of public health.
>
> The English version of the virtual campus can be found at:
> http://www.campusvirtualsp.org/eng/index.html

PHA-Exchange is hosted on Kabissa - Space for change in Africa
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Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

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22/4/03

SSP Action taken 09/05/03
Please download the main home page and details about the virtual campus and circulate to me/TN/CMF/PK May be useful help to PHM/CHC contacts if it is in English
RN
22/4

PHM - Exchange

PHM Secretariat

From: vena persaud <perbois@hotmail.com>
To: <sjabbour@aub.edu.lb>; <pha-exchange@kabissa.org>
Sent: Monday, May 05, 2003 3:04 AM
Subject: Re: PHA-Exchange> Trade in health services

Dear Samer,
You may want to look at some of the work that Dr Ron Labonte, University of Saskatchewan, Canada, has been involved in re globalization and health. He examines trade and health services from a population health/health promotion perspective.
Best wishes,
Vena

>From: "Samer Jabbour" <sjabbour@aub.edu.lb>
>To: "PHA exchange" <pha-exchange@kabissa.org>
>Subject: PHA-Exchange> Trade in health services
>Date: Sat, 3 May 2003 22:37:52 +0200
>
>Dear Friends,
>
>Last year, PAHO and WHO published a book/report called "Trade in Health
>Services: Global Regional and Country Perspectives" while compiles the
>proceedings of a meeting held in 1999 at PAHO headquarters in
>Washington, DC. Do you know if anyone has looked critically at the
>contents of this report? Do you know of resources/articles on the
>subject of trade in health services which examines the subject from a
>perspective that is close to what is represented by members of this
>list?
>
>Many thanks
>
>Samer

— RN

RD 6/5/03

PHM Exchange→

RN 6/6/03

>
>
>
>----------
>Samer Jabbour, MD, MPH
>American University of Beirut
>Van Dyck Hall
>Beirut, Lebanon
>Tel: +961-1-374-374
> x4640 (Sec.) x4642 (Direct)
>Fax: +961-1-744-470
>http://www.aub.edu.lb
>

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Satya Sivaraman <satyasagar@yahoo.com>
Sent: Thursday, May 01, 2003 5:15 PM
Subject: Fw: PHA-Exchange> The SARS farce?

Dear Satya,

Greetings from People's Health Movement Secretariat (Global) at CHC, Bangalore!

Thanks for this very humane, proactive and thought provoking piece on SARS. Keep it up.

Best wishes,

SSP
Please print
Gut Article only.
in Lasertet

RN
2/5

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org
----- Original Message -----
From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Tuesday, April 29, 2003 6:23 PM
Subject: PHA-Exchange> The SARS farce?

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>
> SARS, Wars and the FARCE
> Satya Sagar
>
> The depression hits me on a warm and humid Bangkok evening. I am just
> through with dinner in the city's crowded Sukhumvit business district, my
> head full of the War on Iraq and I spot these people- with masks on their
> faces.
>
> A couple of weeks ago anybody with a cloth covering his face in this city
> would have been branded a `jihadi' a possible Arab/Muslim/dark skinned dark
> intentioned `terrorist'. The city has been on alert well before the war on
> Iraq started to prevent `Arab looking' people from doing bad things- for
> eg., looking Arab.

5/1/03

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Tuesday, April 29, 2003 6:23 PM
Subject: PHA-Exchange> The SARS farce?

SARS, Wars and the FARCE
Satya Sagar

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Just around the time of the Anglo-American attack on Iraq, if there were to be an `Arab' behind a mask in Bangkok - the entire city would have been evacuated.

Apparently, not anymore. Respectable people wear masks now in Thailand, Singapore, Malaysia, Hong Kong. In fact mandatory they say to save yourself from SARS- the flu-like virus that has much of south-east Asia in deep panic. Tourists are canceling their trips in droves, schools are closing down, economies plunging, governments in crisis and the Chinese- oh those `super-contaminating Chinese'- are being spurned everywhere.

Suddenly, an irrational panic grips me. God- there is no escape. If the Apostles of Armageddon running the White House do not get you some mysterious malevolent microbes will. For a fleeting moment, a deep frozen moment, I lose hope. We are finished. They will get us one way or the other.

This is what the new/OLD colonial world order is going to be all about- complete helplessness for us common citizens. Caught between SARS and THEIR Wars the only safe place is soon going to be- you guessed right- on planet Mars.

Yes, the people I saw wearing those masks have a right to protect themselves. I will not mock them in any way. To paraphrase Voltaire I do not believe these masks medically help them in any way but I will defend to death their right to wear them. And then there are so many of THEM out there who deserve to have a mask fixed on their faces anyway (so we won't have to `read their bloody lips').

Yes, there are these microbes and many of them are dangerous. Yes, people

DGS

Dear Satya
Thanks for the
this very humane,
provocative and
thought provoking
piece on SARS. Keep
it up.
Best wishes
Ron

→ Forward
BSP
i) PHA- ncc yahoo
Group
ii) mfc yahoo group
iii) AID Bangalore
and other AIDs

30/4

PHM - Exchange

have died and still continue to do so. And it is indeed true we really do not know which way this pandemic is going to turn out. There are constant references to the great Influenza outbreak after World War One which killed an estimated 20 to 40 million people. Is SARS going to be that big ?

I am no kin to any Indian sage and I cannot predict such things. But I am betting neither can the `medical experts' or the `media' give us a real idea of what is going to happen. At this stage, given the sparse information on hand about SARS, it is all idle speculation- an activity that SOME people usually make lots of money out of.

Even assuming the deeply depressing thought that much of humanity is going to be wiped out by SARS over the next year (that is what the media is making it sound like) let us take a step back from this approaching abyss, take a deep breath (go ahead, do it while it is still safe) and reflect on a few questions about other aspects of this PANDEMONIUM of a pandemic.

First the CONTEXT: Why are we so full of fear only of THESE microbes and not those dozen other ways in which people die completely avoidable deaths ?

To anyone who is not already aware of these facts let me spell them out:
- 250,000 to 500,000 people die every year around the world due to ordinary influenza, the common `garden variety' flu. In the United States alone, with vaccine and medical care available, flu kills 36,000 people die every year.
- Anywhere between 1 to 2.7 million die every year due to Malaria- a vast majority of them in Africa, particularly children
- Tuberculosis kills 2 million people every year and 98 per cent of these in developing countries
- HIV/AIDS claimed 3 million lives in 2002, including an estimated 610,000 children.
- Traffic accidents kill 300,000 people every year in Asia alone.
- The Anglo-American invasion of Iraq killed at least 10 to15,000 Iraqi soldiers and over 2,300 Iraqi civilians in just the initial two weeks and maybe several hundred British and American troops.

And I am not even counting those millions who die of poverty and malnutrition around the globe annually. Every year the Indian media attributes hundreds of deaths to the `cold wave', `the heat wave', `too much rain' and `too little rain'. The fact is these deaths have nothing to do with the weather- in my country there people die every hour, wantonly, in PERFECTLY good weather. We all know WHY.

I would say this. If we choose to cover our faces let it be in anger and in shame- not just due to some microbes alone.

The RECORD so far: Here is the latest status of the number of SARS cases worldwide and deaths so far since 1 November 2002 when the disease is

supposed to have broken out in southern China. In almost six months since the outbreak a total of 4439 cases of SARS and `suspected' SARS have been recorded in 26 countries and 263 people have died. The mortality rate due to SARS is estimated between 3 to 4 percent- just above that of normal influenza-but even this is not confirmed because the total number of real SARS cases is not yet known. Nor is its exact method of transmission clearly understood- which is why wearing masks may not be a useful precaution at

The MEDICAL ESTABLISHMENT: The alarm bells about SARS started ringing only when the WHO issued a global alert in mid-March . A war of words broke out soon between the WHO and the Chinese health authorities- the latter being accused of 'hiding information' about SARS in its first few months. The Chinese said something back, which nobody understood (they are never going to be a `superpower' this way).

One of the big critiques of bodies like the WHO from health activists has been the way they have adopted a purely `vertical' approach to global health problems at the cost of a sustained, holistic and long-term approach. So whenever there is an outbreak or more usually an `outcry' about a particular disease WHO and other global health officials organize a `posse', mobilize some resources, and ride into the wilderness ready to `lasso' the villain. Once the `critter' is temporarily caught or suppressed the issue is then mostly forgotten.

There is no attempt to even address underlying causes of new virus and diseases emerging for eg., due to super-intensive techniques of animal husbandry, recycling of animal offals in animal feed, the use of a variety of artificial hormones and growth-enhancers and of course from biological warfare experiments. Nor is there any attempt to mitigate the conditions, such as overcrowding, poverty and lack of housing infrastructure, under which infectious diseases such as SARS spread so rapidly. The WHO has failed to push policies that tackle other basic social and economic determinants of public health also - such as conflict, environmental pollution and privatization of health care.

The MEDIA: Has anybody really asked how much of the SARS scare is due to the media's penchant for simplistic, alarmist reporting ? One of the first `big ' SARS cases to make the headlines was that of Johnny Cheng, a Chinese-American businessman who died at a hospital in Hanoi, Vietnam after flying in from Hong Kong. Just a month ago Hanoi was one of the `epicentres' of the SARS pandemic going by media reports. No more. The country seems to have slipped down the hit list of `no go' places with just 63 reported SARS cases and 5 deaths.

How did this `super-contagious', `killer' disease get contained in a crowded country like Vietnam with a very average public health system ? Nobody in the media is following the Vietnam story anymore because that is not on the map of the usual globe-trotting elites. Hong Kong, Singapore and Toronto are on that MAP and hence the panic about viruses traveling on the business

4/30/03

class seat next to THEM. (If nothing else, maybe there is a great `success story' out there in Vietnam, with details of how a poor, third world country has successfully contained this deadly new infectious disease.)

And what happened to the media follow up to the various other health scares we have had in the past decade all around the globe ? Bubonic plague in India, Ebola in Africa, the Mad Cow Disease in the UK (I won't take a dig at Tony B on this one) ? And why was there virtually no coverage in the `international media' of the influenza outbreak in Madagascar in mid-2002, where more than 27 000 cases were reported within three months and 800 deaths occurred despite rapid intervention ?

There is an apocryphal story going around this part of the world which shows how much of a media `thing' this SARS scare probably is. The question asked is why is this new form of flu being called the Severe Acute Respiratory Syndrome ? `Severe' and `Acute'- two synonymous terms together - WHY ? Apparently- the term `Severe' was added (only in early March this year) to avoid an awkward acronym resulting from what was originally dubbed the Acute Respiratory Syndrome ? What's the secret here- cover your face and save your --- ?

That story is most probably a bad joke-but let me tell you- I think so is the way the entire SARS scare is being reported and played out.

I AM NOT SAYING that the deaths due to SARS are not a real, serious tragedy or that it could not turn into a dangerous pandemic. Far from it. There is no moral mathematics involved here, please. Every human life is precious- Iraqi or American, Chinese or Singaporean. A very unique, irreplaceable Universe of its own- disappears forever with each physical death. All I am pleading for is some more PERSPECTIVE.

WHY are those dying of malaria, tuberculosis, HIV/AIDS and poverty in most developing countries every day not making the headlines ? Is it not because those who die unseen, unheard, untreated are not in the same league as the Gold Card holding frequent flyers of our world ? Is it not because there is such a `low probability' of a TB infected African child coughing in the same air-conditioned corridors as our elites frequent ?

A couple of years ago a senior editor of one of India's major newspapers, when asked by a women's rights activist to publish a story about high rates of malnutrition among girl children, is reported to have refused and said ` The readers of our newspaper do not suffer from malnutrition'. Sure, Mr Let Them Eat Cake- but aren't YOU and YOUR readers who are the CAUSE of malnutrition in India. (Ahem, what I wanted to say was -' Will someone pass me that cutting edge of the French Revolution !')

When one hears stories such as these a question arises in my mind. This is just a nasty, nasty question that I just can't get out of my head. COULD IT BE that those who die unseen, unheard, untreated are themselves MICROBES in the worldview of our Masters ? Has the microbe become a metaphor for the

unwashed, unwanted millions who don't fit into the corporate globalisation of our Empire builders ?

Good riddance, THEY suppose, of those teeming, troublesome microbes- of so little value to the Empire. Microbes, who cannot afford to BUY and have nothing to SELL.

And from this high point of MORAL CLARITY it is just a little leap away to identifying those other microbes that need to be dealt with. The bearded, turbaned, different, DISSIDENT, multi-tongued microbes. To be screened and searched at every airline check-point, discouraged, disinfected, disposed off like a dirty secret. Microbes, whose very EXISTENCE, is a form of biological warfare to SOME.

No, I really want to bring this subject up. However depressing the subject is to me and many of you reading this. It is important to see where our dear world is headed towards. A world in which there are perishable, pestilent MICROBES and there are those HUMAN BEINGS- moulded in the image of GOD.

OK, OK not all of us are microbes of course. Many of us are a slightly higher caste- tolerated, employed, paid, domesticated, sheep, cattle. And there is also that special category - well-fed, trained dogs. God bless the creatures- I really have nothing against their species. (In fact, some of them are my best friends) But I can't help objecting to the worst of canine qualities that many of these four-legged ones in our midst display. Whining and Dining with the Masters, Biting and Barking at the Poor.

I know all this is getting a bit too depressing and I don't like it one bit. I have been reading too much Orwell these days, and that too, on the front pages of daily newspapers.

So how does one get out of this Animal Farm we all seem to be trapped in ? I would say- let's go back to our roots and our traditions- the great traditions of the ancient microbes.

Think of it- the microbes- the first form of LIFE on Planet Earth. Microbes- mating, multiplying, mutating into higher, more virulent forms of cognitive, COMBATIVE life. Weathering all storms, RESISTING all predators and surviving every sterile environment. Microbes evolving, exploring, EXPLODING till every form of LIFE finds its place under the sun.

I have got it figured now. What this globe really needs now is a Movement of All Microbes and the Mother of All Movements. A million MOAMS to match the challenges ahead.

Satya Sagar is a journalist based in Thailand. He can be reached at
sagarnama@yahoo.com

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Monday, April 28, 2003 11:47 AM
Subject: PHA-Exchange> Food for not so childish thoughts (2)

Re: HR Reader 44

From: "George Kent" <kent@hawaii.edu>

>3. Moreover, HR have no time limit: up until a specific right is fully realized, this right is violated. This brings into serious question the setting of goals to 'halve poverty or malnutrition'. [So, should we continue to pursue goals such as halving malnutrition by 2015...?].

-Why would the first sentence here bring into question the merits of setting time-bound targets en route to the goal? I could see questioning any government that set the targets too low, but the idea of targeting as such, as a tool of strategic thinking, has merit.

> 6. Rights are to be seen as our exercise of free will and of choice and are, therefore, dependent on the claim holders' capacity to have their rights enforced.

- This might be clearer if written something like this: Rights holders and their representatives (e.g., parents for children) should have the capacity and the opportunity to take action to insist that those who have the corresponding duties do in fact carry out their duties.

> To have rights is not dependent on having current capacity to exercise or assert them.

- This seems to contradict your preceding sentence. I would rewrite it as: "However, rights holders retain their rights even if they are unable to take any action to demand their realization."

RN
28/4/03

> There is a fundamental difference between protecting children --because they are dependent (and deserve our compassion)-- and respecting children, because they are powerful. [Actually, the CRC prohibits those who already have power from exerting that power over children].

- Where does the CRC prohibit that? I am not sure... Even parents?

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— RN

2-8/4/03

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: jamie <jamie@netnam.vn>
Sent: Sunday, April 27, 2003 4:31 PM
Subject: PHA-Exchange> Food for not so childish thoughts

Human Rights Reader 44

An introduction to Children's Rights.

Review of some of the general underlying principles:

1. The motivation to realize all human rights (HR) should be based on a sense of justice and solidarity; compassion is not the right motivation.

2. In this domain, Governments have Obligations of Result (e.g., achieving the Millenium Goals) and Obligations of Conduct (e.g., implementation of a plan to achieve the latter). Remember that they do not have the option to indefinitely defer efforts to ensure the full realization of these obligations; they have to immediately begin to take steps to fulfill them. In that sense, we can identify HR violations through the direct action of States and through their omissions. The latter, because there are minimum core State obligations to ensure the satisfaction of, at the very least, minimum levels of each of the violated rights. Remember also that resource scarcity does not relieve States from these minimum obligations and that all basic needs are HR (but not vice-versa). HR cannot be prioritized either, but actions to reduce and end their violation can and should e prioritized (in the form of concrete, explicit plans).

3. Moreover, HR have no time limit: up until a specific right is fully realized, this right is violated. This brings into serious question the setting of goals to 'halve poverty or malnutrition'. [So, should we continue to pursue goals such as halving malnutrition by 2015...?].

4. Always keep in mind that a HR approach does not only change what we should do, but it will also change why and how we do our work. The first change is to recognize poor people --and children-- as protagonists in their development; this requires changing the mentality of all sorts of development workers. There simply cannot be a HR-based society without individuals who have internalized the HR philosophy (hence this Reader).

RN 28/4/03

Realizing children's rights:

5. All human beings have HR, whether or not a particular country has ratified a specific universal instrument. For example, children in the USA --which has not yet ratified the Convention of he Rights of the Child-- have every bit the same rights as children living in countries that have

— RN

28/4/03

ratified the CRC.

6. Rights are to be seen as our exercise of free will and of choice and are, therefore, dependent on the claim holders' capacity to have their rights enforced. To have rights is not dependent on having current capacity to exercise or assert them. There is a fundamental difference between protecting children --because they are dependent (and deserve our compassion)-- and respecting children, because they are powerful. [Actually, the CRC prohibits those who already have power from exerting that power over children].

7. UN-sanctioned conventional HR basically regulate the relationships between individuals and the State. The CRC is different. Towards children, it recognizes duties of parents and other non-state duty bearers at all levels of society, including at the international level.

8. Not infrequently, the violations of children' rights are a direct result of the violation of the rights of their care-givers own HR. To begin with, a large majority of children whose rights are violated live in poor families and poor communities. Therefore, a child-rights approach must always also be focused on the alleviation of the poverty of the family. So, when we advocate and mobilize for the realization of children's rights, we have to do that in the larger context of HR, including women's, children's and other pertinent economic, social and cultural rights.

9. Always keep in mind that rights are not just claims, but claims against someone! Therefore, in the Children's Rights domain (as much as in other HR domains), capacity building has to be empowering so as to empower children's guardians to confront Government inertia, as well as to empower children themselves (yes, children...) to claim their rights.

Claudio Schuftan, Ho Chi Minh City
aviva@netnam.vn

Mostly taken from U Jonsson, Realization of Children's Human Rights: Charity or solidarity?. Mimeo. 1997.

PHM Secretariat

From: nadira.ashraf <nadira.ashraf@aku.edu>
Cc: fauziah.rabbani <fauziah.Rabbani@aku.edu>; imtiaz.jehan <imtiaz.jehan@aku.edu>; salman.sabir <salman.sabir@aku.edu>; israr.syed <israr.syed@aku.edu>; amin.hirani <amin.hirani@aku.edu>; sarah.saleem <sarah.saleem@aku.edu>; nasiruddin.muhammadali <nasiruddin.muhammadali@aku.edu>; parvez.nayani <parvez.nayani@aku.edu>; masood.kadir <masood.kadir@aku.edu>
Sent: Monday, May 19, 2003 1:18 PM
Attach: RegPHC2003-nak1-e.doc
Subject: PHA-Exchange> Continuing Education Program Courses - 2003

Official: Yes

<<RegPHC2003-nak1-e.doc>>

ANNOUNCEMENT!!!

Continuing education program Courses – 2003

Dear Sir/Madam,

This is with reference to our earlier announcement of February 10 and 25, 2003 regarding short training courses of year 2003. We are pleased to announce that in addition to our existing courses, we are now also offering a new course on **"Primary Health Care"**. Updated list of the courses is as follows:

	Course	Date	Deadline to Receive Applications
1.	Statistics, Data Management & Analysis, and Computer Skills	July 1 – 30	May 15, 2003
2.	Epidemiology, Biostatistics and Surveillance	August 1 – 29	May 30, 2003
3.	Primary Health Care	August 6 – Sep. 4	June 30, 2003
4.	Health Systems Research and Management	September 8 - 26	July 25, 2003

Detailed information of the courses is available at:
http://www.aku.edu/news/majorevents/chscourse/index.htm whereas brief information on the Primary Health Care (PHC) course is given below:

PHC Course: A four weeks course (21 working days - eight hours a day, five days a week) will be held from August 6 – September 4, 2003 at the Department of Community Health Sciences, Aga Khan University, Karachi. This course mainly focuses to build upon and compliment existing knowledge and skills of frontline and other related healthcare providers in Primary Health Care and to equip them with necessary tools for improved performance in Primary Health Care. For more detail visit the above mentioned site. Electronic version of the registration form is also attached for convenience of those not having access to web site.

Goal of the Course: This course aims to train participants in Primary Health Care philosophy, principles, concepts and strategies, and focus on key techniques, to supplement their knowledge and hands on experience; enabling them to provide leadership in effective Primary Health Care as an essential component of healthcare system.

Course Contents:

- Health and Development and Healthcare Systems
- Primary Health Care and Community Health

PHM - Pakistan →

5/26/03

RN
26/5/03

- Communication Skills and Quality of Care
- Community Participation and its Importance for Healthcare
- Community Health Program Management
- Reproductive Health and Child Survival Strategies
- PHC and Communicable and Non-communicable Diseases and Environmental Health
- Primary Health Care Revisited

- Field Based Training on PHC techniques

Teaching Methodology: The basic educational strategy will be "Learning By Doing", with participatory approach. The interactive classroom sessions, group work and panel discussions will be complemented with relevant field based exposure for experiential learning.

Course Fee: Pak. Rupees 17,600.00, which covers classroom instructions, field visits, course material, simple lunch and refreshments during working hours. Travel, boarding and lodging during the course period, and self-care arrangements will be the responsibility of the participant(s) or their parent organization(s).

Accommodation: We can facilitate accommodation arrangements for interested participants at the Higher Education Commission (HEC) guesthouse, depending on the availability of vacant rooms. This is an average guesthouse, situated at about 15 minutes walking distance from the Aga Khan University campus. It has single rooms with double occupancy at approximately Rs. 700 per room per night excluding meals, which are available at request. The payment must be made directly by the participants or by their sponsoring agencies to Director, Higher Education Commission, Regional Office & Foreign Students Centre, Stadium Road, Karachi. Tel: 9231476; Tel/Fax: 9231477, preferably through demand/bank draft in favour of 'Higher Education Commission, Karachi'. **Should you desire accommodation at the HEC Guest House, please inform us by indicating in the registration forms to arrange accordingly.**

The last date of receiving applications is **June 30, 2003**. Participants will be selected on the basis of criteria set by the program.

We encourage you/your colleagues, friends to apply as soon as possible for the Health Systems Research and Management, and PHC Courses as seats are already occupied for other courses. Interested individuals/organizations should submit a brief bio-data along with filled registration form to Mr. Amin Hirani, Program Officer, Continuing Education Program, Department of Community Health Sciences. His e-mail address is: amin.hirani@aku.edu and telephone contact is 4930051 (Extension 4839) or 48594839 (Direct).

Please feel free to contact us for any further information you may need about the course.

Best regards,

Nadira Ashraf

Coordinator

Educational Administrative Support Unit

Department of Community Health Sciences

Tel: 92-21-4930051 Ext: 4802/4839

92-21-48594802 (Direct)

Fax: 92-21-4934294, 4932095

E-mail: nadira.ashraf@aku.edu

Continuing Education Program

Department of Community Health Sciences
The Aga Khan University, Karachi, Pakistan.

Primary Health Care Training Program

August 6 – September 4, 2003

Full Name (capital letters):_____

Sex : Male ☐ Female ☐ Age:_____

Qualifications: _____
(with degrees)

Current Designation :_____

Job responsibilities :_____

_____

_____

_____

Organization :_____

Mailing Address :_____

_____

Telephone - Office :_____ Home:_____

Mobile :_____

Fax :_____

E-mail address, if any :_____

Did you have any training(s) in PHC? Yes ☐ No ☐

If yes, specify:

Training course_____

Institution:_____Date: _____

Are you involved in any PHC projects? Yes ☐ No ☐

If yes, please mention name(s) of the project(s) with date(s) (if any):

_____

_____

_____

Your future goal, objectives, and expectations from the course!
(Please attach one page)

Accommodation Required: YES ☐ NO ☐
(@ Rs. 700/- per day/room)

If YES, please give your preference SINGLE OCCUPANCY ☐ DOUBLE OCCUPANCY ☐

Tuition Fees: Pak. Rupees 17,600.00, which covers classroom instructions, field visits, course material, simple lunch and refreshments (Mode of payment will be communicated to selected participants).

Please complete this form and mail/e-mail or fax it along with your **CV and one page on your future goal, objectives and expectations from the course by/before, June 30, 2003** to Mr. Amin Hirani, Program Officer, Continuing Education Program, Department of Community Health Sciences, The Aga Khan University, Stadium Road, P.O. Box 3500, Karachi 74800, Pakistan; Tel: (92) 21 4930051 (Ext: 4839/4802); Direct Lines; 48594839/48594802; Fax: (92) 21 4934294; E-mail: amin.hirani@aku.edu/ nadira.ashraf@aku.edu

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>
Sent: Friday, May 23, 2003 4:14 PM
Subject: PHA-Exchange> Efforts to overcome patent obstacles

Dear exchangers. I am in Sudan and had 6 ds of problems with my remotemail so pha-exch was silent. I have solved the problem and am on line again. Sorry, you may get many pending messages in the next 3 ds.
Claudio
your moderator

Medecins Sans Frontieres (MSF) Puts Drug Patents Under The Spotlight

Geneva, 22 May 2003 - A few days before the 192 countries at the World Health Assembly (WHA) discuss "intellectual property rights, innovation and public health" (provisional agenda item 14.9), MSF is releasing a report setting straight common misconceptions about patents and highlighting country efforts to overcome patent obstacles to accessing life-saving medicines.

"Patents are social policy tools," explains Ellen 't Hoen, MSF Campaign for Access to Essential Medicines. "When patents are issued for a method of swinging sideways on a swing, no-one's life is in the balance. But when it comes to pharmaceuticals, intellectual property must be weighed against the needs of people whose lives depend on medicines."

Most developing countries' patent laws are still modelled on developed country systems. But in developed countries, patents are regularly challenged in court and in some cases deemed invalid. In developing countries, the practice of contesting patents has not been established. As a result invalid patents remain in place.

"Developing countries should not hesitate to check and challenge the validity of patents," says Ellen 't Hoen. "This is already beginning to happen in some countries, such as Kenya and Thailand."

An example cited in the report is the case of Bristol-Myers Squibb's (BMS) ARV ddI. In one of the few cases of a patent being contested in a developing country, the Thai Central Intellectual Property and International Trade Court ruled to throw out the patent on a particular dosage of the drug. The Doha Declaration on TRIPS and Public Health was cited in the court's brief.

The report also makes public all the information MSF has gathered on 18 drugs in 29 countries so that Ministries of Health and non-profit purchasers can benefit from the information, and not be bullied into

buying more expensive drugs when it's not necessary.

MSF appeals to the World Health Organization (WHO) and the World Intellectual Property Organization (WIPO) to continue this work by setting up a user-friendly, public database providing comprehensive and transparent data on pharmaceutical patents of key medicines. This information should be accompanied by clear advice to countries on how to overcome patent barriers to medicines, and with technical assistance in doing so.

You can find the full report "Drugs Patents Under The Spotlight" at the following address:
www.accessmed-msf.org/documents/patents_2003.pdf and a "highlights" document summarising the key points of the report at
www.accessmed-msf.org/documents/patents_2003highlights.pdf

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: <PHA-EXCHANGE@KABISSA.ORG>
Sent: Friday, May 23, 2003 6:12 PM
Attach: clip_image001.gif
Subject: PHA-Exchange> PHC:More Action Less Words please! Revive the spiritof Alma Ata! Press release from the PHM

22 May 2003 03:12:57 -0700

People's Health Movement
URGENT PRESS RELEASE
Primary Health Care: More Action Less Words please!
Revive the spirit of Alma Ata !
Geneva, May 21: The People's Health Movement welcomes the proposed adoption of a resolution affirming the Alma Ata vision of Primary Health Care (PHC) as the cornerstone of national health systems by member states of the World Health Organization.

PHM however believes that the WHO, as well as many member states, while paying lip service to the PHC approach have been in practice promoting a completely different route, often detrimental, to public health. The Who's current approach is highly selective and disease focused and driven by donor initiatives at the expense of people-centred and holistic approaches.

PHM therefore calls upon the WHO to return to the original Alma Ata vision that promised `Health for All` by providing primary health care while at the same time tackling the underlying socio-economic and political causes of disease. Health, according to the PHM is a basic human right and neither charity nor a mere input to economic growth.

The PHM also warmly welcomes the statements made by the New Zealand, South African, Nigerian and Thai delegations to WHA, 2003 that variously called upon the WHO to address inequalities in access to health care and not to reduce the PHC concept to a set of 'nice words'. The statement of one of these delegations pointing out that PHC is not just about diseases and technology and requires a comprehensive approach is also to be applauded. The delegations have welcomed the WHO resolution on PHC but called for it to be strengthened in a number of ways.

PHM Media Release->
RN 26/5/03

'There is little point in constructing a perfect building if the foundation is weak. Primary Health Care is the foundation of health systems globally" said the delegate from New Zealand.

