sochara

From: Claudio Schuftan <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>
Sent: Wednesday, August 29, 2001 10:03 PM
Subject: PHA-Exchange> Health, equity, justice, globalization and the PHA

> Debate: Health, equity, justice and globalisation
>
> Journal of Epidemiology and Community health
> September 2001 JECH's debate on globalisation and health is entirely free
> access.
>
>
> Health, equity, justice and globalisation: some lessons from the People's
> Health Assembly (PHA)
> F Baum - J Epidemiol Community Health 2001;55:613-6
> Full text at: http://www.jech.com/cgi/content/full/55/9/613
> <http://www.jech.com/cgi/content/full/55/9/613>
>
> "..... Can you imagine a world in which the spread of globalisation
meant
> the world becoming a more just and equitable place? This seems like an
> impossible dream. All the indications are that the current forms of
> globalisation are making the world a safe place for unfettered market
> liberalism and the consequent growth of inequities. This economic
> globalisation is posing severe threats to both people's health and the
> health of the planet....."
>
>
> Towards a more sustainable globalisation: the role of the public health
> community
> DOUGLAS W BETTCHER and HEATHER WIPFLI - J Epidemiol Community Health
> 2001;55:617-8
> Full text at. http://www.jech.com/cgi/content/full/55/9/617
> <http://www.jech.com/cgi/content/full/55/9/617>
>
> ".....In her article Fran Baum is correct in pointing out that the
> political complexities of our globalised world must be taken into account
by
> public health professionals. Global health futures are directly or
> indirectly associated with the transnational economic, social, and
> technological changes taking place in the world. Issues such as poverty,
> equity, and justice must be firmly rooted in any discussions aimed at
> improving global public health. However, globalisation is a "janus faced"
> creature: the double face of globalisation, one promising and the other
> threatening, is a fact of life as humanity is being catapulted into a more
> interdependent future....."

→ RN
AL
30/08

To PHA-CG file ← RN 30/8

8/30/01

>
>
> A dialogue of the deaf? The health impacts of globalisation
> KELLEY LEE - J Epidemiol Community Health 2001;55:619
> Full text at: http://www.jech.com/cgi/content/full/55/9/619
> <http://www.jech.com/cgi/content/full/55/9/619>
>
> "..... Opinion about the true impacts on human health of globalisation
> remains sharply divided. On the one hand, a wide range of health
> professionals, non-governmental organisations (NGOs), scholars and
activists
> fear globalisation is worsening the divide between haves and have nots to
> unprecedented degrees....."
>
>
> Liberalisation, health and the World Trade Organisation
> RONALD LABONTE - J Epidemiol Community Health 2001;55:620-1
> Full text at: http://www.jech.com/cgi/content/full/55/9/620
> <http://www.jech.com/cgi/content/full/55/9/620>
>
> "....The contemporary globalisation project of which Baum writes rests on
> the promise that economic growth benefits all.1 Originally enforced
through
> Structural Adjustment Programs' trinity of privatisation, reduced public
> spending and increased trade liberalisation, it is the benefits of the
> latter that now dominate the "globalisation is good" argument. So dominant
> is this claim that it deserves closer scrutiny....."

Moderator: I would like to apologize for the barrage of long emails on Monday. I was having difficulties in my connections with the server and what should have been a message per day went out all in one day. It should not happen again.
Claudio

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

Subject: PHA-Exchange> Welcome to the PHA's new website
Date: Wed, 29 Aug 2001 23:59:14 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

> >*Update on the People's Health Assembly (PHA2001)*
> >
We are an international grassroots network oforganisations and individuals
that came together in 2000 to reignite thecall for Health for All Now!
> >
> >*Good News! The new PHA Website is at last up and running. It is*
> >
> >*www.phamovement.org. The new website includes charter, newsletters,*
> >*issue papers and updates of follow-up action since the PHA2000*
international
> >*event held in Bangladesh in December, 2000, and attended by 1500 people*
> >*from 77 countries. VISIT IT.*
> >
> >*For a Critical Analysis of the PHA2000 Event, with suggestion for an even*
> >*more successful follow-up, see the HealthWrights Newsletter from the*
Sierra
> >*Madre, #44. This piece is available on the Website:*
www.healthwrights.org.
> >
> >*The current secretariat for the PHA, worldwide, is coordinated by Qasem*
> >*Chowdhury, whose address is:*
> >*GONOSHASTHAYA KENDRA*
> >*P.O. Mirzanagar via Savar Cantonment*
> >*Savar, DHAKA - 1344*
> >*BANGLADESH.*
> >*PHONE# 00880 2 7708316*
> >*FAX: 00880 2 7708317*
> >*EMAIL: gksavar@citechco.net*

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Website: http://www.kabissa.org/mailman/listinfo/pha-exchange

RN 31/8

(200) 31/8/01 TU: 54. RN

[illegible] health policy draft

Lib

news brief

PHA PARTICIPATION AT THE WORLD HEALTH ASSEMBLY

- meeting between People's Health Assembly representatives and WHO DG

A meeting between the representatives of the People's Health Assembly and the WHO Director-General Ms Gro Harlem Brundtland was held on 18 May 2001 on the occasion of the World Health Assembly in Geneva, Switzerland. Zafrullah Chowdhury, Mira Shiva, Pam Zinkin, Maria Zuniga and Mike Rowson were present there on behalf of the PHA. Ms Gro Harlem Brundtland, David Nabarro (Chef de Cabinet), Anarfi Asmoah-Baah (Head of External Relations) and Eva Wallstam (Director of new civil society initiative) were present for WHO.

Maria Zuniga opened the meeting by thanking the WHO DG for agreeing to meet the representatives of the PHA. Maria commented positively about the Civil Society Initiative aimed at improving WHO's relationships with NGOs and other civil society actors. DG said that she had initiated this project in order to scale up and systematise WHO's response to NGOs.

Zafrullah Chowdhury summarized the success of the PHA – the process had included more than 5,000 meetings and 1,500 people had gathered in Bangladesh. The grassroots had mobilized themselves to fight for Health for All.

DG said that events such as the WTO ministerial meeting at Seattle, USA and the battle over the revised drug strategy in 1998 had also shown the power of the civil society voice.

Pam Zinkin presented the Charter in 20 different languages and said that new versions were arriving almost everyday and emphasized that this type of work was being undertaken without funding, underlining the commitment of civil society to carrying forward the PHA process.

Mike Rowson said that the main political messages to arise from the Assembly were that:
(1) Health for All and Comprehensive Primary Health Care should be the fundamental principles which guide international health policy; and
(2) there was great concern about the ability of WHO to stand up to the forces of globalization, in terms of analysing the health impact of global economic change and in terms of the role of WHO in relation to other global institutions such as WTO, The World Bank and International Monetary Fund.

DG said that she would not use the words 'stand up' to describe what WHO should be doing: it had to be remembered that WHO is an organization of member states and must work with that in mind. WHO should use its expertise to contribute to the evidence-base on these problems.

She then said that it is important to look broadly at what is happening with globalization and human rights as well as the divisions between people, the inequities and the differences in accessibility and to see where there are weaknesses in order to make an impact. WHO had started putting a stronger emphasis on the human rights issue and the need for better distribution of health care in developing countries. She has asked WHO representatives (WRs) to work to achieve these goals.

Zafrullah added that what we meant by 'stand up' is for WHO to take stronger position in favour of developing countries in the face of the globalization process.

DG said that the Department of Health in Sustainable Development had been systematically addressing the global institutions in its work. WHO now had observer status on the TRIPS Council.

2000. She argued that it was an attempt to make health accountable.

Zafrullah noted that many of WHO's messages do not reach the community level and that there needed to be greater [illegible] undertook this work. For example, the WRs should be [illegible] PHA [illegible] much greater attention to making sure that health ministers listened to WHO.

Mira Shiva emphasised the need to place representatives of civil society on strategic WHO committees in order to balance the role of commercial interest groups.

DC replied that this would be one of the issues looked at by the Civil Society Initiative.

WHO's Civil Society Initiative: Ms Brundtland announced on 11 May 2001 a new initiative to improve WHO's relation with the civil society. The initiative will be placed in the external relations department and led by Eva Wallstam (former head of Health in Sustainable Development, which is now called Health in Development and headed by Andrew Cassels). Margareta Gould will join Eva's team and they will probably employ others. The task is to develop within the coming year a plan on how the relationships could be improved. Eva and Maga are keen to hear any suggestions from our side. They will start by mid-June and probably set up a website to facilitate dialogue. During the WHA the PHA representatives had several talks with both Eva and Maga. NGO-accreditation and developing links (especially with WHO representatives at regional and country level) [illegible] were among the points. The initiative is very much welcomed, but should not become a one-off exercise. Eva Wallstam's request on 'Civil Society Initiative' needs to be [illegible] examined. PHA have to decide how we are going to relate with this initiative. We need [illegible] from the PHA participants to develop the strategy. If anybody is interested to have the copy of [illegible] speech, please let the PHA Secretariat know it.

PHA at WHO NGO Forum for Health: Besides disseminating the Charter to the delegates and Ministers and discussions on PHA follow-up, e.g., in Africa, a presentation on PHA was held on 16 May 2001, in the final session of the NGO Forum for Health meeting chaired by Dr Eric Ram. The spirit of the PHA was brought forward to this well attended meeting. There were presentations of Zafrullah Chowdhury, Bala, Pam Zinkin, Claudio Schuftan and many others. Maria Zuniga facilitated the meeting. They shared information on the PHA process, the main messages of the People's Charter for Health. Examples of follow-up activities in the different regions were given and the BBC World service video was shown.

UPMRC prize: The Union of Palestine Medical Relief Committees received the United Arab Emirates Health Foundation Prize from WHO for their work in Primary Health Care. The prize was presented to Mustafa Barghouthi and it means a great honor to and support for UPMRC.

Post-PHA Activities

Nepal: "People's Health National Coordinating Committee, Nepal" has been formed to undertake post-PHA activities in Nepal. Professor Mathura Prasad Shrestha is the convener of the committee and Shanta Lall Mulmi is its General Secretary. The newly formed National Committee has decided to organize a national consultative meeting on the 18th August 2001 in Kathmandu. The Committee has invited PHA Global Secretariat to take part in the consultative meeting.

Sri Lanka: Seven Regional Seminars were held in Sri Lanka since the last People's Health Assembly held in Savar, Bangladesh. A National People's Health Assembly has been planned to be held on 1st September 2001 at Matale, Sri Lanka.

Arab Countries: The Arabic version of the People's Charter for Health has been published already.

A booklet on the Charter in English, French and Arabic has been also published. The booklet is available at UPMRC's website www.upmrc.org, in PDF or word format. It will also be available on the PHA website when it is operational again. Copies of the two publications will be disseminated to the UPMRC partners and they will be asked to hold national workshops to promote the Charter.

In Palestine, a small workshop will be held for the people who were invited to the PHA Assembly 2000 in Bangladesh, and discussions will be held on the Charter. A national meeting of the interested NGOs will also be organized. It has been planned that the Charter will be further promoted through the Palestinian NGO Network (PNGO), of which UPMRC is an active member. Meetings will be held with the Government ministries to promote the document. In addition, UPMRC has decided to distribute the Charter to many of their international partners and funders and lobby with them to accept the Charter as part of their work in the Middle East and throughout the world. It has also planned to ask its partners and funders to utilize their networks and contacts through the world, particularly in their region, to generate support. It has succeeded to get the Charter on the agenda of the regional meeting of the Arab Forum for Health and Social Studies that will be held in Beirut in November 2001. The meeting is expected to help make new contacts and garner further support for the PHA movement.

Tanzania: Ifaka a International Health Research Centre, where research on Malaria disease is being carried out, is interested to do post-PHA activities in Tanzania on the basis of the People's Charter for Health. The director of the Research Centre is ready to collaborate with the PHA activists in Africa to undertake any activity there. The touchiest issues for any part of Africa are HIV and Safe Motherhood. Focus is being given on these issues. The PHA participants in Africa think that the People's Charter for Health is a starting point for them.

Kenya: As part of post-PHA activities in Africa, Consumer

Information Network (CIN), an independent non-profit national consumers' organization in Kenya, have come up with the following decisions: 1) CIN will enhance her activities on PHA at the local, sub-regional, regional and global scenes; 2) CIN will initiate dialogue and networking amongst the organizations and individuals working/involved in PHA activities locally and regionally; and 3) CIN will support and promote effective participation of Africa in PHA activities. They have the desire to promote and advance the objectives of the PHA and the vision and the aim of the People's Charter for Health as the fundamental prerequisite to human development. They will develop simple brochures both in English and Kiswahili and use cartoons and other illustrations as may be necessary.

[illegible]

All over the Americas people are discussing the PHA and what happened in Savar, Dhaka. There have been local and regional meetings to discuss the People's Charter for Health and determine in which ways it might be applied to the present situations in many distinct communities.

In Latin America, the Regional Committee for the Promotion of Community Health (Mexico, Central America, and the Dominican Republic) have prepared a three-year plan for the Committee which includes intensive follow-up of the PHA at community, national, and regional levels. Later this year, the RCPCH will hold a region-wide encounter on Health and Globalization. In the meantime, the participants from the region are carrying out activities to raise awareness in their respective organizations, communities and countries.

In Jamaica, copies of the Charter are being used to promote the PHA there. A proposal on the Jamaican People's Health Assembly is being produced to be presented to the University of the West Indies. It is a collaborative proposal to the Ministry of Health.

[illegible]

France: Lucien Rigeault and Dr Didier Potte who attended the PHA event at Savar, Dhaka gave a presentation of the PHA to some of Public Health department professors and students of Medical College Bichat in Paris. The head of this department is Professor Marc Brodin who is also a member of the PHA Committee in Paris.

A copy of the 'People's Charter for Health' was sent to Professor Claude Jasmin, president of ICGPH organizing the 4th Congress on Global Health Equity at UNESCO. He has called Lucien over telephone by asking him to send them names of the members desiring to participate in this congress so that they could send Lucien and others invitations. Lucien may accompany Professor Marc Brodin.

Russia: Lidia Shmeltsova, a participant of the PHA 2000 event, chaired the big conference having 150 persons as participants, on "Availability of Health Care in St Petersburg", which was conducted by political movement "Power of St Petersburg". It was a great chance to present once more the People's Health Assembly ideology and documents. The People's Charter for Health, documents on The Global Fund, PHA representatives' meeting with WHO DG Ms Brundtland and her letter with GS UN and The World Bank Director to G8 heads were presented and received with big enthusiasm at the conference. The all city population elected fifty persons of the Legislative Assembly of St Petersburg. Many of them were present at the conference on 19 June 2001. Mr Sergey Mironov, Vice-Chairman of the Legislative Assembly of St Petersburg and in the same time Speaker of the upper chamber Parliament in Moscow was also present there. Twenty-five persons work in the Council without salary, many of them are professors in the research institutions and leaders of big health care facilities.

CONTACT the Regional Coordinators at your respective regions/countries to get into the PHA local [illegible]

[illegible]
[illegible], CIRCAIR, 11 Connaught Road, Avondale, Harare, Zimbabwe, tel 263-4-302 [illegible], fax 263-4-303 092, email [illegible]

[illegible]
Dr Umaiyeh Khammash, UPMRC
P.O. Box 51483, Jerusalem. Tel: +972-2-583-4021
Fax: +972-2-583-[illegible]
E-mail: [illegible]

South Africa
David Sanders, [illegible], University of the Western Cape, P Bag X17, Bellville 7535, South Africa, fax 27-21-959 2619, email [illegible]

India
Prem Chandran John, ACHAN, Post Bag 1494, Madras 600 105, India, tel 91-44-823 1551, fax 91-44-827 0471, email achan@[illegible].net

[illegible]
[illegible]

[illegible]
Paul Zollner, MEDACT/IPPNW, [illegible] Holloway Road, London N7 [illegible], United Kingdom, tel 44-20-7 [illegible], fax 44-20-7 [illegible], email [illegible]

[illegible]
Mary Murray, 42 [illegible] Village, [illegible] Circuit, Kambah ACT 2902, Australia, tel 61-26-231 7748, fax 61-26-296 2530, email [illegible]

[illegible]
[illegible]

[illegible]
Maria Hamlin Zuniga, PRHC, Apartado 1340, Managua, Nicaragua, tel 505-2-662 275, fax 505-2-662 275, email [illegible]

Arturo Quizhpe, Faculty of Medical Sciences, University of Cuenca, [illegible], Calle [illegible], Cuenca, Ecuador, tel [illegible], fax [illegible], email [illegible]@yahoo.com

PHA EUROPE MEETING

The PHA Europe Meeting was held on 4 April 2001 in London, where countries represented were Sweden, Italy, France, the Netherlands, Scotland, and UK. Dr Qasem Chowdhury from PHA Secretariat in Bangladesh and Maria Zuniga from Nicaragua were invited to the meeting as special guests. A number of actions and responsibilities were agreed in the meeting. It was decided in the meeting that Europe PHA e-group should be consolidated and enlarged. There are now 30 names on the Europe PHA e-group. Its address is PHA-europe@egroups.com. Currently the e-group deals with news and events. To

[illegible] PHA Europe subsidiary at Dogtrouds.com. It was also decided to promote awareness of the Charter/PHA. The following points were discussed in the meeting: what should we do as a region; how do we use the Charter; what should we take at the global level; [illegible] building a network and structure. They decided to present the PHA at the [illegible] and demand [illegible] activities, to focus on WHO in May 2002 and to target Rio plus 10 in Johannesburg and UN Financing for Development Conference in Mexico City in March 2002.

PHA CHARTER PRESENTATION AT UNESCO

The Congress on Global Health Equity was held at UNESCO on 25-27 June 2001 in Paris, France, where Nobel Laureate Professor Amartya Sen and Dr Mohammad Yunus of Grameen Bank gave their presentations. Lucien Bigeault, a participant of the PHA 2000 from France, was invited to give a presentation on PHA at the Congress. He gave a presentation on PHA and a workshop on 26 June 2001 where the Civil Society and NGOs group joined the government and intergovernmental organizations group. During the workshop, 70 copies of the PHA Charter (People's Charter for Health) were distributed among the participants there. The International Council for Global Health Progress (ICGHP) presented a paper at the Congress at UNESCO. In the Congress paper the mission of ICGHP has been mentioned as follows: "the aim of ICGHP is to contribute to the global work and application of health which are destined to be increasingly needed. This body is interested in the equality of life of men and women of all ages. Its mission is to elaborate international recommendations in order to take part in the improvement of health the world over." Lucien Bigeault observed that the problem of ICGHP is that they are having with "experts" who are far from the ordinary people. He felt that they certainly need to have their organs connected to the civil society.

PHA FINANCE GROUP AND STRATEGY MEETING

The PHA Finance Group and Strategy Meeting was held on 1st and 2nd April 2001 in London, U.K. Dr Qasem Chowdhury, Anis Chowdhury, Bill Rowntree, Andy Rutherford, Fam Zimmi, Maria Zuniga were present at the meeting. At the beginning Qasem gave a brief overview of the present arrangement and activity of the PHA Secretariat. Later he and Andy Rutherford presented a brief report on the financial matters. Some budget items were underspended due to [illegible] own contribution. But other areas were higher than budgeted, especially, travel and person related as due to consolidation of work people. Overall there is still a deficit budget. At the meeting a number of actions were decided, such as, Unite would ask for release of remaining US$30,000 from the Dutch Government. Andy would make claim from DFID for balance fund; WSM would make claim fund from the Belgian Government. The revised budget for the period 1st April 2001 to 31 March 2002 was approved. It was agreed in the meeting that we must look for new donors. We would present requests for funds based on the new budget to SIDA, Dutch Government and the Rockefeller Foundation. Andy would try to raise fund from other donors. Some seed money had to be kept for the next budget for different countries/regions.

It was decided at the London meeting that the provisional list of the participants of the PHA-2000 event should be completed by May 2001. A total of 1,500 copies of the list will be printed for the participants with a request to amend errors if seen. Everybody was pleased with the format of the Charter with an introduction. Copies can be ordered from the secretariat. Qasem proposed to request those organizations that have websites to put the Charter in their websites. During the discussion Secretariat was asked to send [illegible] to PHA organizers for their level of commitment, and who are they representing.

[illegible] was decided to set up a group to [illegible] the PHA Secretariat in advisory capacity till 31 December 2001. The members of the group are Fam, Maria, Unite, Prem and Andy.

It was decided to hold the PHA follow-up meeting in October 2001 and the venue is Sever[illegible]

[illegible]
PHA Secretariat
[illegible]
[illegible]
[illegible]

[illegible]
P.A. Mail

Verbal Autopsy

Introduction

At the Bhopal Peoples' Health and Documentation Clinic run by the Sambhavna Trust, Verbal Autopsy (VA) is used as a method for monitoring mortalities related to the December 1984 Union Carbide disaster in Bhopal. VA is a scientific method of proven validity used for establishing the cause of death of individuals in a community. This is particularly useful in situations where the proportion of deaths occurring under medical care are low and where no autopsies are carried out. This method has been successfully employed in India, Bangladesh, Kenya, Nigeria, Philippines, Indonesia, Egypt, and several other countries to determine the cause of death of individuals in various circumstances.

The Technique of Verbal Autopsy

This method is based on the assumption that most causes of death have distinct symptom complexes and these can be recognized, remembered and reported by lay people. It involves trained workers administering a questionnaire on the carer of the deceased. Information is collected on the symptoms suffered by a panel of physicians individually and independently for ascertaining the probable cause of death.

Appropriateness of VA in Bhopal

Since the official committee for recording exposure-related deaths was wound up in December 1992, there is no official agency to monitor continuing exposure-related deaths in Bhopal. Also, an overwhelming majority of these deaths occur in people's homes resulting in autopsies rarely being conducted and often there being no competent doctor to certify the cause of death. Medical records of the deceased prior to death are often unavailable as they have had to be deposited with the compensation tribunals. Where available these are often incomplete. Given such a situation, VA appears to be the most appropriate method for monitoring exposure-related deaths in Bhopal.

How VA is carried out at the Sambhavna Clinic

The four fieldworkers conduct door-to-door surveys to identify households and question carers of the deceased on the medical history and clinical symptoms suffered. Using culturally appropriate language, the fieldworkers, all of whom are known in the community, apply stringent criteria in the collection and recording of information. Information is recorded on a questionnaire designed to elicit details of exposure to the toxic gases, the health status of the deceased prior to and after exposure, medical examinations and their results, treatment including duration etc. All fieldworkers have been trained in interviewing skills, administration of the questionnaire and signs and symptoms of diseases.

The VA questionnaire

The 21 page verbal autopsy questionnaire (VAQ) begins with general, introductory questions to determine the lifecycle of the deceased. An instruction sheet is used by the field workers as a guideline for administration of the questionnaire. The health workers also confirm which medical records of the deceased are in the possession of the carer. General questioning familiarizes the carer with the type of information to be collected and enables the interviewer to create favorable conditions for the carer to speak openly regarding personal and often traumatic details regarding the deceased.

Direct questions on symptoms existing prior to the gas exposure are asked to compare the health status of the deceased in the post disaster situation. The health worker then begins an open section in which the interviewee is invited to explain what happened in their own words, details of the exposure, subsequent illness/es, and responses to treatment received till the death of the deceased. The statement is recorded verbatim and serves as one of the means to check the veracity of information given by the interviewee. With the use of filter questions, specific recordings of the symptoms related to different body systems are then made. Thus the health worker identifies a body system, e.g. the respiratory system and encourages the carer to provide voluntary information on any particular symptoms, e.g. breathlessness, cough, expectoration tightness in chest etc. Care is taken to ensure that the interviewer does not provide any direct or indirect suggestions during questioning. The systems of the deceased, as the carer may be embarrassed or unaware of the medical implications of certain symptoms such as recurrent nightmares. Information on medical treatment received and documents related are also gathered.

Assessment of Verbal Autopsy Questionnaires

The filled VAQ is then sent to a panel of three physicians along with available medical records of the deceased. The physicians in the verbal autopsy assessment panel write their opinions on the probable cause of death of the individual and whether it is attributable to the individual's exposure to the Union Carbide's gases. The doctors who are volunteering their services in the assessment panel are:

Dr. U.N. Das (MBBS, MD) Chief, Division of Internal Medicine and Clinical Immunology, L. V. Prasad Eye Institute, Hyderabad. He was awarded the prestigious Shanti Swaroop Bhatnagar prize for his contribution to Medical Sciences in 1992.

Dr. Ajitt Vigg (MBBS, DTCD, MRCP) Consultant physician and chest specialist at Apollo Hospital, Hyderabad. He is one of the members of the international panel for lung cancer in India.

Dr. P.N.Rao (MBBS, MD, DM) Consultant Hepatologist and Gastro-enterologist, Mediciti Hospitals, Hyderabad.

Dr. Daniel Chandramohan. Head of the Verbal Autopsy group at the London School of Hygiene and Tropical Medicine, UK is the advisor to the verbal autopsy project at

Sambhavna Clinic. He has made two visits to the clinic to review the work being carried out and has expressed satisfaction with the quality of work.

The final opinion on the probable cause of death and relatibility with exposure to Union Carbide's toxic gases until just recently was given by Dr M. P. Dwivedi, former Director of the Bhopal Gas Disaster Research Centre (BGDRC) set up by the Indian Council of Medical Research (ICMR). The final opinion is arrived at on the basis of the level of agreement among the three dependent medical options. In case all the three doctors in the assessment panel opine that death has been caused due to exposure to Carbides' toxic gases, the final opinion states that the 'most probable' cause of death is attributable to the December 1984 gas disaster. The final opinion states 'probable' in case two of the three doctors agree on the nexus between exposure and subsequent death and 'possible' if only one of the doctors in the panel mentions exposure as a probable cause of death. In case all three doctors opine that the disease or condition of death is not related to the person's exposure to Union Carbide's gases in December 1984, the final opinion issued by the Sambhavna Trust states that the cause of death is unrelated to the disaster.

Validity of the method of Verbal Autopsy in ascertaining cause of death

The method of Verbal Autopsy has been found, through numerous studies carried out in different parts of the world, to have a positive predictive value in the range of 70% to 80% depending on the cause of death and age of the deceased. This range of validity has been confirmed through comparison of opinions on cause of death as ascertained through usual autopsies (post-mortem examinations) and that through Verbal Autopsy.

Verbal Autopsy Data

The information collected through Verbal Autppsy up to March 31, 2000 is presented below in Table - X

Deaths recorded	Interviews completed	Medical autopsy done	Verbal Autopsy final opinion	Most Probable	Probable	Possible	Unrelated to exposure
219	99	01	81	14 [17.28%]	30 [37.0 %]	26 [32.1 %]	11 [13.5 %]

Subject: PHA-Exchange> N. Mandela's closing address
Date: Tue, 21 Aug 2001 19:45:27 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

CLOSING ADDRESS BY FORMER PRESIDENT NELSON MANDELA
AT THE 13TH INTERNATIONAL AIDS CONFERENCE, 14 JULY 2000, DURBAN

> To have been asked to deliver the closing address at this conference,
> which in a very literal sense concerns itself with matters of life and
> death, weighs heavily upon me for the gravity of the responsibility
> placed on one.
>
> No disrespect is intended towards the many other occasions where one has
> been privileged to speak, if I say that this is the one event where
> every word uttered, every gesture made, had to be measured against the
> effect it can and will have on the lives of millions of concrete, real
> human beings all over this continent and planet. This is not an academic
> conference. This is, as I understand it, a gathering of human beings
> concerned about turning around one of the greatest threats humankind has
> faced, and certainly the greatest after the end of the great wars of the
> previous century.
>
> It is never my custom to use words lightly. If twenty-sever years in
> prison have done anything to us, it was to use the silence of solitude
> to make us understand how precious words are and how real speech is in
> its impact upon the way people live and die.
>
> If by way of introduction I stress the importance of the way we speak,
> it is also because so much unnecessary attention around this conference
> had been directed towards a dispute that is unintentionally distracting
> from the real life and death issues we are confronted with as a country,
> a region, a continent and a world.
>
> I do not know nearly enough about science and its methodologies or about
> the politics of science and scientific practice to even wish to start
> contributing to the debate that has been raging on the perimeters of
> this conference.
>
> I am, however, old enough and have gone through sufficient conflicts and
> disputes in my life-time to know that in all disputes a point is arrived
> at where no party, no matter how right or wrong it might have been at
> the start of that dispute, will any longer be totally in the right or
> totally in the wrong. Such a point, I believe, has been reached in this
> debate.
>
> The President of this country is a man of great intellect who takes
> scientific thinking very seriously and he leads a government that I know
> to be committed to those principles of science and reason.
>
> The scientific community of this country, I also know, holds dearly to
> the principle of freedom of scientific enquiry, unencumbered by undue

HIV/AIDS resource file JN 30/8.

To: Dr. TN/AK (182) 23/8/01 JN

> political interference in and direction of science.
>
> Now, however, the ordinary people of the continent and the world - and
> particularly the poor who on our continent will again carry a
> disproportionate burden of this scourge - would, if anybody cared to ask
> their opinion, wish that the dispute about the primacy of politics or
> science be put on the backburner and that we proceed to address the
> needs and concerns of those suffering and dying. And this can only be

PHA-Exchange> N Mandela's closing address

> done in partnership.
>
> I come from a long tradition of collective leadership, consultative
> decision-making and joint action towards the common good. We have to
> overcome much that many thought insurmountable through an adherence to
> those practices. In the face of the grave threat posed by HIV/AIDS, we
> have to rise above our differences and combine our efforts to save our
> people. History will judge us harshly if we fail to do so now, and right
> now.
>
> Let us not equivocate: a tragedy of unprecedented proportions is
> unfolding in Africa. AIDS today in Africa is claiming more lives than
> the sum total of all wars, famines and floods, and the ravages of such
> deadly diseases as malaria. It is devastating families and communities,
> overwhelming and depleting health care services; and robbing schools of
> both students and teachers.
>
> Business has suffered, or will suffer, losses of personnel, productivity
> and profits; economic growth is being undermined and scarce development
> resources have to be diverted to deal with the consequences of the
> pandemic.
>
> HIV/AIDS is having a devastating impact on families, communities,
> societies and economies. Decades have been chopped from life expectancy
> and young child mortality is expected to more than double in the most
> severely affected countries of Africa. AIDS is clearly a disaster,
> effectively wiping out the development gains of the past decades and
> sabotaging the future.
>
> Earlier this week we were shocked to learn that within South Africa 1 in
> 2, that is half, of our young people will die of AIDS. The most
> frightening thing is that all of these infections, which statistics tell
> us about, and the attendant human suffering, could have been, can be,
> prevented.
>
> Something must be done as a matter of the greatest urgency. And with
> nearly two decades of dealing with the epidemic, we now do have some
> experience of what works.
>
> The experience in a number of countries has taught that HIV infection
> can be prevented through investing in information and life skills
> development for young people. Promoting abstinence, safe sex and the use
> of condoms and ensuring the early treatment of sexually transmitted
> diseases are some of the steps needed and about which there can be no
> dispute. Ensuring that people, especially the young, have access to
> voluntary and confidential HIV counselling and testing services and
> introducing measures to reduce mother-to-child transmission have been
> proven to be essential in the fight against AIDS. We have recognised the
> importance of addressing the stigmatisation and discrimination, and of
> providing safe and supportive environments for people affected by
> HIV/AIDS.
>
> The experiences of Uganda, Senegal and Thailand have shown that serious
> investments in and mobilisation around these actions make a real
> difference. Stigma and discrimination can be stopped; new infections can
> be prevented; and the capacity of families and communities to care for
> people living with HIV and AIDS can be enhanced.
>
> It is not, I must add, as if the South African government has not moved
> significantly on many of these areas. It was the first deputy president
> in my government that oversaw and drove the initiatives in this regard,
> and as President continues to place this issue on top of the national

> much more remains to be done. I do not doubt for one moment that he will
> proceed to tackle this task with the resolve and dedication he is known
> for.
>
> The challenge is to move from rhetoric to action, and action at an
> unprecedented intensity and scale. There is a need for us to focus on
> what we know works.
>
> We need to break the silence, banish stigma and discrimination, and
> ensure total inclusiveness within the struggle against AIDS; those who
> are infected with this terrible disease do not want stigma, they want
> love.
>
> We need bold initiatives to prevent new infections among young people,
> and large-scale actions to prevent mother-to-child transmission, and at
> the same time we need to continue the international effort of searching
> for appropriate vaccines; and
>
> We need to aggressively treat opportunistic infection; and
>
> We need to work with families and communities to care for children and
> young people to protect them from violence and abuse, and to ensure that
> they grow up in a safe and supportive environment.
>
> for this there is need for us to be focussed, to be strategic, and to
> mobilise all of our resources and alliances, and to sustain the effort
> until this war is won. About two years ago I invited one of the stars
> who opened this conference, Nkosi Johnson and as I spoke to him, I asked
> him a question: "what do you want to be when you are old?" and he said
> "well, I don't know." And I said "well you have enough time to consider
> that question", and I said "don't you want to be a president?" and he
> said "it looks like hard work." But the point is that all of us have a
> duty to give support and love to all those who, on many occasions, have
> become HIV positive not because of any bad behaviour on their part,
> especially children.
>
> I invited to my house a young fellow who is sixteen but he is about this
> size, and he asked me a question I dreaded because in the course of the
> conversation with other children, some suffering from cancer, other from
> HIV, others from tuberculosis and he said to me: what do you think of
> men like myself. It was very difficult to answer because he suffers from
> a type of cancer which affects the bone, which has made his bones
> brittle and every time somebody touches him roughly there is a breakage
> somewhere in his body and he asked me this question: "what do think of
> people like myselves? The difficulty was that I did not want to give him
> a false hope, at the same time I could not refrain from answering the
> question, I then said to him "the important thing is that you are alive,
> you have the security of having two parents who love you, you are a very
> bright, intelligent youngster, don't thing you will leave your family,
> your beloveds, your people, your country under a cloud of shame. You
> must be determined that you will disappear under a cloud of glory and I
> quoted to him a verse which I often repeat, especially when I am faced
> with the situation of having to say good bye to somebody "cowards die
> many times before their death, the valiant never taste of death but
> once, of all the wonders I yet have seen it seems most strange that men
> should fear seeing that death, a necessary act will death when it will
> come" that was Shakespeare and everyone who listens to those words
> disappears under a cloud of glory, becomes a worthy candidate for
> immortality. We want to move away from rhetoric to practical action and
> as I said earlier this morning we want men and women who can penetrate
> the exterior and appreciate the beauty inside every human being.
>
> We need, and there is increasing evidence of, African resolve to fight
> this war. Others will not save us if we do not primarily commit
> ourselves. Let us, however, not underestimate the resources required to

> conduct this battle. Partnership with the international community is
> vital. A constant theme in all our messages has been that in this
> inter-dependent and globalised world, we have indeed again become the
> keepers of our brother and sister. That cannot be more graphically the
> case than in the common fight against HIV/AIDS.
>
> As one small contribution to the great combined effort that is required,
> I have instructed my foundation to explore in consultation with others
> the best way in which we can be involved in the battle against this
> terrible scourge ravaging our continent and world. It is, I think, not
> something that can be achieved by a single individual. No matter how
> important, how influential, it is essentially a package in each country
> between governments, because no government anywhere in the world has
> sufficient resources on its own to be able to fight and win this battle.
> Therefore, there must be a partnership between business and the
> community without that this battle will not be won and also to use the
> skills, the experience, the research that have been conducted all over
> the world in order to enlighten our people as how to approach this
> tragedy.
>
> With these words, I thank all of you most sincerely for your involvement
> in that struggle. Let us combine our efforts to ensure a future for our
> children. The challenge is no less.
>
> I have been asked on countless occasions, which of the heads of states
> of the world has impressed me most. Well I have to be careful because
> that answer to that question could lead to a diplomatic row any many
> countries I do not mention could withdraw their ambassadors from South
> Africa but I often say that my heroes are not necessarily men and women
> who have titles, it is the humble men and women that you find in all
> communities but who have chosen the world as the theatre of their
> operations, who feel the greatest challenges are the socio-economic
> issues that face the world like poverty, illiteracy, disease, lack of
> housing, inability to send your children to school - those are my
> heroes. If any head of state qualifies in this, he is my hero.
>
> I thank you.

Subject: [PHA2001] FW: JECH Debate: Health, equity, justice and globalisation
Date: Wed, 29 Aug 2001 09:28:01 +1000
From: "Ken Harvey" <k.harvey@bigpond.net.au>
Reply-To: PHA2001@yahoogroups.com
To: "PHA2001" <PHA2001@yahoogroups.com>

TVI

-----Original Message-----
From: Equidad, Salud y Desarrollo. División de Salud y Desarrollo Humano (HDP) [mailto:EQUIDAD@LISTSERV.PAHO.ORG]**On Behalf Of** Ruggiero, Mrs. Ana Lucia (WDC)
Sent: Tuesday, 28 August 2001 12:39 AM
To: EQUIDAD@LISTSERV.PAHO.ORG
Subject: JECH Debate: Health, equity, justice and globalisation

Debate: Health, equity, justice and globalisation

Journal of Epidemiology and Community Health
September 2001 JECH's debate on globalisation and health is entirely free access.

Health, equity, justice and globalisation: some lessons from the People's Health Assembly
F Baum - J Epidemiol Community Health 2001;55:613-6
Full text at: http://www.jech.com/cgi/content/full/55/9/613

"..... Can you imagine a world in which the spread of globalisation meant the world becoming a more just and equitable place? This seems like an impossible dream. All the indications are that the current forms of globalisation are making the world a safe place for unfettered market liberalism and the consequent growth of inequities. This economic globalisation is posing severe threats to both people's health and the health of the planet....."

Towards a more sustainable globalisation: the role of the public health community
DOUGLAS W BETTCHER and HEATHER WIPFLI - J Epidemiol Community Health 2001;55:617-9
Full text at: http://www.jech.com/cgi/content/full/55/9/617

".....In her article Fran Baum is correct in pointing out that the political complexities of our globalised world must be taken into account by public health professionals. Global health futures are directly or indirectly associated with the transnational economic, social, and technological changes taking place in the world. Issues such as poverty, equity, and justice must be firmly rooted in any discussions aimed at improving global public health. However, globalisation is a "janus faced" creature: the double face of globalisation, one promising and the other threatening, is a fact of life as humanity is being catapulted into a more interdependent future..... "

A dialogue of the deaf? The health impacts of globalisation
KELLEY LEE - J Epidemiol Community Health 2001;55:619
Full text at: http://www.jech.com/cgi/content/full/55/9/619

"..... Opinion about the true impacts on human health of globalisation remains sharply divided. On the one hand, a wide range of health professionals, non-governmental organisations (NGOs), scholars and activists fear globalisation is worsening the divide between haves and have nots to unprecedented degrees....."

Liberalisation, health and the World Trade Organisation
RONALD LABONTE - J Epidemiol Community Health 2001;55:620-1
Full text at: http://www.jech.com/cgi/content/full/55/9/620
"....The contemporary globalisation project of which Baum writes rests on the promise that economic growth benefits all.1 Originally enforced through Structural Adjustment Programs' trinity of privatisation, reduced public spending and increased trade liberalisation, it is the benefits of the latter that now dominate the "globalisation is good" argument. So dominant is this claim that it deserves closer scrutiny....."

(206) 314/6, B: SDE

Subject: IPAA weekly e-bulletin no 61
Date: Fri, 31 Aug 2001 08:52:16 +0200
From: masonj@unaids.org
To: FAX_000021639900_{Smali_Mohamed}@unaids.org,
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"Bernadette Mpekeyimana" <anss@cni.cbinf.com>, " Sophia Mukasa Monico" <tasodata@imul.com>,
"Shanta Lall Mulmi" <recphec@infoclub.com.np>, "James B. Musslewhite" <Jim@ucan-wa.org>,
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"Francina Nyirenda" <manaso@malawi.net>, " Bill O'Loughlin" <billol@magna.com.au>,
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"Ana Oliveira" <anao@gmhc.org>, FAX_00012022934167_{David_Oot}@unaids.org,
"Eugene Oscapella" <eoscapel@fox.nstn.ca>, FAX_00037125336312_{Gunars_Osis}@unaids.org,
"Yuri Osoianu" <falesti@mednet.md>, "Cheryl Overs" <hartpetz@hotmail.com>,
"Tarikul Islam Palash" <aid@bdonline.com>, "Carmen Murguia Pardo" <ics@terra.com.pe>,
"Warren Parker" <cadre@icon.co.za>, "Nick Partridge" <nick.partridge@tht.org.uk>,
"Rodrigo Pascal" <cornavih@interactiva.cl>, FAX_000632899556111_{_PATH}@unaids.org,
"Anthony Patten" <tbca@ksc.net.th>

61E~1.DOC	**Name:** 61E~1.DOC **Type:** Winword File (application/msword) **Encoding:** base64 **Description:** MS Word document

61E~1.DOC	**Name:** 61E~1.DOC **Type:** Winword File (application/msword) **Encoding:** base64 **Description:** MS Word document

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INTERNATIONAL PARTNERSHIP AGAINST AIDS IN AFRICA
Info e-mail weekly bulletin No 61, 31 August 2001

1. Addressing stigma in the Kenyan media
2. Launch of Congo-Oubagui-Chari river initiative
3. Toll-Free AIDS hotlines for South Africa and Nigeria
4. Awareness programme for UN staff in Uganda

TI-AK

(207) 3/9/01

1. Addressing stigma in the Kenyan media
Southern Africa AIDS Information Dissemination Service (SAfAIDS) hosted a workshop for Kenyan media practitioners between 3 - 5 August 2001 to explore the extent of stigma in HIV/AIDS media coverage and to examine the media's role in influencing/reducing HIV/AIDS-related stigma. Participants developed three recommendations as a way of reducing HIV/AIDS stigma in the media: training media practitioners, developing a resource base, and developing a media policy on HIV/AIDS. For more information contact Aurora Stally at aurora@safaids.org.zw

2. Launch of Congo-Oubagui-Chari river initiative
On 20 August, Dr Peter Piot, Executive Director of UNAIDS, launched an initiative for the four countries that the Congo, Cubabgui and Chari rivers flow through (Congo, Central African Republic, Democratic Republic of Congo and Chad), in the presence of the four countries' Ministers of Health and Transport . The purpose of the initiative is to contribute to a reduction of HIV/AIDS and STIs and reduce the socio-economic impact of the epidemic in the subregion, by promoting subregional collaboration and setting up interventions generating added value to countries efforts. For more information, please contact Damien Rwegera at rwegerad@aviso.ci

3. Toll-Free AIDS hotlines for South Africa and Nigeria
Two African countries have launched toll-free hotlines that provide callers with the latest and most accurate information on the HIV/AIDS epidemic. The Johns Hopkins University Center for Communication Programs (JHU/CCP) and USAID helped both nations to set up the services. A partnership was established with the Lagos State HIV/AIDS foundation and the local Youth Empowerment Foundation to establish Nigeria's hotline, while the South African government worked with the local NGO Lifeline to establish their new hotline. The phone number for the south African hotline is 27-11-0800-012-322. The Nigeria-based hotline can be reached at 234-01-772-2200 or 234-01-773-2201.

4. Awareness programme for UN staff in Uganda
Heads of UN agencies decided recently to hold an awareness programme on HIV/AIDS and to include antiretroviral drugs in the basic health insurance for staff on local service contracts. The awareness programme was conducted from 6-10 August, with facilitation of Milomay Centre, one of the health facilities participating in the UNAIDS Drug Access Initiative, and UNAIDS. The aim of the workshop was to promote awareness and understanding of issues around HIV/AIDS for staff working for UN organisations in Uganda. Concerning the provision of comprehensive HIV/AIDS care, a costing study on management of opportunistic infections has been undertaken and negotiations with the local health insurance company are close to finalization. The outcomes of this are available to interested business partners. For more information please contact Jantine Jacobi at jacobi@infocom.co.ug

The International Partnership against AIDS in Africa (IPAA) is a coalition of actors who have chosen to work together to achieve a shared vision - to significantly scale up efforts in Africa to curtail the spread of HIV, reduce its impact and halt the further reversal of human, social and economic development. The actors of the Partnership are: African governments; co-sponsors of UNAIDS; donors; the private sector including labour; and the community sector. (See www.unaids.org/africapartnership/whatis.html)

More information on the Partnership and related issues is available at www.unaids.org/africapartnership/html . Kindly forward this e-mail to any organizations or individuals who could be interested, or provide their name and both e-mail and physical addresses to: masonj@unaids.org

END

1. Lutte contre la stigmatisation dans les media kenyans
2. Lancement de l'initiative du fleuve Congo-Oubangui-Chari
3. Un numéro vert pour le SIDA en Afrique du Sud et au Nigeria
4. Un programme de sensibilisation pour le personnel des Nations Unies en Ouganda

1. Lutte contre la stigmatisation dans les media kenyans
Le Service de diffusion de l'information SIDA en Afrique australe (SAFAIDS) a accueilli du 3 au 5 aout 2001 un seminaire destiné aux professionnels des media au Kenya dans le but d'explorer le degré de stigmatisation dans la couverture du VIH/SIDA par les media et d'examiner leur rôle potentiel dans la réduction de cette attitude: formation des professionnels, élaboration d'une base de ressources et d'une politique des media en matière de VIH/SIDA. Pour de plus amples informations, contactez Aulora Stally à aulora@safaids.org.zw

2. Lancement de l'initiative du fleuve Congo-Oubangui-Chari
Le Directeur executif de l'ONUSIDA, le Dr Peter Piot, a lancé le 28 août 2001 à Brazzaville (Congo), l'Initiative des pays riverains des fleuves Congo-Oubangui et Chari en présence des ministres en charge de la santé et des transports des quatre pays de l'initiative (Congo, République centrafricaine, République démocratique du Congo et Tchad). Le but de l'initiative est de contribuer à la réduction des IST/VIH/SIDA et d'atténuer l'impact socio-économique de l'épidémie dans la sous-région par la promotion de la collaboration sous-régionale et la mise en application des interventions pouvant générer une valeur ajoutée aux efforts de chaque pays. Pour de plus amples informations, contactez Damien Rwegera à rwegerad@aviso.ci

3. Un numéro vert pour le SIDA en Afrique du Sud et au Nigeria
Deux pays africains ont mis en place des numéros verts qui offrent aux appelants les informations les plus récentes et les plus exactes sur l'épidémie de VIH/SIDA. Le centre des programmes de communication de l'université Johns Hopkins (JHU/CCP) et l'USAID ont aidé les deux pays à mettre en place ce service. Un partenariat a été établi avec la fondation publique VIH/SIDA de Lagos et la fondation locale de "Youth Empowerment" pour installer le numéro vert au Nigeria tandis que le gouvernement sud-africain a travaillé avec l'ONG locale Lifeline. Le numéro vert d'Afrique du Sud est le 27-11-0800-012-322. Celui du Nigeria est le 234-01-772-2200 ou le 234-01-772-2201.

4. Un programme de sensibilisation pour le personnel des Nations Unies en Ouganda
Les directeurs des agences des Nations Unies ont récemment décidé de mettre en œuvre un programme de sensibilisation au VIH/SIDA et d'inclure les antirétroviraux dans l'assurance maladie du personnel sous contrat local. Le programme de sensibilisation a été réalisé du 6 au 10 août, avec l'aide du Centre Mildmay, l'une des structures de santé participant à l'initiative ONUSIDA d'accès aux medicaments, et de l'ONUSIDA. Le but du séminaire était de sensibiliser le personnel des Nations Unies en Ouganda et d'améliorer sa compréhension des questions relatives au VIH/SIDA. En ce qui concerne la fourniture de soins d'ensemble pour le VIH/SIDA, une étude du coût de la prise en charge des infections opportunistes a été entreprise et les négociations avec la société d'assurance maladie locale sont près d'aboutir. Les résultats de celles-ci sont à la disposition des partenaires intéressés. Pour de plus amples informations, contactez Jantine Jacobi à jacobi@infocom.co.ug

Le Partenariat international contre le SIDA en Afrique est une coalition composée d'acteurs qui ont choisi de travailler ensemble dans une perspective commune – renforcer massivement les actions en Afrique pour ralentir la propagation du VIH, réduire son impact et interrompre tout nouveau renversement du développement humain, économique et social. Les acteurs de ce partenariat se composent des gouvernements africains, des organismes coparrainants de l'ONUSIDA, des donateurs, du secteur privé y compris les travailleurs et du secteur communautaire. www.unaids.org/africapartnership/ghana.html

Prière de faire suivre ce bulletin à tout organisme ou personne susceptible d'être intéressé(e), ou d'envoyer leur adresse e-mail à: masonj@unaids.org

FIN

LE PARTENARIAT INTERNATIONAL CONTRE LE SIDA EN AFRIQUE
Bulletin d'information e-mail hebdomadaire, 61, 31 août 2001

1. Lutte contre la stigmatisation dans les media kenyans

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sensibiliser le personnel des Nations Unies en Ouganda et d'améliorer sa compréhension des questions relatives au VIH/SIDA. En ce qui concerne la fourniture de soins d'ensemble pour le VIH/SIDA, une étude du coût de la prise en charge des infections opportunistes a été entreprise et les négociations avec la société d'assurance maladie locale sont près d'aboutir. Les résultats de celles-ci sont à la disposition des partenaires intéressés. *Pour de plus amples informations, contactez Janine Jacobi à jacobi@infocom.co.ug*

Le Partenariat international contre le SIDA en Afrique est une coalition composée d'acteurs qui ont choisi de travailler ensemble dans une perspective commune - renforcer massivement les actions en Afrique pour ralentir la propagation du VIH, réduire son impact et interrompre tout nouveau renversement du développement humain, économique et social. Les acteurs de ce partenariat se composent des gouvernements africains, des organismes coparrainants de l'ONUSIDA, des donateurs, du secteur privé y compris les travailleurs et du secteur communautaire. www.unaids.org/africapartnership/whatis.html

Prière de faire suivre ce bulletin à tout organisme ou personne susceptible d'être intéressé(e), ou d'envoyer leur adresse e-mail à: masoni@unaids.org

FIN

Subject: PHA-Exchange> Food for a sceptic's thought
Date: Sat, 1 Sep 2001 12:55:45 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.com>

AIMING AT THE TARGET: WHAT'S LEFT FOR THE DEVIL TO ADVOCATE?
Some thoughts on the setting of goals and targets in nutrition:Have they helped progress or not?

The big hype:
There is a big difference between the excitement and the expectations generated while preparing for a big international gathering to set or to monitor the status of time-bound, monitorable global goals and targets, and saying that the same will be or are being really useful. Keep in mind that setting these goals is the result of a process in which public admission of dissent is difficult. Therefore, countries pledge, but do not really embark and comply.

The real challenge, therefore, comes after the (usually expensive) international gathering. It comes during the process of preparing, finding the funding and executing down-to-earth action plans. Unfortunately, this process is rarely participatory. And for this process, the international conference, more often than not, is not too helpful, because the respective strategies to achieve the targets are left a bit in the air (or in the paper).

The outcome process riddle:
Getting to where we want to go requires not so much knowing and quantifying where we want to be at a given time, but more so the process(es) through which we are going to get there. Goals and targets address the former. Processes are left to the planners and implementers to decide/execute --often excluding community representation. But it is the process that carries in it the seed of sustainability. Unfortunately, as nutrition professionals, we fear prescribing processes (or denouncing processes we know do not work or are not working). We also have not spent the time to arrive at universally acceptable indicators that can measure sustainable progress in processes such as participation, mobilisation and empowerment. Instead, we have spend time and money choosing and monitoring outcome goals and targets that have unduly overmedicalised the nutrition problem. Think about it.

Being realistic:
With a pinch of self-criticism, some goals and targets set in the 90s called for a number of pretty unrealistic measures, unaffordable to most developing countries' state coffers. With low resources, one cannot but get low coverages --and this is by definition, not only ineffective, but also wasteful. The danger I see is that we may be doing it again for goals to 2015. At the moment, we have no assurances that the new set of goals will mobilise leaders, the media and members of civil society any more than before. Business as usual will not get us there for anaemia, stunting and underweight: at present rates, it will take us decades to halve the prevalence of child malnutrition.

Moreover, three serious concerns arise here.
One is on who the judges should be of what is realistic. Certainly not only us the technicians. And certainly, realism can no longer be based on global, across-the-board targets.
Another related concern is that being realistic also has to do with the quality of the data we use to monitor progress towards achieving the respective goals. If the latter is poor, the intrinsic value of the number reflecting how far one is from achieving the target can certainly be

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misleading. This comes out clearly in the responses we received to the questionnaire sent out to field workers which you can find in the next section.
The third concern is that I still find colleagues saying that this or that goal may be ambitious. I think the time has passed for 'maybe' positions. (I am reminded of a small poster hanging on the wall of my office which reads "I said maybe, and that's final!"). The facts are out. After democratic consultation, we are expected to endorse concrete advice on directions and finish lines.

On convergence:
An issue not often touched is the convergence of some of the goals and targets set in the 90s.
Even if they branch out to achieve different primary outcomes, actions to overcome more specific aspects of malnutrition can be additive.
For example, improvements in vitamin A status positively affect nutritional anaemia; improvements in iron status can positively affect the appetite of a child. Quite a few other examples can be found. Our actions to address micronutrient deficiencies and chronic malnutrition are thus complementary and impact on the overall well-being of individuals.
But these individuals live in imperfect societies that cause them to suffer from the different forms of malnutrition.
I guess what I want to highlight is the centrality of the individual with her/his multifaceted problems. With a goals and targets mindset, we tend to forget and depersonalise the individual, especially the fact the s/he lives in an adverse environment. Yes, we can get the retinol levels of a child up to normal, but the child goes on to die very anaemic from malaria. So, to what avail our efforts? We simply cannot afford to miss the big picture.

When it comes to processes, it behoves us to jointly embark on the processes needed to make change sustainable. The processes still in need of much more convergence are those related to tackling the underlying and basic causes of malnutrition. Much more needs to be done on this, perhaps starting with the demedicalisation of our goals, as well as with focusing more on these processes than mostly on outcomes. And this applies to all of us.

The Human Rights twist:
As members of institutions and/or as individuals, many of us are moving towards a change in the paradigm giving direction to our work. What we may not have thought enough about is that goals and targets --many of them intermediate in nature-- are, in a way, antithetical to the Human Rights paradigm. This, because it rests on the principle that we cannot rest until the rights of all are restored or instated, i.e. a target of 100% ...not ten years down the road, but the soonest possible. Consequently --and being realistic-- we should be talking of steps to be achieved in the process of fulfilling the Human Rights of all claim holders. In our case, the issue is nutrition rights and food as a right. And, for most of us, this is a whole new approach.

A complementary compromise position could be to start working on goals and targets in reverse. We could express targets as an expected decrease in the number of malnourished (or what it will still take to close the gap and uphold the right of 100% of them).

The equity factor:
Reaching targets (usually followed by a congratulatory stage) can be misleading. Applying all prescribed interventions primarily to the easier-to-reach near poor --say the second lowest income quintile-- can, eventually, get us to achieve national targets on schedule. I do not need to tell you what this means to equity. Here, I just want to bring to your attention what some are calling the distributional concerns of (sometimes short-cut) actions (imposed) to achieve goals.