'We need to set specific targets for Primary Health Care funding' said a representative of the Nigerian delegation suggesting that 40 % of the

health budget be set aside for Primary Health Care.

According to the PHM, the proposed resolution on PHC to be adopted at the World Health Assembly, 2003 while talking about the health needs of the disadvantaged ignores the following factors that affect public health, especially of the very poor:

- Increasing global inequities - the gap between developing and developed countries is growing

- Increasing inequities within countries

- Declining life expectancy in many African countries where HIV/AIDS offers new challenges for PHC which are not acknowledged in the resolution

- The absolute number of people living in poverty has increased world wide and sharply in some regions.

According to the PHM the major cause of the growing inequities, both within and among countries, is the increasingly unipolar world economic order and its impact on the lives and livelihoods of people around the world. Neither the Who's global report nor the resolutions acknowledge this impact. Until the world is characterised by fair economic and trade relationships the promise of Health for All cannot be achieved.

Neo-liberal economic policies and World Bank/IMF inspired `health reforms` being pushed through in developing countries have resulted in:

- Privatisation of public health services

- The introduction of user fees for patients

- Lack of public investment in state-run primary health care systems

- Lack of attention to leadership and management development for PHC

Sharp reductions in basic vaccination coverage since 1990 are stark evidence of this.

All this has obviously also resulted in the overall deterioration in quality and equitable delivery of public health services and had a devastating effect on the ability of the poor to access health care.

PHM calls for wider consultation between WHO and civil society members to revive the goal of Alma Ata!

'Governments have a fundamental responsibility to ensure universal

access to quality health care, education and other social services according to people's needs, not according to their ability to pay' People's Charter For Health. The Charter, the guiding spirit of the PHM is the largest consensus document on health in the world.

Dr Ravi Narayan
Prof. David Sanders
Co-ordinator- PHM Secretariat
International People's Health Council & PHM

Dr. Armando De Negri
ALAMES (Latin American Association for Social Medicine) & PHM

For media enquiries, please call: May 15th till May 24th

Geneva: Local mobile: 078- 876 5437 (dial +41 78 876 5437 from abroad)
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PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>
Sent: Saturday, May 24, 2003 9:44 PM
Subject: PHA-Exchange> New book - Poverty Health and Development

From: sunil.deepak@aifo.it

Dear all,

AIFO is an Italian NGO, firmly committed to the goals of People's Health Movement. Our new book (Health Cooperation Papers volume 17) on Poverty Health and Development is finally ready. Many persons linked to PHM have contributed articles to this book. The book was officially released during the NGO forum at the World Health Assembly in Geneva on 21 May 2003. The list of articles and authors is given below.

If you wish to receive a free copy of the book, please send an email to Ms. Felicita Veluri at the folowing address: <felicita.veluri@aifo.it>

The book will be available also on the AIFO webpage (under publications) for complete download by the end of June 2003.
http://www.aifo.it/english/homeenglish.htm

With best wishes,

Sunil

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Director, Medical Support Department
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Homepage: www.aifo.it

RM 26/6/03

HCP VOLUME 17 - HEALTH, POVERTY AND DEVELOPMENT

CONTENTS

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>
Sent: Saturday, May 24, 2003 10:01 PM
Subject: PHA-Exchange> Public-Private Partnerships for Public Health

From: EQUIDAD@LISTSERV.PAHO.ORG

>Public-Private Partnerships for Public Health
>Edited by Michael R. Reich
>
>Published by Harvard Center for Population and Development Studies,
>2002
>Harvard Series on Population and International Health
>
>Online book available as PDF file [218p.] at:
>http://www.hsph.harvard.edu/hcpds/partnerbook/Partnershipsbook.PDF
>
>".....Global health problems require global solutions, and
>public-private
>partnerships are increasingly called upon to provide these solutions.
>Such
>partnerships involve private corporations in collaboration with
>governments,
>international agencies, and non-governmental organizations. They can
>be very
>productive, but they also bring their own problems. This volume
>examines the
>organizational and ethical challenges of partnerships and suggests
>ways to
>address them.
>
>How do organizations with different values, interests, and worldviews
>come
>together to resolve critical public health issues? How are shared
>objectives
>and shared values created within a partnership? How are relationships
>of
>trust fostered and sustained in the face of the inevitable conflicts,
>uncertainties, and risks of partnership? This book focuses on
>public-private
>partnerships that seek to expand the use of specific products to
>improve
>health conditions in poor countries. The volume includes case studies
>of
>partnerships involving specific diseases such as trachoma and river
>blindness, international organizations such as the World Health

>Organization, multinational pharmaceutical companies, and products
>such as medicines and vaccines. Individual chapters draw lessons from
>successful
>partnerships as well as troubled ones in order to help guide efforts
>to
>reduce global health disparities....."
>

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: <"pha-exchange@kabissa.org;dahlgrengoran"@hotmail.com;>
Sent: Saturday, May 24, 2003 10:04 PM
Subject: PHA-Exchange> Free Government Health Services

From: EQUIDAD@LISTSERV.PAHO.ORG

Free Government Health Services:
Are They the Best Way to Reach the Poor?

Davidson R. Gwatkin, March, 2003
World Bank

Available online as PDF file [13p.] at:
http://poverty.worldbank.org/files/13999_gwatkin0303.pdf

".....Equity is a frequently stated justification for government involvement in the health care market. This is often taken to mean directly providing all segments of the population with a wide range of government-operated health services at no cost: free universal care.

Yet a look at the record suggests that this goal all too often remains elusive, especially in poor countries; that governments in fact serve only a some of the population; and that the people served are disproportionately concentrated among the better-off. When this happens, government health services, far from promoting equity, work against it.

The purpose of this chapter is to illustrate that there are many ways for governments to pursue the goal of ensuring that the poor receive adequate, affordable services through alternative approaches to resource allocation and purchasing. The first section summarizes the information known about the distribution of benefits from government health services across social groups in order to document the regressive pattern that now frequently exists and the need for significant changes in approach if the poor are to benefit. The second and third sections illustrate the kinds of changes that might be considered....."

RN
26/5/03

5/26/03

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

PHM Secretariat

From: Carmelita C. Canila, M.D. <carmelita@ciroap.org>
To: <pha-exchange@kabissa.org>
Cc: Dr. Sothi Rachagan <sothi@ciroap.org>
Sent: Friday, June 06, 2003 12:36 PM
Subject: PHA-Exchange> Resource Management and Cost Containment

The following is one of the articles on Health Care Financing published in Asia Pacific Consumer, No. 30, the quarterly magasine of Consumers International Office for Asia Pacific based in Kuala Lumpur. For more information, visit our website, www.consumersinternational.org/roap

Resource Management and Cost Containment
AP Consumer, Health Care for All
No. 30 4/2002
By Sharon Kaur and Dr. Carmelita C. Canila

Health care for all does not always mean increased health expenditure. This article looks at various strategies that may be employed to save costs and maximise resources.

Health policy reforms alone have not been successful in containing health care cost. While lack of money is often a governing constraint, it does not mean that progress is not possible without the injection of money into the system. It is necessary to identify areas of wastage, inappropriate spending and strategies to contain health care cost while improving quality of health care provision.

It makes sense to start by spending money on cost-effective interventions that save a lot of lives. A recent experiment in Tanzania illustrates the impact of rational spending. Researchers were sent to the rural districts of Morogoro and Rufiji. They carried out a door-to-door survey asking whether anyone had died or been laid low recently, and if so, with what symptoms. They found that the amount of money local authorities spent on each disease had no relation whatsoever to the harm it inflicted on local people. Malaria was horribly neglected. It accounted for 30% of the years of life lost but only 5% of the 1996 health budget with a tiny infusion of cash (80 cents per person per year) they redirected money to a more effective approach to Health Care. Health workers were provided with a simple algorithm to show how to treat common symptoms, cheapest treatments were offered first, drugs were ordered according to need and people were encouraged to use preventive methods proven to be effective. Infant mortality then fell by an amazing 28% in a single year.

Below are brief descriptions of six priority areas where cost containment strategies might prove very useful:

1) Prioritisation of primary health care services

Primary health care has been proven to be a more cost-effective intervention compared to curative services. An immunisation programme for measles, mumps, and rubella can save approximately $14 for every dollar spent. Programmes that target smoking during pregnancy can save more than $6 for every dollar spent.

Different ministries or departments can contribute to health promotion with healthy lifestyles programmes. These can be financed using tobacco and alcohol taxes. For example:
- Victorian Health Promotion Foundation, Australian State of Victoria gets Aus$ 22M per year from a dedicated levy of 5% on sales of tobacco products
- Thai Health Promotion Foundation gets US$30M per year from a dedicated 2% of the tobacco and alcohol taxes.

2) Health infrastructure

Establishment and maintenance of curative facilities in urban areas incur a greater portion of national health budgets over and above primary health care activities. This trend must be reversed. There should be an equitable infrastructure build-up in rural areas to satisfy their primary health care needs. The utilisation of these infrastructures must also be regularly checked.

3) Utilisation of appropriate technology in health
The rampant use of modern technology in diagnosis and treatment is inappropriate in countries where the primary determinants of illness are poverty related.

6/10/03

To CMF
For information + reference
RN
24/6

Technology in health care must be based on the assessment of current and future trend of diseases, demographic changes (ex. population getting older), epidemiological distribution of diseases, and other social factors.

4) Human resource management
Expenditure for human resource management in the public health care system takes a substantial portion from health budgets. The potential benefits of reforms such as on financing and organisational restructuring are greatly reduced if the need to improve staff performance is not adequately addressed. Human resources must be managed to effectively meet people's health needs. There should be a regular assessment of training needs and evaluations of Performance Management Systems

5) Research capabilities of the Ministry of Health.

There is a need for further research into areas of cost containment. This was recognised by one of the members of the Commission on Macroeconomics and Health, Professor Anne Mills, who said, " ...it is important to emphasise that our knowledge on how best to scale up health care services, particularly in the most constrained countries is limited and that research on this is badly needed". Timeliness and quality of data are primary pre-requisites for changes to be more meaningful and substantial.

6) Procurement, affordability and quality of medicines

Drugs are among the most salient and cost-effective elements of health care. Often 20 - 50% of the recurrent government health budget are used to procure drugs and medical supplies. The best-cost containment measure in relation to drugs is the practice of rational drug use.

Rational drug use means patients receive medications:
- Appropriate to their clinical needs.
- In appropriate doses.
- For an adequate period.
- At the lowest cost to them.

Intervention strategies

1. Educational materials - such as standard treatment guidelines, flow charts, newsletters, bulletins and leaflets
- Standard treatment guidelines (STGs) used in Fiji for acute respiratory infections resulted in a 50% reduction in antibiotic use.
- Drug bulletins are an ongoing source of objective drug information for prescribers. In Sri Lanka, a controlled study on the use of a newsletter on antibiotic prescribing showed some improvement, albeit nothing significant.

2. Introduction of an essential drug list

The 12th Model List of Essential Drugs prepared by a WHO expert committee in 2002 contains 325 individual drugs including 12 antiretroviral medicines. Today the list contains safe, effective treatments for the infectious and chronic diseases, which affect the vast majority of the world's population.

3. Financial interventions

Making people pay for drugs, which used to be provided free of charge, could reduce over consumption of drugs. In Nepal, improved drug supply and cost sharing resulted in more appropriate prescribing in terms of dosage, but led to more polypharmacy and excessive drug use. There should be appropriate mechanisms to guard against over-prescribing practices in such schemes.

4. Consumer and patient education

In Pakistan, community health workers received training in appropriate drug use in order to provide health education to mothers. Preliminary results of an evaluative study reveal that health education sessions resulted in considerable change in knowledge and practice among the mothers.

Indonesia's drug supply during the economic crisis

In mid-1988, Asian currencies underwent rapid devaluation leading to extensive unemployment and massive downturns in economic production. In Indonesia, the affordability of drugs was a serious problem. The effects of drug price increases were exacerbated for many people by job loss, as well as the escalating prices of other commodities.

The Ministry of Health took effective focused action. Priority was given to ensuring the availability and affordability of generic essential drugs in private pharmacies and to ensuring generic drug supply to health centres. Actions taken included:
- Allocation of additional funds for provision of generic drugs to health centres.
- Continuous monitoring of availability of "key drugs" in the districts.
- Set and published maximum prices for generic essential drugs in the private sector.

As a result, the health centre drug supply system weathered the economic crisis fairly well. Meanwhile the private sector followed the market and switched to generic supplies for essential drugs.

Fake Drugs
In a recent survey of pharmacies in the Philippines, 8% of drugs bought were fake. A countrywide survey in Cambodia in 1999 showed that 60% of 133 drug vendors sampled sold, as the anti malarial mefloquine, tablets that contained the ineffective but much cheaper sulphadoxine-pyrimethamine, obtained from stock that should have been destroyed, or fakes that contained no drug at all. In another recent survey, 38% of tablets sold in five countries in mainland South East Asia as the new anti-malarial were fake.

WHO Model Formulary

In its efforts to promote safe and cost-effective use of medicines, the World Health Organization (WHO) released the first edition of the WHO Model Formulary. The formulary is the first ever publication to give comprehensive information on all 325 medicines contained in the WHO Model List of Essential Drugs. It presents information on the recommended use, dosage, adverse effects, contra-indications and warnings of these medicines. Correct use of this tool will improve patient safety and limit superfluous medical spending.

The new formulary is primarily intended to be used as a basis for developing national formularies. It is particularly relevant for developing countries, where commercial and promotional materials are often the only available source of drug information to health workers, prescribers and patients.

References:

- Introducing Performance Management in National Health Systems: Issues on Policy and Implementation By Javier Martinez and Tim Martineau. An IHSD Issues Note, 2001
- The work of the Commission on Macroeconomics and Health, Bulletin of the World Health Organisation 2002, 80(2), 164.
- Brudon P, Comparative Analysis of National Drug Policies in 12 Countries. WHO/DAP/97.6 Action Programme on Essential Drugs. Geneva: World Health Organisation, 1997:114.
- Le Grand A, Hogerzeil HV, Haaijer_Ruskamp FM, Intervention research in rational use of drugs: a review. Health Policyand Planning 14(2) 89-102
- 'Murder by fake drugs. Time for international action.' British Medical Journal Vol. 324 6 April 2002
- Progress in Essential Drugs and Medicines Policy 1998-1999, World Health Organisation 2000.
- The Economist, Special Report: For 80 cents more - Health care in poor countries, August 17, 2002
- WHO Model Formulary is available on the internet at the following address: www.who.int/medicines

Carmelita C.Canila, M.D

Programme Officer
Health & Pharmaceutical

Consumers International
Asia Pacific Office
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Fax: (603) 77268599

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: RAVI <phmsec@touchtelindia.net>
Sent: Monday, June 16, 2003 8:43 PM
Subject: Clau Interesting and encouraging

Just a quick piece of info:
For the last +/- 4 months, we are receiving an average of 5 requests per week from people who want to join pha-exchange.
Hug
Clau

Act on Token
19/06

Good
RM
14/6

PHA - Exchange

PHM - Vietnam

PHM Secretariat

From: David Woodward <woodwarddavid@hotmail.com>
To: <phmsec@touchtelindia.net>; <iphc@cisas.org.ni>; <dsanders@uwc.ac.za>; <gk@citecho.net>; <pamzinkin@gn.apc.org>; <mikerowson@medact.org>; <marjan.stoffers@wemos.nl>; <r.keith@scfuk.org.uk>; <ketzelison@hotmail.com>; <mariameus@club-internet.fr>; <vicki.brault@wanadoo.fr>; <pwillard@ohchr.org>; <alison.linnecar@gifa.org>; <nankoe@yahoo.com>; <ebalem@hotmail.com>; <mku@wco-coe.org>; <elizabeth-chamorand@wanadoo.fr>; <uque@bluemail.ch>; <martine.toulotte@wanadoo.fr>; <Bermonnot@aol.com>; <nance@aids-bells.org>; <epn@wananchi.com>; <eric_ram@wvi.org>; <monika.vonderMeden@wanadoo.fr>; <jjmonot@citoyen.net>
Sent: Saturday, June 07, 2003 1:36 PM
Attach: CMHOmis1.doc
Subject: Dialogue on CMH

Dear All

I had a meeting on Thursday with the WHO team working on the follow-up to the Commission on Macroeconomics and Health (CMH) report, following the comments I made at their presentation at the WHA (mainly stressing the need for more emphasis on the link from the economy to health). At the meeting, I also emphasised the risk of the health-to-growth direction skewing priorities inappropriately, and the need to go beyond the national level to factors in the international economy which constrain policies (debt, aid, structural adjustment, trade agreements, etc). I attach a note I sent yesterday with some further points.

CMH Report → Dialogue ± NGOs

Anyway, they have suggested a continuing dialogue on these issues - so if anyone has anything they would like to feed into this process please do let me know. It could be a useful advocacy opportunity.
At the meeting, Sergio Spinaci also mentioned that they were planning to hold a meeting on CMH follow-up with NGOs in 6-8 months. He sees this partly as a means to get NGOs engaged in service delivery, but also to develop an alliance for advocacy. (See my comments in the attached note.) This may make them more open to NGO concerns. If PHM and others could develop a broadly common position, this could give us a real opportunity.

Incidentally, there is an interview with WHO DG-designate J.W. Lee on the WHO web-site (at http://www.who.int/features/2003/05/en/), in which he says:

"Listening" will be one of the key motifs of my tenure as Director-General. For me, this means paying attention not only to health officials and policy experts, but also to community-based organizations that truly represent the poor. I will pursue active outreach to ensure that such organizations have a strong voice in shaping WHO's agenda.

RN 9/6/03

It might be worth seizing on this to say that the PHM is a natural interlocutor, and is ready and waiting, and looking forward to a continuing constructive dialogue.

To Claudio For Exchange

RN 24/6

RN 9/6/03

Please do forward this message to others who may have an interest in making

PHM ->

6/9/03

an input on the CMH and related issues.

All the best,

David Woodward

Further Comments on WHO's CMH Follow-Up

David Woodward, 6 June 2003

1. I have now checked out the wording of the relevant "strategic directions" in the Corporate Strategy (http://www.who.int/gb/EB_WHA/PDF/EB105/ee3.pdf). This is: "reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes" [and] "promoting an effective health dimension to social, economic, environmental and development policy". The Strategy was designed "to reflect the values and principles articulated in the Global Strategy for Health for All reaffirmed by the Fifty-first World Health Assembly in 1998 (http://www.who.int/archives/hfa/ear7.pdf), which states: "We recognize the improvement of the health and well-being of people as the ultimate aim of social and economic development". This provides a clear mandate for efforts to put health at the centre of economic policy-making and economics development more generally, through effects on risks/determinants as well as health services/systems. See also *Health for All in the 21st Century* (www.who.int/wha-pdf98/ea5.pdf).

2. The problem of measuring "physical, mental and social well-being" was mentioned. This is an area in which I would have thought that the subjective views of the individuals concerned could be deemed to provide a reasonable proxy. Given that this is WHO's definition of its area of responsibility, it should be working on this. The social psychology literature, in which I believe the measurement of well-being and quality of life are important issues, would be a useful starting point. More generally, I think it is dangerous to allow the ability to measure things statistically to dictate the scope and nature of our work. As *The Economist* memorably remarked some years ago, the objective should be to make what is important measurable, not to make what is measurable important. WHO too often gives the impression of doing the latter. Developing the measurement of WHO's definition of health would be an important step towards putting health at the centre of economics.

3. Another potentially valuable step in this direction would be to develop a health-based poverty line. The present "$1-a-day" and "$2-a-day" definitions of poverty are entirely arbitrary. There is a need for a more objective measure, but problems of inter-country comparison limit the scope for using a conventional "basket-of-goods" approach. Health (in the broad or narrow sense) provides a potentially useful alternative. One could set "acceptable" levels of health (or well-being) indicators, and determine the level of income (or assets) associated with this on average on the basis of the statistical relationship between the two. This would provide a globally comparable measure of poverty according to its health effects, which would have much greater validity than "dollar-a-day" definitions.

4. There was some mention at the meeting of WHO not having the capacity to work on the linkages from economic policies to health. While this may very well be true given the current human resources available, there is nothing to stop WHO from recruiting the human resources it needs to do this work. The World Bank employs public health professionals, so why shouldn't WHO employ development professionals? Both I and the only other economist I came across in WHO (excluding "health economists" focusing on health-sector interventions, health-service financing, etc) left when our

contracts were not renewed. I made a proposal for mainstreaming development issues while I was at WHO, which was well-received superficially, but no action was taken. This is attached for information.

5. There was some emphasis at the meeting on easing the financial constraints facing the health system. This is a critical issue, but only one dimension of the problem. Economic policies more broadly affect, for example, household food security and nutrition (through effects on incomes, prices, savings, access to and cost of credit, etc), housing and living conditions, work-place health and safety, access to and quality of education, etc, etc. It is important not to focus narrowly on the level and composition of public spending on health and related services. The framework I developed for analysing the effects of globalisation on health (attached) may provide a useful outline of these effects.

6. In liaising with NGOs on advocacy, I mentioned the importance of making it an equal partnership, finding common ground and working together. WHO needs to bring something to the table, and if it could take a position on issues which could help to ease financial and other constraints on health at the international level (eg debt reduction, the level of aid, structural adjustment programmes, trade agreements), this would help considerably. I should also have mentioned the importance of not giving "operational" NGOs the impression that you see them *only* as a means of programme delivery. Many also have strong views on policy, and on what should be delivered and how, and they can all too easily be alienated if they are seen as instruments of WHO policy. (A WHA resolution on relations with NGOs la"Listening" will be one of the key motifs of my tenure as Director-General. For me, this means paying attention not only to health officials and policy experts, but also to community-based organizations that truly represent the poor. I will pursue active outreach to ensure that such organizations have a strong voice in shaping WHO's agenda st year caused some resentment because it referred to NGOs only in this way – and the problems may have been compounded since by the serious disappointment NGOs feel over the outcome of the Civil Society Initiative.)

PHM Secretariat

From: GK <gk@citechco.net>
To: claudio <aviva@netnam.vn>; pha-exch <pha-exchange@kabissa.org>
Sent: Monday, July 21, 2003 12:39 PM
Subject: PHA-Exchange> Re: International Drug Price Indicator Guide

At 08:11 AM 6/10/03 +0700, claudio wrote:
>From: "Dietterich,Amy" <adietterich@MSH.ORG>

>Dear Colleagues,

>I am happy to announce the publication of the 2002 edition of the International Drug Price Indicator Guide. The International Drug Price Indicator Guide provides what the name implies-an indication of drug prices on the international market. It provides a spectrum of prices from nonprofit drug suppliers and commercial procurement agencies, based on their current catalogs or price lists. It also contains prices obtained from international development organizations and from government agencies.

>The International Drug Price Indicator Guide helps supply officers determine the probable cost of pharmaceutical products for their programs. It can be used as a reference list to compare current prices paid to prices for products available on the international market. It can also be used to assess the potential financial impact of changes to a drug list.

>This edition of the Guide includes nearly 90 new items (for a total of more than 750 items) and prices from 17 different sources. The therapeutic classes with the most new entries this year are antibacterials, including antituberculosis drugs; anticonvulsants; cardiovascular drugs; and drugs used in psychotic disorders. We have also included the ATC code for each product.

>Management Sciences for Health produced the 2002 edition of the Guide in collaboration with the World Health Organization. Development and publication of the Guide were supported by the Strategies for Enhancing Access to Medicines (SEAM) Program, which is funded by the Bill & Melinda Gates Foundation.>20

>The electronic version of the 2002 edition is posted on the Manager's Electronic Resource Center (http://erc.msh.org), along with data since 1996. We encourage you to visit the site and explore the features such as creating custom lists of drugs, comparing your prices, and planning a budget. If you are not already on our mailing list and would like to receive a print copy of the 2002 International Drug Price Indicator Guide, please contact the MSH Bookstore at bookstore@msh.org. The print copies will be ready in early June.

>If any of you would like to contribute your organization's ICB or tender award results to the next edition of the Guide, please contact me at jmcfadyen@msh.org. I would be delighted to discuss this with you.

PHM Exchange →

RN
22/7

>Best regards,
>
>Julie E. McFadyen
>Editor, International Drug Price Indicator Guide
>Center for Pharmaceutical Management
>Management Sciences for Health
>Arlington, VA USA
>Phone: +1.703.524.6575
>Fax: +1.703.524.7898
>E-mail: jmcfadyen@msh.org
>
>

Best wishes.
Zafrullah Chowdhury

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Claudio Schuftan <aviva@netnam.vn>
Sent: Friday, July 11, 2003 5:27 PM
Attach: Global3 HealProspectus.doc
Subject: Plan of Action and overall strategy for PHM

Dear Claudio,

Greetings from People's Health Movement Secretariat (Global) at CHC, Bangalore!

1. Did you get communications I to III? They are all part of a longish communication to Steering group but sent out in three sets so that they are not overwhelming. As soon as I hear from the steering group -- a slightly edited version will be sent for exchange (but again probably in stages).
2. I wish we were able to meet soon so that you could really help with editing the proposal. I have gone ahead with the log frame exercise even while waiting for the responses, which are coming in slowly. Bala has agreed to help too. Will send you a first draft soon.
3. My deadlines and work schedules are in severe crisis and I was just wondering whether you would be willing to respond to one request -- long overdue, but strategic all the same. I am forwarding the message to you. We could do it as a Joint Piece, but we have little time. Can you update any of your pieces that match the requirement and I could add an update here and there and send it on to Richard Harris and Melinda Seid, before we miss the bus? Should have written to you earlier, but do you think you could respond soon?

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW!" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

Claudio
PHM Exchange
RN
14/7/03

----- Original Message -----
From: richard harris
To: PHM Secretariat
Cc: Melinda Seid
Sent: Thursday, May 29, 2003 2:10 AM
Subject: Re: Contribution for Journal Issue and Book on Globalization and Health

Dear Ravi,

Thank you for your response. We sent you via email the prospectus for our publication in our follow-up to our meeting in Berkeley -- evidently you didn't receive it. At any rate, we are attaching it to this email and also including it below. The editorial perspective of the collection is quite similar to that of the PHM and the larger Global Social Justice Movement, although presented in more "academic" style. We would like you to send us something in the next 30 days. It could be a revised version of a paper or essay that you have already written or that the PHM has produced, but it would be best if it was written in a more or less "academic" or professional style (with citations). We would like to place it as the last essay in the collection and refer to it in our concluding essay where we will point to the PHM as a progressive counterforce to the neoliberal and corporate-dominated forces that are currently promoting the globalization of health care around the world. Let us know if we can be of any help. For formatting and style criteria, please consult the journal's Instructions for Authors at
http://easweb.utoledo.edu/pqdt/instructions.htm. Because time is of the essence, you can submit your

Attachment May 29 + July 9

PHM Secretariat

From: Aviva <aviva@netnam.vn>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Thursday, July 10, 2003 8:23 PM
Subject: plan of action and overall strategy for PHM - Communication - III

Friends,
Acknowledge receipt of this plan. Why don't we put it in pha-exch??
Post it yourself.
Am still in Brussels but back home tomorrow.
Volunteer to edit the proposal I understand is being prepared for fundraising. (I did it last time in 1999)
Warm regards
Au

RN
11/7/03

PHM - Communication

(P)

Sent
11/7/03

Dear Claudio

i) Did you get Communications I to III
They are all part of a longish communication to steering group but sent out in three sets so that they are not overwhelming. As soon as I hear from the steering group – a slightly edited version will be sent for exchange (but again probably in stages).

ii) I wish we were able to meet soon so that you could really help with editing the proposal. I have gone ahead with the logframe exercise even while waiting for the responses which are coming in slowly. Bala has agreed to help too. Will send you a first draft soon

iii) My deadlines and work schedules are in severe crisis and I was just wondering whether you would be willing to respond to one request – long overdue but strategic all the same. I am forwarding the message to you. We could do it as a joint piece but we have little time. Can you update any of your pieces that match the requirement and I could add an update here and there and send it on to Richard and Melinda before we miss the bus. Should have written to you earlier but do you think you could respond soon. Best wishes
Ravi

PHM Secretariat

From: richard harris <drdragonnet100@attbi.com>
To: PHM Secretariat <phmsec@touchtelindia.net>
Cc: Melinda Seid <seidmj@nhs4.hhs.csus.edu>
Sent: Thursday, May 29, 2003 2:10 AM
Attach: Global& HealProspectus.doc
Subject: Re: Contribution for Journal Issue and Book on Globalization and Health

Dear Ravi

Thank you for your response. We sent you via email the prospectus for our publication in our follow-up to our meeting in Berkeley -- evidently you didn't receive it. At any rate, we are attaching it to this email and also including it below. The editorial perspective of the collection is quite similar to that of the PHM and the larger Global Social Justice Movement, although presented in more "academic" style. We would like you to send us something in the next 30 days. It could be a revised version of a paper or essay that you have already written or that the PHM has produced, but it would be best if it was written in a more or less "academic" or professional style (with citations). We would like to place it as the last essay in the collection and refer to it in our concluding essay where we will point to the PHM as a progressive counterforce to the neoliberal and corporate-dominated forces that are currently promoting the globalization of health care around the world. Let us know if we can be of any help. For formatting and style criteria, please consult the journal's Instructions for Authors at: http://sasweb.utoledo.edu/pgdt/instructions.htm. Because time is of the essence, you can submit your contribution to us as an email attachment (in MS Word if possible). It does not have to be too long -- perhaps around 15 (plus or minus) double spaced pages.

Warmest regards,

Richard Harris and Melinda Seid

In addition to attaching the Prospectus for the Collection we have also pasted it into this email below your response.

DGS | SBP
Please download instructions to authors and put up
+
30/5/03

Dear Richard and Melinda

Thanks for the details about the focus and framework of the publication to which I have been invited to contribute on behalf of PHM. The instructions have been very helpful & hope to send you the paper before the end of June.
Best wishes
Ravi Narayan

----- Original Message -----
From: PHM Secretariat
To: richard harris
Sent: Wednesday, May 28, 2003 4:30 AM
Subject: Re: Contribution for Journal Issue and Book on Globalization and Health

Dear Richard,

Greetings from People's Health Movement Secretariat (Global) at CHC, Bangalore!

Thanks for your letter. I have just returned after a hectic two week trip in Europe attending a PHM Evaluation in London and a PHM Geneva - Alma Ata Anniversary dialogue as well as the World Health Assembly. We were among the largest delegation to the WHA - over 75 delegates from 30 countries. I recall your request for an essay, but I was expecting a letter with further details including number of words etc. How soon is 'as soon as possible'. Do you have a deadline? If you have a note on the Editorial perspective of this special journal or book, please do send it to focus the article better. Best wishes,

RN 29/5/03

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore

Prospectus for Special Issue/Collection of Essays on Globalization and Health

by

Richard L. Harris and Melinda J. Seid*

We are organizing and co-editing a collection of essays that will be published as a special issue of the new journal of Perspectives on Global Development and Technology and also as a book by Brill Academic Publishers. The focus of this collection of essays will be on the effects of globalization on the health of people in both the northern and the southern hemispheres of the planet. The issue will include both single country, comparative and global analyses. We are inviting prospective contributors to focus their contributions on the health of the entire population of a single country, the populations of various countries or groups of countries, or the health of specific populations such as women, children, youth and the poor. Since there are many competing definitions and conceptualizations of globalization, contributors will be expected to define their use of this key concept in the context of their particular analysis. The collection of essays will emphasize the impact of globalization on the following areas of health and health care, but will not be limited to these areas:

- Changes in the structure and delivery of health services
- Access to health care
- Maternal and child health outcomes
- Infant and adult mortality
- Health care costs and finances
- Public health policies and issues
- Communicable as well as non-communicable, "life-style" diseases
- The privatization of health care
- The economic, social and natural environments of health
- Changes in diet and nutrition
- Marketing and Consumption of alcohol, tobacco and other drugs (ATOD)
- HIV/AIDS
- Pharmaceutical patents and use
- Dissemination of medical technology and/or information
- Biotechnology
- Sanitation and hygiene
- Alternative treatments and options for care
- Government regulation of health care
- Global public health initiatives and campaigns

We are soliciting contributions that are unpublished works and that do not exceed 25 double-spaced pages in length (in 12 point font). They should be submitted in English, in a standard word-processing format such as MS Word, with references at the end of each manuscript, and copies of the manuscript should be provided in both an electronic (diskette or email attachment) and printed version. The anticipated date for submission of this collection of essays to the publisher is March 1, 2003. We will contribute an introductory essay and concluding essay that provide an integrative overview of the issues and topics addressed in the issue and a summary and synthesis of the conclusions. Please consult the Instructions for Authors at:
http://sasweb.utoledo.edu/pgdt/instructions.htm

* Richard L. Harris is Professor of Global Studies at California State University, Monterey Bay; and Melinda J. Seid is Professor of Health Science at California State University, Sacramento. We are the co-editors and contributors to a collection of essays entitled Critical Perspectives on Globalization and Neoliberalism in the Developing Countries published as the Spring 2000 special issue of the Journal of Developing Societies and as a book by Brill Academic Publishers (Leiden, Köln and Boston, 2000). Contact: richard_harris@csumb.edu and seidmj@hhs4.hhs.csus.edu

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Thursday, June 19, 2003 5:17 PM
Subject: Re: Clau interesting and encouraging

Dear Prassana, I would not know how to get the info of the dates of each member joining the list, sorry. So, difficult to confirm the loop
hug
Clau

Ron SSP
20/6/03

PHon — Exchange

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Friday, August 01, 2003 9:13 PM
Subject: PHA-Exchange> The Policy Processes

From: "Ruggiero, Mrs. Ana Lucia" <ruglucia@PAHO.ORG>
(Jos Mooij, Veronica de Vos: Policy Processes; Working Paper 221 - July 2003, ODI, London)
Available online as PDF file at:
http://www.odi.org.uk/publications/working_papers/wp221.pdf

Policy processes are always formulated and implemented in particular social and historical contexts, and these contexts do matter - in terms of which issues are put on the policy, the shape the policy will take, the institutions that will be involved, and the final budget allocated for the implementation process. In short, context influences the outcome of policies.

Policies are thus no pre-determined prescriptions resulting from of a 'rational process of problem identification by a benevolent agency (usually the state)'. The 'policy as prescription' approach is still way too prevalent; the process dimensions of policy are more important and are not to be skipped.

Policies are not 'natural phenomena' or 'automatic solutions' flowin from the 'objective analysis' of particular social problems and they do not privilege the state as an actor fundamentally different from, or superior to, other social actors. The why, how and by whom questions can only be answered by concrete empirical research with the participation of potential beneficiaries.

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@lists.kabissa.org
Website: http://lists.kabissa.org/mailman/listinfo/pha-exchange

RN
4/8/03 Lon

PHAR Exchange

TN.
I am sure you would agree with this paper. For your collection after circulation
to CMF/PK/SSP

RN
4/8

PHM Secretariat

From: Dhruv Mankad <mankad_nsk@sancharnet.in>
To: pha-exchange <pha-exchange@kabissa.org>
Sent: Thursday, July 24, 2003 8:00 AM
Subject: PHA-Exchange> PHC Survival Crisis!

Press release

UNICEF report finds 'Child Survival Crisis' in Caucasus and Central Asia

EMBARGOED UNTIL TUESDAY, 22 JULY 2003 until 05:00 GMT

ROME, 22 July 2003 - Infant mortality rates in nine countries of Eastern Europe and the Commonwealth of Independent States are much higher than official figures have long claimed, according to a new report by UNICEF released today. UNICEF found that in some countries deaths among children less than one year old were four times higher than the official counts.

According to UNICEF's Social Monitor 2003, the infant death rate in the Caucasus and Central Asia is five times greater than in the rest of Central and Eastern Europe and the Commonwealth of Independent States, and 12 times greater than in western industrialised countries.

"Our research shows that infant mortality is a far greater problem in these countries than suggested in the official data," said UNICEF Executive Director Carol Bellamy. "We have looked beyond the official statistics and talked to mothers in their own homes. And their stories reveal a child survival crisis."

Most of the infant deaths are preventable, according to the report, which was produced by UNICEF's Innocenti Research Centre in Florence. UNICEF said a mix of factors such as poverty, poor maternal health and nutrition, infection and poor medical care were to blame for most of the deaths.

"What we have is two distinct problems," Bellamy said. "We have tens of thousands of infant deaths that should be prevented. And we have a systemic failure to properly count the lives being lost. Misunderstanding the scope of what's happening prevents effective action to fix it, so getting the numbers right is a major issue. It's a crucial first step to saving young lives."

The report focuses on infant mortality trends in the eight countries of the Caucasus and Central Asia, plus Romania and Ukraine. It compares the official infant mortality rate in these countries against data gathered in face-to-face interviews with women. In all eight countries of the Caucasus and Central Asia, the estimated infant mortality rate from the surveys is far higher than the official rate. In Azerbaijan, for example, the survey estimate is four times greater - 74 infant deaths for every 1,000 live births, compared to an official rate of 17 per

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1,000. Romania also appears to be affected by under-reporting, although on a smaller scale.

"These kinds of inaccurate and misleading statistics can breed complacency," Bellamy said. "They keep governments and health workers unaware of the risks of child death and the need for action, and they keep parents and community leaders in the dark."

What's Going Wrong

Examining the reasons for the gap, the Social Monitor highlights three problems: failure to define 'live birth' according to accepted international standards, misreporting of infant deaths at the local level, and barriers to birth registration.

The report finds that the death of a baby may go unrecorded because, officially, the baby was never 'alive'. According to the definition established by the World Health Organization, an infant is alive at birth if breathing or showing any other signs of life, such as muscle movement or heartbeat. Under the Soviet era definition, however, breathing is the only criterion for life. In addition, infants who are born at less than 28 weeks, weighing less than 1,000 grams, or less than 35 centimetres in length are not counted as live births if they die within seven days. This Soviet definition still predominates in many countries of the Commonwealth of Independent States.

Misreporting pushes the official figures down further. The communist system stressed the need to keep infant mortality low, and hospitals and medical staff faced penalties if they reported increases in infant deaths. As a result, they sometimes reported the deaths of babies in their care as miscarriages or stillbirths. With deteriorating conditions in health services and little focus on health care reform, this has proved a hard legacy to overcome and misreporting continues in some countries.

Difficulties in measuring infant morality are exacerbated by barriers to birth registration. A recent study estimated that about 10 per cent of births in poorer parts of the region each year go unregistered - most of them in the Caucasus and Central Asia. Parents face obstacles to registration such as the costs or difficulty of travel to the nearest civil registration centre, heavy bureaucracy, and the lack of incentives to register births promptly. If a birth is not registered, it is unlikely that a death will be registered.

Why So Many Lives Lost?

By global standards, new surveys show high infant mortality rates in the Caucasus and Central Asia, ranging from 36 per 1,000 live births in Armenia to 89 per 1,000 in Tajikistan.

Many of these deaths are rooted in poverty, linked to malnutrition and health problems among women and resulting complications in pregnancy and childbirth. Poverty restricts access to health care and drug treatment,

as one mother in Tajikistan told researchers, when describing the death of her son: "I went to a paediatrician who prescribed drugs, but I did not have any money to purchase drugs. I went to a healer. But the child's condition became worse. On the seventh day he died."

Poor medical care is also an issue. Problems cited in the report include a lack of preventive health care, and failure to carry out basic, non-technological tests at birth, such as weighing the baby or assessing his or her activity, pulse, grimace, appearance and respiration (the APGAR test).

The Report Calls For:

. Adoption and implementation of the WHO definition of live birth in every country
. Improved training of medical staff and better management of health care
. Incentives for parents to promptly register the births of their children

Resumed economic growth in the region presents an opportunity to reduce poverty, improve the well-being of mothers and children, increase investment in basic and preventive health care, and, with international help, upgrade the skills of medical staff and administrators in order to provide effective health care services. Good statistics have a crucial role to play in alerting governments and the public to the magnitude of the problem, in supporting reform and in mobilizing resources and action.

"States have an obligation to give every child the best possible start in life," said Bellamy. "States in this region have all ratified the Convention on the Rights of the Child. They have all signed up to the Millennium Development Goals and to the goals of a World Fit for Children - goals that can only be reached by tackling the issue of preventable infant death and its causes. It is time to give infant mortality the attention it deserves as a sign of national well-being - a sign that is every bit as important as economic growth and poverty reduction."

The Social Monitor Covers 27 Countries

The Social Monitor is an annual regional report examining the well-being of children in the transition countries of Central and Eastern Europe and the Commonwealth of Independent States.

And while it finds the risk of infant death is low in some of the 27 countries in the region, such as the Czech Republic, official figures suggest that in the region as a whole, at least 60,000 babies died before their first birthday in 2001. This is three times greater than the number of infant deaths in the European Union, which has only slightly fewer births each year.

In addition, Social Monitor 2003 looks at other trends affecting

children in the region.

. It finds economic growth but continuing poverty, with almost 11 million children in poverty in Russia alone.
. It highlights the debt crisis, with Georgia, Kyrgyzstan, Moldova and Tajikistan spending at least one-third of government expenditure on debt servicing.
. It reports three million refugees, asylum seekers, and displaced people in the region at the end of 2001, with numbers falling in the countries of the former Yugoslavia but rising in Russia and Uzbekistan.
. It finds that there have been at least 100,000 adoptions since 1989 from the region, which now accounts for one-third of the world total and for most of the increase in intercountry adoption to industrialized countries in recent years.
. And an examination of latest trends in HIV/AIDS reveals that only 1 in every 25 people registered with HIV in the region receives antiretroviral therapy.

The report includes a statistical annex covering a broad range of indicators for the years 1989 to 2002, and statistical profiles on each country in the region.

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[1]Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyz Republic, Tajikistan, Turkmenistan, Uzbekistan

[1]The 27 countries of Central and Eastern Europe, the Commonwealth of Independent States and the Baltics are: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyz Republic, Latvia, Lithuania, former Yugoslav Republic of Macedonia, Moldova, Poland, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

* * *

Note to Editors

The Social Monitor is produced by the UNICEF Innocenti Research Centre in Florence. Embargoed media materials, including information on UNICEF activities on infant mortality and downloadable copies of the report in English and Russian, are available from the IRC Newsroom:
http://www.unicef-icdc.org/presscentre/indexNewsroom.html

Early childhood care - to give every child the best start in life - is a major UNICEF priority, along with immunization, education for all boys and girls, preventing the spread of HIV/AIDS among young people, and protection of children from violence, abuse, and exploitation.

For further information, please contact:

Angela Hawke, UNICEF Regional Office for CEE CIS and Baltics, Geneva (+41 22) 909-5607
Patrizia Faustini, UNICEF Innocenti Research Centre, Florence (+39 055) 203-3253
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Kate Donovan, UNICEF New York, Media Section, (212) 326 7456

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With warm regards,

Dhruv Mankad
5, Gokul Apartments Ushakiran Society,
Gangapur Road, Nasik 422002
(0253) 2570340

Please visit websites
http://www.cehat.org
http://www.mfcindia.org
http://www.locostindia.com

Please visit the Primary Health Care Group's new website:
http://www.bharatvaidyak.co.in

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Tuesday, August 05, 2003 1:05 PM
Subject: PHA-Exchange> Psychosocial needs of Afghan people

From: "UNNIKRISHNAN PV (Dr)" <unnikru@yahoo.com>

Dateline: Mazar-E-Sherief, Afghanistan, July first week, 2003
"If you are not with her, you are against her"

Psychosocial needs of Afghan people demand an SOS response.

Dr Unnikrishnan PV

Life has gone for a spin for Munira (name changed). Looking tired and anxious in the overflowing female ward of the Shafakhan Mulki Civil hospital at Mazar-I-Sharif, this 35-year-old mother of four children, talks about her uncertain future.

Over 27 million Afghan people have been caught up in violent wars, armed internal conflicts, military action and super power occupation for the past 24 years. Life has been tough for Munira -- uncertain, uprooted and unkind.

As a result of her miseries, Munira now suffers from a loss of sleep, sadness, palpitation, intolerance, and loss of interest in work. She also weeps and cries intermittently and hits and harms herself from time to time.

"She is a case of panic attack and depressive disorder," notes Dr. Mohammed Nadir Alemyi, the head of the psychiatry and neurology department of the hospital.

About 97 per cent of women interviewed in Kabul and refugee camps in Pakistan showed signs of depression, says a research study. The details of the study published in the prestigious Journal of American Medical Association added that 86 per cent of the women had significant anxiety symptoms.

But the study came out before the last round of bombing by the US and their allies. The bombings and the fighting that intensified have added to the suffering of people like Munira.

Conflicts and war situations spawn psychosocial disorders. Research shows that in conflict situations one-tenth of the people who experience traumatic experiences will have serious mental health problems. Another one-tenth will develop behaviour that will hinder their ability to function efficiently. In real terms this means over 27 million people need immediate support.

Women and children are the most vulnerable in conflict situations. Loss of family members, traumatic experiences, displacement and constant terror rewrite their biography into a nightmare.

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Worse is the situation of the people with other limitations. For example, people disabled due to landmines are doubly disadvantaged. Poverty, insecurity, uncertainties and other social factors complicate the plight of the war-affected.

Life becomes a struggle for survival.

Referring to Munira's ailment, Dr. Alemyi notes: "Her anxieties originate from financial insecurity".

Munira has four children, aged 19,15,13 and 11. All are struggling to find employment, some means of survival. Her husband is a casual worker, who gets up early and waits at the city market by 5 am for someone to give him the day's work. On a rare lucky day, he earns 100 Afs (roughly US $2).

Packed in the overflowing wards of this hospital, which doubles also as a referral hospital in the second largest city in Afghanistan, are people identified with psychiatric and neurotic disorders and drug addiction. Fazluddin, an 18-year-old boy is diagnosed with schizophrenia. The war has split his personality.

The 62-year-old hospital has stood the test of the time, like the Shrine of Hazrat Ali, the 15th century mosque that gives Mazar-i-Sharif its name - Tomb of the Exalted.

The Soviets, Mujahideens, Talibans and the coalition forces that invaded and controlled Afghanistan have left this hospital almost untouched, a rare honour.

It is the last bastion of a brutalised people. Apart from the long-term fallouts of the trauma and sufferings, the skeletal health facilities worsen the people's plight.

Take the case of the ramshackle, ill-equipped section that passes off as the psychiatry department. There are not enough doctors, no new equipments and absolutely no medicine.

About a quarter of century caught in violent conflicts and nature's fury in the form of droughts and earthquakes have taken a heavy toll on the Afghan people. They are struggling to cope.

Add to this the plight of the returnees who have been part of an unrealistic repatriation programme. Between March and September 2002, approximately 1.7 million refugees are estimated to have returned to Afghanistan.

This, in reality, means added anxiety and extra pressure on the local people. A fact-finding mission to Pakistan found that 30% of the Afghan refugees who seek medical care at local health care facilities are presenting psychosomatic complaints resulting from psychological problems.

"New research and refresher courses are required," says Dr. Alemyi, who is

always in a hurry. An unending stream of patients come from far off places, often travelling for seven days in buses, cars, on donkeys and horses and on foot. The doctor cannot keep pace with the latest developments in mental health care. Medical journals are not available; as for Internet, there is a rare connection with the UN system in Mazar.

"There is an urgent need to undertake serious research to understand the level of psychosocial morbidity amongst the Afghans," says Dr Alemyi. "The situation in the villages are worse and a community based intervention is a must." He runs a successful TV programme on public health and is a guest columnist in the local newspaper, besides being a member of the Loya Jirga, constitutional body.

Afghan families consider emotional and social development important for their children is one of the key findings of 'The Children of Kabul', a recent study by Save the Children and UNICEF.

Rural health care system is almost non-existent or remains in a shambles and people have limited resources to pay even if services are offered. Plans are on to hand over the health system to the private sector. But analysts say may not work. "In the absence of any successful experiments elsewhere, even in non-conflict situations, the sensitivity of the private sector has been a matter of concern," says Prof. S Parasuraman, Policy Director of Action Aid, an international agency that works in Afghanistan.

International humanitarian agencies and UN organisations do not recognise the need to respond to the psychosocial needs of the Afghan people and refugees. "Mental health is nobody's agenda," remarks Dr. Alemyi. Their vision gets blurred in the high profile visible activities like construction.

To make the situation worse, a few humanitarian and development agencies still involved are leaving Afghanistan. Besides, their limited resources are getting diverted to respond to the crisis in Iraq.

For women like Munira and the millions of uncertain Afghans urgent mental health care at this stage is a matter of life and slow death. In this struggle, if we are not with her, no doubt, we are against her.

(Dr.Unnikrishnan PV (unnikru@yahoo.com) is a medical doctor working on humanitarian issues. He is Fellow: Humanitarian Action, Action Aid Asia regional Office, Bangkok. He was in Afghanistan in July first week. The opinions expressed need not necessarily reflect the views of the organisation.)

PHM Secretariat

From: Alexandra Barnabas <lexi@ihst.org.za>
To: PHM Exchange <pha-exchange@lists.kabissa.org>
Cc: Kaneta Chowdhury (E-mail) <Kaneta@icddrb.org>
Sent: Tuesday, August 05, 2003 2:17 PM
Subject: PHA-Exchange> Posting for PHM Exchange: Regional Fellowship onPoverty and Health Research

Regional Fellowship on Poverty and Health Research

ICDDR,B wishes to offer some research fellowships in Poverty and Health for one year to institutional candidates from the south Asia region The fellowship is extendable for further period depending on the project need. The aim of the fellowship is to build capacity to strengthen the knowledge base in understanding the health problems of the poor, interaction of poverty and ill-health, and identifying policy and programmatic options to improve health especially of the poor , and to reduce poverty in the developing world. During the Fellowship period the Fellows will have the opportunity to work closely with the various investigators of the ongoing Poverty and Health project of ICDDR,B. In addition they will also have the opportunity to attend various training programmes carried out at ICDDR,B. It is expected that the on return the Fellow will carry out the agenda of poverty and health research in their own countries.

Requirements: A minimum of Masters degree in Social Science subjects including economics and statistics or MBBS/MD with interest in topics similar to the aims of the fellowship mentioned above. The candidates should be mid-level staff working with institutions or organisations involved in poverty alleviation programmes or in research addressing similar issues. Candidates having particular research concepts in mind that they would like to further refine while at ICDDR,B will have an added advantage in the selection process. The candidates should have outstanding verbal and written communication skills in English. The selection process may involve on site identification of potential candidates before final recruitment decision is reached. The selected fellows are expected to complete the one-year term in Bangladesh without any break.

Stipend: Monthly stipend of US$1000.00 (one thousand only) and return airfare from the country of origin.

Certification: After successful completion of training, the fellows will be awarded a certificate.

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Applications with detailed bio-data, and a recent passport size photograph should reach the Head, ISD, ICDDR,B, Mohakhali, Dhaka 1212 by September 15, 2003 or by email to pthorpe@icddrb.org.

Candidates in employment should apply through proper channel.

PHM -- Exchange

PHA-Exchange is hosted on Kabissa - Space for change in Africa

RN
2/8/03 Jm

To post, write to: PHA-Exchange@lists.kabissa.org
Website: http://lists.kabissa.org/mailman/listinfo/pha-exchange

PHM Secretariat

From: claudio <avive@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Tuesday, August 05, 2003 1:16 PM
Subject: PHA-Exchange> Use of Nevirapine

From: "Leela McCullough" <leela@healthnet.org>

> Use of Nevirapine
> ----------
> 1. Use of Nevirapine in South Africa
> 2. WHO reconfirms its support for the use of Nevirapine
>
> August 1, 2003

> Officials from South Africa's Medicines Control Council have said that they will prohibit the use of nevirapine to prevent mother-to-child HIV transmission unless drug maker Boehringer Ingelheim provides data proving that the drug is safe. Last year, the South African government approved nevirapine for universal distribution to state hospitals in an attempt to reduce the nation's mother-to-child HIV transmission rate. The announcement followed a Pretoria High Court ruling in December 2001 that said that the government must provide nevirapine to HIV-positive pregnant women through the public health system. The government appealed the decision, citing concerns over the drug's safety and efficacy, but the Constitutional Court in July 2002 denied the appeal, saying that the government's restriction of the drug's distribution to 18 pilot sites "fell short of its constitutional obligation to offer the best treatment available" Boehringer ingelheim in March 2002 pulled its FDA application for the right to market nevirapine in the United States for the prevention of mother-to-child HIV transmission after FDA regulators said they uncovered procedural problems with the study. The drug is approved for use in adults in the United States, and the U.S. Public Health Service Task Force endorses its use for prevention of vertical HIV transmission.

> In March 2002, FDA officials said that concerns over the drug's safety were "unwarranted" If the drug maker fails to provide alternate data, the government will revoke nevirapine's temporary approval, Reuters reports. Matsoso said, "We have to be cautious. If information is available that meets rigorous scientific standards, we will look at it" .

"The overall scientific validity of (the Ugandan trial) is not questioned. The scientific community accepts this single, low dose [of nevirapine] is an appropriate medication to reduce the risk of mother-to-child transmission."

> 2. Meanwhile, WHO reconfirms its support for the use of Nevirapine to prevent Mother-to-Child Transmission of HIV. (July, 03)

PHM-AIDS →

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> The Division of AIDS, National Institute of Allergy and Infectious
> Diseases, National Institutes of Health, Bethesda has recently re-
> leased the final report (dated March 2003) from the reassessment of
> the trial procedures and results in the HIVNET 012 trial conducted in
> Uganda.
>
> This trial, the first to demonstrate the safety and efficacy of nevi-
> rapine to prevent mother-to-child transmission (MTCT) of HIV, was
> started in Uganda in 1997 and the results were published in 1999.
>
> A single dose of nevirapine given at onset of labour plus a single
> dose to the newborn within 72 hours of birth reduced the risk of HIV
> transmission down to 13%, almost 2-fold lower than a short course of
> Zidovudine started during labour.
>
> WHO continues to support the use of nevirapine in MTCT-prevention
> programmes.
>
> Each year, about 800,000 infants become infected with HIV, mainly
> through mother-to-child transmission.
>
> WHO and its partner United Nations agencies recommend that MTCT pre-
> vention using antiretroviral regimens such as nevirapine should be
> included in the minimum standard package of care for HIV-positive
> women and their children.
>
> WHO is not aware of any information that should lead to a change in
> this recommendation.
>
> For further information please contact:
>
> Dr Tim Farley,
> Department of Reproductive Health and Research
> mailto:FarleyT@who.int

PHM Secretariat

From: claudio <avlve@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Wednesday, August 06, 2003 1:54 PM
Subject: PHA-Exchange> WHO and ARV access

WHO looks to ease access to AIDS drugs 30 July 2003

The Boston Globe

By John Donnelly

The World Health Organization announced yesterday that it will create a new model to buy antiretroviral AIDS drugs in hopes of dramatically speeding distribution and reducing the cost of the life-saving medication.

The plan comes from a collaboration among tuberculosis experts, foremost among them the new WHO director general, Jong-wook Lee. That program, called the TB Drug Facility, purchases drugs in bulk on behalf of countries and then oversees the distribution.

Global health specialists have applauded the program because it created a larger market for TB drugs and spurred competition. That in turn drove down the cost of TB drugs, 30 percent for front-line, or commonly used, medication and 95 percent for secondary drugs.

The program, which has reached nearly 2 million TB patients the past two years, also has provided an additional benefit: The WHO works with local partners to ensure that the drugs are being distributed properly, providing a safeguard against improper use, which can lead to drug resistance.

At a cost of less than $20 million, the program has delivered drugs to 33 countries and decreased the price of the main TB drugs to as low as $11 for a six-month daily regimen of medicine.

"The main issue is getting drugs to patients, and we've got to make it more rapidly available," said Ian Smith, one of Lee's top advisers.

Lee has embraced a goal of treating 3 million people with antiretroviral medicines by the year 2005. Now, about 300,000 people in the developing world receive those drugs.

The WHO has pledged to draw up a plan by Dec. 1 to meet its goal. The plan, which the WHO hopes will begin in three to four months, also will cover anti-malarial medication. Others in the health field, including those working in family planning, are also examining the model and may adopt it, WHO officials said.

"The primary goal in this is to dramatically increase access," Smith said. "We also want to reduce the price, but that is a byproduct of the program

PHM-AIDS →

To
TN → Pacific AIDS Group
→ CIAFF
→ Kamakaka AIDS forum

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The price of generic antiretroviral drugs tumbled sharply last year to roughly $1 a day for people with AIDS in the developing world. The cost in the United States is about $10,000 a year. AIDS activists hope the price falls even further, and some believe the TB model holds great promise.

"The principles of the program were very successful and we think could be applied" for AIDS drugs, said Paul S. Zeitz, executive director of the Global AIDS Alliance, an advocacy organization. "It could be fantastic." Zeitz cautioned that developing countries still should explore options under consideration for pooling resources regionally, until a new WHO program proves successful.

But he said, "If you can bring on other producers, and create competition among generics, you'll have Thai producers, Brazilian producers, Chinese generic producers, all competing with the Indian producers, and as you create more and more demand for the drugs, we believe it will continue to drive the price down."

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Andrew Chetley <chetley.a@healthlink.org.uk>
Sent: Saturday, August 23, 2003 5:35 PM
Subject: Re: [PHM_Steering_Group_02-03] Urgent Response needed

Dear Andrew,

Greetings from PHM Secretariat (Global)!

It was a great relief to get your mail. Sorry about the shift, but evaluation report is necessary. Send it to me as a draft urgently, because I have held up the project proposal and log frame circulation to include only 2 more substantial issues.

Feedback on PHA - Film Media, Armando and group
PHM Evaluation and recommendations for the future. Even a check list of recommendation is okay at this stage. More later - next week.

Nand visit on 2nd / 3rd September to formally handover website to Prasanna in the PHM Secretariat. Any guidelines, suggestions for this from you will be welcome.

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
C/o. -Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all NOW" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

(UK)
PHM-Exchange communication

PN
25/8

----- Original Message -----
From: Andrew Chetley
To: 'PHM_Steering_Group_02-03@yahoogroups.com'
Sent: Friday, August 22, 2003 7:33 PM
Subject: RE: [PHM_Steering_Group_02-03] Urgent Response needed

Ravi,
sorry to be late in replying, but Rome is the only option that would work for me. I need to be in Africa for three weeks the following week, so could do one or two days in Rome. What I would like to do for that meeting is present the evaluation report, a draft of which should beging to circulate in early September.
best wishes,
Andrew

-----Original Message-----
From: PHM Secretariat [mailto:phmsec@touchtelindia.net]
Sent: 18 August 2003 11:45
To: PHM_Steering_Group
Subject: [PHM_Steering_Group_02-03] Urgent Response needed

Dear Friends,

Greetings from PHM Secretariat (Global)!