On accusations of dependency and top-down implementation:

The achievement of micronutrient goals has created dependency. How? Not only are many iodine deficiency disorders (IDD) and vitamin A deficiency disorders (VADD) schemes top-down --with an element of dependency there-- but supplies and other resources are, more often than not, donor provided. In the long run, in terms of sustainability, what worries some of us is the 'ownership-donorship' interplay. At the end of the day, it is a zero sum game.

On this issue of top-down, I do disagree with what some colleagues imply when they tell us that solutions lie in a continuum from vertical micronutrient interventions to those addressing stunting and underweight so that the former call for vertical goals which need little action at community level and only the latter need active community involvement; I disagree with them when they say that it is only when goals need action at community level that actionable levels must be consulted with community representatives.
To me, the idea of 'some amount of community action' is non-sensical. Implying that for child chronic malnutrition most actions are to be devised and carried out by the community implies shifting the responsibility for having so many malnourished children among them to the community itself --so they better deal with it.

Donors (and we ourselves) touch some projects more than others. What are the reasons for a lack of commensurate donor support for iron deficiency anaemia (IDA) and for the reduction of child malnutrition? Does it have something to do with donor fatigue or with targets for these two having been set at unreasonable levels? (Remember that, justifiably or not, UNICEF dropped the monitoring of the underweight goal from its mid-decade review). Are we then in part responsible for having set ourselves up for failure? I tend to think that the response to the latter two questions is no. In the eyes of donors (.and many amongst us) IDA and chronic malnutrition are more messy to deal with than IDD and VADD. There is all this bottom-up, community action, poverty alleviation, equity and other such involved in them, as well as longer time horizons. Donors pay plenty of lip service to these more than, so far, embarking head-on on working on solutions for them. That is not fatigue; it is not a lack of will, it is a political choice. Internal and external resources allocated to IDA and under five malnutrition have thus remained a pittance, unmatched to the challenge. And there is nothing in sight that tells me that this is changing soon.

Again, it is in the process of selecting the strategies and the steps to progressively achieve them where donors and many amongst us have been and continue to be undemocratic and where we have failed those whose nutrition rights are being violated. As long as we consider the strategies needed to tackle the basic causes of malnutrition to be outside the realm of our professional scope of work, we should consider ourselves part of the problem and not the solution.

The poverty alleviation connection:
Will the new global shift of all donor agencies towards poverty alleviation strategies happen? and will it change what has been said above? The reduction of child malnutrition has now been selected as a key outcome indicator to measure progress in poverty alleviation. But, alas, this does not automatically translate into greater advocacy, more actions and more donor resources going for the prevention of malnutrition. Being an indicator does not translate into being the object of concerted new efforts and investments directed at halving malnutrition. We have a lot more to do here. Improved socio-economic status will improve nutrition, but we know that is only part of the story --although quite a big one.

To sum up, the take-home message perhaps is that there is probably no such thing as across-the-board realistic targets. At most, they can be proposed by us on some technical grounds. But consensus must be painstakingly built for them in many, many places with both bottom-up and top-down inputs. There

simply are no short-cuts. Goals or no goals, for people to gain control over the resources they need to overcome all aspects of malnutrition remains the key. Remember UNICEF's conceptual framework of the causes of malnutrition and the bottom-centred (top-down and bottom-up) AAA (assessment analysis and action) process.

Claudio Schuftan, Hanoi
avivahnetnam.vn

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To post, write to: PHA_Exchange@kabissa.org
Website: http://www.kabissa.org/mailman/listinfo/pha_exchange

Subject: PHA-Exchange> Bull of the WHO: Issue on Globalization
Date: Fri, 31 Aug 2001 23:09:38 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: "hlthpol" <hlth.policy@hn.vnn.vn>
CC: <pha-exchange@kabissa.com>

Moderator: Dear friends, when you post articles, please make sure you 'clean' them, that is cut out all lines that are superfluous (e.g. about font, routing of email, footnote with the server company or advertising, or even another email -especially if in another language...;. Just post the main text of what you want to forward and share, OK?
Claudio

This will interest you:
> *Bulletin of the World Health Organization*
> *Volume 79, Number 9, September 2001*
>
> *Special Theme - Globalization*
>
> *Available online at:*
> *http://www.who.int/bulletin/tableofcontents/2001/vol.79no.9.html*
> *<http://www.who.int/bulletin/tableofcontents/2001/vol.79no.9.html>*
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> *? Globalization: changing the public health landscape - Nick Drager & Robert*
> *Beaglehole*
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To post, write to: PHA-Exchange@kabissa.org
Website: http://www.kabissa.org/mailman/listinfo/pha-exchange

Subject: PHA-Exchange> Cigarette advertizing to youth
Date: Fri, 7 Sep 2001 23:49:37 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

> *CALL FOR INFORMATION*
> *From WHO:*
"Tobacco industries are marketing to youth in several ways,
> *with softer or stronger tactics depending on the legislation existing*
> *and implemented in the specific country. We are looking for examples*
> *of sports events, cultural happenings and sponsorships , distribution*
> *of free samples, brand stretching by Tobacco companies ...any direct*
> *or indirect marketing tactics by tobacco companies that you think are*
> *targeting children and young people. We are looking for examples have*
> *taken place in 2000/2001 or for events/campaigns that have been*
> *scheduled for the future. If you know of significant examples on the*
> *ability of Tobacco companies to advertise and market to children and*
> *youth, please send us a short description of the event/advert/product/*
promotion If you have images we would love to have them as well. We are collecting examples to build our advocacy campaign.
> *Contact: Tobacco Free Initiative <tfi@who.int>*

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Website: http://www.kabissa.org/mailman/listinfo/pha-exchange

RN

Subject: PHA-Exchange> Scientists plan to wipe out malaria with GM mosquitoes
Date: Tue, 4 Sep 2001 09:29:37 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.com>

> Scientists plan to wipe out malaria with GM mosquitoes
> ---
> James Meek, Science correspondent
> Monday September 3, 2001
> The Guardian
>
> Scientists fighting malaria are preparing the ground for one of the most audacious attempts ever to wipe out disease: genetically modifying an entire animal species in the wild.
>
> In laboratories around the world, there is increasing confidence that scientists will acquire the ability to spread a synthetic gene throughout the populations of dangerous mosquitoes, making it impossible for them to pass malaria on to humans.
>
> Until now, spreading genes throughout a species was something only evolution was capable of, over millions of years of natural selection. But scientists think it might be possible to transform the malaria-carrying mosquito into a subtly different species - still a bloodsucking nuisance, but no longer a killer - within two to 25 years of releasing the first GM insects.
>
> In a sign of how fast research is moving, specialists in the field are gathering in London next week for a conference to discuss the risks and benefits of releasing GM mosquitoes into the wild.
>
> "We're not talking about one to one replacement of lab mosquitoes for wild mosquitoes," said Tony James, of the University of California in Irvine, who is attending the conference at Imperial College. "There's no question of competition between transgenic and non-transgenic insects. What we're talking about is actually driving the gene through a population. It's an ambitious idea."
>
> In the lab, Dr James's team has already inserted a gene into mosquitoes which makes it impossible for the parasite that causes malaria to gain a foothold.
>
> Last year, a joint British German team, partly led by one of the organisers of next week's conference, Andrea Crisanti of Imperial College, created a transgenic mosquito - a GM mosquito whose offspring would also carry the inserted gene.
>
> "For the past decade, our efforts have been rather esoteric, trying to get to a certain stage. We are at that stage now," said Dr James. "We're able to put genes into animals in a stable way."
>
> But there are concerns. Luke Alphey, a specialist in the field at Oxford University, supports the release of GM insects into the wild to combat disease. But he is wary of the idea of genetically modifying an entire species. "I have a rather negative view of this strategy," he said. "One of my concerns is that once you've let such a thing go, you can never recall it."
>
> Supporters of the approach point out that it is not necessary to modify every single dangerous mosquito to stop the disease. But the nature of the technique is such that this could well be the end result.

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(239) 5/9/01 TO: NY-RN

> Normally, a new gene will spread to cover an entire species only if
> it gives animals who have it some survival or reproductive advantage
> over animals that do not. But scientists have found two ingenious
> ways to drive a non-advantageous gene through mosquito populations so
> that eventually all mosquitoes inherit it.
>
> One is to attach the gene to a bacterium called wolbachia, which can
> be made to infect mosquitoes, becoming effectively a part of the in-
> sect. When GM females mate with males, they produce GM offspring,
> whether the males are GM or not. But because of the peculiar proper-
> ties of wolbachia, non-GM females cannot have offspring with GM
> males. In other words, GM females will always have more children,
> eventually crowding out their non GM rivals completely.
>
> freakish
>
> The other method attaches the gene to a freakish chunk of DNA called
> a transposable element, which hops between chromosomes during repro-
> duction.
>
> Normally, mating between parents with different genes gives the off-
> spring a 50% chance of inheriting either gene. Because of the trans-
> posable elements moving around, however, the GM mosquito will always
> pass on the added gene to more than 50%of its offspring - again,
> eventually covering an entire species.
>
> Sixty of the 380 mosquito species can transmit malaria, although one,
> Anopheles gambiae, is responsible for a large part of the 2.7m deaths
> caused by the disease each year. In order to transform a single spe-
> cies, GM insects would have to be released in many locations to
> spread the gene through different populations of that species.
>
> Steven Sinkins, of the Liverpool School of Tropical Medicine, who has
> done extensive research into mosquitoes and wolbachia, said tests of
> a complete system were unlikely in the next two years, but progress
> had been rapid.
>
> "From the theoretical point of view, there's no reason why either ap-
> proach should not be successful," he said.
>
> Malaria is transmitted by female mosquitoes who harbour a parasite
> called plasmodium. The parasite infects humans from the insect's sa-
> liva when it drinks the person's blood. The World Health Organisation
> estimates that there are 500m cases of malaria each year, with plas-
> modium becoming resistant to drugs and mosquitoes becoming resistant
> to insecticides.
>
> Dr Sinkins argued against the idea that human intervention in a wild
> species on such a scale was unnatural or wrong. The species would
> live on: it would just be more human-friendly.
>
> "It doesn't have to be anything too unnatural," he said. "Within a
> mosquito population there will always be some with a natural inabil-
> ity to transmit the parasite. All you're doing is increasing the per-
> centage of individuals with those genes. They'll still be biting."
>
> Dr James said the genetic approach was no more unnatural than the
> massive, failing effort of drugs and insecticides.
>
> "The last thing anybody wants to be known for is irrevocably screwing
> up mankind or the environment. The whole idea is to figure out how
> one conducts experiments, what's going to be safe, and what's not.
>

> "The problem of infectious disease is going to be an eternal strug-
> gle. What we are looking for is the next wave of useful tools that's
> going to buy us time."
>
Courtesy of Dr Brian Razvakavambwa, MBChB, MPH
> World Health Organization (Geneva)

Subject: [PHA2001] BMJ article says globalisation is good for health
Date: Tue, 04 Sep 2001 23:10:11 +0100
From: pamzinkin <pamzinkin@gn.apc.org>
Reply-To: PHA2001@yahoogroups.com
To: PHA2001@yahoogroups.com, PHA-Europe@egroups.com

Dear Friends
Please try to look up this web site and Richard Feachem's article, David Legge and others replies. But we need replies from the South. This is really important.
?Ravi, Ekbal, Zafrullah...who can take this on?

http://www.bmj.com/cgi/content/full/323/7311/504

BMJ 2001;323:504-506 (1 September)
Pam

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RN

(246) P. ST. RN 5/9/01

Subject: [PHA2001] people against privatisation
Date: Sat, 08 Sep 2001 00:23:15 +0100
From: pamzinkin <pamzinkin@gn.apc.org>
Reply-To: PHA2001@yahoogroups.com
To: Andy Rutherford <arutherford@oneworldaction.org>, achakera@oneworldaction.org, chetley.a@healthlink.org.uk, vincent.r@healthlink.org.uk, drew.r@healthlink.org.uk, mikerowson@medact.org, PHA2001@yahoogroups.com, PHA-Europe@yahoogroups.com
CC: allyson.pollock@ucl.ac.uk, j.lancaster@ucl.ac.uk, ckchan@usm.my, sphdgl@pop.latrobe.edu.au, DeLogie@aol.com, marjan.stoffers@wemos.nl, 106313.301@compuserve.com, hanna.tapanainen@helsinki.fi, ilen.verheul@wemos.nl, nick.alex@virgin.net, chd@compass.com.ph, aquizhpe@yahoo.com, aprocsal@ejje.com, ikezumi@mtb.biglobe.ne.jp, ghada@upmrc.org, u.kmammash@unrwa.org, ellen.verheul@wemos.nl, barschimmer@hotmail.com, kasturi@mx2.vsnl.com, sen <ks231@hermes.cam.ac.uk, vukaenzele@hotmail.com, sunil.deepak@aifo.it, benos@med.auth.gr

This is a really important and useful article for all of us from Hixinio. Apologies if you have received it more than once success

Related Articles, Books

1: J Public Health Policy 2001;22(2):139-152

The people's campaign against health care counter-reforms in Spain.

Sanchez Bayle M., Beiras Cal H.

Hospital Nino Jesus, Madrid, Spain.

Since 1996, when the conservative Partido Popular was elected in Spain, it has attempted to weaken and dismantle the national health service. It has focused on three areas: privatization of health facilities and services, increasing patient copayments and decreasing publicly financed benefits, and increasing the role of private insurance in health coverage and care. A major role in this neoliberal strategy has been the creation in one of the regions of "Fundaciones," independent substitutes for NHS facilities and services, which are essentially copies of the "Trusts" developed by the Conservative government in the U.K. The paper describes the development of a broad people's movement which campaigned successfully to combat the "Fundaciones"; these were returned to the regional public sector, and the conservative government in Madrid announced they would abandon their previous principal policy of transforming public hospitals into "Fundaciones."

PMID: 11469148 [PubMed - indexed for MEDLINE]

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RN

D RN
10/09/01

Subject: PHA-Exchange> links
Date: Fri, 7 Sep 2001 12:29:46 +0300
From: "Alexis Benos" <benos@med.auth.gr>
To: <PHA-Exchange@kabissa.org>

Dear friends,

have a look to the International Association of Health Policy site
www.healthp.org
IAHP is an international association sharing the same ideas and goals with PHAmovement. The site use could help in information exchange, coordiantion and cooperation. Note the next Conference in Mallorca, Spain.
Alexis Benos,
member of PHA

Dr Alexis Benos
President of the International Association of Health Policy
Assistant Professor in Social Medicine
Medical Dept
Aristotle University
Thessaloniki 54006
Greece

RN

RN · RN 10/9/01

Subject: PHA-Exchange> Yes, it is easy to have simplistic views about Globalization...(2)
Date: Sun, 9 Sep 2001 19:28:28 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

(part 2)

The Equity/Equality approach:

Equal relations between unequals reinforces inequality! (3)

To illustrate this, think for a while that equity under Globalization is a bit like the fight of the Mongoose and the Snake:
Both are of about the same strength, but invariably the mongoose wins --it is more resourceful and it organizes its strategy better to strike. The First World is like the mongoose; the Third World is like the snake. The lesson of this fable is that an asymmetry in the use of market power aggravates inequality. The affluent always end up having more political clout (and more wealth). Therefore, promoting self-interest (the soul of the market) is simply not enough. We have to put some heart into it; add solidarity to self-interest. (14) [A modicum of anti-greed policing actions may help as well.].
To achieve greater equity, a set of "equity modifiers" have been proposed. These include: targeting interventions (geographically and/or to vulnerable groups or individuals), land reform, educational/water and sanitation/health/nutrition and family planning interventions, employment generation, grassroots participation in setting priorities, development of the non-farm rural economy, aid to rural women, and the levying of taxes on polluters and degraders. (2)

As pertains to gender, the latter has reached a unique status in the transnational liberal order. Gender equality is (finally) considered compatible with the basic tenets of the neo-liberal credo. But economic equality, not. (16)

Remedies proposed to specifically increase equity and access to basic services thus include financial and non-financial approaches. To recap and add, among the former are the targeting of subsidies (i.e. selective subsidies of goods and services disproportionately consumed by the poor), prepayment plans (e.g. community based health insurance), exemptions and the selective dropping of some fees (e.g. health and educational). Among the latter are a greater emphasis on decentralization, on the use of social marketing (*), on prevention and on improvements of the quality of care (in health), as well as on a fairer urban/rural distribution of resources.
[(*):Social marketing --one of the sweetheart companions of Globalization attempting to give it a human face-- focuses on high-powered "Madison Ave-type" messages and communication strategies that pursue behavior modification and not informed choices. It is quite obvious that we should rather be trying to better understand what motivates people to change and why, and then letting them decide by themselves what steps to take to get there].

Surprising as it may seem, the IMF thinks that more equity need not hamper growth, it could indeed reinforce it! (sic) They actually see a strong negative link between high unequal distribution of assets and subsequent rates of growth. They see equity only requiring 'equality of opportunities' , though, not necessarily 'equality of outcomes'. In that sense, they agree

10/7/01

poor need to increase their human capital. Equity, to them, is critical for the political viability of Globalization. (sic). Therefore, decentralization and changing the composition of public expenditure is for them a must. For instance, expenditures on health have to increase, they say, but to be equitable, they have to be concentrated on preventive activities in rural areas and should be targeted to the lower income quintile (*). (11)
[(*): Beware that valid arguments have been raised against 'targetry': Targeting misrepresents complex realities, involves big cost in monitoring, distorts policy and destroys political momentum for structural changes. (16) (17)]

Regardless of whether the IMF follows up with concrete actions on what they philosophize, we need not apologize to act with a more resolute equity bias beyond lip service since such a bias is an important corrective to the other more dominant inequitable value biases out there in the heartless market place. (One of them, for sure, is basing decisions on interventions on cost-benefit analyses only; cost-benefit analyses are understandable to economists and policy makers, but they are grounded in a different reality than most of us live in. Economists make decisions guided by what is ultimately measurable if convertible into monetary value only).

Is this more resolute equity bias a radical proposition? Yes. Is it necessary? Absolutely. Is it impossible? Possible. Is it likely? Not very likely based on my latest dispassionate reality check. But what, then, are the alternatives and could they do the job on time? (5)

The Human Rights approach:

A human rights framework is the emerging UN response to foster development in the new millennium.

Globalization may be inevitable, but what it looks like is not --there are forces that can shape it, and human rights must be one of those forces. (18)

As someone said, human rights can set limits to the sways of the market. (19)

To restate the dogma of Human Rights, they are indivisible; they do not apply some yes and some no, some today and some tomorrow, some to us and some to them, some to the rich and some to the poor, some to women and some to men. These obligations are universal for their implementation. We are therefore compelled to operationalize civil, political, economic, social and cultural rights in our daily work..

We have to be on the lookout, though. There is still much righteousness and hypocrisy in this field. One can easily lose faith in those who preach human rights and have little to offer.
Actually, with Globalization, "Might is Right" has come back with a vengeance. And in a defeatist stance, we have so far accepted this fact and have bowed to the forces we think we cannot effectively oppose. (20)

To make the human rights approach concrete and giving it substance is a political task. Their enforcement and holding governments accountable for their human rights record can only be achieved through political action. Soft approaches will not do. (21)

Steps in the right direction, at this time, will be the establishment of National Human Rights Committees and the setting of concrete examples of rights-based programming. But bolder steps will have to follow.

Furthermore, we have to fight the indifference of our youth to the present human rights situation. Our young and upcoming colleagues also remain largely indifferent to the overwhelming negative effects Globalization is having in the world. [It is during our youth --when we have faith in and fight for the ultimate answers-- that we have to interest the upcoming

always going to have to live with the big questions leaving the responses to undefined others]. We have thus to enroll the youth before they resign themselves to the fact that all they can do is pose the same unanswerable questions over and over again (even if in new ways), without sticking their own necks out to seek the right answers. (1)

Our youth seems more interested in the information superhighway. As if Marshall Mc Luhan's predictions were right, in terms of action orientation, the Internet has so far been more part of the problem than of the solution. There is a valid growing lament that wisdom, imagination and virtue are lost when messages double, information halves, knowledge quarters, and often deceiving noise without origin, quality and purpose is everywhere. We have to overcome this downward spiral by using the same medium to give more appropriate direction and guidance on options to counter Globalization and more aggressively foster human rights.

Our endeavors to achieve the latter two in the new millennium will only succeed if and when the youth becomes more central in the process of intellectual rejuvenation (a role they are now not taking up), and women (whose gender roles are being explicitly suppressed) also move more to center stage. (22)

In sum, an effective challenge against Globalization and its negative effects on human rights is possible, but demands the same kind of intellectual commitment and vigor that characterized anti-colonial or independence fights.

Questions of the relevance, accountability and utility of the social sciences in this process need to be explored. Are they confronting the real problems? Are the problems of Globalization and the violation of human rights being made focal points of the social sciences' analyses and actions? Western intellectuals have simply abandoned their commitment to challenge the exploitation and oppression of the poor as they continue being brought about by Globalization. Concerted campaigns and struggles against poverty, tyranny any exploitation will form the only sustainable basis of an intellectual renaissance of our youth and of ourselves.

Bolder steps are needed:

When we talk about Sustainable Development, we're talking about what we should try to become today and in the future and what that compels us to do now.

Taking a minimalist stand towards Globalization will do no harm, but neither will it do much good. Inertia in history (has) and will always work(ed) against the more visionary and radical changes deemed necessary when the same fall outside the ruling paradigm. (1)

Development cooperation must thus become more political, because only structural reforms will deliver sustainable development.
In many an aid recipient country, conventional politics simply is increasingly losing its primacy over commerce and industry. (All too frequently we see the failure of elections as an instrument of political

renewal. As somebody said, the problem with political jokes is they get elected). Therefore, new, bolder approaches are needed. Solutions must be geared to control that which fuels the problem at its roots.

The solutions to the consequences of Globalization on the health and nutrition sector, for example, cannot be medicalized any longer. Technical assistance focused on health/nutrition matters only is not enough to uproot the structural inequities underlying pervasive and unrelenting ill-health and malnutrition in the world.

But the inertia is so great and our collective virtual view of reality so distorted and entrenched, in part due to Globalization, that the likelihood of us changing that reality remains dim. Neither greater individual responsibility nor containment strategies will do. A solution will somehow have to be imposed on us by some powerful or strategic force, either by fate or by design and it better be soon.

In short, we need to give a larger intellectual and political scope to our discussions on Globalization. In doing so, we have to manage to develop a political program of more universal appeal. We need to set up the framework that will connect all the different social actors to come up with a focused common agenda.

More than ever before, we need an overt political intervention, simply because economic violence is best counteracted by political antibodies, and what the people's movements around the world want is simply "More", from life, from history and from us.

When economics has ceased to strengthen social bonds and its prescriptions are actually further pauperizing millions, it is time to start thinking in political terms again. This is one of my cherished iron laws.

Three caveats:

1) As hinted above, intellectual and cultural imperialism now penetrates our minds by remote control via satellite links and the information superhighway and poses great danger to the production and development of local knowledge. But this is not a fatalistic statement. While not denying that the giant tentacles of Globalization reach into every corner of the world, this should not be equated with omnipotence.

2) Stereotyping the object of criticism (Globalization) risks to emotionalize the issue rather than objectively analyzing and diagnosing it. We have to give up our quick prescriptive impulses (saying what should have been done) and become more empirico-analytical (describing and dialectically interpreting what is actually happening). (22)

3) One can set morally desirable goals so high or set goals without following them with sincere, workable policies that they remain out of all realistic reach and lose all power to determine the direction of action. Even rules can be set or imposed more as a source of comfort than of good choice. (23)

In closing:

As you finish reading this, make no mistake, these seemingly abstract issues about which we write papers are matters determining the lives of millions of people. We all know that, as Benjamin's law says, when all is said and done, a lot more is said than done. It is therefore not enough to bring these issues under the spotlight; as someone else said, we need to make more

The facts discussed here are more than enough to allow us to go negotiate (or struggle) for new more radical equitable/pro-poor/pro-women/human rights based strategies on the highest of moral grounds. (3)

We need to awaken the 'investigative reporter' in us to constantly go after the human story behind the statistic. After all, journalism is the rough draft of history --and we want to be counted in shaping it. Those whose interests we claim to serve also expect it from us.

Claudio Schuftan, Hanoi
aviva@netnam.vn

References available upon request

RN

Subject: PHA-Exchange> Fwd: NUTRITION EDUCATION AND INTERVENTION MATERIALS
Date: Fri, 14 Sep 2001 21:52:31 +0600
From: gksaver <gksavar@citechco.net>
To: "pha-exchange@kabissa.org"@mail.citechco.net

>
>
>NUTRITION EDUCATION AND INTERVENTION MATERIALS
>
>Healthwise (Nigeria) is a non-governmental organization, which is working
>in a local suburban area of Lagos. We are engaged in advocacy, counseling
>and primary healthcare intervention services amongst the immediate
>populace. Breastfeeding, Childhood Immunization, Domestic Food Security,
>Healthy living attitudes, School Health Services, and Nutrition guidance,
>Poverty Alleviation and Disease Control including HIV/AIDS education are
>all aspects of our initiatives. The rationale is to affect the people's
>lives holistically using nutrition IEC approach as entry point. There is a
>special emphasis on infant, pre-school and adolescent child nutrition.
>
>We publish the Humanity Health Digest Magazine and are now focusing on
>building capacity on nutrition education and primary intervention within
>the local community.
>
>Sir, this is to respectfully request for resource materials on nutrition
>IEC that will facilitate or goals.
>
>Thank you for helping our cause.
>
>Yours faithfully,
>Dr. E.I.B. Okechukwu
>Project Advisor
>Healthwise (Nigeria)
>43 Adediran Ajao Crescent
>(By Apostolic Faith)
>Anthony Village
>P. O. Box 72221, Victoria Island
>Lagos.
>email: "Emmanuel I.B. Okechukwu" <healthwise.ng@lycos.com>
>
>Get 250 color business cards for FREE!
>http://businesscards.lycos.com/vp/fastpath/

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RN

RN
AA
18/09

Subject: PHA-Exchange> World Trade Center
Date: Fri, 14 Sep 2001 13:35:50 -0400
From: Steve Minkin <smink@sover.net>
To: pha-exchange@kabissa.org

The World Trade Center Tragedy: Real People, Not Symbols

by Stephen F. Minkin and Debra Blake

In thinking about the World Trade Center, and in thinking about New York, we are struck by one obvious thought: that the building, like the city itself, was filled with people from all over the world. Some were citizens, some were on their way to becoming citizens; others had come to visit this most cosmopolitan of cities. The World Trade Center not only represented diversity, but in fact housed diversity's daily face.

It is this diversity of the people in New York that fills us with wonder: its diversity of appearances and gestures, of clothing, skin tones, languages, and even the most obvious badges of religious affiliation, its churches, synagogues, mosques, Hindu and Buddhist temples.

In the aftermath of the tragedy, we have received too many e-mails or read about too many attacks on Muslims throughout the country. But could any of those who now attack have visited New York? For if they had, and if they had walked through the World Trade Center -- or almost any other building in the city -- they would know without question that there must be many innocent Muslims lying now, shoulder by shoulder, with the Jewish, Christian, Buddhist and Hindu dead. What an insult to the grieving families of all the victims.

Americans need to learn more about the world and in doing so learn more about this country. And vice-versa: Americans need to learn more about their own country and in so doing learn more about the world.

The sight of the airplanes hitting the building, of terrified people jumping to their deaths, and of the buildings later collapsing was overwhelming. But what we haven't seen is even worse to imagine, because those images will now never come to light: the intertwined stories of all those people crushed and buried in the rubble; their family tales, their past struggles and triumphs, their personal histories that brought them, in the first place, to those buildings on that fateful day.

It was, in a very real way, beyond the fear and terror and sadness that their final images evoke in all of us, a day in which a great diversity of people came together. They had worked together that day, traded goods, shared food. In the end, regardless of what they cried out in their final moment -- God, or Allah, or Jesus, or any other name of divine recognition, or if they said nothing -- they spoke the truth of who we are as a country for we are diverse and they were us. Those who died were, by unlucky chance, people caught in a profound tragedy and so are we. Not symbolically, but actually.

RN

The lesson in this heart-wrenching tragedy is that people matter more than symbols. The tragedy, however, is that the devastation occurred because symbols mattered more than people. The terrorists attacked what they saw as a mighty symbol of America, but in the end they killed people. Nothing more and nothing less.

Stephen F. Minkin and Debra Blake

→ RN

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Subject: PHA-Exchange> Yes, it is easy to have simplistic views about Globalization...(1)
Date: Sun, 9 Sep 2001 19:25:23 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

GLOBALIZATION, OR THE FABLE OF THE MONGOOSE AND THE SNAKE:

What is history, but a fable agreed upon?
Peter Hoeg (1)

Globalization and its negative consequences:

The peculiar current form of Capitalism rechristened as 'free market economics' rules in the vast majority of countries as our century draws to a close. This paradigm --at the core of the transnational liberal order-- has become the current hegemonic development philosophy as well. It goes by the motto of "trade, not aid", no matter how uneven the former may be.

Globalization --the new Capitalism's flagship-- denotes the ability of international capital and transnational corporations to switch investments across the globe. In doing so, Globalization creates wealth for the few and depresses local wages and conditions of employment for the many.

Globalization has brought about a shift in power: the nation state has weakened and there is a reduction in social accountability. This makes sovereign states row rather than steer in the process of development, i.e. if countries do not intensely participate in this paradigm set by the North, they are "out". As a consequence, the poor countries' very right to development is threatened by this unrelenting liberalization/ globalization process. (2) (3)

Globalization has put the fate of those many in the hands of large corporations. Although the 'corporocracy' (or 'corporarchy' of Robin Sharp) very well knows the negative effects of Globalization, few of them are committed to change. They tend to ignore the root causes of the social problems they see as patently as everyone else, but seldom address the negative social impacts of their activities. Since they lack the openness and transparency required, they pay only lip service to change and seldom change their practices (or change them in very marginal ways). (4)

Moreover --in the dealings of Globalization-its intricate connections are so patently disguised as to become almost invisible. Or worse, the deceptions are so brilliantly woven into its processes that falling for those deceptions is deemed as both fashionable and progressive. (5) (6)

In the Globalization context, the privatization called for often ends up meaning denationalization with Globalization further pursuing a removal of trade barriers, (often dependence creating) technology change, and a rise in consumerism. This, on top of being rightly singled out as additionally creating and accelerating poverty, disparities, exclusion, unemployment, alienation, environmental degradation, exploitation, corruption, violence and conflict. (7) (8)

Not by accident then, has Globalization been called "the imperialism of the 1990's". (What is different between imperialism and globalization is just the latter's speed of expansion).

RN

PHA-Exchange> Yes, it is easy to have simplistic views about Globalization...(1)

10/9/01

Because the Globalization of the economy brings about marginalization on a massive scale and economic and political domination of a magnitude not seen since the days of colonialism, it is turning in to a process of Globalization of poverty and of an intensification of the plunder of the neo-colonies. The effects of Globalization are thus terribly uneven and produce big winners and losers. (9) (6) (2)

Due to these negative consequences of Globalization, communities in many Third World countries are no longer able to cope --their previously successful coping strategies diminishing daily. The immediate challenge is to bolster the same communities' coping strategies so they can continue to help themselves under the new set of rapidly changing circumstances. (10)

Even business executives espousing Globalization are aware of its negative effects. An Asian executives poll carried out by the Far Eastern Economic Review in November of 1997 (p.38) showed 71% of the business leaders polled across the region agreeing that the benefits of Globalization had not been equitably distributed in their respective countries. 46% were of the opinion that Globalization had widened income disparities in their countries. 50% said that it was contributing to social tensions and 60% said their respective governments were not doing enough to help those hurt by Globalization.

More surprising yet is the IMF's very own overall view on Globalization. For them, the latter links labor, production and capital markets of economies around the world. They do accept that it leads to sharp 'short-run' changes in the distribution of income. They further accept that Globalization is to blame for growing inequalities in developed countries as well. For example, to them, Globalization limits the ability of union workers to bargain, as well as making it more difficult for governments to implement equitable policies. (11)

Because they are unable to do the latter, governments in the Third World are simply assumed to be incapable of assuming a minimum level of welfare for their citizen. Fitting the ideology, it is then implied that it is necessary to look for alternatives in the private sector or to directly privatize services (and NGOs are occasionally a convenient form of privatization). Only that, often, such privatization strategies lower the quality of services for the poor and end up widening the gap between the rich and poor. The alternative that is being written off a-priori is the need to improve the state's credibility, accountability and responsiveness to welfare matters.(*)
[(*): After all, the extraordinary and more equitable growth of Vietnam and China contradicts the view that a state control of the economy and the market is inimical to growth].
One has to acknowledge that most governments have not adopted the right strategies. But let us not develop yet new ones; let us make governments adopt and adapt the right and proven pro-poor strategies providing them with a set of options, and not a single pathway. Sustainable solutions proposed need to be sound and appropriate both in the way things will be done as much as in what to be done. (8)

At this point, we hardly need to be reminded of the hard facts documenting the negative effects of Globalization. Tid bits of the evidence should suffice to close this quick, maybe caricaturized, review of its negative consequences:
-Under Globalization, the annual losses to developing countries run at an estimated $500 billion --an amount much higher than what they receive in foreign aid.

-As a consequence, developing countries have had a series of years of consecutive negative financial flows; this is equivalent to at least seven years of an economic hemorrhage.
-From 1960-99, there has been a 60% fall in the prices of commodities other than oil! This has resulted in a reduction of two thirds in the buying power of developing countries. (12)
-As a result, the number of hungry people around the world keeps rising every year and poverty is becoming increasingly feminized (70% of all the poor are women). Free trade has been free for business and industry, but not for women and the poor. New technologies have not shown to have intrinsic pro-poor or pro-women positive effects either, although they have such a potential (which unless we help steer in that direction will invariably continue favoring the already wealthy and male). Therefore, any genuinely poverty-redressing policy is bound to be a gender-oriented policy.

A dearth of workable solutions?

There is no single universal solution in sight that will promote just the benefits of Globalization to all people: giving the same advice to everyone simply has not and will not work; this is what has been called "the fallacy of composition".

A balanced and realistic value-free response to Globalization is difficult, especially if one considers the current reality of a unipolar world with a North-centered and North/transnationals-dominated economic order. (13)

On the one hand, the transnational corporations cannot be allowed to continue to duck and dive, invest in smoke screens, espouse gradualist solutions and attempt to derive maximum publicity from piecemeal changes. They must be persuaded, cajoled or even forced to change..
On the other hand , new insights are emerging as to the appropriate mix of market and government activities needed to complement each other. (4)

Whatever the response, promoting the economic benefits of Globalization requires mechanisms to prevent its excesses, because there is a clear trade-off between market efficiency and the social welfare of workers and peasants.

Turning again to the IMF, they see the policy responses to counter Globalization to include a mix of two elements:
a) 'safety net interventions' such as targeted subsidies, cash compensations, severance payments to and retraining of sacked employees, wage subsidies, and public works programs, and
b) 'fiscal policies' (the most direct tool of redistribution) such as levying highly progressive taxes, distribution of shares in privatized enterprises, and increased government spending in health and education (i.e. reallocation of spending to the social sector), as well as higher minimum wages, good unemployment benefits, job protection, keeping inflation low, subsidizing lower quality commodities, and giving better access to credit, justice and public services. (11)
How this is to be achieved, and whether the IMF plans to go for broke for these changes remains unsaid in the source here cited.

The truth is that, in the real world, the more radical visions or sustainable solutions calling for deeper social and environmental change

been diluted or silenced further with the onslaught of Globalization. In a mix of insensibility and unresponsive, the prevalent attitude has been to selectively reject (depending on the bias) the main features of any criticism and to keep important issues from surfacing to critical consciousness. This is what has been called "the exclusion fallacy" (".if we have not considered it, it is not important.").

In the international scene of (mercenary) technical development assistance, for example, issues of substance are turned into technical matters by paid consultants while underlying more structural issues get obfuscated. Or, what amounts to the same, aid agencies too often remain unwilling to respond politically to political situations. (3)

(contd next email)

Claudio
aviva@netnam.vn

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PHA Conference) File

Subject: Message from Mira Shiva
Date: Thu, 20 Sep 2001 01:30:23 -0700 (PDT)
From: Mira Shiva <mirashiva@yahoo.com>
To: sochara@vsnl.com
CC: cerd@satyam.net.in, kb@eth.net, sundar@indonet.com

20 Sep 01

Dear Ravi,

You must have received Alok's email. I am glad it is being reconsidered.

When you come can you please bring the overheads you had prepared for PHA. If you have the video film, could I please have a copy? The bill for the posters and the flip chart will be sent to you by post by the distribution division. I was categorically told before I left for the NWG meeting that VHAI's involvement in the NWH/PHA was only upto Dhaka and hence my email. I paid my fare for the NWG meeting.

Are you coming for the National Health Policy meeting?

It may be better that we withhold the communication to VHAI till its role is decided. We can reconsider continuing communication after the decision is taken. Please communicate to me at my email address mirashiva@yahoo.com. I am contacting JWT about their continuing in the NWG. I will get back after I speak to them.

Needless to say that you will be sensitive and wise about your discussions here in Delhi.

Sundar,

I am sending you the Bill for "Where Women have no Doctor". Please give the address so that it could sent to that address.

With regards,

Mira Shiva

2/9

Dear Mira,

Thanks for your message of 20th. I have written to Alok that I shall not be able to attend the NHP meeting due to other constraints. I agree to your position about VHAI. Shall send you the videos and OHPs separately.

Best wishes
Ravi

cc. Amulya Sengupta

RN 2/9/01

To reply.

RN 21/9

4.3

Subject: PHA-Exchange> UPDATE - GLOBAL PETITION ON ACCESS TO MEDICINES & TRADE
Date: Tue, 18 Sep 2001 14:34:19 +0100
From: amitchell@Oxfam.org.uk
To: amitchell@Oxfam.org.uk

Health Before Wealth - Demand the World Trade Organisation Changes its Patent Rules

The Oxfam - Third World Network - Health Gap Coalition global petition on world trade rules and access to medicines was temporarily suspended last week due to concerns that it may have been viewed as insensitive following the September 11th terrorist attacks in the US.

The petition has now been re-focused to take these sensitivities into account while continuing to focus on the same goal - demonstrating the strength of global public concern about World Trade Organisation (WTO) patent rules that put the profits of powerful drug companies before public health in poor countries.

The revised petition is live on the internet NOW at http://www.oxfam.org.uk/health and will run through till November when it will be presented to the WTO at its meeting in Qatar. The petition calls on WTO members, in particular the United States, to demonstrate their commitment to put health before wealth by changing and clarifying global patent rules at the forthcoming WTO summit conference.

To achieve mass support for the revised petition we rely on the support of individuals and organisations across the world.

As an individual you can support the campaign by signing the petition online now at http://www.oxfam.org.uk/health and by telling all your friends and colleagues to do the same!

Your organisation can also support the global petition in one or more of the following ways:

1. Advertise and put a link to the petition on your website - the petition page is at http://www.oxfam.org.uk/health

2. Circulate details of the petition to member organisations, alliances and networks

3. Encourage supporters to sign the petition and encourage member organisations and alliances to promote the petition to their supporters or partners

4. Endorse the petition by sending your organisations name and contact details to amitchell@oxfam.org.uk. We will display the names of all organisations that endorse the petition on the petition site.

A variety of resources have been produced to help promote the petition

RN
19/9

including campaign banner adverts or logo's are available if you want make your website link more visual. The adverts can be downloaded from the petition site. To access the banner advert and for further information on how to download it onto your own website go to http://www.oxfam.org.uk/health and click on 'download'. A4 petition sheets for use 'offline' can also be downloaded from the petition website.

I hope you and your organisation will be able to support the petition. If you have any queries please contact Anna Mitchell at Oxfam GB on +44 1865 313198 or at amitchell@oxfam.org.uk

Anna Mitchell, Oxfam gb

Subject: PHA Exchange> A poem for these days of turmoil...
Date: Tue, 18 Sep 2001 20:59:59 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

ROSALIA

Orlando Leon (1970s Venezuelan young poet) (*)

Rosalia Sanchez has seven children,
twelve diseases, three abortions,
and a shanty and garbage for a sociologist's fruition.
Rosalia is twenty seven years, one hundred years, five thousand years old.
For fifty years, one hundred years, five hundred years,
Rosalia has needed to eat.
Who wants to buy the eating machine of Rosalia?
Who wants to buy five hundred years, five hundred Rosalias?
... not making a technical point about the quinquenia?
Rosalia is a maid who once had a policeman, who once had a share cropper,
who once had a child, ... seven times a child.
Rosalia is made of bones, is made of flesh; the same as a cow, the same as a hen,
but without a pasture, without a coup.
Hay for Rosalia! Maize for Rosalia! Rice for Rosalia!
For five hundred, one thousand, twelve thousand years, since the times of Ur and Uruk,
Rosalia has wanted a staple food to eat.
When they were painting in the caves of Altamira,
Rosalia was twenty years old, had three children, and the moon was shining...
Rosalia has always had three children,
twenty years of age, one abortion, and the moon was shining...
Pregnant, Rosalia lives under a bridge.
I can see Rosalia. Rosalia is lucky to live in an organized world!...
Rosalia fills forms to ask for a little house.
Rosalia stands in line in the Ministry of Public Health, lines lasting five hours,
with a pissed child in her arms.
-The President says: "No citizen will... , etc."
Rosalia indeed lives in an organized world...
There is a Constitution, Human Rights, Prostitution, the Church.
But, if Rosalia doesn't have enough to eat a biscuit,
how can she understand the palpitations of a refrigerator,
or to soak in milk an automobile,
or lying on a sofa switch-on a record player?
And this is Civilization, now that Rosalia cannot squeeze,
at five o'clock, a jazz in tea?
Rosalia has to live in an organized world!
We have already gone to the moon:
"I'll drop you a line from the moon, love!"
Potatoes in photosynthesis, carnations in photosynthesis, roses in photosynthesis.
Through a chemical orchard the insects will fly.
But Rosalia has seven children,
in midst of Civilization,
a metaphysical Civilization that cannot solve the problems of Rosalia...
How many years is it that Rosalia has been going with her children from dung to dung,
from Constitution to Constitution, from God to God!?
Rosalia is twenty seven years old, one hundred years old, five thousand years old.

RN 19/9

[illegible] has dung in her dreams,
Rosalia dreams about dung,
But dung is not herself.

(*): Translated from the Spanish by C. Schuftan

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Subject: PHA-Exchange> DGH Job Opening: Development Coordinator
Date: Wed, 19 Sep 2001 21:23:21 -0400
From: DGH Info <dghinfo@dghonline.org>
To: <pha-exchange@kabissa.org>

Doctors for Global Health
Job Opening: Development Coordinator

Doctors for Global Health was founded in 1995 as a private, non-profit organization promoting health and human rights through education, art, activism and direct service. We have more than 500 active supporters and volunteers including health care workers, educators, attorneys, engineers, students and others. Volunteers work in their own communities or in one of our supported projects in El Salvador, Mexico, Nicaragua, Uganda and other countries. Our mission guides us to work in partnership with communities around the world on projects that emphasize Community Oriented Primary Care, Liberation Medicine (promoting human rights through health care), volunteerism, and a democratic approach to administration (for more information about DGH, see http://www.dghonline.org).

The Development Coordinator will work in concert with a very active Board of Directors to improve our effectiveness and expand the organization. Tasks will include (but are not limited to):

Fundraising (approximately 70% of time):

* Spearhead grant writing/fundraising initiatives (especially non-governmental sources).
* Develop sustainable base of individual donors.
* Maintain donor database.
* Correspond with donors.
* Produce reports on fundraising initiatives.

Administration and Project Support (approximately 30% of time):

* Facilitate communication with the Board about new project proposals.
* Potentially travel internationally to project sites for in-country project review for up to 4 weeks out of the year.
* Aid in coordinating and developing the DGH international and national volunteer programs.
* Assist the Board in organizing biannual board meetings and the annual General Assembly meeting.
* Respond to messages sent to the DGH email address.
* Update mailing list.
* Perform general secretarial tasks as needed.
* Act as liaison to the Board.
* Coordinate national volunteers to aid in these administrative tasks.
* Potentially supervise student intern.

Qualifications:

* Highly motivated, positive work ethic, self-directed, flexible, responsible, detail oriented, and has the ability to meet deadlines.
* Experience working in fundraising or development.
* Experience working or volunteering with health or human rights non-profit organizations.
* College degree.
* Excellent written and spoken English skills required, preference for candidates with Spanish fluency, additional languages a plus.
* Must be comfortable working in consensus-style with a diverse group of very committed Board members.
* Commitment to social justice.

awareness of current events related to human rights around the world preferred.
* Willing to work out of her or his home. DGH will provide office supplies, fax machine, phone line, and copy machine.

Full time position. Salary commensurate with qualifications, plus medical benefits, paid vacation, and sick days. DGH is an equal opportunity employer, women and people of color encouraged to apply.

To apply, please e-mail your resume, salary history and references to dghinfo@dghonline.org. Position will be open until filled, first applications to be reviewed mid-October.

Subject: PHA-Exchange> articles on the PHA in J. of Epidemiology
Date: Fri, 21 Sep 2001 12:27:41 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

> Debate: Health, equity, justice and globalisation
> <http://www.jech.com/content/vol55/issue9/index.shtml#DEBATE>
>
> This debate, in the September 2001 issue of the Journal of Epidemiology and
> Community Health, can be accessed for free. It includes articles on the
> People's Health Assembly, the WTO and the health impacts of globalisation.
>

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

24/9

Subject: PHA Exchange> Aftermath of 11 September
Date: Thu, 20 Sep 2001 12:16:08 +0100
From: Andrew Chetley <chetley.a@healthlink.org.uk>
To: "'PHA-Exchange@kabissa.org'" <PHA-Exchange@kabissa.org>

Sir John Sulston, the eminent scientist who led the team mapping the Human Genome and who fought to ensure that there would be free access to the genetic map, shared some of his feelings and thoughts about the World Trade Center atrocity in London's Evening Standard newspaper on 19 September 2001. I think they have relevance for all of us who are struggling with how we can keep attention focused on the underlying causes of global terror, and to encourage solutions that support people.

'My daughter lives in New York on the Upper West Side and my grandson, my relatively new-born grandson, is in day care eight blocks from the World Trade Center. They are fine, absolutely fine, but you can imagine it was a pretty dramatic day trying to get through on blocked phone lines. I say all that because I am absolutely at one with them. My daughter is an American citizen, a dual citizen, lives there with her American husband. So all of that is clear.

' On the other hand, I cannot help, in my heart of hearts, relating this to the way both the American and the European military industrial complexes are treating the rest of the world. Although you cannot say if we are all liberal and kind there will not be any nasty Afghan terrorists around, on the other hand, it is very clear to me that Western policies are driving the world further and further apart in terms of rich and poor, and causing large groups of people in the world to have justifiable resentments. These are the people who feed the terrorists. The terrorists themselves are beyond the law. They are going to try and do nasty things anyway; there are bunches of people who genuinely do go morally wrong. I do not in any way condone flying planes into the World Trade Center; but what I do say is, in Bush's words, these people would have nowhere to hide if we tried to make the world a fairer place.'

Andrew Chetley
Programme Director, Exchange
A networking and learning programme on health communication for development

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Subject: PHA-Exchange> Can Research Fill the Equity Gap?
Date: Mon, 24 Sep 2001 13:00:10 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

The following has been extracted from EQUINET Policy Series no 1
Co-published by EQUINET (www.equinet.org.zw) and Training and Research Support Centre, Harare (www.tarsc.org). The full document can be downloaded from http://www.equinet.org.zw/policy.html

Can Research Fill the Equity Gap?

Weak delivery on equity implies that it needs to be given greater profile as a health priority and more sustainable ways found of delivering on it. Research can build constituencies that pressure for equity in health.

Disparities in access to health inputs and healthcare have widened between population groups everywhere. Inequalities exist in relation to health inputs, such as literacy, educational status - particularly in women -income, household savings and assets, housing tenure and standards, access to safe water, sanitation and reliable energy supplies. They also are striking with regard to health status and health care. In both cases, low income, rural communities have been shown to be comparatively disadvantaged.

The burden of disease of the poor with its impact on mortality weighs public and household budgets, increasing chronic and potentially intergenerational poverty.

What drives inequity?
Why have these problems of health inequity persisted despite aspirations to the contrary?

It would appear that our economies continue to have weak mechanisms for distributing health and other resources towards those who have greater need, least power and least access. Macro-economic and health reforms have enabled more powerful medical and middle class interest groups to exact concessions at the cost of the poorer, less organised rural and urban poor.

This situation has been encouraged by a number of policy developments, including:

- Globalisation and related market-led policies, which have increased the concentration of wealth in fewer hands and chronic poverty in the south. Poor communities have suffered heavily in globalisation's drive towards satisfying the profit motives of the biggest players in the market.
- Structural adjustment reforms which condone declines in public spending on health and education.
- In the area of health policy, with an over-optimistic preoccupation with technical management tools, at the expense of the real equity issues.

Challenging Inequity
Within health, we need to ensure that those with the greatest health needs obtain and access greater public inputs for improved health.
This implies that it is not only how much governments spend on health, but also how they spend and who they target with resources, that determines the health status of their populations.
It is precisely when resources are scarce that even greater importance should be given to ensuring that health care resources are allocated progressively, and reach those who most need them.

Public health and health services, cannot be an area of activity that is provided through the market.

We need
& to egotiate changes in global institutions, policies, rules and standards that subordinate human development to profit, or that unfairly

RN 27/9

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25/9/01

distribute the returns from markets.
§ to giv higher profile and attention to national policies that more effectively allocate public resources towards those with greatest health needs. Equity should become one of the most important targets of practical attention in resource allocation systems.
§ to involve population groups more actively in defining, shaping and implementing health policies. The amount of resources that people get depends on the extent to which they are able to make and articulate their choices.

Researchers need to focus more on health equity issues; expose the differences in health status that are unnecessary, avoidable and unfair; propose ways of more effectively addressing differences in need; assess the extent to which different groups in society have the power and means to make choices over health issues; monitor health equity levels, the impact of globalisation and macro-economic policies on health; enable participation by beneficiaries in their research by using participatory research methods that involve the affected groups more directly; and more direct link research and action on problems in te affected communities.

Research can give direction to the changes being called for by communities by empowering people for effective participation in all economic and social processes that affect them.

Adapted from
Dr Renee Loewenson

25/9/01

Subject: PHA-Exchange> Study urges overhaul of U.N., IMF, World Bank
Date: Wed, 26 Sep 2001 10:54:14 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

- The U.N., World Bank and IMF today operate on badly outdated political and economic foundations and need to be overhauled before a crisis induced by globalization forces the changes required.

Prepared by the World Institute for Development Economics Research of U.N. University, with support from the U.N. and the gov. of Finland, the study calls for a repeal of the Security Council veto accorded the five major post-war powers and the addition of other countries as permanent members of that body.

The U.N. suffers from a "democratic deficit" that was "an integral part of the original design" but needs to be remedied now. The U.N.'s moral authority is "seriously undermined because its laws or principles are enforced selectively when it suits the interests of the rich and the powerful."
Circumventing the veto granted to the five permanent Security Council members and enlarging the membership of that body are "imperative" for the U.N.'s continued credibility.

"The responsiveness of the United Nations to the globalization issues of our times has been limited to global meets such as the Earth Summit or the Social Summit," useful fora for public concern, but insufficient as solutions to the problems at stake.

The U.N. needs to become more representative, fostering the participation of global civil society to a greater degree, and more democratic in its decision-making, involving greater participation, transparency and accountability.

Reform of the U.N. has stalled as its legitimacy, effectiveness and the credibility erodes. "The unipolar world has eliminated the competition between systems." "As competition has vanished, the urge for cooperation has diminished."

In addition to Security Council reforms, the study proposes:

1) Full or partial independent U.N. financing to "loosen the political control now exercised by the powerful member-states" and "ease the pressures of resource constraints of the UN." The financing issue "is less about money and more about political control," the study says, calling for "some version of the Tobin tax on international foreign exchange transactions or stock market transactions, and some charges on the use of the global commons."
2) Establishment a Global People's Assembly, modeled on the European Parliament, to run parallel to the General Assembly but serve as "the voice of global civil society."
3) Creation of an Economic Security Council, "essential as a means of governing globalization. It would ensure consultations on global economic policies.
4) Establishment of a high quality Volunteer Peace Force to "de-politicize intervention by the United Nations" and enable it to provide a prompt collective security response wherever humanitarian emergencies arise.

"There is still no system in place to take care of, let alone prevent, complex humanitarian emergencies. Some new problems are a direct consequence

PHA-Exchange> Study urges overhaul of U.N., IMF, World Bank

globalization.

IMF and World Bank: "It's time to reform the reformers"

The IMF and World Bank "have been the most ardent advocates of economic reforms in recent times. It is time to reform the reformers".

"The world has changed since the mid 1940s. But these institutions' concerns have become much narrower," "Their orthodoxy has not resolved the economic problems of borrowing countries. Indeed, the solution has often turned out to be worse than the problem."

The study argues that the IMF and W B are incapable of exerting needed management influence on today's international financial system.
"The essence of the problem is international capital flows without any international controls. The failure in promoting development, which is reflected in persistent poverty and growing inequalities, is another. The crisis of development has, in fact, been accentuated in the era of globalization.

"These flaws are, in part, attributable to the virtual ideology of these two institutions, which do not recognize the importance of public action in coping with and correcting market failures.

Reform the IMF: "We need to redefine the governance of the IMF. It needs greater transparency. Its operations are shrouded in secrecy. The absence of public scrutiny means that there are few checks and balances." We need a system of disclosure of information and an independent evaluation of operations. The accountability of the IMF is limited, at best, to finance ministries and central banks, which, in turn, have close connections with the also secretive financial community. "There is now ample evidence that its stabilization programmes lead to adjustments that contract output and employment."

Redefining the World Bank: The WB "should cease to be a moneylender" and "transform itself into an institution more concerned with development."
As with the IMF, greater representation and accountability are "imperative." "A very large proportion of the voting rights are vested in a very small number of industrialized countries, the principal shareholders in terms of paid-up capital. But it is developing countries that are the principal stakeholders since their interest payments provide most of the income of the WB! "The need to restructure such a voting system is obvious."

The study calls for "independent evaluation" of WB supported projects as a way to begin improving accountability to people.

The Bank nees to re-orient its thinking about development: Simple prescriptions that emphasize more openness and less gov. intervention and that advocate a rapid integration into the world economy, and a minimalist state that simply opens space for the market, have not proven to work.

Missing institutions: New financial architecture needed to manage global macroeconomics.

The study calls for new institutional arrangements to cope with the complexity of macroeconomic management, including inflation control, restoring full employment, stimulating investment and dealing with crisis management and crisis prevention. A greater supply of emergency financing to assist in times of crisis is needed, as well as orderly debt workout procedures.

The study also calls for an international system of governance for transnational corporations. "The economic space of their activities extends way beyond the geographical space of nation states." "International regimes should be concerned with the obligations and restrictive business practices of these corporations, and effective anti-trust laws."