PHM Secretariat

From: Andrew Chetley <chetley.a@healthlink.org.uk>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Friday, August 22, 2003 7:33 PM
Subject: RE: [PHM_Steering_Group_02-03] Urgent Response needed

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best wishes,
Andrew

23/8/03

Dear Andrew
It was a great relief to get your mail. Sorry about the draft but evaluation report is necessary. Send it to me as a draft - urgently because I have held up the project proposal and log frame circulation to include only 2 more substantial issues (i) Feedback on PHA-II from Mona Armendaris group (ii) PHM Evaluation and recommendations for the future. Even a check list of recommendation is okay at this stage More later - next week. Need visit on 2/3rd Sept to formally handover to Rosanna as PHM - AAA the PHM Secretariat Any guidelines suggestions, for the future from you will be welcome
Best wishes Ravi

-----Original Message-----
From: PHM Secretariat [mailto:phmsec@touchtelindia.net]
Sent: 18 August 2003 11:45
To: PHM_Steering_Group
Subject: [PHM_Steering_Group_02-03] Urgent Response needed

Dear Friends,

Greetings from PHM Secretariat (Global)!

We are on the verge of completing the first draft of a 3-year plan based on some ideas that some of you sent in response to our three communications in July and some guesses and estimates we made through more indirect methods of communication. We shall send this to you all soon.

In the meanwhile, this is a **very important and practical communication**, which we would like you all to take seriously and respond as soon as you can.

The issue before us is as follows:

1. The Iran Alma Ata Anniversary meeting which was proposed to be held between 16th - 21st September, has now been postponed to October 2003 (dates still being explored). They have even suggested December as another option.

   We had hoped that from among the up to 50 invitees from PHM background (originally planned to be invited) Steering group members and secretariat support group members would be given first preference, since it is time we had a full steering group meeting as well, with all plans for WSF, Health Forum (January 2004) and PHA - II , July 2004, beginning to evolve and **hence the urgency.**

2. October is a quite a difficult month because from all the communications so far, the following events are evolving in different parts of the world (PHM related)

   i. 13th to 17th October - CHE and ESPEJO Forum, CUENCA - Ecuador (Latin America)

   ii. 20th to 25th October - International Primary Health Care Forum - Quito

RN 23/8/03

PHM Secretariat

From: claudio <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Wednesday, August 06, 2003 1:48 PM
Subject: PHA-Exchange> WSF 2004: events registration deadlines and procedures

----- Original Message -----
WSF 2004: events registration deadlines and procedures

To register events or self organized activities for the WSF 2004, that will take place in Mumbai, India, from January 16 to 21 of next year go to the following link: www.wsfindia.org/event2004/.

At present, the form is only available in the English version but, soon, it will be also available in French and Spanish.

The registration format has changed regarding the last three editions of the WSF, in Porto Alegre. It will be carried out in two steps.

Phase I: In the first moment, it will be registered the self-organized activities, i.e., seminars, workshops, meetings etc. That registration can be made till September, 30 2003. The proposition of activities only can be made by organizations (not individuals).

Phase II: In the second moment, it will be possible to do the registration of organizations and its delegates. This will start on next week and goes to November, 30 2003.

Deadlines anticipation

The deadlines for registration of activities were anticipated regarding the last three editions of WSF (in Porto Alegre). This is to facilitate the interlinkage among those activities and to allow that the general program of the WSF2004 be available in anticipation for the public who will attend the event so they can prepare its participation in Mumbai. The WSF organization does not intend to reopen the registration process for activities after the deadlines. For 2004, it was established a maximum limit of 04 activities per organization.

During October, it will be prepared a first evaluation of all proposals, in order to identify double registration and to see which activities can be unified. That work will be carried out by the India Organizing Committee in collaboration with the IC commission on content and thematic. In that occasion, they will meet in order to define the set of activities programmed by the WSF organizers. Also, there will be consultations to the proponents to insure adequate space and time available for the activity. All the activities will be accepted (maximum of 04 activities by organization), except those which are not in accordance with the WSF Charter of Principles.

In October-November, the organizations will receive a confirmation of their

To send
to pha-steering group
+ exchange

E covering letter

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activities. Anther change regarding the former forums is that the organization that is proposing an event shall pay the registration fee of at least one delegate as soon as possible. The registered activities not paid until beginning November 2003 will be canceled.

Registration calendar

Activities: until September, 30
Organizations and delegates: until November, 30
Confirmation of the activity: October-November
Payments: until December, 15

Click to see the most common doubts on WSF 2004:
http://www.forumsocialmundial.org.br/noticias_01.asp?cd_news=660

From: "PHM-Secretariat" <secretariat@phmovement.org>
To: <PHA-Exchange@kabissa.org>
Sent: Friday, August 27, 2004 5:31 PM
Subject: PHA-Exchange> Edition 2: A view from the Secretariat, Aug 27 2004

For PHA Exchange

A view from the Secretariat

Edition: 02 **Aug 27th 2004**

Dear Friends,

Continuing with the previous update, this is to keep you informed about some more of the PHM Activities all over the world.

PHM Mauritius, Africa

Mouvement Sante Communataire (PHM Mauritius) held its first International Health Forum as an Alma Ata Anniversary initiative on 31st July and 1st August 2004. The Creole and Bhojpuri translations of the People's Charter for Health were launched. PHM Global was represented by Prof. David Sanders (PHM South Africa) and Dr. Zafrullah Chowdhury (PHM Bangladesh). A more detailed report will be featured on the Exchange shortly. [Mr. Jagadish Goburdhun (mscmu@yahoo.co.in) and Dr. Rudul Boodhun (rudul@intnet.mu)].

PHM Geneva, Europe

Some PHM members and CETIM Geneva are planning a book on **Neo liberal obstacles to Health for All** for release at People's Health Assembly in Ecuador. The book will be action oriented with the aim of encouraging and mobilizing people through awareness raising of the neo-liberal obstacles to Health for All and to showing that action can be taken to counter it by providing examples of success in resistance.

To increase the widest possible representation in the book, the group may organize workshops on the themes / chapters at PHA II for inputs, comments and additions.

It will be multi-sectoral in focus and editions in French, English, Spanish are planned. All PHM members are invited to contribute and circulate [contact Alison (katza@who.int) and Claudio (Claudio@hcmc.netnam.vn) for further details].

PHM Italy, Europe

AIFO Italy, the PHM focal point in Italy and PHM Africa are inviting articles in English, French, Portuguese, Italian from activists, NGOs and grass roots organizations based in Africa related to experience of innovative approaches in community involvement; community participation; community awareness; improving access and awareness and health care for disadvantaged groups; and creative methods for health promotion and strengthening of local organizations.

Articles selected by an International Jury will be part of a book to be released and distributed at PHA II. The objective is to give more international voice to health activists in Africa; advocate greater support; strengthen networking; and enhance involvement of Africa in PHM and PHA II [For further details contact Sunil Deepak – sunil.deepak@aifo.it].

Karachi, Pakistan

Dr. Kausar Khan, Professor of Social Sciences at Aga Khan University and a PHM supporter informed us of her recent experience of teaching the People's Charter for Health and using the Russian version of the Charter as a discussion document among students in Tajikistan in a 3 week course on Community based social development. The students have shared their endorsement through her. (kausar.sklian@aku.edu).

[If any of you have used the charter or any other PHM materials in your training programes and courses, please let us know]

DGS
A Lovely copy please

IFMSA – PHM Evolving Linkage

1/9/04 RN 1/9/04

The **International Federation of Medical Students Association** (IFMSA) co-facilitated a workshop on Medical education at PHA – I in December 2000. At Geneva, May 2004, the PHM Coordinator met around 12-14 IFMSA delegates to WHA and after a short orientation, invited them to actively link into PHM by joining GHW and PHA II initiatives. They were also encouraged to involve their members, who are bilingual (English / Spanish) to help Latin American PHM with PHA II.

Emily Spry, the president of IFMSA writes – "Its excellent to hear from you. I know that Andreas has already been talking to some youth organizations about volunteers for the PHA in Ecuador (lunesco@ifmsa.org). At the moment we are all in Macedonia with around 600 students from 80 countries arriving tomorrow for our General Assembly. Thanks again and delighted to have our links with PHM revived".

Global Health Watch

This initiative towards an Alternative World Health report is evolving though meetings, teleconferencing and email dialogue with the objective of providing a platform for academics, policy analysis, activists and non governmental organizations to promote the accountability of global institution that effect health (WHO, WTO, G8, World Bank); identify unfair, injustice policies and practices at global and national level; highlight needs of the poor and reinvigorate the principles of Health for All; shift health policies to recognize political, social and economic barriers to health; and advocate alternative to market driven approach.

The GHW initiative, a collaborative effort of PHM with Global Equity Gauge Alliance and Medact have called for case studies short essays and testimonies for the 2005 report. (visit www.ghwatch.org.uk for further details and contributions)

Looking forward to hearing from all of you

Best wishes

The PHM Secretariat Team

PS: One of the purposes of these short updates from the secretariat in the exchange is to invite the "PHM - Digital conduits" to disseminate the information further to the e-marginalised groups with whom they are working [Digital conduits are the PHM friends who are moderately e-enabled and could act as a conduits to disseminate information and bring the voices of the e-marginalised into this newsletter. So do circulate this newsletter to others, who cannot access]

.....

PHM-Secretariat

From: "PHM-Secretariat" <secretariat@phmovement.org>
To: <PHA-Exchange@kabissa.org>
Sent: Friday, August 13, 2004 4:07 PM
Subject: A view from the Secretariat - Edition 01 - August 10th 2004

A view from the Secretariat

Edition: 01 **10th Aug**
2004

Dear PHM Friends,

Greetings from People's Health Movement Global Secretariat!

We are starting this communication initiative from the secretariat to share with all of you a 'grand stand' view of the growing People's Health Movement all over the world. As the hub of the PHM wheel, which has spokes reaching to all the country and regional circles, issue circles and PHM partners all over the world, we receive daily through email, post, and visitors and other means of communication a very special view of the PHM activities all over the world. We are starting this new column in the PHM Exchange with an overview of July 2004.

This is not a comprehensive report. It is just a communication of some highlights since nowadays, there are too many to include. We hope it inspires you to join, support and do likewise. Please keep the secretariat informed of any PHM related activity that you or others initiate. And thanks to those all over the world, whose commitment has inspired this communication.

Best wishes from the PHM Secretariat Team

PHM Global Secretariat Team

July 2004 has been a significant month for the People's Health Movement. 44 months beyond the first People's Health Assembly at GK Savar, Bangladesh (December 2000), the movement is beginning to evolve into a multi-dimensional initiative at various levels - local, national, regional and international level. Small and not so small events and processes are taking place all over the world indicating that the PHM has come to stay and is growing.

Thailand

The People's Charter for HIV / AIDS bringing together the voices and concerns of a large number of PHM members and people living with or tackling the HIV / AIDS epidemic was released at the end of the XV International AIDS Conference on 16th July 2004. The Charter had been finalized at a special discussion at a satellite symposium attended by delegates and AIDS activists from many parts of the world and PHM activists from Ecuador, Germany, India, Iran, Philippines, Palestine, Thailand, USA, UK, Zimbabwe etc., An Asian People's Alliance for Combating HIV & AIDS (**APACHA**) was formed to take this activity further. (hiv@phmovement.org)

India

The first Regional Public Hearing on the Denials of Right to Health Care was held in Bhopal, facilitated by Jana Swasthya Abhiyan (PHM India) in collaboration with the National Human Rights Commission. 50 documented cases of denial were presented. This was part of the Right to Health Care campaign, a major initiative launched by PHM India in 2004. (for more details visit www.phmovement.org/india under section 'Campaign')

Pakistan

PHM Circle in Pakistan was reinvigorated and launched through a week's tour of Islamabad, Karachi and Lahore by the PHM Global Coordinator and the PHM India National Convener. A series of meetings and dialogue were held with civil society, academics and policy makers, media and the community. The People's Health Charter

PHM Exchange
RN
8/18/04.

translated into Urdu and Sindhi were distributed (for more details visit www.thenetwork.org.pk/phm.htm).

USA

The US Health Care system was put on trial at the Boston Social Forum held in July. PHM joined a host of organizations, who organized the health track of the forum on the Theme 'Making Health a Human Right'. Dr. Balasubramanian (Sri Lanka) , a key PHM Steering group member was on the International Jury representing PHM. The workshop topics included Racial and Ethnic inequities; Health care workers' struggle; Immigrant access to health care; Global Trade – Democracy and Health; Pharmaceutical Apartheid in the African AIDS programs; Liberation Medicine; Health consequences of WTO, among others. Significantly the flyer of the Health Track mentioned that it was based on the preamble to the People's Charter "Achieving optimal Health for All means that powerful interests have to be challenged that corporate globalization has to be opposed and that political and economical priorities have to be drastically changed. [For more details write to Denise Zwahlen of Doctors for Global Health, PHM at denisezwahlen@yahoo.com and visit www.bostonsocialforum.org].

Latin America

It has become the focus of a lot of PHM Global initiatives in the year to come. Ecuador as host of the Second People's Health Assembly in July 2005, will host the first International PHA – II Advisory committee meeting to start the detailed planning process in September 2004.

In Mexico City in November 2004, PHM has been invited to facilitate a special dialogue on role of Civil Society on Health Research linked to the next Global Forum for Health Research Forum 8 (contact: David Sanders at lmartin@uwc.ac.za)

In January 2005, the next **International Health Forum in Defense of People's Health** will take place at Porto Alegre, Brazil, before the World Social Forum (contact Armando - armandon@portoweb.com.br)

In July 2005, **the second People's Health Assembly** will be hosted by the National Front for the Health of the People (Frente Nacional Por la salud de los Pueblos) in collaboration with fraternal networks and organizations. The first announcement for this has been made and the same can be accessed on our website at the following weblink http://www.phmovement.org/pha-II . You could write to the PHA-II secretariat at phaII@phmovement.org

PHM Evaluation

A report entitled 'Keeping the promise: The People's response to Health For All' (arising out of the evaluation of the process that led to the People's Health Assembly 2000 and the development of the PHM in the last four years) has identified learning experiences and challenges for this movement. The report will be widely distributed soon.

In its final chapter it records "Now, in mid 2004, it is safe to begin to describe PHM as a young, strong and growing movement, one that is drawing on a wealth of wisdom, knowledge and experience from around the world, and one that offers hope that social change to improve People's Health can become more of a reality".

The events of July 2004 definitely give us hope in that direction.

Best wishes

The PHM Secretariat Team

PHM-Secretariat

From: <claudio@hcmc.netnam.vn>
To: "PHM-Secretariat" <secretariat@phmovement.org>
Sent: Tuesday, July 27, 2004 3:33 PM
Subject: For Ravi from Clau (2)

Thank you, Ravi.
I see now that it is not an accross the board problem with WHO. So, of course, what you suggest is miore logical.

Anything I can help on the proposals,I will.
Well stay in touch, OK?
A Hug
Claudio

.

RM 28/7/04

RM 28/7/04

Phan - Claudia
WHO-WHA Circle

PHM-Secretariat

From: "PHM-Secretariat" <secretariat@phmovement.org>
To: <claudio@hcmc.netnam.vn>
Sent: Monday, July 26, 2004 5:04 PM
Subject: Re: For Ravi from Clau

Dear Claudio,

Greetings from PHM Secretariat (Global)!

Post Mumbai - so much has happened that I have been unable to write the fortnightly column, though I do see it as a missed opportunity. Hope to start this from 30th July, then 15th and 30th of every month. Regarding WHO, rather than breaking with every unit because of Jim and Ian's style, I feel we should just ignore the HIV / AIDS unit and continue advocacy with some of the others who are responding - Research unit / Equity unit of EIP etc. The CETIM initiative is a good one and I hope you and Alison can be actively involved and ensure the PHM input into the process.

Will request Andy to keep you informed about the fund raising proposal. The core project to Dutch Government is in and the DFID proposal is in the process of been redone after the first stage proposal. Maria has a PHA - II proposal.

All these are being forwarded to you separately. Please acknowledge and follow up.

PHM-Fundings
Claudio

Best wishes

Ravi Narayan

RN
28/7/04

----- Original Message -----
From: <claudio@hcmc.netnam.vn>
To: <secretariat@phmovement.org>
Sent: Friday, July 23, 2004 6:47 PM
Subject: For Ravi from Clau

> Hi Ravi,
>
> I just left Gva. Met Eu and A and talked on the phone with Nance (although with
> her NOT on the Gva PHM NGO issue).I heard your flop visit to see Jim Kim and
> heard about your response letter. Eu and I agreed we have to make a quick
> choice: if we are ignored, we should consider breaking with WHO. Perhaps we
> achieve more in the opposition.
> A and I had a meting with CETIM. They were interested to publish a book on

FROM: claudio@hcmc.netnam.vn
DATE: Fri, 23 Jul 2004 20:17:24 +0700
TO: <secretariat@phmovement.org>
SUBJECT: For Ravi from Clau

Hi Ravi,

I just left Gva. Met Eu and A and talked on the phone with Nance (although with her NOT on the Gva PHM NGO issue).I heard your flop visit to see Jim Kim and heard about your response letter. Eu and I agreed we have to make a quick choice: if we are ignored, we should consider breaking with WHO. Perhaps we achieve more in the opposition.
A and I had a meting with CETIM. They were interested to publish a book on health and neoliberalism. A and I sugested they participate with PHM and publish the book with the chosen core preparatory papers for PHA II with the advantage that such papers will be sanctioned by a wide PHM membership and will
thus have an invaluable added weight. They liked the idea. We have to work with Maria on this, because IPHC is also looking into the topics for papers.

I had asked you several times about the fundraising proposal. Where does this stand? Can I be of any help? perhaps in editing. I have a good experience in these docs.

A hug
Clau

I urge you to write that fortnightly column for pha-exch.Short and crisp is good.

This mail sent through Netnam-HCMC ISP: http://www.hcmc.netnam.vn/

responding - Research unit/Equity unit of EIPek
The CETIM initiative is a good one and I hope you and Alison can be actively involved and ensure the PHM input into the process. Will request Andy to keep you informed about the fundraising proposal. The core project proposal to Dutch Govt. is in and the DfID proposal is in the process. Meanwhile, for Swiss proposal of been redone after the fiasco. Mane has PHA-II proposal.

All these are being forwarded separately. Please acknowledge and follow up.

RN
26/7/04

RN
26/7/04

PHM. Claudio (Vietnam)

26/7/04

Dear Claudio
Post Mumbai - so much has happened that I have been unable to write the fortnightly columns - though I do see it as a missed opportunity. Hope to start this from 31st July - then 15th and 30th of every month. Regarding WHO rather than breaking with every unit because of Jim and Ian's style I feel we should just ignore the HIV/AIDS unit and continue advocacy with some of the

PHM Secretariat

From: Claudio <avhw@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Thursday, August 28, 2003 5:33 PM
Subject: PHA-Exchange> People's Charter in Greek

From: "Alexis Benos" benos@med.auth.gr>

> Dear Claudio,
> With a great surprise I noticed in the ALma Ata aniversary pack that you
still
> ignore the greek version of the Peoples Charter, already available 2 years
ago...
> Please find it and copy from the following address,
> http://www.healthp.org/article.php?sid=93&mode=thread&order=0
>
> Alexis Benos
> PHA member, preisdent of IAHP,
> Greece

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@lists.kabissa.org
Website: http://lists.kabissa.org/mailman/listinfo/pha-exchange

RM
1/9/03

RM
1/9/03 for Action taken

2/09/03.

PHM - AD Exchange

Main Identity

From: "cehatpun" <cehatpun@vsnl.com>
To: "CHC" <chc@sochara.org>; "N. B. Sarojini" <sama_womenshealth@vsnl.net>; "Ekbal" <ekbal@vsnl.com>; "Vandana Prasad" <chaukhat@yahoo.com>; "FMRAI" <fmrai@vsnl.net>
Cc: "Sundaraman" <sundar2@123india.com>; <ctddsf@vsnl.com>; "Sundararaman" <sundararaman.t@gmail.com>
Sent: Monday, January 02, 2006 12:41 PM
Subject: Re: meeting with P. Hota

Dear friends,
Mr. Hota is out of Delhi from 5th to 12th Jan (see his reply below) - he has suggested that we meet Ms. Jalaja but I am doubtful if that would be of any use - preferable to meet Hota later.
Do give your views on this - and when we could plan to meet Hota later. I am likely to be in Delhi again around 23rd Jan.
With regards,
Abhay

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Sunday, December 04, 2005 10:12 AM
Subject: PHA-Exchange> Course Reader: Health Equity - Research To Action (fwd)

from EQUIDAD@LISTSERV.PAHO.ORG

> COURSE READER
>
> Health Equity - Research To Action
>
> Lexi Bambas and Qamar Mahmood
>
> Course Reader was compiled from the Health Equity - Research to Action
> Trainer's Manual
> by the School of Public Health, University of the Western Cape. 2004
>
> Available online as PDF file [72p.] at:
> http://www.gega.org.za/download/ResearchtoAction04.pdf
> <http://www.gega.org.za/download/ResearchtoAction04.pdf>
>
> ".....An Equity Gauge is a health development project that uses an active
> approach to monitoring and addressing inequity in health and health care.
> It moves beyond a mere description or passive monitoring of equity
> indicators, to a set of concrete actions designed to effect real and
> sustained change, in reducing unfair disparities in health and health
> care. This entails an on-going set of strategically planned and
> coordinated actions, involving a range of different actors, who cut across
> a number of different disciplines and sectors. An Equity Gauge is
> therefore innovative, logical, challenging and effective...."
>
> Content:
>
> 1 Introduction to the Course
>
> 2 Course Aims and Objectives
>
> 3 Programme: Health Equity - Research to Action
>
> 4 Concepts of Equity
>
> 5 The Equity Gauge Approach
>
> 6 Developing an Equity Plan
>
> 7 Assessment & Monitoring: The First Pillar of the Equity Gauge
>
> 8 Advocacy: The Second Pillar of the Equity Gauge

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In
5/12/05 Lib

12/5/2005

>
> 9 Community Empowerment and Participation: The Third Pillar
>
> 10 Planning Action For Equity
>
> 11 Course Readings and Additional Readings of Interest

> The Equity Gauge: Concepts, Principles, and Guidelines
> * English version
> <http://www.gega.org.za/download/gega_guide.pdf> [1.23mb pdf file]
> * French version
> <http://www.gega.org.za/../download/gega_guide_fr.pdf> [852kb]
> * Spanish version
> <http://www.gega.org.za/download/gega_guide_esp.pdf> [662kb]

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@lists.kabissa.org
Website: http://lists.kabissa.org/mailman/listinfo/pha-exchange

UNITED STATES LIBRARY OF CONGRESS
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TELEPHONE: 3316841 FAX 91-11 -373-6066
Web address: http://lcweb.loc.gov/acq/ovop/delhi/delhi.html

June 05, 2000

Request for permission to microfiche publications of your organization

Dear Dr. Narayan :

The Library of Congress Office in India acquires government, commercial and institutional publications for the Library of Congress, Washington, D.C., and other research institutions in the United States which offer facilities for Indic studies. In the operation of this program, we receive a number of publications which are:

a. **not available in sufficient number for all our participants to receive one copy each;**

b. **mimeographed;**

c. **on such poor quality paper that they will not stand the test of time; or**

d. **important documents needing special preservation care.**

This Office has, therefore, implemented a program of making microfiche editions of such publications enabling libraries to continue to obtain valuable research material, preserve them for posterity and also to conserve shelf space in the libraries. A brief explanation of the microfiche program is attached for your information.

The publications issued by your organization are of great interest to research scholars and to depository libraries in the United States. We plan to microfiche your publications for the Library of Congress only. For our program participants we will buy the hard copies of these if available and as required. If not, they can solicit copies from the Library's Photoduplication Service, at cost. As we wish to preserve these valuable publications issued by your Office for use by future generations of researchers worldwide, we would appreciate it if you could extend your cooperation and grant us permission to microfiche your publications for deposit in the Library of Congress. In return for this we will provide you with diazo prints of each of your titles that we microfiche.

Contd...2.

Enclosed is a form letter granting us permission to microfiche your publications for Library of Congress. For authorization, please sign and fill in your name and title.

We hope you will also assist us in our program and give us the necessary authorization. We look forward to hearing from you at your earliest convenience.

Thank you.

Sincerely yours,

Lygia Ballantyne

(Mrs.) Lygia M. Ballantyne
Director

Attachments : as above

Dr. Thelma Narayan
Coordinator
Community Health Cell
Society for Community Health Awareness
Research & Action
367, Srinivasa Nilaya, Jakksandra
I Main, I Block, Koramangala
BANGALORE – 560 034
Karnataka

MICROFICHE PROGRAM

The United States Library of Congress which is located in Washington, D. C. serves the Congress of the United States, the nation, and the world as a reference and research library. It is considered a leader in the dissemination of bibliographic information. As part of its worldwide interests and responsibilities, the Library of Congress has established offices in a number of African, Asian and Latin American countries.

The New Delhi Office was established in 1962 with the purpose of acquiring and processing publications produced in India. Later the responsibility was added for the acquisition and bibliographic control of publications from Bangladesh, Bhutan, Burma, the Maldives, Nepal, Sri Lanka, Mongolia and Tibet. The New Delhi Office does not retain a collection of the materials it acquires but ships all copies to the Library of Congress in Washington and a number of other research libraries in the United States. Titles selected for the Library of Congress are assigned a Library of Congress Control Number (LCCN) / cataloged by the New Delhi office and included in *The South Asian Bibliographer*, a bi-monthly bibliography published and distributed by Sage Publications (New Delhi/London/Thousand Oaks) in collaboration with the New Delhi Office.

In response to the need of libraries to economize on storage space, the Library of Congress Office in India began microfilming selected newspapers and official gazettes from India in 1965. The master negatives are stored in the Library of Congress in Washington and reels of positive microfilm are available from the Library's Photo-duplication Service.

In 1977 the New Delhi Office acquired a microfiche camera-processor enabling it to produce microfiche as well as microfilm. The Office produces microfiche copies of documents of research value which are printed or mimeographed on poor quality paper or are available in insufficient copies to meet the needs of research libraries and scholars throughout the world. As with the microfilm produced by the New Delhi Office, the master negative microfiche is deposited in Washington. Positive film prints are available at cost from the Library of Congress, a non-profit organization. All necessary copyright clearances are obtained before fiching any material.

Director
U.S. Library of Congress Office
American Center
24, Kasturba Gandhi Marg
NEW DELHI - 110 001

Dear Madam :

Thank you for your letter of June 05, 2000 requesting microfiche permission. We hereby authorize you to microfiche our publications. We would appreciate receiving the diazo prints of our publications which you may microfiche.

With best wishes,

Sincerely yours,

Dr. Thelma Narayan
Coordinator
Community Health Cell
Society for Community Health Awareness Research & Action
367, Srinivasa Nilaya, Jakksandra
I Main, I Block, Koramangala
BANGALORE – 560 034
Karnataka

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Sunday, December 04, 2005 10:43 AM
Subject: PHA-Exchange> 2005 world summit at the UN

2005 WORLD SUMMIT

HIGH-LEVEL PLENARY MEETING ¦ 14–16 SEPTEMBER 2005 UNITED NATIONS

2005 WORLD SUMMIT OUTCOME

The world's leaders, meeting at United Nations Headquarters in New York from 14 to 16 September, agreed to take action on a range of global challenges:

DEVELOPMENT

» Strong and unambiguous commitment by all governments, in donor and developing nations alike, to achieve the Millennium Development Goals by 2015.

» Additional $50 billion a year by 2010 for fighting poverty.

» Commitment by all developing countries to adopt national plans for achieving the Millennium Development

Goals by 2006.

» Agreement to provide immediate support for quick impact initiatives to support anti-malaria efforts, education, and healthcare.

» Commitment to innovative sources of financing for development, including efforts by groups of countries to implement an International Finance Facility and other initiatives to finance development projects, in particular in the health sector.

» Agreement to consider additional measures to ensure long-term debt sustainability through increased grantbased financing, cancellation of 100 per cent of the official multilateral and bilateral debt of heavily indebted poor countries (HIPCs). Where appropriate, to consider significant debt relief or restructuring for low and middle income developing countries with unsustainable debt burdens that are not part of the HIPC initiative.

» Commitment to trade liberalization and expeditious work towards implementing the development dimensions of the Doha work programme.

TERRORISM

» Clear and unqualified condemnation—by all governments, for the first time—of terrorism "in all its forms and manifestations, committed by whomever, wherever and for whatever purposes."

» Strong political push for a comprehensive convention against terrorism within a year. Support for early entry into force of the Nuclear Terrorism Convention. All states are encouraged to join and implement it as well as the 12 other antiterrorism conventions.

» Agreement to fashion a strategy to fight terrorism in a way that makes the international community stronger and terrorists weaker.

PHexchange file
Ls
Stin Lib

12/5/2005

PEACEBUILDING, PEACEKEEPING, AND PEACEMAKING

» Decision to create a Peacebuilding Commission to help countries transition from war to peace, backed by a support office and a standing fund.

» New standing police capacity for UN peacekeeping operations.

» Agreement to strengthen the Secretary-General's capacity for mediation and good offices.

RESPONSIBILITY TO PROTECT

» Clear and unambiguous acceptance by all governments of the collective international responsibility to protect populations from genocide, war crimes, ethnic cleansing and crimes against humanity.Willingness to take timely and decisive collective action for this purpose, through the Security Council, when peaceful means prove inadequate and national authorities are manifestly failing to do it.

HUMAN RIGHTS, DEMOCRACY AND RULE OF LAW

» Decisive steps to strengthen the UN human rights machinery, backing the action plan and doubling the budget of the High Commissioner.

» Agreement to establish a UN Human Rights Council during the coming year.

» Reaffirmation of democracy as a universal value, and welcome for new Democracy Fund which has already received pledges of $32 million from 13 countries.

» Commitment to eliminate pervasive gender discrimination, such as inequalities in education and ownership of property, violence against women and girls and to end impunity for such violence.

» Ratification action taken during the Summit triggered the entry into force of the Convention Against Corruption.

MANAGEMENT REFORM

» Broad strengthening of the UN's oversight capacity, including the Office of Internal Oversight Services, expanding oversight services to additional agencies, calling for developing an independent oversight advisory committee, and further developing a new ethics office.

» Update the UN by reviewing all mandates older than five years, so that obsolete ones can be dropped to make room for new priorities.

» Commitment to overhauling rules and policies on budget, finance and human resources so the Organization can better respond to current needs; and a one-time staff buy-out to ensure that the UN has the appropriate staff for today's challenges.

ENVIRONMENT

» Recognition of the serious challenge posed by climate change and a commitment to take action through the UN Framework Convention on Climate Change. Assistance will be provided to those most vulnerable, like small island developing states.

» Agreement to create a worldwide early warning system for all natural hazards.

INTERNATIONAL HEALTH

» A scaling up of responses to HIV/AIDS, TB, and malaria, through prevention, care, treatment and support, and

the mobilization of additional resources from national, bilateral, multilateral and private sources.

» Commitment to fight infectious diseases, including a commitment to ensure full implementation of the new International Health Regulations, and support for the Global Outbreak Alert and Response Network of the World

Health Organization.

HUMANITARIAN ASSISTANCE

» Improved Central Emergency Revolving Fund to ensure that relief arrives reliably and immediately when disasters happen.

» Recognition of the Guiding Principles on Internal Displacement as an important international framework for the protection of internally displaced persons.

UPDATING THE UN CHARTER

» A decision to revise and update the Charter by:

• Winding up the Trusteeship Council, marking completion of UN's historic decolonisation role;

• Deleting anachronistic references to "enemy states" in the Charter.

The full text of the document is available on the Summit website: www.un.org/summit2005

ISSUED BY THE UNITED NATIONS DEPARTMENT OF PUBLIC INFORMATION—SEPTEMBER 2005

URGENT

Community Health Cell

From: <Prashanth_Vasu@mckinsey.com>
To: <chc@sochara.org>; <secretariat@phmovement.org>
Sent: Tuesday, February 14, 2006 9:18 AM
Subject: PHFI - Call with Rajat Gupta and Prashanth Vasu

Hi Ravi.

Per our discussion yesterday. Rajat and I shall call you at 6:00pm on monday, 20-feb-06 at your residence. dont expect it to go for more than 30 mins.

look forward to talking to you.

regards.
prashanth

Prashanth Vasu
McKinsey & Company
Taj Palace Hotel
2, Sardar Patel Marg
Diplomatic Enclave, New Delhi 110 021
Ph : 91-11-2302 3580 / 5562 1245
Fax : 91-11-2687 3227

TO RN / TN (for info)
14/2
File

Main Identity

From: "PHM - Secretariat" <secretariat@phmovement.org>
To: <odw@aber.ac.uk>
Cc: "Claudio" <claudio@hcmc.netnam.vn>
Sent: Thursday, December 16, 2004 6:17 PM
Subject: Re: PHA-Exchange> Globalization and Health Book

Dear Owain,

Greetings from the PHM Global Secretariat!

If you read the note carefully 'it is the first academic book on Globalisation and Health' which includes a contribution from PHM and cares to comment, substantially, on PHM and the People's Charter on Health (now translated into over 50 languages)'. Being an old 'Globalisation and Health' hand I have kept track of all the books – with or without 'Globalisation' in the title but so far they have not noted the evolution of the movement from below. I know Kelly and others at the London School so its not ignorance about books on the subject or about authors, but taking note of an increasing visibility and credibility of the movement. For over four years now academics have been too far removed from grass roots realities to notice a strong evolving movement from below, consisting of strong public health oriented professionals committed to a Health for All goal and building up a countervailing pressure on the system that is getting distorted towards 'Health for those who can pay' by neo-liberal economics. At the recently concluded WHO Interministerial summit on Health Research/Global Forum for Health Research – Forum 8 at Mexico city 16 –20 Nov. 2004, there were twelve of us from the Movement who made 18 inputs as papers and discussants. It was just refreshing to note the independent assessment and comments of Richard and Melinde in their new book. That's all.

I would be glad to get the reference list just incase I have missed some books.

Best wishes,

Ravi Narayan
MD (AIIMS), DTPH (London), DIH (UK).

Coordinator
PHM Secretariat (Global)

RN 17/12/04

Pharm. Exchange

12/17/04

Action Later 17/12/04

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "Owain Williams" <odw@aber.ac.uk>
Cc: "PHM - Secretariat" <secretariat@phmovement.org>
Sent: Thursday, December 16, 2004 9:34 AM
Subject: Re: PHA-Exchange> Globalization and Health Book

point well taken, Owain. Thanks
Claudio

Dear all

I'm afraid this is far from the first book on Globalization and health. Try for instance books recently published by Kelley Lee (2003 I think) titled - Globalization and Health'. There are others in and around the theme but lacking Globalization in the title. I can provide references if anybody needs them.

Cheers

Owain

Dr Owain Williams
Centre for Health and International Relations
Canolfan Iechyd a Gwleidyddiaeth Rynglwadol
Department of International Politics
University of Wales, Aberystwyth
Penglais, Aberystwyth
Ceredigion SY23 3DA
tel: 01970 621799
fax: 01970 622709

>This is the first academic book on Globalization and Health, which not only has a small contribution about PHM as a counter initiative to the ill effects of globalization on health, but also has some interesting comments about the significance of PHM in the Global and globalization context in the introductory and concluding chapters of the book....

cc Claudio

Dear Owain

If you read the note carefully it's the first academic book on Globalisation and Health' which includes a contribution from PHM and cares to comment, substantially on PHM and the Peoples Charter on Health (now translated into over 50 languages. Being an old 'Globalisation and Health' hand I have kept track of all the books - with or without 'Globalisation' in the title but so far they have not noted the evolution of the movement from below I know Kelly and others at the London School so it's not ignorance about books on the subject or about authors, but taking note of an increasing visibility and credibility of the movement. For over four years now academics have been too far removed from grass roots realities to notice a strong evolving movement from below, consisting of strong public health oriented professionals committed to a Health for All goal and building up a counterveiling

12/16/04

6/1/04

Main Identity

Knowledge
WHO - ~~GPH~~ Networks
(new)

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>
Sent: Tuesday, February 22, 2005 4:03 PM
Subject: PHA-Exchange> Politics of health website (reminder)

The Politics of Health Knowledge Network – Invitation to Participate

HealthWrights and the International People's Health Council (IPHC) is developing an online resource called 'Politics of Health Knowledge Network' (see www.politicsofhealth.org). This will be a user-friendly information-sharing tool providing solid facts and well analyzed data, so that concerned people can better respond IN A MORE POLITICALLY ADEQUATE WAY to the most urgent health-related issues confronting humanity.

The 'Politics of Health' web site will summarize and place in the larger MACRO context a spectrum of major health-related concerns. It will, FOR EXAMPLE, map the connections linking the AIDS/TB pandemic to the world's 3 biggest industries (military/arms, illicit drugs, and oil). It will examine how giant corporations and globalizING trade policies Affect human and environmental health, why tobacco is becoming the world's number one killer, and how efforts to reduce poverty and global warming have been stymied. It will explore the new partnerships of UN organizations (UNICEF, WHO) with the pharmaceutical companies and FAST food industry ("the McDonaldization of Primary Health Care") and the World Bank's takeover of Third World policy AND POVERTY ALLEVIATION planning. All of the above will BE tieD into the way that big money buys public elections and undermines democratic processES.

For the many problems the Network WILL map out, it will try to include examples and suggestions for positive alternatives and organized actionS, EMPHASIZING GIVING information ON how to connect WITH OTHERS AND NETWORK.

This online resource is just getting started. The first topic we are beginning to develop is the **'Politics of AIDS.'** We plan to present published data and reference materials in a way that provides the 'big picture' on AIDS policy, education, prevention and treatment. We also hope to bring together voices from around the world BY POSTING a diversity of case studies showing how local events are influenced by policies at the macro level.

please help us make this information tool a success. We seek contributions from people in the People's Health Movement, IPHC, Medact, the International Forum on Globalization, and SO MANY other progressive groups in making this resource grow. If you have a story to tell or a lesson to highlight, please send it TO US by email AT politicsofhealth@igc.org. MORE specifically, we are looking for:

Key Data and Talking Points. We ask your help in pulling together key, well-referenced data, relevant to the politics of health, which make clear points and can be used in constructing useful, convincing arguments. Especially useful are "talking points", I.E., POINTS that juxtapose facts in an eye-opening way. (For example, "Of the world's 100 biggest economies, 51 are transnational corporations and only 49 are nations." Or "WHO estimates that an additional $1 billion per year is needed to halve the incidence of TB by 2020. "The world spends $10/CAPITA per year on perfumes and cosmetics, $15 Billion a year on golf, $30 billion a year on pet food, and $4,000 billion a day on international speculative investments (the global casino)."

Policy and Situational Analysis – We are looking for clear, well-referenced analysEs of government or global policies, and critiques of international bodies OR OFFICIAL DOCUMENTS (right now, especially concerning AIDS, but also on any other health-related issue). We particularly want give an opportunity to TRADITIONALLY marginalized groups to voice their concerns. Send us your own writings, or any information/articles you consider important, on political aspects of the AIDS/TB or other public health issues.

Links and Interaction. We especially want to draw on information/experiences that show how one particular concern ties into others, and how different forces affecting health interconnect. For example, the links between AIDS and TB are evident. But we would also like help in documenting the links BETWEEN HIV/AIDS AND poverty, socioeconomic polarization (and its many causes), debt burden, SAPs, gender and racial inequality, chronic nutritional deficitS, drug companies, patent laws, trade policies, religious dogma, and –perhaps above all else -- the multinational attempt to combat AIDS by disciplining the behavior of victims rather than confronting the need to build a more equitable, PEOPLE'S health-FRIENDLY, and sustainable socioeconomic environment.

Case Studies - Voices from around the world, especially those in remote localITIEes and villages, sharing success stories, as well as failures in their fight against AIDS (or other health issueS). You could tell us your own story and what impact your work is having. Again, we especially want stories that draw a link between policies at the macro level and how they Affect people's health and lives at the micro level. A brief write-up will be adequate. A drawing or photo that drives home a key point can give the story more power, and will help bring the web site to life.

Positive Alternatives and Organized Action - To balance the discouraging data and critical analysEs with positive alternatives and possibilities of action, we hope to devote a separate section to 'Positive Alternatives'. We will document actionS taken and advocacy efforts to reform or transform unhealthy policies, from the local to THE global level. To contribute, you could describe a problem/issueS BEING faced by your community and then provide the actionS/strategIES taken to improve the situation. Others facing similar problems can learn from your experience.

Please note: The PHA-exchange has generated a tremendous wealth of materials on every aspect of the Politics of Health. If well organized and indexed, it could be an invaluable resource, much of which we would like to make available through the Politics of Health Knowledge Network. But this will be a huge job. Is anyone linked to the PHA-exchange doing any kind of culling, organization by themes, or indexing of the messages that pour in? Has anybody pulled out the "best articles" or data on a particular theme, and filed it in an organized way? Or is anybody prepared to take on any of these responsibilities? It would be a way of making the PHA-exchange a much more powerful and useful instrument, and through the Politics of Health Knowledge Network we hope to contribute to that process by making the data and information more easily and widely accessible. Anyone interested? Please contact us.

Also please note:

THE Politics of Health is taking shape almost entirely based on voluntary efforts and will remain a collectively owned and sustained resource.

We are looking not only for persons to send in useful material. We also desperately need persons willing to help with the organization and presentation of the data and information. We are still figuring out the best way to present the information and lay out the web site, to PULL the related subjects together, and to map them within the larger picture.

We need all the help we can get. If you think there is any way you might help, please contact us.

Looking forward to your interest and involvement.

David Werner,
Shefali Gupta,
'Politics of Heath Knowledge Network'
Email: politicsofhealth@igc.org
Website: www.politicsofhealth.org

From: "IPS - Civil Society" <civilsociety@ipsnews.net>
To: <prasanna@phmovement.org>
Sent: Thursday, December 16, 2004 10:19 PM
Subject: The PHM was mentioned in an IPS story

Dear Friend,

We thought you would be interested to see that the People's Health Movement was mentioned in a recent IPS story. Please visit the general news site of the Inter Press Service at http://ipsnews.net or go directly to the story in which the PHM was mentioned:

The Cost of Dying Without Having Been Born
http://ipsnews.net/new_nota.asp?idnews=26386

IPS is an independent, professional news agency with a focus on the South, development, civil society and the process of globalisation and those excluded from it.

To comment on an IPS story or on our coverage in general, please contact us at civilsociety@ipsnews.net

With best wishes,
The IPS team

SSD

To

PHM Exchange

TSA-NCC yahoogroup

RN
17/12/04

12/17/04

12/12/04

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Thursday, August 04, 2005 5:58 AM
Subject: PHA-Exchange> TREATY TO PREVENT WATER-RELATED DISEASES IN EUROPEENTERS INTO FORCE

> > *TREATY TO PREVENT WATER-RELATED DISEASES IN EUROPE ENTERS INTO FORCE
> > *
> >
> > *Copenhagen/Rome -* The Protocol on Water and Health to the 1992
> > Convention on Protection and Use of Transboundary Watercourses and
> > International Lakes enters into force on 4 August 2005, following
> > ratification by the minimum 16 countries: Albania, Azerbaijan,
> > Belgium, the Czech Republic, Estonia, Finland, France, Hungary,
> > Latvia, Lithuania, Luxemburg, Norway, Romania, the Russian Federation,
> > Slovakia and Ukraine. The Protocol will improve health by contributing
> > to the prevention, control and reduction of water-related diseases. It
> > covers both the provision of safe drinking-water and adequate
> > sanitation and the basin-wide protection of water resources. The
> > Protocol calls on the ratifying countries:
> >
> > * to strengthen their health systems;
> > * to improve planning for and management of water resources;
> > * to improve the quality of water supply and sanitation services;
> > * to address future health risks; and
> > * to ensure safe recreational water environments.
> >
> > In the WHO European Region, the implementation of the Protocols
> > provisions is jointly coordinated by the WHO Regional Office for
> > Europe and the United Nations Economic Commission for Europe (UNECE).
> >
> > Its a significant date for public health. The Protocol on Water and
> > Health is the worlds first legally binding international agreement in
> > the fight against water-related diseases,says Dr Marc Danzon, WHO
> > Regional Director for Europe. This is an effective instrument to help
> > ratifying countries achieve the Millennium Development Goals.
> >
> > Transboundary water resources are common in the Region. Some countries
> > depend on their neighbours for over 5090% of their water, so
> > international cooperation is crucial to ensure the sustainable use of
> > such resources.
> >
> > Lack of safe drinking-water and poor sanitation threaten the health of
> > millions of people in the WHO European Region. While most of the
> > Regions 877 million people take clean water for granted, too many
> > still lack a regular supply:
> >
> > * almost 140 million (16%) do not have a household connection to a
> > drinking-water supply;

PHA-Exchange

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4/8/05

> > * 85 million (10%) do not have improved sanitation; and
> > * over 41 million (5%) lack access to a safe drinking-water supply.
> >
> > Water-related diseases of microbiological origin that are identified
> > for priority action include cholera, bacillary dysentery,
> > enterohaemorrhagic/ Escherichia coli/, typhoid (and paratyphoid) and
> > viral hepatitis A. The countries that are Parties to the Protocol will
> > review their systems for disease surveillance and outbreak detection,
> > and implement the most appropriate measures to reduce disease,
> > including vaccination or water treatment and distribution measures.
> > Chemical contaminants of drinking-water and related diseases are also
> > under review.
> >
> > This aspect of implementing the Protocol contributes to achieving the
> > two Millennium Development Goals that include improving water supply
> > and sanitation and reducing child mortality. The incidence of
> > infectious diseases caused by poor-quality drinking-water is often
> > highest in children aged 611 months. In the WHO European Region, this
> > risk factor causes over 13 000 deaths from diarrhoea among children
> > aged 014 years (5.3% of all deaths in this age group) each year, with
> > the countries of central and Eastern Europe and central Asia bearing
> > the largest share of the burden.
> >
> > The entry into force of the Protocol is not the end, but the beginning
> > of a process intended to increase the number of European citizens with
> > access to safe drinking-water and basic sanitation,concludes Dr
> > Roberto Bertollini, Director of the Special Programme on Health and
> > Environment at the WHO Regional Office for Europe. We encourage
> > countries to ratify the Protocol, thus developing a national and
> > international system to manage and use water resources safely and
> > sustainably, for the benefit of human health.
> >
> > Further information on the Protocol and the water and sanitation
> > programme of the WHO Regional Office for Europe is available on the
> > Regional Office web site (_http://www.euro.who.int/watsan_).
> >
> > **Thirty-six countries signed the Protocol during or after the Third
> > Ministerial Conference on Environment and Health, held in London,
> > United Kingdom in 1999. Progress made under the Protocol since then
> > includes the building of a framework for setting country-specific
> > targets, harmonized data collection and reporting, and water-related
> > disease surveillance.**
> >

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>
Cc: "goran" <dahlgren38@telia.com>
Sent: Tuesday, December 14, 2004 5:59 PM
Subject: PHA-Exchange> Understanding China's (uneven) progress against poverty

Understanding China's (uneven) progress against poverty
Learning from Success

Martin Ravallion and Shaohua Chen, World Bank Development Research Group
Finance & Development December 2004
Volume 41, Number 4

Available online as PDF file at: http://www imf.org/external/pubs/ft/fandd/2004/12/pdf/ravallio.pdf

".....Over the past 25 years, China has made huge strides in its battle against poverty as it has transformed into one of the most dynamic
economies in the world. China's poverty rate today is probably slightly lower than the average for the world as a whole.
But around 1980 the incidence of poverty in China was one of the highest in the world.
What might the many developing countries that have been less successful against poverty learn from China's experience? And
what can China learn for its continuing efforts against poverty?

The study shows that, while the incidence of poverty in China fell dramatically, progress was uneven. Rural areas accounted for the
bulk of the gains to the poor, although migration to urban areas helped. However, for China to make more progress against poverty, it
will have to confront the problem of rising inequality....."

China's (Uneven) Progress Against Poverty
Working Paper No.: 3408 - September, 2004
Research Paper [PDF 57p.] at: http://econ.worldbank.org/files/38741_wps3408.pdf

PHM-Exchange

RN
15/12/04

12/15/04

15/12/04

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>
Sent: Tuesday, December 14, 2004 5:58 PM
Subject: PHA-Exchange> Study on the Impact of the Implementation of the CRC

From: Ruggiero, Mrs. Ana Lucia (WDC)

Study on the Impact of the Implementation of the Convention on the Rights of the Child

The UNICEF Innocenti Research Centre (IRC), Florence, Italy
United Nations Children's Fund (UNICEF) 2004

Summary available online as PDF file [30p.] at: http://www.unicef-icdc.org/publications/pdf/CRC_Impact_summaryreport.pdf

".....2004 marks the fifteenth anniversary of the adoption and subsequent ratification of the United Nations Convention on the Rights of the Child (CRC). The CRC is currently closer to being universally accepted than any other international human rights treaty. The CRC is also unique in that it so fully embodies civil, economic, political, social and cultural rights.

Critical questions: is the impact of the Convention on the Rights of the Child (CRC) real or rhetorical? How has it been implemented? Ultimately, what has been the effect of the CRC on the daily lives of children? How far has the enjoyment of their human rights been advanced? What has been its effect in terms of generating social change?

The study celebrates the achievements that have taken place since the adoption of the CRC, in regions the world over. At the same time, it is a study that acknowledges the many challenges that remain, in implementing a treaty with such a broad scope.

...The study focuses on the general measures of implementation of the CRC in 62 countries, with a particular emphasis on legal and institutional reforms at the national level aimed at ensuring the effective application and enforcement of the

PHM. Exchange

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15/12/04

12/15/04

15/12

Main Identity

From: "PHM - Secretariat" <secretariat@phmovement.org>
To: <odw@aber.ac.uk>
Cc: "Claudio" <claudio@hcmc.netnam.vn>
Sent: Thursday, December 16, 2004 6:17 PM
Subject: Re: PHA-Exchange> Globalization and Health Book

Dear Owain,

Greetings from the PHM Global Secretariat!

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I would be glad to get the reference list just incase I have missed some books.

Best wishes,

Ravi Narayan
MD (AIIMS), DTPH (London), DIH (UK).

Coordinator
PHM Secretariat (Global)
c/o CHC
No. 359 (old No. 367)
Srinivasa Nilaya, Jakkasandra 1st Main
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Fax: 00-91-80-25525372
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PHM-Exchange
Dialogue

RN
20/12/04

Dear Owain,

Greetings from the PHM Global Secretariat!

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towards 'Health for those who can pay by

16-20 Nov 2004,

refreshing to note the

I would be glad to get the reference list just incase I have missed some books.
Best wishes,

Dr Ravi Narayan, Co-ordinator PHM Global Secretariat.
MD (AIIMS), DTPH (London), DIH (UK).

cc Claudio

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>
Cc: "Kent" <kent@hawaii.edu>
Sent: Wednesday, December 15, 2004 12:28 PM
Subject: PHA-Exchange> Food for the right thoughts in health fedback

From: "George Kent" <kent@hawaii.edu>
A few comments on Human Rights Reader 91
> > THE HUMAN RIGHTS DISCOURSE IN HEALTH. (Part 1 of 2)
(Claudio's reactions added)

> > 2.... This is to be seen in good
> > part as a failure of beneficiaries themselves to act as empowered
> > claim holders placing their demands from a power base that can
> > force non-performing duty bearers to provide the services and resources
> > needed to reverse those violations.

(gk1) Rights holders normally do not have a clear idea of the services to
> which they are entitled on the basis of international human rights.
> It is essential to have human rights law concretized in national
> law to spell out how the national government understands it obligations.
(cs1) Agree.

> > 3....We have become quite good at doing detailed Situation Analyses
> > of unfulfilled needs and entitlements.

(gk2) We have? Can we cite some good examples? Do we have ANY examples of such analyses undertaken by the rights holders themselves?
(cs2) I think there are a few. For example, the people of Iringa province in Tanzana on the 1980s come to mind.

(gk2a) Sound human rights education should prepare rights holders to do situation analyses.
(cs2a) Agree.

>>... But these only list and sometimes characterize the multiple violations of >> the right to health. So these represent diagnoses only.

(gk3) Only? This is a major achievement! I have not yet seen any analysis that distinguishes between health service deficiencies in general, and those particular deficiences that represent violations of the human right to health.
(cs3) True.

PHM-Exchange

>>... Moreover, entitlements and needs do not carry correlative duties for
> duty-bearers. Rights do!

(gk4) In my usage of the term, entitlements do have correlative duties. How are you using the term?
(cs4) I am sure needs do not carry correlative duties. Entitlements, I declare my ignorance. Will check.

RN
16/12/04

> > 4.... Capacity Analyses have also been
> > called Accountability Analyses, because seeking accountability
> > provides claim holders with the opportunity to understand how duty
> > bearers have discharged their obligation and provides duty bearers
> > with the opportunity to explain their conduct.

15/12/04

(gk5) Capacity alone does not automatically imply obligation. Thus I prefer the term "Accountability Analysis." In using this term, do you mean the process of figuring out who is accountable in general terms, or do you mean the actual process of calling the duty bearer to account in relation to a specific violation?
(cs5) Calling the duty bearers to acount in relatoin to a specific violation.
The literature calls this 'capacity analysis'; not my invention.

> > 5. ...After carrying out these capacity analyses, we have to --in an
> > organized way, through proactive community mobilization-- embark
> > with the beneficiaries in doing-something-about-those-violations.

(gk6) I prefer to speak of them as rights holders, rather than beneficiaries. The rights holders themselves should participate actively in the analyses, insofar as that is feasible.
(cs) Agree.

> > 7. ...Unfulfilled-needs-and-entitlements-seen-as-violations-of-human-
> > rights, on the other hand, DO bind duty bearers legally under
> > international law and, among other, under the Constitution of the
> > World Health Organization (WHO).

(gk7) Human rights law alone is not concrete enough to give rights holders a clear idea of what they should expect from their national governments and other duty bearers. National governments should be pressed to make their commitments very clear by passing appropriate national legislation that says how they will carry out their obligations.
(cs7) Agree.

> > 8. ... There is
> > thus now a growing body of international HR law and practice to
> > help us identify the specific interventions and policies that are
> > needed to achieve human (people's) rights goals in health.

(gk8) I would say much of this work should be about lobbying for appropriate national law that is designed to concretize existing obligations under international human rights law.
(cs9) Agree.

> > 10. ...It needs to be emphasized here that reaching the MDGs also will
> > have to pass through breaking the poverty syndrome behind pretty
> > much all the indicators of the MDGs. In our case, looking at these
> > goals only through the prism of the right to health will only
> > advance our cause in the health indicators (goals), i.e., a very
> > partial victory.

(gk9) The leaders of the MDG process at the global level are not proposing strategies that can seriously be expected to achieve the goals. They are simply elevating the levels of disappointment. Perhaps we can get serious strategic efforts to achieve the goals within a few countries. Which are the most likely candidates? Where are these goals being taken seriously?
(cs9) Agree. Do no have an answer to the two questions.

> > 11. ...The HR cause gives us the possibility to advance our political
> > agenda towards equity, towards the indispensable structural
> > changes that need to be made for health and other social services
> > to receive the resources they need to reverse the corresponding
> > rights currently being violated.

(gk10)There is the danger that in strategizing the task of sharply
> improving health, food, and economic situations, many poor countries
> look to rich countries for assistance of various kinds. All the evidence
> tells us the rich really don't care enough to do what needs to be done.

> have the problems, and on their strong leaders. They need to do their
> own strategizing, because the strategies proposed by the rich are based
> largely on protecting the interests of the rich.
(cs10) Agree, but have my doubts about 'their strong leaders".

> > 12. ...If not willing to cooperate, we now can face duty bearers
> > accusing them of violating international law. And that is a
> > tactical advantage. We can now demand structural changes under the
> > wing of international law.

(gkl1) Yes, international human rights law is of enormous value in that it clearly articulates widely accepted norms. However, there is still a need for concretization of these norms at the national level, and for serious political work to assure that these norms are met. This means there is a need to mobilize serious strategic thinking, not among the supposed patrons of the poor, but among the poor themselves.
(cs11) Agree.

Main Identity

From: "Dr.Dabade" <drdabade@sancharnet.in>
To: <PHA-ncc@yahoogroups.com>; "drug action India" <drugactionindia@healthyskepticism.org>
Sent: Tuesday, May 03, 2005 7:43 PM
Subject: [pha-ncc] Fw: FDA Calls Efforts For Bayer Illegal

Dear All
An interesting article about misdeeds of Bayer
GOPAL

.....

Dr Gopal Dabade ,
57, Tejaswinagar,
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----- Original Message -----
From: CBGnetwork
To: c.a.woolfson@socsci.gla.ac.uk
Sent: Tuesday, May 03, 2005 3:21 PM
Subject: US: FDA Calls Efforts For Bayer Illegal

Send to Exchange PHM
Also to PHM Screening Group

RN 4/5/05
PHA2 website story?

Washington Post, April 30, 2005

FDA Calls Efforts For Bayer Illegal

Lawmakers' Help for Drug Firm Tests Limits

The German pharmaceutical giant Bayer suffered a serious setback last year when a federal administrative law judge backed a proposed ban on a drug used to fight poultry infections at factory farms. The judge cited growing scientific evidence suggesting that the practice was reducing the effectiveness of antibiotics vital to human health.

Facing defeat in a three-year legal battle, Bayer sought help in a new arena -- Congress. In a letter written in the office of Rep. Charles W. "Chip" Pickering Jr. (R-Miss.), and with the assistance of a Bayer lobbyist who was a longtime Pickering friend, 26 House members argued that the poultry medicine was "absolutely necessary to protecting the health of birds." It called on Lester M. Crawford, acting commissioner of the Food and Drug Administration, to set aside the judge's decision regarding the class of drugs. The Bayer product is known as Baytril.

The Baytril case provides an unusual look at an attempt by lawmakers to influence the executive branch's handling of an important public health issue involving parochial economic interests and complex science. In stepping in, the congressmen entered a murky area and overstepped legal limits on their involvement, FDA officials said. While members of Congress frequently write to agencies as part of regular oversight, they are not supposed to intervene in formal, trial-type proceedings.

Less than a month after the July 22, 2004, letter, the FDA informed the legislators in writing that their attempt to sway Crawford violated federal rules intended to shield him and other decision makers in similar quasi-judicial proceedings from outside pressure. They admonished the lawmakers that they were "not allowed" to communicate with Crawford because the lengthy public record of testimony and documentary evidence was closed.

RN 4/5/05

Pickering, who is vice chairman of the House Energy and Commerce Committee, which has jurisdiction over the FDA, strongly defends the letter. A statement from his office said he "acted under legislative branch rules, representing his constituents and defending their interests." The congressman, it added, "believes the medicine discussed in the letter is vital to maintaining the jobs and businesses in Mississippi based on poultry, and he stands by the content of the letter." Crawford, now awaiting confirmation as FDA commissioner, is still considering Bayer's formal appeal of the judge's decision upholding the proposed ban. The FDA has declined to say whether he saw the congressmen's letter. Baytril is still being used in the poultry business.