Cross-border movements of people: Globalization is creating demand for greater labour mobility across borders. "There is a potential conflict between the laws of nations that restrict the movement of people across borders and the economics of globalization that induces the movement of people across borders."
"The almost complete absence of international institutions, or rules, in this sphere is a cause for concern (especially to protect the rights of migrant workers and protect illegal migrants from exploitation and abuse)."

International 'public goods' and 'public bads':
Globalization has reduced the power of national governments in economics and politics "without a corresponding increase in effective international cooperation or supra-national government which could regulate this market driven process."

"In a world where the pursuit of self interest by nations means uncoordinated action of non-cooperative behaviour, sub-optimal solutions, which leave everybody worse off, are a likely outcome."

Without effective international oversight, international problems (such as international crime or trade in drugs, guns, people and organs) will increase while international public goods (world peace, sustainable development) will be undermined. Needed here are institutional mechanisms for cooperation between nation states.

It is essential to create institutional mechanisms that give poor countries and their people a voice in the process of global governance. "Even if they cannot shape decisions, they have a right to be heard."

Several chapters of the study "New Roles and Functions for the U.N. and the Bretton Woods Institutions," can be accessed online at http://www.wider.unu.edu/publications (WP166.pdf; wp169.pdf; wp190.pdf; wp194.pdf; wp195.pdf)

Subject: PHA-Exchange> FW: [drumbeatchat] Using the People's Charter for Health
Date: Wed, 26 Sep 2001 09:17:05 +0100
From: Andrew Chetley <chetley.a@healthlink.org.uk>
To: pha-exchange@kabissa.org

Hi,
Some of you might find the response below of interest. This comes from the Communication Initiative's discussion list, DrumbeatChat, where I posted a notice about the People's Charter.
best wishes,
Andrew

-----Original Message-----
From: Penny Poole [mailto:ppoole@mo2com.com]
Sent: 22 September 2001 06:19
To: drumbeatchat@comminit.com
Subject: Re: [drumbeatchat] Using the People's Charter for Health

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This is a contribution to the Drum Beat Chat discussion forum. Please send all contributions to drumbeatchat@comminit.com

To subscribe or unsubscribe, contact Warren Feek wfeek@comminit.com

If this message comes to you in a language you do not speak, please go to the following website for an electronic translation.

Si recibe este mensaje en un idioma que Usted no entiende, por favor dirjase a la siguiente pgina web en donde podr acceder a una traduccin electrnica.

http://www.freetranslation.com/

Thanks for this Andrew. There are several nimble NGOs that have developed programs that use health, or other interventions, as opportunities for management of violent social conflict.

The Carter Center www.cartercenter.org has made the link between peace and health and those are its core programs. The health programs complement the peace programs by providing a venue to fight a common enemy. In Africa the common enemies are guinea worm and river blindness. The intervention planning venues provide opportunity for trust to build among people who would not ordinarily choose to be in the same room together. Communication is opened at a high enough level between parties to the conflict to build relationships and through them, plant seeds of peace. Much of conflict is stoked by information asymmetry, and health programs are one way to begin building bridges of communication that can lead to peace. (btw, the Carter Center has nothing to do with Habitat for Humanity. The Carters work for Habitat one week a year, and Habitat uses that fact well.)

4 of 4 9/27/01 9:58 AM

Another useful conflict theory is the Multi Track Diplomacy model of Louise Diamond and Ambassador John McDonald. The MTD model identifies more than two tracks to peace. (Track one is the official government to government peace negotiations, track two is conflict professionals, usually NGOs like the Carter Center, but also government employees at lower levels who do the groundwork to prepare for Track One). In fact, Diamond and McDonald name nine tracks, including financing, education, activism, religion, etc. http://www.imtd.org/about_theory.htm . It is no surprise to communicators that Track Nine, public opinion and communication (media) runs through the

RN 2/19

1 of 2 9/27/01 10:03 AM

RN 2/19

spokes of the other eight tracks in the system model, forming an "inner circle."

Still another excellent conflict transformation NGO (and member of this list) is the Search for Common Ground www.sfcg.org , which uses media such as community radio, drama, television, film, and training to work towards building peace in wounded parts of the world. Clearly, in a country such as Afghanistan that suppresses communication, where you can be jailed for owning a television and where people exist in a state of utter oppression and dire poverty, transformation communication has to take a more personal form, such as what led to the recent arrests of the Christian aid workers in Kabul.

I echo the sentiments of many earlier contributions, that we must attack the twin roots of the world's conflicts -- poverty and inequity. I fervently hope the US will increase its contribution to ODA from .01 percent to the .07 percent GDP pledged at Rio and that conflict prevention / transformation / and peacebuilding through poverty reduction and communication be the focus of every aid agency on the planet, whether public or NGO or corporate foundation or private philanthropist. Now, more than ever before, we have witnessed first hand that poverty is everyone's business and affects everyone.

Thank you all for your rich contributions and commentary. I have noticed that many are dealing with this long gasp since Sept. 11 through this type of sharing and reflection, which offers opportunity for healing.

With all my good wishes,

Tenny Poole
Development Communication Specialist/
Conflict Management Strategist
Currently on assignment to the Asian Development Bank in Manila

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

Subject: PHA-Exchange> WABA Global Forum 2
Date: Wed, 26 Sep 2001 11:07:34 +0800
From: secr@waba.po.my (World Alliance for Breastfeeding Action)
Organization: WABA
To: pha-exchange@kabissa.org
CC: mcarter@ipen.org, spatton@igc.org

Save the dates!

WABA GLOBAL FORUM 2
23-27 September 2002, Arusha, Tanzania
Nurturing the Future-Challenges to Breastfeeding in the 21st Century

The WABA Global Forum 2 will bring together a diverse group of individuals and organisations and provide a unique opportunity to discuss, review and formulate strategies to improve infant and young child health, nutrition and care through the protection, support and promotion of breastfeeding, with the focus on the community. The Forum 2 aims to provide an opportunity for rallying worldwide participation in the movement to protect, support and promote breastfeeding and childcare, and spread awareness on the rights of children and women to adequate food, health and care especially in developing countries.

Forum 2 will focus on:
Researchwhich provides the evidence base for appropriate actions
Capacitybuilding to enable groups to implement more effective actions
Popularmobilisation to ensure that actions are community and people-centered

WABA invites participation from individuals and groups interested in the topics of Forum 2, ranging from health, women, children, environmental and consumer groups, to individuals such as health workers and young people.

Attached with this email are:
1. Preliminary Announcement in pdf: layout version to print for dissemination
2. Preliminary Announcement in word: text only
3. Reply form (DEADLINE: 30 October 2001)
We have also put them on our website <www.waba.org.br>. Please also share this announcement to those who would be interested.

We look forward to hearing from you and your participation at the coming WABA Global Forum 2, Arusha, Tanzania. So, save the dates and plan to join us in the WABA Global Forum 2!

With best wishes,
WABA Secretariat
P.O. Box 1200, 10850 Penang, Malaysia
Tel: 604-6584816
Fax: 604-6572655
Email: secr@waba.po.my
---------- Preliminary Announcement - Save the Dates!

Nurturing The Future:
Challenges to Breastfeeding in the 21st Century

WABA GLOBAL FORUM 2
23-27 September 2002, Arusha, Tanzania

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The Key Facts

The World Alliance for Breastfeeding Action (WABA) announces plans to hold their Second Global Forum entitled Nurturing the Future: Challenges to Breastfeeding in the 21st

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RN 2719

locally. The Forum will bring together a diverse group of individuals and organisations and provide a unique opportunity to discuss, review and formulate strategies to improve infant and young child health, nutrition and care through the protection, support and promotion of breastfeeding, with the focus on the community.

Forum 2 will focus on:
Researchwhich provides the evidence base for appropriate actions
Capacitybuilding to enable groups to implement more effective actions
Popularmobilisation to ensure that actions are community and people-centered

With its African venue, Forum 2 will focus on lessons the rest of the world can learn from this unique and age-old breastfeeding culture and ways of protecting it from today's threats, varying from the baby food industry and its exploitation of the HIV/AIDS issue to globalisation and free marketeer's efforts to destroy the Code. The Forum has been planned with assistance, funding, and enthusiastic support of a host of groups involved in the breastfeeding and allied movements, including women, environment, consumer, human rights and food security groups.

. . . What?
The two main goals of the Second WABA Global Forum are:

- To provide an opportunity for rallying worldwide participation in the movement to protect, support and promote breastfeeding and childcare;
- To spread awareness on the rights of children and women to adequate food, health and care especially in developing countries.

. . . Where?
Forum 2 will be held in the city of Arusha in northern Tanzania. With a temperate climate and its location close to Mount Kilimanjaro, the city offers excellent conference and hotel facilities and is close to world famous attractions such as Serengetti National Park and the Ngorogoro Crater.

. . . Who?
WABA invites participation from individuals and groups interested in the topics of Forum 2, ranging from women, children, environmental and consumer groups, to individuals such as health workers and young people. There will be a strong training and capacity building focus. The presence of many experts in the fields of health and nutrition, child care and community participatory action will make it possible to share skills and knowledge about advances along a wide front.

Key Issues

The thrust of the Forum programme is on the primary goal of the Innocenti Declaration: all women should be enabled to practise exclusive breastfeeding for six months and to continue to breastfeed while providing appropriate complementary foods, for up to two years of age or beyond. WABA aims to do this through strengthening the four Innocenti targets and addressing key issues:

HIV/AIDS
A strategy to strengthen the protection, promotion and support of breastfeeding in the face of HIV/AIDS.

MaternityProtection
Inspiring the development of regional and national strategies for implementing the new ILO Convention 183 on Maternity Protection by promoting its ratification. Also strengthen maternity protection among women working in the informal sector.

The Code
Continue to strengthen the promotion of the International Code of Marketing of Breastmilk Substitutes in the face of the baby food industry's recent marketing initiatives (such as new ways of marketing via the Internet, and promotion during emergencies). Adopting the code is part of governments' obligation when they implement the Convention on the Rights of the Child (CRC).

MotherSupport

Recognise and strengthen mother support groups and other community based support systems. WABA is developing a Global Initiative on Mother Support (GIMS) as a means to build support from the grassroots as well as from international organisations to foster global initiative to support women throughout their reproductive cycle and in particular before, during and after birth. GIMS aims to link with the UNICEF CARE initiative and other relevant international programmes and initiatives.

BFHI& Birthing Practices

Extend the Baby-Friendly Hospital Initiative (BFHI) to include good birthing practices in order to transform the BFHI into a Mother-Baby Friendly Initiative. Work with UN agencies and others to develop new guidelines for maternity care and a joint declaration for maternity. BFHI practitioners have noted that poor birthing practices lead to poor breastfeeding initiation.

What's New

ThisForum will expand the horizons for the breastfeeding movement, moving us into unchartered territory and linking us with new partners.

Our African venue will lend an African perspective to the proceedings, giving us all a chance to learn from one of the world's strongest breastfeeding cultures.

The most dynamic international activism today is pitting people power against market power and globalisation. The breastfeeding movement must harness and join this effort to ensure that the free market is never allowed to mean free access for the baby food and transgenic food industries to our babies.

The way that the threat of transmission of HIV/AIDS from mother to infant is now being dealt with is a bigger threat to breastfeeding than the virus itself. We must update ourselves, become proactive and build a united front calling for science and ethics, not politics and Northern domination. to determine which approaches are used.

Thereis momentum toward protecting, respecting and facilitating the breastfeeding rights of working women. The Forum will bring us up to date on ratification and implementation of the new ILO Maternity Protection Convention 183 and explore how to expand coverage to informal workers.

Againand again the mass media exploit breastfeeding's emotive quality, especially regarding environmental pollutants. The Forum will empower us all to proactively and confidently deal with this locally, putting us in contact with scientific data, environmental groups, UN and other statements.

Forum2 will launch a new international initiative for support to mothers. For the first time all the necessary component of the support we all know is necessary to enable mothers to breastfeed successfully will be explored and mobilised simultaneously.

Joinus in setting up a Hall of Fame to celebrate the movement's successes and a Hall of Shame to document past and present industry violations of the International Code of Marketing of Breastmilk Substitutes and Subsequent WHO Resolutions—and dirty tricks!

Breastfeedingworks best where it is the norm, supported by community and family structures. Yet we have so far failed to develop many community-based approaches to protect, support and promote breastfeeding. The Forum will showcase what has been done so far and provide a brainstorming arena in which new approaches can be designed for the settings in which you live and work.

The Baby-Friendly Hospital Initiative is the most widespread of all breastfeeding programmes. We will explore how to build on it to achieve baby and mother friendliness throughout the health care system, including birthing and will discuss the threat posed by misinformation about HIV/AIDS.

Background

The first WABA Global Forum was held five years ago in December 1996 in Bangkok (see WABA website www.waba.br.org). It resulted in building, inspiring and strengthening the breastfeeding movement and it led to new activities, and brought on board new partners. Many network members have over the past few years expressed the need for another such revitalising forum.

Several brainstorming sessions on the goals, objectives and programme of Forum 2 have taken place from 1998-2001. These meetings have confirmed the validity of the first Forum goals, major themes and programme as well as laid out the Ten Critical Areas for Action (see back page). They have especially recognised the need to strengthen the implementation of the Innocenti Declaration targets and to move beyond it to support such activities as more humane birthing practices, good maternity care and greater community support.

Pre-Forum Meeting on HIV and Breastfeeding

It is proposed that a two-day international meeting be held in Arusha to discuss the important topic of appropriate infant feeding for babies born to HIV positive mothers and the impact of the HIV pandemic on support for breastfeeding. Mother to child transmission (MTCT) of HIV occurs in utero, during child birth and through breastfeeding. The meeting will concentrate on infection occurring through breastfeeding, and on the importance of risk assessment both in advice to mothers and in public policy. That is, the risk of HIV transmission through breastfeeding versus the risk of not breastfeeding. Alternative methods of infant feeding will be discussed. The impact of concern about MTCT on activities in support of breastfeeding such as BFHI, Code implementation, World Breastfeeding Week and others will also be reviewed.

10 Critical Areas for Action
WABA Global Forum 2, Nurturing the Future: Challenges to Breastfeeding in the 21st Century
23-27 September 2002, Arusha, Tanzania

1. HIV/AIDS
Participants will be presented with the latest scientific information on mother to child transmission of HIV/AIDS. They will critically review research and pilot study outcomes, UN policies and various organisations' position statements and learn about risk assessment both to assist individuals and policy makers and will develop appropriate guidelines for their settings. Best practices will also be shared.

2. National Breastfeeding Mechanisms
Lessons learned from a global survey on the first Innocenti target and from existing committees will be examined. Based on this, a recommended terms of reference for such a committee will be produced and a strategy for putting together one that has a clear mandate, a budget, and accountability.

3. Popular Mobilisation
Best practices in community mobilising initiatives to support breastfeeding will be presented. Participants will learn and share various popular mobilisation techniques (e.g. WBW), develop skills in proposal writing, advocacy, and linking breastfeeding to broader global campaigns, such as UNICEF's Global Movement for Children.

4. Baby-Friendly Hospital Initiative
Participants will discuss how to build on the best practices in the BFHI to achieve mother and baby friendliness throughout the health care system including non-interventive maternity
care and birthing practices, and to change health worker curricula accordingly. A discussion of the decline in government, WHO and UNICEF support for BFHI will take place and recommendations for strengthening the BFHI in the era of HIV/AIDS will be developed.

5. Globalisation
Participants will discuss the risks and dangers to breastfeeding of the introduction of transgenic human milk components in infant formula, genetically-modified foods, and of market liberalisation and globalisation in general. Concerns over the increasing power of transnational corporations versus weakening of governments, the role of World Trade Organisation and related topics will be discussed. Creative ideas for action are expected to emerge regarding how to build linkages with other actors working to create a world that puts people first.

6. The International Code
Discuss the Code, and subsequent WHA resolutions, as a unique international effort to control the marketing activities of baby food companies, in order to actively protect the health and well-being of babies. Celebrate the movement's successes (Hall of Fame) and document past and present industry violations and dirty tricks (Hall of Shame). Participants will be offered training in code implementation, monitoring and reporting techniques for use in their own setting.

7. Support for Working Women
Participants will be updated on progress around the world in ratifying and implementing the new ILO Maternity Protection Convention 183. Join brainstorming and project planning efforts to extend work on breastfeeding rights to women working, including the informal sector. Training on establishing mother friendly workplaces and child friendly creches will be available.

8. Breastfeeding and the Environment
Discuss breastfeeding as an environmentally friendly activity and how alternative feeding methods have adverse environmental impacts. Every breastfeeding advocate needs to know how to deal locally with recurring attacks on breastfeeding, whether intended or not, that result from environmental scares based on breastmilk contaminants. Join us in reviewing the scientific data, learning about key statements by environmental health and justice groups and relevant UN statements, and developing our own statement and action plan.

9. Outreach to Women's Organisations
Develop ways to build links with organisations working on women's issues and gender equality and help establish common agendas and actions. Join the dialogue on women's empowerment and related concerns (e.g. health, nutrition).

10. International Initiative for Support to Mothers
For the first time ever, WABA is bringing together all the forces working for the various kinds of support needed by breastfeeding mothers from the health care and employment sectors, other experienced women, the family and community. Groups will share their experiences on their early work and success stories. You are invited to join and help shape this Initiative in your own area.

The Ten Critical Areas for Action were identified by the 36 participants from 21 countries of the
Global Breastfeeding Partners Meeting held in Salvador, Brazil, 23-25 July 2001.

Further details regarding registration, travel, accomodations and the Forum Programme will be available in December 2001. The World Alliance for Breastfeeding Action (WABA) is a global people's initiative to protect, promote and support breastfeeding. WABA acts on the Innocenti Declaration targets and works in close liaison with the United Nations Children's Fund (UNICEF). Contact us at: WABA, PO Box 1200, 10850 Penang, Malaysia Tel: 604-658 4816 | Fax: 604-657 2655 Email: secr@waba.po.my Website: www.waba.org.br www.waba.org.my
---END---
REPLY FORM

WABA GLOBAL FORUM 2
NURTURING THE FUTURE:
CHALLENGES TO BREASTFEEDING IN THE 21ST CENTURY
23-27 September 2002, Arusha, Tanzania

To help prepare for the Forum, please complete this form and return it to the WABA Secretariat not later than 30 October 2001. The purpose of this form is to identify groups and individuals who are potentially interested in attending the Forum or contributing to its programme. The responses received will be used to develop a provisional Forum programme that we plan to send out in December 2001 with an official registration form.

q Yes! I am interested in attending the Forum.
q Yes! Please send me the Registration Package.

Name:

_____

Organisation:

_____

Address:

_____

Country: _____ Telephone: _____ Fax: _____
Email: _____

I would like to participate and contribute by:
q Presenting a paper entitled: _____
q Presenting a poster on: _____
q Presenting a case study on: _____
q Setting up an information booth/exhibit on: _____
q Selling publications/products: _____

My organisation/I would like to organise a special event/s:
q Workshop on: _____
q Training session on: _____
q Others: _____
Any additional comments and suggestions (attach additional paper if necessary):

_____

The Global Forum does not accept funds or gifts from manufacturers of breastmilk substitutes, commercial complementary foods, feeding bottles and other products used in infant feeding such as breast pumps. WABA encourages all participants to adopt the same ethical stance.

Please complete this form and return to WABA by
30 October 2001

Fax: 604-6572655

WABA Global Forum 2, WABA Secretariat
PO Box 1200, 10850 Penang, Malaysia
Tel: 604-6594916 | Fax: 604-6572655
Email: secr@waba.po.my
Website: www.waba.org.br | www.waba.org.my

Subject: PHA-Exchange> cash-strapped ministries
Date: Thu, 4 Oct 2001 21:13:46 +0700
From: "Claudio Schuftan" <aviva@netnam.vn>
Organization: AVIVA
To: <pha-exchange@kabissa.org>

Triage management in third world health ministries

Keeping services running by juggling items of expenditure in the budget of a ministry of health can only go so far. The often practiced 'management of cuts' makes running health services an impossible task. Management options reach a point where triaging is the only alternative and selected health services are the clear victims of such a slashing exercise.

In times of severe resource constraints health managers face challenges for which they are ill-prepared,. There is no training that prepares them for operating under such tight financial decision-making options. What keeps being ignored is the dire constraints under which health ministries work in the South. Here, government management simply does not obey the golden rules of 'good management' as they have been set in the North. Existing theories and recommended practices do not seem to work.

In the 1990s, and under structural adjustment, managing a health ministry in Africa simply was (and still is) a monumental task. It would be monumental even for the top-paid champion managers of Europe or North America...

The reason is that ministries are managing their affairs under conditions of extreme poverty; they are practising management under conditions of severe financial constraints, with an extreme scarcity of cash resources. To this, add each country's chronic problems with an inflated civil service that uses over 70% of the recurrent budget and this 'catch-22' scenario becomes fully apparent.

Unfortunately, the type of critical (triage) management skills needed are taught nowhere! No university teaches this brand of management that could prepare public managers to make difficult daily decisions when scarce resources have to be allocated among so many vital competing, real-life priorities.

Triage management is several steps worse than 'management by crisis'. No financial forward planning holds when one gets the news that the water supply of a major government hospital was cut for non-payment of bills for the last year...

Health ministries not only start the fiscal year with scarce financial voted resources, but with an accumulated debt of unpaid bills skillfully carried over to the current fiscal year. This debt further erodes already skimpy budgets. Further, when senior management tries to call-forward its voted budgetary allocations, it finds the Treasury has a cash-flow problem and delivers those funds late (or never). When Treasury cannot balance its own books anymore, it may even 'close' the fiscal year a month or two ahead of its usual date of closure. Even the 'Fortune 500' managers would not be able to cope, and yet the 'Misfortune 100' ministerial managers in Africa somehow *do*.

Donor funds-typically already comprising over 70% of development budgets of health ministries - actually also get affected by triage management. If and when Treasury makes these donor funds available they are often used as temporary stop-gap measures to manage the latest crisis thus being, at least temporarily, syphoned away from

their intended purpose.

All the above is *not* an apology for Third World ministries of health mismanagement or despondency, of which there is a fair amount. This is rather a desperate call for technical support, for a search of new avenues that can come up with realistic managerial triage techniques to cope with this kind of extreme adversity. What this calls for is an effort commensurate with the challenge economists had to face to cope with the unknowns of hyperinflation. Some of their theories had to be revised from scratch *in* the places where this was happening, and not in their own ivory towers.

I am aware that there will be no miracle management techniques coming up from such a search, primarily because the main challenge remains -- i.e. solving the chronic fiscal insolvency issue. However, perhaps a South-South sharing of tricks can yield some collective wisdom from which to select coping interventions that can be tried elsewhere, especially as relates to identifying no-cost or minor-cost interventions that show or make a difference. Perhaps there is a recipe that can maximize the utilization of human and other resources already in place: direct fund-raising techniques (e.g. tobacco taxes) may have to be considered as a realistic alternative. A more systematic survey of such palliative measures is needed. Perhaps some readers are willing to share their experience with the rest of us or to influence an academic institution to start such a research. I believe most potential help will come from a South-South sharing since the prospects for more structural adjustment-like measures will continue to squeeze public funding in the Third World in the foreseeable future.

Claudio Schuftan, Hanoi

aviva@netnam.vn

Subject: PHA-Exchange> Big capital owns your cells
Date: Sun, 07 Oct 2001 16:09:10 +0200
From: "Ted Greiner" <ted_greiner@hotmail.com>
To: pha-exchange@kabissa.org

http://www.Irna.org/league/PT/PT.2001.08/PT.2001.08.6.html

"Privatizing Your Cells

By Steven Miller In the early '90s, Baylor University went to Europe to patent cows that would produce pharmaceutical products in their milk. Buried in the legalese was a request to patent genetically engineered human women. When the court asked why, the University's lawyer said that they wanted the patent rights in case, somewhere, sometime, someone might decide that humans are patentable. A year ago, government and corporate researchers held a public relations love fest, announcing that the entire Human Genome -- all human DNA -- had been sequenced. Now a law is being debated in Oregon that will make it illegal for a person to claim his or her DNA as personal property. This law is being pushed by Ph! RMA -- the Pharmaceutical Manufacturers and Researchers of America -- the ultrapowerful drug manufacturers lobby that has one lobbyist for every two members of Congress. Global capitalism intends to privatize every resource on the planet. PhRMA intends to add DNA to the list. PhRMA is against personal ownership of DNA because it would make commercial exploitation of biotech products more difficult. They publicly admit that personal ownership is a barrier only to commercialization of human DNA; it puts no real limits on research. They have no problem, of course, with corporate property. Though few people realize it, corporate ownership of human tissue, cells, cell products and DNA is quite advanced. In the late '80s, John Moore, a Seattle businessman, contracted hairy cell leukemia. He went to UCLA to get top medical treatment. After treatments, the doctors told Moore he was cured but they kept asking him to come back and give! more tissue samples. Moore finally became suspicious and discovered that his own cells had been patented by the doctors -- patent # 4,438,032. Rightfully angered, Moore sued the university and the doctors for malpractice and property theft. The doctors claimed that his cells and his genetic essence were their property. The California Supreme Court held that, since Moore had no property rights in his body, he had no rights to the profits. Capitalist ownership of cells and tissues has now become universal. If you give up tissue for a medical test, you have no rights over what is done with it. Your cells are being harvested for private profit! The current debate over stem cells reveals the drug-company desires to privatize an essential element of the growth process. Stem cells have the ability to develop into other types of cells, just as your own first cells differentiated into liver cells, eye cells and all your other cells. Stem! cells have a vast potential to cure many diseases. Corporations are now aggressively mining "human live stock" around the world. The inhabitants of the remote island Tristan da Cunha have the highest incidence of asthma in the world. Canadian doctors asked for volunteers to donate blood samples by promising to research the disease. They then sold the blood to Boehringer Inselheim, a German biotech firm, for $70 million. The people of the island have no rights to any profits from their own natural resources. Such

bio-piracy is regularly used by both the U.S. government and corporations in Panama, New Guinea, the Solomon Islands, India, and right here in the U.S. itself. The government began collecting tissue from infants in the 1960s to test for phenylketonuria (PKU). This is a metabolic disease that leads to mental retardation unless the child gets a special diet. Test after test has been added to newborn screening programs.! All these cell samples can and do wind up in the hands of private corporations who grow cell lines in labs that

can be mined for decades -- even after the person is dead. Harvesting of human tissue is protected by a growing bio-police state. Parents in Missouri and South Carolina can be jailed if they refuse to donate their newborn's cells. Children are required to give up tissue samples again when they enter school. Pre-employment medical exams demand tissue, as do life-insurance tests. Prisoners and soldiers are routinely mined for tissue. Andrews and Nelkin describe this industry in their alarming book "Body Bazaar -- The Market for Human Tissue in the Biotechnology Age." Now that corporations are privatizing our humanity, they charge us thousands of dollars a year for the medical by-products of our own resources. It wasn't always like this. When Jonas Salk discovered the polio vaccine in the 1950s, he gave it for free to the people of the world and never made a penny from it. The result was immediate, large-scale programs that immunized millions of people for free. Compare this to how capitalists hold the world hostage to AIDS by pricing the

medicine out of reach. Tissues, cells and DNA are our common heritage as human beings. The best protection for our personal right to benefit from our cells is the public ownership of all important resources. Contact the People's Tribune/Tribuno del Pueblo Speakers Bureau (<A HREF="mailto:speakers@noc.org">speakers@noc.org</A>) to book Steve Miller as a speaker. Join us in an online discussion with Steve sometime in August. To find out the exact dates, look at our website at: <A HREF="http://www.lrna.org/">http://www! .lrna.org</A> This article originated in the People's Tribune (Online Edition), Vol. 26 No. 8 / August, 2001; P.O. Box 3524, Chicago, IL 60654, <A HREF="http://www.lrna.org/">http://www.lrna.org</A>. For free electronic subscription, email <A HREF="mailto:majordomo@gocatgo.com">majordomo@gocatgo.com</A> with a message of subscribe pt-dist
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Subject: PHA-Exchange> Action Alert: Oppose US taxpayer promotion of tobacco - Stop the Etheridge Amendment
Date: Mon, 8 Oct 2001 23:05:39 +1000
From: "FCA Secretariat" <FCTCalliance@inet.co.th>
To: <pha-exchange@kabissa.org>

Action Alert
Oppose US taxpayer promotion of tobacco
Stop the Etheridge Amendment

Please contact your US Representative NOW urging him/her to "oppose Rep. Bob Etheridge's tobacco amendment to The Farm Security Act (HR 2646) that would force US taxpayers to fund the promotion of tobacco in foreign countries."

House Switchboard 202-225-3121

Background:

Tomorrow afternoon (Thursday, October 4), US Representative Bob Etheridge (D-NC) plans to offer an amendment to the Farm Security Act of 2001 (HR 2646) on the floor of the US House, which would make leaf tobacco eligible for the $200 million Market Access Program (MAP) administered by the US Dept. of Agriculture. MAP provides federal funds to help farmers and associations promote US agricultural products overseas.

Leaf tobacco has been banned from MAP benefits since 1992. However, Rep. Etheridge amended the bill to include leaf tobacco during the House Agriculture Committee mark-up in July. Subsequently, Rep. Etheridge's provision was removed from the bill by a 24-7 vote on an amendment offered by Rep. Earl Blumenauer (D-OR) during the House International Relations Committee mark-up on September 6.

To quote the American Lung Association, "Precious taxpayer dollars should not be spent to subsidize the sale or promotion of tobacco."

For your reference, following are a letter from the American Lung Association and an Advisory sent to all members of the Congressional Task Force on Tobacco and Health from Co-Chairs Jim Hansen (R-UT) and Marty Meehan (D-MA). Also, I circulated a Lexington (KY) Herald-Leader news article about Etheridge's amendment on August 3.

- - - -

American Lung Association letterhead

October 2, 2001

The Honorable Lloyd Doggett
U. S. House of Representatives
Washington, D.C. 20515

Dear Representative Doggett:

Thank you for your commitment to protect the world's children from tobacco. The American Lung Association shares your concern that children around the world are prime targets for the tobacco industry.

The World Health Organization calls the worldwide tobacco problem a global epidemic. The WHO estimates that tobacco attributable

deaths in about 2030. The United States has an obligation to help reduce, not add to this number.

The American Lung Association supports measures to eliminate government promotion of the export, marketing or sale of tobacco products.

The United States government should not be engaged in the promotion of tobacco abroad or at home. Our government should send a clear and consistent message to discourage tobacco use. It would be hypocritical for the federal government to fund programs and research to reduce the horrific health toll of tobacco and to promote tobacco abroad through the Market Access Program. Precious taxpayer dollars should not be spent to subsidize the sale or promotion of tobacco.

The American Lung Association opposes any amendment to H.R. 2646, the Farm Security Act of 2001, which promotes tobacco sales and marketing or any other tobacco subsidy.

Sincerely,

John L. Kirkwood
Chief Executive Officer

- - - -

ADVISORY on The FARM SECURITY ACT of 2001

- STOP THE ETHERIDGE AMENDMENT -

Dear Task Force Members:

Rep. Etheridge plans to offer an amendment to the Farm Security Act of 2001 (HR 2646), which would make leaf tobacco eligible for the Market Access Program (MAP). As you may know, MAP helps farmers and associations market agricultural products overseas. The Co-Chairs of the Tobacco Task Force, Representatives Hansen and Meehan, are opposed to the amendment and plan to vote against it.

Leaf tobacco has been banned from MAP benefits since 1992. However, Rep. Etheridge amended the bill to include leaf tobacco during the Agriculture Committee mark-up. Subsequently, Rep. Etheridge's provision was removed from the bill by Rep. Blumenauer during the International Relations Committee mark up.

The American Lung Association and the American Society of Clinical Oncologists are also opposed to the Etheridge amendment. To quote the ALA, "Precious taxpayer dollars should not be spent to subsidize the sale or promotion of tobacco." Copies of both organizations' letters of opposition are attached to this e-mail.

If you would like more information, feel free to contact us. Thanks.

The Congressional Task Force on Tobacco and Health

Representative James V. Hansen (R-UT), Co-Chairman
Representative Marty Meehan (D-MA), Co-Chairman

For more information, please contact:
Justin Harding with Rep. Hansen (202-225-0453)
Kate Leeson with Rep. Meehan (202-225-3411)

Belinda Hughes
Coordinator
Framework Convention Alliance (FCA)
www.fctc.org
Tel: (66-2) 278 1828 or (66-2) 278 1829
Fax: (66-2) 278 1830

The Framework Convention Alliance is an alliance of NGOs from around the world committed to a strong global treaty to control tobacco for the health of all people.

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

Subject: PHA-Exchange: on poverty (4 and last)
Date: Sun, 25 Nov 2001 15:48:12 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

(4)
Poverty is not only a state of existence, but also a process; it can be chronic or transient; it can trap future generations.

To be pro-poor, economic growth has to reduce income inequality.

Rural poverty accounts for nearly 63% of all poverty worldwide, reaching 90% in China and Bangladesh and 65-90% in Sub-saharan Africa. In Latin-america, poverty is concentrated in urban areas. Rural women tend to suffer far more than rural men.

Much of the urban poverty is caused by the rural poor moving to the cities.

Most of the poor depend on private transfers among households, extended families and other kinship groups. The rural poor increasingly depend on wage labor; a flexible public works program can thus help to smooth household consumption.

Unfair laws or poor enforcement of existing laws worsen the plight of the poor. In this respect, the rights to land and water are of key importance in reducing rural poverty.

Claudio
aviva@netnam.vn

DO NOT FORGET TO VISIT OUR NEW WEBSITE AT WWW.PHAMOVEMENT.ORG

Subject: PHA-Exchange> one liners on poverty (3)
Date: Sat, 24 Nov 2001 11:44:21 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

(3)
Privatization has weakened the role of the state which is now failing to deliver benefits due to the poor.

In the battle against poverty, success in only a few countries, no matter how large, is not enough!

Poverty's non-economic dimensions and attributes:
powerlessness/voicelessness,
vulnerability/deprivation,
low capacity to cope,
limited choices, no access to basic services,
discrimination,
inability to influence or control what happens to one's family,
lack of connections (dependence only on the informal network of kin... while the rich are always well connected),
no assets,/no skills/ill equipped to absorb external shocks,
lack of information,
thinking in terms of very short time horizons (surviving the present),
no direct access to resources (always mediated by institutions),
precarious seasonal livelihood,
unofficial payments to receive government services,
crime and violence/widespread violence against women,
unequal gender relations,
cut off from information about one's rights (abused and excluded by the more powerful),
disconnected (no organization into networks that can exert pressure).

Poor people are not the problem. Poor people work hard, are remarkably resourceful and show determination in providing for their families.

If a government is not fully committed to consulting the poor, it is unlikely to act on research results that run counter to its own interests.

Claudio
aviva@netnam.vn

RM 26/11

RM 26/11

Subject: PHA-Exchange> PHA NEWSNEWSNEWS
Date: Sat, 24 Nov 2001 11:12:29 +0100
From: schuftanc@who.ch
To: pha-exchange@KABISSA.org

There are a number of developments that I need to share with you:

Zafrulla and Ravi Narayan were in Geneva in October and pressed the need with WHO to have a PHA meeting during the World Health Assembly next May. I am currently in Geneva for a few weeks and was notified that WHO has agreed in principle and details will be worked out. I also met with the new Civil Society Initiative staff of WHO to discuss further possible collaboration with the People`s Health Movement (the prefered way to refer to us now). We will attempt to have as many as possible PHA members come to Geneva in May. We want to use the opportunity to do as much lobbying for the PCH (charter) as possible.

There was an important meeting of internatiojal coordinators of PHA in Savar (Dhaka) at the end of October. A proposal for our further organization and plan of action was discussed. It contains strategies to disseminate the Charter and creating consensus around it, ideas to stengthen our movement over the next 3 years, a new proposed structure how the movement should be oganized and a timetable for things that need to be done. Dr Qasem in the Secretariat will post the document later in this list as it is reviewed and finalized.

On December 4th, the European PHA groups will hold a one-day 1st aniversary meeting in London. I urge our friends organizing it to post more information in this list in the next few days. From Asia, Dr Thelma Narayan of the Community Health Cell in Bangalore has been invited to attend.
In India, April 7th has been changed by PHA members from WHO Day to People`s Health Day and in 2001 Health as a Right was the theme.

PHA`s lobbying with UN agencies has till now concentrated mostly on WHO. It is now clear that we need to be more proactive with other agencies; UNICEF is key among them. If anyone of you has good contacts, please communicate this to the Secretariat (gksavar@citechco.net). A first step is to more widely distribute the People`s Charter to theses agencies` officers and then to establish more formal linkages of consultation with them.

Does anybody else have first aniversary meetings scheduled next month? Please tell us.

Claudio

RN

PHA.

RN
26/11

26/11

Subject: PHA-Exchange> On poverty (2)
Date: Fri, 23 Nov 2001 17:56:01 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

Here are some more facts you ought to master to better structure your discussions on poverty:

Policies that increase the incomes of the poor enhance the productive capacity of the whole economy.

A country pursuing redistributive policies could reduce poverty even if its total income did not grow... but we are hard-pressed to find real-world examples.

The poor remain poor because they cannot borrow against future earnings to invest in education, skills, new crops and entrepreneurial activities. They are cut off from economic activity because they are deprived of many collective goods (property rights, public safety, infrastructure) and lack information about income opportunities.

The debate on what's first, growth or poverty reduction is a meaningless debate that diverts attention from the questions that should be our real focus: what works, how and under what circumstances.

Although some progress is being made in poverty alleviation in some places, it has been painfully slow, as the gap between rich and poor countries continues to grow.

In most countries, poverty reduction strategies are inseparably linked to debt relief operations, to tariff reductions in the rich countries and in many cases to tax reform. Debt relief has to be linked with poverty alleviation programs WITH civil society participation in the decision-making.

To hold governments accountable, indicators of the social impact of reforms implemented and of poverty beyond income need to be tracked.
Just recently, the combination of lower Third World commodity prices and higher oil prices resulted in trade losses of 15% in half of the poorest countries. The debt service of these same countries increased on average from about 17% of exports in 1980 to a peak of about 30% of exports in 1986. In 1997 it was 15%.

Claudio
aviva@netnam.vn

RN
26/11

RN
26/11

PHA Exchange file →

Subject: PHA-Exchange> ONE-LINERS ON POVERTY: USE THEM (1)
Date: Fri, 23 Nov 2001 08:27:06 +0100
From: schutlanc@who.ch
To: pha-exchange@kabissa.org

(1)
Sound economic policies are conducive to growth, but so are sound social policies.

In countries where income inequality is low, growth is twice as effective in reducing poverty as in countries with high income inequality.
In countries where the distribution of income worsens during growth, the impact of growth on poverty is not strong.

The impact of providing social services to the poor has been less than expected, mainly because:
a) investments in health and education, for example, have grown at a slower pace than the GDP has grown (for redistribution to occur, what is needed is increasing the share of public spending on poor people's needs);
b) the quality of the services expanded is poor;
c) interventions do not respond to the poor people's real needs;
d) there is no community involvement in making decisions about these safety-net programs which do not attack the root causes of poverty.

The effects of adverse external shocks such as volatile capital flows and falling terms of trade are not only transitory; such shocks can lock people into poverty for the long term by causing irreversible damage to children, for example (malnutrition, abandoning school, etc). [Indonesia an example?]

The total number of people living on less than $1 a day has risen from 1.16 billion in 1987 to 1.2 billion (24% of the world's population) in 1998; if one excludes China, the figures are 880 million people in 1987 and 986 million (26.2% of the world's population) in 1998.

Poverty is more than low income, a lack of education and poor health. The poor are powerless to influence the social and economic factors that determine their well-being (...or poverty) and have their legal rights violated all the time.

Unresponsiveness of state institutions and corruption are additional barriers to poverty alleviation. Needed are participatory mechanisms to prevent the domination by local elites.

Poor people define their poverty in terms of lack of opportunities, lack of power and lack of security. This broader definition of poverty requires a broader set of actions to fight it...

In international terms, industrial countries' protectionism causes annual losses in welfare of more than twice the amount of overseas development assistance.

(more to come)

Claudio
aviva@netnam.vn

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Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

PHA Exchange

RN
26/11

RN
26/11

Subject: PHA-Exchange> HIV and Infant Formula
Date: Fri, 23 Nov 2001 11:45:30 -0500
From: "S.Minkin" <smink@sover.net>
To: <PHA-Exchange@kabissa.org>

Dear PHA friends,

This is a letter I sent to the Editor of the New York Times after they published a very misleading headline endorsing infant formula. I'm very happy that the PHA exchange is back at work.

Steve Minkin

Letter to the Editor,

Your headline "Formula Supported for Mothers With HIV" (Nov 21) was totally misleading and dangerous. The study of HIV-positive Kenyan mothers, reported in the Journal of the American Medical Association, found 'there was no significant difference in death rates or various illnesses between breast-fed and formula-fed babies. " Significantly, breast-fed babies tended to have better nutritional status, especially during the first six months of life. Infant formula remains a major killer in developing countries, and the attempt to promote bottle-feeding as AIDS prevention in poor countries remains an ill-advised and often cynical marketing smokescreen.

Stephen F Minkin

PO Box 6073

Brattleboro, VT 05302

PHA Exchange file →

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26/11

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26/11

Subject: PHA-Exchange> We are up again!
Date: Fri, 23 Nov 2001 08:24:27 +0100
From: schulfanc@who.ch
To: pha-exchange@kabissa.org

Dear friends,
The list has been off almost 7 weeks. There were problems with the server in Washington. But it is all resolved now.
So please, start posting your news and interesting pieces again.
Cordially,
Claudio
(your moderator)

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

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23/11

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26/11

Subject: PHA-Exchange> BATA English newsletter
Date: Tue, 27 Nov 2001 16:32:59 +0600
From: wbb <wbb@pradeshta.net>
To: PHA-Exchange@kabissa.org

BATA Newsletter

(Bangladesh Anti-Tobacco Alliance)

(Note: the BATA English newsletter presents highlights only of the Bengali version.)

Press Conference on BAT's Youth Smoking Prevention Campaign

On the 13th of August, BATA held a press conference to discuss the true objectives of the youth smoking prevention campaign of British American Tobacco (BAT). The speakers, from Manas, the Consumers' Association of Bangladesh, and Work for a Better Bangladesh (WBB) exposed the intentions of BAT to improve its public image while drawing youth to smoking by portraying it as an adult behaviour.

Publication of report on the true objectives of BAT's Youth Smoking Prevention Campaign

On the 28th of July 2001, BAT launched its youth smoking prevention campaign, consisting of a 30-second TV spot, three one-minute radio scripts, and a billboard and sticker. In order to understand youth reactions to the campaign, WBB and Manobik conducted research with a group of 14- to 16-year olds, and a survey of 300 schoolboys under age 18. The results showed a high level of awareness of BAT cigarette advertising, and little positive about the youth prevention messages. The report is available in English and Bengali on WBB's website: http://wbb.globalink.org

Award of WHO Tobacco Free World Award Certificate

On the 29th of July at the WHO office in Dhaka, Sumiti Acharya presented BATA with a certificate to accompany the Tobacco Free World Award gold medal that was presented on World No Tobacco Day this year. Various BATA member organizations were present to celebrate the presentation.

New Tobacco Control Websites

WBB and BATA have recently set up their websites, with information about tobacco use and control in Bangladesh. In addition, PATH Canada's tobacco control resources, most of which have been produced jointly with WBB, are available on WBB's website. Our thanks to GLOBALink for its help in establishing the websites.
http://wbb.globalink.org and http://bata.globalink.org

Publication of "Hungry for Tobacco" in Tobacco Control

The September 2001 issue of Tobacco Control featured a photograph of a poor smoker in Bangladesh on the cover; the cover essay was written by staff of the World Bank on the issue of poverty and tobacco use; and ran the article "Hungry for Tobacco: an analysis of the economic impact of tobacco consumption on the poor in Bangladesh." The article illustrates the serious impact on malnutrition and poverty in general of the diversion of income to tobacco.

Divisional Workshops on Tobacco Control

Work for a Better Bangladesh organized workshops in Rajshahi in August and in Sylhet in September, to train NGOs, government officials, and members of the press about the need for tobacco control, and some ways to begin the work. Funded by the American Cancer Society, the workshops are being

conducted around the country to increase NGO and government support for tobacco control, and the

extent and effectiveness of BATA's national network.

Change of Address

Work for a Better Bangladesh and the
Bangladesh Anti-Tobacco Alliance have moved. The new address is:
House No. 49, Road No. 4/A
Dhanmondi R/A
Dhaka-1209, Bangladesh
Phone: (8802) 966-9781, 862-9273
Fax: (8802) 862-9271
WBB: wbb@pradeshta.net http://wbb.globalink.org
BATA: bata@pradeshta.net http://bata.globalink.org

BATA Acknowledges the financial and technical Support of PATH Canada

--
Work for a Better Bangladesh
House-49 Road-4/A
Dhanmondi, Dhaka-1209, Bangladesh
Ph- 880-2-9669781 Fax-880-2-8629271
E-mail-wbb@pradeshta.net
website: http://wbb.globalink.org

Subject: PHA-Exchange> Notice - Equal Recognition of Traditional Medicine Systems Needed
Date: Tue, 27 Nov 2001 10:47:07 +0800
From: kireenmm <kireenmm@tm.net.my>
To: pha-exchange@kabissa.org
CC: idris md <idrismd@tm.net.my>

Dear PHA friends,

NOTICE

EQUAL RECOGNITION OF TRADITIONAL MEDICINE SYSTEMS NEEDED

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

It was recently reported by a senior Singapore Government official that almost one in eight Singaporeans now prefers traditional medical treatment over established Western medicines. There were calls for increased research into these ancient cures. This is indeed laudable.

The WHO constitution has defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Traditional systems of therapy are closer to this approach to health. Their focus is on the maintenance of health and well-being through holistic means rather than symptomatic treatment.

Besides, Singapore, many other countries are already promoting and integrating traditional systems of medicine into their national healthcare and delivery systems. For instance, in China, traditional medicine systems are officially recognized and integrated into the healthcare system. Hospitals and colleges have been designated for the training in traditional systems.

India, last year, doubled its budget for the promotion of traditional medicine practices such as ayurveda, sidha, unani, naturopathy, Tibetan medicine and homeopathy. The Minister of Health has also requested all ministries to recognize traditional systems in the reimbursement schemes of medical expenses for employees in the government sector.

Malaysia, being a multiracial country, has a rich base of traditional systems of healthcare which include Malay, Chinese, Indian and indigenous medicine. These non-Western or traditional systems of medicine were practised before the advent of the colonial era. With the advent of colonialism, they were gradually sidelined in favour of the allopathic concept of medicine. However, efforts are now being made to revive these age-old systems.

Many of our healthcare systems today are grounded on the allopathic or modern concept of medicine. The emphasis on private curative health measures, sophisticated technology and expensive drugs has given rise to increasingly exorbitant medical costs and the incidence of medical errors. Shortages of manpower in the various health sectors compound the problem.

We need to let go of the present obsession with the modern system of medicine and turn to other systems that do not depend on this sophisticated technology and other expensive modes of treatment delivery. Authorities are called upon to do more to raise the level of traditional systems of medicine to an equal footing with modern medicine. Among the measures that must be given emphasis are:

- an equal recognition of traditional systems of health in the existing healthcare system
- active promotion of traditional systems of medicine by the Ministries of Health in their national health programmes
- the creation of a laws, under a separate Act, to regulate all aspects of traditional medical systems, including the registration of traditional practitioners
- the provision of grants, incentives and other support mechanisms for training, research and setting up of facilities
- the setting up of traditional medicine colleges within the existing university framework

RN 28/11

- the convening of national and international conferences on traditional medical systems to promote

Greater efforts are called for if we are to raise the status of traditional systems of medicine. Otherwise, these systems will continue to remain a "second class" healthcare option in the eyes of the medical personnel as well as the public at large.

Kiren

on behalf of:

S.M. Mohamed Idris,

President,

Consumers Association of Penang,

228, Jalan Macalister,

10400 Penang,

Malaysia.

Subject: Re: PHA-Exchange> Notice - Equal Recognition of Traditional Medicine Systems Needed
Date: Wed, 28 Nov 2001 08:47:08 +0100
From: "Ted Greiner" <ted_greiner@hotmail.com>
To: kireenmm@tm.net.my, pha-exchange@kabissa.org
CC: idrismd@tm.net.my

Friends,

I would agree that there is a great need for research on when and where traditional systems are superior and how to integrate them into modern health care systems. However, that is not the same as saying that when integration is achieved the patient's interests will always be served. Earlier this year in a review of how iron deficiency is being dealt with in China, I found that often the village doctors (who commonly provide both types of care) tend to offer traditional treatment with herbs (which tends to cost 150 yuan and is of uncertain efficacy) rather than iron tablets, which cost less than 4 yuan.

Regards,

Ted Greiner, Associate Professor

International Nutrition Research Group
Department of Women's and Children's Health
Uppsala University Academic Hospital, Entrance 11
751 85 Uppsala
Sweden
phone: +46 18 6115937
fax: +46 18 508013
email: Ted.Greiner@kbh.uu.se
or ted_greiner@hotmail.com
personal website: http://www.geocities.com/HotSprings/Spa/3156

----Original Message Follows----
From: kireenmm
To: pha-exchange@kabissa.org
CC: idris md
Subject: PHA-Exchange> Notice - Equal Recognition of Traditional Medicine Systems Needed
Date: Tue, 27 Nov 2001 10:47:07 +0800

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NOTICE
EQUAL RECOGNITION OF TRADITIONAL MEDICINE SYSTEMS NEEDED
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government sector.

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Ø the convening of national and international conferences on traditional medical systems to promote their importance and encourage further understanding of these health systems

Greater efforts are called for if we are to raise the status of traditional systems of medicine. Otherwise, these systems will continue to remain a "second class" healthcare option in the eyes of the medical personnel as well as the public at large.

Kireen
on behalf of:
S.M. Mohamed Idris,
President,
Consumers Association of Penang,
228, Jalan Macalister,
10400 Penang,
Malaysia.

Subject: Bhopal Remembrance Day on December 3rd
Date: Thu, 29 Nov 2001 12:47:54 +0530
From: "L.C. Jain" <lcjain@bgl.vsnl.net.in>
To: Ravi Narayan Dr. <sochara@vsnl.com>

Dear Dr. Ravi Narayan,

Thank you for your invitation letter of November 27, 2001 for Bhopal Remembrance Day on December 3rd.

I am so sorry. I cannot join you on December 3. I am in Delhi for Nata Duvvury's meeting on violence against women. All the best.

affectionately,

Devaki Jain

Devaki Jain
"Tharangavana"
D-5, 12th Cross,
RMV Extension,
Bangalore - 560 080.
Karnataka
INDIA.

Tel: +91-80-334 4113
Fax: +91-80-331 2395
E-mail: lcjain@bgl.vsnl.net.in

PHA-NCC file →

30/11/01

Dear Dr Devaki Jain

We shall miss you on the 3rd but please book 15th December afternoon - both of you since we propose to have a PHA Anniversary meeting in Bangalore - entitled Reaching the Unreached. But the unreached will be Government officials, policy makers, academics, researchers Rd Staff and students of medical colleges, social sciences and social work colleges and departments, NLSU, IIM, ISEC etc. Because they must be provoked and challenged by the Peoples Health Charter. A more detailed letter of invitation will follow after our Planning meeting on 3rd. The Advocacy with the PHA charter is going well. At National level we have submitted a strong letter comparing the draft Health Policy 2001 with the Peoples Health Charter to the Central Health Minister, Health Secretary and all the health secretaries in the country. At international level I presented it to 701 participants from 92 countries at the Global Forum for Health Research Meeting at WHO Geneva and now PHA has been invited to present it at the next World Health Assembly, May 2002. So the process goes on.

Best wishes Ravi

Subject: Re: [PHA2001] Comments on the future of the PHA
Date: Thu, 29 Nov 2001 00:30:11 +0600
From: Dr Qasem Chowdhury <gksavar@citechco.net>
Reply-To: PHA2001@yahoogroups.com
To: PHA2001@yahoogroups.com

Dear Stephanie,

Thanks for your reply before the deadline. You are absolutely right PHA movement should link the networks and other movements as we go forward to strengthen our collective efforts. I hope once our new structure is finalised we will move to develop the strategy for those linkages. Each working circle will have contact person who will link with regional and international circle on the same issue. This is the vertical linkage. The geographic circle will work together with the different working circle at national, regional and international level. People already express their interest to involve in different working circles.

Different country may have different issues to address. Each country will develop the national working circle first considering their National issues and later link up with the regional and international circle on the same issue.

With very best wishes.

Qasem

At 03:30 PM 11/27/01 +0200, you wrote:
>Dear Friends,
>
>Happy Ramadan! Warm wishes to everyone during this holiday season.
>
>We would like to offer our comments on the documents sent by Qasem,
>reporting on the October meeting in Dhaka on the ways forward for the
>PHA. We want to thank everyone for their hard work on the PHA, especially
>to the group that met in Dhaka and helped to formulate the new
>structures. The idea for the structures/circles sounds great, and our
>collective support and coordination will make them a success.
>
>We liked the tone of the proposal, and it is good that we are all in
>agreement on the basic values and principles behind our movement. In
>order to ensure that the proposed structures work properly, we should
>focus on linking the circles in order to make our work more comprehensive
>and to make sure that the geographic and working circles intersect
>properly. For example, the proposal states that one of our aims will be
>to "take root so that international bodies such as the WHO, WTO, UNICEF
>and World Bank listen to the People's Health Movement." Many
>organizations and individuals in different regions are already conducting
>advocacy work that targets these institutions, so it would be productive
>to link people's past and present work in these areas in order to work
>together in the future. We feel that linking with networks and movements
>is really essential, and that we have a huge potential for impact if we
>cooperate with different partners around the world.
>
>One additional thing we would like to add - it seems that the working
>circles are very broad at this point and we would have to narrow down
>which ones we wanted to work on, based on interest and participation. It
>seems that this geographic-working circle intersection could come into
>play here, as some regions might decide they would like to work in certain

RN 29/11

PHA-2001 file →

RN 29/11

>"working circles." But of course the working circles would remain open to

>
>Otherwise, we accept the proposal and thank you for all your efforts.
>
>Thank you,
>Stephanie M. Hansel
>Jihad Mashal
>UPMRC
>Palestine
>
>Yahoo! Groups Sponsor
>ADVERTISEMENT
>

>To unsubscribe from this group, send an email to:
>PHA2001-unsubscribe@yahoogroups.com
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>
>Your use of Yahoo! Groups is subject to the
><http://docs.yahoo.com/info/terms/>Yahoo! Terms of Service.

Subject: PHA-Exchange> Rethinking the terms of debates on Traditional Medicine Systems
Date: Thu, 29 Nov 2001 09:35:21 +0500
From: Madhulika Banerjee <madhulikab@vsnl.net>
To: "Ted Greiner" <ted_greiner@hotmail.com>, kireenmm@tm.net.my, pha-exchange@kabissa.org

Dear friends,

I was heartened to see the issue of Traditional medicines coming up in this public health programme. The key words about these nowadays are integration, efficacy and need for more research and support. Each one of these terms, particularly for those who understand not only politics of the issues of health but the politics of knowledge of medical systems everywhere, need to be understood very carefully.

I would like to share with everyone that I have been researching on precisely these questions for many years now, but within the confines of Delhi University, and not been able to publish much of it. I have carried out an extensive analysis of the postcolonial Indian government's policies in this arena and many of you may know that the historians of the colonial period in India have done extensive work too. My work has alerted me to how much the keywords in the current debate are products of the policies followed by modern states and international organisations. Take 'integration' for example. It is worth asking: what would be the terms on which integration happens? and why does it seem to be a given that the traditional medical systems would need to be integrated in to the modern healthcare systems? Given that the TM are older and in some ways wiser and also that the definitions of health seem to be having to move towads those already provided by them, rather than away or ahead of them, it is worth asking whether 'integration' shouldn't it be taking place the other way round.

The other, equally important question that needs to be understood in a complementary way to that of policy, is that of the market. How do the big 'herbal pahrmaceutical' companies influence the market and in what direction of usage of the systems do we think they are heading off to? Is mass production and proving the efficacy to modern doctors essential to the survival of Traditional Medicinal Systems?

I am currently finishing the first draft of a manuscript precisely on this subject-- all discussion would be welcome.

Regards,
Madhulika.

Madhulika Banerjee
XB4 Sahvikas Society,
68 I.P.Extension,
Delhi 110092. INDIA
Phones (work): +91-11-6499019
Answerphone (home): +91-11-2443430

RN
30/11

Subject: RE: Thanks for your prompt reply
Date: Thu, 29 Nov 2001 12:15:39 +0100
From: villara@who.ch
To: sochara@vsnl.com

Dear Ravi

I fully understand and agree with keeping "internally" the proposal, therefore I will keep it and respond to Dr. Qasem from Lima on any suggestion or comment.

What a pitty the books are taking longer but I ma sure they will arrive, but pls. let my secretary know since she will be here.

May I take this opportunity to thank you and wish you and your family and group the best for 2002!!

Do you know if someone from the PHA will attend the social (alternative) forum in Porto Alegre in Early 2002? This is the alternative to the Davos forum where I think the PHA should be present. maybe Maria Zuniga?

Saludos

Eugenio

-----Original Message-----
From: Community health cell [mailto:sochara@vsnl.com]
Sent: Thursday, 29 November 2001 03:58
To: villara; Qasem Chowdhury, Dr
Subject: Thanks for your prompt reply

Dear Eugenio,
Thanks for your very prompt reply and for collecting the books and posting them. I am looking forward to receiving them soon. About the attachment - They were sent to you as a PHA supporter for endorsement. Kindly send your views and endorsement to Dr. Qasem (GK-Savar) after you have read it in detail.
Regarding your circulating it within WHO - it may be better to wait till the endorsement procedure is over and all the PHA participants have had a chance too respond to the document. These were drafts. When the final one's are ready you can then circulate it after your return in January.
All the best. Keep in touch
sincerely
Ravi. CHC

PHA_2001

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29/11

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29/11

Subject: DATE FOR factfinding team to Warangal
Date: Fri, 30 Nov 2001 14:12:36 +0500
From: Madhumita Dutta <mdutta@vsnl.net>
To: sochara@vsnl.com, nityv68@vsnl.com, creind@hd2.dot.net.in, thanal@md4.vsnl.net.in, spadre@vsnl.com, davuluri_v@yahoo.com, 'tichennai@vsnl.net', 'bjcu@vsnl.com', 'bittusahgal@vsnl.com

THE TENTATIVE DATES FOR THE FACTFINDING TRIP IS 19TH-22ND DECEMBER, NOT NOVEMBER. I APOLOGISE FOR THE MISTAKE.
PLS. DO LET US KNOW ASAP ABOUT YOUR AVAILABILITY ON THOSE DATES.

[redacted]
THANKS
MADHU

>Date: Wed, 28 Nov 2001 17:15:31 +0500
>To: sochara@vsnl.com, Nityanand Jayaraman, creind@hd2.dot.net.in, thanal@md4.vsnl.net.in, spadre@vsnl.com, davuluri_v@yahoo.com, Toxics Link Chennai
>From: Madhumita Dutta <mdutta@vsnl.net>
>Subject: factfinding team to Warangal
>Cc: tlmumbai@vsnl.com, bittusahgal@vsnl.com, bjcn@vsnl.com
>X-Attachments: C:\My Documents\madhu\Background for factfinding team to Warangal.doc;
>
>Dear Dr Ravi Narayan, Nity,Jayan, Shree Padre and Dr Venkateswarlu,
>
>To investigate the recent pesticide exposure deaths in Warangal, AP, Toxics Link and Centre for Resource Education, Hyderabad is planning to form a factfinding team. I am attaching a background note prepared by Mr Narshima Reddy, CRE on the same explaining the objectives and outcomes of the factfinding team, dates etc.
>Please get back to us ASAP with your inputs and comments and whether you will able to join the team. We are trying to raise funds to cover your cost of travel and expenses during the visit.

[redacted]
>cheers
>madhu
>
>

Madhumita Dutta
Central Coordinator
Toxics Link
B 2 Jungpura, New Delhi 110 014
Phone: +91 11 4320711, 4328006
Fax: +91 11 4321747
email: mdutta@vsnl.net

To: JDI. RN
30/x1/01

Subject: Re: [PHA2001] People's Health Movement
Date: Fri, 30 Nov 2001 13:43:14 +0000
From: pamzinkin <pamzinkin@gn.apc.org>
Reply-To: PHA2001@yahoogroups.com
To: PHA2001@yahoogroups.com, PHA2001@yahoogroups.com

Dear Qasem and Maria
This is what I would like to do as well. I will add UPMRC comments, but I have not seen any others.
The hurry is that we need to have copies for our meetings on 4th and 5th of December.
Pam

At 08:40 PM 11/29/01 +0000, marham_99@yahoo.com wrote:
>*Dear Qasem, et al,*
>*We have reached the deadline for people to react to the proposals*
>*made by the group that met in Savar in October.*
>
>*I have read some comments, but am not clear on how many people have*
>*responded.*
>
>*Given that we have an important meeting coming up here in just a few*
>*days with PHA participants and movement people from Latin America,*
>*along with Andrew Chetley from The Exchange, I wondered if we might*
>*go ahead and share the structural ideas about how PHM could function*
>*in the future.*
>
>*Please advise Qasem. We want to respect the consultation process,*
>*but now we must get on with our future plans.*
>
>*Greetings to all of you out there.*
>
>*Cheers, Maria*
>
>
>
>*To unsubscribe from this group, send an email to:*
>*PHA2001-unsubscribe@yahoogroups.com*
>
>
>
>*Your use of Yahoo! Groups is subject to http://docs.yahoo.com/info/terms/*

Pam Zinkin tel:44 (0)20 7609 1005
pamzinkin@gn.apc.org fax:44 (0)20 7700 2699
45 Anson Road
London N7 0AR
UK

Date: Fri, 30 Nov 2001 08:20:14 +0530
From: "K. Kalpana and M. Balaji Sampath" <kb@eth.net>
To: <tnsf-friends@www.sidindia.org>

Dear Friend,

We had promised to send you newsletters about our work once every month - but this newsletter comes to you after a whole year and we apologize for this. Now there is a new team of volunteers in Chennai and we are better organized. Hopefully will be able to keep our promise of sending an update once a month regularly.

This newsletter - covering a year's work and also introducing TNSF to some of the new members - is a bit long. The regular newsletter which will come out once a month will be much shorter. Since many members on this list are from Chennai, one column of the newsletter will focus on activities in Chennai.

For some of you who are new to TNSF (or those who have forgotten us during this long silence), below we start with a short introduction to the TNSF before describing the activities of the previous year. We are also updating our website and moving it to a new location. We will send you information on this as soon as it is done. That will provide you with a lot more information about our activities.

Thank you for your support and good wishes.
Bye,
[redacted]alaji Sampath and Chandra Anil

The People's Science Movement ..

Movements are about ideas - ideas that shape society and change the way we live and think. Our freedom struggle showed us how colonial rule was making us dependent and weak. It showed us the strength we had within us to free ourselves. Democratic, Socialist and Women's movements have also changed the way we think and live. Building on this heritage, the Science Movement, adds a new dimension to these progressive ideas - a critical understanding of science.

The 20th century has made the role of science and technology central to how society works. Not just in production, economics and war, but also in shaping public opinion, in defining culture, in politics, in music, in government, today science plays a major role. Though it is easy to see how science impacts society, it is harder to see how society impacts science.

[redacted]w does society decide what a Newton sitting under an apple tree is thinking?

It is easy to see how vested interests influence politics and economics. It is harder to see this in science. Even in Newton's time, prevalent social ideas influenced the way science was done. This is much more true today, when science is no longer an individual pursuit. Science is a social effort funded and directed by governments. Why does Nuclear Research get more attention than Solar Energy? Who decides that the science of weapons needs more money than the science of agriculture? Why should government subsidize research that benefits only the rich? Why must we pour money into big dams instead of on local water harvesting efforts? These are questions of social choice and they decide what science is done.

We have a say in what science is done !

Long ago, it was felt that ordinary people needn't worry about government and politics - it was best left to kings. Today it is felt that science policy and research is best left to governments and scientists. Science affects all of us. Ordinary people should have an informed say in deciding what science is being done, how and why. This is the first [illegible]

Science Movement - analyzing policies, educating people and mobilizing public opinion on issues.

We do more than just critique state policy.

We also develop alternate models in literacy, education, health, enterprises and agriculture. Through these models we attempt to restructure science and technology so that even the poorest can use science - so that people depend less on specialists who exploit. Training teachers to use innovative teaching methods, training village women to use health information, training farmers to experiment and use science to improve soil - this then is the second agenda of the Science Movement. These programmes mobilize the poorest and put into practice the promise of science - improving living conditions of people.

Creating a Scientific Culture.

Thinking critically about science policy, using science in our daily lives and not getting fooled by superstitions - this requires a rational society. Explaining natural phenomena using science, countering harmful irrational beliefs and increased scientific awareness one hopes will lead to a more rational society. Creating a scientific culture is the third agenda of the Science Movement.

Thinking Globally and Acting Locally

Our strength lies in our ability to campaign on larger policy issues while at the same time demonstrating how these ideas actually improve the lives of the poor.

Our strength lies in our volunteers - working people who spend their spare time helping in schools, visiting villages, organizing programmes, training and raising funds.

A democratic structure ensures a participatory organization - volunteers see that they have a say in how things are done and therefore become more committed.

>From the pages of our history...

TNSF was started by a group of scientists from IIT and IMSc in 1980. By 1987, we were critiquing science policy, organizing science lectures, bringing out a Tamil children's science magazine, working with teachers on science education, doing slide shows in villages and publishing popular science books. Our members were scientists, insurance and bank employees and teachers from cities and towns.

Then the science movement discovered street theatre (Jatha) as a tool for social mobilization, and all over the country we organized village Jathas on a number of social issues - water, health, literacy, education, employment and gender. The response - tremendous! But when people came to us expecting solutions, we had very little to offer! We knew how chemicals destroy soil fertility - but we didn't know how to actually create a viable alternative!

It was now time for us develop and demonstrate alternatives.

>From talking literacy to actually doing literacy...

We developed the mass literacy campaigns, coined the word Arivoli and pushed the government into adopting this as the strategy for literacy. 1989-95 - TNSF was synonymous with literacy. In 8 districts we mobilized and trained people and organized literacy classes. In each district we reached 2000 villages, mobilized 20,000 teachers and 200,000 learners. Most volunteers and learners were women. In anti-arrack agitations, learn-cycle campaigns, employment programmes and credit networks, women participated in large numbers. The local vested interests (arrack shops, money lenders, quarry contractors) and even the government felt threatened. The Govt-TNSF [illegible] and we pulled out of the literacy campaigns.

"After literacy, what ?"

There were no easy answers - each district tried its own experiments. Kanyakumari and Virudunagar built self-reliant women's networks around savings and credit. These networks now have 40000 women who have together saved Rs. 2 Crores! Ramnad and Vellore started a health programme - training village volunteers to provide individual advice on children and women's health needs. Madurai experimented with enterprises for women, Pudukottai with quarry contracts for women's groups, Villupuram and Cuddalore with school drop-outs, Vellore with an activity based school and Ramnad with a support shelter for women victims of violence. Lots of experiments - some worked, many failed. Just like life evolved, ideas that worked began to spread.

And this bring us to the present...

We are now integrating and expanding the ideas that have worked. Self-reliant women's savings groups, community health programmes, libraries for women, rural IT centers, innovative teaching methods - are all ideas that we taking to new blocks. These block programmes demonstrate how science can be used by ordinary people, they demonstrate how even the poorest can plan their own development. These efforts also strengthen our ability to fight larger policy issues. Most importantly, these programmes save thousands of children from malnutrition, from dropping out of school, empower lakhs of women with credit and with enterprise and health skills and help farmers improve their soil and their yield.

These village programmes require corresponding work at the city - interacting with officials, writing reports, preparing training materials and arranging funds. We need volunteer teams who can work on these. The Friends of TNSF was formed to create a space for this - small but sustained efforts to support a block. Financial support is the easiest way to start, but soon this can expand to an active linkage with the block - visiting and providing other kinds of support.

This Year in TNSF

People's Health Assembly

This campaign mobilized 2000 organizations, reached 30,000 villages in 1000 blocks across the country - demanding Health for All. Five cartoon books presented our collective thinking on health issues. The books analyzed the failure of the existing health system, the changes that were needed and highlighted the need for a perspective that sees gender equality, education, employment and sanitation as necessary in ensuring health. The books - translated into 9 languages - served as basic campaign material. The campaign focused on the role of globalization in worsening the health status

of the poor. Village level enquiries into health status, followed by dialogues with the Govt health department were organized in many districts. A People's Health Watch to monitor the Govt has helped improve the utilization of health services.

The 8-month village level campaign, with rallies and state conventions in 20 states, culminated at Calcutta with 2000 delegates from all the districts attending the 2-day National Health Assembly and adopting the People's Health Charter. 300 Indian representatives then proceeded to Dhaka for the International PHA - 1500 people from 93 countries participated. This unique event reiterated the government responsibility in ensuring that health care reaches the poorest and the weakest sections. This is particularly important in the current context of reduced government spending on health, education and social programmes. A video on the PHA is available.

Arogya Iyakkam

This programme reaches 5 lakh people in 500 villages in 10 blocks. In each village, a trained health volunteer records the health status of children and advices mothers on feeding practices and diseases. She ensures that

simple curative services and maintains a village medical kit. She also helps the Govt nurse in immunization and antenatal care. A full-timer at the block trains and supports 10 such volunteers. A recent impact study found that 30 % more children in these villages improved because of the programme. This is a very significant improvement - and a number of agencies like the UNICEF have taken serious note of this approach. There is now a demand to expand the programme to new blocks and to other states.

Savings, Credit and Enterprises

Following the models developed by Kanyakumari and Virudhunagar districts, other districts have started self-reliant women's savings groups. The Arogya Iyakkam programme also helped create these in several blocks. Apart from easier access to credit, these groups also help women start enterprises. In many district in the last one year several small scale industries have been started - all run by women. Sandal Soaps, Fruit Jam, 'Computer Sambrani', Phenyl, Nutrition mix, paper bags, envelopes and covers, screen printing, ready made garments - the list is long. Many of these enterprises are still in their infancy. Product quality is very good and the cost is much less than market rates. But without funding and advertisement, it requires a committed people's marketing network to sustain this effort. Most of the selling is done locally, but we can help by selling some of the products in cities as well - to help do contact us.

Health, Savings and Enterprises are part of a larger plan for a women's movement. The plan includes libraries, work based continuing education, support shelters and legal aid for victims of violence.

Agriculture Programmes

In a dry wasteland in Sedapatti landless women improve soil fertility through fast growing trees. They then plant mango trees and use root zone methods to reduce the water needed. Still experimental, this has the potential to develop wastelands in south Tamilnadu - providing employment to lakhs of people. In Ramnad an innovative tank based water management programme has just been initiated. The impact of our first tank renovation programme in Pondicherry was so dramatic, that the government has asked us to lead the tank renovation efforts in the whole area. A soil fertility module has also been developed where bio-fertilizers replace chemicals. These efforts together form an integrated package on water, soil and crops that not only help poor farmers, but also make our life

environment-friendly.

Basic Education

The Thulir School in Latheri and the Non Formal Education centers for child labour in Sivakasi & Kanchipuram have been continuing. Villupuram's Universal Primary Education programme ensures school enrollment and provides support classes to help the weaker children. Aruna's recent study of the Govt DPEP will help us plan a larger education intervention. Teacher-networks in several places have been strengthened by Vizhuthu -a teacher's magazine.

Information Technology

IT is affects our lives is a big way - but the poor miss out on this revolution. Two reasons for this - access and appropriate applications. In our small way, we develop applications for the poor - in tamil. Pest and soil packages for farmers, software on animal husbandry, hand-pumps, health, educational opportunities and accounting packages for small savings networks. We are developing educational software for schools and have started 20 computer education and information centers in rural areas. This was possible thanks to the Association for India's Development and people like Sundar Balaguryan who have been donating computer parts and also helping coordinate the efforts.

Environment

[illegible] help from [illegible] have started [illegible]

leading a campaign against the use of non-recyclable plastics.

XVII Tamil Nadu People's Science Congress

This December Science Movement activists across the country will meet at Chennai to share experiences and to plan for the next two years. This 4-day event will give a flavor of the nation-wide science movement to new volunteers and also train activists on a number of field programmes - health, education, science communication, women's empowerment, agriculture, environment, etc.

Science Popularization & Science Education

12 Thulirs, 6 Jantar Mantars and a number of new science books were published. Statewide Thulir, JM quiz programmes and the Children's Science Congress were conducted. A science education campaign on sunspots was organized. In several places science clubs have been running and a 3-day Children's Science Festival in Chennai was organized in June. Teacher training programmes were also organized in several districts.

Campaigns

Apart from the PHA, we have been active in the anti-nuke campaign and in the recent campaign against introduction of B.Sc. Astrology in colleges. The UGC's introducing B.Sc in Vedic Astrology as a legitimate course has appalled thinking people everywhere. A belief in astrology is a matter of individual choice. But state funding to legitimize it as a science cannot be allowed - so we launched a campaign against this decision and have been educating people about the issue.

Activities in Chennai

We have a lot of new activities to report. The children's science festival at Olcott School generated a lot of new ideas in mathematics, physics and geography. Kids loved the sessions on origami, chemistry, drama, painting

as also the magic snow and the live snake demo by snake park.

Working with School Children

Taramani branch is running a library cum tuition center for 70 children. TNSF-SCM is running a science club in Taramani. HCL-NM Rd Branch organized a successful Metric Mela in T.T. Arasu School and runs a science and a maths club in the school. HCL-Greams Rd Branch has started 3 science clubs - 2 in Gopalapuram Girls High school and 1 in Sarada School. One of their volunteers, Vijay, started a mobile library in T.Nagar. Students from Stella Maris have been running a science club in Sewa Sadan. These clubs meet once a week for an hour, try out experiments using low-cost materials available at home and think science - education and fun at the same time! In 10 schools we organized slide shows on nuclear weapons, followed by a painting competition on "Peace, not War".

Working with Colleges

Stella Maris organized a number of video and slide shows to sensitize students on social issues. Some students are developing educational materials, charts and software for use in schools. Our IIT-Madras student branch also plans to work with schools.

IT, ECO, NCSC, Books, Soaps

Valmiki Nagar branch has started a computer center for women in the area. We now have 20 eco-clubs in the city. A teacher's workshop on the Children's Science Congress was organized and many children have registered their projects. We organized several book and toy sales - this needs more focused effort. For the coming month, we have planned teacher training and quiz programmes. We are selling products made by poor women - Sandal Soaps, Washing Powder, Fruit Jam, Computer Sambrani. These products are cheap, of good quality and help village industries - you can also help by buying and

selling these products.

We Need Volunteers !

You can start a branch in your area and work with a nearby school - organize education clubs and science festivals. It takes up very little time: 1 to 2 hrs/week is all you spare. As the group grows, you can expand your activities, raise funds, work with a village, etc. Do call a meeting of your friends and invite one of us to come and speak to you about it.

How Can I help ?

1. Make a donation. Post a crossed cheque payable to: Friends of TNSF to our address.
2. Volunteer for one of our programmes
3. Visit a block/village and write a report about the programme - if possible in a newspaper.
4. Form a branch - call your friends or office-mates for a meeting and invite one of us for the meeting to discuss various options.

Friends of TNSF
Tamilnadu Science Forum
[illegible], Aswai Shanmugam Salai
Gopalapuram, Chennai - 600086
Phone: (044) 8113830

Contact Persons
Chandra Anil (chandra@scmmicro.co.in)
Balaji Sampath (kb@eth.net)

1.0 AP 30/11/01

Subject: PHA-Exchange> World Forum on Food Sovereignty
Date: Sun, 2 Dec 2001 11:42:06 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

Final Declaration of the World Forum on Food Sovereignty
Havana, Cuba, September 7, 2001

For the peoples' right to produce food, feed themselves and exercise their food sovereignty.

We-some 400 delegates from peasant and indigenous organizations, fishing associations, non-governmental organizations, social agencies, academics and researchers from 60 countries met in Havana to analyze the reasons why hunger and malnutrition grow every day throughout the world, why the crisis in peasant and indigenous agriculture, artisanal fisheries and sustainable food systems has worsened, and why the people are losing sovereign control over their resources. We gathered to collectively develop viable alternatives for action on a local, national and global scale, aimed at reversing current trends and promoting new policies that can guarantee a hunger-free present and future for all men and women of the world.

Five years after the World Food Summit, seven years after the agricultural agreements of the Uruguay Round, and following two decades of the application of neoliberal policies, the promises and commitments made to satisfy the food and nutritional needs of all are far from being fulfilled. Actually, the economic, agricultural, fishing and trade policies imposed by the World Bank, IMF and WTO, and promoted by the transnational corporations, have widened the gap between the wealthy and poor countries and accentuated the unequal distribution of income within countries. They have worsened the conditions of food production and nutrition of the majority of the world's people, even of some in the developed countries. As a consequence, the right to food and nutritional well-being enshrined in the Universal Declaration of Human Rights, is not guaranteed for the world's poor.

The sustainability of food systems is not merely a technical matter. It constitutes a challenge demanding the highest political will of states. The profit motive has led to the unsustainability of food systems often surpassing the limits on production imposed by nature.

The hope for a new millennium free of hunger has been frustrated, to the shame of all humanity.

The real causes of hunger and malnutrition

Hunger, malnutrition and the exclusion of millions of people from access to productive goods and resources are not a result of fate, of geographical location or climatic phenomena. Above all, they are a consequence of deliberate policies that have been imposed by developed countries and their corporations to maintain and increase their hegemony within the current process of global economic restructuring.

In the face of the neoliberal ideology behind these policies we affirm that:

- Food is not a merchandise and that the food system cannot be viewed mainly according to a market logic.
* The liberalization of international agricultural and fishing trade does not guarantee the people's right to food.
* Trade liberalization does not necessarily facilitate economic growth and the well-being of the poor.
* The underdeveloped countries are capable of producing their own food

now and in the future if external constraints are lifted.

The neoliberal concept of comparative advantage negatively affects food systems. The importing of cheaper food commodities leads to the dismantling of domestic production and the reorienting productive resources towards export crops for the First World markets.

* Peasant, indigenous farmers and artisanal fisherfolks are indeed able to meet the growing needs of food production. Intensive industrial agriculture and fishing are ill-suited to solve the world's hunger problems.
* Current efforts to privatize agricultural and fisheries natural resources are steps in the wrong direction.
* Privatization leads, among other, to massive migration to the cities and abroad supplying cheap labor to corporations and exacerbating urban unemployment.
* Transnational food models being imposed threaten the diversity of peoples' food cultures.
* Developed countries use food as a weapon. We recognize the efforts of Cuba which, despite a four decades US blockade has managed to guarantee the right to food for all of its people.
* All of the above is taking place while we see a weakening of the real participation of the rural population in the discussion and adoption of public policies.

The consequences of neoliberal policies

* Developed countries have reaped most of the benefits while the peoples of the Third World have seen a growth of their external debt and heightened levels of poverty and social exclusion. The international agricultural market is cornered by a small number of transnational corporations while dependence and food insecurity is the reality for the majority of the rural poor.
* A number of countries continue to heavily subsidize their export crops giving no protection to small farmers who produce for the domestic market.
* Neoliberal policies are promoting a process of forced deruralization.
* Artisanal fishing communities have been increasingly losing access to their own resources.
* Hunger and malnutrition are growing, not because of an absence of food, but rather because of an absence of rights.

But the eradication of hunger and malnutrition and the exercise of lasting and sustainable food sovereignty are possible. We have seen in practically every country countless examples of sustainable food production in peasant and indigenous communities, as well as sustainable and diversified management of rural areas.

In view of the foregoing, the participants in the World Forum on Food Sovereignty declare:

1. Food sovereignty is the peoples' right to define their own policies and strategies for the sustainable production, distribution and consumption of food. This sovereignty centers on supporting small and medium-size producers; it respects farmers' own cultures and diversity and their own forms of fishing and agricultural production in which women play a fundamental role.
2. Food sovereignty is primarily oriented towards the satisfaction of the needs of the local and national markets.
3. The rights, autonomy and culture of indigenous peoples is a prerequisite for combating hunger and malnutrition as is the recognition of their right to autonomous control of their territories and natural resources
4. Food sovereignty further implies guaranteed access to safe and sufficient food for all individuals.

> Ravi Narayan
> Community Health Adviser,
> Community Health Cell
>

Re: PHA-Exchange> Rethinking the terms of debates on Traditional MedicineSystems

Subject: **Re: PHA-Exchange> Rethinking the terms of debates on Traditional MedicineSystems**
Date: Sun, 2 Dec 2001 08:06:06 +0530
From: "Mathura P Shrestha" <enhrn@mos.com.np>
To: "Ted Greiner" <ted_greiner@hotmail.com>, <kireenmm@tm.net.my>, <pha-exchange@kabissa.org>, "Madhulika Banerjee" <madhulikab@vsnl.net>

Dear Madhulika

Thank you for your e-mail and for your interest in the research in traditional and medicine.

However, the problem you mentioned lies not in concept, research or process of traditional medicine. The key problem is the imitation complexes. Some marketing practices used by the producers of so called traditional medicine have adopted or copied those from the MNCs of so called liberal market economy pushed by forces of globalization. In other words, they themselves are converts of MNC. They thus practice aggressive marketing and promotions. They promote consumerism and are equally profit oriented. Like any company these tend to glorify their products and put a lot of haloes around their products. In addition, they mystify their products and reap enormous profit out of ignorant consumers. Due to inherent weakness in western medicine and failure to embrace holistic aspects, some companies take Ayurveda and other formal or non-formal traditional systems as alternative gold mines for their hunt for profit.

The questions of research in traditional systems is to be seen from a paradigm different than that of western pharmacopeia. Traditional system is to empower the people in all matters of health - from knowledge/information to care. It is also to make them self reliant. Traditional health systems try to cut barriers between the providers and users of health services. Expertise and technological interphases too are to be as easily accessible as their neighbors or counselors. Unfortunately this has not been so with western medicine.

Similarly, the question of integration although looks nice on the surface will not solve the problem because of inherent biases, political and socioeconomic practices.

I think we need to open this important question for a greater debate. We need to involve all especially the consumers and people in the debate. This way we can hope to get nearer to both the truth and solution.

We have to bring information, sciences, technology closest to people's homes for the greater benefit as well to prevent misuse or harms out of these. We have to work for the rights of the people and to protect the people from the disinformation associated with advertisements, mystified glorification of the products and processes.

With regards,

Mathura P. Shrestha.

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

Subject: Re: PHA-Exchange> Rethinking the terms of debates on Traditional MedicineSystems
Date: Mon, 03 Dec 2001 03:55:54 +0000
From: "norman nyazema" <nnyazema@hotmail.com>
To: enhrn@mos.com.np, ted_greiner@hotmail.com, kireenmm@tm.net.my, pha-exchange@kabissa.org, madhulikab@vsnl.net

I could not agree with you more. Unfortunately you seem to have concentrated mainly on herbalism, which is only but a part of traditional medicinal practice. A system is also something very different. This may sound semantic, but think about it deply when debating about research.

Cheers

Norman

>From: "Mathura P Shrestha" <enhrn@mos.com.np>
>To: "Ted Greiner" <ted_greiner@hotmail.com>, <kireenmm@tm.net.my>,
><pha-exchange@kabissa.org>, "Madhulika Banerjee" <madhulikab@vsnl.net>
>Subject: Re: PHA-Exchange> Rethinking the terms of debates on Traditional MedicineSystems
>Date: Sun, 2 Dec 2001 08:06:06 +0530
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RN
12/4/01 10:26 AM

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Website:http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

Subject: PHA-Exchange> First aniversary of PHA in Bangladesh
Date: Mon, 3 Dec 2001 09:22:32 +0100
From: schuftanc@who.ch
To: pha-exchange@Kabissa.org

Dear friends,
It has been a year... Many good memories come back to those of us who lucky to be there. The spirit and the consciousness that we were bein of something important stand out in my memory. The world has perhaps for the worse since and the things we stand and fight for are perhaps to be a bit in the backburner for a while. But this is then a time to organize and project ourselves to positions of greater power in our j struggle for better health for all now. With the economic downturn th is experiencing, millions more are going to count on us for our renew activism. The PHA movement is alive and getting better organized. You be hearing more about it shortly.
Talk about this aniversary with others. Share your thoughts and exper with us in this list (which is reaching 500 of you).
Best wishes
Claudio
oderator)

RN 4/12

RN
4/12

Subject: PHA-Exchange> Neoliberalism worldwide (1 of 2)
Date: Tue, 4 Dec 2001 15:05:17 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

Ways in which Neoliberalism is Radically Redistributing wealth Worldwide by Jeff Gates (the author was once an official in the US Congress and then ran unsuccessfully for governor in Georgia as a Green).

1. The bottom and the top.

As the US is the leading advocate for the neoliberal/WTO model of globalization, the trends emerging in the US are instructive. The wealth of the 400 richest Americans grew by an average of $1.44 billion each from 1997-2000, for an average daily increase in wealth of $1,920,000 per person ($240,000 per hour or 46,000 times the minimum wage). The financial wealth of the top 1% of US households now exceeds the combined household financial wealth of the bottom 95%. The share of the nation's after-tax income received by the top 1% nearly doubled from 1979-1997. By 1998, the top-earning 1% had as much combined income as the 100 million Americans with the lowest earnings. The top fifth of US households now claim 49% of national income while the bottom fifth gets by on 3.6%.
In the 1970s, the average wealth of the 400 richest families was $200 million and the list included 13 billionaires. By 1986, the average wealth was $500 million. By 2000, $725 million in wealth was required for admission to a list where average wealth was $1.2 billion and the list included 274 billionaires.
Between 1979 and 1997, the average income of the richest fifth jumped from nine times the income of the poorest fifth to roughly 15 times. The average hourly earnings for white-collar males was $19 in 1997, and $19 in 1973. These results reflect the key distributional principle embodied in neo-liberalism and in the present version of globalization.

2. Democracies or plutocracies?

Today's capital markets-led development model is replicating US wealth distribution patterns worldwide. For instance, 61% of Indonesia's stock market value is held by that nation's 15 richest families. The comparable figure for the Philippines is 55% and 53% for Thailand.
Worldwide, there's now roughly $60 trillion in stocks and bonds. If the WTO succeeds in reviving the Multilateral Agreement on Investment, no member-nation could impose conditions on cross-border capital flows. Even without this, neoliberal rule-making will bring a future where a handful of the world's most well-to-do will pocket more than 50% of that $60 trillion in financial wealth. The neoliberal goal is for the forces of finance to operate unimpeded by public policy.

3. Producing for the common good or "skimming"?

Unsustainable production methods are now standard practice worldwide, due largely to globalization's embrace of a financial model that insists on maximizing net present value. That richly rewards those who reap in gains and disregard external costs (such as cleaning up the environment). Today's shareholder value-maximizing model leads managers to embrace short-sighted manufacturing practices worldwide: "Maximize financial returns and, trust us, everything will work out fine." US money managers now invest relying on that mechanistic model. This WTO-endorsed "money on autopilot" paradigm assumes that any increase in numeric value automatically adds to the common good.

4. Of the rich and the poor.

Today's version of globalization assumes that unrestricted economic flows will benefit the 80 percent of humanity living in developing countries as well as those 20 percent living in

developed countries. Yet UNDP reports that 80 countries have per capita incomes lower than a decade ago; sixty countries have grown steadily poorer since 1980. In 1960, the income gap between the fifth of the world's people living in the richest countries and the fifth in the poorest countries was 30 to 1. By 1990, the gap had widened to 60 to 1. By 1998, it had grown to 74 to 1. Meanwhile, the world's 200 wealthiest people doubled their net worth in the four years to 1999, to $1,000 billion (165 of the 200 live in OECD countries). Their combined wealth equals the combined annual income of the world's poorest 2.5 billion people. Three billion people presently live on $2 or less per day while 1.3 billion of those get by on $1 or less per day. With the global population expanding 80 million each year, World Bank President James Wolfensohn cautions that, unless we address this imbalance, 30 years hence we could have 5 billion people living on $2 or less per day. UNDP further reports that two billion people suffer from malnutrition, including 55 million in industrial countries. Current trends suggest that in three decades, today's version of globalization could create a world where 3.7 billion people will suffer from malnutrition. UNDP's assessment is that: "Development that perpetuates today's inequalities in neither sustainable nor worth sustaining."
In the 7 years since the passage of the North American Free Trade Agreement (NAFTA), 33,000 US farms with under $100,000 annual income have disappeared --a rate six times steeper than the pre-NAFTA period. During those seven years, farm income declined (in the US, Mexico and Canada) and consumer prices rose. Over that same period, the giant agri-businesses who pushed these policies reported record profits. Prosperity is not trickling down, as the assumption underlying globalization goes --it is trickling up.

5. Of oligopolies and monopolies.

Prior to the dot-com companies collapse, Wired Magazine projected Microsoft's Bill Gates would become a trillionaire by March 2005 and, by March 2020, a quadrillionaire (a million billionaire). We can look forward to a future where a single person could have more financial wealth than his/her entire generation combined. From 1983-1997, only the top five percent of US households saw an increase in their net worth, while wealth declined for everyone else. While the global economy grows 2 to 3% each year, transnational firms typically grow 8 to 10% annually. The 200 largest firms account for 28% of global economic activity while employing less than one-quarter of one percent of the global workforce. The wave of cross-border megamergers is fast concentrating economic power in megacorporations.

6. Climate change.

We must add to today's fast-widening economic gap the fact that industrial nations (located mainly in Northern temperate zones) are primarily responsible for the ongoing loss of natural capital elsewhere in the world. In its July 2001 report, the International Panel on Climate Change confirms that relentlessly rising global temperatures --due primarily to fossil fuel use in the world's 30 most developed economies-- are going to create catastrophic conditions worldwide. Agricuture, health, human settlements, water, animals --all will feel the impact on a planet that's warming faster than at any time in the past millennium: the poor of the world will be the hardest hit. With 4.5% of the world's population, the US accounts for 25% of the CO2 emissions that contribute to global warming.

(contd)

Subject: PHA-Exchange> neoliberalism worldwide (2 of 2)
Date: Tue, 4 Dec 2001 15:06:34 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

(contd)

7. When health clashes with wealth.

The financial benefits of globalized production practices are reaped predominantly by a financially sophisticated few while costs are usually passed on to the public. For instance, there's now 75,000-plus man-made chemicals in use worldwide; all end up somewhere. Where? More than 500 measurable chemicals are found in our bodies (they were not in anyone's body before the 1920s) probably causing a range of adverse health effects. `Civilized` governments have rules that imprison those who cause intentional harm to others. Yet WTO rule-makers object if lawmakers propose sanctions on managers who dump known carcinogens into the environment. To date, the WTO has ruled against every environmental and conservation law it has reviewed, dismissing each as a "non-tariff barrier."

8. Of free-trade, protectionism and debt.

OECD nations channel $326 billion a year in subsidies to their own farmers while (a) restricting agricultural imports from developing countries, and (b) insisting that debtor nations repay their foreign loans in foreign currency, which they can earn only by exporting. According to a World Bank study, the elimination of import barriers against textiles, sugar and a few other key exports of developing nations would raise their export earnings by more than $100 billion a year --enough, if those restrictions had been removed since 1982, to repay all debts presently owed. In other words, the richest nations have insisted that poor nations pay debts, but have refused the entry of goods offered in payment.
In 1999, leaders of the G-8 nations announced the debt reduction initiative for Heavily Indebted Poor Countries, aiming to cap debt servicing for each of the world's 41 poorest countries at 15-20 percent of export earnings. So far, these measures remain poorly enacted and results are yet to show real impact.

9. Of tax payers and tax evaders.

Financial experts report that roughly $8,000 billion of the wealth of the rich is hidden in tax havens worldwide, ensuring that many among the most well-to-do can benefits from globalization without incurring any of the costs. If WTO rule-making identified the owners of that $8 trillion, held in an estimated 1.5 million offshore corporations, this could generate $280 billion public revenue each year. That's 165 times the current budget for all UN development programs, or 93 times the UN's annual expenditure for peacekeeping operations. That's enough to build 140,000 schools at $2 million a piece. That's also the bulk of the $300 billion that environmental researchers report would be required to "save the planet."

10. Warfare or welfare?

UNDP identifies six core ingredients as minimal conditions for a decent life: safe drinking water (1.3 billion people lack access to clean water), adequate sanitation, sufficient nutrition, primary health care, basic education (one in seven children of primary school age is out of school), and family planning services for all willing couples. UNDP calculates the ongoing cost at $35 billion each year. That's about what the US spent in 1999 to maintain its nuclear readiness. For the world community to bear the annual cost would require 1/7 of 1% of global GDP. The US typically contributes roughly 0.09 percent of its GDP to foreign aid. Every jet fighter sold to a developing country costs the schooling of three million children. The cost of a submarine denies safe drinking water to 60 million people. The current US defence

budget tops $343 billion in annual outlays. According to FAO, more than 35,000 children die each day from conditions of starvation.

11. To add insult to injury, globalization is leading us from a world of diverse cultures to a monoculture.

12. Of markets, democracy, personal and financial freedoms.

To equate markets with the expression of the common will of people is misleading, even deceptive. Markets don't respond to people, but to people with money. Private enterprise is based on the sanctity of private property as a bedrock component of Western democracy. Yet for its legitimacy, private property depends on concentrating ownership in a way that endangers both private enterprise and democracy. In the US, unlimited personal cash outlays equate with the right to unlimited free speech and being elected to office. Both markets and democracies are based on the principle that people should have an influence on forces that have an influence on them. Today's economic model would strike Adam Smith, the father of free enterprise, as a freak of free enterprise. He assumed that financial capital would remain in the country where it originated. As we've discovered, over-reliance on today's neoliberal model is at the cost of lack of social effectiveness, lack of civil cohesion, lack of cultural diversity and environmental unsustainability.

13. Of job-holders and wealth-holders.

Industrial entrepreneurs pit the employed in the North against a global labor pool, so capital gravitates to wherever labour costs are lowest. Such labor-cost savings abroad show up back in the North as weakened consumer demand and record-breaking consumer debt. The pay gap between top executives and production workers in the 362 largest US companies grew from 42:1 in 1980 to 475:1 in 1999.

14. Of education and incarceration.

Since 1980, US prison outlays have increased at a pace six times faster than that for higher education. States spent roughly $25 billion on prison construction during the 1990s while annual operating costs for state and federal prisons totalled roughly $30 billion. In 1973, the US imprisoned 350,000 people nationwide. By early 2000, the prison population exceeded two million or roughly 687 people per 100,000 (6,926 per 100,000 for African-American men). Europe-wide, the imprisonment rate is 60 to 100 per 100,000. Florida now spends more on corrections than on colleges. California spent ten percent of its 2000 budget on prisons. On a typical day, one of every three African-American men ages 20 to 29 is either in prison, in jail or on probation/parole. 76% of African-American 18 year-olds living in urban areas can now anticipate being arrested and jailed before age 36. In 1865, African-Americans owned 0.5 percent of the nation's net worth. By 1990, their net worth totalled 1%.

15. From myth to reality.

Today's neoliberal-dominated perspective on progress insists that globalization has helped the US achieve two decades of unprecedented financial prosperity. Yet social, fiscal, cultural, political and ecological indicators confirm that the world's richest nation is experiencing a steady 20-year decline across a broad array of key quality-of-life indicators, and in numerous living systems.
Jeff Gates

Subject: PHA-Exchange> Thanks to Claudio
Date: Tue, 04 Dec 2001 15:42:53 +1030
From: Fran Baum <fran.baum@flinders.edu.au>
To: pha-exchange@Kabissa.org

Dear Friends

I would just like to thank Claudio for his inspiring words. Frank Tesoriero and I were sharing our memories of the PHA yesterday when we realised that a year ago we were at GK. It was an inspirational meeting and a great achievement that so many of us were able to come together and discuss our ideals for a world in which the struggle for health could be advanced and the dreams of better health and more equitable distribution of health throughout the world realised. Like Claudio I feel it is true that our dreams seem to be further away than ever. But the only times I can feel more optimistic for the future are when I feel the solidarity of friends and colleagues around the world. Then I know I am not a mad lonely voice!! So this list helps in reducing feelings of both loneliness and insanity!!

So thanks Claudio for reminding us of the dream of the PHA!

Best Wishes to everyone on the list for a merry festive season and a more optimistic, healthy and equitable new year!

Best Wishes

Fran Baum

Professor and Head
Department of Public Health
Director, South Australian Community Health Research Unit
Immediate Past President, Public Health Association of Australia

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Feb
5/12

Subject: PHA-Exchange> Revisioning/Remissioning
Date: Sun, 16 Dec 2001 10:52:57 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

Some food for thought again from Hanoi.

I am concerned about donors' transition from where they are now to where they need to move to as soon as possible to catch up with the 21st century.
The emerging paradigms in development work are now focused on two main approaches: on poverty alleviation and on human rights- based planning and acting.
The UN is already moving in that direction. It is a fait accompli.
The only way donors will all jump into the bandwagon before it is too late (and a new fashion comes flying by) is to do as many NGOs are now doing: holding serious Revisioning and Remissioning Retreats at executive and operational levels at their central and peripheral offices.
In these meetings they have to start with a (painful) self-criticism and ask themselves:
How have we been part of the problem and not of the solution?
Then, a thorough review of the new emerging paradigms above has to be done for all in the organization to standardize their understanding of the conceptual details of both; they then have to agree on what it will take to get there and what new commitments this will mean for the organization.
This is followed by a brain storm and final selection of the New Vision the organization sets for itself for a five and a ten years horizon (strictly addressing the key issues of the new paradigms!).
Agreeing on the objectives for a new mission based on the vision arrived at should then come easy.
The retreat itself, as an event, is crucial. It marks the breaking point for the old paradigm. If not tackled as an acute event, changes will linger and fade.
If well prepared, this can truly mark the beginning of a new era. A lot of what has been discussed in this list server would come up in the self-criticism.
Groups of committed consultants could specialize in the coming two yrs to facilitate such retreats for many different donor organizations and NGOs.

Claudio

Visit www.phamovement.org

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

Subject: PHA-Exchange> About Technical Cooperation (TC)
Date: Sun, 16 Dec 2001 11:29:20 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

From: <Profitinafrica@aol.com>

What TC looks like from a rural village resident's perspective:

> ..... TC looks like a Toyota Land Cruiser with a big agency
> sticker on the doors to announce who funded the vehicle;
>
> ..... TC looks like a big sign on a compound ..... inside a
> place to park the cars, a generator to give light, and drive the air
> conditioners and refrigerators ..... and a room with computers and
> copying machines;
>
> ..... TC looks like people coming to the village to ask
> questions ..... sometimes very polite and correct ..... usually very
> intrusive and arrogant ..... with lots of questions and questionaires;
>
> ..... TC never seems to ask about what is of priority and
> importance to our community. What we need is never on the
> agenda of the TC visitors.
>
> ..... TC people never seem to stay long enough to learn
> anything;
>
> ..... Some people stay a long time ..... but usually they are
> young and really do not have much understanding of the
> complexities of our life ..... and they never seem to know
> anything about our traditions and our values. We try to be polite, but
it is not easy when they are so demanding. We do not have much material
resource, but they want us to use it in ways that make no sense to us. When
they go it takes us a long time to get back to normal.
>
> ..... When we have the chance to talk to TC people it is clear
> that they offer absolutely nothing that will make a difference in our
> lives. In fact it is often the opposite. They create a legitimacy for
> government rules and regulations that are very damaging to our
> community economy;
>
> ..... When we talk about the big government programs (funded
> by World Bank) and others they are more interested in money
> made from export crops than in crops to feed our families. Export
> crops mostly impoverish our community. We only grow them
> because the government makes us. We have to use good land for
> these crops which could be better used feeding our people.
>
> ..... Credit programs ..... why do you make us buy a
> complete pack of items in order to get credit when we could buy
> just what we need and not have to throw out everything else. It
> really is very silly.
>
> ..... Womens programs ..... the women are the backbone of
> our community. We (the men) have to listen to them. Giving them

> more opportunity to work when they are already working
> enormously hard is maybe not a good idea.
>
> ..... Education ..... is very good ..... but most of us
> cannot afford the cost of fees and uniforms ..... and the school is a
> long way away. Educating girls ..... OK ..... but most of the
> boys are not getting schooling either;
>
> ..... What is the government doing? ..... well .....
> making it difficult to travel by doing nothing about the rural roads which
are awful;
>
> ..... Telephone, electricity? ..... they hardly have
> them in the cities ..... do you expect anything in rural areas?;
>
> ..... Health ..... it was getting better ..... the
> children could get primary health care when UNICEF teams would visit.
Government health programs have been getting worse and worse for the past
ten years (... since Structural Adjustment);
>
> ..... HIV-AIDS ..... yes we know ..... but what can we
> do about it? ..... and what about behavior change? ..... well what
change? ..... there are no condoms ..... there is child spacing to
> reduce family size, but that is not "safe sex" ..... and we do need
> large families in our rural environment;
>
> ..... Any questions? ..... yes ..... why do TC people
> and urban people come to our community and tell us what to do,
but will not ask us to tell them about our problems and what we
> might be able to do to solve them. Though we may not be able to
> read and write, we have lived in this situation for many generations and
we have learned a lot ..... we could learn more, but it would be nice to
learn something that has value in our community and in our situation.

> The above could go on ..... I hope I have been fair.
> Peter Burgess

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Subject: PHA-Exchange> State of the World's Cities Report 2001
Date: Sun, 16 Dec 2001 11:36:54 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

> *"State of the World's Cities Report 2001"*
The United Nations Center for Human Settlements (Habitat)
> *Available online as a series of PDF-files at:*
> *http://www.unchs.org/Istanbul+5/stateReport.htm*

> *"..... Three billion people - nearly every other person on earth -*
> *already live in cities. Today the planet hosts 19 cities with 10 million*
or more people; 22 cities with 5 to 10 million people; 370 cities with 1 to
5 million people, and 433 cities with 0.5 to 1 million people. By 2030, over
60 percent of the world's population (4.9 billion out of 8.1 billion people)
will live in cities.

> *Developed country cities are rapidly disappearing from the list of the*
world's largest cities. Between 1960 and 2000, Lagos, Dhaka, Cairo, Tianjin,
Hyderabad and Lahore, among others, joined the list of 30 largest cities in
the world. By 2010, Lagos is projected to become the third largest city in
the world, after Tokyo and Mumbai, Milan, Essen and London will disappear
from the 30 largest cities list, and New York, Osaka and Paris will have
slipped farther down the list by 2010.
>
> *The current worldwide rate of urbanization (that is, the percentage, per*
year, that the urban share of the total population is expanding) is about
0.8 percent, varying between 1.6 percent for all African countries to about
0.3 percent for all highly industrialized countries.
Urbanization of poverty is a growing phenomenon; it is estimated that
between one-quarter and one-third of all urban households in the world live
in absolute poverty.

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Feb
18/12

Subject: PHA-Exchange> Nestle Nutrition Institute for Africa
Date: Sun, 16 Dec 2001 14:21:54 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>
CC: "norman" <nnyazema@hotmail.com>

Dear Colleagues,

I would appreciate if you could share this email with everyone.

In the quote from Nestle's website they use the word "nutrition" to refer to infant formula. They claim that one of their formulas kills bacteria from contaminated water, and in a statement no doubt designed to further "the knowledge and pure joy of eating good food," inform readers that "The formula is now available in southern and eastern Africa."

I do not see that anything in the statement below, apparently signed by those NNI Board members who are not Nestle employees, that addresses these points, beyond referring to them as assumptions and allegations. The statements in my email were quotes from the Nestle website.

The NNI functionaries ask that future questions be sent directly to an unnamed person associated with the Institute, which no doubt would be preferable to messages like mine that go directly to the public. Although I am aware of the desperate financial situation African academics may now find themselves in, it is saddening to see some allowing their good names to be used by Nestle in its current efforts to exploit AIDS hysteria to further its marketing aims in Africa.

I would point out to anyone else who believes that the Nestle Company is a charity, that its shareholders would rightly not allow management to use its money for purely charitable purposes, even if they wanted to. Its job is to make a profit and breastfeeding obviously cannot contribute. The NNI, on the other hand, is no doubt expected to be a good investment in public relations.

Regards, Ted Greiner

Here is a quote revealing that Nestle misuses the word nutrition as a synonym for their commercial products: "The long term goal is to improve nutrition in southern and east Africa, in particular nutrition used in the HIV vertical transmission programme through infant formula," according to Ferdinand Haschke, Nestle's director of nutrition for southern and eastern Africa. Nestle is now openly claiming that one of its brands of infant formula "kills bacteria from contaminated water. The formula is now available in southern and eastern Africa." (http://www.busrep.co.za/html/busrep/br_frame_decider.php?click_id=343&art_id=qt20010802191035322N2523628&set_id=60) This is an obvious ploy to use unscientic arguments to promote artificial feeding throughout the countries where water is commonly contaminated, efforts which public health experts and the International Code of Marketing of Breast-milk Substitutes and relavant World Health Association Resolutions have frustrated for the past two decades."

----Original Message Follows----
> Names and affiliations of NNI:
> Prof. Gabriel Anabwani, MBChB, M Med (Paed), M.Sc. (Epid), Senior Consultant and Head of Paediatrics,

Princess Marina Hospital, Gaborone, Botswana.
>
> Prof. Ganapati Bhat, M.B.B.S, M.D, DCH, Head Department of Paediatrics & Child Health, University Teaching Hospital, Lusaka, Zambia.
>
> Prof. Peter A. Cooper, M.D, FC Paed (SA), PhD, Department of Paediatrics and Child Health, University of Witwatersrand & Johannesburg Hospital, Johannesburg, South Africa.
>
> Dr. Chand Domah, M.B.B.S; MD (Paed), Consultant Paediatrician, Flacq Hospital, Mauritius.
>
> Ms. Jane Downs, B.Sc.: Post Grad Dipl Hosp. Diet, B.Sc (Hons) Diet., Principal Dietician & Head of Department, King Edward VIII Hospital, Durban, South Africa.
>
> Prof. Demetre Labadarios, B.Sc. (Hons); MBChB, Ph.D, FACN, Head, Department Human Nutrition, Faculty of Health Sciences, University of Stellenbosch, South Africa.
>
> Dr. Joseph Kariuki Mbuthia, MBChB; M. Med, Chairman, Kenya Paediatrics Association, Gertrude's Garden Children's Hospital, Medical Advisory Committee, Nairobi, Kenya.
>
> Dr. Precious Moloi, MBChB, DCH, General Practitioner, Women's Clinic, Sandton Medcare Centre, Johannesburg, South Africa.
>
> Prof. Norman Nyazema, B.Sc. B.Sc (Hons), Ph.D, Department of Pharmacology, University of Zimbabwe, Zimbabwe.