Federal rules require communications from outside channels, such as the lawmakers' letter, to be made part of the public record of the case so that all sides are aware of them. But in this case the letter was not placed in the public docket until December, more than four months after it was sent, because of what the FDA said was an "inadvertent oversight."

"They are weighing in on the side of parochial economic interests against the public health, and that's disappointing," said Margaret Mellon, director of food and environment programs at the Union of Concerned Scientists.

Antibiotic Resistance

The October 2000 decision by the FDA's Center for Veterinary Medicine to withdraw approval for Baytril was a milestone in the agency's attempts to protect human health. It was the FDA's first formal withdrawal notice for an animal drug based on concerns that it could make human drugs less effective. The decision set the stage for current regulatory steps that could lead to bans on other animal drugs, such as penicillin and tetracycline.

Baytril is a fluoroquinolone antibiotic, among the strongest class available to treat humans suffering from food poisoning and a broad range of bacterial infections, including anthrax. When the FDA's veterinary division approved Baytril in 1996, public health advocates warned that it could lead to an increase in bacteria impervious to Cipro, Bayer's highly successful fluoroquinolone for humans.
In withdrawing approval, the CVM cited a study that found rising levels of fluoroquinolone-resistant bacteria in supermarket chicken and in people who prepared and ate chicken. Cipro-resistant bacteria, all but unknown in the 1990s, soared to 13 percent of the bacteria sampled in 1997. Follow-ups showed resistance rising to 20 percent in 2002 before dropping slightly in 2003. The FDA's findings and proposed action were supported by the Centers for Disease Control and Prevention, the American Medical Association, the Union of Concerned Scientists, and two agencies at the Department of Agriculture.

None of the research pointed to Baytril as the sole culprit. Public health officials had long recognized that the overprescribing of antibiotics increased resistance to the drugs in humans. But the data persuaded the FDA's veterinary regulators to propose banning Baytril and SaraFlox, a similar product from Abbott Laboratories. Abbott agreed to withdraw its product. But Bayer contended the FDA data were so flawed that there would be repercussions for the entire animal-drug industry if they went unchallenged. Forty to 70 percent of U.S. antibiotics are used in agriculture.

Robert Walker, spokesman for Bayer's Animal Health Division in Shawnee Mission, Kan., denies that Baytril is a significant contributor to the spread of resistant bacteria, saying there are "a lot of other factors at play." He added: "We don't feel there's anything from a scientific standpoint that supports taking it off the market." Bayer has argued that although only 2 percent of chickens were treated with Baytril, the industry would lose millions of dollars a year if it were removed as an option. The company noted that the incidence of human infections resistant to Cipro-type medicines has declined sharply. The congressmen's letter said cases in which Cipro did not work dropped from 3.28 per 100,000 in 1997 to

2.62 per 100,000 in 2001.

Bayer's appeal triggered a review that over the next 38 months produced thousands of pages of documents and days of testimony before FDA Administrative Law Judge Daniel J. Davidson. To wage the legal battle, Bayer HealthCare, the subsidiary that oversees animal drug production, hired McDermott, Will and Emery of Chicago, the world's 14th-largest law firm. The Animal Health Institute (AHI), the main trade group of animal-drug makers, quickly joined Bayer in contesting the ruling.

Bayer and AHI got little public help from the huge, vertically integrated retail chicken producers that are the main users of Baytril. While the broiler industry, as it is known, views Baytril as "a valuable medication that ought to be available," said Richard Lobb, spokesman for the National Chicken Council, many big companies that sell chicken under their own labels to customers in supermarkets were unwilling to publicly embrace the use of antibiotics. "It's not something we're up there banging away on" in Congress, Lobb said.

Bayer and AHI pursued other avenues. AHI filed petitions with the FDA and the CDC under a new business-friendly law, the Data Quality Act, seeking a "correction" of the information the agencies were putting out about Baytril. And in 2002, AHI hired former senator Robert W. Kasten Jr. (R-Wis.), paying him $75,000 a year to facilitate contacts with top officials at the Department of Health and Human Services on the Baytril matter. The department was the FDA's parent and was then led by former governor Tommy G. Thompson, a longtime Kasten political ally. AHI was "writing letters and not getting answers back," Kasten said. He said he arranged meetings with "legal people around the secretary" and may have mentioned the matter to Thompson. He also recalled at least one meeting with Crawford, then number two at the FDA.

Separately, Bayer HealthCare hired lobbyist Wayne Valis to work with administration officials on the validity of the government data on fluoroquinolones. Valis recalled setting up one or more meetings with officials at the White House office that oversees regulatory issues, as well as with officials from the FDA and several other agencies.

Bayer was unsuccessful in getting the corrections it sought from the FDA or the CDC, however, and in March 2004, Davidson strongly backed the veterinary division's proposed ban in a 68-page decision. He said the evidence "does not establish that the social and economic benefits [of this class of antibiotics] outweigh the risks to public health." Davidson cited recent studies of bacteria in chicken showing increased levels of drug resistance. A 1999-2000 sampling of retail meat in the Washington area also mentioned in his ruling found that 35 percent of the suspect bacteria was resistant to Cipro-type drugs.

Cash and Catfish

By then, Bayer had already begun looking for help in Congress. Christopher Myrick, a lobbyist hired by Bayer in early 2004, had a long-standing connection to Pickering. They both grew up in Jones County, Miss., and their families knew each other well, attending church and school together, according to the congressman's office. When Pickering -- whose father was a federal judge and former state GOP chairman -- decided to run for a House seat in 1995, Myrick was one of his first contributors.

Myrick, a former Senate staff member, has been counsel to pharmaceutical giant Wyeth/American Home Products Corp., and has held leadership posts on trade associations, including AHI, according to his résumé. In March 2004, he attended a small Pickering fundraiser for drug company representatives at the 116 Club, a Capitol Hill favorite of southern lawmakers that serves home-style catfish on request, along with chicken, dumplings and crab.

The event raised $11,000, Pickering spokesman Brian Perry said. Lobbyists for Merck, Pfizer, Abbott

Laboratories and Hoffmann-LaRoche chipped in, campaign finance records show. Myrick contributed $1,000, and two partners in his lobbying firm, Larson, Dodd, Stewart & Myrick, donated to Pickering then or later in the year. Myrick did not return a phone call seeking comment.

Bayer representatives met with Pickering's congressional staff on June 17 and 23, according to his office. Perry identified the participants as Myrick and Julie Spagnoli, Bayer HealthCare's new chief Washington representative. Bayer, he said, "produced verbiage" for the letter and "brought in a lot of the material." "We put together a kit to educate members of the media on the issue. It's most likely that is what she [Spagnoli] shared with them," said Walker, the spokesman for Bayer's Animal Health Division. "But I must stress generation of the letter was not due to Bayer writing it."
Pickering's office said a senior House Democrat, Rep. Bobby R. Etheridge (N.C.), and members of the House Agriculture Committee were given a chance to make changes. In all, 18 Republicans and eight Democrats signed. Among them were the House's third-ranking Republican, Whip Roy D. Blunt (Mo.); John A. Boehner (Ohio), second-ranking Republican on the Agriculture Committee; and Nathan Deal (R-Ga.), who recently became chairman of the Energy and Commerce Committee's health panel.

Blunt's office explained his stance by saying, "The poultry industry is a $1.77 billion industry in Missouri's 7th District, creating nearly 16,000 jobs for Congressman Blunt's constituents." Ten of the 26 signers, including Pickering, Etheridge and Blunt, received campaign contributions from Bayer's political fund in 2003 and 2004.

Rep. Sherrod Brown (Ohio), ranking Democrat on the Energy and Commerce Committee health panel, said he learned of it only when told about it in March.

The lawmakers, who did not mention either Bayer or Baytril by name, urged Crawford to "go the extra mile" to ensure FDA action on fluoroquinolones was based on valid science. But last Aug. 17, the FDA responded that the Code of Federal Regulations prohibited such contacts at that stage. The code, however, specifies no criminal penalties.

In defending the decision to send the letter while Crawford was reviewing the case, Pickering's office cited a 1970 advisory opinion of the House ethics committee saying a member may contact a federal agency to "call for reconsideration of an administrative response which he believes is not supported by established law, federal regulation or legislative intent." Lawyers specializing in ethics issues say Congress's oversight duties give members considerable leeway to contact officials, but there are limits during formal proceedings such as those the FDA is conducting. The House Ethics Manual states, "Since 1976, the Government in the Sunshine Act has prohibited anyone from making an ex parte communication to an administrative agency decision-maker concerning the merits of an issue that is subject to formal agency proceedings."

Such an intrusion amounts to "unfair and undue congressional interference in a judicial proceeding," said Stanley Brand, a former chief counsel of the House. Donald Kennedy, a former FDA commissioner, said: "I never received any letters like that when I was in the position of making a quasi-judicial decision, and should not have. It is clearly improper."
(By Dan Morgan and Marc Kaufman)

Coalition against BAYER-dangers (Germany)
www.CBGnetwork.org
CBGnetwork@aol.com
Fax: (+49) 211-333 940 Tel: (+49) 211-333 911
please send an e-mail for receiving the English newsletter Keycode BAYER free of charge.
German/Italian/French/Spanish newsletters also available.

Please support us. Our international campaigns are expensive to run. We receive no public support and depend entirely on your donations.

Please send checks to: CBG, Postfach 15 04 18, 40081 Duesseldorf, Germany

or by bank transfer to bank account number 8016 533 000 at GLS Bank, Germany
sort code: 430 609 67

BIC/SWIFT Code: GENODEM1GLS (Bank Identifier Code)

IBAN: DE88 4306 0967 8016 5330 00 (International Bank Account Number)

Please note that bank transfers within Europe are usually no more costly than within your own country, if you quote the BIC and IBAN

Main Identity

From: "Nisha Susan" <nisha@phmovement.org>
To: <pha-exchange@lists.kabissa.org>
Sent: Thursday, June 02, 2005 11:28 AM
Subject: PHA-Exchange> arts and crafts at the assembly

Is your region rich in indigeneous art and craft? In days past did travellers long for the handlooms of your country because they blazed with colour and life? Have the people of your region in possession of a knowledge of eco-friendly alternatives to a high-consumption lifestyle. Does your region have craft collectives that are reviving indigeneous art and craft forms? Well then, bring your shawls, beads, sculptures and wall-hangings to Cuenca. Share the skills of your people with the world.

What you can do:

- Bring samples of art and craft from your region that is distinctive to your region.
- Bring a mobile exhibition or a video that shows the people and the story behind the craft
- Bring art and craft for sale
- Organize materials and resource persons for demonstrations at the assembly.<>

<>

Things to remember

- <><>If you are selling crafts do remember to print some simple one or two page fliers with a few pictures of your products, pricing information and the story behind your crafts.
- Avoid bringing food as there are restrictions about carrying food across borders.

<>

For further enquiries please contact : Dr Hari John (hariprem@eth.net)

Warm regards,

Nisha Susan

Main Identity

From: "Nisha Susan" <nisha@phmovement.org>
To: <pha-exchange@lists.kabissa.org>
Sent: Tuesday, May 31, 2005 1:14 PM
Subject: PHA-Exchange> Bring a pinch of harmony

Bring a pinch of harmony

In recognition of the important role of traditional medicine *Track Two* of the Second People's Health Assembly in Cuenca will focus on the Intercultural Encounters and Health. It is estimated that in Africa up to 80% of the population use traditional medicine for primary health care. Even in the industrialized First World where these systems of medicine are called alternative 50% of the population are estimated to have used alternative medicine at least once. The provision of safe and effective traditional medicine is therefore a critical tool to increase access to health care.

Multiple systems of medicine are thriving in Ecuador and a Harmony Point will be an important part of the Assembly at Cuenca to promote holistic care (of even the delegates!) This desk will offer care by indigeneous physicians and healthworkers.

What you can do:

1. Bring delegates who are practitioners of traditional medicine so that demonstrations and workshops can be arranged.
2. Bring samples of indigenous medicine from your region for the exhibition of traditional medicine from around the world.
3. Bring special tools used to make indigenous medicine
4. Bring literature (posters, charts, leaflets, instructional manuals) on traditional healing practices from your region.
5. Bring films/videos on traditional and indigenous systems of medicine.

Please note that if you are bringing herbs they need to be packaged as it may not be a good idea to carry fresh herbs across borders.

For further enquiries please contact Dr.Hari John: harikumarijohn@yahoo.co.in

Warm regards,

Nisha Susan

RN
31/5/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Tuesday, August 02, 2005 7:37 AM
Subject: PHA-Exchange> International Conference: Creating Healthy Societiesthrough Inclusion and Equity

From: Ruggiero, Mrs. Ana Lucia (WDC)

International Society for Equity in Health - ISEqH Fourth International Conference

September 11 to September 13, 2006 - Adelaide, Australia
The Conference Theme: *Creating Healthy Societies through Inclusion and Equity*

Website: http://www.iseqh.org/temp_conf2006.htm

In addition, the conference will focus on two new topics, to encourage the presentation and discussion of research and evaluation on the achievement of equity:

- **aboriginal health,** acknowledging the need to address the inequities experienced by many indigenous communities; and
- **arts and equity in health,** exploring ways to evaluate how working through the arts improves social inclusion and enhances equity in health

Working Definitions

Equity in health: The absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically

Inequity in health: Systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically.

Equity (policy and actions): Active policy decisions and programmatic actions directed at improving equity in health or in reducing or eliminating inequalities in health.

Equity (research): Research to elucidate the genesis and characteristics of inequity in health for the purpose of identifying factors amenable to policy decisions and programmatic actions to reduce or eliminate inequities.

Important Dates

PHM Exchange
Conference notice

RN
2/8/05

1/1/99

Submission of Abstracts	**until March 1, 2006**
Selection of Abstracts	by April 15, 2006
Early registration	until July 11, 2006
Conference	September 11 to 13, 2006

Additional Information: International Society for Equity in Health
263 McCaul Street, 4th floor
Toronto, Canada, M5T 1W7
email: iseqh.info@utoronto.ca phone: +1-416-978-3763 fax: +1-416- 946-3147

Main Identity

From: "Jennifer Staple" <Jennifer.Staple@aya yale.edu>
To: <pha-exchange@lists.kabissa.org>
Sent: Friday, August 05, 2005 11:36 PM
Subject: PHA-Exchange> Final Call for Abstracts - International HealthConference

CALL FOR ABSTRACTS - Unite For Sight's 3rd Annual International Health Conference "Empowering Communities to Bridge Health Divides"

ABSTRACT SUBMISSION DEADLINE: AUGUST 15

When: April 1-2, 2006
Where: Yale University, New Haven, Connecticut
Theme: "Empowering Communities to Bridge Health Divides"
Who should attend? Anyone interested in medicine, health education, health promotion, public health, international health, international service, or eye care
Conference Goal: To empower conference attendees to identify health needs and to develop solutions to improve access to care for the medically underserved
How to Register - Early Bird Registration!
http://www.uniteforsight.org/2006_annual_conference.php
Early Bird Registration Rate: $25 student rate; $30 for all others
How to Submit Abstract: http://www.uniteforsight.org/2006_conference_posters.php

Abstract Categories - Submission Deadline August 15

1. International Medicine and International Health
2. Public Health
3. Scientific Research
4. Advocacy and Health Policy
5. Nonprofits in Health

PHM- USA

RJ 9/8/05

FEATURED SESSIONS - Additional Speakers To Be Announced

Keynote Address
"Environment, Behavior and Health: Societies Matter" Al Sommer, MD, MHS

The Health of Women and Children: A Global Overview
"Women's Health: A Global Overview," Allan Rosenfield, MD
"Strengthening Community Capacity for Maternal, Newborn and Child Health," Charles MacCormack
"The Challenges of Pediatric AIDS in Africa - A Lesson in Hope and Humanity" Shaffiq Essajee, BMBCh

Strategies in Global Health
"Global Health Governance in a Time of Rapid Change: Opportunities and Concerns" Derek Yach, MBChB, MPH
"Community Approaches to Achieve Global Health Goals," Jacob Kumaresan, MD, MPH, Dr.PH
Andre-Jacques Neusy, MD, DTM&H
Nora Groce, PhD
"Public-Private Partnership as a Strategy for Addressing Global Health Issues: Lessons Learned from

The Mectizan Donation Program," Brenda Colatrella

Community Strategies to Improve Eye Care
"Update on Vision 2020: the Right to Sight," Louis Pizzarello, MD
"Barriers to Eye Care: Results of Qualitative Research," Rosie Janiszewski, MS, CHES
Ilene Gipson, PhD
"Teaching the Teachers: Empowering Refugee Communities Through School-Based Education." Valda Ford, MPH, MS, RN
"Community Strategies To Improve Eye Care," Satya B. Verma, OD, FAAO
Janet Leasher, OD, MPH
"Volunteer Optometric Services to Humanity Globalizing Eye Care" Harry I. Zeltzer, OD
"Strategic planning for trachoma control in nine endemic countries," A. Sam-Abbenyi, MD, MSc

Building Capacity Through Surgical Eye Care
"Sustainable Surgical Eye Care Delivery." Victoria Sheffield and John Barrows, MPH
Harry S. Brown, MD
"Challenges and Successes of Surgical Eye Care in Africa," Cathy Schanzer, MD

Refractive Error: From Needs To Eyeglass Empowerment
"Estimates of Functional Blindness and Impaired Vision Due To Uncorrected Refractive Error," Brien A. Holden, PhD, DSc, OAM
"Community-Based, Self-Sustaining, Easy-to-Replicate InFOCUS Vision Stations: Helping to Meet and Increasing Need for Primary Vision Care, Head-On" Ian B. Berger, M.D., M.P.H. Dr.PH
"Social Entrepreneurship and Presbyopia" Jordan Kassalow, OD, MPH
Joshua Silver, PhD

Glaucoma Angles and Approaches
"What is Glaucoma?" Robert Ritch, MD
"Glaucoma Care For The Medically Underserved in the U.S." Martin Wand, MD
"Glaucoma Screening in a High Risk Population of New Haven," Bruce Shields, MD
"Population Based Glaucoma Screening, Why Not To Do It," James Standefer, MD
Leon W. Herndon, MD
Roger W. Martin

Vision Screening Strategies
Bruce Moore, OD
Erik Weissberg, OD

Vision and Clinical Research
Shachar Tauber, MD
"The Ethics Behind Clinical Research in Developing Nations," Matthew D. Paul, MD

Breakout Workshop Sessions

Cultural Competency
"Lessons from the Camps: Why You Should Not Hug the Monk and other Faux Pas," Valda Ford, MPH, MS, RN

Best Practices: Microfinance's Role in Sustainable Development
Jordan Kassalow, OD, MPH
"Fonkoze: Providing Financial and Educational Services to Haiti's Poor" Sharmi Sobhan and Anne

Hastings, PhD

Lessons from India: Health Outreach and Capacity Building
"Lok Swasthya Sewa, a Model Health Cooperative in Ahmedabad, India." Chirag Shah, MD, MPH
Jacqueline de Chollet
Keith Tauro

Clinical and Pubic Health Approaches to Eye Care
"From Eye Charts to Eye Clinics: Building Community Health Infrastructure," Sachin Jain, MD, MPH Candidate
"A Vision of Possibilities: Merging Clinical and Public Health Perspectives in Ocular Health." Rohit Ramchandani, MPH
"Eye Health Among Internally Displaced Persons in Northern Uganda: Restoring the Lost Hopes." Kenneth Daniel, MD Candidate

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Wednesday, August 10, 2005 7:36 PM
Subject: PHA-Exchange> CLAUDIO Re: a new paradigm in public health research

> >A new paradigm: Research for health and for life?

> >RESEARCH IN SOCIAL MEDICINE AND PUBLIC HEALTH:

> >1. Development is about people.

> >2. Each research project in these areas has to be judged by the criterion of whether it serves the purposes of development --and this purpose is the wellbeing of people who, for centuries or decades, have been marginalized.

> >3. The question that researchers are NOT asking is WHY a given problem is given consideration for being researched.

> >4. Social and health problems require that we look at them from three perspectives:
-scientifically (to find out what CAN be done);
-Ethically (to find out what SHOULD be done); and
-politically and ideologically (to determine what MUST be done).

> >5. - Science is (or purports to be) objective.
-Ethics is normative.
-Politics is pragmatic (.notice is taken of the difference between
politics >and 'politiquing').

> >6. -Science advances by observation and logical deduction.
-Ethics advances by reaching consensus through dialogue and reflection.
-Politics advances promoting a consciousness-raising dialogue.

> >7. Research in social medicine and public health must always be carried out with a scientific, an ethical AND a social/political perspective and thus
get involved in studying the factors that dis-empower and empower marginalized populations and people.
Why? Because if we do not agree on the causes/determinants of dis-empowerment of people it is impossible for us to agree on what actions we need to put forward and pursued.

8. "We find what we look for"

> >9. Therefore, for researchers to pursue/go after research funds available in public health is to follow the ideology of those who make these funds available. They are thus bound to 'find what the funders are looking for".

Claudio Schuftan, Ho Chi Minh City
claudio@hcmc.netnam.vn

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Wednesday, August 10, 2005 6:27 AM
Subject: PHA-Exchange> A Pilot E-Learning course on Strengthening theEssential Public Health Functions

From: Ruggiero, Mrs. Ana Lucia (WDC)

Strengthening the Essential Public Health Functions
Course Code: HNP382-37-337

A PILOT E-LEARNING COURSE

APPLICATION DEADLINE: 15 September 2005
ORGANIZERS: The World Bank Institute and the Pan American Health Organization

Website
http //wbln0018.worldbank org/wbi/wbicatalogue nsf/vewExternalEvents/E1FDB31A5C65E9EE85257054004E31(
OpenDocument

Dates: From October 05, 2005 to February, 01, 2006
Cost: No Fees.
Delivery Mode: Fully Web-based/Fully Online-asynchronous (EL) Language. English

Hmmm!
Claudio

BACKGROUND OF THE COURSE:

At the UN Millennium Summit in September 2000, the 189 states of the United Nations reaffirmed their commitment to work towards a world in which elimination of poverty and sustainable development would have the highest priority. The World Bank and the Pan American Health Organization (PAHO) along with numerous organizations, are committed to an unprecedented global effort to work towards the Millennium Development Goals (MDGs) as part of their corporate mandates.

Since the Summit, it has become apparent that the achievement of the Millennium Development Goals (MDGs) is at risk in many parts of the world. Nearly over a half of the targets and the MDGs directly or indirectly concern health and at present there are several alarming trends in health indicators that need to be addressed in order to achieve the MDGs. Moreover, poor health contributes to declines in per capita income and productivity, ultimately undermining these countries? efforts to reduce poverty.

As the World Bank analysis of MDGs shows in the Health, Nutrition and Population Millennium Development Goals,?Rising to the Challenges?, effective interventions exist, the challenge is to strengthen the health sector through: stronger policies and institutions; improved household practices; improved service delivery, tackling of human resources and pharmaceutical market constraints; sustainable financing and the strengthening of core public health functions.

With regard to the latter, there is a growing consensus on the need to strengthen the public health capacity of national health systems as an indispensable condition to attain, and more importantly, to sustain the health MDGs. However, the consensus is broader in scope, as all nations, rich and poor, have to address health challenges linked to their socio-epidemiologic and demographic profiles and trends, in a context of globalization.

PAHO, in collaboration with the Centers for Disease Control and Prevention (CDC) and the Latin American Center for Health Systems Research (CLAISS), developed a set of 11 Essential Public Health Functions that captures the role of national health authorities in public health. An instrument was prepared to assess the performance of these functions and further applied in 42 countries and territories in the Region of the Americas, providing a rich experience and strong empirical basis for the development of specific plans of action.

Similarly, the World Bank recognized the importance of embracing the principles and practices of public health through a public health note and the adoption of a Poverty Reduction Strategy framework.

To ensure the relevance and quality of its content and delivery, the e-learning course has been designed and organized by leading experts in the fields of public health and distance learning. Along with these technical content experts, the course designers have

Rd

To steering group members
Dear Friends This is an interesting course we should keep track 8/10/05 of in the light of IPHU which we. Does anyone have the [illegible] and motivation to join and track the perspectives/learning on behalf of PHM. It's an interesting combination of resources WBI (which PHM has reservations on) and PAHO (whom we see as a potential partner) [illegible]

ensured that the course blends technical knowledge and policy relevance with the right mix of interactivity and practical examples to stimulate the learner.

OBJECTIVES

The overall objective of the course is to develop leadership and competencies in the performance and assessment of the Essential Public Health Functions (EPHF), as a critical component in strengthening national capacity in public health.

At the end of the course participants will be able to:

- apply the conceptual framework that supports the Essential Public Health Functions (EPHF)
- describe and analyze each of the EPHF in detail;
- apply the methodology and diagnostic tools to assess and monitor the performance of the EPHF at the national and sub-national levels;
- design plans of action and strategies to strengthen public health functions and capacities within a specific country context;
- analyze the contribution of health systems and EPHF to achieve the MDG making use of the provided framework.
- employ strategies for encouraging participation of key stakeholders in achieving public health objectives and reorienting health care services; and
- identify health problems that require cross-sectoral strategies to address them.

COURSE STRUCTURE

The course is structured around the 11 Essential Public Health Functions as identified by PAHO and will be clustered in an introductory module and 3 tracks.
Participants will be required to take the introductory module and the first track (basics and organization) and then to choose one from the other two tracks (the strategy and policy track or the access and quality track).
Participants can also take all three tracks if they have the interest and availability to do so.

Required:
Introductory Module
Track 1: Basis and Organization
1. Health Situation Monitoring
2. Surveillance and Risk Control
3. Human Resource Development
4. Emergencies and Disasters

Choose either track 2 or track 3:
Track 2: Strategy and Policy
5. Policy Development
6. Regulation
7. Health Promotion
8. Research

Track 3: Access and Quality
9. Quality of Services
10 Equitable Access
11. Social Participation
12. Inter-sectoral Action for Health

COURSE FORMAT

You will take the pilot course entirely through the internet (World Wide Web). Upon acceptance as participant you will be given a course ID and password, with which you will be able to access the course site. The format of the course relies heavily on 'action learning' which means that you will be required to actively participate in all online activities, which will mainly consist of reading the course content and posting assignments and reacting to other participants' postings. As most of the weeks' assignments are based on team work and joint products, it is imperative that you are able to log in and work on the course regularly so that your team can effectively produce the team products, and that you can adhere to deadlines. Active participation is required to qualify for receiving a completion certificate.

Technical Requirements: Participation in the course requires an internet connection, the Internet Explorer browser and the Acrobat Reader and Flash
Player (vs 6 or higher). More detailed technical requirements will be sent upon confirmation of participation.

The working language of the course will be English. Because of the nature of internet based learning you will have to have good to excellent English writing skills, since all the communication within the course will be in written format.

Since this is an e-learning course there will be no travel involved. We require that you be able to set aside 8 to 10 hours per week to devote to the training. It is important that you get your manager's approval for this time commitment prior to applying to this course. We advise spreading the workload out over the week, working everyday on it for an hour or two, rather than doing it all in one day. This will enable you to actively participate in all discussions and respond to your fellow participants' postings in a timely manner and thus satisfying the completion requirements for this course.

Given that the course is a first offering (a pilot), your feedback on the course will be used for future improvement of the course.

DURATION AND COURSE LOAD: Three tracks of 5, 4 and 4 weeks respectively - 8 to 10 hours per week.
Participants are required to do the introductory module and Track 1 and either Track 2 OR Track 3.

See below for more information about the tracks.
DATES: TRACK 1:October 5 - November 9 2005,
TRACK 2: November 23 - December 21 2005 and
TRACK 3: January 4 - February 1 2006.

PARTICIPANTS: Technical cadres of Ministries of Health, mid-level policy makers, World Bank staff, PAHO and WHO staff, other development agency and donor agency staff and other agents of change.

REGIONS TARGETED: There will be 25 slots for participants from the Caribbean Community and Common Market (CARICOM) region, the remainder of the 25 slots are open for participants from any region of the world.

APPLICATIONS

On behalf of the course organizers, we take great pleasure in inviting you, or a member of your staff, to participate in this event. Please feel free to forward
this announcement to anyone you think might be interested to participate or nominate a participant.

We would also like to invite you to nominate participants from countries you work with. We are particularly interested in receiving nominations from Ministries of Health, Finance/Planning, Parliament, etc, as well as NGOs, private sector organizations, the donor community and others working in this field. We encourage teams from each country to participate and collaborate in this course.

Please apply online for this offering at.

http://wbln0018.worldbank.org/wbi/wbicatalogue.nsf/ExtApp?OpenForm&code=HNP382-37-337&trail=ByDate

(Make sure you copy the entire URL in your browser, starting from "http" to "ByDate")

If you have problems locating the electronic application form, please send an email to jhindriks@worldbank.org. Upon acceptance you will receive information
how to log on to the course.