Subject: PHA-Exchange> International Society for Equity in Health Newslet
Date: Sun, 16 Dec 2001 17:23:13 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

> *fyi . ..... There is a lot to report about ISEqH activities since our last*
> *Newsletter.*
> *As of September 30, 2001, we now have a permanent Secretariat, located in*
> *Toronto, Canada. The role of the Secretariat is to coordinate all* activities and carry out the daily business of the Society.
> *The contact there is Monica Riutort; her email address is*
> *iseqh.exec@utoronto.ca <mailto:iseqh.exec@utoronto.ca> .*
>
> *We are actively planning for our SECOND MEETING, TO BE HELD IN TORONTO ON* JUNE 14-16, 2002. (Visit our website for more information: www.iseqh.org.)
> *As a result of the successes of the Havana meeting last year, the schedule* of activities will be similar, but we will add some
additional workshops. Several excellent people have already volunteered to organize workshops, which will be on topics such as the potential for regional research collaborations, the particular role of health services in improving equity in health, and writing for publication.
>
> *Our first issue of the International Journal for Equity in Health (IJEqH)* should be ready by early spring. It will be an all-electronic journal, with all sections of the journal free to members of the ISEqH. (Non-members will be able to access the scientific articles free, but will have to pay for special sections such as bibliographies, review articles, abstracts, and the journal's own innovative sections.) At least 50 members have already signalled their intent to submit one or more papers within the next few months. The Journal will be part of the family of journals published electronically by BiomedCentral (see their website www.biomedcentral.com). BiomedCentral will be sending all members and contacts a notice about the IJEqH; if you would rather that we didn't give them your name, let us know.
>
> *We have greatly appreciated the grants recently received from the Pan* American Health Organization (PAHO), the March of Dimes Foundation, the Rockefeller Foundation, and the Soros Foundation. The grant from PAHO is to prepare for the next international meeting in June 2002 and to assure that the ISEqH website and other written communications are available in Spanish
> *as well as in English. The March of Dimes Grant is earmarked for* encouraging participation in ISEqH activities for those working in maternal and child health, especially perinatal issues. The Rockefeller grant is to provide financial assistance to people from poor countries to participate in ISEqH activities. The Soros grant is to provide financial assistance to people from central and eastern Europe and the former Soviet Union to participate in ISEqH activities.
>
> *At this time, we are urging you to do the following:*
> *- prepare a paper or papers to submit to the IJEqH. The uidelines for* formatting papers should be ready by November
> *- think about abstracts to submit for the Toronto meeting (due January 4,* 2002). Instructions will be available on the ISEqH website (www.iseqh.org) soon
> *- help in recruiting new members and attendees for the Toronto meeting.*
Please remember that there are several benefits of membership, including

Feb 18/12

the following:
> - reduced registration fee for the Society's international meetings
> - entire contents of Journal, without fee
> - updated bibliographies
> - representation in the only open international society devoted to
> developing knowledge and its application to improving equity in health
- linkages with colleagues worldwide who share interests and commitments to improving knowledge and its applicability to increasing equity in health
> As a result of the generosity of some of the members of ISEqH, we have some money to pay for the membership fee of individuals from developing countries who are unable to afford to pay it. If you know of anyone that you believe would fit in this category, please have them send me (by electronic mail) a statement of why they are requesting subsidized membership and what they have contributed or hope to contribute to the ISEqH as a member.
>
> We look forward to hearing from you with your reactions, thoughts, and new ideas.
>
> Barbara Starfield, MD, MPH
> University Distinguished Professor
> The Johns Hopkins Medical Institutions
- Fax 410 614 9046 - email bstarfie@jhsph.edu

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Subject: PHA-Exchange> Hunger to Harvest Resolution passes US Congress
Date: Fri, 14 Dec 2001 17:58:49 +0700
From: "Aviva" <aviva@nemam.vn>
To: <pha-exchange@kabissa.org>

> Hunger to Harvest Resolution passes US Congress
> ---
>
> Dear Friends of Africa:
>
> US House of Representatives just passed the "Africa: Hunger to Harvest Resolution" (H. Con. Res. 102). The companion measure passed the Senate last July (SConRes 53). The House has substituted the somewhat stronger Senate language requesting the Bush Administration to present Congress with a 5-year and 10-year plan to reduce poverty and hunger in Sub-Saharan Africa.
>
> In his remarks on the floor of the House, Rep. Payne noted that passage of this resolution signalled Congressional support the "New Partnership for African Development", the comprehensive, African-led, strategy brought forward under the leadership of the Presidents of South Africa, Nigeria, Senegal and Algeria.
>
> The bipartisan bill was introduced by Rep. Jim Leach (R Iowa) and Rep. Don Payne (D-New Jersey). 154 other members joined in cosponsoring the measure in response to a year-long national grassroots lobbying effort by Bread for the World members and partner organizations. Senator Chuck Hagel (R-Nebraska) and Patrick Leahy D-Vermont) introduced the Senate bill.
>
> BILL SUMMARY:
>
> Hunger to Harvest Resolution: A Decade of Concern for Africa - Expresses the sense of Congress that:
> (1) the United States should declare "A Decade of Concern for Africa" and commit to increased levels of effective, poverty-focused development assistance to sub- Saharan Africa until significant progress is made toward reversing current levels of hunger and poverty;
>
> (2) the President should work with the heads of other advanced industrial and sub-Saharan African countries, and with United States and sub-Saharan African private voluntary and other civic organizations, to increase development assistance to sub- Saharan Africa;
>
> (3) Congress should undertake a multi-year commitment with other donors to provide the resources necessary to cut hunger by one-half in that region;
>
> (4) such funding should support both bilateral and multilateral poverty-focused development efforts; and
>
> (5) the Administrator of the United States Agency for International Development should annually submit to Congress a progress report.
>
> WHAT'S NEXT?
>

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18/12

> *Throughout Fiscal Year 2003 U.S. budget cycle, Bread for the World*
> *and its coalition partners are determined to work with Congress and*
> *the Administration to begin to realize the goals of the Hunger to*
> *Harvest resolution. We will be actively pushing for new funding for*
> *poverty focused development accounts.*
>
> *We are also working with partners around the world to insist that in-*
> *creased long-term development assistance for Sub-Saharan Africa must*
> *be major outcome of the next G-8 Summit of the world's richest coun-*
> *tries.*
>
> *Thanks to everyone that continues to work on this campaign.*
>
> *Friends of Africa*
> *mailto:africa@bread.org*
>

Subject: PHA-Exchange> DAC Network on Poverty Reduction
Date: Fri, 14 Dec 2001 17:55:56 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

EVEN IF LATE CONSIDER APPLYING!!
Claudio

> DAC Network on Poverty Reduction
> ---
>
> Request for nominations of developing country participants
>
> Dear colleagues,
>
> My name is Joan Lennock and I have recently started working with Paul Isenman and Stephanie Balle at the OECD Development Co-operation Directorate on secondment from WHO to support the work of the POVNET Subgroup on Poverty and Health.
>
> I am pleased to inform you that the next meeting of the POVNET Sub group on Poverty and Health is scheduled for 20 February 2001 at the OECD in Paris. This meeting will discuss the next draft of the Report on Poverty and Health and a first set of reference papers prepared by Subgroup members for inclusion in the report. The agenda will be circulated early in the New Year together with the documents for discussion.
>
> At recent meetings, Subgroup members emphasized the value of involving partner countries in current efforts to produce guidance on aid effectiveness for pro-poor health. We would like, therefore, to propose inviting about ten developing country representatives to participate in the next meeting.
>
> We will rely on your own networks to identify potential participants and would be grateful if you could nominate personalities who would match the following criteria:
>
> Participants from both government and civil society who should combine expertise in poverty reduction and health and have a good understanding of the links between health outcomes and poverty reduction. In addition, they should be familiar with the key issues related to aid effectiveness. In considering potential participants, Members may wish to keep in mind the need for gender balance, geographic spread among countries and continents, and adequate representation from both central and local government. Civil society should be understood in the broadest sense to include not only development NGOs, but also elected nationals and local officials, representatives from academia, professional associations, private enterprises, and community organisations.
>
> We would greatly appreciate it if you could provide a short profile of the participants you suggest explaining the rationale for their

Lib 12/17

> selection as well as indicating their coordinates (e-mail, fax,
> phone, and address). This will greatly facilitate the final selection
> of participants and alternates.
>
> Due to the organisational demands of arranging this partnership meet
> ing, we would like to receive your nominations before 10 December so
> that invitations can go out prior to the Christmas holiday.
>
> We look forward to receiving your suggestions.
>
> Yours sincerely,
>
> Jean Lennock (Ms.)
> DCD/SMDC
> OECD
> 2, rue André Pascal
> 75775 PARIS CEDEX 16
> France
> Tel: +33-1-4524-1887
> Fax: +33-1-4430-6147
> mailto:Jean.LENNOCK@oecd.org
> http://www.oecd.org/
>
> --
> To send a message to AFRO-NETS, write to: afro-nets@usa.healthnet.org
> To subscribe or unsubscribe, write to: majordomo@usa.healthnet.org
> In the body of the message type: subscribe afro-nets OR unsubscribe
afro-nets
> To contact a person, send a message to: owner-afro-nets@usa.healthnet.org
> Information and archives: http://www.afronets.org

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Subject: PHA-Exchange> happy Eid/Hari Raya
Date: Wed, 12 Dec 2001 10:27:08 +0800
From: secr(@waba.po.my (World Alliance for Breastfeeding Action)
Organization: WABA
To: PHA-Exchange@kabissa.org

WABA would like to wish all Muslim friends a happy Eid/Hari Raya for the coming holidays from 16-18 December 2001.

Our office will be closed and will re-open on Weds, 19 Dec 2001.

Peace and goodwill to all!
The World Alliance for Breastfeeding Action (WABA) is a global people's initiative to protect, promote and support breastfeeding. WABA works in close liaison with the United Nations Children's Fund (UNICEF).
WABA, PO Box 1200, 10850 Penang, Malaysia
Tel: 604-658 4816 Fax: 604-657 2655 Email: secr@waba.po.my Website:www.waba.org.br
Website: www.waba.org.br

LSb
14/12

Subject: PHA-Exchange> Dec 4 many thanks to all
Date: Tue, 11 Dec 2001 15:56:54 +0000
From: Alifia Chakera <achakera@oneworldaction.org>
To: pha-exchange@kabissa.org

Dear Friends,

The conference Health for All : A Question of Social Justice was fantastic. Not just for the diversity of speakers but because of the breadth of experience, knowledge, energy and clear commitment to achieving 'Health for All' by the participants.

It was a wonderful opportunity to share ideas, network and galvanize more support for the PHA now the PHM

Usefully the UK press were interested with what we had to say, and a wider audience was introduced the PHM which is vital if we are to continue raise our profile to strengthen our work.

For those who do not know, the themes of the day were divided roughly into three areas looking at both domestic and global perspectives.

1. the impact of trade rules of health
2. the impact of privatisation of health services
3. Democracy, civil participation and influence in shaping health.

In addition to all of us learning a great deal from each other a number of useful actions were documented and the day fed into the PHM Europe meeting on the 5th.

A synthesis report from this event will be made available on the PHM website hopefully by mid January. Hard copies (fingers crossed) will be available probably by February.

In addition special thanks to people making the trip from all over Europe to London and all the many people who on the run up to the conference sent in participant contacts, ideas for the working agendas, helped with promoting the conference with the press (always tough) or made documents available that I would have had trouble getting in time with all my other admin. THANK YOU!!!!

Please note programme for Dec 4 is still accessible on One World Action's website and will be until the final report is out. www.oneworldaction.org

In solidarity,

Alifia Chakera

Register early for our conference Health for All: a Question of Social Justice. December 4, 2001
Speakers include : Rt Hon Alan Milburn, Professor Allyson Pollock of University College London and Karen Jennings Head of Nursing at UNISON. For full programme go to http://www.oneworldaction.org/

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Registered Charity No. 1022298

One World Action works in Europe and with partner organisations in poor countries to defeat poverty and to promote democracy and respect for human rights. Through such partnerships for change we are working for a just and equal world.

Subject: PHA-Exchange> A Long Road to Travel: Declaration on TRIPS at Doha
Date: Mon, 10 Dec 2001 18:04:08 +0100
From: "Gopal Dabade" <dabade_pal@yahoo.com>
To: <pha-exchange@kabissa.org>

Dear friends,
This is with referece to the article titled "A Long Road to Travel: Declaration on TRIPS at Doha" by Dr.Amit Sen Gupta.As far as my knowledge and understanding goes both compulsory licensing and parallel import are part of TRIPS - isn't it so? If it is so, why so much confusion and why does the conference in Doha "instruct the council of TRIPS to find an expeditious solution and present before 2002 end"?
Hoping to hear from you soon.
From:
Ms Sharada Gopal
Dr Gopal Dabade
Hassebrock 8A
D-33719 Bielefeld
Tel +49 (0)521 336 7723
Fax +49 (0)521 63789
dabade_pal@yahoo.com

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12/12

Subject: PHA-Exchange> Tobacco Control Treaty - Round three completed
Date: Thu, 6 Dec 2001 00:16:24 +0700
From: "FCA Secretariat" <FCTCalliance@inet.co.th>
To: <pha-exchange@kabissa.org>

Dear Friends at PHA

I am sure you are all keen to hear the updates on the world's first global treaty on tobacco control. I do hope you will take the time to give some thought to this issue as it is a lot more complex and important than it is given credit for. A legal product is killing four million people a year and its producers are getting away with virtually no regulation. If there was ever an issue which incorporated everything that PHA stands for then this is it!

REGIONAL POSITIONS: Overall progress was very good with strong positions from South and Southeast Asia, Oceania, the Pacific and Africa. Though containing countries with progressive tobacco control measures, the EU's involvement in the negotiations has been diluted by the weaker countries in the union, notably Germany. In the Americas Canada and the Caribbean were progressive with the US and Latin America generally poor. The Eastern Mediterranean (Middle East) region was generally strong however there was concern that tobacco industry pressure had kept some delegations away from the negotiations.

ISSUES RAISED: Strong support for comprehensive bans on tobacco advertising were noted, their was progress in regards to packaging and labelling requirements and many voices of support for health to be specifically placed above trade in the treaty language (this is a very important debate given its implications for other movements).

TOBACCO INDUSTRY OPPOSITION: The tobacco industry has been increasing its activities through indirect approaches including through the International Tobacco Growers Association (ITGA) and through journalists (many of whom turn out to be on the payroll of tobacco companies).

NGO MOBILISATION: The need to inform and obtain the support of the broader NGO community was noted by some tobacco control NGOs, some of whom are perplexed about the seeming disinterest in the FCTC by groups that should be interested by virtue of their platforms.

I urge you to look at our website and take the time to become more familiar with tobacco control and the FCTC. I am always willing to answer questions etc if you have any.

Sincerely,
Belinda Hughes
Coordinator
Framework Convention Alliance (FCA)
www.fctc.org
Tel: (66-2) 278 1828 or (66-2) 278 1829
Fax: (66-2) 278 1830

The Framework Convention Alliance is an alliance of NGOs from around the world committed to a strong global treaty to control tobacco for the health of all people.

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10/12

Subject: PHA-Exchange> TRIPS + the Doha Declaration - what you need to know
Date: Wed, 5 Dec 2001 16:57:33 +0100
From: schuftanc@who.ch
To: pha-exchange@kabissa.org

You will find this useful.

A Long Road to Travel: Declaration on TRIPS at Doha.

Dr.Amit Sen Gupta, Jana Swasthya Abhiyan (Peoples Health Movement),India.

The Doha meeting of the WTO adopted a "Declaration on the TRIPS Agreement and Public Health". The declaration has been hailed as a landmark in the negotiating history of the World Trade Organisation. In a way it is a landmark because this is the first time, since the signing of the WTO Agreement in 1994, that a portion of that agreement has been interpreted in a manner that is favourable to developing countries. While there is a need to recognise the significance of this, there is also the need to examine the events which led to the adoption of the declaration. Also, we need to understand how much has really been gained by the adoption of the declaration.

History of the TRIPS Accord
The Trade Related Intellectual Property Rights (TRIPS) agreement, signed as a part of the WTO agreement, was the most bitterly fought during the GATT negotiations. Till 1989, countries like India, Brazil, Argentine, Thailand and others had opposed even the inclusion of the issues of TRIPS in the negotiating agenda. They did so based on the sound argument that Intellectual Property Rights -- which includes patents over medicines -- is a non trade issue. India and others had argued that rights provided in domestic laws regarding intellectual property should not be linked with trade. They had further argued that the history of IPRs shows that all countries have evolved their domestic laws in consonance with the stage of economic development and the development of thei science and rechnology capabilities. Laws that provide strong patent protection limit the ability of developing countries to enhance their S&T capabilities and retard dissemination of knowledge. Japan, for example, was able to enhance its domestic capabilities through the medium of weak patent protection for decades -- well into the second half of the twentieth century. Italy changed to a stronger protection regime only in 1978 and Canada as late as in 1992. It was thus natural that many countries like India had domestic laws that did not favour strong protection to patents before the WTO agreement was signed. It was illogical to thrust a single patent structure on all countries of the globe, irrespective of their
stage of development.

These arguments were however systematically subverted during the GATT negotiations, leading to the signing of the TRIPS agreement. The TRIPS agreement required countries like India to change over to a strong patent protection regime, a regime that would no longer allow countries to continue with domestic laws that enabled domestic companies to manufacture new drugs invented elsewhere, at prices that were anything between one twentieth and one hundredth of global prices. It may be recalled that it was the 1970 Patent Act which, by encouraging Indian companies to develop new processes for patented drugs, also facilitated the development of world class manufacturing facilities in a developing country like India.

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fifteen companies with the highest profits, six are pharmaceutical companies - Microsoft, Cable and Wireless, DuPont, Eli Lilly, Glaxo Wellcome, the Roche Group, Bristol-Myers, Squibb, Novartis and Pfizer. Five are from the information technology sector, Microsoft, Cable and Wireless, Telefonos de Mexico, Intel and Textron. Yet, none of these figure anywhere among the top 100 in terms of turnover.
Microsoft is 216th in the list in terms of turnover, but has the highest return on revenues (39.4%). Clearly rent incomes, today, are one of the major driving forces of the economies of the developed countries.

Setback to Pharmaceutical Companies
In 1995, the pharmaceutical MNCs seemed to be sitting on top of the world. Unanticipated by them, a major development in the field of health care set in motion a chain of events. The AIDS epidemic was fast gripping the imagination of the global community. In the nineties, almost all of Africa was under the grip of this epidemic. In some countries, an estimated third of the adult population are infected by AIDS! The tragedy was compounded when drugs to contain AIDS started being developed. These drugs allowed AIDS patients the opportunity to live normal lives even
if they were infected. But there was a catch. Because of patent protection, these drugs were priced beyond the reach of patients in developing countries. The ridiculous effect of patent protection was evident when one found that the cost of treating AIDS patients in some African countries was many times their total GNP! Even more ridiculous, and tragic, when we know that these drugs can be produced at one fortieth of prices being charged by MNCs.

AIDS became a rallying point for activists from all parts of the world and developing country governments alike. In a few years, one saw the forging of an unparalleled global coalition. Countries like Brazil and Thailand defied the TRIPS agreement and allowed domestic companies to produce cheap anti-AIDS drugs. South Africa changed its laws to allow imports of cheap anti-AIDS drugs. The MNCs and the developed countries struck back. 39 pharmaceutical companies challenged the South African law in the country's court of law. Brazil was dragged by the US to the WTO appellate body for infringement of TRIPS. But the tide was clearly turning. In the face of mounting criticism and hostile reactions towards the pharmaceutical industry, the industry and its sponsors were forced to step back. The companies were forced to withdraw their case in South Africa and the US did not proceed with its dispute with Brazil in the WTO.

The coalition that was built around the AIDS issue then pressed for clarifications from the WTO that the TRIPS accord did not prevent country governments from legislating in favour of protection of public health. In this they were supported by almost the entire community of developing nations. The industry fought to the last to prevent this. In the draft declaration circulated in September, the US and other developed countries tried to limit any clarification to just measures related to AIDS. But the momentum of the global movement was able to increase the scope of the declaration to include public health crises not limited only to AIDS.

What has Been Achieved
Let us now turn to what has been achieved by the declaration. Contrary to popular perception, the declaration in no way changes the TRIPS accord. It does not even say that the accord needs to be renegotiated. In that sense, it is really in the nature of a clarification, stating what can be done by countries to safeguard public health while not at the same time infringing

Today the campaign on access to drugs draws strength from Indian companies like Cipla who are offering anti-AIDS drugs at one tenth to one fortieth of the prices being charged by large pharmaceutical countries. It also draws strength from the ability of Brazil to indigenously manufacture 8 out of the 12 anti-AIDS drugs and also to distribute them to all those who require these drugs. Let us not forget that this could not have happened if the TRIPS accord had been signed in 1976 and not in 1995! It is this that we stand to lose as we move towards "harmonised" standards of strong patent protection.

Importance of the TRIPS Accord

Implications of a product patent regime are not limited only to the area of technological self reliance. Technological dependence on MNCs is the proverbial "thin edge" which will be used by the MNCs to establish their sovereignty over the Indian Drug market once again (a position they had lost after the mid seventies). They will then again start charging exorbitant prices for drugs in the Indian market. Since the early eighties, the categories of drugs which show the maximum rise in sales are categories which include overwhelming majority of drugs still under Product Patent or w[redacted]se roduct patents have expired recently. In other words, if we had a product patent regime today, the drugs showing fastest growth would have been priced way beyond the capacity of the average consumer.

It must be understood that, notwithstanding the rhetoric, the TRIPS accord was not pushed through just to access markets of developing countries. These markets represent just a fraction of the global market - India, for example, accounts for 0.8% of the market, in contrast to 33%, 24% and 20% for the US, Europe and Japan respectively. Rather, the TRIPS agreement became a necessity
to protect the markets of large pharmaceutical companies in the developing world against competition from cheaper generic drugs manufactured in countries like India and Brazil. TRIPS in other words is not about "free" trade, but has to do with protection of markets in developed countries. In order to safeguard this market, giant pharmaceutical companies railroaded all
opposition and forced the signing of the TRIPS accord. The draft which formed the bases of the accord was prepared by industry representatives from the US, Europe and Japan.

T[redacted]ere were other compelling reasons why developed Capitalist countries, led [redacted] the US, exerted such enormous pressure during the GATT negotiations to ensure that the TRIPS agreement was pushed through. In the mid-80's, the United States was faced with waning industrial competitiveness which hurt U.S. companies and U.S. trade internationally. As a consequence, it began searching for new areas of commerce which would maintain U.S. dominance in the world market. Around this time several intellectual property dependent industries, namely information technology, entertainment (records, films and books) and pharmaceuticals were becoming extremely important
contributors to the U.S. economy. All these sectors were heavily IPR dependant as they dealt in products of which the development costs were high, but the replication costs were small. These were sectors where, in order to maintain high levels of returns, monopoly incomes had to be protected through the mechanism of strong Intellectual Property Protection.

The importance of the knowledge-based sectors to the US (and global) economy can be gauged from the performance of large companies today. Among the top

the TRIPS accord. Thus the declaration says: "Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all". Clearly, the intent is still to maintain that the TRIPS accord is inviolable and at the same time say that the accord allows certain measures to safeguard public health. Specifically, the declaration clarifies that countries can issue compulsory licenses when faced with a health crises or emergencies. It further states that: "Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted". It must be understood that such clarifications do constitute an advance because, in the past, the US has tried to prevent countries like Brazil and Thailand from doing exactly what the clarifications now says is perfectly compatible with TRIPS.

In concrete terms, this means that countries can provide a license to produce life saving drugs to domestic companies, even if patents for these drugs are held by foreign patent holders. But this is still far short of what the 1970 Patents Act of India allowed. Our Patents Act did not allow patents to be held for any product, irrespective of whether they were required to address
any health crisis or not. It is this provision that allowed the development of a domestic drug industry and also the development of an R&D base in the pharmaceutical sector. It needs to be realised that what may be construed to be drugs "that are required to address emergencies" will always constitute a small fraction of the total number of drugs manufactured. Hence MNCs will be able to control the production and distribution of a majority of drugs. This means that Indian companies will not have the unhindered freedom that the 1970 Patents Act provided. In the long run, this will have an impact on the balance in the pharmaceutical sector, allowing the MNCs to once again assume a dominant position. Moreover R&D and manufacturing capabilities are built over a period, and cannot be suddenly switched on when "emergencies" arise. Restricting the space in which domestic companies can operate to produce newer drugs will have an adverse impact on their manufacturing and R&D capabilities, as well as R&D capabilities built up in the public sector.

The declaration falls short of requirements in another key area. It says that: "We recognize that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002". Most developing countries, unlike India, have no manufacturing capability. So the declaration does not enable them to access cheaper drugs because they cannot get these drugs produced cheaply in their country. The declaration does not explicitly allow them to import cheaper drugs from countries like India.

A Long Road to Travel

There is a long road to travel before it can be claimed that the TRIPS accord has been successfully undermined. What we see today is a small corporate retreat in the face of hostile global reaction. The issue of access to AIDS drugs is, arguably, the weakest link in the TRIPS accord and the emerging global patenting system. The tremendous evocative appeal of the "Access Campaign to AIDS Drugs" lends it the potential to delegitimise the TRIPS agreement.

However, to effectively strike at the "weakest link", the campaign around

access to cheap medicines has to look beyond AIDS or even beyond "health emergencies" and beyond the TRIPS framework. The "access campaign" must eventually extend to cover access to all essential medication and draw-in interest groups from across the globe. The campaign needs also to look beyond the TRIPS framework. While arguing for a more "liberal" interpretation of the TRIPS language to ensure better access, it is also necessary to understand that the TRIPS agreement was arrived at on the basis of submissions of the pharmaceutical industry. It is an agreement designed to promote monopolies and hinder competition. The campaign needs to look beyond TRIPS, and use the present momentum to force that the TRIPS agreement be interpreted in a manner that promotes competition and technology dissemination. The minimum that such an interpretation must recognise is the automatic invocation of provisions that promote competition in all markets, and curb the monopoly over knowledge that the present TRIPS regime is interpreted to allow.

Finally, we need to note that India is a late entrant in this recent fight against TRIPS. After abandoning the ship in 1989, we seem to have just got on board again. In the last few years, India's voice was not heard clearly with those of Brazil, Thailand and the large group of African countries. This was evident even in Seattle in 1999. The Access Campaign will be hoping that the
Indian negotiating team's perseverence in Doha was not merely an attempt to play to the gallery.

[redacted]-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

Subject: Re: PHA-Exchange> Thanks to Claudio
Date: Wed, 5 Dec 2001 11:39:04 +1100
From: "Prue" <hcca@tpg.com.au>
To: <pha-exchange@kabissa.org>, "Fran Baum" <fran.baum@flinders.edu.au>

Dear All
On the anniversary of the PHA Health Care Consumers Association ACT, organised a Playback Theatre Performance at the Canberra Hospital titled " Hospital Stories". Playback Theatre is improvisational theatre where audience members tell stories from their lives and then watch as actors and musicians enact them without script or rehearsal.The 2 performances were very moving and many stories were told from those who had experienced the hospital system and a smaller number from Health professionals. I was reminded of the the Assembly and the many stories I heard last year which I won't forget and which has inspired our work here in the ACT to highlight these, with those who plan health services.--
Best wishes

Prue Borrman
Coordinator
Health Care Consumers Ass ACT
[redacted]berra
[redacted] 62901660
hcca@tpg.net.au
--- Original Message -----
From: Fran Baum <fran.baum@flinders.edu.au>
To: <pha-exchange@kabissa.org>
Sent: Tuesday, December 04, 2001 4:12 PM
Subject: PHA-Exchange> Thanks to Claudio

> *Dear Friends*
>
> *I would just like to thank Claudio for his inspiring words. Frank* Tesoriero
> *and I were sharing our memories of the PHA yesterday when we realised that*
> *a year ago we were at GK. It was an inspirational meeting and a great*
> *achievement that so many of us were able to come together and discuss our*
> *ideals for a world in which the struggle for health could be advanced and*
> *the dreams of better health and more equitable distribution of health*
> *throughout the world realised. Like Claudio I feel it is true that our*
> *dreams seem to be further away than ever. But the only times I can feel*
> *[redacted]more optimistic for the future are when I feel the solidarity of friends*
> *and colleagues around the world. Then I know I am not a mad lonely voice!!*
> *So this list helps in reducing feelings of both loneliness and insanity!!*
>
> *So thanks Claudio for reminding us of the dream of the PHA!*
>
> *Best Wishes to everyone on the list for a merry festive season and a more*
> *optimistic, healthy and equitable new year!*
>
> *Best Wishes*
>
> *Fran Baum*
>
> *Professor and Head*
> *Department of Public Health*
> *Director, South Australian Community Health Research Unit*
> *Immediate Past President, Public Health Association of Australia*
>
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Subject: PHA-Exchange> Re: report on PRSPs and health
Date: Fri, 21 Dec 2001 18:16:00 -0100
From: ellen.verheul@wemos.nl
To: <pha-exchange@kabissa.org>

Dear all,

Wemos published a briefing paper 'Poverty Reduction Strategy Papers: what is at stake for health?', for civil society organisations and health policy makers. It provides background information on the potential impact of PRSPs on health and encourages debate on health issues that need attention in the development and implementation of PRSPs.

PRSPs offer both challenges and pitfalls for health improvement in low-income countries. The strategies should be country-owned and developed with civil society participation, linking poverty reduction to structural and macro-economic policies. PRSPs are a condition for debt relief and soft loans from the World Bank and IMF.

The paper can be downloaded at:
http://www.wemos.nl/documents/%20paper.pdf

Season's greetings,

Ellen Verheul

Wemos is a Dutch NGO lobbying and campaigning on health and development issues.

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Heb
27/12

Subject: Re: PHA-Exchange> Nestle Nutrition Institute for Africa
Date: Tue, 18 Dec 2001 10:24:43 +0000
From: "norman nyazema" <nnyazema@hotmail.com>
To: aviva@netnam.vn, pha-exchange@kabissa.org

Dear Ted,

I am sure you have noticed that I am one of those people who are on the NNIA board. I am on it because of my consumer activism. As a board we have taken to task the company of the alleged statement on the anti-microbial activity of one of its products and have also queried it from a clinical pharmacologic point of view. I am with the Zimbabwe's drug regulatory authority and would query that claim if it appeared on their product in Zimbabwe.

As an active researher in HIV/AIDS, and in breastfeeding and HIV/AIDS in particular, I can assure you that I am not on the board as anyone's poodle. I certainly do not need the money. We have made it clear to the company that we have our integrity to protect. As a clinical pharmacologist I have had my experience from the drug industry who are now being regarded as partners in the fight against HIV/AIDS. I use the same philosophy and thought process when dealing with both industries.

Anyone who has any queries regarding NNIA, please do not hesitate to contact me. I encourage you to raise any questions

I just want to let you know that I accepted the board appointment with my eyes open.

Cheers

Norman Z. Nyazema
>From: "Aviva" <aviva@netnam.vn>
>To: <pha-exchange@kabissa.org>
>CC: "norman" <nnyazema@hotmail.com>
>Subject: PHA-Exchange> Nestle Nutrition Institute for Africa
>Date: Sun, 16 Dec 2001 14:21:54 +0700
>
>
>
>Dear Colleagues,
>
>I would appreciate if you could share this email with everyone.
>
>In the quote from Nestle's website they use the word "nutrition" to refer
>to infant formula. They claim that one of their formulas kills bacteria
>from contaminated water, and in a statement no doubt designed to further
>"the knowledge and pure joy of eating good food," inform readers that "The
>formula is now available in southern and eastern Africa."
>
>I do not see that anything in the statement below, apparently signed by
>those NNI Board members who are not Nestle employees, that addresses these
>points, beyond referring to them as assumptions and allegations. The
>statements in my email were quotes from the Nestle website.
>
>The NNI functionaries ask that future questions be sent directly to an

>unnamed person associated with the Institute, which no doubt would be
>preferable to messages like mine that go directly to the public.
>Although I am aware of the desperate financial situation African academics
>may now find themselves in, it is saddening to see some allowing their good
>names to be used by Nestle in its current efforts to exploit AIDS hysteria
>to further its marketing aims in Africa.
>
>I would point out to anyone else who believes that the Nestle Company is a
>charity, that its shareholders would rightly not allow management to use
>its money for purely charitable purposes, even if they wanted to. Its job
>is to make a profit and breastfeeding obviously cannot contribute. The NNI,
>on the other hand, is no doubt expected to be a good investment in public
>relations.
>
>Regards, Ted Greiner
>
>Here is a quote revealing that Nestle misuses the word nutrition as a
>synonym for their commercial products: "The long term goal is to improve
>nutrition in southern and east Africa, in particular nutrition used in the
>HIV vertical transmission programme through infant
>formula," according to Ferdinand Haschke, Nestle's director of nutrition
>for southern and eastern Africa. Nestle is now openly claiming that one of
>its brands of infant formula "kills bacteria from contaminated water. The
>formula is now available in southern and eastern Africa."
>(http://www.busrep.co.za/html/busrep/br_frame_decider.php?click_id=343&art_i
>d=ct20010802191033322N2523628&set_id=60) This is an obvious ploy to use
>unscientic arguments to promote artificial feeding throughout the countries
>where water is commonly contaminated, efforts which public health experts
>and the International Code of Marketing of Breast milk Substitutes and
>relavant World Health Association Resolutions have frustrated for the past
>two decades."
>
>----Original Message Follows----
>
> > Names and affiliations of NNI:
> > Prof. Gabriel Anabwani, MBChB, M Med (Paed), M.Sc. (Epid), Senior
>Consultant and Head of Paediatrics, Princess Marina Hospital, Gaborone,
>Botswana.
> >
> > Prof. Ganapati Bhat, M.B.B.S, M.D, DCH, Head Department of Paediatrics &
>Child Health, University Teaching Hospital, Lusaka, Zambia.
> >
> > Prof. Peter A. Cooper, M.D, FC Paed (SA), PhD, Department of Paediatrics
>and Child Health, University of Witwatersrand & Johannesburg Hospital,
>Johannesburg, South Africa.
> >
> > Dr. Chand Domah, M.B.B.S; MD (Paed), Consultant Paediatrician, Flacq
>Hospital, Mauritius.
> >
> > Ms. Jane Downs, B.Sc.; Post Grad Dipl Hosp. Diet, B.Sc (Hons) Diet.,
>Principal Dietician & Head of Department, King Edward VIII Hospital,
>Durban, South Africa.
> >
> > Prof. Demetre Labadarios, B.Sc. (Hons); MBChB, Ph.D, FACN, Head,
>Department Human Nutrition, Faculty of Health Sciences, University of
>Stellenbosch, South Africa.
> >
> > Dr. Joseph Kariuki Mbuthia, MBChB; M. Med, Chairman, Kenya Paediatrics

>Association, Gertrude's Garden Children's Hospital, Medical Advisory
>Committee, Nairobi, Kenya.
> >
> > Dr. Precious Moloi, MBChB, DCH, General Practitioner, Women's Clinic,
>Sandton Medcare Centre, Johannesburg, South Africa.
> >
> > Prof. Norman Nyazema, B.Sc. B.Sc (Hons), Ph.D, Department of
>Pharmacology, University of Zimbabwe, Zimbabwe.

Subject: PHA-Exchange> More on Nestle Nutrition Institute in Africa - NNIA
Date: Tue, 18 Dec 2001 19:14:50 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

(excerpts from a letter)

I am concern about NNIA partly from my own experiences over the years with this kind of corrupting approach taken by the baby food industry. There are few health professionals or nutritionists even in Northern countries that can maintain a principled stance when offered industry largesse. Thus one can hardly blame anyone at the individual level who is in an underprivileged position, though the professor who sent the original letter is no doubt as well to do as many northern academics (he is a white South African).

The breastfeeding movement has chosen to polarize in very strong terms regarding the acceptance of support from the industry so that people who do decide to take industry money understand in as clear terms as possible that they are crossing a line. I know several cases of leading international public health experts who have turned down things for fear of harming their reputations.

I suspect that half or more of the people on this list were not aware of that they were doing so. But for our movement, it is important that they are known, so that in debates, policy discussions, international meetings, etc. one can take into account the bias that comes from associating in this way with industry.

My former boss is on the Board of the Nestle Foundation, an international equivalent of NNIA. He claimed it was "clean" and had no Nestle influence, as it was run not by the company but by a fund that Nestle had no direct control over. He invited me to investigate to find out if this was not the case. What I found out was:

(1) A high level manager from Nestle is always present as a non-voting participant in NF meetings. (The excuse for this was that his expertise in nutrition was valuable to the group.)

(2) NF's executive director claimed they were independent but admitted they had never been critical of Nestle's actions.

(3) NF had asked for more money to be added to the fund. Nestle agreed. If NF had ever criticized them, one doubts they have received it.

(4) The Board of NF complained about the low quality of proposals they received from developing countries for research projects. Thus they were allowed to apply themselves for the support and much if not most of it goes to them. I saw the 1995 budget and the head of the Board had the largest grant. I was informed that each of them walks out when his own proposals are dealt with. The oppportunity for mutual back-scratching among these half-dozen or so colleagues is clear.

(5) On at least one occasion I was informed by a researcher at the research institute headed by the head of the NF Board that the institute needed equipment which was too expensive to be covered by the NF budget and therefore the company agreed to provide the extra funds. I asked why the company did not do this directly and he said this child health research institute would never risk its reputation by taking money directly from the company. Thus (a) NF was laundering

the money for the head of its board, and (b) there were examples that let the Board know that if they behaved in ways that Nestle liked (and which its informal Nestle staff participant could report to the company), they could ask for and receive extra money.

(6) I reported back to our professor on this. He claimed he did not know this. He stated that clinicians must maintain contact with baby food companies to help them develop better products (which he did for another company earlier). I pointed out that he was no longer a clinician, but working with public health . He called for a seminar run by an expert in the ethics of contacts between health workers and industry.

(7) We held such a seminar with a doctoral student in theology who was doing his disseration on development assistance. He pointed out that each work place has its own ethical stances and when one changes work places one must respect those of the new place. He also said that cooperation with industry should be undertaken only on two conditions: (a) one shares objectives regarding this particular activity, and (b) one has thought through and judged as small the risk that this cooperation be exploited to achieve objectives one does not share with them.

(8) Our professor was asked by the chancellor of the University to get off the NF Board two years ago but still has not done so.

There have been many examples over the years of people trying to reason and negotiate with industry and being exploited for doing so, achieving no more than helping the companies in the public relations efforts. As you may know, these were described in detail in a new book by Judith Richter.

I do not see that there is any possibility for a shared objective between the breastfeeding movement and the infant food industry. Seeming exceptions are simply public relations efforts. As I pointed out in my previous letter, this will be enforced by shareholders. Even you and I would be dissapointed if, when we retire, we are informed that we get no pension because the companies in which our stocks were invested decided to focus on child health instead of making money. Child health can never be the responsibility or goal of industry.

Best,
Ted

Subject: PHA-Exchange> More about the arrest and whereabout of Dr. Jitendra Mahaseth.
Date: Wed, 26 Dec 2001 15:35:28 +0530
From: "Mathura P Shrestha" <mathura@healthnet.org.np>
To: <Undisclosed-Recipient:@mailhost.healthnet.org.np;>

Dr. Jitendra Mahaseth, 46 years old Deputy Director of Lord Buddha Medical College, Kohalpur, Nepalgunj, Nepal was arrested by Royal Nepal Army on December 15 (Paush 1, 2058 BS) at about 11 AM while on duty in Medical College Hospital. His whereabouts is not known (although he is rumored that he is kept in a local Army Barrack) according to his son, Dr. Vinod Mahaseth and Informal Sector Service Centre (INSEC). According to INSEC, when it inquired The Chief District Officer (CDO or equivalent to District magistrate) he replied that he was arrested for treating Maoists and he is detained for "interrogation". According to Dr Mahaseth's wife, Ms Shanti Mahaseth, nobody from the family are able to meet him. They are afraid even to make necessary inquiry. She and other family members have earnestly requested human rights activists, media personnel and concerned organization to initiate public inquiry on his whereabouts, howabouts and to help release him.
In 1986 while serving as Medical Officer of Udayapur District Hospital Dr. Mahaseth was also arrested for being active in Nepal Democratic Front (A political Party banned at the time). He was released after about 7 months. He was also sacked from his government job as medical officer. After this he was arrested several times on the same charge. Since 1988 Dr Mahaseth dissociated from any political activities and strictly devoted himself to professional dispensations. Following the success of Peoples' Democratic Movement the Democratic Front was legalized and charges against its all members were formally withdrawn by the government. But Dr. Mahaseth did not join the party again. He was elected chairperson of the Human Rights Organization of Siraha District in 1990.In 1947 he was contested a seat in the Parliament though not elected. Dr Mahaseth has wife, two sons and a daughter.

Pasted here is an e-mail from INSEC.

Dear Mathura Sir,

On Dec. 15, Dr. Jitendra Mahaseth, working in the Medical College of Kohalpur, Banke was arrested by the armed police from the college on the charge of medical treatment extended to the Maoists.

This if the information received from INSEC, Mid-west Region, Nepalgunj.

Sincerely,

Devika Timilsina
Director

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Lib
28/12

Subject: PHA-Exchange> Fw: HMG's restriction to treat victims during conflict is against all principles of medical ethics and geneva convention.
Date: Sun, 23 Dec 2001 10:21:45 +0530
From: "Mathura P Shrestha" <mathura@healthnet.org.np>
To: <Undisclosed-Recipient:@mailhost.healthnet.org.np;>

----- Original Message -----
From: INSEC <insec@wlink.com.np>
To: Mathura P Shrestha <enhrn@mos.com.np>
Sent: Friday, December 21, 2001 3:00 AM
Subject: Re: HMG's restriction to treat victims during conflict is against all principles of medical ethics and geneva convention.

> Dear Mathura Sir,
>
> On Dec. 15, Dr. Jitendra Mahaseth, working in the Medical College of
> Kohalpur, Banke was arrested by the armed police from the college on the
> charge of medical treatment extended to the Maoists.
>
> This if the information received from INSEC, Mid-west Region, Nepalgunj.
>
> Sincerely,
>
> Devika Timilsina
> Director
>
>
> ----- Original Message -----
> From: Mathura P Shrestha <enhrn@mos.com.np>
> To: David Rush <rushd@mediacne.net>
> Sent: Wednesday, December 19, 2001 5:46 PM
> Subject: Re: HMG's restriction to treat victims during conflict is against
> all principles of medical ethics and geneva convention.
>
>
> > Dear All
> > We come to know that Dr. Jitendra Manaseth from Nepalgunj Medical
College
> > Hospital is arrested and his whereabouts is unknown. No explanation on
> why.
> > Probably he is arrested for treating Maoist upholding Medical ethics.
> > PSRN.
> >
> >
> >
>
>
>

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Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

Lib
27/12

Subject: PHA-Exchange> Futurer PHA Structure
Date: Thu, 27 Dec 2001 02:14:06 +0600
From: Dr Qasem Chowdhury <gksavar@citechco.net>
To: "pha-exchange-kabissa.org" <pha-exchange@kabissa.org>

Future PHA Structure (1)

PHA Secretariat, Savar
December 3rd 2001

Dear Friends of the People's Health Movement

We are very pleased to be able to share with you the agreed plan to enable the development and strengthening of the People's Health Movement. We believe that it provides the foundation for our People's Health Movement.

The proposals that were developed at a meeting in Savar in October have now benefited from wide consultation receiving many comments. We have received many important contributions and wherever possible these have been incorporated. We are very happy to say that all the comments we received were very positive about the new structure and comments focused on clarifying and strengthening the new structure. Many people went on to suggest where and how they wanted to be involved and how to enable more people to be involved. The positive responses have been very inspiring.

Summary of the proposal

The structure will enable places and spaces for all who wish to be part of the People's Health Movement. At the same time we believe that this will enable the People's Health Movement to be inclusive and transparent, democratic and open. In summary, the proposal is to develop a series of linked circles. These will be of two types. First, Geographical Circles at national, regional and international levels. Second, Working Circles for areas of work and activity of the People's Health Movement. These could range from policy and lobbying issues such as one bringing people and their organizations together to work on issues and lobbying related to PRSPs or Rational Drugs to the work of the movement through Publications or Popular Communications. The circles and how they link are outlined in detail below.

Background

A year ago nearly 1,500 people from 93 countries came together in the Conoshasthaya Kendra center at Savar to celebrate the first People's Health Assembly (PHA2000). This historic event was the result of a worldwide pre-assembly process involving tens of thousands of people. Why?

In 1978 representatives of the world's governments committed themselves to Health for All by the year 2000. The year 2000 came and the enormous distance that millions of women, men and children were away from that right was a terrible indictment of governments and international institutions. It was, and is, also a clear and tragic expression of the unjust and unequal world that we live in today. The people and their organizations across the world that are building a People's Health Movement believe that this must change and that we must enable a movement to

advocate for and pressure for health rights and generate credible people-centered alternatives to existing approaches to health.

Here we share with you: -

1. The new structure for the People's Health Movement
2. The timetable for the taking forward of the new structure

We believe that this new structure is crucial as we move towards developing a vibrant People's Health Movement. You are part of this movement and believe that the new structure will give a space and place for you and more people and their organizations to join together in the People's Health Movement.

Thank you

Yours sincerely

Dr. Qasem Chowdhury
PHA Co-ordinator

1. THE CONTEXT FOR OUR PROPOSALS

BUILDING OF PHA2000

The People's Charter for Health

The People's Charter for Health that emerged at the end of the Peoples Health Assembly 2000 (PHA2000) at Gonosnastnaya Kendra, Savar, Bangladesh on 8th December 2000 is an important landmark, perhaps as significant as the Alma Ata Declaration. It is now an important instrument for advocating the Health for All - goal. Its significance has at least three if not more components:

Firstly, it arose out of a mobilization and preparatory process for the PHA2000which took place all over the world culminating as a document that was ratified by nearly 1,500 members of Civil Society from 93 countries. It therefore represents the largest consensus document on the current health situation and the challenges.

Secondly, it provides both an analysis of problems and causes as well as 'perspectives for action'. Health is not just bio-medical but has an economic, political, socio cultural and environmental dimension as well. It highlights the point that Health Action must involve action at all these levels so that the deeper determinants of health are tackled. It also challenges the vertical, top-down, market economy determined, programmes or 'magic bullet' prescriptions as not being representative of comprehensive primary health care approach which was at the core of the means to achieve the Health for All goal.

Thirdly, the charter also emphasizes in a more indirect way that the mainstream of health including health ministries and health departments of national governments, international agencies like WHO, UNICEF, World Bank and the corporates have conveniently largely ignored the Health for All goal and sidelined it.

Challenging the Mainstream
The challenge for the Post PHA2000 initiatives is therefore to bring back the People's Charter for Health into the mainstream of health action. This can be done by advocating it in a strategy that challenges the mainstream to respond to it and integrate it within their evolving agenda. So, advocating the People's Charter for Health actively, consistently, collectively in as many forums, meetings, workshops and also institutions, networks, at local, state, national regional and international levels should therefore be a primary concern till we get it into mainstream thinking on health.

PREPARATORY PHASE. WHICH WE ARE IN AT PRESENT

Building collective consensus
Building further collective consensus on People's Charter for Health within Civil Society should continue to be the first step in every country and region. The pre-PHA2000 mobilization phase took shape in different ways and at with different levels of intensity in different regions, and countries of the world. Though 93 countries finally participated at the event, the participants

---

Subject: PHA-Exchange> Future PHA Structure (3)
Date: Thu, 27 Dec 2001 02:16:04 +0600
From: Dr Qasem Chowdhury <gksavar@citechco.net>
To: "pha-exchange-kabissa.org" <pha-exchange@kabissa.org>

Future PHA Structure (3)

THE NEW STRUCTURE

Circles

The Circles are the foundation of our structures.

Circles are created and made up of people who are representatives and activists from organizations and are people committed to working on the issue or activity that is the focus of the circle.

Circles are open and not closed.

Circles can have autonomy to agree on their most appropriate ways of working.

Circles should develop and agree plans for their work and share these as appropriate.

Circles will intersect.

Circles, when formed, will elect a link person(s) to link to other appropriate circles.

Types of circles

Circles are envisaged at different geographical levels and for different areas of work Working Circles.

Geographical Circles are envisaged at a minimum of three levels
1. National People's Health Movement Circles
2. Regional People's Health Movement Circles
3. International People's Health Movement Circles

Different areas of work can generate different Working Circles. These are also envisaged to exist at the three geographical levels when appropriate. Some may first be established at the international level. As activity and interest is developed then connected regional and or national circles might be developed.

A member of a working circle would come from and be on a national or regional circle. They would be the link person for that area of work or activity on their circle.

Members of working circles have the obligation and responsibility to share their work with other members of their national or regional circle.

Linking of Circles

One of the most important parts of the structure is the way in which

circles link together. Elected members of each circle will be the link person to other appropriate circles. This could be between two different working circles or between a working and geographical circle. The linking has many roles and responsibilities. It is key to enabling the People's Health Movement to be more comprehensive and to making sure that the geographic and working circles share their ideas and activities. The links can also enable us to join and co-operate with other movements and networks.

Many individuals and organisations involved in the PHM across the world are already involved in specific advocacy work. The PHM aims not only to generate credible people centred alternatives but also to recognise, collate and endorse such alternatives that emerged before and after the People's Health Assembly 2000 and that will emerge in the future. Some are linked to the PHM and others are independent. The new structure ensures that they have a place for this to continue, to be able to share this better with other activists and to link with other people and organisations engaged in complementary activity.

Geographical Regions

The initial regions are based on areas where the People's Health Movement has some strength with two exceptions. These are West Africa and China, where we plan to have some strength in due course.

The initial regions proposed are;

1. India
2. South Asia, not including India
3. South-East and East Asia, not including China
4. China
5. Pacific, Australia and New Zealand
6. Middle East and North Africa
7. West Africa
8. East and Central Africa
9. Southern Africa
10. Europe
11. South America
12. Central America including Mexico and the Caribbean
13. North America

This is not a complete or perfect regionalization of the world and through discussion, consultation and evolution we will be able to evolve a regionalization which reflects what each region feels is a viable and a positive contribution to the People's Health Movement. National Circles would need to decide on what is the most suitable and appropriate region for them.

Some countries may feel it necessary and appropriate to establish regional, province or state level circles.

National circles would elect link person(s) with a Regional People's Health Movement Circle.
One elected representative from each of these Regional People's Health Movement Circles will be a representative for the International People's Health Movement Circle.

Secretariat

It is proposed that there is a Secretariat for the International People's Health Movement. The Secretariat will play an important role in catalysing

and facilitating the different circles and their inter-relationships. The Secretariat is likely to rotate after an agreed period if this was felt to be desirable and feasible. It is expected that the Secretariat will move every few years. It would not be permanently in one place. The role and functions of the Secretariat would need to be agreed.

International People's Health Movement Circle

The International People's Health Movement Circle will be the reference body for the Secretariat.

It is also proposed that the co-ordinator or facilitator of the Secretariat for the International People's Health Movement will be representative on the International People's Health Movement Circle. This will mean that the initially the International People's Health Movement Circle has a minimum of fourteen members.

It will be the right of the International People's Health Movement Circle to increase this if appropriate.

Ways of working would be agreed for the International People's Health [redacted]vement Circle.

It may be desirable for the for the International People's Health Circle to elect a smaller group who would be a reference group for the secretariat on certain agreed issues.

Working Circles

a) Working Circles- to enable the development and strengthening of the PHM

Working Circles could be developed for activities that are key to the development and strengthening of the People's Health Movement itself. These will generally begin as International Working Circles.

Subject: PHA-Exchange> Future PHA Structure (2)
Date: Thu, 27 Dec 2001 02:15:12 +0600
From: Dr Qasem Chowdhury <gksavar@citechco.net>
To: "pha-exchange-kabissa.org" <pha-exchange@kabissa.org>

Future PHA Structure (2)

From these 93 countries did not always represent or bring with them a broader consensus from their own region or country. In some cases there were individuals representing countries; in others there were NGOs representing some mobilization in Civil Society; in some countries and regions there were more collective efforts; like India where there were very intensive efforts to organize. All were seeds for the future of the People's Health Movement.

There is urgent need to continue this process of consensus building, to strengthen the civil society consensus and endorsement or the People's Charter for Health in each country, region and globally.

Some key issues in developing and strengthening the People's Health Movement

a) Developing a core circle of individuals willing to give time to People's Health Movement
b) Focusing on Networks / Membership organizations and not just individuals or NGOs. We are a movement and not an NGO.
c) Ensuring as far as possible collective, democratic decision making, so that all constituents have opportunity to contribute, participate, suggest and facilitate the work of the People's Health Movement. The organizational framework should be circular and not pyramidal.
d) Respecting the autonomy of each participating network to do other activities in the People's Health Movement spirit.
e) Maintaining good communications between circles, countries and regions through regular email communication, newsletter, website etc.
f) Producing 'consensus' documentation authored collectively and not by individuals so that ownership of ideas and perspectives is enhanced and collectivized.
g) Strengthening instruments for advocacy
WHERE DO WE WANT TO GET TO BY 2005?
- To generate credible people-centered alternatives to existing approaches to health.

o To enable a movement to advocate for and pressure for health rights.

o The People's Charter for Health should be a guiding document both for the People's Health Movement, for a growing number of national governments (not just Ministries of Health) and parts of the UN institutions i.e. the WHO, UNICEF, UNFPA, UNDP etc.

o People and their movements to be enabled to popularize and use the People's Charter for Health and to develop and lobby for local and national level alternatives.

o By 2005 the People's Charter for Health should be 'on the table' and, it and related documents which share positive people-centered practice, should be seen as credible alternatives.

o That the movement is recognized as the People's Health Movement as

A-Exchange> Future PHA Structure (2)

opposed to the People's Health Assembly

o For the People's Health Movement to take root so that international bodies such as the WHO, WTO, UNICEF, World Bank, listen to the People's Health Movement.
This could be achieved by;
- the weight of the presentation of our strategies for alternatives and exposing the gap between rhetoric and reality.
- collective pressure
- the perceived weight and presence of the People's Health Movement

o Development of specific strategies and actions with respect to national governments. These would be focused on national level health and related policies and practices and on highlighting the current and potential role of national government on international bodies such as the WHO, WTO and World Bank. The People's Health Movement should contribute to the demystification of the WHO and World Bank etc. and demand national-level accountability.

o We will have developed documents that present key principles and people-centered and community based practices.

o To have held a series of Regional People's Health Movement Circle assemblies during 2003 2004

We will decide if a second People's Health Assembly, PHA2, will take place. If there is a positive decision, we will also decide when and where. By January 2005 we will have reviewed the People's Charter for Health.

A
People's
Web

Towards Structures
for
A People's Health Movement

Agreed
December 2001

TOWARDS FACILITATING STRUCTURES FOR A
PEOPLE'S HEALTH MOVEMENT

Principles

o Develop a feeling of belonging to a movement for change.

o Inclusive. We will enable people and organisations with different and diverse backgrounds to be part of the PHM. However we will ensure that a pro-people orientation remains fundamental. (This will sometimes require positive action i.e. for people with disabilities)

o Transparent, democratic and open

o Representative of
- South/North
- Genders
- Ethnicity/Race
- Emailing and without access to email
- Different languages as possible
- Ages/Generations - especially young and older people

o We need to celebrate diversity and encourage and recognize that there are multiple solutions.

o We recognize that Women's access to health often is still unequal and inappropriate and that this needs to be challenged and changed.

o Linking with networks and movements, being complimentary to the work of others and providing a space for others. The PHM places importance on membership organisations, networks and movements with democratic decision making processes. This is key.

o Work based and building on the People's Charter for Health. This is our fundamental common ground.

o Build on collective energies and actions

o Each country in their own way

Assumptions

1. There is a need for a global structure and that this has to be founded, informed and inspired by people's experiences, strategies and visions.

2. The base should be geographical, building on our strengths. The regions of the world should suit us.

3. Our structure should bring together organizations and movements and facilitate exchanges of experiences, information, strategies and actions between them.

4. The focus is not on decision making though this is of course needed

The type of organizational structure most appropriate to the development and strengthening of the People's Health Movement is not pyramid shaped but circular.

TOWARDS FACILITATING STRUCTURES FOR A PEOPLE'S HEALTH MOVEMENT

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5. The type of organizational structure most appropriate to the development and strengthening of the People's Health Movement is not pyramid shaped but circular.

Subject: PHA-Exchange> Public Health Diploma, Degree and Short Courses
Date: Thu, 3 Jan 2002 16:27:09 +0500
From: "nadira.ashraf" <nadira.ashraf@aku.edu>

Official: Yes

Dear Friend,

Wishing you a very happy new year 2002!

As you know we are offering short training courses since 1994 on regular basis and hope that you have received the information about our scheduled courses for year 2002 (sent during December 2001). If not, please let us know and we shall send you the information again.

We are also interested to know if other institutions in the country are **offering similar short courses and/or postgraduate degree and diploma courses in public health.** We would highly appreciate if you could send us information on any such courses/programs offered by your institution/organization or if you have details about any other private/government institution in your province offering these.

Your early response will be highly appreciated.

Best regards
Nadira Ashraf
Senior Administrative Officer
Regional Training Program
Department of Community Health Sciences
The Aga Khan University,
Stadium Road, PO Box 3500, Karachi

The Aga Khan University, Karachi, Pakistan www.aku.edu

RM/Lib
11/1/02

Subject: PHA-Exchange> a different proposal
Date: Wed, 2 Jan 2002 21:03:00 -0600
From: "SOYNICA" <soynica@sdnnic.org.ni>
To: pha-exchange@kabissa.org

Managua, 02 de enero, 2002.{PRIVATE }
S-0002-02

ello, Claudio! Thanks for sending your communication on the women-centered approach to Family and Security. More and special attention must be given to women because the quality of life itself depends much on the quality of her motherhood; we have to give priority in all things to girls from [redacted]th on, many people object this [redacted]rgumenting with equality of rights, forgetting that boys are already given priority practically ion all cultures. But it is a big need for health. Girls do always receive less health attention then man, because the general feeling is that "men have to work and must be strong"; women don't work and can go on living with anything. Women's nutritional levels must be bettered enormously so that she can be an active participant as a "sujeta de su propio desarrollo". We have to protect her from anemia that so often doesn't let her participate in decisions and active life as a citizen and good consument. Thanks again.
Luci

[redacted]

archivo
cronológico

Asociación Soya de Nicaragua
SOYNICA
De los Semáforos del Mercado Roberto Huembes, 5 cuadras al Sur, m/d
Managua, Nicaragua
Apartado Postal A-157 C.C. Managua
Teléfono: 2 99 49 55
Telefax : 2 69 49 41
Email: soynica@sdnnic.org.ni

Lib
1/1/02

Subject: PHA-Exchange> Midlevel health care providers' role in abortion care
Date: Thu, 3 Jan 2002 09:59:12 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

From: <Merrill.Wolf.WolfM@ipas.org>
>
> *December 27, 2001 At a recent landmark conference in South Africa,*
> *50 prominent health care providers, issued a call to action in support of*
advancing the role of midlevel health care providers in menstrual regulation
and safe abortion care.
>
> *Worldwide, midlevel health care providers including nurses, mid-*
> *wives, physician assistants and others are far more numerous than*
> *physicians.They also tend to be much closer to women and in many cases are*
their only contact with the formal health care system. As such, these
[redacted]oviders
> *have a critical role to play in reducing deaths and injuries of women*
> *from unsafe abortion, which is a major cause of maternal mortality*
> *worldwide."*
>
> *Especially in the world's poorest countries, women's inability to ob-*
> *tain high-quality medical care for abortion or abortion complications*
> *leads many to rely on unqualified practitioners or to try dangerous*
> *folk remedies. The World Health Organization estimates that, world-*
> *wide, more than 70,000 women die every year as a result of abortions*
> *performed by unqualified personnel in unhygienic conditions, or both.*
> *Experts agree that these deaths and the millions of injuries that*
> *also result from unsafe abortion are wholly preventable.*
> *The deaths and suffering of women from unsafe abortion will not de-*
> *crease significantly until a range of reproductive health care in-*
> *cluding postabortion care and elective abortion is available and*
> *accessible to women at the most local level possible.*
>
It is essential for health systems to create policy and service delivery
environments that enable menstrual regulation and/or abortion care to be as
[redacted]ccessible as possible to women.
> *The experience in several countries shows that training and equipping*
midlevel providers greatly improves women's ability to obtain needed
services.
>
Conference statement:
>
> *Worldwide, nearly 80,000 women die every year and millions more suf-*
> *fer serious complications and disabilities from unsafe abortion,*
> *which is wholly preventable. Even in countries where abortion-related*
> *maternal mortality is low, women still often lack access to abortion*
> *care and other reproductive health services that they want and need.*
>
> *Increasing the accessibility of menstrual regulation (MR) and/or safe*
> *abortion care is a key strategy in reducing unacceptably high rates*
> *of maternal mortality and morbidity, and in ensuring women's ability*
> *to exercise their sexual and reproductive rights. Since midlevel*
> *health care providers are more numerous and tend to be closer to*
> *women than physicians, they have a critical role to play in meeting*

> women's needs for postabortion care, MR and in circumstances where
> it is legal termination of pregnancy.
>
> Experience in Bangladesh, South Africa and several other countries
> demonstrates that authorizing, training and equipping midlevel pro-
> viders to deliver MR and/or abortion care can make an important dif-
> ference in improving women's access to needed services.
>
> Creating an enabling environment to expand and strengthen midlevel
> providers' scope of practice is especially important in situations
> where they are the principal or only health care providers in the
> communities where women live.
>
> As health care providers, researchers, policymakers and representa-
> tives of technical agencies, we, the participants in the first-ever
> international meeting exploring midlevel providers' role in MR and
> abortion care, strongly believe:
>
> . that women deserve prompt access to high-quality MR and/or abortion
> care,
> . that it is essential for health systems to create policy and ser-
> vice-delivery environments that enable MR and/or abortion care to be
> as accessible as possible to women, and
> . that women's access to such care can be greatly enhanced by better
> integrating these services into midlevel providers' scope of prac-
> tice.
>
> All of us who are committed to enhancing women's health and lives
> have a responsibility to facilitate women's access to the reproduc-
> tive health care they want and need, including menstrual regulation
> and abortion care.
>
> This conference has strengthened our commitment to fulfill this
> critical mandate an effort in which midlevel providers clearly play
> a key role. As a network of concerned professionals, we call on gov-
> ernments, health policymakers, nongovernmental organizations, inter-
> national organizations, donors and others to take action in support
> of advancing the role of midlevel providers in menstrual regulation
> and safe abortion care.
>

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

Subject: PHA-Exchange> Small-Scale Tobacco Farmers Lose Out As Global Industry Prospers
Date: Sun, 6 Jan 2002 09:14:53 -0700
From: "FCA Coordinator" <FCTCalliance@inet.co.th>
To: <PHA-Exchange@kabissa.org>

For Immediate Release

December 18, 2001

Contact: Ross Hammond

1-415-695-7492

NEW REPORT DETAILS ECONOMIC, SOCIAL & ENVIRONMENTAL COST OF TOBACCO FARMING IN DEVELOPING COUNTRIES

Washington, D.C. (December 18, 2001) - A new report released by the Campaign for Tobacco Free Kids examines the economic, social and environmental costs of tobacco farming. â□□Golden Leaf, Barren Harvest: The Costs of Tobacco Farmingâ□□ makes the case that the rapid growth of tobacco farming in the developing world encouraged and facilitated by the tobacco industry has not brought with it the promised economic benefits. Indeed, the Report finds that the rapid spread of tobacco farming in developing countries has brought with it a host of environmental, health and social problems. It has also caused over production in the global tobacco market, that contributes to the profitability of the manufacturers but undermines the economic well-being of farmers as more and more farmers compete with each other to sell tobacco leaf to the companies at lower and lower prices.

The Report draws primarily on tobacco industry sources. While a few large-scale tobacco growers have prospered, the vast majority of tobacco growers in the developing world barely eke out a living while toiling for the companies. Many tobacco farmers are now stuck producing a crop that is labor and input intensive and causes a myriad of health and environmental dangers. The Report details the many serious economic and environmental costs associated with tobacco cultivation that the tobacco companies have

tried to gloss over. These include:

à,— Chronic indebtedness among tobacco farmers (usually to the companies themselves).

à,— The diversion of land previously used for growing food to grow tobacco.

à,— New technologies employed by the companies which reduce the amount of tobacco used per cigarette.

à,— Manipulation by the tobacco companies of the grading system which has led to lower prices for farmers.

à,— Serious environmental destruction caused by tobacco farming, particularly the massive deforestation caused by tobacco curing.

à,— An increase in pesticide-related health problems for farmers and their families.

The Report also details the tobacco industryâ□™s efforts to manipulate the plight of tobacco farmers for their own gain through the use of front groups and their current efforts to undermine the global tobacco control treaty currently being negotiated under the auspices of the World Health Organization. As the Report shows, even with global demand for tobacco leaf growing, the inescapable problems with tobacco farming make it a losing investment for most countries and farmers.

The report is available on the web at:

http://tobaccofreekids.org/campaign/global/FCTCreport1.pdf.

Copies can also be obtained by writing to Monica Flores at

[redacted]lores@TobaccoFreeKids.org>

****

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USA

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Fax. 1-801-729-6580

USA

http://tobaccofreekids.org/campaign/global/

Small-Scale Tobacco Farmers Lose Out As Global Industry Prospers

The rapid spread of tobacco farming in impoverished countries over recent years has failed to live up to its economic promise and has worsened conditions for small-scale growers, according to a new report from a major United States anti-smoking organization.

Based primarily on tobacco industry sources, the report--released this week by Campaign for Tobacco-Free Kids--concludes not only that tobacco farming has fallen short of expectations, but that it has also created environmental, health, and social problems in communities which have taken up the practice.

"While a few large-scale tobacco growers have prospered," according to the report, 'Golden Leaf, Barren Harvest: The Costs of Tobacco Farming,' "the vast majority of tobacco growers in the Global South barely eke out a living toiling for the companies."

In many cases, poor tobacco farmers fall into debt, often to the tobacco companies themselves, and suffer health problems due to the large amounts of pesticides required to grow a healthy crop.

In addition, surrounding areas often suffer serious environmental damage, primarily because the wood needed for curing tobacco is cut from nearby forests, contributing to "massive deforestation" over time, according to the report.

The report was released amid heightened international controversy over tobacco due to ongoing efforts by the Geneva-based World Health Organization (WHO) to draft a Framework Convention on Tobacco Control (FCTC) by the year 2003.

Anti-tobacco activists hope the FCTC, when completed, will include a global ban on the advertising and promotion of cigarettes, backed up with tough sanctions against tobacco companies which violate it.

The world's three largest tobacco companies--British American Tobacco (BAT), Philip Morris, and Japan Tobacco--oppose such a ban and argue that the industry can regulate itself. The companies have tried to gain allies among tobacco-producing countries in the FCTC negotiations by arguing that their economies could be hit hard by a tough Convention.

Some four million people a year currently die from tobacco-related diseases, a number that could jump to 10 million over the next three decades given current trends, particularly increased smoking in poor countries.

As the United States and other developed countries have tightened tobacco advertising rules over the past 30 years and smoking has declined in popularity, tobacco companies have increasingly looked to developing countries as markets of the future.

Major cigarette companies have spent billions of dollars in poorer countries building new factories, entering joint-venture agreements with private and government-owned tobacco companies, and buying formerly state-owned factories.

The top three companies now own or lease manufacturing facilities in over 50 countries and buy tobacco in dozens more. Companies have also provided credit and other inputs at bargain rates to encourage farmers to switch from food crops to tobacco.

As a result, global tobacco production has grown by almost 60 percent since the mid-1970s with the bulk of the increase coming from developing countries, particularly China, India, Brazil, Malawi, Zimbabwe, and Vietnam.

This massive increase in production has resulted in a worldwide surplus and a sharp decline in prices that has proved ruinous to small farmers in poor countries, according to the report.

"Even with global demand for tobacco leaf growing," according to the report, "the inescapable problems with tobacco farming make it a losing investment for most countries and farmers."

The World Bank, which has also taken a dim view of both the economic and health effects of tobacco, stopped providing loans for tobacco production, processing or marketing, in 1992 and in 1997 joined the WHO in calling for tight tobacco controls.

Both WHO and the Bank are backing efforts to develop alternative crops for tobacco farmers in poor countries.

Source: Jim Lobe, 'Small-Scale Tobacco Farmers Lose Out As Global Industry Prospers', Friday December 28, OneWorld US

URL:
http://dailynews.yahoo.com/h/oneworld/20011228/wl/small-scale_tobacco_farmers_lose_out_as_global_industry_prospers_1.html

Subject: PHA-Exchange> Re: Doctor Released
Date: Thu, 10 Jan 2002 18:44:23 +0530
From: "Mathura P Shrestha" <mathura@healthnet.org.np>
To: "Stephen Bezruchka" <sabez@u.washington.edu>

Thanks to every body. Dr. Jitendra Mahaseth is now released. The show of international solidarity was very effective.
Mathura P. Shrestha
PSRN

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

Subject: PHA-Exchange> About PRSPs
Date: Mon, 7 Jan 2002 21:48:09 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

Where is health? a contribution to the PRSP review

December 2001

Ellen Verheul, Wemos, the Netherlands (ellen.verheul@wemos.nl); Mike Rowson, Medact, UK (mikerowson@medact.org)

INTRODUCTION

11% of the global health budget is spent in the low- and middle-income countries, where 84% of the global population lives. 1,1 billion people do not have access to clean water. 2,4 billion people lack access to sanitation. One third of deaths in developing countries are due to preventable and/or treatable conditions.

Health is a fundamental human right and a prerequisite for development. Health targets are central to the International Development Targets, meant to be the overriding goals for the PRSP approach. Although health is often claimed to be a priority area in poverty reduction strategies, a review of 2 full PRSPs and 8 I-PRSPs shows that key concerns in relation to poverty and health are ignored or insufficiently addressed.

In this contribution to the PRSP review process, we focus on what we feel is still *missing* in the PRSPs and identify areas where donors fail to support the PRSP countries. Our concerns are listed under the main headings of the Key Questions for Review of the PRSP Approach. Areas for future action are presented in the boxes.

content of strategies

Missing links between poverty reduction and macroeconomic and trade policies:

PRSPs show a gap between social policies and the macro-economic framework. Protection of government social expenditures is one important aspect. But equally important for health is consideration of how economic change influences incomes, prices and household coping strategies. This issue has been brought to the fore repeatedly over the last two decades in relation to the debt crisis of the 1980s, the problems in the transition economies in the 1990s and then in the aftermath of the Mexican and East Asian financial crises. In each case, increases in poverty (often dramatic) have followed these economic changes. The role of safety nets and other social protection instruments is often promoted as a solution to problems caused by rapid economic change. However, in view of the limited resources and coverage of most safety nets, clearly a much better solution would be to ensure that economic policies, as far as possible, do not cause harm to vulnerable population groups in the first place.

Similarly, PRSPs fail to identify and challenge the hindrances that international policies may have on health or national poverty reduction strategies. The international trade agreements under the WTO regime, like the TRIPS and GATS agreements, need to be assessed on their potential health impact before being implemented in national regulation and policies.

Countries should weigh alternative macro-economic and trade policy options and their trade offs in the development of poverty reduction strategies. Ex-ante impact assessments of policy options would greatly enhance an informed dialogue and transparent and democratic decision making. PRSPs should be clear about the redistributive impact of the proposed policies.

Limited increase health budgets:

Health systems of low-income countries are generally severely under-resourced, prohibiting these countries to achieve the 2015 health

targets. A growing number of countries in fact even face reversals in the decline in infant and child mortality as well as declining life expectancies. The median per capita health budget for sub-Saharan Africa stands at $6, only 50% of the $12 basic package. The mean for the lowest income countries in Africa is just $3 per capita. WHO estimates that $60 per capita is needed for reasonable health care.

PRSPs show in general modest commitments to increase budget allocations for health services. The problem is that in these countries the national economy is simply too small to generate adequate health budgets. This is illustrated by Tanzania, which has undertaken a health costing exercise as part of the PRSP development. The technical studies indicate that the financing of acceptable levels of health care would cost about $9 per head. This would mean a doubling of the present health budget, which would be still 25% below the recommended $12 per capita basic package. Instead of asking for increased donor assistance, the government of Tanzania has decided to limit the budget.

PRSPs should clearly indicate the financing gap for health, in order to challenge donors to fill this gap. Budgets should be determined on the basis of needs rather than estimations of (limited) donor resources. The achievement of development targets should not be compromised.

Failure to tackle adverse impacts of user fees:

There is widespread international consensus on the need to avoid user charges at the point of service delivery, because of the adverse impacts on the poor. It is therefore remarkable that most PRSPs continue to promote user fees for health, including for basic services. Most PRSPs do not go beyond proposing exemption schemes to protect access for (categories among) the poor. In practise exemption schemes are difficult to implement and in general fail to protect many poor from being charged. User fees force patients to use all kinds of coping mechanisms that are poverty-inducing, like borrowing, reducing other essential expenses, selling productive assets or delaying use of health services. Furthermore user fees may provide incentives for health workers to over-prescribe and over-refer to higher levels of care, thereby reducing the quality of care.

Governments should revisit their user fee policies in view of poverty reduction. They should develop a long term financing scheme based on risk-pooling between the sick and healthy and risk-sharing between the rich and poor. The most equitable and feasible option for low-income countries are tax-based health financing systems, supported by external aid, as recommended by WHO. Donors should refrain from imposing the introduction or increase of user fees in developing countries.

'Pro-poor' content of health policies unclear:

Economic crisis and austerity measures imposed by structural adjustment led to plummeting health budgets in the 1980s. Governments had no choice but to withdraw from health service provision, leaving growing gaps to be filled by the profit and non-profit sector. The health sector reforms initiated in the context of structural adjustment have not been very successful in many countries. This is largely due to severe underfunding and underestimating the complexity of the process. While the reforms focussed strongly on financial management and organisational matters, service delivery was neglected.

PRSPs seem to continue downsizing the government's role in service provision and encourage private provision. Governments with weak capacities for service provision often welcome private provision, even though the costs may be higher. However, there is an inherent contradiction in this situation, as governments with weak capacities for service provision usually have weak regulatory capacities. Privatisation within an unregulated environment will foster unregulated private provision of essential services, with obvious adverse consequences for access for the poor. In this scenario, efficiency, quality and equity goals for the health system as a whole can easily be undermined.

The PRSPs reviewed also show a narrow approach to health. They describe health from a target-oriented basic health and disease approach, and strongly emphasise the 'diseases of the poor' - AIDS, tuberculosis and malaria. The question is whether these priorities really reflect national priorities or merely donor wishes, with large funds being available to tackle the major communicable diseases.

PRSPs should outline a long-term strategy for health sector development that will guarantee access for the poor to quality services. Countries can learn from the experiences of low-income countries that achieve good health outcomes, by providing equitable and comprehensive public health care at low costs, such as Sri Lanka, Jamaica and Botswana These countries have emphasised the improvement of services in the areas where most of the poor live. Prevention and medical services were combined with community

action and improvement of water, sanitation, nutrition and education.

Donors should finance nationally defined, integrated policies instead of linking funding to their own priorities, which often focus solely on a few 'diseases of the poor'.

constraints

Insufficient aid flows:

ODA fell to a historic low average of 0,23% of GDP in the nineties. About $3 billion of total ODA is spent on health in low-income countries. Donor assistance to health in the least developed countries is only $2 dollar per capita per year. The WHO Commission on Macroeconomics and Health estimates that besides comprehensive debt relief, an extra $10-20 billion per year would be needed for disease control alone. The much trumpeted Global Health Fund, which aims to mobilise new funding for health, has only received commitments of $1,5 billion. Much of this money however is coming from existing ODA budgets.

Insufficient grant flows increase low-income countries' reliance on loans to finance the health sector. This is problematic for highly indebted countries, since health services in themselves will not deliver the foreign currency needed for debt repayments. The global economic downturn, deepening after September 11, will only further diminish the economic prospects of countries with weak economies. Average per capita incomes in Africa have not risen since 1970.

Rich countries should set a timeframe to achieve the minimum ODA level of 0,7% GDP. ODA should be given in the form of untied grants to implement the national poverty reduction strategies. Resources for the health sector should flow through nationally defined strategies. The creation of new parallel aid mechanisms, such as the Global Health Fund, should be avoided.

Insufficient and debt relief and creditors not accountable for own mistakes:

It is widely acknowledged that the HIPC Initiative fails to offer a way out of the debt crisis. Many countries in sub-Sahara Africa are still repaying their creditors more than twice the budget available for health. Debt sustainability criteria that do not reflect countries development needs. In addition, HIPC does not offer a solution for the debt accrued for failing programmes and projects. While the World Bank is the single largest financier of health in developing countries, the Bank admits a weak knowledge base for pro-poor health interventions. The Bank's performance record in health is weak according to its own evaluation department. Less than half of all HNP projects were sustainable after completion. Only 21% of the projects made substantial contributions to institutional development and policy change in the sector. As a result, the population in the recipient countries suffers from the consequences of the debts repayments for projects that do not contribute to improvement of health service delivery.

There is an urgent need for broader and deeper debt relief beyond the current HIPC initiative, to prevent the outflow of resources that countries need for reaching the development goals. Debt sustainability criteria should be based on development needs. Decision making on debt relief needs to be shifted to a transparent and independent arbitration system. Creditors should be held accountable for their mistakes and cancel debts accrued for failing projects.

Not bridging the gap between health and macro-economic policies:

The Bank and the Fund have thus far failed to assess the social and poverty impact of the macro-economic framework of their programmes, despite acknowledging at the launch of the PRSP approach that 'poverty and social impact analyses of the policy measures underpinning poverty reduction strategies are critical to ensuring that the potential effects on the poor and vulnerable groups are taken into account in programme design'. The World Bank has only recently started with pilots in six countries.

Specialised UN agencies like the World Health Organisation should provide independent support to governments for assessing the potential impact of economic and trade policies on equity and health. Monitoring the implications of structural adjustment measures for health falls within in the mandate of the WHO.

Incoherent donor policies:

Donors should respect and support nationally developed strategies. This is not only relevant to PRCS and PRGF credits, which are in theory linked to the PRSP, but should apply for all Bank/Fund supported programmes and strategies. This is not the case. The draft Private Sector Development strategy of the World Bank for example envisages an increasing role for (profit and non-profit) private sector provision of basic social services. Commercial health care provision however will not lead to improved access to the poor, especially in unregulated environments. The Bank's strategy would undermine government efforts to build universal public health systems in the context of poverty reduction. The Bank is in fact a significant driving force for privatisation in health care, through projects, investments and institutional support for multinationals. IFC is explicit about its objective to move "aggressively" to invest in sectors such as health care. The question is what happens if countries choose not to privatise health care provision in their PRSP.

The World Bank and IMF should respect national strategies in all their programmes and conditions. Furthermore the Bank and Fund should adhere to the international body of human rights law. The human rights framework should be the basis for all policies, programmes and projects. Countries should resist accepting reforms and conditions that force them to breach their obligations towards the rights of their own populations. These rights include the right to development, participation, non-discrimination and the right to health and education.

Subject: PHA-Exchange> WHO Commission on Macroeconomics and Health: Possibility of Collaborative Analysis
Date: Tue, 15 Jan 2002 23:05:31 +1100
From: David Legge <d.legge@latrobe.edu.au>
To: IPHCWORLDWIDE@yahoogroups.com, PHA-Exchange@kabissa.org, health-fin@lists.vicnet.net.au

Globalisation on trial
world health warning issued

Report of WHO Commission on Macroeconomics and Health

A high level WHO commission has warned the rich world that unless there is a dramatic increase in development assistance for health the legitimacy and stability of the current regime of global economic governance may be seriously threatened.

The report
The report of the WHO Commission on Macroeconomics and Health (CMH) is now available at:
<http://www3.who.int/whosis/menu.cfm?path=whosis,cmh&language=english>
This report will have a big impact on policies and programs in the field of health development. It is a major intervention in discussions about official development assistance including the role of the World Bank (and PRSPs).

Opportunity
The debate around the report will also provide an important opportunity to challenge neoliberal orthodoxy in development policy and to further undermine the legitimacy of the prevailing regime of global economic governance.
The purpose of this posting is to invite health activists, NGOs and academics, who see in this regime of global economic governance the major causes of health stagnation in the developing world, to a collaboration in developing a strong response to the CMH: building uopn its sombre warning to the captains of capital while challenging many of its assumptions and conclusions.

Background
The WHO Commission on Macroeconomics and Health (CMH) was established by the Director-General of WHO in January 2000. The Commission was chaired by Professor Jeffrey Sachs of Harvard. It members and helpers included former ministers of finance, people from the World Bank, the International Monetary Fund, the World Trade Organisation, the United Nations Development Program, the Economic Commission on Africa and the Organisation for Economic Cooperation and Development. The Commission was financially supported by the Bill and Melinda Gates Foundation, the Rockefeller Foundation and the UN Foundation and by the governments of the UK, Luxembourg, Ireland, Norway and Sweden. The CMH presented its final report to Dr Bruntland in December 2001.
The Commission set up six working groups, on: health, economic growth, and poverty reduction: international public goods for health; mobilisation of domestic resources for health; health and the international economy; improving health outcomes of the poor: development assistance and health. The reports of the working groups are indexed at:
<http://www3.who.int/whosis/cmh/cmh_papers/e/papers.cfm?path=cmh,cmh_papers&language=english>
[you may need to reconstitute this URL if it gets broken in transmission]

PHA-Exchange> WHO Commission on Macroecon...ic Possibility of Collaborative Analysis

WHO Director-General Dr Gro Harlem Brundtland welcomed the report of the WHO Commission on

Macroeconomics and Health on December 20th 2001: "This report is a turning point," she said. "It will influence how development assistance is prioritized and coordinated in the years to come."

A provisional assessment

It is a difficult report to analyse. The argument is tortuous and quite selective in its use of evidence. In places it stretches fact, logic and credulity to the point of combustion. It is difficult to read the strategic purpose of the DG in commissioning the report and that of the members of the Commission in framing their presentation. It is clear that the report is meant to be read at several different levels.

The core of the report is this: globalisation is on trial: unless there is a dramatic increase in development assistance for health care in low income countries the legitimacy and stability of the current regime of global economic governance will be seriously threatened. It is a warning to the G8, the Paris Club and the Bretton Woods institutions to slow down on globalisation and redirect significant resources to health care in the poorer countries.

This is quite a finding, given the members of the Commission - which is partly why it is such an important opportunity for engagement.

However it is a big report and is accompanied by dozens of working group reports. There is a lot of material to absorb and consider. This raises questions about how Third World governments, health activists, NGOs and academics who had already come to this central conclusion might respond to the report.

A global collaboration in analysing and responding to the CMH report?

I have read the report and most of its working group reports and I have prepared a preliminary analysis which I have posted at:

<http://users.bigpond.net.au/sanguileggi/PrelimAnalCMHReport.html>

I hope this preliminary review will encourage people to read and think about the CMH report. I hope that the perspectives that I have presented may be useful to others in the task of interpreting, analysing and critiquing the report.

However, the work involved in considering thoroughly the report and that of the working groups is not trivial. The Commission had the resources of Bill Gates and the World Bank at its disposal. The networks of activists, NGOs and academics who might wish to take the opportunity to challenge the logic and legitimacy of the current regime of global governance do not have such resources. But we have our own experts and we are in touch with the current lived circumstances of different settings and different countries.

So I am proposing a global collaboration around the task of analysing and responding to the CMH report.

A global analysis would need a coordinating function; a systematic approach to analysis and critique; a coordinated approach to generating alternative strategies and policy principles; a process and avenues for dissemination and follow up. I really don't know how these should be organised.

Process and outcomes

As I envisage it the material outcomes of this collaboration would be a collection of articles published in a very wide range of websites and journals. They might or might not be identified as arising from this collaboration (which might or might not be blessed with an formal name).

I am expecting that through this collaboration people in different parts of the world might collaborate in producing different critiques or commentaries for different purposes and different audiences.

As a starter I have produced the preliminary analysis addressed above. I would like to publish this commentary but I am not sure where and I would greatly appreciate feedback and commentary on the current draft before I do.

Perhaps the commentary might serve as a useful framework for claiming and allocating the work which is yet to be done.

Another framework would be the set of working papers referenced above.

A global collaborative critique?
Please read the report and my preliminary analysis and answer the following questions:

- Do you agree that the report of the CMH justifies a strong and critical response?
- Do you agree that we could organise and collaborate in a globalised analysis and response through the medium of this and related lists?
- How does a loosely knit global community of health activists undertake such a project?
- What can you and your organisation contribute to such a process?
- Are there particular aspects of the report that you would like to focus upon?

Best wishes

david legge

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Subject: PHA-Exchange> South Asia Alliance for Poverty Eradication: Statement of Concern; statement of purpose
Date: Wed, 16 Jan 2002 19:23:07 +0600
From: "Rural Reconstruction Nepal-RRN" <rrn@rrn.org.np>
Organization: RRN
To: <pha-exchange@kabissa.org>

"Eradication of abject poverty is the utmost necessity to affirm social justice and lasting peace"<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

~*South* <?xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarttags" />*Asia Alliance for Poverty Eradication (SAAPE)*

Statement of Concern: Statement of Purpose

On the occasion of the 11th Summit of South Asian Association for Regional Co-operation (SAARC) in Kathmandu, Nepal from 4 to 6 January 2002, the members of the South Asia Alliance for Poverty Eradication (SAAPE) call upon the Heads of States or Governments gathered here to renew their commitments for promoting the welfare of the people of South Asia, particularly the excluded, the poor, the marginalized, and all those who have not had access to basic health care, basic education, shelter and fundamental rights. The tasks of eradicating poverty, hunger, disease, illiteracy, unemployment, tackling environmental degradation and food insecurity need to be jointly addressed. As members of social movements and organisations working for the development through empowerment of the people living in poverty, we urge SAARC members to implement the commitments of their governments and bring at a regional level increased serious and meaningful cooperation for eradiating poverty and eliminating social injustice. In this context, we share with you our statement of concern and purpose as follows;

Senior development workers, social movement leaders, leading academics and concerned citizens from Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka came together to discuss critical issues of poverty eradication, to strategise about ways to create more just societies within the region, and to plan for serious regional cooperation. This meeting was held in Kathmandu, Nepal, and was a follow-up to the earlier South Asian Civil Society Conference held in September 2000 at Manesar, Haryana, India. The Kathmandu meeting resolved to establish a regional Alliance for collective work on poverty eradication. This statement was adopted as the basis for future action together in the newly formed South Asia Alliance for Poverty Eradication.

The Alliance Members share the views that governments of the region have a responsibility to ensure that all of their citizens have basic human rights to life and livelihood. The State collects taxes from the people, and has a direct responsibility to provide affordable quality education, health services, food security, etc. The State should not only confine its role to regulating the freedom of the marketplace; nor should the state abdicate its role by handing over the responsibility for providing social services to the private sectors, NGOs and other civil society actors. The state, with honesty, sincerity, economy, and simplicity must play its rightful and historical role in the countries of the region.

In addition, the members reject the dominant development thinking which dictates that the best way to get the best life for the largest number of people is to promote a globalised world economy marked by "free trade", liberalization and privatisation. In the region of South Asia, we know that this approach to development causes hardship and misery to many people living in our region. We believe that Alternative Development Approaches will better serve the people of South Asia. We commit ourselves supporting to discover, define, and disseminate these Approaches, evolved through listening to, learning from and working with the people of our countries.

Members of the Alliance will continue to work with people living in poverty, urging their national governments to review and implement their commitments to the eradication of all forms of poverty which result in marginalisation. At the same time, members of the Alliance feel that some of the major problems faced by people living in conditions of poverty are particularly accentuated by globalisation, liberalisation and privatisation. These cannot be solved in isolation from other countries in the region. The members of the Alliance from various civil society organisations have agreed to build and strengthen alliances around common issues.

15/1/02

Alliance members underscore the grave crises that mark the entire region -

- growing numbers of people living in conditions of extreme poverty,
- skewed development policies leading to large scale displacements of poor people,
- mass migration increasing the fragility of rural based populations, particularly landless labourers and poor peasants,
- the escalating violence faced by women living in abject poverty,
- the declining social sector expenditures by governments,
- the increasing costs of militarisation,
- the acute distress of large masses of people neglected by unresponsive governments implementing distorted agenda of development priorities,
- severely endangered food security aggravated by multinational companies acquiring patent rights over our bio-diversity,
- the dismantling of government food security systems in the name of privatisation,
- forced and exploited labour,
- escalating communalism and fundamentalism which are undermining the people's struggles to address the root causes of poverty,
- the people's right to information not being uniformly available in the region,
- social conflict within countries resulting from state and other systemic suppression over people. People raise their voices about real problems, and the State does not listen to them, resulting in frustration, and violence in society,
- governments not addressing the structural causes of poverty,
- escalating numbers of refugees in the region, and
- extremely high national debt as a result of international financial institutional borrowing, etc.

Members of the Alliance call on governments in all countries of the region to implement genuine agrarian reforms, to put in place mechanisms to ensure profitable prices for all peasants and to initiate rural development policies which would provide further food securities to those living in poverty and deprivation.

Members of the Alliance call for the governments of the region to protect the People's Rights over natural resources- land, water, forest, minerals, shrubs and herbs. The bio-diversity of the region must be protected for local people.

To address the problems of landless labourers and poor peasants, the Alliance Members call for a campaign against the use of every kind of forced and bonded labour, and at the same time, for a campaign for Minimum Wages to all informal sector workers, especially agriculture labourers - both men and women.

Women living in poverty in all the countries of the region are facing high degrees of exploitation, both in terms of denial of their rights as citizens, their exclusion from political participation, and also in terms of property rights. Trafficking in women and children has increased and it is alarming to note the lack of sensitiveness to this issue. Forced violence against women even extends to "honour killings", "dowry deaths", and female foeticides in the region, leading to alarming decline in female to male sex ratio. Governments must act to protect and empower vulnerable women. Active steps must be taken to stop these practices.

Various religious and social factors and an overall situation of patriarchy prevent women's participation, decision making and equal rights, including access and control over property and resources. These can only be addressed through legal reform, and changes in resource allocation. Also, when there are more opportunities and space for women to improve their situations, women themselves will act. Governments should take effective and efficient actions to implement all

of Discrimination Against Women) to protect and promote the fundamental rights of women.

Attention of governments is also drawn to the need to eradicate child labour and to provide compulsory free basic education. Likewise, concrete actions need to be taken to materialise the vision of signed International Conventions such as CRC (Convention on the Rights of the Child).

Debt payments are a crippling feature of the economies of the region. They are a result of the pressures of Globalised Economic Policies, and are one of the causes of continuing poverty. Members call for the immediate and unconditional Cancellation of Debt in the countries of South Asia, and governments are urged to divert the resources that would be used for debt payment to women and children's health, education, socio-economic empowerment, drinking water, and subsidies for farm inputs and food security.

In order to address the plight of refugees, negotiations are needed to facilitate repatriation, refugees returning to their countries with dignity and honour, without fear of persecution. Further, the repatriation of refugees is important in addressing the impoverishment that results for the citizens of the countries in the region that house refugees.

Alliance members urge governments to address in a timely planned way the fundamental causes of social conflicts with multiple strategies involving local people so that such conflicts can be prevented from escalating into violence.

The South Asia Alliance for Poverty Eradication and its members are committed to undertake the following roles and responsibilities:

- monitor national governments in their performance to implement their commitments,
- resist anti-poor policies, be they economic, social, political or environmental,
- encourage regional development cooperation amongst the governments of the region, as well as amongst non-state actors,
- develop strategies which create space for people's initiatives and support people's struggles for reinstating social justice, recognising the specific and different contexts of marginalised groups,
- facilitate alliances in the region and support existing networks, to work on strategies that could effectively change and combat the harmful economic policies of corporate globalisation, liberalisation and privatisation which cause increasing poverty in the region,
- develop common strategies that make governments, states, and local authorities accountable and responsive to people's needs and aspirations,
- establish regional dialogue with the European Union, and other international bodies and networks, both state and civil society ones that can be seen as allies in the struggle to control and change strong international actors who are causing impoverishment in the region - indeed, in the world,
- set up a "People for Peace" initiative in the region to work towards peace in the region. This will include influencing governments to reduce defence expenditures, and
- incorporate "Community Media" for communicating and informing about technology, success stories of differing communities and people's initiatives within the region.

The times call for joint resistance to external interventions that harm equitable distribution of resources within countries. All development policies, plans and budget exercises need a people's audit so that the planning process may be owned by the people living in the areas.

Civil and political rights essentially fortify people's access to economic, social and cultural rights. Social justice is under siege and people's organisations have indeed shown success in realising constitutional rights, as a result of their field and policy interventions.

South-South and South-North exchanges and alliances strengthen social actions, and are necessary in these complex economic and social times. Therefore, the members of the Alliance present in Kathmandu invite all like-minded social development organisations and movements in South Asia to join, and propose a system of affiliation for supporters living outside the region.

"Let us join hands to unitedly fight against poverty, hunger and social injustice"

December 21, 2001

Kathmandu, Nepal

Sincerely yours,

Sarba Raj Khadka
Executive Director

Rural Reconstruction Nepal (RRN)
(NGO in Special Consultative Status with ECOSOC of the United Nations)
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1/18/02 10:47 AM

Subject: PHA-Exchange> Codeine Cough Mixture Abuse
Date: Wed, 23 Jan 2002 14:35:07 +0800
From: kireenmm <kireenmm@tm.net.my>
To: pha-exchange@kabissa.org
CC: idris md <idrismd@tm.net.my>

22nd January 2002

Dear Friends

CODEINE COUGH MIXTURE ABUSE

The lure of lucrative profits has led to the abuses in sales of cough mixtures containing the drug codeine. These cough preparations are being indiscriminately sold to vulnerable targets, with drug addicts and youths being the prime victims.

These mixtures are intended for use as a cough suppressant and are deemed harmless in the public eye. However, it must be noted that the active ingredient, codeine, is a narcotic drug and its effects resemble those of morphine. It has the potential to cause addictive, or habit-forming, dependency.

A narcotic drug is dangerous in large doses, causing stupor, coma, convulsions or death. Withdrawal symptoms such as stomach cramps, muscle aches and pains, nausea, anxiety, feelings of fear, craving, weakness and body chills can occur following indiscriminate use.

The abuse of codeine cough mixture sales supports the addiction habits of drug addicts. There is no good reason to justify the use of these narcotic cough mixtures as there are safer alternative treatments available. Furthermore, in many cases a cough is beneficial, an automatic reflex that the body employs to rid itself of accumulated phlegm in the chest.

Crimes involving other narcotics such as heroin and marijuana result in harsh legal penalties for the offenders. CAP believes that similar strong measures are needed to curb yet another ugly facet of drug-pushing and addiction.

CAP has been calling for a ban on the sale of this narcotic medication. Instituting a ban will allow powers to pass to other agencies such as the police. The harsher punitive actions that follow will act as another deterrent in the control of drug abuse.

Some countries, like Egypt and Nepal, have taken such strong measures. We would like to hear of the situation in other countries, namely:

- is there a ban on the sale of codeine cough mixtures in your country, and if so, what were the circumstances which led to such a ban; and,
- if no ban exists, how is the sale of codeine cough mixtures controlled.

[redacted] would appreciate any information you can share with us.

Kireen

(on behalf of:
S.M. MOHAMED IDRIS
President
Consumers Association of Penang
226, Jalan Macalister
10400 Penang
Malaysia.)

✓

Subject: PHA-Exchange> A Call to Health Professionals to Participate in anti-WorldEconomicForum Events
Date: Sat, 12 Jan 2002 15:20:09 -0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

> Dear Friends and Colleagues:
>
> From January 31 to February 4, heads of the world's largest transnational
> corporations and world political leaders will meet at the WORLD ECONOMIC
> FORUM (WEF) in New York City.
>
> For the second year in a row, in dedicated and informed opposition, the
2nd
> Annual WORLD SOCIAL FORUM (WSF) will be meeting from January 31 to
February 5, in Porto Alegre, Brazil. (www.forumsocialmundial.org.br) Here,
> international representatives from human rights to labor to student
> organizations will stand is solidarity against the present state of
> globalization. The WSF states:
>
> "The alternatives proposed at the World Social Forum stand in opposition
to
> a process of capitalist globalization commanded by the large multinational
> corporations and by the governments and international institutions at the
> service of those corporations' interests....Our alternatives respect
> universal human rights...of all citizens - men and women - of all nations
> and the environment and will rest on democratic international systems and
> insitutions at the service of social justice, equality and the sovereignty
> of peoples." > World Social Forum Charter of Principles, Number 4
>
> Acting in parallel with the WSF in Porto Alegre, teach-ins and mass
> demonstrations have been planned by multiple groups in New York during the
> same time period. From demonstrations in Seattle against the 3rd WTO
> Ministerial Conference in Nov/Dec 1999 to those in Quebec against the
Summit
of the Americas in April 2001, the events in New York City on Feb 1 and 2
> may prove to be a similar mass protest against harmful and secretive
> international trade policy and negotiations.
>
> This letter is a call for health professionals to stand in solidarity as a
> health community against the disastrous effects of profit over health and
> human rights of people worldwide. Effects include: Destruction &
> contamination of the environment, long work hours, dangerous/toxic work
> environments, no benefits, no unionization, sexual abuse, very low wages,
> malnutrition....
>
> International ANSWER is one group organzing mass events
> (www.internationalanswer.org) on Feb 1 and 2. There are five actions you
> can take with international ANSWER: OMITTED, BECAUSE IT PERTAINS TO
ACTIONS IN NEW YORK CITY..

Other activities are listed on the ANSWER website. Also,
housing/transportation needs are addressed on website.
>
> Thank you for your time and interest,

1/18/02 2:02 PM

2

PHA Exchange → JN 11/2

RN 13/2

> Debbie Daniels, MD
> Doctors for Global Health Volunteer,
> Social Medicine - Montefiore
> daniels_debbie@hotmail.com
> Jen Cohn, MSII
> AMSA, Doc Bloc
> jecohn@mail.med.upenn.edu

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

Subject: Re: Clau
Date: Sun, 21 Apr 2002 18:18:40 +0700
From: "Aviva" <aviva@netnam.vn>
To: "Community health cell" <sochara@vsnl.com>

RAVI,
ANY REACTION ON THE TWO PIECES I POSTED IN PHA-EXCH FOR USE IN WHAT
CLAU

Am off to Angola 2 wks on Fri. But will be on my mail.

Please download all exchanges
and Claudius cycles in particular | AK ?

RN
25/4

RN
22/4

RN
22/4

re: Your letter on PHA Exchange!

Subject: RE: Your letter on PHA Exchange!
Date: Wed, 03 Apr 2002 18:24:59 -0530
From: Community health cell <sochara@vsnl.com>
To: lofanpg@tm.net.my, Claudio Schuftan <aviva@netnam.vn>, Alison Linnecar <alison.linnecar@gifa.org>

Dear Annelies Allain

Greetings to IBFAN! from PHA in solidarity. I saw your letter in PHA Exchange and hope you saw the note about the PHA related initiatives at WHA-2002. As a convenor of the WHO-WHA circle in PHM I welcome you and all your colleagues to an increasing collaboration in IBFAN and PHM efforts at WHA. We all need to join hands because the global forces making profits out of people's health are becoming more complex, indidious and distorted. So complementarity and inter network solidarity is crucial.
Please share your paper on the Global Strategy on Infant and Young Children and we will send you soon our response to WHO-CSI. We remember Halfdan Mahler's comments who continues to be a PHM well wisher and supporter in solidarity so that Alma Ata can be resurrected some day. Perhaps at the next WHA-May 2003 when it will be the 25th Anniversary of Alma Ata and the HFA-2000 goal.

Do send us details of sessions you would like us to attend and keep a date with us at the NGO forum on 14th May; the PHA get together at WCC on 16th May and the Technical briefing session at WHA on People's Health Charter on 17th May 2002.

Incidentally you will be glad to know that at the Chennai meeting in december 2002, IFBAN India joined the PHM process in India (18 Networks working together!!)
Best wishes

Ravi Narayan
Community Health Advisor CHC
WHO/WHA Circle, PHM

Subject: PHA-Exchange> Move for Health!
Date: Fri, 12 Apr 2002 20:26:14 +0200
From: "Fawzia Rasheed" <rasheedf@bluewin.ch>
To: <PHA-Exchange@kabissa.org>

Dear Friends

I happened to stumble into festivities for World Health Day in WHO, Geneva, last week. I thought you might like to see what the Director General has as a message for the world in the year 2002. You might also like to have a look at some of the pictures which mark this event in headquarters. It is a pity I can't show you the posters which shows people jogging and swimming etc with the slogan 'Move for health!' in a variety of languages. Here is a site where you can see the photos of the event as well as the Director General's message.

Best wishes

Fawzia
****

(Please see the photos at:
http://www.who.int/inf-tmedia/who2002/photo.html)

Physical inactivity a leading cause of disease and disability, warns WHO

Physical inactivity can have serious implications for people's health, said the World Health Organization today on the occasion of World Health Day. Approximately 2 million deaths per year are attributed to physical inactivity, prompting WHO to issue a warning that a sedentary lifestyle could very well be among the 10 leading causes of death and disability in the world.

World Health Day is celebrated annually on April 7 and used to inform the public about leading public health issues. By choosing physical activity as the theme for World Health Day, WHO is promoting healthy, active and tobacco-free lifestyles. The aim is to prevent the disease and disability caused by unhealthy and sedentary living.

Sedentary lifestyles increase all causes of mortality, double the risk of cardiovascular diseases, diabetes, and obesity, and increase the risks of colon cancer, high blood pressure, osteoporosis, lipid disorders, depression and anxiety. According to WHO, 60 to 85% of people in the world-from both developed and developing countries-lead sedentary lifestyles, making it one of the more serious yet insufficiently addressed public health problems of our time. It is estimated that nearly two-thirds of children are also insufficiently active, with serious implications for their future health.

RN
15/4

Physical inactivity, along with tobacco use and poor diet and nutrition, are increasingly becoming part of today's lifestyle leading to the rapid rise of diseases such as cardiovascular diseases, diabetes, or obesity. Chronic diseases caused by these risk factors are now the leading causes of death in every part of world except sub-Saharan Africa, where infectious diseases such as AIDS are still the leading problem. These chronic diseases are, for the most part, entirely preventable. Countries and people could save precious lives and health care resources by investing in preventing these diseases, says WHO.

"The habit of maintaining a healthy lifestyle, including regular exercise and a nutritious diet ideally begins in childhood and we hope that parents and schools everywhere will use this day to spread this message," said Dr Gro Harlem Brundtland, WHO's Director-General. "We should all be ready to move for health and to adopt healthy and active lifestyles. World Health Day 2002 is a call to action to individuals, families, communities governments and policy-makers to move for health," she added.

Among the preventive measures recommended by WHO are moderate physical activity for up to 30 minutes every day, tobacco cessation, and healthy nutrition. In addition to individual lifestyle changes, governments and policy makers are also recommended to "move for health" by creating a supportive environment for people. Among the measures recommended: implementing transportation policies that make it safer for people to walk and ride bicycles; legislating tobacco-free public buildings and spaces; building accessible parks, playgrounds and community centres; and promoting physical activity programmes in schools, communities and health services.

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Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

RN
15/4

PHA Exchange

Subject: PHA-Exchange> 12th March -WHO Statement on Middle East Conflict
Date: Fri, 5 Apr 2002 18:20:29 +0200
From: "Fawzia Rasheed" <rasheedf@bluewin.ch>
To: <PHA-Exchange@kabissa.org>

12th March 2002

Statement by Dr Gro Harlem Brundtland, Director-General of the World Health Organization

ESCALATION IN MIDDLE EASTERN CONFLICT RAISES MAJOR CONCERNS FOR HUMAN HEALTH
The latest escalation of violence in the Occupied Palestinian Territories, in Israel, and in the refugee camps in the West Bank and in Gaza represents a new and serious threat to the health of affected people - Palestinians, Israelis, and others caught up in conflict. I have read reports prepared by the International Committee of the Red Cross, the United Nations Relief and Works Agency for Palestine Refugees and our own WHO staff. I am seriously concerned about the consequences of the hostilities for people's health, not only in injuries, disability and loss of life. They also severely disrupt health services.

The targeting of civilians in the conflict is a deplorable development. Beyond the immediate death and injuries there is a long term price that will be borne, particularly by children, whose psychological health is being directly affected.

I am particularly concerned about the difficulties for people in need to reach and receive health services. This applies especially to children, pregnant women and the disabled.

I am deeply troubled by the fact that several of the casualties of the fighting have been health workers responding to people's acute needs and distress.

I appeal to all sides in the conflict to accept the critical role of doctors, nurses and paramedical workers on duty, to respect their neutrality, equip them to save lives and relieve suffering, and allow them to do this vital work in safety.

For further information, journalists can contact: Mr Jon Lidén, Office of the Director-General, WHO, Geneva, Telephone: (+41 22) 791 3982, Fax (+41 22) 791 4999, e-mail: lidenj@who.ch.

All WHO Press Releases, Fact Sheets and Features as well as other information on this subject can be obtained on Internet on the WHO home page http://www.who.int/

Subject: [science-movement] (unknown)
Date: Wed, 3 Apr 2002 02:45:02 -0800 (PST)
From: asha mishra <asham_200@yahoo.com>
To: bgvs-samata@yahoogroups.com
CC: bgvs-statecoord@yahoogroups.com, science-movement@yahoogroups.com

4/4/02 8:02 AM

MPBGVS EC on 12 – 4 – 2002 & Retreat of BGVS MP and Chhatisgarh on 13th to 15th April 2002, Pachmarhi Hoshangabad, MP

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Dear friend,

MPBGVS Executive Committee meeting will be held on 12 – 4 – 2002 and it is also proposed to hold a three day Retreat of BGVS MP & Chhatisgarh EC members, District secretaries [BGVS & Samata] and few other members from 13th to 15th April 2002 at Sanjay Gandhi Yuva Netrutwa Prashikshan Sansthan, Panchayatan –02 [Near Circuit House, Pachmarhi, Hoshangabad, MP.

The Retreat will be focused on the following few points:-

- What should be the long term prospective of BGVS in the present day Socio – Political situation?
- Our coordination & approach with Rajiv Gandhi Shiksha Mission, Padhna – Badhna Andolan & the coming CE program?
- Our approach with other area of activities like Health, Primary Education, Gender & other developmental programs?
- The role of BGVS District Units?
- Sustainability of the

PHA JSA

RN 4/4

RN 1/9-

4/4/02 8:03 AM

Organization?

BGVS MP & Chhatisgarh will be happy if you contribute your valuable times to our cadre in this important cadre camps.

Please confirm your participation.

With regards

Asha Mishra

Secretary.

Subject: PHA-Exchange> Palestine URGENT
Date: Tue, 02 Apr 2002 06:32:52 +0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

4/2/02 7:54 AM

I just spoke to Mustafa. He says Jihad and neighbours have been confined to
one room for the past 36 hours. Meantime hospitals have been attacked and
UNRWA staff also. Water supplies electricity are also cut.
Pressure needs to be put on International Red Cross re denial of treatment
to injured and sick especially in Ramallah. Apparently they do not intervene.
Israeli embassies should be pressurized and also US to understand the situation,
Pam

pamzinkin@gn.apc.org

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RN | TN
2/4

nge> Urgent Appeal

Subject: PHA-Exchange> Urgent Appeal
Date: Tue, 02 Apr 2002 06:28:13 -0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

Urgent Appeal
from the General Assembly of the
Association for Health and Environmental Development

The general assembly convened on Friday 29 March, 2002 reviewed the dangerous situation developing as a result of the invasion and occupation by the Israeli armed forces of Palestinian territory and laying siege to the office of the Palestinian president, Yasser Arafat. The Israeli army is prohibiting ambulances from moving within Ramallah and transporting the injured, to the extent that some of the injured were left to bleed to death. In fact, some Palestinian ambulances have been commandeered by the Israeli forces and used for military purposes. As if all this was not enough for the Israeli occupation forces, they have intentionally hit certain Palestinian hospitals, such as the Obstetrics Hospital in Ramallah, and shot at doctors and ambulance workers, wounding and killing some of them.

The Israeli invasion forces have also imposed curfews and have cut off electricity supplies in Ramallah. This has prohibited the local population from purchasing food, and has obstructed provision of basic amenities such as home heating, sanitation and water supplies, all of which impacts negatively on the health situation of the Palestinian population.

This dangerous situation blatantly contradicts the stipulations of the Geneva Convention for the protection of peoples under occupation, as well as other internationally ratified agreements pertaining to the provision of medical aid, emergency food rations, and all medical services to the wounded and sick and the general needs of the populace.

In light of all these events, the general assembly of the Association for Health and Environmental Development calls on the International Red Cross and Red Crescent Societies and their branches across the world, along with all other international emergency and relief organisations to pressure the Israeli government to halt this brutality and allow the delivery of health services and food to the besieged Palestinian populace. We also call on these organisations to send medical and food aid to the Palestinians, along with sending fact-finding missions to assess the deteriorating situation on the ground, and ascertain that supplies and services delivered are actually reaching their intended destination.

Association for Health an Environmental Development
General Assembly
Cairo
29/3/2002

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

TN/RN
2/4.

Subject: PHA-Exchange> World Bank PSD
Date: Thu, 21 Mar 2002 06:00:47 +0700
From: "aviva" <aviva@nemam.vn>
To: pha-exchange@kabissa.org

Subject: World Bank PSD

I wrote to Clare Short expressing concerns about the Private Sector Development Strategy.

I thought to you would be interested to hear the response from the British
Dept of International Development on behalf of the Minister. These are the
main points from the letter I received:

"[redacted]ould like to reassure you that the UK has been stressing many of the
points you make .. for example, private sector interventions from the [redacted]d
Bank will have to be very much set in the context of consultative country
owned strategies such as the PRS Papers...

The precise mix between public and private provision will be determined on
a country-by-country basis..
"for a vast number of the world's poorest...the only source of provison now
and in the foreseeable future for basic social services is from private
sector sources - not-for-profit as well as for-profit."

Re User fees : "the position of the World Bank and DfID is clear - neither
supports user fees for primary education and primary health service delivery"

th[redacted]se of output-based aid should be piloted.... we are keen to see that
the debate includes evidence on effectiveness.

[redacted] Strategy deliberately avoids links to the WTO

"we have extensive evidence that PSD approaches can work to reduce poverty
... but a great number of factors need to be taken into account to make
sure they do.."

"there is no way that low-income countries are going to experience
substantial poverty reduction without far reaching reforms that develop
both the private sector and the public sector"

I plan to respond to this -
best wishes
Nicola Ruck

TN →

RN
22/3

Nicola Ruck
Health and Development consultant
UK
Email nicola_ruck@bigfoot.com

RN
21/3

3/21/02 8.05 AM

3/21/02 8.08 AM

Subject: PHA-Exchange> Re:Disappearence of Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle
Date: Fri, 22 Mar 2002 09:36:50 -0800
From: Sarah Shannon <sarahs@hesperian.org>
To: PHA-Exchange@kabissa.org, "Mathura P Shrestha" <mathura@healthnet.org.np>, "Sindhu Nath Pyakuryal" <sarinapyakurel@hotmail.com>, "RRN" <rrn@rrn.org.np>, "PHECT" <phect@mos.com.np>, "Mangal Siddhi Manandhar" <msm@col.com.np>, "Khagendra Sangroula" <sangroula@infoclub.com.np>, "Kamal Krishna Joshi" <kkjoshi@wlink.com.np>, "INSEC" <insec@wlink.com.np>, "Ganga Kasaju" <vinaya@wlink.com.np>, "Dr. Sharad Onta" <shonta@mos.com.np>, "Dr. Mahesh Maskey" <mmaskey@healthnet.org.np>, "Dr. Bhogendra Sharma" <bsharma@cvict.org.np>, "CWIN" <cwin@mos.com.np>, "CVICT" <cvict@mos.com.np>, "Bijaya Silwal" <Vijay@reena.mos.com.np>, "Dr. Hemang Dixit" <hdixit@healthnet.org.np>, "Sushil Chandra Amatya" <chandra@wlink.com.np>, "recphec" <recphec@infoclub.com.np>, "Neenu Chapagain" <indira@healthnet.org.np>, "Komal Bhattarai" <gaide@ecsl.com.np>, "Kalyan Dev Bhattarai" <Kalyp@wlink.com.np>, "Hari Phuyal" <aryu@wlink.com.np>, "Daman Nath Dhungana" <daman@wlink.com.np>, "Bhola Pokharel" <bholapokharel345@hotmail.com>, "Allaince for HR and SJ" <allhr@info.com.np>, "Aruna Uprety" <bbs@healthnet.org.np>

Dear friends,
Attached, and below, is a copy of a letter that the Hesperian Foundation has sent to the Nepali Embassy in the United States regarding the disappearances of Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle. We extend our support and solidarity to all of our Nepali friends and colleagues during these very difficult times.