FEES

For this pilot only there will be no fees.
For any other information contact Jo Hindriks at jhindriks@worldbank.org

LANGUAGE: English only

GENERAL COURSE CONTACT: Jo Hindriks at jhindriks@worldbank.org

APPLY: Please go to the online application form at:

* * * *

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Thursday, August 11, 2005 7:55 AM
Subject: PHA-Exchange> Bellagio Conference on International Nurse Migration

From: Ruggiero, Mrs. Ana Lucia (WDC)

Bellagio Conference on International Nurse Migration

This project from AcademyHealth also interfaced with other ongoing international initiatives concerned with migration, such as the Joint Learning Initiative and the new U.N. Commission on Migration. Sponsors included: Rockefeller Foundation, Nuffield Trust, Canadian Nursing Association, Canadian Health Services Research Foundation and the Agency for Healthcare Research and Quality.
Bellagio, July 5-10, 2005

Website: http://www.academyhealth.org/international/nursemigration/recommendations.htm

"... Nursing shortages in the United States, Canada, United Kingdom and many other developed countries, have become a global problem. In recent years, provider organizations in developed countries have been actively recruiting nurses from English-speaking countries. With an expected shortage of 270,000 nurses in the U.S. by the year 2010, the potential impact of private sector recruitment of nurses on health systems in poor countries, especially those that are small, is devastating. While some supply countries, such the Philippines and India, have traditionally promoted emigration of professionals to generate remittances, most now view the recruitment of nurses as a looming threat. The greatest damage, however, will be in the countries with high burden of HIV/AIDS, such as the Sub Saharan African countries, where a stable health workforce a prerequisite for any effective aid efforts.

For the first phase of this project, nine case studies, three from developed countries and six from developing countries, were commissioned. Researchers gathered data on the existing stocks of nurses, as well as the inflow and the outflow from the professional and their countries. They also performed a stakeholder analysis of the interests and viewpoints of multiple sectors within their countries in relation to this issue. The nine teams then met in July 2005, together with representatives from major international agencies, to deliberate three questions:

1) What are the continuing information gaps that need to be addressed in order to inform policy?
2) What domestic policies that address the flow of nurses in both rich and poor countries are politically feasible?
3) What is the potential for international agreements on the recruitment of nurses?

The project also interfaced with other ongoing international initiatives concerned with migration, such as the Joint Learning Initiative and the new U.N. Commission on Migration. Sponsors include: Rockefeller Foundation, Nuffield Trust, Canadian Nursing Association, Canadian Health Services Research Foundation and the Agency for Healthcare Research and Quality.

Recommendations developed at the Bellagio meeting, power point presentations, a participant list and a photograph of the group may be found below.

Recommendations

Presentations:

United Kingdom: Jim Buchan, Professor, Queen Margaret University College, Scotland

PowerPoint Slides | PDF Handout of Slides

PHM - Health Human Resources Migration

RN 11/8/05

Sub-Saharan Africa Synthesis: Delanyo Dovolo, Independent Consultant

PowerPoint Slides | PDF Handout of Slides

India: Binod Khadria, Professor of Economics, Zakir Husain Centre for Educational Studies, Jawaharlal Nehru University

PowerPoint Slides | PDF Handout of Slides

Commonwealth Policies: Peggy Vidot, Chief Programme Officer, Health Section, Social Transformation Programmes Division, Commonwealth Secretariat

PowerPoint Slides | PDF Handout of Slides

United States: Linda Aiken, Professor and Director, Center for Health Outcomes and Policy Research, University of Pennsylvania

PowerPoint Slides | PDF Handout of Slides

Canada: Lisa Little, Health Human Resources Consultant Manager, HHR Component, Canadian Nurse Practitioner Initiative,Canadian Nurses Association

PowerPoint Slides | PDF Handout of Slides

Jamaica: Jean Yan, Chief Scientist Nursing and Midwifery, EIP/HRH, World Health Organization

PowerPoint Slides | PDF Handout of Slides

Caribbean Review: Marla Salmon, Dean and Professor, Nell Hodgson Woodruff School of Nursing, Director, Lillian Carter Center for International Nursing, Emory University

PowerPoint Slides | PDF Handout of Slides

Philippines: Marilyn Elgado-Lorenzo, Director, Institute of Health Policy and Development Studies, National Institutes of Health-Philippines, University of the Philippines, Manila

PowerPoint Slides | PDF Handout of Slides

China: Zack Fang, Consultant, Health Administration Program, Washington University, School of Medicine, Vice President, Corporate Development
First Call Team, Inc

PowerPoint Slides | PDF Handout of Slides

WHO Stakeholders Meeting on Nurses' and Midwives' Contributions to MDGs: Jean Yan, Chief Scientist Nursing and Midwifery, EIP/HRH, World Health Organization

PowerPoint Slides | PDF Handout of Slides

Joint Learning Initiative: Kim Beazor, Chief Operating Officer, The Nuffield Trust

PowerPoint Slides | PDF Handout of Slides

ravi narayan

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "Ravi Narayan" <ravi@phmovement.org>
Sent: Saturday, October 01, 2005 9:55 AM
Subject: Claudio on his 60th birthday

PHM - Exchange
Ravi
4/10/05

Dear Ravi,

This is to again thank you and the whole team for the terrific job you did. PHM is light years from where it was when you took over.

I am looking forward to the 12 briefs which put the finger right on the key issues for the imediate future.

I have not succeeded to get the list of emails from PHA2 attendees from Abraham after like 3 emails. Who can I ask for it? I need to put these people up in pha-exch! Pls advise.

Aviva and I are preparing for big party this afternoon. Have 15 friends who came from overseas.
Hugs
Clau

sent on 4/10/05 afternoon.

PS will follow up with Roseann and Abraham about PHA2 attendees.

Dear Claudio 4/10/05

A belated greeting on your 60th birthday. Hope you and Aviva had a nice party including with the overseas friends. I am only 57 but I sometimes feel over 65 post PHM/PHA2! and am looking forward to the transition so that I can get some respite from this high pressure-demanding global challenge and read, reflect and reach it to the next generation in a more relaxed and objective way. We are in the midst of a CHC Fellowship course and from 3-7th I am taking a five day course on PHM/Health for All. Now. Tomorrow is the afternoon a group of 17 Final year medicos from the Government medical college in Bangalore are spending afternoon with me to find out what PHM is all about and on 7th I shall be in Delhi for 2 days and the assignment includes a visit to my postgraduate alma-mater - AIIMS where I did my PG in Community Medicine (1978) to give a guest lecture on 'Bringing the Public in Public Health'. Best wishes Ravi

10/3/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Friday, September 16, 2005 4:59 PM
Subject: PHA-Exchange> on PAHO's new PHC policy

From: David Werner

Dear Dr. Maria Magdalena Herrera,

Thank you for sending us the draft of the Primary Health Care Renewal statement drafted by the Pan American Health Organization. Overall I think it is excellent. It delights me to see PAHO taking action to restore and revitalize Primary Health Care, with emphasis on the Comprehensive rather than Selective approach, and with a stronger focus on Health as a Human Right. I am glad to see that stress is placed on the underlying "man made" causes of poor health which lie outside the health sector, including poverty, poorly regulated economic globalization, and lack of participatory democratic process. The undermining of the UN by the United States is surely another contributing factor.

I would, however, like to see more detailed analysis, and exploration of strategies for change, in relation to these sociopolitical and macro-economic causes of poor health, rather than talking in such vague (and therefore probably ineffective) terms. This "politically safe" shying away from detailed analysis and the need for regulatory measures with teeth on both the national and global scale, is one of the reasons that Comprehensive PHC never got off the ground.

By the same token, in the PHC Renewal statement most of the talk of the need for "greater equity" is limited to health services. However the area where greater equity is most important for the health of the most vulnerable populations lies in the arena of global trade and macro-economic policies. Achieving greater equity in this area will requires strong international regulations, with a restructuring of the World Bank, IMF, and WTO so as to make these powerful bodies more responsive to human and environmental needs, and less beholden to the corporate "growth at all costs" agenda. These measures need to be spelled out clearly, with proposals of how "Health as a Human Right" can be used as a political tool to mobilize action for change -- i.e.the step by step transformation of our unhealthy and unsustainable macro-economic system. Short of progress toward such far-reaching structural change, Primary Health Care Renewal, as well as the watered-down "Health for at least a few more" by the year 2015 (the MDGs), will go the way of Health for all by the Year 2000.

Good luck. You'll need it. It's an uphill battle!

But the Primary Health Care Renewal statement is a good start. Have courage!

Sincerely,

David Werner

The document in question is available from healthwrights
healthwrights@igc.org

HRM/VNR
Download the document
RN
19/9/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Cc: <afro-nets@healthnet.org>
Sent: Wednesday, September 14, 2005 5:39 PM
Subject: PHA-Exchange> Population Challenges and Development Goals

Population Challenges and Development Goals

Department of Economic and Social Affairs, United Nations 2005

Available online as PDF file [70p.] at:
http://www.un.org/esa/population/publications/pop_challenges/Population_Challenges.pdf

World population reached 6.5 billion in 2005. But considerable diversity in population size and growth lies behind this number. The population of many countries,
particularly those in Africa and Asia, will increase greatly in the coming decades. In contrast, owing to below-replacement fertility levels, some developed countries are expected to experience significant population decline.

Half the world's population is expected to live in urban areas by 2007. The number of very large urban agglomerations is increasing. Nonetheless, about half of all urban-dwellers live in small settlements with fewer than 500,000 inhabitants. In addition to becoming more urban, the world population is also becoming older and the proportion of older persons is expected to continue rising well into the twenty-first century....."

Content:

PHA-Exchange

RJ 23/9/05

RJ 19/9/05

9/19/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Sunday, September 04, 2005 10:08 AM
Subject: PHA-Exchange> Food for a soul searching thought

Human Rights Reader 118

WOULD YOU CONSIDER YOURSELF TO BE (AT LEAST PART-TIME) A HEALTH AND HUMAN RIGHTS ACTIVIST?: A VERY INFORMAL AND TENTATIVE QUIZZ. (*)

Going through the following questions may give you a clue…

Do you engage in any of the following?:

- Advancing people's health rights, be it in Primary Health Care, in patients rights or in equitable access to treatment?
- Having employers' taking responsibility to protect workers' health?
- Resisting and opposing the known damaging health impacts of globalization?
- Resisting moves towards privatization of essential health services?
- Protecting the rights of people living with HIV and AIDS?

Do you contribute to bring power to the people through any of the following?:

- Strengthening people's voices in decision-making through organizing and uniting beneficiaries and through building their political consciousness?
- Promoting a vision of health guided by goals for Health For All as a right?
- Challenging the current paths of globalization by engaging in the struggles over trade policies (e.g., GATS, TRIPS) and over global policies and practices affecting the health of the poor?
- Advancing health rights at the national political level and directly engaging on health issues at the local level?
- Advancing health by participating in the struggles over income and employment, food security, poverty and discrimination?
- Supporting the informal economy as an important income generator for the poor?
- Denouncing the negative impact of corporate practices and commercial interests in health?
- Denouncing the privatization attempts of essential public services (water, sanitation, health care, electricity) and the lack of access of the poor to the same public services?
- Denouncing public-private partnerships that give undue weight to the private sector in decision-making in the public domain?
- Advocating for grater real beneficiaries' participation thus fostering greater transparency and accountability in the decision-making over the use of resources for

PHA-Exchange

health?

Do you directly engage yourself in health issues in the interest of equity, justice and health rights:

- By getting involved in the struggle over equity in general and over gender equality in particular, especially in response to the HIV and AIDS pandemic (including access to treatment, home care and ancillary services)?
- By demanding trans-national corporate responsibility in regards to health and nutrition issues and to safe working conditions worldwide?
- By monitoring and denouncing injustices in the distribution, migration of and investment in health workers and in the protection of their working conditions?
- By demanding greater investment in the public sector health services?
- By supporting thre incorporation of traditional health services into PHC?
- By struggling for universal access to quality health care and to PHC?
- By getting involved in the protection of poor households from inequitable cost burdens related to their health and health care?
- By actively promoting public literacy in health, in health systems and in treatment alternatives?

Do you regularly get involved in discussions with health workers, traditional health workers, rural, urban and minority civil society members and with labor unions in processes related to health and welfare?
Do you work with others in fostering a unified and shared analysis that can lead to shared goals and strategies in the area of health as a right?
Do you get involved in strategies and campaigns related to all the above, and in building common tactical platforms by identifying key common opportunities and critical constraints, as well as major strategic allies and opponents?
Does whatever you do of the above lead to agreements on mechanisms and actions to:
Strengthen linkages and build networks?
Empower beneficiaries?
Encourage the sharing of resources? and
Prioritize solidarity action?

(*): This quiz is to be graded by each of you in private consultation with your own self.

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Tuesday, September 06, 2005 9:21 AM
Subject: PHA-Exchange> Key issues guide on service delivery indifficultenvironments

From: "Ingrid Young" <I.Young@ids.ac.uk>

> New HRC/Eldis key issues guide on service delivery in difficult
> Environments
> ----------
>
> The HRC/Eldis Health Systems Resource Guide has recently
> launched a new feature.
>
> 500 million people, including around 200 million people living
> in extreme poverty, live in countries that have been categorised
> as difficult environments, poor performing countries, fragile
> states, or failed states. The international community has in-
> creasingly recognised the human cost of not engaging with these
> countries and that new approaches are needed to meet the needs
> of poor people in these environments. However, most analyses on
> how to address the basic quality of life of poor people say very
> little about the most effective aid instruments and channels
> that support basic social services for the poor.
>
> This HRC/ELDIS key issues guide provides an in-depth exploration
> of service delivery in fragile states and other difficult envi-
> ronments. Produced in collaboration with subject experts and
> drawing heavily on country case studies, it explores major prob-
> lems in delivering services that benefit the poor, reviews evi-
> dence, and outlines policy and operational recommendations to
> help improve donor interventions. Access the guide at:
> http://www.eldis.org/healthsystems/sdde/index.htm
>
>
> --
> Ingrid Young
> DFID Health Resource Centre
> Institute of Development Studies
> at the University of Sussex,
> http://www.eldis.org/hivaids/
> http://www.eldis.org/healthsystems/
> http://www.eldis.org/health/

PHA-Exchange

RN
6/9/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Monday, August 15, 2005 8:50 AM
Subject: PHA-Exchange> Food for a capital thought (4)

From: "Caleb Otto" <calebotto@yahoo.com>

Thanks, Caleb. I have a few comments in Upper Case.
Cordially,
Claudio

Thanks for sharing such food for thought and ammunition for our work. I have read all comments with great interest as I am trying to learn more about issues of Human Rights, poverty alleviation or elimination and other social issues, including politics of distribution of resources.

Recently I saw or heard a commentary on the dimishing base of 'political capital' of Mr. Bush, the US President. Such thinking leads me to agree with Theodore MacDonald, that advancing the issue of HR as a form of capital might be misleading and even harmful. I BEG TO DISAGREE.
I am saying this because:
(1) While I agree that HR is usually 'accumulated' over time and in various amounts or at different levels, this is where the harm could be done - I believe that HR is so essential that it should not be viewed or advanced as something that can be distributed in pieces (while this may be the reality, it is not what it is supposed to be and should, therefore, not be advocated or advanced as such). IN OUR SOCIETIES, THE RIGHTLESS DO ACQUIRE THEIR RIGHTS BY STRUGGLE, i.e., BY PROGRESSIVELY CLAIMIMG THEIR RIGHTS AND SUCCEDING, IN A DIALECTICAL POWER STRUGGLE. THAT IS WHY HR ARE ACQUIRED "IN PIECES". YOU ARE RIGHT: THIS IS NOT WHAT IT IS SUPPOSED TO BE, BUT IT IS "THE REALITY" AS YOU SAY.
(2) HR are not like a political power which can have a minimum base that is effective. I AM AFRAID, IN THE REAL WORLD, THEY ARE A POLITICAL CAPITAL AND THUS TRANSLATE INTO POWER.
Every single person is born with all of his/her HR intact, and it is for the society to protect it from become fragmented (OR DENIED), rather than to put the pieces together from the start. NOT EVERYBODY AGREES WITH THE FIRST PART OF YOUR STATEMENT, SO, THRU INTENSE SOCIAL MOBILIZATIN OF CLAIM HOLDERS, WE HAVE TO "PUT THE PIECES TOGETHER". IT IS OUR DUTY AS HR ACTIVISTS.

Thanks for the opportunity to participate in the discussion.

Caleb Otto

RTHC Dialogue

RJ
16/8/05

8/16/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Friday, August 12, 2005 7:43 AM
Subject: PHA-Exchange> The media and their control

Laurie Garrett, the only reporter to win all three of journalism's big "P awards (the Peabody, the Polk and the Pulitzer). The author of two major public health books, Betrayal of Trust and The Coming Plague: Newly Emerging Diseases in a World out of Balance, she was a science correspondent at National Public Radio before joining the science-writing staff of Newsday in 1988.

Garrett resigned from Newsday earlier this year after winning the paper both the Polk and Peabody awards. She cited a deteriorating climate for journalism: "All across America, she wrote, "news organizations have been devoured by massive corporations -- and allegiance to stockholders, the drive for higher share prices, and push for larger dividend returns trumps everything that the grunts in the newsrooms consider their missions."

Specifically, the newsroom conditions that allowed her to travel to Africa and India to report on AIDS, or take six months to report from the former Soviet Union, no longer existed. "A 32-part series on the collapse of public health in the former Soviet Union?" she said. "I don't know any institution today that would publish that."

Today, Garrett is Senior Fellow for Global Health at the Council on Foreign Relations. Her story "The Next Pandemic?" was published in the July/August issue of Foreign Affairs, the Council's bi-monthly magazine.

PHM - Exchange

RN
12/8/05

8/12/05

Main Identity

From: "mohammad ali barzgar" <m_barzgar@hotmail.com>
To: <secretariat@phmovement.org>
Sent: Sunday, October 09, 2005 12:59 AM
Subject: CONDOLENCE FOR THE LOSS OF LIFE BY EARTHQUAKE

Dear Ravi,

I was shocked to hear the tragedic news of Earthquake of India,Pakistan and Afghanistan.On behalf of my colleagues in PHM of Iran and my own behalf I condole the great people of India specially our friends in PHM ,and the Government of India for the loss of life and devastation caused by the quake.I am sure the great people of India with the support from theire government and civil societies will reconstruct the devastation.In the meantime we expect from international communities and friendly countries show theire sympathy and solidarity in such a difficult time.With deep sarrow and sympathy.Dr.M.A.Barzegar,PHM Iran.

PHM-Steering Group

PHM-Exchange

>
>
>----------
> Yahoo! for Good
> Click here to donate to the Hurricane Katrina relief effort.

ravi narayan

From: "Passanna" <passanna@haiap.org>
To: <Undisclosed-Recipient: ;@host334.ipowerweb.com>
Sent: Monday, October 10, 2005 10:03 AM
Subject: Earthquake

Dear All,

We are hoping against hope that this email will find all of you and your family are safe. Our thoughts are with you in these very difficult days.

Wishing you more and more courage,
Passanna and the rest at HAIAP

RN 10/10/05

Send to PHM Pakistan

Main Identity

From: "Pam Zinkin" <pamzinkin@gn.apc.org>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Cc: "'Alexis Benos'" <benos@med.auth.gr>
Sent: Friday, October 07, 2005 5:22 AM
Subject: RE: [PHM_Steering_Group_02-03] Two comments for consideration

Just to say that Aliexis Benos email is benos@med.auth.gr
He is the PHM Europe person chosen at the PHA2 and I am just there for support during the handover but also I am continuing with keeping track of the translations etc.
Pam

From: PHM_Steering_Group_02-03@yahoogroups.com [mailto:PHM_Steering_Group_02-03@yahoogroups.com]
On Behalf Of PHM - Secretariat
Sent: 06 October 2005 13:58
To: PHM_Steering_Group_02-03@yahoogroups.com
Subject: Re: [PHM_Steering_Group_02-03] Two comments for consideration

Dear Fran, Maria and friends,

PHM-Europe
Focal Point

RN
10/10/05

VNR / SSP
Please enter
in website

Remove David Wood... and include

RN
10/04

Aliexis
Benos

Main Identity

From: "Dr.Dabade" <drdabade@sancharnet.in>
To: "cehatpun" <cehatpun@vsnl.com>, <pha-ncc@yahoogroups.com>
Sent: Monday, October 10, 2005 7:04 PM
Subject: Re: [pha-ncc] NRHM PPP concept note

Dear All,
I was just wondring what the person from Germany of GTZ doing in PPP? (Dr. J. P. Steinmann, GTZ). Is GTZ a donor?. The other person is from EC. (Ms. Frederika Meijer), EC Is EC European Community. Does it represent the European Union?
More on hearing from you.
Best wishes
GOPAL

PHA-JSA

RN
11/10/05

ravi narayan

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "Fran Baum" <fran.baum@flinders.edu.au>
Cc: "Ravi Narayan" <ravi@phmovement.org>
Sent: Tuesday, October 18, 2005 10:44 AM
Subject: Launch of the UCL International Institute for Society and Health and IHMEC/Lancet Lecture 2005

International Institute for Society and Health

Michael Marmot, Malcolm Grant, Department of Epidemiology and Public Health, University College London, UK
Richard Horton, Editor of *The Lancet*, London, UK
The Lancet 2005; 366:1339-1340 - DOI:10.1016/S0140-6736(05)67545-9

Website: http://www.thelancet.com/journals/lancet/article/PIIS0140673605675459/fulltext
[Free subscription]

".....The number of funds and foundations, charities, and non-governmental organisations devoted to global health has expanded dramatically in recent years. This pluralist expression of commitment to the neglected diseases of poverty is one of the surprising benefits of globalisation. It reflects a widened circumference of concern about the world's peoples. And it comes at a time of heightened anxiety about not only our failures to deliver on promises to achieve international development goals, but also the worsening environment in which we might make good on those promises. AIDS, wars, terrorism, and natural disasters are combining to slow progress to barely perceptible levels. Now more than ever, we need new thinking to provoke us and reliable evidence to guide us through the shared predicaments we face. Universities should be leading this work. In no area is this clearer than in health....."

".....University College London is, this week, launching its UCL International Institute for Society and Health (IISH). The institute is founded on the assumption that understanding and solutions to global-health problems need to be based both on best biomedical science and best social science. IISH is, therefore, an interdisciplinary collaboration of economists, anthropologists, sociologists, urban planners, and scientists working in maternal and child health, cardiovascular disease, infectious disease, and ageing...."

Launch of the UCL International Institute for Society and Health and IHMEC/Lancet Lecture 2005

Website: http://www.ihmec.ucl.ac.uk/events/Lee/Leedetails.htm

UCL International Institute for Society and Health

The International Institute for Society and Health (IISH) is a unique interdisciplinary collaboration of leading academics working on health and society in a global context. Its aim is to conduct research, to review evidence, to advocate, and to develop action for improving the health of populations globally, in developed and less developed countries. Its mission is to take action on the social determinants of health, to provide solutions to global health problems, and to improve the health and well being of all, especially the poorest.

The Institute will link UCL's strengths in biotechnology and medicine with the humanities and social sciences, in order to tackle the problems of global health and will be guided by the core values of Social Justice, Sustainable Human Development and Global Commitment.
International Health and Medical Education Centre/Lancet Lecture 2005

"....This year the annual IHMEC/Lancet lecture was given by Professor Daniel Kahneman, Nobel Prize winner 2002, speaking on 'Progress in the Study of Well-being'.

An interdisciplinary conversation has been held for several decades, concerning the nature of well-being, approaches to its measurement, its relation to health and its distribution across social classes and over continents. The pace of this conversation has picked up considerably in recent years and its main

PHMExchange RN 19/10/05

10/18/05

character has changed as economists joined it. The lecture will present a view of the main issues that are currently debated and describe some recent developments in the measurement of well-being and misery.

Following the lecture there was a discussion between Professor Kahneman and Richard Horton, Editor of the Lancet, exploring the international health dimensions of Daniel Kahneman's research.

Professor Kahneman is Professor of Public Affairs at the Woodrow Wilson School of Public and International Affairs at Princeton University. He was awarded the 2002 Nobel Prize in economic sciences for "having integrated insights from psychological research into economic science, especially concerning human judgement and decision making under uncertainty".

Kahneman's work, it's said, has laid the foundation for a new field of research by discovering how human judgement may take shortcuts that systematically depart from basic principles of probability.. .."

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Saturday, October 15, 2005 3:54 PM
Subject: PHA-Exchange> giving money rather than food or other kinds of aid

From: "Rosemary Cairns" <rosemary.1cairns@Community.RoyalRoads.ca>

> You may want to have a look at the Humanitarian Practice Network
> Paper entitled "Cash relief in a contested area: lessons from
> Somalia", written by Degan Ali, Fanta Toure and Tilleke Kiewied.
> It is HPN Network paper number 40, published March 2005. The HPN
> website is http://www.odihpn.org
>
> "The paper concludes that, even in areas of political instabil-
> ity, cash relief can be an effective and viable alternative.
> There can be no 'blueprint' for the use of cash across all emer-
> gencies and in all circumstances. However, evidence is growing
> to suggest that, where circumstances are amenable, there is
> scope for increasing the use of cash as an instrument in humani-
> tarian response." (From HPN website)
>
> Several other papers discuss the idea of distributing cash
> rather than aid, or outline projects where this has been done,
> but I don't have details handy at the moment. I will look for
> them and post them later, if anyone is interested.

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@lists.kabissa.org
Website: http://lists.kabissa.org/mailman/listinfo/pha-exchange

PHA-Exchange
Discover Relief

RN
17/10/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Friday, October 14, 2005 7:28 PM
Subject: PHA-Exchange> Why Did The Poorest Countries Fail to Catch Up?

From: Ruggiero, Mrs. Ana Lucia (WDC)

Why Did The Poorest Countries Fail to Catch Up?

Branko Milanovic is lead economist in the World Bank Research Department
Carnegie Endowment for International Peace, November 2005

Available online as PDF file [38p.] at: http://www.carnegieendowment.org/files/CP62.Milanovic.FINAL.pdf

".....DURING THE PAST TWENTY YEARS, THE POOREST COUNTRIES of the world have fallen further behind the middle-income and rich countries. The median per capita growth of the poorest countries was zero. This is an unexpected outcome because, from the perspective of economic theory, both globalization and economic-policy convergence imply that poor countries should grow faster than the rich.

The main reasons why this has not happened lie in poor countries' much greater likelihood of being involved in wars and civil conflicts. This factor alone accounts for an income loss of about 40 percent over twenty years. Slower reforms in poor countries compared with faster reforms in middle income countries played some, albeit a minimal, role. Increased flows from multilateral lenders did not help either because the net effect of the flows on growth rates is estimated to have been zero.

Finally, neither democratization nor better educational attainment of the population can be shown to have had any notable positive impact on poor countries' growth. Reducing the prevalence of conflict seems to be the first and most important step toward restoring growth.

PHM-Exchange
Equity

RJ
17/10/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Sunday, October 09, 2005 10:52 AM
Subject: PHA-Exchange> hanging Social Institutions to Improve the Status ofWomen in Developing Countries

From: Ruggiero, Mrs. Ana Lucia (WDC)

Changing Social Institutions to Improve the Status of Women in Developing Countries

Johannes Jütting and Christian Morrisson
Organisation for Economic Co-operation and Development (OECD) POLICY BRIEF No. 27 - 2005

Available online at: http://www.oecd.org/dataoecd/24/32/35155725.pdf

".....To address gender inequality in a country properly requires knowledge of the sources and the depth of discrimination. Valid indicators that capture various aspects of gender inequality are indispensable for informed policy making. The existing indicators tend to focus on gender disparities related to access to education, health care, political representation, earnings or income and so forth.

The aggregate indices that have received the most attention are the UNDP's Gender Development Index (GDI) and the Gender Empowerment Measure (GEM). The UNDP's Human Development Reports cover both regularly for individual countries. The GDI is an unweighted average of three indices that measure gender differences in terms of life expectancy at birth, gross enrolment and literacy rates and earned income. The GEM is an unweighted average of three other variables reflecting the importance of women in society. They include the percentage of women in parliament, the male/female ratio among administrators, managers and professional and technical workers, and the female/male GDP per capita ratio calculated from female and male shares of earned income.

Both of these indices have a fundamental problem. They measure the results of gender discrimination rather than attempt to understand its underlying causes. The school enrolment ratio and the percentage of women among managers, for example, are useful in comparing different country situations, but neither explains why these differences arise. They ignore the institutional frameworks that govern the behaviour of people and hence the treatment of women. In most developing countries, especially poor ones, cultural practices, traditions, customs and social norms hold the keys to understanding the roots of gender discrimination...."

PHA-Exchange
Women Health

10/10/05

RL
10/10/05

Main Identity

From: "Claudio" <claudio@hcmc.netnam.vn>
To: "pha-exchange" <pha-exchange@lists.kabissa.org>
Sent: Wednesday, October 19, 2005 8:59 AM
Subject: PHA-Exchange> Transparency International Corruption Perceptions Indexis out today

From: RKoppenleitner@t-online.de

The Transparency International Corruption Perceptions Index is out today (8:30 GMT). The complete data and explanatory material is available at

http://www.ICGG.org

Passau University, 18 October 2005: The new CPI index is out today: and judging from history, there will soon be a wave of international anti-corruption investigations based on its work.

In the past ten years the CPI has caused over ninety high-profile investigations around the world. The unequivocal message from these investigations: corruption is disastrous to societies. The very people who deserve our help are the most victimized: the honest, the poor and the powerless. The honest are deprived because they do not participate in the shady deals; the poor are worse off because they cannot afford the costly bribes; the powerless are victimized because they cannot escape the extortionate demands of a greedy environment.

The CPI has become an important tool in fighting corruption. It has placed the fight against corruption firmly on the public agenda. It has helped spark major legislative reform. And it has helped change the popular perception that corruption was always "someone else's problem": Firms point to politicians as causing corruption; politicians mention unscrupulous private interests as being at the core of the problem; rich countries delegate responsibility to corrupt leaders of less developed countries; for poor countries the problem rests with bribe-willing multinationals. By putting countries in an integrity-league the CPI provides a simple sports-like logic. Whatever one may think about other countries in the league, one's home country is placed in a sequence of countries rather than being on top by force of xenophobic prejudice.