Sincerely,

Sarah Shannon
Hesperian Foundation

Honorable Mr. Jai Pratap Rana
The Royal Nepalese Embassy
2131 Leroy Place, NW
Washington, DC 20008

Dear Ambassador Rana,

I am writing you regarding some very disturbing news we have received about our Nepali colleagues Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle. On their way to participate in an Interaction Meeting Nepal Concern Group of South Asian People's Solidarity yesterday in New Delhi, they were apparently arrested at the Tribhuvan International Airport by the military.

The Prime Minister verbally confirmed their arrest, but we have not been informed yet of their release. Besides being concerned about the arrest of trusted

nge> Re:Disappearence of Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle

people in Nepal, we are concerned about the illegality of their arrest in a country known for its commitment to democratic rights:

1. They were arrested by the military during a period of civilian rule (although a state of emergency may exist, martial law does not).
2. They received no prior notification and were shown no warrant for arrest.
3. No information of their whereabouts has been provided by the government authority or the army.
4. The victims were not permitted to inform their relatives or friends of their arrest.

We would appreciate knowing the current status of Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle. I hope you will communicate our concerns for their safety to the Royal Government of Nepal.

Thank you for your intervention and assistance in this matter.

Sincerely,

Sarah Shannon
Executive Director

nepali denuncia.doc	Name: nepali denuncia.doc Type: Winword File (application/msword) Encoding: base64

the Hesperian Foundation

publishing for community health and empowerment

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Website: www.hesperian.org
Telephone: (510) 845-1447
Fax: (510) 845-9141

21 March 2002

Honorable Mr. Jai Pratap Rana
The Royal Nepalese Embassy
2131 Leroy Place, NW
Washington, DC 20008

-- 1 page only --
Fax: 202 667 5534

Dear Ambassador Rana,

I am writing you regarding some very disturbing news we have received about our Nepali colleagues Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle. On their way to participate in an Interaction Meeting Nepal Concern Group of South Asian People's Solidarity yesterday in New Delhi, they were apparently arrested at the Tribhuvan International Airport by the military.

The Prime Minister verbally confirmed their arrest, but we have not been informed yet of their release. Besides being concerned about the arrest of trusted colleagues who have devoted their lives to making health care a right for poor people in Nepal, we are concerned about the illegality of their arrest in a country known for its commitment to democratic rights:

1. They were arrested by the military during a period of civilian rule (although a state of emergency may exist, martial law does not).
2. They received no prior notification and were shown no warrant for arrest.
3. No information of their whereabouts has been provided by the government authority or the army.
4. The victims were not permitted to inform their relatives or friends of their arrest.

We would appreciate knowing the current status of Dr. Mahesh Maskey, Shyam Shrestha and Pramod Kafle. I hope you will communicate our concerns for their safety to the Royal Government of Nepal.

Thank you for your intervention and assistance in this matter.

Sincerely,

Sarah Shannon
Executive Director

RN
25/3

Subject: PHA-Exchange> 'Encounter".
Date: Fri, 22 Mar 2002 07:36:50 +0530
From: "Mathura P Shrestha" <mathura@healthnet.org.np>
To: "WORT-FM Community Radio" <wort@terracom.net>, "VHAI" <vhai@sify.com>,
"Thomas Achard" <thomas.achard@bluewin.ch>,
"Steve Mikesell" <villagespring@yahoo.com>,
"Stephen Bezruchka" <sabez@u.washington.edu>,
"South-South Solidarity" <south@giasdl01.vsnl.net.in>,
"Sophie Beach" <SBeach@cpj.org>, "PHANetwork" <pha-exchange@kabissa.org>,
"Nadine Gasman" <gasmauna@netmex.com>, <mohan@jnumjv.ernet.in>,
"Mary Des Chene" <mdesche@emory.edu>, "Ipshita (ITE)" <Ipshita@intoday.com>,
"Ian Harper" <ian_harper2000@yahoo.com>, "gk" <gk@citechco.net>,
"Edelina de la Paz" <bdelapaz@uplink.com.ph>,
"David E. Kapell" <dkapell@optonline.net>,
"anna dehavenon" <adehavenon@mindspring.com>

Summary Report of the investigation of HR Organizations (several) with the involvement of a representative from National Human Rights Commission:

Kanchha Dangol along with four other men of Saraswoti Village of Kathmandu district was arrested by army personnel without warrant or charges on Friday 15 March 2002. There whereabouts were unknown. However on Monday, 18 March Kanchha Dongol was alleged to be 'dead on encounter'. The team observed the body of the Kanchha Dongal at the Maharajgunj TU Teaching Hospital in the presence of the NHRC member on 20 March and found:

1. Th cloth was stained with blood, tear, and mud,
2. Multiple contusions all over the body,
3. Multiple stab like injuries over the legs bellow the knees,
4. Perforated injury on the middle of lower part of the chest,
5. three punctured wounds on the back of the body,
6. Through and through perforated injury in the skull over the temporal regions,
7. Ligature mark like injury over the neck.

Eye witness in the Saraswoti Village confirmed their arrest by the army personnel after cordoning off the village on 15 March. The villagers also reported Army exercise with firing in the Bhutkhel forest nearby on Monday at about 7 PM. No one was allowed to enter the forest from the evening. HR members suspects fake encounter after the arrest. The bullet wound may be postmortem.

RN
2513

Subject: PHA-Exchange> Please help - La Pena del Bronx has been shut down by police
Date: Sat, 02 Mar 2002 15:02:43 -0500
From: DGH Info <dghinfo@dghonline.org>
To: pha-exch <pha-exchange@kabissa.org>

**********ALERT/ALERTA**********
(abajo en espanol)

La Pena del Bronx has been shut down by police

Dear companeros/companeras:

On Friday night, March 1st, la Pena del Bronx, the South Bronx community organization was shut down by the NYC police. The 40th precinct police dept. Has been harassing "la Pena" for the past couple of months, including confiscating property and issuing absurd tickets and citations based on false premises. la Pena del Bronx is a multicultural, multiethnic community organization where Latino, African American, native cultures, immigrants and people from the community have a space to meet, organize and demand their rights. la Pena del Bronx was closed down without any prior warning or explanation. This is a criminal, racist, political action by the city or New York and the police. There is a citation for Tuesday, March 5th for a court appearance.

We are asking for your solidarity in this moment of need. If you have any contact with lawyers they will be needed. Please send statements of support, and if you can stop by la Pena. We will be meeting outside in protest of the closing until it is opened again. la Pena is located at 226 E. 144th. Bronx NY (behind Lincoln Hospital parking)

please call: 1-718-292-6137 or email: mveneg1@yahoo.com or laPena2000@aol.com for more information.

!!!!!!!!!!!!OPEN LA PENA DEL BRONX NOW!!!!!!!!!!!!

**********ALERTA**********

La Pena Cultural del Bronx fue cerrada por la policia

Estimados companeras y companeros:

Anoche viernes, marzo 1, policias llegaron a la Pena del Bronx, y la cerraron sin pretexto o justificacion. hace meses que policias del precincto 40 del Bronx han estado hostigando la Pena, citando violaciones falsas y confiscando propiedad y allanando eventos. La Pena cultural del Bronx es una organizacion comunitaria multietnica, multicultural del sur del Bronx, nueva york. Aqui llegan latinos, afroamericanos, imigrantes, y gente de la comunidad que encuentran un lugar para juntarse, organizar y demandar los derechos.

PHA-Exchange
RN
4/3

La Pena del Bronx a sido cerrada sin pretexto o justificacion. Esto es un acto criminal, racista y politico por la ciudad de Nueva York y la policia. estamos citado para la corte superior el martes 5 de marzo.

Pedimos la solidaridad en este momento dificil. Pedimos si tienen contacto con abogados que nos puedan ayudar. Agadecemos mensajes de apoyo o que pasen a la Pena. Vamos a estar afuera de la Pena en protesta hasta que se vuelva a abrir. la Pena esta localizada en el 226 E. 144st Bronx, NY (atras del estacionamiento del Hospital Lincoln) contactos: tel: 718-292-6137 email: mveneg1@yahoo.com o laPena2000@aol.com

!!!!!!!!!!QUE SE ABRA LA PENA DEL BRONX!!!!!!!!!!

RN
4/03

*^

DOCTORS FOR GLOBAL HEALTH
Promoting Health and Human Rights
"With Those Who Have No Voice"
PO Box 1761, Decatur, GA 30031 USA
Tel. & Fax: 1-404-377-3566
dghinfo@dghonline.org
http:www.dghonline.org

*^

Subject: PHA-Exchange> NGOs to participate in Global Fund
Date: Thu, 21 Feb 2002 08:13:27 +0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

Courtesy of Ellen Verheul <ellen.verheul@wemos.nl>

> > *Subject: Nominations: GFATM Technical Review Panel. > Importance: High.*
> >
> >
> > *Nominations: GFATM Technical Review Panel*
> >
> > *Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM): Call for*
> > *Technical Review Panel Nominations*
> >
> > *The Global Fund to fight AIDS, Tuberculosis and Malaria has opened the*
> > *recruitment process for the Technical Review Panel (TRP) members.*
> > *Applications should be submitted to the Global Fund Secretariat no later*
> > *than 28 February 2002. The Board will select 17 members of the TRP.*
> >
> > *Candidates for members of the TRP should come from the widest range of*
> > *partners, including government organizations, NGOs, civil society,*
> > *multilateral and bilateral agencies, the private sector and academia are*
> > *encouraged to apply.*
> >
> > *The Board will also select a Roster of Experts of up to 100 individuals*
who
> > *will serve as a Technical Review Support Group from the same pool of*
> > *applications received.*
> >
> > *The newly selected TRP members are expected to review the first round of*
> > *proposals received by 10 March, as announced in the Call for Proposals.*
> > *Proposals submitted after this date will be reviewed by the TRP in*
> > *subsequent rounds, generally three times a year.*
> >
> > *TRP members are expected to be available in Geneva to work during the*
period
> > *of 25 March - 4 April to review the first round of proposals. The TRP's*
> > *recommendations will be submitted to the Board for approval at the*
Second
> > *Board meeting, which will take place on 23-24 April in New York.*
> >
> > *Curriculum Vitae forms for applicants and the Terms of Reference of the*
> > *Technical Review Panel are available on the GFATM web site:*
> > *http://www.globalfundatm.org/TRP.html*
> >
> > *Or contact the GFATM Secretariat at trp@tss-twg.be*
> > **********

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

Leb
22/2/02

Subject: PHA-Exchange> AFRICAN ORGANISATIONS SPEAK OUT ON SUSTAINABLE DEVELOPMENT
Date: Sun, 17 Feb 2002 17:36:04 +0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

> *AFRICAN ORGANISATIONS SPEAK OUT ON SUSTAINABLE DEVELOPMENT*
> *Firoze Manji, Fahamu - Learning For Change, UK.*

> *About 200 organisations from around Africa, including representatives* NGOs,
> *trade unions, women's organisations, farmers and young people's groups met*
> *in Bamako, Mali, recently to prepare African inputs to the World Social*
> *Forum held at the end of January.*
>
> *They resolved, among other things, that globalization is just a new and* more
> *acceptable term for imperialism, that double standards were being applied*
> *with the selective imposition of rules about trade to the detriment of*
> *Africa. They expressed concern that the "New Partnership for Africa's*
> *Development" (NEPAD) was based on accepting the neo-liberal analysis and*
> *strategies of the rich countries and was therefore not acceptable as a* basis
> *for planning Africa's future.*
>
> *The importance of the African Social Forum was in presenting development* in
> *Africa as a political issue about power to decide on Africa's future. For*
> *too long development has focussed on the physical consequences of this*
> *unjust world order and has limited itself to addressing the lack of water,*
> *health, incomes, basic services etc. This has led to NGOs becoming*
> *instruments of neo-liberal globalisation that have colluded in undermining*
> *the state by providing services and using funding destined for them. (For* a
> *fuller report see below).*
>
> *Sustainable development is about much more than the rise and fall of GNP.* It
> *is about creating an environment in which people can develop their full*
> *potential under conditions where there is respect for human dignity and*
> *human rights. The goal of sustainable development must be human freedom,* and
> *the measure of its success must be a measure of the extent to which* citizens
> *of a country are able to exercise that freedom. But, as Professor Amartya*
> *Sen, Nobel Prize Winner in Economics, has argued in his book 'Development* as
> *Freedom', "Freedoms are not only the primary ends of development, they are*
> *also among its principal means." Development should be seen as a process* of
> *expanding freedoms. "If freedom is what development advances, then there* is
> *a major argument for concentrating on that overarching objective, rather*
> *than on some particular means, or some chosen list of instruments". To*
> *achieve development, he argues, requires not only the removal of poverty,*
> *lack of economic opportunities, social deprivation, and neglect of public*
> *services, but also the removal of tyranny and the machinery of repression.*
>
> *Such a view is in contrast to what has become the 'conventional wisdom' of*
> *development that sees economic growth as both the means and the end.*
> *Development, the story goes, is possible only if there is growth. And* growth
> *is equated with the 'right' of a minority to amass wealth. Only when this*
> *freedom is unrestricted will others in society benefit from any associated*
> *spin-offs (the trickle-down effect). All other freedoms are only* achievable

> if such growth occurs. The purpose of 'development' is, therefore, to
> guarantee 'growth' so that ultimately other freedoms can, at some
> indeterminate time in the future, be enjoyed. Such a view has increasingly
> been associated with the international financial institutions (IMF and
World
> Bank) whose influence on economic policy - especially in Africa - has been
> so pervasive. State expenditure, according to this view, should be
directed
> towards creating an enabling environment for 'growth', and not be 'wasted'
> on the provision of public services that, in any case, can ultimately be
> provided 'more efficiently' by private enterprise. This is the approach
> that, as Professor Sen points out, makes socially useful members of
society
> such as school-teachers and health workers feel more threatened by
> development policies than do army generals.
>
> Such an approach to development has had dire consequences for the
developing
> world in general and Sub-Saharan Africa in particular. Of the nearly 5
> billion people in the developing world, more than 850 million are
> illiterate; 325 million boys and girls are denied schooling; 2.4 billion
> have no access to basic sanitation. More than 30,000 children under the
age
> of 5 years die each day from preventable causes. And some 1.2 billion
people
> live on less than a dollar a day. Add to that the fact that more than 36
> million people were living with AIDS. Of the 36 million people living with
> HIV/ AIDS, 70% are to be found in sub-Saharan Africa.
>
> Only 60% of adults in Sub-Saharan Africa are literate in the region, as
> compared with 73% in the rest of the developing world. Life expectancy at
> birth is less than 49 years, and nearly half the population survives on
less
> than $1 a day. Economic growth in the region has fallen during the last 25
> years, with GDP per capita growth averaging -1%. Per capita income in 1960
> was about 1/9th of that in high-income OECD countries, but by 1998 it had
> fallen to 1/18th.
>
> Sub-Saharan Africa's massive external debt, estimated at more than $300
> billion is perhaps the single largest obstacle to development and economic
i
> ndependence. The 48 countries of sub-Saharan Africa spend $13.5 billion
each
> year repaying debts to foreign creditors. Over the last 20 years, African
> countries have paid out more in debt service to foreign creditors than
they
> have received in development assistance or in new loans. Trade
> liberalization associated with the Structural Adjustment Programmes may
have
> increased the importance of international trade for Africa, but the
region's
> share of world trade has declined.
>
> But it is not that sub-Saharan Africa is devoid of wealth. There is
abundant
> mineral wealth in Sierra Leone, Liberia, Angola, in the Democratic
Republic
> of Congo (DRC), in South Africa and elsewhere. Yet it is this very
abundance
> of natural resources that has led to vicious competition for access and
> control, frequently supported by outside vested interests. The result has
> been armed conflict, mass displacement of people, torture and ill
treatment,
> and frank impunity for the perpetrators. Unarmed civilians have frequently
> been the victims of such conflicts with killings, amputations, rape and
> other forms of sexual abuse and abductions being rife in countries such as
> Sierra Leone, the DRC, and Burundi. Angola, which has seen an estimated
> 500,000 people killed since 1989 and an estimated 3 million refugees. It
is

> also being torn apart directly as a consequence over the competition for
> resources such as diamonds and offshore oil, with various factions
fighting
> for these prizes.
>
> But, as Mahmood Mamdani has pointed out, despite the current dogmas, "the
> story of independent Africa is not one of unremitting decline. The first
two
> decades of independence were decades of moderate progress. Between 1967
and
> 1980 more than a dozen African countries registered a growth rate of 6%
[.]
> To be sure there was a downside. That was that the failure to transform
> agriculture, and thus to bring the vast majority of the population into
the
> development process. This shortcoming in economic policy went alongside
and
> was sustained by a political authoritarianism."
.>
> The economic policies followed by many African countries, frequently under
> pressure from international financial institutions, have resulted in high
> levels of income equality. And it is this that has created instability in
> the region. Development policies have, it is true, resulted in enrichment.
> But it has been the rich in these countries who have been getting richer,
> while the poor have become poorer. According the UNDP, "In 16 of the 22
Sub-
> Saharan countries with data for the 1990s, the poorest 10% of the
population
> had less than 1/10 of the income of the richest 10%, and in 9 less than
> 1/20." Marked, and growing, inequalities have had serious consequences on
> the social fabric of these countries. It has resulted in massive social
> exclusion, the growth in organized street crime, disillusionment with the
> political process, and the growth in the appeal for the use of violence
for
> political ends. Faced with growing discontentment, corruption, abuse of
> state power, many governments have become intolerant of legitimate protest
> and political opposition. The use of excessive force to deal with public
and
> political discontent has become all too common, as vividly illustrated by
> the current crisis in Zimbabwe where, as a result of recent legislation,
it
> has become illegal to criticize the president.
>
> Time has come for there to be substantial changes to current approaches to
> development. Ten years ago at the "Earth Summit" in Rio de Janeiro,
> Governments committed themselves to a plan of action known as Agenda 21.
> Principle 5 of that plan stated that:
>
> "All States and all people shall cooperate in the essential task of
> eradicating poverty as an indispensable requirement for sustainable
> development, in order to decrease the disparities in standards of living
and
> better meet the needs of the majority of the people of the world."
>
> "But commitments alone", as the Secretary General of the United Nations,
> Kofi Anan has put it, "have proven insufficient to the task. We have not
yet
> fully integrated the economic, social and environmental pillars of
> development, nor have we made enough of a break with the unsustainable
> practices that have led to the current predicament."
>
> The Jury at the International People's Tribunal on Debt, convened at the
> recent the World Social Forum in Porto Alegre, called for the external
debt
> to be declared "as fraudulent, illegitimate and the cause of the loss of
> national sovereignty and the quality of life of the majority of the
> population of the South". Similar proclamations are needed in the build up
> to the World Social Summit on Sustainable Development scheduled to be held
> in Johannesburg 26 August to 4 September. One hopes that the alternative

Subject: PHA-Exchange> Re: Codeine Cough Mixture Abuse, "PHENSEDYL in BANGLADESH" an example
Date: Sun, 10 Feb 2002 10:13:19 +0600
From: "Dr Md Sayedur Rahman Khasru" <srkhasru@bdcom.com>
Organization: Bangabandhu Sheikh Mujib Medical University
To: <pha-exchange@kabissa.org>

In Bangladesh, codeine containing cough preparations were banned in Drug (Control) Ordinance 1982, due to its abuse potential as mentioned by Consumers Association of Penang. As a consequence of "deregulation in the name of liberalization", codeine phosphate and dihydrocodeine were approved later as single ingredient antitussive agent.

According to law of Bangladesh, these agents are prescription only medicine. However, the fallacy is "to become a prescriber in Bangladesh, you need only a pen and a piece of paper". Even if someone don't have those, he/she can buy drug from the pharmacy (there are very few exceptions in this regard).

In this connection, I like to share another experience of Bangladesh regarding codeine containing cough linctus. It was expected from the Indian experts that they mention few words about "PHENSEDYL", a combination of

Promethazine HCl	5.0 mg per 5 ml
Codeine Phosphate	9 mg per 5 ml
Ephedrine HCl	7.2 mg per 5 ml

Though this so-called cough suppressant is banned in Bangladesh, "PHENSEDYL" is the number one abused medicine by the addicts in our country and thereby producing huge social instability especially in the youth encouraging them to commit crime. This experience and observation could be referred to relevant regulatory authority to justify banning of codeine containing cough suppressant as either a combination or single ingredient product. In addition, it should be mentioned here that banning of such product in only one country is not sufficient. Production of these codeine containing cough preparations in neighboring country can also be disastrous. Therefore, the initiative of Consumers Association of Penang should be supported by similar organizations of other "PHENSEDYL" manufacturing countries.

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

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Subject: PHA-Exchange> WHO Executive Board
Date: Tue, 15 Jan 2002 09:27:50 +0100
From: "Fawzia Rasheed" <rasheedf@bluewin.ch>
To: <PHA-Exchange@kabissa.org>

http://www.accessmed-msf.org/prod/publications.asp?scntid=14120021123512&contenttype=PARA&

MSF Statement for the WHO Executive Board
14 January, 2002

Contents:
Next steps for the Essential Drugs List (EDL)
Equity pricing
[redacted]-qualification of low cost producers
The Doha declaration on TRIPS and public health
Gap in research and development

MSF would like to take the opportunity of the WHO Executive Board to highlight a series of issues related to the WHO and the important role it must play in increasing access to essential medicines in developing countries.

Next steps for the Essential Drugs List (EDL)

The EDL is one of the most important public health tools, promoting access to vital medicines and their rational selection and use. Essential drugs are those that satisfy the health care needs of the majority of the population: they should therefore be available at all times in adequate amounts and in the appropriate dosage forms, and at a price that individuals and their communities can afford. The Essential [redacted]gs concept guides countries in selection of drugs, in decisions about procurement and pricing policies and rational drugs use. The essential drugs concept also provides guiding principles for NGOs.

MSF welcomes the revised procedure for updating WHO’s Model List of Essential Drugs as outlined in document EB109/8. The procedure ensures an evidence-based, transparent, and independent process for revising the EDL. We particularly welcome the fact that expensive drugs, when their use is justified, will no longer be excluded from the list solely because of price.

The expansion of the EDL should go hand-in-hand with measures to ensure that these medicines become affordable for the individuals and communities involved.

Equity pricing

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[redacted] equity pricing of essential medicines, many

some progress has been made in bringing the prices of certain medicines down, a lot remains to be done by governments and international organisations. An equity pricing system should include political and legal measures to increase generic competition, global/regional procurement and distribution, local production through compulsory or voluntary licensing and technology transfer.

MSF would like to warn against unwarranted optimism with regard to the multinational industry’s willingness to bring drug prices down to an affordable level. Equity pricing will not be achieved by relying on voluntary actions by pharmaceutical companies only. Without decisive action from key players such as the WHO, the price of medicines for many diseases will remain too high. For example, the price of an essential drug used to treat AIDS-related meningitis, fluconazole, varies greatly depending on who produces it and where it is sold: in Thailand, a generic producer sells it for US$ 0.29 (per 200 mg capsule; June 2000) but in Guatemala, where the drug is patented and manufactured by Pfizer, it costs as much as US$ 27.60.

In the case of a high-profile disease such as AIDS, where public pressure and media attention is intense, lack of transparency from the pharmaceutical companies about pricing their products in different countries is emerging as a new challenge. Obtaining up-to-date pricing information is difficult, and negotiating drug prices with different companies for each individual product is time-consuming for the governments of poor countries. WHO should support across the border negotiations regarding the pricing of medicines for neighbouring countries with similar needs.

MSF is pleased to work with the WHO, UNAIDS and UNICEF on providing information on drug prices and welcomes the collaboration within the NGO Roundtable process on development of price monitoring methodology for NGOs. We hope to expand the work on drug price information even further in the future.

Pre-qualification of low cost producers

Medicines should be essential, available, affordable and of quality. To offer treatment to the highest number of people possible in developing countries, it is essential that all funds be used to buy quality medicines at the best possible price. This is simple mathematics: using the lowest cost suppliers, whether proprietary or generic companies, will increase the number of people who can be treated and will allow for greater investments in other important components of care and prevention.

The WHO should support countries and NGO’s in procuring affordable medicines for these particular diseases by identifying quality producers through a pre-qualification process. This will also facilitate procurement that will take place as a result of the activities of the Global Fund for TB, malaria and HIV/AIDS. Cheaper alternatives of important products, such as antiretrovirals, are becoming available on the markets of developing countries, and it is paramount to assist countries to assure the quality of these products. The added value of the pre-qualification process cannot be underestimated.

The Doha declaration on TRIPS and Public Health

2001 was marked by progress in the discussions on patent barriers to access to medicines at the World Trade Organisation (WTO). The Doha declaration on TRIPS and Public Health lays out the options countries have to take measures when prices of existing patented drugs are too high for their populations. 2002 is the perfect opportunity for the WHO to take up the challenge, together with other relevant international organisations, to provide practical technical assistance to make sure that the Doha declaration makes a difference at the national level. One pragmatic and effective way of doing this is to provide countries with examples or models of intellectual property legislation that will allow them to develop TRIPS compliant laws – all the while making maximum use of the safeguards of the TRIPS agreement to ensure that pharmaceutical patents do not hamper access to medicines.

Gap in research and development

2002 is also the time to improve the availability of essential medicines to treat neglected diseases, such as leishmaniasis, sleeping sickness, [illegible] compensate for the lack of research and development into these diseases, and other infectious diseases such as malaria and tuberculosis – an issue that was flagged in Doha but not resolved.

Again, this is where the WHO clearly must play a major role, along with governments and donor countries, in determining the R&D needs and stimulating R&D activities. R&D for neglected diseases cannot be left to the market place. Public Private partnerships alone will not offer a solution because there is insufficient market incentive. Radical new approaches are needed to kick-start R&D, including new funding mechanisms in areas that are now totally abandoned. Not-for-profit drug development initiatives should be explored to take drug R&D for neglected diseases out of the marketplace altogether.

MSF looks forward to contributing to an active dialogue and joint action

Subject: PHA-Exchange> Re: [IPHCWORLDWIDE] WHO Commission on Macroeconomics and Health: Possibility of Collaborative Analysis
Date: Mon, 14 Jan 2002 21:24:42 -0500
From: Fundación Niño a Niño <iphc.sa@etapa.com.ec>
To: <IPHCWORLDWIDE@yahoogroups.com>, <PHA-Exchange@kabissa.org>, <health-fin@lists.vicnet.net.au>

----- Original Message -----
From: David Legge
To: IPHCWORLDWIDE@yahoogroups.com ; PHA-Exchange@kabissa.org ; health-fin@lists.vicnet.net.au
Sent: Tuesday, January 15, 2002 7:05 AM
Subject: [IPHCWORLDWIDE] WHO Commission on Macroeconomics and Health: Possibility of Collaborative Analysis

Globalisation on trial
world health warning issued

Report of WHO Commission on Macroeconomics and Health

A high level WHO commission has warned the rich world that unless there is a dramatic increase in development assistance for health the legitimacy and stability of the current regime of global economic governance may be seriously threatened.

The report

The report of the WHO Commission on Macroeconomics and Health (CMH) is now available at:
<http://www3.who.int/whosis/menu.cfm?path=whosis,cmh&language=english>
This report will have a big impact on policies and programs in the field of health development. It is a major intervention in discussions about official development assistance including the role of the World Bank (and PRSPs).

Opportunity

The debate around the report will also provide an important opportunity to challenge neoliberal orthodoxy in development policy and to further undermine the legitimacy of the prevailing regime of global economic governance.
The purpose of this posting is to invite health activists, NGOs and academics, who see in this regime of global economic governance the major causes of health stagnation in the developing world, to a collaboration in developing a strong response to the CMH: building uopn its sombre warning to the captains of capital while challenging many of its assumptions and conclusions.

Background

The WHO Commission on Macroeconomics and Health (CMH) was established by the Director-General of WHO in January 2000. The Commission was chaired by Professor Jeffrey Sachs of Harvard. It members and helpers included former ministers of finance, people from the World Bank, the International Monetary Fund, the World Trade Organisation, the United Nations Development Program, the Economic Commission on Africa and the Organisation for Economic Cooperation and Development. The Commission was financially supported by the Bill and

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Melinda Gates Foundation, the Rockefeller Foundation and the UN Foundation and by the governments of the UK, Luxembourg, Ireland, Norway and Sweden. The CMH presented its final The Commission set up six working groups, on: health, economic growth, and poverty reduction; international public goods for health; mobilisation of domestic resources for health; health and the international economy; improving health outcomes of the poor; development assistance and health. The reports of the working groups are indexed at:
<http://www3.who.int/whosis/cmh/cmh_papers/papers.cfm?path=cmh,cmh_papers&language=english>
[you may need to reconstitute this URL if it gets broken in transmission]
WHO Director-General Dr Gro Harlem Brundtland welcomed the report of the WHO Commission on Macroeconomics and Health on December 20th 2001: "This report is a turning point," she said. "It will influence how development assistance is prioritized and coordinated in the years to come."

A provisional assessment

It is a difficult report to analyse. The argument is tortuous and quite selective in its use of evidence. In places it stretches fact, logic and credulity to the point of combustion. It is difficult to read the strategic purpose of the DG in commissioning the report and that of the members of the Commission in framing their presentation. It is clear that the report is meant to be read at several different levels.

The core of the report is this: globalisation is on trial: unless there is a dramatic increase in development assistance for health care in low income countries the legitimacy and stability of the current regime of global economic governance will be seriously threatened. It is a warning to the G8, the Paris Club and the Bretton Woods institutions to slow down on globalisation and redirect significant resources to health care in the poorer countries.

This is quite a finding, given the members of the Commission - which is partly why it is such an important opportunity for engagement.

However it is a big report and is accompanied by dozens of working group reports. There is a lot of material to absorb and consider. This raises questions about how Third World governments, health activists, NGOs and academics who had already come to this central conclusion might respond to the report.

A global collaboration in analysing and responding to the CMH report?

I have read the report and most of its working group reports and I have prepared a preliminary analysis which I have posted at:
<http://users.bigpond.net.au/sanguileggi/PrelimAnalCMHReport.html>

I hope this preliminary review will encourage people to read and think about the CMH report. I hope that the perspectives that I have presented may be useful to others in the task of interpreting, analysing and critiquing the report.

However, the work involved in considering thoroughly the report and that of the working groups is not trivial. The Commission had the resources of Bill Gates and the World Bank at its disposal. The networks of activists, NGOs and academics who might wish to take the opportunity to challenge the logic and legitimacy of the current regime of global governance do not have such resources. But we have our own experts and we are in touch with the current lived circumstances of different settings and different countries.

So I am proposing a global collaboration around the task of analysing and responding to the CMH report.

A global analysis would need a coordinating function: a systematic approach to analysis and critique: a coordinated approach to generating alternative strategies and policy principles: a process

and avenues for dissemination and follow up. I really don't know how these should be organised.

Process and outcomes
As I envisage it the material outcomes of this collaboration would be a collection of articles published in a very wide range of websites and journals. They might or might not be identified as arising from this collaboration (which might or might not be blessed with an formal name).
I am expecting that through this collaboration people in different parts of the world might collaborate in producing different critiques or commentaries for different purposes and different audiences.
As a starter I have produced the preliminary analysis addressed above. I would like to publish this commentary but I am not sure where and I would greatly appreciate feedback and commentary on the current draft before I do.
Perhaps the commentary might serve as a useful framework for claiming and allocating the work which is yet to be done.
Another framework would be the set of working papers referenced above.

A global collaborative critique?
Please read the report and my preliminary analysis and answer the following questions:

- Do you agree that the report of the CMH justifies a strong and critical response?
- Do you agree that we could organise and collaborate in a globalised analysis and response through the medium of this and related lists?
- How does a loosely knit global community of health activists undertake such a project?
- What can you and your organisation contribute to such a process?
- Are there particular aspects of the report that you would like to focus upon?

Best wishes

david legge

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Subject: IDRC Event - Événement au CRDI
Date: Fri, 31 May 2002 17:14:05 -0400
From: Pauline Dole <PDole@idrc.ca>
Reply-To: "Social and Political Sciences" <corp-socpolisci-dl@lyris.idrc.ca>
To: "Social and Political Sciences" <corp-socpolisci-dl@lyris.idrc.ca>

(Version française plus bas)

Maureen O'Neil, President of Canada's International Development Research Centre (IDRC), invites you to a presentation on

HELPING POLICYMAKERS MANAGE COMPLEX ISSUES

with Dr. Thomas Homer-Dixon author of the award-winning book The Ingenuity Gap

Tuesday, June 18, 2002
from 7 p.m. to 9 p.m., 14th floor Auditorium
IDRC, 250 Albert St., Ottawa, Canada

Canadian policymakers face immense challenges. They are asked to solve - or manage - a multitude of interconnected problems that can develop into crises without warning. Dr. Homer-Dixon will explain why human interaction has become so fast and complex. He will describe the consequences this has on public policy and will explain how and why complexity arises. He will also offer some guidelines and suggestions for policymaking. Dr. Thomas Homer-Dixon is Director of the Centre for the Study of Peace and Conflict at the University of Toronto.

Space is limited. RSVP with Jennifer McCue at: jmccue@idrc.ca, Tel: 236 6163 ext. 2086.

For more information, link to:
http://www.idrc.ca/media/events/homer-dixon_e.html.

Maureen O'Neil, présidente du Centre Canadian de recherches pour le développement international (CRDI), vous invite à un exposé sur le thème

AIDER LES POLITIQUES À MAÎTRISER DES QUESTIONS COMPLEXES

donné par Thomas Homer-Dixon, Ph.D., auteur du livre primé Ingenuity Gap

le mardi 18 juin 2002
de 19 h à 21 h, à l'auditorium du CRDI
14e étage, 250, rue Albert, Ottawa, Canada

Les politiques canadiens font face à d'immenses défis. Ils sont appelés à résoudre - ou du moins à maîtriser - une multitude de problèmes interdépendants susceptibles à tout moment d'évoluer vers des situations de crise. M. Homer-Dixon cernera les raisons pour lesquelles les échanges humains sont devenus aussi trépidants et compliqués et décrira les conséquences de cette réalité sur les politiques publiques. Il démontera les rouages de la complexité et offrira quelques lignes directrices et suggestions utiles à l'élaboration des politiques. Thomas Homer-Dixon est directeur du Centre d'études pour la paix et le règlement des conflits.

Le conférencier fera sa présentation en anglais.

Les places sont limitées. RSVP avec Jennifer McCue: jmccue@idrc.ca; Tel : 236 6163 ext. 2086.

Pour plus d'information, visitez

PHA-Exchange →

RN/TM 6/6/02

Subject: IDRC Event - Événement au CRDI
Date: Fri, 31 May 2002 17:14:05 -0400
From: Pauline Dole <PDole@idrc.ca>
Reply-To: "Social and Political Sciences" <corp-socpolisci-dl@lyris.idrc.ca>
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For more information, link to:
http://www.idrc.ca/media/events/homer-dixon_e.html.

Maureen O'Neil, présidente du Centre Canadian de recherches pour le développement international (CRDI), vous invite à un exposé sur le thème

AIDER LES POLITIQUES À MAÎTRISER DES QUESTIONS COMPLEXES

donné par Thomas Homer-Dixon, Ph.D., auteur du livre primé Ingenuity Gap

le mardi 18 juin 2002
de 19 h à 21 h, à l'auditorium du CRDI
14e étage, 250, rue Albert, Ottawa, Canada

Les politiques canadiens font face à d'immenses défis. Ils sont appelés à résoudre - ou du moins à maîtriser - une multitude de problèmes interdépendants susceptibles à tout moment d'évoluer vers des situations de crise. M. Homer-Dixon cernera les raisons pour lesquelles les échanges humains sont devenus aussi trépidants et compliqués et décrira les conséquences de cette réalité sur les politiques publiques. Il démontera les rouages de la complexité et offrira quelques lignes directrices et suggestions utiles à l'élaboration des politiques. Thomas Homer-Dixon est directeur du Centre d'études pour la paix et le règlement des conflits.

Le conférencier fera sa présentation en anglais.

Les places sont limitées. RSVP avec Jennifer McCue: jmccue@idrc.ca; Tél : 236 6163 ext. 2086.

Pour plus d'information, visitez

DHA-Exchange →

RN/TN 5/6/02

10. The PHM's website has been up two years now. It needs more dynamic updates and also more contributions.

11. If, as a global movement, we want to really be what we call ourselves --as tough as it may be-- we all have to stay reasonably up to date and provide people's outlooks on and progressive analyses of what is happening (both in general and in health), plus giving some guidance for concerted action. On key issues, the list-server should thus spill into the website. I.e. the website has to become the repository of our collective thought and our concrete calls for action.

12. This is why PHM is now organizing itself in 'action circles' --small groups collectively working on specific topics, mostly through email. These groups are starting to give direction to our actions, actions rooted in equity/human rights/sustainable development-based analyses applied mostly to the most urgent global health issues. These circles have to and will multiply from now on.

13. As regards the PCH's many 'Calls for Action' --all pointing at blocking or reversing negative, and promoting positive determinants of health-- all of them are still very much current. As a reminder, these are calls for specific actions made in the areas of:

-health as a human right (and not only the right to health),

-the economic, social, political and environmental challenges to health,

-war, violence, conflict and natural disasters,

-a comprehensive, more democratic PHC with adequate resources

and greater accountability,

-greater people's empowerment and their greater participation, and

-stronger local people's organization and a strong global movement.

14. The specific actions proposed in the PCH under each of these headings are not to be seen as the content for a collection of fitting slogans or as a wish-list. Eventually, the PHM will have one or more action circles addressing each of these areas and these circles will network with other groups already working on each of these issues.

15. But for this to happen, more of each of you need to get involved. It is, therefore, not sufficient for this short document to reassess where the People's Health Movement stands in 2002. Each of its members needs to re-commit her himself. We need more of your time! Perhaps the moment has come to abandon some of the irrelevant work we all get involved in. We can no longer afford missing the forest by focusing on the trees..

16. Furthermore, we are sure that --world events going the way they are-- our potential PHM constituency has grown out there (!). More people oppose what is happening. People are more anxious than before to be counted-in in actions that will do something to reverse current trends. PHM will reach out to these new strategic allies. We can offer a global and working organization --with clear, explicit rallying points and principles

1/23/02 8:28 AM

Re: Cuadal

(found in the PCH)-- that is engaged in providing a sustained and coherent set of proposed people-centered actions adapted to existing and emerging situations. These actions may still be small and scattered, but they are additive.

17. The People's Health Movement can and has taken up the historical challenge to be

18. Yes, the world has become more complicated in just 18 months since our PHA2000 in Bangladesh. And it is heading to greater uncertainties, all negatively impinging on the health of the poorest among us. But our challenge is still the same --though more urgent-- and still calls for the main actions and demands called for by our flagship document, the People's Charter for Health.

19. We particularly call on delegates to and participants in this year's WHA to join our Movement --regardless of your official or non-official status.

[To start with, you can visit, our website at www.phm2002.org (??), contact our Secretariat at gksavar@citechco.net and join the pha-exchange list-server by writing to its moderator at aviva@netnam.vn].

Note: Come October, the PHM's Secretariat will be shifting from GK in Savar to the Community Health Cell (CHC) in Bangalore, India. The reigns of it will be passed from Qasem Chaudhury to Ravi and Thelma Narayan assisted by an existing worldwide Management Circle.

(If you have suggestions for changes in the text send them to Ravi at sochara@vsnl.com with copies to Claudio at aviva@netnam.vn and make them in capital letters (!) so it will be easier to make such changes. If you have comments to specific points made, please email us and kindly refer to the respective paragraph's number).

4/23/02 8:38 AM

(I submit this piece primarily, but not only, for the consideration of and feedback from my fellow members of the PHM WHA Circle)

Claudio

THE PEOPLE'S HEALTH MOVEMENT (PHM): TIME TO TAKE STOCK.

(RE-VISIONING THE GLOBAL HEALTH CRISIS: THE PHM's POSITION IN 2002).

1. The People's Charter for Health (PCH), The PHM's manifesto, is one and a half years old. It has been disseminated quite widely worldwide.

2. The world has moved on since. But, clearly, for the worse in almost all fronts the PHM has strong feelings about. Most worrisome is the fact that most of the world's shifts for the worse have become so depressingly predictable, and nobody seems to be succeeding in doing much about them.

3. The PCH's 'Call for Action' predicted much of what we are witnessing: we were "on the dot". So, to continue to be "on the dot", we simply have to reassess where we are and what we have, and have not, achieved. Just to make yet further predictions of doom would be to utterly fail all that and those we stand for.

4. The claims on various duty bearers made in the People's Charter for Health have, in all honesty, mostly not been heard or heeded, and much less fulfilled. There have been advances, yes. But not so many we can call our own little victories.

5. Our activism has not been commensurate to the fast changes we are all witnessing in the world, i.e. tougher times call for more commitment, more militancy and, above all, more intensive networking and coordinated local and global action.

6. Much more action is needed both locally AND globally: it is not either or: it is both. Succeeding in mobilizing local communities is simply not enough: in the end, global events tend to supercede the many local victories we are having.

7. Does this mean we deserve what we are getting? Or, is our Charter too ambitious? The answer is two times NO.
The PCH is a long-term platform of what principles we strive for. But to strive, we have to start acting. And the PCH does call for very concrete actions. But a call is just that: somebody has to respond to it. There just are no miracles: we have to make them happen... Nothing is given to our cause; we have to fight for it.

8. It all boils down to power relations. For us, power comes from creating greater clarity about the problems and issues of our times, clarity about their structural causes and how they affect health, plus clarity about the best courses of ACTION to follow to remove the major barriers and determinants of negative outcomes. Power also crucially comes from coalescing into a veritable global movement.

9. pha-exchange@kabissa.org , the PHM's list-server, now serving close to 600 individuals and organizations, has started to open a forum for global discussion and education. It needs more contributions from more members.

Subject: PHA-Exchange> RE: PHM PRESS RELEASE (14th May 2002), Geneva.
Date: Fri, 24 May 2002 22:24:13 +0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

-----Original Message-----
From: Marcella.DeSmedt@cm.be

Dear Dr.Qasem Chowdury ,dear Dr. Ravi Narayan,

I agree entirely with you about the very negative impact of
WHO-INDUSTRY
partnership on people's health !.....

Marcella De Smedt
Member of the A.I.M. pharmaceutical expert group (A.I.M.=Association
Internationale de la mutualité)
Clinical pharmacist & Adviser
Medical Direction

Haachtsesteenweg,579 1031 Brussels Belgium.
Tel; 00-32-2 2464477
Fax 00-32-2 2464649
E-mail marcella.desmedt@cm.be <mailto:marcella.desmedt@cm.be>

13/6/02

Dear Marcella De Smedt

Thanks for your message. Please send us more details about your organisation and A.I.M and the pharmaceutical expert group. If you have data, evidence or articles on the negative impact of WHO-Industry partnership on peoples health please send it to the PHP exchange to keep all our members and networks informed.

Best wishes

Ravi Narayan
CHG/PHM

cc Qasem & Claude

Sent 04/13/6/02 reply

RN 13/6

(aviva @ netnam.vn)

Dr. RN
27/5/02

5/27/02 1:06 PM

Subject: PHA-Exchange> GM MOSQUITO COULD PREVENT SPREAD OF MALARIA
Date: Thu, 23 May 2002 19:45:54 -0500
From: "George(s) Lessard" <media@web.net>
Organization: http://mediamentor.ca
To: pha-exchange@kabissa.org

GM MOSQUITO COULD PREVENT SPREAD OF MALARIA
Scientists have created transgenic mosquitoes that were largely unable to transmit malaria to mice. They hope to wipe out the disease by transferring the gene into the entire population of malaria-carrying mosquitoes.
FULL STORY:
http://cbc.ca/stories/2002/05/22/gm_mosquito020522

-------- End of forwarded message ---------
:-) Message Ends; George(s) Lessard's Keywords Begin -:
Freelance Media Arts, Management, Training, Mentoring & Consulting
On line: Internet / Workshops / Research / Presence / Content /
On location: TV / Radio / Production / ENG / EFP / Editing
Interests: Access / Activism / Communities / Culture / Arts
Resume and more @ http://members.tripod.com/~media002
Queries / Offers / Patronage /
Commissions should be sent to
media@_no_spam_web.net
Rostered Volunteer UNV# 120983 & CESO/SACO VA# 11799

-Caveat lector- Disclaimers, NOTES TO EDITORS
& (c) information may be found @
http://members.tripod.com/~media002/disclaimer.htm
Because of the nature of email & the WWW,
please check ALL sources & subjects.
- 30 -

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

RM 6/6/02

file:///Untitled

Subject:
PHA-Exchange> Let's get educated about the Monterrey Consensus
Date:
Wed, 10 Apr 2002 16:39:30 +0700
From:
"aviva" <aviva@netnam.vn>
To:
pha-exchange@kabissa.org;, aviva@netnam.vn;

AK
Please .
Print out
For Media Kit
without the
#8217
numbers
RN
23/4

A proposition for PHM approval as our group’s position

Heads of State met in Monterrey, Mexico at the end of March this year.
They discussed how to finance development in the Third World worldwide.
They came out with the ‘Monterrey Consensus’.

Here is what this document says and does not say.

The document is more a ‘declaration of intentions’ than a ‘declaration
of principles or intentions’ advancing some concrete commitments. It does not provide concrete responses regarding the quantity and quality of resources that the rich countries are willing to commit to support development efforts in the poor countries.
The document is rather a consensus among unequal partners. The weaker partners agree to accept the norms set by the strong who, in turn, define what good governance (a pre-requisite to join the club) is. Therefore, the Consensus document rather is an instrument of coersion around policies set by the rich governments and the IFIs. It unequivocally favors globalization in which financial capital is to continue having a controlling role on productive and development investments.
The document’s motivation is the promotion of longer term development without paying attention to the many current crises (i.e. aims expressed in the Consensus are mostly long term, disregarding urgent measures needed in the short term).
The document thus never arrives at proposing meaningful, needed transformations of what we already have. It puts too much emphasis on de-regulating private capital markets --not proposing any measures against the well known accompanying risk of speculation. Moreover, it does not systematically critique the failure of the international development strategies used so far.
The document recognizes the existence of an enormous deficit in

PHA- Exchange →

RN
13/4

commitment by signatory governments to needed structural changes. There are no mechanisms presented to assure greater accountability and greater all-inclusive participation of civil society in the decision making related to development work worldwide.
The documents does not mention the need for the mobilization of local national) resources for development that is as much a must as the need for foreign resources; it leaves our own governments off the hook. It also ignores the issues of foreign debt and the need for poor governments to also mobilize domestic resources towards more equitable development alternatives.

The Consensus is further weakened by making no mention of the need to profoundly reform the global economic governance system.

As PHM, we do not accept the economic model underlying the Consensus, the conditionalities that it imposes and its foreseeable negative impacts, including those related to health, education, gender relations, human rights and many other. We denounce the absence of language directed at equity, human rights, and sustainable development. We contend that foreign aid has never been, nor will be, a panacea if the types of investments to be made are not defined in advance and with full civil society inputs. (Investments that are against a sustainable development with a gender perspective also have to be identified and opposed). On the other hand, we contend that foreign aid has not to be allowed to denationalize our own Third World economies and has to fully respect the free movement of labor (and not only capita) across North South borders.

Any new consensus has to tackle the issues of fair trade, illegal capital flight, land reform, access to land, access to health and education, protection of internal markets and national enterprises, the penetration of transnational corporations and their dumping of products (especially agricultural) in our market. The Monterrey Consensus does not. International development institutions have to show their commitment to change in development policies more forcefully and with facts that point in the right direction. The Monterrey Consensus fails to do so.

This Consensus basically recommends that the private sector directs and supervises the development of the nations in the South. It totally avoids mentioning the issue of rich nations having to devote 0.7% of their GNP for aid, as well as the issues related to a Tobin tax. It tells us nothing how rich countries use their monopoly over and manipulation of information channels to ‘sell’ us their ideology (with
the passive complicity of all those this information subordinates...).
Instead, the Consensus document continues to tell us that globalization will bring us universal happiness.
Moreover, there is a veiled warning to be found between the lines: those who oppose globalization have to be conscious that the rich countries and IFIs will combat them, even at the expense of further

Finally, it is to be pointed out that NGOs in Monterrey at the time were allowed no access to the official deliberations process, as opposed to what has become practice in such meetings elsewhere.

Claudio

Subject: PHA-Exchange> Work of PHM affiliate Arogya Iyakkam in Tamil Nadu recognized
Date: Thu, 23 May 2002 21:50:39 -0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

From: Balaji Sampath <kb@eth.net>
Arogya Iyakkam reported as one of the ten best programmes in the World.

Dear Friends,

Some of you are aware of the work on health - Arogya Iyakkam - being done by the Tamilnadu Science Forum. This work has be going on in about 300 villages in 10 blocks. Now with the help of Association for India's Development, we are expanding it to more than 30 blocks in Tamilnadu and 13 blocks in Bihar.

You might have read earlier reports on the programme that I had sent on email. Some of you have even visited a few of these programme areas and have been financially helping sustain this programme.

Sometime back a team from UNICEF (United Nations Children's Fund) visited the programme and evaluated the work done.

The Arogya Iyakkam programme was selected as one of the ten best in India and forwarded to the UNICEF office in New York. There it was selected as the ten best programmes in the world and has been reported in the UNICEF's Innovations report.

I want to share this happy news with you. Below is the report from the UNICEF document which describes our work.

This recognition adds to the encouragement we get from seeing children we are able to save. With this expansion to more blocks we have to and will work much harder and build up a larger team committed to eliminating malnutrition.

We now need your support - moral, physical and financial - more than ever before.

Dr. R.V. 27/5/02

Thanks once again for your interest in this work.

Bye,
Balaji Sampath

A SYNOPSIS OF INNOVATIONS AND LESSONS LEARNED IN UNICEF COOPERATION

AN EDITED SELECTION FROM THE 2001 COUNTRY OFFICE ANNUAL REPORTS (4th Edition)

MARCH 2002

Compiled for UNICEF staff members by the Programme Group, NYHQ.

Community Initiatives to Improve Child Health and Nutrition in Tamil Nadu,
India: Strategies and Preliminary Results on Nutritional Impact - India

Background

This programme was started in May 1999, and is being implemented in roughly
500 villages in 10 blocks in Tamil Nadu. Supported by UNICEF, the programme
is executed by the NGO Tamil Nadu Science Forum. The programme has three main aims:

- Improve the use of primary health care services;
- Improve children's health and nutritional status; and
- Organise and empower women around their health needs.

The programme organised village health committees (VHCs), which each selected a local health activist. These voluntary health activists were trained together, and more intensively in the field, in talking to mothers
about nutrition and diseases, and to pregnant women about nutrition, delivery, breast-feeding and other health matters. The VHCs also met to read
and discuss health books, and helped the health activist to promote nutrition and health education.

The main strategies used to address child health are:

At the family level:
- identify children at risk by weighing each child
- constantly follow up each child at risk and assist families to prevent malnutrition or reverse it by appropriate health education and better use of
existing health services

At the community level:

- strengthen primary health care and Tamil Nadu Integrated Nutrition Programme (TINP) services through advocacy
- make child malnutrition the most important index of health for local planning, and sensitise panchayat members as to its significance.

The activists were given intensive training in child health and nutrition
to: analyse the combination of factors that led to particular cases of malnutrition; identify those factors that can be addressed in that individual and social context; discuss with the family about the child's risk factors and the importance of addressing those factors; and reinforce
the initial message by repeated visits at the family level as well as through cultural programmes and village-level meetings.

Programme principles:

The interaction between the health activist and the mother is central to the
programme, and is based on principles derived from experience:

1. Respect . The mother and pregnant woman are seen as intelligent people
coping with difficult conditions, and not as ignorant people who won't listen to sensible advice.

2. Understanding . The focus is therefore on understanding why a mother does
not follow advice, rather than blaming her for not doing so. She already has
a world-view, formed by her own experiences and what she has learned from
her community. That world-view guides her health practices for herself and
her child. The advice she is given by the programme often differs from her
own information; to succeed, one must integrate this advice with her world-view, by discussing in detail why it makes sense and how it can be adopted within the limits of her resources.

3. Skilled and patient negotiation . This kind of dialogue is difficult, time-consuming and requires considerable skill and confidence on the part of
the person giving the advice. Training the activist in dialogue takes time;
she must learn not only to advise, but to counter arguments and elaborate
ways in which advice can be adopted in a resource-poor setting. The activist
needs support from a group of trainers who visit her regularly, provide her
work with legitimacy and constantly encourage and provide her with further

training.

4. Peer discussion and reinforcement . One-to-one sessions between the activist and mother are complemented by group meetings called by the activist to discuss specific issues (e.g. feeding the colostrum). In such a meeting, a mother will invariably say they have fed the baby with colostrum and the baby is healthy; this can be used as "proof of concept" to convince others. This kind of negotiation with a larger group also requires skill, and often the block-level trainers help the activist to conduct such discussions.

Preliminary results on child malnutrition

As part of programme activities, children aged under five were weighed at the beginning of the programme, and again roughly 1.5 years later (in October-December 2000). Of 7,133 children weighed during both periods, the percentage of children with a "normal" weight increased from 34.5% to 45.8%. The percentage of "grade 1" children increased by 1.3 percentage points, while the percentage of children in grades 2-4 decreased by 12.6 points.

If one compares each child's status at the two times of measurement, one finds that 34.3% of children improved their category, while 13.5% deteriorated; the remainder stayed in the same category. That is, there was a net categorical improvement among 21.4% of the children.

These results understate the programme's impact, in that the nutritional status of a cohort of under-fives is not static in the absence of positive interventions in their favour. Rather, one expects their nutritional status to worsen. In areas of the State where the programme is not being implemented, one finds that the overall nutritional status of a cohort of children aged under five deteriorates over a 1.5 year time period; indeed this pattern is commonly found throughout India.

Organisational insights

Explanations for these positive results can be found in the actions of the health activist: the programme's design and operations place great emphasis on motivating her and making her effective:

· When measuring the activist's work, she is not blamed for children who are malnourished or in poor health. The emphasis is rather on measuring her work, i.e. talking to mothers and pregnant women. If children have worsened, the reasons are sought in her training or in programme design. Investigation sometimes reveals that there are underlying factors beyond her control, such as diarrhoea epidemics.

· The activist is always praised in front of the mothers. To boost her respect in the village and her self-confidence, village meetings are organised in which she is honoured and called to talk to the village community. These measures gain her respect locally and motivate her to work harder.

· An egalitarian and intensive relationship between the trainers and the activists is important. The motivation of these trainers, and their willingness to meet with mothers, often over a period of days, are crucial to providing the activist with a good example as well as the skills she needs.

· The activists' voluntary status is important to their motivation. The activists and the village understand that the work is done for the sake of improving children's nutrition.

· To ensure that the focus of the activist is on actually meeting mothers and pregnant women, administrative tasks such as report writing and maintaining records are kept to a minimum. The trainer is responsible for monitoring the programme, and is primarily responsible for administrative tasks; the activist is asked to maintain only one page from which all relevant data are gathered.

While the preliminary results will need to be independently verified, they suggest that this programme might provide a viable model to reduce child malnutrition. More time will be required to determine how long it takes to raise a community's capacity sufficiently to address malnutrition without ongoing support from an NGO; and to determine the cost of this model.