International investors also dislike countries perceived to be corrupt, fearing arbitrary decision making and a poor protection of their property. Countries with a higher score in the CPI, to the contrary, suffer less from capital flight and are preferred as safe havens. According to recent research, if a country were to improve its score in the CPI by 1 point (out of 10), foreign direct investment would increase by 15 percent.

Here is the bad news: the following countries, some of them very high-income, have deteriorated in the CPI since 1995. A reduction in the score (in descending order of significance) was observed in Poland, Argentina, Philippines, Zimbabwe, Canada, Indonesia, Ireland, Malaysia, Israel, Slovenia, Czech Republic, United Kingdom and Venezuela.

Prosperity is no guarantee against corruption. This is best seen in the oil-rich countries, scoring poorly in the CPI. For example, this year, for the first time, Equatorial Guinea enters the index. Its recent boom in oil extraction contrasts to its 152 position in the CPI, one of the lowest this year. This underpins that high income from natural resources produces ample

PHM-Exchange Corrupt.on RN 19/10/05

opportunities for corruption, rather than helping development.

But there is hope. Corruption is not a fate. It prospers where business, society and politics turn a blind eye to its damaging effects.

Here is the good news; countries can improve their ranking in the CPI. They can "compete for integrity". The South Korea government had announced its goal to belong to the top-ten countries in the CPI. They improved their ranking from 47 in 2004 to 40 this year. This is one of the starkest improvements - and evidence that the right type of competition has been initiated by the CPI.

There are other signs of positive change, recent research at the University of Passau indicates significant improvements between 1995 and 2005 occurred (in descending order of significance) in Estonia, Italy, Spain, Colombia, Finland, Bulgaria, Hong Kong, Australia, Taiwan, Iceland, Austria, Mexico, New Zealand and Germany.

These are the places to look at when seeking good precedent. Given the international attention and support given to anti-corruption programs, the prospects of a sustainable reduction of corruption are higher than ever. Some poorer countries in the CPI are already indicative that poverty need no longer place a country in a downward spiral. Countries such as Chile, Barbados, Uruguay, Jordan and Botswana score rather well in this year's index. They are also prime candidates for improved economic and social development

In a recent study two authors, Lee and Ng, show that firms from countries scoring badly in the CPI are valued lower by international investors. If a country improves by 1 point in the CPI, the valuation of stocks of its domestic firms increases by roughly 10 percent. This illustrates that fighting corruption is not only a moral obligation - it is increasingly part of good business.

Main Identity

From: "Ravi Duggal" <raviduggal@vsnl.com>
To: "MFC eforum" <mfriendcircle@egroups.com>; <pha-ncc@yahoogroups.com>
Sent: Friday, October 21, 2005 10:38 PM
Subject: [pha-ncc] Fw: [EQ] Nanny or Steward? The role of government in public health

From: Ruggiero, Mrs. Ana Lucia (WDC)
To: EQUIDAD@LISTSERV.PAHO.ORG
Sent: Friday, October 21, 2005 6:57 PM
Subject: [EQ] Nanny or Steward? The role of government in public health

Nanny or Steward? The role of government in public health

Karen Jochelson
The King's Fund, London, UK October 2005

Available online at: http://www.kingsfund.org.uk/resources/publications/nanny_or.html

".....The past year has seen some contentious debates about public health in the United Kingdom, focusing on a ban on smoking in public places, food labelling and food advertising to children. Some people have argued that any government intervention in these areas is 'nanny statist' – an unnecessary intrusion into people's lives and what they do, eat and drink. Others have argued that only the state can effectively reduce the poverty that is so often the root cause of ill health...."

"....This paper suggests that there is a strong argument to be made for government intervention to safeguard public health. Legislation brings about changes that individuals on their own cannot, and sets new standards for the public good. Rather than condemning such activity as nanny statist, it might be more appropriate to view it as a form of 'stewardship'.

Stewardship implies government has a responsibility for protecting national health, and to serve in the public interest and for the public good (Saltman and Ferroussier-Davis 2000). It suggests a protective function, where individuals are protected from harm by others and sometimes from themselves. Stewardship implies that paternalistic government is acceptable under certain conditions, and the debate should focus both on defining these conditions and the likely benefits.

The first part of this paper looks briefly at the options open to governments that want to influence individual and collective behaviour to reduce health risks. It then examines the 'nanny state' debate, looking at examples from the past and today. It looks at how government views its activities, and what opinion polls tell us about public views of government intervention.

The second part of this paper looks at historical and contemporary evidence on the impact of state intervention on public health through case studies on alcohol, smoking and road safety. The final part draws some conclusions about the role of government, the impact of government intervention, and the nature of stewardship....."

Content:

To PHM Exchange →
RN
24/10/05
Sent on 24/10/05

Restrictive measures
Impact on inequalities
References

* * * *

Main Identity

From: "Ted Lankester" <tedlankester@hotmail.com>
To: <secretariat@phmovement.org>; <claudio@hcmc.netnam.vn>
Sent: Tuesday, October 25, 2005 8:43 PM
Subject: RE: Fw: Onto your mailing list

Thankyou- and best wishes to you Ravi. Keep up the vital work and influence- SO needed

Best regards

Ted

From: *"PHM - Secretariat" <secretariat@phmovement.org>*
To: *"Claudio" <claudio@hcmc.netnam.vn>*
CC: *"Ted Lankester" <tedlankester@hotmail.com>*
Subject: *Fw: Onto your mailing list*
Date: *Mon, 24 Oct 2005 16:58:19 +0530*

Dear Claudio,

Please put Ted on the PHM Exchange. He has been a long-standing community health promoter

PHM-Exchange
Ted-UK

RJ
28/10/05

Main Identity

From: <claudio@hcmc.netnam.vn>
To: <escr-right-to-health@yahoogroups.com>
Sent: Wednesday, October 26, 2005 9:05 PM
Subject: PHA-Exchange> The Patients' Charter of the Tuberculosis Community (2)

>From George Kent <kent@hawaii.edu>: Comments by Claudio

> The draft charter on tuberculosis begins with a claim of a right to
> free care for tuberculosis. This needs some explanation and perhaps
> qualification because, as it stands, I think many people who might
> otherwise be supportive will not be able to get past that point. AGREE
>
> Are you saying that all tuberculosis victims have this right,
> everywhere, whether they are rich or poor? THAT IS WHAT IS BEING PROPOSED, AS I UNDERSTAND IT.
>
> Are you claiming that this is an existing right, under current
> international human rights law? ALTHOUGH IT MAY BE CLAIMED, IT CLEARLY IS NOT SUCH.

What would be the basis for that? A BASIS, THERE WOULD BE, AS TB IS A WORLDWIDE PUBLIC HEALTH PROBLEM MOSTLY AFFECTING THE POOR WHOSE RIGHTS ARE VIOLATED.

If you are saying this is a new right that you propose, that is another
> matter. THAT IS WHAT IT SEEMS TO IMPLY.
>
> If free care is--or is proposed to be--a right, who carries the
> correlative obligation? GOVERNMENT HEALTH SERVICES.
That needs to be discussed fully.
>
> I'd like to hear more about these issues.
>
> Aloha, George AND CLAUDIO
>
>
>
>
> On Oct 10, 2005, at 5:16 AM, Claudio wrote:
>
> > From: loud.n.clear
> >
> > Greetings,
> >
> > We have been collecting input for the first draft (below) of the
> > Patients' Charter, encouraging people with TB, TB-HIV and MDR-TB to
> > "Write Your Rights!".

Requested Claudio to forward the Patients' Charter Articles

Print out full Charter

RN 28/10/05

10/28/05

Main Identity

From: <claudio@hcmc.netnam.vn>
To: <pha-exchange@lists.kabissa.org>
Sent: Wednesday, November 02, 2005 1:34 AM
Attach: unnamed.htm
Subject: PHA-Exchange> preventive interventions and implications forchild-survival strategies

---- from "Ruggiero, Mrs. Ana Lucia (WDC)" <ruglucia@PAHO.ORG> -----

Co-coverage of preventive interventions and implications for child-survival strategies: evidence from national surveys

Cesar G Victora, Bridget Fenn, Jennifer Bryce, Betty R Kirkwood
Lancet 2005; 366: 1460-66, October 22, 2005
Universidade Federal de Pelotas, Pelotas, RS, Brazil and London School of Hygiene and Tropical Medicine, London, UK

Summary at:
http://www.thelancet.com/journals/lancet/article/PIIS014067360567599X/abstract

Professor Cesar G. Victora email: cvictora@terra.com.br

In most low-income countries, several child-survival interventions are being implemented. We assessed how these interventions are clustered at the level of the individual child (Bangladesh, Benin, Brazil, Cambodia, Eritrea,Haiti, Malawi, Nepal, and Nicaragua).

The percentage of children who did not receive a single intervention ranged from 0*3% (14/5495) in Nicaragua to 18*8% (1154/6144) in Cambodia. The proportions receiving all available interventions varied from 0*8% (48/6144) in Cambodia to 13*3% (733/5495) in Nicaragua. There were substantial inequities within all countries. In the poorest wealth quintile, 31% of Cambodian children received no interventions and 17% only one intervention; in Haiti, these figures were 15% and 17%, respectively.
Inequities were inversely related to coverage levels.
Countries with higher coverage rates tended to show bottom inequity patterns, with the poorest lagging behind all other groups, whereas low-coverage countries showed top inequities with the rich substantially above the rest.

Interpretation

The inequitable clustering of interventions at the level of the child raises the possibility that the introduction of new technologies might primarily benefit children who are already covered by existing interventions. Packaging several interventions through a single delivery strategy, while making economic sense, could contribute to increased

PHM-Exchange
Surveys

RN
3/11/05

inequities unless population coverage is very high. Co-coverage analyses of child-health surveys provide a way to assess these issues.

Main Identity

From: <claudio@hcmc.netnam.vn>
To: <pha-exchange@lists.kabissa.org>
Sent: Tuesday, November 08, 2005 8:42 AM
Subject: PHA-Exchange> WHA Resolution on "Global Framework on Medical Researchand Development"

From: "Bala" <bala@haiap.org>

> Dear friends,
>
> Greetings from Sri Lanka. I need your assistance.
>
> NGOs, working on issue of Access to Medicines, including HAI have drafted
> a
> resolution on "Global Framework on Medical Research and Development"
> soliciting the support of members of the Executive Board of WHO to sponsor
> and support this resolution. The resolution is attached.
>
> The current Chair of the Executive Board is the Minister of Health from
> Pakistan. Ministries of Health from your countries are also current
> members.
>
> We shall very much appreciate if you will be able to lobby your ministry
> and
> get the Minister to sponsor and support this resolution. You may wish to
> see the following links for background information.
>>
>> http://www.cptech.org/workingdrafts/rndtreaty.html
>> http://www.cptech.org/workingdrafts/rndsignonletter.html
>> http://www.cptech.org/workingdrafts/rndtreaty4.pdf
>>
> Best wishes,
>
> Bala
>
> Dr K Balasubramaniam
> Advisor and Coordinator
> Health Action International Asia - Pacific

Please access and pursue
RN
8/11/05
Thakur 8/11/05

VNR
cc Mira Shiva
Amit Sengupta
Gopal Dabade
Anuradha Gupta
Amar Phadke
B. Ekbal
Sanjay 15/11/05
RN
15/11/05

11/8/05

Medical Research and Development Treaty (MRDT)

Discussion draft 4[1]

Table of Contents

[1] February 7, 2005

1 Preamble.

The State Parties to this Treaty (hereinafter referred to as the "Parties") seek to create a new global framework for supporting medical research and development that is based upon equitable sharing of the costs of research and development, incentives to invest in useful research and development in the areas of need and public interest, and which recognizes human rights and the goal of all sharing in the benefits of scientific advancement.

2 General Provisions And Basic Principles

2.1 Objectives of the Treaty

Members seek to promote a sustainable system of medical innovation that will:

i. *ensure* adequate and predictable sources of finance for medical research and development,
ii. *allocate* fairly the costs of supporting medical research and development,
iii. *identify* priority areas of research and development,
iv. *encourage* the broad dissemination of information and sharing of knowledge, and access to useful medical inventions,
v. *enable* medical researchers to build upon the work of others,
vi. *support* diversity and competition,
vii. *utilize* cost effective incentives to invest in promising and successful research projects that address health care needs,
viii. *enhance* the transfer of technological knowledge and capacity in a manner conducive to social and economic welfare and development, and
ix. *promote* equitable access to new medical technologies, so that all share in the benefits of scientific advancement.

2.2 Mechanisms to Support Research and Development

The treaty will provide:

i. *Obligations* for minimum levels of investment in medical research and development,
ii. *Processes* for priority setting,
iii. *Obligations and Incentives* to support
    a. Medical research and development, including priority research and development,
    b. broader dissemination of scientific information and knowledge,
    c. enhanced transfer of technology and capacity for research and development in developing countries, and
iv. *Obligations and standards* for transparency, including mechanisms to report, measure and understand the nature of the scientific, economic and

social dimensions of investment flows in medical research and development.

2.3 Relations to other agreements

Members agree that in creating a global framework for minimum levels of investment in medical research and development it is possible and appropriate to rely less upon other, indirect mechanisms. Members thus agree to forgo certain WTO TRIPS dispute resolution cases, or bilateral or regional trade sanctions, in areas where compliance with the terms of the Treaty provides an alternative and superior framework for supporting innovation.

3 Governance

3.1 Assembly for Medial Research and Development (AMRD)

An Assembly for Medical Research and Development (AMRD) is hereby established. Every Party entering the treaty is a voting member of the AMRD. The first session of the AMRD shall be convened [by the World Health Organization] not later than one year after the entry into force of this Agreement.

3.2 Council for Medical Innovation (CMI)

The AMRD shall establish a Council on Medical Innovation (CMI), serving fixed terms.

3.2.1 Elected Members

The CMI shall have [18] elected members.

ALTERNATIVE 1

> Half of the members of the CMI will be elected among member nations classified as high income by the World Bank. Half will be elected among member nations classified as middle or low income by the World Bank.

ALTERNATIVE 2

> One third of the members of the CMI will be elected among member nations classified as high income by the World Bank. One third will be elected among member nations classified as high middle income by the World Bank. One third will be elected among member nations classified as low middle income or low income by the World Bank.

No country will have more than one representative.

[

3.2.2 Civil Society Members

The elected members of the CMI will appoint [ten] addition non-voting members representing civil society.]

3.3 Secretariat

The AMRD shall designate a permanent secretariat and make arrangements for its functioning. [Until such time as a permanent secretariat is designated and established, secretariat functions under this Treaty shall be provided by the World Health Organization.]

Secretariat functions shall:

i. make arrangements for sessions of the AMRD, the CMI and subsidiary bodies and provide services as required;
ii. transmit reports received by it pursuant to the Treaty;
iii. provide support to Members, particularly developing country Members and Members with economies in transition, on request, in the compilation and communication of information required in accordance with the provisions of the Treaty;
iv. prepare reports on its activities under the Treaty;
v. ensure the necessary coordination with the competent international and regional intergovernmental organizations and other bodies;
vi. enter into such administrative or contractual arrangements as may be required for the effective discharge of its functions; and
vii. perform other secretariat functions specified by the Treaty and by any of its protocols and such other functions as may be determined by the AMRD or the CMI.

3.4 Meetings

The AMRD will determine the venue and timing of subsequent regular sessions at its first session.

Extraordinary sessions of the AMRD shall be held at such other times as may be deemed necessary by the AMRD, or by request of the CMI, or at the written request of any Member, provided that, within six months of the request being communicated to the Secretariat of the Treaty, it is supported by at least one-third of the Parties.

The CMI will meet at least once every year.

3.5 Finances

The AMRD shall adopt financial rules for itself as well as governing the funding of any subsidiary bodies it may establish as well as financial provisions governing the functioning of the Secretariat. At each ordinary session, it shall adopt a budget for the financial period until the next ordinary session.

3.6 Observers

The AMRD shall establish the criteria for the participation of observers at its proceedings.

4 General Obligations

4.1 Qualified medical research and development

Members agree to support certain medical research and development. Qualified medical research and development (QMRD) includes:

i. Basic biomedical research,
ii. Development of biomedical databases and research tools,
iii. Development of pharmaceutical drugs, vaccines, medical diagnostic tools,
iv. Medical evaluations of these products, and
v. The preservation and dissemination of traditional medical knowledge.

4.2 Minimum levels of investment in medical research and development

The minimum support for QMRD will depend upon the capacity of each country. Minimum levels of support shall depend upon national income. Higher income countries will contribute more in both absolute and relative terms.

ALTERNATIVE 1

Depending upon the classification of the country, using the World Bank definition of income groups, the minimum support for QMRD, as a share of GDP, are as follows:

i. High Income, 15 basis points (.0015)
ii. High Middle Income, 10 basis points (.001)
iii. Lower Middle Income, 5 basis points (.0005)
iv. Low Income, 0 basis points of GDP (0)

ALTERNATIVE 2

The obligation of each party to support QMRD will increase with per capita income. The relevant rates as a share of national income are as follows:

i. 1 basis point of GDP for the per capita income from $300 to $999,
ii. 5 basis points of GDP for the per capita income between $1,000 and $4,999,
iii. 10 basis points of GDP for the per capita income between $5,000 and $9,999,
iv. 15 basis points of GPD for the per capita income between $10,000 and $19,999, and
v. 20 basis points of GDP for the per capita income of $20,000 or more.

The CMI will review the minimum levels every two years. Minimum levels can be changed by consensus, or with support of two-thirds majorities of the high-income members and two-thirds majority of the developing country members.

5 Priority Medical Research

5.1 Committee on Priority Medical Research and Development

The CMI will appoint a Committee on Priority Medical Research and Development (CPMRD).

The CPMRD will meet at least once a year to evaluate targets for priority research, and to make recommendations to enhance priority health care research, and improve access to knowledge, technology and products.

5.2 Identification of priority medical research targets

Every two years the CPMRD will adopt global targets for priority medical research and development (PMRD) in the following areas:

a. Vaccine development
b. Neglected diseases
c. Global infectious diseases
d. Databases, research tools and other public goods
e. Health systems and appropriate technology
f. Preservation and dissemination of traditional medical knowledge
g. Other appropriate priority research

5.3 Minimum support for priority medical research

Depending upon the classification of the members by income (using World Bank definitions), the initial minimum share of GDP devoted to PMRD is the following:

ALTERNATIVE 1

a. High Income, 2 basis points, at least half for neglected diseases,
b. High Middle Income, 1 basis point
c. Lower Middle Income, .5 basis points
d. Low Income, 0 basis points of GDP

ALTERNATIVE 2

The obligation of each party to support PMRD will increase with per capita income. The relevant rates as a share of national income are as follows:

i. .2 basis point for GDP for the per capita income between $300 and $999,
ii. .5 basis points of GDP for the per capita income between $1,000 and $4,999,
iii. 1 basis points of GDP for the per capita income between $5,000 and $9,999,
iv. 2 basis points of GDP for the per capita income between $10,000 and $19,999,
v. 3 basis points of GDP for the per capita income of $20,000 or more.

The CMI will review the minimum levels every two years. Minimum levels can be changed by consensus, or with support of two-thirds majorities the high-income members and two-thirds majority of the developing country members.

6 Methods of finance

Projects that support QMRD (including PMRD) are selected by Member States. Eligible finance mechanisms include:

i. Public sector support for QMRD
ii. Tax expenditures, such as tax credits for QMRD investments
iii. Philanthropic expenditures on QMRD
iv. QMRD financed by businesses or non-profit organization pursuant to government obligations,
v. National expenditures on relevant medical products, to the degree that such expenditures create incentives for investments in QMRD,
vi. Innovation prizes or other innovation incentives, to the degree that such expenditures support QMRD.

7 Decentralization and Diversity

Parties are free to decide themselves on specific investments and finance mechanisms for QMRD (including PMRD). Members are free to embrace a diversity of management approaches to support QMRD, including the direct funding of profit or non-profit research projects, market transactions such as purchases of medicine that provide incentives for research and development, payment of royalties to patent owners, tax credits, innovation prizes, investments in competitive research

intermediators, research and development obligations imposed on sellers of medicines or other alternatives that have the practical effect of either directly or indirectly financing QMRD.

Every two years the CMI will publish a report illustrating different mechanisms members have used to directly and indirectly finance QMRD.

8 Measurement of QMRD and PMRD

The CMI shall adopt regulations providing for measurement and reporting of investment flows for QMRD and PMRD. These regulations shall be consistent with the following principles:

i. **No double counting**. The mechanisms to finance QMRD (including PMRD) can be complex, involving mixed sources of finance and transnational flows of products and investments. The regulations shall provide that each investment only be counted once.

ii. **Source of finance rather that location of investment**. For purposes of measuring support for QMRD and PMRD, measurement will be based upon the source of finance rather than the location of R&D activity.

Explanatory note: For example, if products are purchased in one country, but R&D is performed in another county, the country that paid for the products would be credited with finance of R&D, even though the R&D itself was performed elsewhere.

iii. **Evidence based estimates.** In cases where measured investments are based upon estimates of the relationship between outlays on products or incentives and actual R&D investments, the estimates shall be based upon the best empirical evidence of such relationships.

The CMI will establish an advisory committee that will adopt and periodically revise "best practices" models for sharing of economic and scientific data.

9 Open Public Goods

The CMI shall appoint a committee on open public goods (COPG). The CORG will adopt regulations that identify qualified open public good projects (QOPGP).

10 Technology transfer to developing countries

Members agree to report on collaborative research projects that enhance technology transfer and capacity building in developing countries. The CMI shall appoint a committee on technology transfer (CTT). The CTT will establish regulations to define qualifying technology transfer projects (QTTP).

11 Exceptionally Productive and Useful Projects

The CMI will appoint a committee on exceptionally productive and useful projects (CEPUP). The CEPUP will establish procedures for the identification of exceptionally productive and useful projects (EPUP), and the assignment of credits for such projects.

12 Incentives to support priority research, open research, technology transfer to less developed countries, and exceptionally productive and useful projects

The CMI will provide economic incentives for members to invest in priority research, open research, technology transfer to less developed countries, and exceptionally productive and useful projects.

12.1 Special Credits

Investments in PMRD, QOPGP, QTTP and EPUP qualify for special credits that can be used in funding a members' minimum contribution to QMRD. The initial values of the special credits are:

50 percent of PMRD,
50 percent QOPGP
50 percent of QTTP, and
The credit assigned by the CEPUP for EPUP.

The CMI may periodically revise the weights for PMRD, QOPGP and QTTP. The global total credits for EPUP may not exceed [10] percent of global minimum PMRD obligations.

The PMRD, QOPGP, QTTP and EPUP credits may be traded between countries.

The CMI may periodically revise the weights.

12.2 Caps on Special Credits

No more than [one third] of QMRD can be satisfied by the special credits. The CMI can periodically revise the caps on special credits.

13 Access to publicly funded research

13.1 Obligations to provide incentives for open access research

The CMI will appoint a committee on open access research (COAR). The COAR will adopt best a practices model for the support of open access research. Within [5] years, every member will adopt procedures concerning obligations for research supported by the public sector to be made available to the public through open access archives or repositories.

13.2 Equitable pricing of government funded inventions,

Within three years the CMI will adopt regulations that ensure equitable access to government funded inventions.

14 Changes in patent laws

14.1 Mechanisms to limit patents on inventions which are derived from certain open public goods databases`

The COPG will adopt procedures whereby persons, organizations or communities that seek to establish certain qualifying open public goods databases (QOPGD) apply for a time limited period during which no patent applications can be submitted that rely upon the data from the QOPGD.

Explanatory note: For example, when it was first created, the developers of the HapMap database (see licensing terms below) asked that patents not be filed for a period of three years. The license did create problems in terms of the dissemination of the information, and was eventually eliminated, but only after it had served its basic purpose, which was to protect the public good against misappropriation by private patents for a critical period of time.

DO NOT translate the text in this box

EXCERPTS FROM THE ORIGINAL TERMS AND CONDITIONS FOR ACCESS TO AND USE OF THE GENOTYPE DATABASE

2. You may access and conduct queries of the Genotype Database and copy, extract, distribute or otherwise use copies of the whole or any part of the Genotype Database's data as you receive it, in any medium and for all (including for commercial) purposes, provided always that:

a. by your actions (whether now or in the future), you shall not restrict

the access to, or the use which may be made by others of, the Genotype Database or the data that it contains;

b. in particular, but without limitation,

i. you shall not file any patent applications that contain claims to any composition of matter of any single nucleotide polymorphism ("SNP"), genotype or haplotype data obtained from the Genotype Database or any SNP, haplotype or haplotype block based on data obtained from the Genotype Database; and

ii. you shall not file any patent applications that contain claims to particular uses of any SNP, genotype or haplotype data obtained from the Genotype Database or any SNP, haplotype or haplotype block based on data obtained from, the Genotype Database, unless such claims do not restrict, or are licensed on such terms that that they do not restrict, the ability of others to use at no cost the Genotype Database or the data that it contains for other purposes; and

14.2 Minimum exceptions to patent rights for research purposes

The CMI will adopt regulations that provide for minimum exceptions to patents rights for research purposes. Members will enact such minimum exceptions within 5 years.

15 Exceptions in laws for copyright and related rights to support research

The CMI will adopt a best practices model for exceptions in laws on copyright and related rights, including laws on databases.

16 Relationship with Other Agreements

a. In order to better enhance medical innovation, Parties are encouraged to exceed the investment standards required by this Agreement, and nothing in this Agreement shall prevent a Party from exceeding the investment obligations of this Agreement.

b. The purpose of the Agreement is to establish an international system that deals directly with sustainable investment in medical innovation, with the intention of both providing sustainable sources of finance for such innovation and fairly allocating the cost burdens of such innovation.

c. The provisions of the Agreement shall in no way affect the right of Parties to enter into bilateral or multilateral agreements, including regional or sub-regional agreements, on issues of or additional to the Agreement, provided

that such agreements are compatible with their obligations under the Agreement, including (d).

d. Members agree, for products defined as QMRD, to forgo dispute resolution cases on Articles 27 through 34 and Article 39.3 of the WTO TRIPS Agreement, and similar provisions in regional or bilateral trade agreements, or in unilateral trade policies. Members further agree to forgo dispute resolution cases in regional or bilateral trade agreements, or in unilateral trade polices, that concern pricing of medicines. However, members may enter into bilateral or regional agreements to increase investments in medical research and development.

e. The Parties concerned shall communicate any agreements on issues relevant to the Treaty to the Council on Medical Innovation through the Secretariat.

17 Transition Arrangements

Members will have [5] years to enact policies consistent with the Treaty.

18 Reservations

[There will be no reservations to this agreement]

19 Appendix A: Abbreviations

AMRD	Assembly for Medical Research and Development
CEPUP	Committee on exceptionally productive and useful projects
CMI	Council on Medical Innovation
COAR	Committee on open access research
COPGP	Committee on open public goods projects
CPMRD	Committee for Priority Medical R&D
CTT	Committee on technology transfer
EPUP	Exceptionally productive and useful projects
MRDT	The Medical Research and Development Treaty
PMRD	Priority medical research and development
QMRD	Qualified Medical Research
QOPGP	Qualified open public good projects
QTTP	Qualifying technology transfer projects

ravi narayan

From: "Tobias Eigen and Kim Lowery" <community@kabissa.org>
To: "Claudio Schuftan" <claudio@hcmc.netnam.vn>
Cc: "Ravi Narayan" <ravi@phmovement.org>
Sent: Thursday, November 10, 2005 5:46 AM
Subject: Action Needed: Kabissa board member election

Attn: Claudio Schuftan and Ravi Narayan
People's Health Movement (PHM)

Dear Claudio Schuftan and Ravi Narayan,

We are writing to you today to invite you to participate in the election of the new Community Representative on the Kabissa board running from November 9-23. We are proud to announce that our three nominees are:

- Bisi Olateru-Olagbegi, Women's Consortium of Nigeria
- Neema Mgana, African Regional Youth Initiative
- Omeire Edward, Ceasefire Project

To learn more about the nominees and to vote, please click the following link now to access your special ballot:

http://www.kabissa.org/election/index.php?code=lf1ovw5b1gji

IMPORTANT: Each organization has only ONE vote. This e-mail has been sent to both the primary and secondary contact people we have on file for your organization. When you vote, you vote for the entire organization - the second person will NOT be able to submit a second vote, so be sure to coordinate this within your own organization.

The Board's community representative will be crucial in bringing perspective to the changing technological needs of our member organizations. This person will serve as a liaison between the greater Kabissa community and the Board, which will allow the Board to better understand the needs of the community members. With this greater understanding, the Board will be able to communicate and connect more effectively with the Kabissa community as it grows.

Please vote today by clicking the link:

http://www.kabissa.org/election/index.php?code=lf1ovw5b1gji

Sincerely yours,

Tobias Eigen and Kim Lowery
Co-Executive Directors

Kabissa - Space for Change in Africa
http://www.kabissa.org

PHM-Exchange

Dear Claudio 10/11/05
Thanks for the short note
about the Canada meetings. Please
attend to the Kabissa.org vote
for community representatives
on behalf of PHM. Just getting ready
for an org. open next week
after a t+ve
Keep in touch with Prem. He is the new
convenor of the PHM
Transitional Team
Best wishes
Ravi 11/10/05

RN
15/11/05