There are three further considerations relating to sustainability and replicability. First, the model requires supportive primary health care and nutritional services, which have traditionally been provided by the

State.
These services need to be reinforced. Second, this model is predicated upon
intensive outreach counselling and personal relations. While resource
constraints play a role in malnutrition, much of child malnutrition can be
explained by behaviours. Poor feeding practices are common, and the in-home
management of illness can be much improved. These problems can only be
addressed through a dialogue that intensively and repeatedly seeks to ensure
that the right behaviour has been understood and is being practised. There
does not appear to be a shortcut or substitute for this approach. Third, the
community's involvement is important: it provides support to the activist
and examples of positive behaviour for others.

Sincere thanks to Tami Farber for her work in support of this collection.
And our thanks to all Country Offices that provided write-ups on innovations
and/or emerging lessons in the 2001 Annual Reports.

----- Original Message -----
From: Nance

Friday's meeting went well; a rather large crowd attended the PHM briefing and
The press says Dr Brundtland is making a special effort to woo countries of the S
Zafrulla spoke right after Dr Brundtland; he said that : "I had a dream, with all
Needless too say this provoked laughter throughout the room...
Drs Brundtland and Nabarro did not like it much.

Ravi gave a very good briefing on the PHA Movement, and afterwards the PHM reps f
Afterward, the Philipine moderator tried to smoothen the comments saying that eve
He took several questions since Dr Brundtland left and Dr Nabarro did not seem to
Among others, David Sanders asked from the floor a question on Gavi: the fact tha

The moderator took two other questions and then asked Dr Nabarro to answer.

Nabarro said something to the effect that he would be very happy to "take all the

Dr Nabarro avoided the indictment on the privatization of WHO issue, and the turn

On the NGO Forum meeting:

The NGO forum organized by Eric Ram was a big success with several hundred people
There were a lot of speakers, Ravi was absolutely excellent, and so was Judith Ri
I (Nance) gave a probably too militant speech on IMF and AIDS, using the book tha
The book says that we are in a situation as serious as that in the 20s, the finan
The IMF steals from the pocket of the State to give to the private sector in a ma
You all should read that book..
So I started with the fact that we are like in the 20s, with a financial system s
Then I developed the problem with the neo-liberal social marketing campaign that
I outlined how the World Bank was positioning itself - so does the Macroeconomic
I also noted that IMF HIPC and World Bank PRSPs, so called debt reducing pro-poor

I was happy to find that all the PHM people agreed totally on the need for public

Of course, Stiglitz does a whitewash of the world Bank, but his indictment of the

THE PHM internal meeting:
All day meeting on Thursday.
Qualities and problems:
1_ spending all day among ourselves is preventing us from being among the delegat
2_ Much time was spent going through what every branch of PHM, and country is doi
Afternoon on action. Discussion on action was very interesting, but lacked emphas
Among the decisions :
Resolution on Palestine, participation in Porto Alegre next winter, and planning
Eric made a masterly intervention warning against getting coopted by WHO...
Ravi told us about the proposal of the Global Forum on Health Research to partici

Dr Feachem was the architect of the World Bank investment in health and in recent
His personal views are antagonistic to PHM, and needless to say the Global Forum'

4_ after the PHM public technical breifing with Dr Brundtland, (the next day) the

Among the decisions:

A As agreed on Thursday, there will be contact established with a view of partic

B- The communication cluster circle will be managed by the webmaster, with Unni o

C- David Sanders had put himself as the contact man organizing the participation

RM 5/22/15

D- The proposal to have an analysis group, suggested the day before, was put up a

E- The idea of organizing the celebration of Alma Ata 25th anniversary next year

F- Dorothy will be the contact person for poverty and AIDS.

G- Ravi proposed that the WHO-PHM group continue, and it was agreed

H- Ravi thanked the seven member Geneva group for the work done and proposed cons

That was it. I hope it gives an overview.

Subject: PHA-Exchange> "Stigma, HIV/AIDS & prevention of mother-to-child transmission"
Date: Sat, 1 Jun 2002 13:46:13 -0500
From: "George(s) Lessard" <media@web.net>
Organization: http://mediamentor.ca
To: creative-radio@yahoogroups.com
CC: pha-exchange@knowssa.org

For the full study "Stigma, HIV/AIDS & prevention of mother-to-child transmission", commissioned to PANOS London by UNICEF, see - http://www.panos.org.uk/aids/stigma_countries_study.htm

-------- Forwarded message follows --------
From: "The Drum Beat" <wfeek@comminit.com>
To: <media@web.net>
Subject: The Drum Beat - 146 - Strategic Communication and PMTCT - UNICEF
Date sent: Sat, 1 Jun 2002 08:40:43 -0600

The Drum Beat - Issue 146 - Strategic Communication and PMTCT - UNICEF
June 3, 2002

from The Communication Initiative...global forces...local choices...critical voices...telling stories...

Partners: The Rockefeller Foundation, BBC World Service Trust, The CHANGE Project, CIDA, The European Union, Exchange, FAO, Johns Hopkins University Center for Communication Programs, The Panos Institute, Soul City, The Synergy Project, UNAIDS, UNICEF, USAID, WHO.

Chair of Partners Group: Denise Gray-Felder, Rockefeller Foundation dgray-felder@rockfound.org Director: Warren Feek wfeek@comminit.com Website: http://www.comminit.com

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THE UNICEF APPROACH TO STRATEGIC COMMUNICATION
http://www.comminit.com/stpmtctmethod/sld-4211.html

1. THE MODEL

UNICEF's "Communication for Development" Model is based on the understanding that effective communication relies on the synergistic use of 3 strategic components:

* ADVOCACY to ensure resources and political/social leadership commitment at all levels

* SOCIAL MOBILISATION to engage civil society organisations (NGOs, Private sector, Religious organisations etc.) and ensure their participation in the development issue being addressed

* BEHAVIOUR DEVELOPMENT COMMUNICATION to encourage healthy behaviours and participation of individuals, families & communities.

2. THE PLANNING PROCESS

RAP 6/6/02

The ACADA Communication Planning Process - Assessment, Communication Analysis, Design, and Action. This process is utilised to develop a research based integrated communication strategy that considers individuals, families and communities within their environment & from their perspective; encourages & fosters community participation; and includes the identification of realistic, measurable objectives & related indicators.

3. THE TOOLS

Based on the Communication for Development model, and using the ACADA process, UNICEF has developed a set of tools for developing synergistic communication strategies for PMTCT, Polio Eradication and a variety of other programmes. These
tools, while generic in content, allow each individual country to develop a tailored communication strategy addressing the unique needs of each country using a consistent and systematic approach to ensure quality. These tools can be used at the national, provincial/state, district or community levels.

***

...taking the PULSE of international development...

Because it underpins all development issues, addressing economic poverty should be the only international development priority and programme.

Agree? Disagree? VOTE - http://www.comminit.com/pulse.html

***

PREVENTION OF MOTHER-TO-CHILD-TRANSMISSION OF HIV (PMTCT)

4. The UN Inter-agency Task Team supports a 3-Pronged Strategic Approach for PMTCT:

ONE - Prevention of HIV in young people; prevention of HIV infection in women of
childbearing age.

TWO Prevention of unintended pregnancies in HIV-positive women.

THREE - Prevention of transmission of HIV, from an HIV-positive woman to her infant.

http://www.comminit.com/stunicefpmtct/sld-4202.html

5. Some of the lessons learned from PMTCT communication interventions in Africa & Asia include:

* Community relevance is best ensured when strategic communication planning and overall programme design begins with participatory, community-based research.

* Capacity building & local ownership is key at all levels.

* Simple community dialogue tools can help communities to better identify & address stigma and discrimination, thus creating more caring & supportive

environments for HIV-affected families.

* Interpersonal communication remains the most effective & powerful tool in addressing issues related to PMTCT.

* Involvement of male partners is key to women's acceptance of PMTCT services.

http://www.comminit.com/stunicefpmtct/sld-4204.html

6. Conclusions drawn from these lessons:

* Increase variety of participants in communication planning, intensifying efforts to look at HIV/AIDS holistically and across all sectors, as a societal issue, not only as a public health issue.

* Begin drawing on rapid social research, incorporating results in programme design.

* Use community dialogue to help communities address stigma, care & support issues.

* Increase participation of men, youth & people living with HIV/AIDS (PLWHAs).

* Make couple counselling friendly for men and couples.

* Invest in interpersonal communication interventions.

* Increase understanding of basic HIV/AIDS transmission & prevention facts, including MTCT.

* Make more effort to research & understand community norms, values & practices related to PMTCT issues.

http://www.comminit.com/stunicefpmtct/sld-4206.html

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The next DB Classifieds - Training, Consultants, Materials Events will be June 5. Contact jinnes@comminit.com

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STIGMA & DISCRIMINATION

7. "Certain people are part of the problem...why do we give them sympathy? ...We know where the problem is. It lies with these girls flirting freely, spreading HIV...We should do away with human rights for such women...Arab states' rules on women seem to be discriminatory but at least they control sexuality" - citizen of Zambia.
http://www.comminit.com/stunicefstigma/sld-4191.html

8. Despite vastly different cultural realities - experiences & research have identified similar aspects of discrimination & stigma throughout the regions of West, East & Southern Africa, South & SE Asia & Ukraine, including:

* the assumption that PLWHAs are members of a pre-determined group, regardless of whether they are or not...

* public's vulnerability to infection.

* the most marginalised and excluded groups in many societies - drug users, sex workers, men who have sex with men, and in general women - bear the brunt of stigma & discrimination.

* stigma related to HIV/AIDS is often layered on pre-existing stigmas of sexual conduct & drug use, thereby playing into & reinforcing existing social inequalities linked to power & domination within communities.

* derogatory name-calling.

http://www.comminit.com/stunicefstigma/sld-4193.html

9. The most extreme forms of stigmatisation being reported are in health care settings. They include:

* denial of drugs & treatment
* being left unattended in hospital and clinic corridors
* being dealt with last
* being labelled or called names in public areas of hospitals and clinics
* being subjected to degrading treatment
* breaches of confidentiality

http://www.comminit.com/stunicefstigma/sld-4194.html

10. "A woman will never decide to do the testing. If she finds herself HIV-positive she is signing three deaths: psychological death, social death & physical death. Don't you think that is a lot?" - Woman, Burkina Faso.

Stigma surrounding MTCT prevents women from accepting testing and negatively impacts their quality of family life. In many cases, once a woman is diagnosed as HIV-positive, she faces rebuke or condemnation for wanting a child, and often
is denied the right to make her own reproductive choices. The "M" in PMTCT can foster incorrect perceptions that a woman is solely at fault in transmitting HIV
to her baby. http://www.comminit.com/stunicefstigma/sld-4197.html

11. Main Causes of Stigmatisation:

* Continued misinformation about basic HIV/AIDS transmission & prevention creates fear, which in turn results in stigma.

* Many communities see mass media as largely responsible for both creating & reinforcing stigma, highlighting death & high-risk groups.

* In clinic settings poor, unsafe working conditions & a fear of infection are cited by health workers as contributing to their stigmatising behaviour towards PLWHAs.

* Other health workers identify their negative behaviours towards PLWHAs as the result of their inability to understand & manage HIV/AIDS. They see no remedy or solution to the despair surrounding the disease & many feel they don't have the psychological resources to cope with somebody whose death is inevitable.

http://www.comminit.com/stunicefstigma/sld-4199.html

12. Recommendations for addressing stigma and discrimination include:

* Consider shifting the terminology "PMTCT" to more inclusive terms such as "PTCT - parent to child transmission", emphasising the responsibility of both parents in HIV transmission.

* Increase efforts to look at HIV/AIDS holistically, as a societal issue, encompassing the broader environmental & contextual factors that contribute to HIV transmission.

* Make more effort to research & understand community norms, values & practices related to PMTCT issues by beginning communication with rapid, participatory research & ensuring that results are incorporated into programme design.

* Increase participation of men, youth & PLWHAs in PMTCT.

* Assist communities in identifying realistic, feasible coping strategies for HIV/AIDS. Simple community dialogue tools have been developed & field-tested, proving that easy-to-use participatory tools can greatly assist & enhance community capacity to identify ways in which they can begin addressing HIV/AIDS & stigma, thus creating more caring & supportive communities...

http://www.comminit.com/strunicefstigma/sld-4200.html

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For the full study "Stigma, HIV/AIDS & prevention of mother-to-child transmission", commissioned to PANOS London by UNICEF, see - http://www.panos.org.uk/aids/stigma_countries_study.htm

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For general information on UNICEF's approach to strategic communication, contact
Silvia Luciani sluciani@unicef.org

For information on strategic communication for PMTCT or the Tools developed by UNICEF, contact Shari Cohen scohen@unicef.org

Many thanks to Ms. Luciani and Ms. Cohen for their assistance with this issue.

***

Please send material for The Drum Beat to the Editor - Deborah Heimann dheimann@comminit.com

Subject: PHA-Exchange> PHM Media coverage in the Associated Press (Economist: spending 1 cent in every dlrs 10 could save 8 million lives in poor nations)
Date: Fri, 31 May 2002 23:48:33 -0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

From: "UNNIKRISHNAN P V (Dr)" <unnikru@yahoo.com>
Subject: PHM Media coverage in the Associated Press (Economist: spending 1 cent in every dlrs 10 could save 8 million lives in poor nations)

People's Health Movement media coverage during WHA 2002 (May 2002)

Economist: spending 1 cent in every dlrs 10 could save 8 million lives in poor nations
Wed May 15, 9:45 AM ET

By JONATHAN FOWLER, Associated Press Writer

GENEVA - By spending just 1 cent in every dlrs 10 of their wealth on health aid, rich countries could save millions of lives each year in poor nations - and boost economic development - Harvard University economist Jeffrey Sachs said Wednesday.

"It's the best investment available in the world bar none," said Sachs, who is in Geneva for the annual meeting of the decision-making body of the 191-nation World Health Organization (news - web sites).

"Health is essential for economic development - without it you can't achieve economic progress," he told reporters.

Sachs led a WHO commission which last year calculated that spending dlrs 66 billion per year on health in developing countries would save around 8 million lives a year by preventing or treating diseases like AIDS (news - web sites), malaria and tuberculosis.

The commission said the investment also could generate economic benefits of dlrs 360 billion per year by 2020 by keeping workers healthy and reducing the need to fight disease in the future.

Some campaigners, however, have criticized Sachs' approach, claiming he looked too closely at the purely economic benefits of health investment and failed to listen to health policy-makers from poor countries.

"Health can't be seen as simply creating more productivity," said Mike Rowson of the British-based medical group MEDACT at a separate news conference. "Otherwise the only investment will be in health for working-age adults, not the old, the disabled or the mentally ill."

Realizing that government intervention alone is not enough, the United Nations (news - web sites) has increasingly fostered the involvement of private corporations and foundations such as the one run by computer tycoon Bill Gates (news - web sites) and his wife Melinda. Most major WHO campaigns against high profile diseases involve alliances with private companies.

Campaigners have alleged such partnerships raise the risk of conflicts of interest, particularly when pharmaceutical manufacturers are involved. Indian health activist Ravi Narayan said there was a danger of focussing on "magic bullets," when the real need was to

RN 3/6

RN 3/6/02

tackle poverty, a major cause of ill-health in developing countries.

But Sachs said initiatives like the Global Fund to fight AIDS, Tuberculosis and Malaria, which brings together business and governments, showed the international community was getting serious about health in developing countries, which are the hardest hit by such diseases.

"We're still nowhere near where we need to be, but the tide has turned," he said.

"But I'm going to keep on saying the same thing. This can't be done without more help from rich countries."

So far, donors have pledged just over dlrs 2 billion to the fund, launched last year, including dlrs 500 million from the United States. The pledges fall far short of U.N. Secretary-General Kofi Annan (news - web sites)'s appeal for at least dlrs 7 billion annually.

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

Subject: PHA-Exchange> Some breastfeeding news
Date: Fri, 31 May 2002 22:12:55 +0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

From: tod.grofner@chello.se

Recent studies have further refined our knowledge on the association between
breastfeeding in intelligence. Tao et al (Effect of breastfeeding on cognitive development of infants born small for gestational age.Acta Paediatr. 2002;91(3):267-71.) conclude: "Duration of exclusive breastfeeding
has a significant impact on cognitive development without compromising growth among children born SGA [small for gestational age]." Similarly, Mortensen et al. (The Association Between Duration of Breastfeeding and Adult Intelligence. JAMA 2002;287:2365-71) found slightly higher intelligence scores in adults who had been breast-fed longer, with many confounders controlled for.

Finally, the International Confederation of Midwives has issued the press release pasted in below regarding their stance on HIV and breastfeeding.

INTERNATIONAL CONFEDERATION OF MIDWIFES

PRESS RELEASE April 15, 2002

Midwives will support mothers with HIV infection in exclusive breastfeeding
or their babies where that is the woman's choice.

Delegates to the ICM Council meeting in Vienna, where 60 national midwifery
associations from 50 countries are represented, have agreed a position statement on the subject of infant feeding when the mother has been diagnosed as HIV positive.
A number of research studies carried out over the past two years were cited,
the findings from which have indicated that to achieve a minimum risk of
transmission of the virus, babies should be fed exclusively either by breastfeeding or by a reliable artificial method. The position statement,
proposed by the Midwives' Society of the Royal College of Nursing and seconded by the Norwegian Association of Midwives, acknowledges the difficulty in some circumstances of finding a safe method of artificial feeding and 'urges the gathering of experience and its dissemination to support midwives [and] policy-makers ... in achieving the above-mentioned
options'.
Midwives joining the discussion included those from the Koninglijke Nederlandse Organisatie van Verloskundigen (Royal Dutch Organisation of Midwives) who felt that, in developed countries, using a reliable method of
artificial feeding has a lower risk of mother-to-baby transmission.
A responder from the Gambia Midwives' Association said that she understood
there was evidence showing that exclusive breastfeeding and bottle-feeding
carried the same risk of transmission to the baby up to at least three

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months of age.
The Iran Midwifery Population's representative stated their association's
support for the promotion of exclusive breastfeeding by HIV-positive mothers
in developing countries.

References
Coutsoudis A et al. 2001. Method of feeding and transmission of HIV-1 from
mothers to children by 15 months of age: prospective cohort study from
Durban, S Africa. AIDS; Feb 16, 15(3): 379-387.
Zetterstom R. 2000. Transmission of HIV type-1 from mother to infant. Acta
Paediatrica; 89(11) November: 1273-1274.
ICM. 1999. Position Statement on Breastfeeding. ICM, The Hague. Young
Infant and Child Nutrition. Resolution 54/7 by the World Health Assembly.
WHO, Geneva, 2001.
HYPERLINK "www.internationalmidwives.org"
www.internationalmidwives.org

Subject: PHA-Exchange> PHM marches on: From Dhaka to Geneva to Porto Alegre !
Date: Fri, 31 May 2002 21:01:34 +0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

From: "UNNIKRISHNAN P V (Dr)" <unnikru@yahoo.com>
Subject: The People's Health Movement marches on : From Dhaka to Geneva to Porto Alegre ! (PHM Press Release May 17th)
URGENT - People's Health Assembly, PHA Secretariat, Gonoshasthaya Kendra, Nayarhat, Dhaka - 1344, Bangladesh
Email: gkpavar@citechco.net website: www.phamovement.org

Geneva, 17th May, 2002: .

The People's Health Movement (PHM) will carry out a series of actions in the coming year to force national governments and international bodies to put 'Health for All' at the center of their policies.

Delegates from around the world attending a PHM caucus here warned that failure by the World Health Organization to change its current corporate-friendly health strategies will be met with serious resistance by grassroots health movements all over the world. The PHM caucus discussed plans to mobilize large numbers of activists to gather in Geneva by May 2003 to hold a People's Health Assembly parallel to the WHO's official World Health Assembly.

Significantly, the PHM has also decided to participate in a big way at the third World Social Forum in Porto Alegre, Brazil in February, 2003. Such participation will enable the PHM to spread the message of the People's Charter for Health (adopted at the People's Health Assembly, Dhaka 2000) to other social forces around the world demanding global justice and protesting the ill effects of neo-liberal economic policies.

It was also decided to intensify the PHM activities at the national level with work ranging from awareness building to political action across different sectors of society. National, regional and international circles of the PHM have initiated social action research and documentation to clearly expose the bankruptcy of the WHO's current approach to healthcare.

The PHM demands the inclusion of people's organizations in the WHO's policy making process. PHM believes that this alone will help to make their policies more realistic and effective.

The delegates of the People's Health Movement (PHM) from Asia, Africa, Americas, Australia and Europe who are attending a PHM caucus at Geneva (to coincide with the World Health Assembly -13th -17th May 2002) strongly condemn the state-sponsored massacres of civilians in the occupied territories of Palestine.

The PHM condemns the violence perpetuated against civilians, particularly children and women. This should be considered a crime against humanity. The health community has been targeted systematically for attack and their humanitarian work obstructed. This constitutes a grave violation of fundamental humanitarian principles and conventions. The PHM also condemns the random suicide attacks carried out against Israeli civilians and other acts of violence.

In Palestine, health services and the basic infrastructure have been destroyed and will take years to rebuild. The PHM calls upon the health community in particular, and the people of the world in general to

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speak out against such aggression against civilians and to assist in initiatives to rebuild the shattered lives of the victims.

The PHM demands the release of the Palestinian and Israeli peace activists who are under detention. It expands its solidarity to the ongoing peace efforts by peace activists in Palestine and Israel.

The delegates of the People's Health Movement also strongly condemn the state-sponsored massacres of civilians in the western Indian state of Gujarat. The PHM expresses their concern over the fragile and inhumane conditions in which the victims of the violence are staying and demands immediate humanitarian assistance and comprehensive rehabilitation.

Dr. Qasem Choudhury — Dr. Ravi Narayan

Co-ordinator, People's Health Assembly — Convenor, PHA- HWA circle

For details, call PHA media team : Dr. Unnikrishnan PV / Satya Sivaraman :
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PHA Coordinating Group : Asian Community Health Action Network (ACHAN) * Consumers International Regional Office for Asia and the Pacific (CI ROAP) * Dag Hammarskjold Foundation (DHF) * Gonoshasthaya Kendra (GK) * Health Action International (HAI) * International People's Health Council (IPHC) * Intra World Network (IWN) * Women's Global Network for Reproductive Rights (WGNRR)

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Encoding: base64

Subject: PHA-Exchange> PHM condemns attacks on civilians in Palestine/Gujarat
Date: Fri, 31 May 2002 20:51:55 -0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

From: "UNNIKRISHNAN P V (Dr)" <unnikru@yahoo.com>
Subject: People's Health Movement condemns ongoing attack on civilians in Palestine and the violence in Gujarat:

URGENT -
People's Health Assembly PHM Secretariat, Comochasthaya Kendra,
Mayarpat, Dhaka - 1344, Bangladesh
Email: gksavar@citechco.net website: www.phamovement.org

Geneva, 17th May 2002

The delegates of the People's Health Movement (PHM) from Asia, Africa, Americas, Australia and Europe who are attending a PHM caucus at Geneva (to coincide with the World Health Assembly -13th -17th May 2002) strongly condemn the state-sponsored massacres of civilians in the occupied territories of Palestine.

The PHM condemns the violence perpetuated against civilians, particularly children and women. This should be considered a crime against humanity. The health community has been targeted systematically for attack and their humanitarian work obstructed. This constitutes a grave violation of fundamental humanitarian principles and conventions. PHM also condemns the random suicide attacks carried out against Israeli civilians and other acts of violence.

In Palestine health services and the basic infrastructure have been destroyed and will take years to rebuild. The PHM calls upon the health community in particular, and the people of the world in general to speak out against such aggression against civilians, to assist in initiatives to rebuild the shattered lives of victims of these recent events.

PHM demands the release of the Israeli and Palestinian peace activists who are under detention. PHM extends their solidarity to the ongoing peace efforts by peace activists in Palestine and Israel.

The delegates of the People's Health Movement also strongly condemn the state-sponsored massacres of civilians in the western Indian state of Gujarat. PHM expresses their concern over the fragile and inhumane conditions in which the victims of the violence are staying and demands immediate humanitarian assistance and comprehensive rehabilitation.

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Subject: PHA-Exchange> PHM: NGOs Warn of Economic Policy Impacts on Medical Services
Date: Fri, 31 May 2002 20:47:24 -0700
From: "aviva" <aviva@netnam.vn>
To: pha-exchange@kabissa.org

From: "UNNIKRISHNAN P V (Dr)" <unnikru@yahoo.com>
Subject: HEALTH: NGOs Warn of Economic Policy Impacts on Medical Services(PHM Media coverage in Inter Press Service)
By Gustavo Capdevila

Civil society organisations are calling on the World Health Organisation (WHO) and health ministers around the globe to recognise and take action to prevent the disastrous impacts that certain economic policies have on public health.

GENEVA,May 17(IPS) - Ravi Narayan, a doctor from India and representative of the
People's Health Movement, said that civil society activists are concerned because the supposed benefits of the WHO association with the World Bank .;are not reaching the poor.

Ellen Verheul, of Memos, an Amsterdam-based non-governmental organisation (NGO) specialising in health and development issues, questioned governments that claim to promote universal access health services while ;supporting World Bank strategies that promote the commercialisation of health care and charging full cost to patients.

The NGOs' criticisms were heard also by WHO director-general Gro Harlem Brundtland during an informational meeting about the World Health Assembly, which took place this week in Geneva.

Most of the NGOs' reproaches, which often also extended to the World Trade Organisation (WTO) and International Monetary Fund (IMF), were based on the direction taken in health policies in recent decades.

David Nabarro, executive director of the WHO director-general's office, denied that the institution has renounced its people-centred health strategy to apply others promoted by major transnational corporations, such as pharmaceutical companies.

The 199 WHO member-states have not given any indication that they think ;the organisation is abdicating its core health responsibility or its role as the international health standard-setting organisation of the UN system said the official.

Nabarro said the evidence in favour of the WHO is the increasing number of initiatives that member-states entrust to the organisation, corroborating the validity of its health policies and regulations.

In a press conference, he responded to criticisms alleging that the WHO has abandoned its Health for All strategy.

The WHO budget, which is approximately 1.25 billion dollars a year and is subject to continued cuts in government contributions, is approximately equivalent to the budgets of two district general hospitals in Britain, he cited as an example of the organisation's financial limitations.

With that sum, the WHO cannot attend to the health needs of the entire world, Nabarro said.

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3/6/02

The WHO heard similar criticisms during a meeting of the People's Health Movement of Africa, held last month in Tanzania.

Africa and other continents have regional People's Health Movements, founded in December 2000 in Dacca, the capital of Bangladesh, to carry out international actions with the aim of achieving Health for All.

In many African countries, most of the people with HIV/AIDS receive medical attention in poor households, services that are provided .;by women who receive little or no assistance from government health or welfare offices, said the African assembly's representative, Mwajuma Saiady Masaiganah.

The assembly, said Masaiganah, sent her to deliver a message to the WHO: The measure promoting the re-use of female condoms is unacceptable and other means to prevent the spread of HIV/AIDS and other diseases must be sought.

After all, rural women cannot afford to buy a condom that costs almost a dollar, which many families in Tanzania, for example, do not earn in a week, she said.

In Latin America, meanwhile, progress was made in the health programmes that have been in place since the 1960s, particularly those aimed at eradicating smallpox, polio and measles.

However, with the structural adjustment programmes and the heavy debt payments, health care systems have been severely affected, said Maria Zuniga, a Nicaraguan national who represents the regional People's Health Movement.

The dynamic of the global immunisation efforts of the past few decades was similar, said Narayan, pointing out that vaccination coverage grew constantly worldwide until the late 1980s.

But since the early 1990s, figures from the WHO and the World Bank show that immunisation rates have fallen in India, China and other countries, which the Indian expert blamed on new economic policies.

Europe must also defend its health systems, said Verheul, underscoring that they are increasingly being subjected to market forces under rules established by the WTO's General Agreement on Trade in Services (GATS). "We, as civil society organisations, want to work with the WHO on these issues, and we want the WHO to take the lead", stated the Dutch activist.

Subject: PHA-Exchange> Israel imposes new control regime leading to long term bantustanization of the West Bank
Date: Wed, 22 May 2002 00:26:13 +0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

rom: Palestine Monitor <palmon@hdip.org>

Information Brief - Israel imposes new control regime leading to long term bantustanization of the West Bank
May 21th, 2002

In a renewed attempt to control the movement of Palestinians and suffocate all aspects of Palestinian life, Israel is set to divide the West Bank nto *eight isolated areas, introducing a new control regime in the West Bank.*

The Israeli army has already informed international representatives and co[illegible]*ulates that they intend to divide the West Bank into eight separate* a[illegible]*s; Jenin, Nablus, Tulkarem, Qalqilya, Ramallah, Jericho, Bethlehem and Hebron. Movement of people and transportation of goods between these areas will be subject to a personal permit system and will be enforced through* he *already existing network of Israeli military checkpoints and roadblocks.*

This territorial division is a further development of the closure and iege *policy that has been imposed on the Palestinians since the outbreak of the current Intifada. During the last 19 months, the closure and siege has had severe effects on the Palestinian economy and the humanitarian situation. Several communities have been completely isolated and deprived of basic services from nearby town centres. A high number of Palestinians have died when held up at roadblocks on the way to hospitals or shot by Israeli soldiers enforcing the closure. With a permanent division of the West Bank enforced through military checkpoints, the lives of the civilian* opulation *will continue to be jeopardized and dictated by Israeli soldiers.*

The Israeli intention to impose this apartheid like system is one of the la[illegible]r Israeli unilateral measures aimed at consolidating the Israeli occupation of the Palestinian territories. It will completely paralyse the Palestinian economy and the already limited movement of people within the West Bank with severe effects on social, administrative and educational aspects of Palestinian life.

For more information contact The Palestine Monitor
ww.palestinemonitor.org

Feb 22/5

sochara

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Saturday, May 18, 2002 1:00 PM
Subject: PHA-Exchange> WHO LAUNCHES GLOBAL STRATEGY ON TRADITIONAL MEDICINE

> WHO LAUNCHES THE FIRST GLOBAL STRATEGY ON TRADITIONAL AND ALTERNATIVE
MEDICINE
>
> WHO, Geneva, May, 2002
>
> Press release: http://www.who.int/inf/en/pr-2002-38.html
> English Document:
http://www.who.int/medicines/library/trm/trm_strat_eng.pdf
> Spanish Document:
http://www.who.int/medicines/library/trm/trm_strat_span.pdf
> French Document: http://www.who.int/medicines/library/trm/trm_strat_fr.pdf
>
> The World Health Organization (WHO) released on May 16,2002 a global plan to
> address those issues. The strategy provides a framework for policy to assist
> countries to regulate traditional or complementary/alternative medicine
> (TM/CAM) to make its use safer, more accessible to their populations and
> sustainable.
>
> Traditional Medicine: Growing Needs and Potential is the core of the WHO
> Strategy for Traditional Medicine for
> 2002-2005. It provides brief information on the growing needs and challenges
> faced by traditional medicine worldwide. It also gives key messages and a
> checklist for the safety, efficacy and quality to policy-makers.
>
> It sets out WHO's role and how the WHO Strategy could meet the challenges
> to support WHO Member States in the proper use of traditional and
> complementary/alternative medicine.

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

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sochara

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Thursday, May 16, 2002 8:18 AM
Subject: PHA-Exchange> INVITATION for a PHM meeting and film show in Geneva

People's Health Movement

invites you, friends and colleagues for a meeting and discussion on the global challenges in health

ON : 16th May, 2002 (Thursday)

At: World Council of Churches, 150 route de Ferney, Geneva

Time: 2 to 5pm (Followed by the screening of *"Hey Ram"* ! A documentary film on the **genocide in Gujarat, India** (where 2000 people have been killed in sectarian strife and resulted in the displacement of over 150,000 people in the last two months)

Meet the architects leading the People's Health Movement ! Meet health and social activists, academicians , planners and others from Africa, Americas, Asia, Europe and Australia !!

What is wrong with the present health systems and policies ? (Well what is right with that !)

What are the challenges and crises in global health care?

What needs to be done to deal with the system and the "deadliest epidemic"- poverty ? How does it matter for the health community ? Who benefits from the new economic policies ? What are the challenges for the health community in the israeli- Palestinian conflict, Afghanistan and other conflict situation ?

RSVP: unnikru@yahoo.com

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17/5/02

5/17/02

sochara

From: UNNIKRISHNAN P V (Dr) <unnikru@yahoo.com>
To: <unnikru@hotmail.com>
Cc: <gk@citechco.net>, <PHA-Exchange@kabissa.org>; Claudio Schuftan <aviva@netnam.vn>
Sent: Wednesday, May 15, 2002 12:04 PM
Subject: PHA-Exchange> Global campaign to be launched: Global campaign to be launched: (PRESS RELEASE (15th May 2002) :

URGENT - Press Release **Geneva:**
15th May, 2002

People's Health Assembly

PHA Secretariat, Gonoshasthaya Kendra, Nayarhat, Dhaka – 1344, Bangladesh

tel: 880-2-770 8316, 770 8335-6, 017-526 558 (Mobile); fax: 880-2-770 8317;

Email: gksavar@citechco.net website: http://www.phamovement.org

Contact details at Geneva (May 2002) : Mobile: +41 78 876 5437 ; E-mail: unnikru@yahoo.com & satyasagar@yahoo.com

Global campaign to be launched:

Revive the vision of Alma Ata!

Geneva: 15th May, 2002: With the 25th anniversary of the Alma Ata declaration on Health for All approaching in 2003, the People's Health Movement will launch a year long global campaign to revive its vision of a holistic approach to healthcare which addresses the social, economic and political determinants of health.

The campaign will be undertaken in over 92 countries around the world – from where delegates came to attend the first ever People's Health Assembly in Dhaka, Bangladesh two years ago. A focus of the campaign will be to promote the worldwide adoption of the People's Charter for Health (PCH), forged at the Dhaka gathering and which constitutes the largest consensus document on health since the Alma Ata declaration of 1978.

A key part of the global campaign will be to get the World Health Organisation (WHO) to rediscover its own mandate for health, its own commitment to primary health care and Health for All. Though the WHO, along with UNICEF, were among the main facilitators of the Alma Ata conference 24 years ago they have since done little to realise the goals of Health for All and indeed repudiated their original commitment to the Alma Ata objectives and process.

The PHM's campaign will also take the People's Charter for Health to other civil society groups such as the environmental movement, trade unions, student unions and global justice movements for their endorsement. Since the PHM's critique of global health policies goes beyond looking at the narrow confines of the health sector alone efforts will be made to build up a truly comprehensive movement that mobilises a wide range of social forces to radically transform the current perspective of health policy makers and institutions.

At the 55th session of the World Health Assembly the People's Health Movement comes with five crucial messages for the WHO:

5/17/02

- Work for the health of the poor, marginalized and indigent who are becoming the victims of neo-liberal economic policies

- Tackle poverty, injustice, exploitation and conflicts that are becoming the key determinants of health

- Bring real inter-sectorality into the discussions and initiatives for health instead of using 'charity funds' for marketing 'magic bullets' for diseases. Avoid vertical top-down approaches to tackling health problems

- Be transparent and accountable in the interaction with the corporate sector- who is not mandated to work for people's health but primarily for profits. Ensure WHO initiatives are free of corporate interest

- Be more participatory in the approach on health issues by engaging in continuous dialogue with the grass roots and people's health movements.

Dr. Qasem Choudhury — Co-ordinator, People's Health Assembly

Dr. Ravi Narayan — Convenor, PHA- WHA circle

For details, call PHA media team : Mobile: +41 78 876 5437 (Dr. Unnikrishnan PV / Satya Sivaraman)

PHA Coordinating Group : Asian Community Health Action Network (ACHAN) * Consumers International Regional Office for Asia and the Pacific (CI ROAP) * Dag Hammarskjold Foundation (DHF) * Gonoshasthaya Kendra (GK) * Health Action International (HAI) * International People's Health Council (IPHC) * Third World Network (TWN) * Women's Global Network for Reproductive Rights (WGNRR)

sochara

From: Nikki Wright <nwright@ieha.info>
To: <PHA-exchange@kabissa.org>
Sent: Tuesday, May 14, 2002 4:47 PM
Subject: PHA-Exchange> Call for papers for new journal focusing on eHealth and Development

Call for papers for *eHealth International* – a new journal focusing on eHealth and Development

Papers are now being received for the new journal of the International eHealth Association being published by BioMed Central - *eHealth International*.

This peer reviewed journal will focus on appropriate technologies in healthcare including all aspects of eHealth. Telemedicine/telehealth use of ICTs. Biotechnology and all issues in electronic healthcare technologies will be considered for publication.

For more information contact Dr. Harry McConnell, hmcconnell@ieha.info.

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15/5

sochara

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Tuesday, May 14, 2002 6:45 AM
Subject: PHA-Exchange> PHM PRESS RELEASE (14th May 2002), Geneva.

From: unnikru@yahoo.com
Subject: PRESS RELEASE (14th May 2002) : People's Health Movement calls on WHO to START ACTING AND STOP THE RHETORIC.

PHM Secretariat cksavar@citechco.net website: http://www.phamovement.org

WHO-Industry partnership-

Who influences Who ?

Geneva: 14th May, 2002: The People's Health Movement (PHM) welcomes the World Health Organisation (WHO) Director-General's reiteration of her organisation's ambition to tackle the *'diseases of poverty'* in her speech to the 55th World Health Assembly but is deeply disappointed that the rhetoric is not backed by meaningful action on the ground.

Indeed the WHO with its selective approach and public-private initiatives for funding healthcare strategies is going back on its commitment towards taking a comprehensive approach on healthcare issues. There is no evidence at all that such public-private initiatives and excessive dependence on the private industry have had any positive impact on the health situation anywhere. Continuation of this strategy by the WHO will only be a case of triumph of empty hope over bitter experience.

The PHM further warns that while the WHO is flirting with industry in the name of raising resources for healthcare this is being done without proper guidelines or long-term vision and is only likely to result in the world body becoming a tool of profits-before-people machinations of the drug and other multinationals.

An example of the WHO's unprincipled liaison with private industry is illustrated by its recent endorsement of the *Global Alliance for Improved Nutrition* (GAIN). This will involve giving assistance to multinationals selling 'fortified foods' in lobbying for favourable tariffs and tax rates and speedier regulatory review of new products in developing countries.

Apart from the very questionable health benefits of such 'fortified foods' the WHO's association with the *'Marlboro' Philip Morris* owned *Kraft Foods*, which is among the leading players in the GAIN consortium raises worrying questions about what criteria the world body uses in such so called public-private initiatives.

That the WHO wants to tackle the problem of malnutrition in poor countries by doing a 'deal' with multinationals, known more for inducing consumers to unhealthy food, only shows up its desperation. The very concept of the GAIN consortium is testimony to the failure of the WHO's healthcare approach so far.

The WHO's involvement in the Global Fund for AIDS, TB and Malaria is also another example of the organisation's selective approach to the worldwide health crisis and is unsustainable in the long-term. The WHO's piece-meal and one-off attitude towards the numerous health problems besetting poorer countries

cannot solve their health problems which need a comprehensive approach to health care and revitalising of values of Health for All.

The PHM also notes with great concern that Director General Brundtland's listing of the WHO's various 'achievements' actually hide her organisation's inability to stand up to other international institutions and corporations that profoundly and negatively affect the health of millions of people around the world. Bodies such as the World Bank and the World Trade Organisation are making decisions that influence health worldwide but the WHO seems to be too coy about using its influence to protect the health sector from the policies of these organisations.

It is true that the WHO's influence on health policies around the world has been dwindling in recent times but that is only because it has lost credibility by refusing to seriously address any of the structural problems that underline health problems in poor and developing countries. **It is time for radical change.**

Dr. Qasem Choudhury — Co-ordinator, People's Health Assembly

Dr. Ravi Narayan — Convenor, PHA- WHA circle

For details, call PHA media team : Mobile: +41 78 876 5437 (Dr. Unnikrishnan PV / Satya Sivaraman)

sochara

From: Saran Shannon <sarahs@hesperian.org>
To: <todd@hesperian.org>
Cc: <davmedia@listserv.uoguelph.ca>; <pha-exchange@kabissa.org>; <wusanet@wusa.ca>
Sent: Monday, May 13, 2002 11:26 PM
Subject: PHA-Exchange> Impact of Media & Communication in Public Health and Biotechnology

Reply to:
Tea Vuku i Rukavina, MD
Andrija tampar School of Public Health
Rockefellerova 4
10 000 Zagreb
Croatia
phone:+385 1 4590 169
fax: +385 1 4684 406
e-mail: tvukusic@snz.hr
------- Forwarded message follows -------
Dear all,

My name is Tea Vukusic Rukavina, I'm fellow researcher at the Andrija Stampar School of Public Health, Department of Medical Sociology and Health Economics, Zagreb, Croatia.

I also work asan executive director of the 5th International Conference "Health Insurance in Transition", 26-28 September 2002, Zagreb, organized by Andrija Stampar School of Public Health, Zagreb, Croatia, London School of Economics and London School of Hygiene and Tropical Medicine.

4th International Conference "Health Insurance in Transition" gathered 450 participants from 17 countries all over the world (report is in the attachment).

One of the modules in Conference 2002 is Impact of Media and Communication in Public Health and Biotechnology. Since you reperesentMedia & HealthGroup, we think you might be interested in participating at our Conference.

We would like to strengthen collaboration between media and health care professionals and present basic PR's skills to health care officials, decision makers and researchers.
Public relations are important for successful research. This module is designed
also for young journalists who are writing about science and for young researchers who would like to have some basic PR skills. It is important to bring together journalists and researchers, because their close cooperation will produce adequate and true and up to date information to general public. Researchers should know that without good public promotion of their work their finding prospects will be severely damaged, but they should also know that journalists are here also to scrutinize their work which should always be of benefit to their communities.
[snipped] you'll find [snipped] preliminary program of this module and 2002 conference, [snipped] at our web site www.dub-conference.org
Sincerely,

Feb
15/5

Tea Vuku i Rukavina
****
Tea Vuku i Rukavina, MD
Andrija Stampar School of Public Health
Rockefellerova 4
10 000 Zagreb
Croatia
phone:+385 1 4590 169
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e-mail: tvukusic@snz.hr
------- End of forwarded message ---------
:-) Message ends, Signature begins (-:
George Lessard, living @ 61.10N 94.05W
Comments should be sent to media@_no_spam_web.net
[Remove _no_spam_ from addresses to e-mail]
"Only those who will risk going too far can possibly
find out how far one can go." T.S. Eliot...
"If you think you are too small to make a difference,
try sleeping in a closed room with a mosquito..." African Proverb
****
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Homepages http://media002.tripod.com
Caveat Lector, Disclaimers & (c) info
http://members.tripod.com/~media002/disclaimer.htm

Semi-random signature quotes follow:
No generalization is true.
-- Alan Dawson

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

Sean Shannon
Executive Director
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Berkeley, California 94704 USA

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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

sochara

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Monday, May 13, 2002 7:35 PM
Subject: PHA-Exchange> 2002 HAZARDOUS TO HEALTH: THE WORLD BANK AND IMF IN AFRICA

From: Firoze Manji <firoze@fahamu.org>

> Action Position Paper by Ann-Louise Colgan, Research Associate, Africa Action, April, 2002.

> Health is a fundamental human right. Health is also an essential component of development, vital to a nation's growth and internal stability. Over the past two
> decades, the World Bank and IMF have undermined Africa's health through the policies they have imposed. The dependence of poor and highly indebted African countries on World Bank and IMF loans has given these institutions leverage to control economic policy-making in these countries. The policies mandated by the World Bank
> and IMF have forced African governments to orient their economies towards > greater integration in international markets at the expense of social services and long-term development priorities. They have reduced the role of the state and cut back government expenditure.
While many African countries succeeded in improving their health care > systems in the first decades after independence, the intervention of the > World Bank and IMF reversed this progress. Investments in health care by > African governments in the 1970s achieved improvements in key health > indicators. In Kenya, for example, child mortality was reduced by almost 50%
> in the first two decades after independence in 1963. Across sub-Saharan > Africa, the first decades after independence saw significant increases in > life expectancy, from an average of 44 years to more than 50 years.
> In the 1980s and 1990s, however, African governments had to cede control > over their economic decision-making in order to qualify for World Bank and > IMF loans. The conditions attached to these loans undid much of the progress
> achieved in public health. The policies dictated by the World Bank and IMF > exacerbated poverty, providing fertile ground for the spread of HIV/AIDS and
> other infectious diseases. Cutbacks in health budgets and privatization of > health services eroded previous advances in health care and weakened the > capacity of African governments to cope with the growing health crisis.
> Consequently, during the past two decades the life expectancy of Africans > has dropped by 15 years.
>
> Africa Action calls for an end to World Bank and IMF policies that undermine
> health. This requires canceling the debts that prevent African governments > from making their full contribution to addressing the health crisis. It also
> requires ending the imposition of harmful economic policies as conditions > for future loans or grants.

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>

> 1. In 1944, The World Bank and IMF were were designed as pillars of the post-war global economic order. The World Bank's focus is the provision of long-term loans to support development projects and programs. The IMF concentrates on providing loans to stabilize countries with short- term financial crises. The World Bank and IMF became
> increasingly powerful in Africa with the economic crisis of the early 1980s.
> In the late 1970s, rising oil prices, rising interest rates, and falling prices for other primary commodities left many poor African countries unable to repay mounting foreign debts. In the early 1980s, Africa's debt crisis worsened. The ratio of its foreign debt to its export income grew to 500%. African countries needed increasing amounts of "hard currency" to repay their external debts (i.e. convertible foreign currencies such as dollars and deutschmarks). But their share of world trade was decreasing and their export earnings dropped as global prices for primary commodities fell. The reliance of many African countries on imports of manufactured goods, which they themselves did not
> produce, left them importing more while they exported less. Their balance of
[redacted]ayments problems worsened and their foreign debt burdens became
> unsustainable.
African governments needed new loans to pay their outstanding debts and to
> meet critical domestic needs. The World Bank and IMF became key providers of
> loans to countries that were unable to borrow elsewhere. They took over from
> private banks as the main source of loans for poor countries. These institutions provided "hard currency" loans to African countries to insure repayment of their external debts and to restore economic stability. The World Bank and IMF were important instruments of Western powers during the Cold War in both economic and political terms.
> They performed a political function by subordinating development objectives
> to geostrategic interests. They also promoted an economic agenda that sought
> to preserve Western dominance in the global economy. Not surprisingly, the
> [redacted]orld Bank and IMF are directed by the governments of the world's richest
> countries. Combined, the "Group of 7" (U.S., Britain, Canada, France,
> Germany, Italy and Japan) hold more than 40% of the votes on the Boards of Directors of these institutions. The U.S. alone accounts for almost 20%. It was U.S. policy
> during the Reagan Administration in the early 1980s, to expand the role of the World Bank and IMF in managing developing economies. The dependence of African countries on new loans gave the World Bank and IMF great leverage. The conditions attached to these loans required African countries to submit to economic changes that favored "free
> markets." This standard policy package imposed by the World Bank and IMF was
> termed "structural adjustment." This referred to the purpose of correcting
> trade imbalances and government deficits. It involved cutting back the role
> of the state and promoting the role of the private sector. The ideology

> behind these policies is often labeled "neo-liberalism," "free market
> fundamentalism,"or the "Washington Consensus." From the 1970s on, this
> orientation became the dominant economic paradigm for rich country
> governments and for the international financial institutions. The basic
> assumption behind structural adjustment was that an increased role for the
> market would bring benefits to both poor and rich. This would encourage
> others to follow their example. The development of a market economy with a
> greater role for the private sector was therefore seen as the key to
> stimulating economic growth. The crisis experienced by African countries
in
> the early 1980s did expose the need for economic adjustments. With
declining
> incomes and rising expenses, African economies were becoming badly
> distorted. Corrective reforms became increasingly necessary. The key issue
> with adjustments of this kind, however, is whether they build the capacity
> to recover and whether they promote long- term development. The
adjustments
> dictated by the World Bank and IMF did neither.
>
> African countries require essential investments in health, education and
> infrastructure before they can compete internationally. The World Bank and
> IMF instead required countries to reduce state support and protection for
> social and economic sectors. They insisted on pushing weak African
economies
> into markets where they were unable to compete with the might of the
> international private sector. These policies further undermined the
economic
> development of African countries.

Structural adjustment refers to a package of economic policy changes
designed to fix imbalances in trade and government budgets.
> In trade, the objective is to improve a country's balance of payments, by
> increasing exports and reducing imports. For budgets, the objective is to
> increase government income and to reduce expenses. In theory, achieving
> these goals will enable a country to recover macroeconomic stability in
the
> short-term. It will also set the stage for long-term growth and
development.
> The structural adjustment programs of the early 1980s were meant to
provide
> temporary financing to borrowing countries to stabilize their economies.
> These loans were intended to enable governments to repay their debts,
reduce
> deficits in spending, and close the gap between imports and exports.
> Gradually, these loans evolved into a core set of economic policy changes
> required by the World Bank and IMF. They were designed to further
integrate
> African countries into the global economy, to strengthen the role of the
> international private sector, and to encourage growth through trade.
Typical
> components of adjustment programs included cutbacks in government
spending,
> privatization of government-held enterprises and services, and reduced

> currency devaluation, increased interest rates, and the elimination of food
> subsidies. The underlying intention was to minimize the role of the state.
>
> World Bank and IMF adjustment programs differ according to the role of each
> institution. In general, IMF loan conditions focus on monetary and fiscal
> issues. They emphasize programs to address inflation and balance of payments
> problems, often requiring specific levels of cutbacks in total government
> spending. The adjustment programs of the World Bank are wider in scope, with
> a more long-term development focus. They highlight market liberalization and
> public sector reforms, seen as promoting growth through expanding exports,
> particularly of cash crops. Despite these differences, World Bank and IMF
> adjustment programs reinforce each other. Governments generally must first be
> approved by the IMF, before qualifying for an adjustment loan from the World
> Bank. Their agendas also overlap in the financial sector in particular. Both
[redacted]work to impose fiscal austerity and to eliminate subsidies for workers, for
> example. The market-oriented perspective of both institutions makes their
> policy prescriptions complementary.
>
> Adjustment lending constitutes 100% of IMF loans. In 2001, approximately 27%
> of World Bank lending to African countries was for "adjustment." In the
> World Bank's total loan portfolio, adjustment lending generally accounts for
> between one-third and one-half. The remainder of World Bank loans are
> disbursed for development projects and programs. The project portfolio of
> the Bank covers such areas as infrastructure, agricultural and environmental
> development, and human resource development. In some cases, the projects
> supported by World Bank loans do make useful contributions to development.
> But these occasional successes must be weighed against the negative
e[redacted]cts
> of increasing debt, imposed economic policies and their consequences. The
> past two decades of World Bank and IMF structural adjustment in Africa have
> led to greater social and economic deprivation, and an increased dependence
> of African countries on external loans. The failure of structural adjustment
> has been so dramatic that some critics of the World Bank and IMF argue that
> the policies imposed on African countries were never intended to promote
> development. On the contrary, they claim that their intention was to keep
> these countries economically weak and dependent. The most industrialized

> countries in the world have actually developed under conditions opposite to

those imposed by the World Bank and IMF on African governments. The U.S. and
> the countries of Western Europe accorded a central role to the state in
> economic activity, and practiced strong protectionism, with subsidies for
> domestic industries. Under World Bank and IMF programs, African countries
> have been forced to cut back or abandon the very provisions which helped
> rich countries to grow and prosper in the past. Even more significantly, the
> policies of the World Bank and IMF have impeded Africa's development by
> undermining Africa's health. Their free market perspective has failed to
> consider health an integral component of an economic growth and human
> development strategy. Instead, the policies of these institutions have
> caused a deterioration in health and in health care services across the
> African continent.
>
> Health status is influenced by socioeconomic factors as well as by the state of health care delivery systems. The policies prescribed by the World Bank and IMF have increased poverty in African countries and mandated cutbacks in the health sector. Combined, this has caused a massive deterioration in the continent's health status.
>
> The health care systems inherited by most African states after the colonial
era were unevenly weighted toward privileged elites and urban centers. In
> the 1960s and 1970s, substantial progress was made in improving the reach of
> health care services in many African countries. Most African governments
> increased spending on the health sector during this period. They endeavored
> to extend primary health care and to emphasize the development of a public
> health system to redress the inequalities of the colonial era. The World
> Health Organization (WHO) emphasized the importance of primary healthcare at
> the historic Alma Ata Conference in 1978. The Declaration of Alma Ata
> focused on a community-based approach to health care and resolved that
> comprehensive health care was a basic right and a responsibility of
> government. These efforts undertaken by African governments after
> independence were quite successful. There were increases in the numbers of
> health professionals employed in the public sector, and improvements in
> health care infrastructure in many countries. There was also some success in
> extending care to formerly unserved areas and populations. Across the
> continent, there were improvements in key health care indicators, such as
> infant mortality rates and life expectancy. The number of doctors and nurses was also significantly increased during this time. Infant mortality was reduced.
While progress across the Africa was uneven, it was significant, not only because of its
> positive effects on the health of African populations. It also illustrated a
> commitment by African leaders to the principle of building and developing

> their health care systems.
>
As African governments became clients of the World Bank and IMF, they forfeited control

> over their domestic spending priorities. The loan conditions of these
> institutions forced contraction in government spending on health and other
> social services. Poverty and Health The relationship between poverty and
> ill-health is well established. The economic austerity policies attached
to
> World Bank and IMF loans led to intensified poverty in many African
> countries in the 1980s and 1990s. This increased the vulnerability of
> African populations to the spread of diseases and to other health
problems.
> The public sector job losses and wage cuts associated with World Bank and
> IMF programs increased hardship in many African countries. During the
1980s,
> when most African countries came under World Bank and IMF tutelage, per
> capita income declined significantly most of sub- Saharan Africa. The
removal of food and agricultural subsidies caused prices to rise and created
increased food insecurity. This led to a marked deterioration in nutritional
status, especially among women and children. Malnutrition resulted in low
birth weights among infants and stunted growth
> among children in many countries. It is currently estimated that one in
> every three children in Africa is underweight. In general, between one-
> quarter and one-third of the population of sub-Saharan Africa is
chronically
> malnourished. The deepening poverty across the continent has created
[redacted]tile
> ground for the spread of infectious diseases. Declining living conditions
> and reduced access to basic services have led to decreased health status.
In
> Africa today, almost half of the population lacks access to safe water and
> adequate sanitation services. As immune systems have become weakened,
> the susceptibility of Africa's people to infectious diseases has greatly
> increased. A joint release issued by WHO and the Joint UN Programme on
> HIV/AIDS (UNAIDS) in April 2001 reports that the number of cases of
> tuberculosis in Africa will reach 3.3 million per year by 2005. WHO
> reported in 2001 that almost 3,000 Africans die each day of malaria. Each
> year in Africa, the disease takes the lives of more than 500,000 children
> below the age of five. Most devastating of all has been the impact of
> the HIV/ AIDS pandemic. The spread of HIV/AIDS in Africa has been
> facilitated by worsening poverty and by the conditions of inequality
> intensified by World Bank and IMF policies. Economic insecurity has
> reinforced migrant labor patterns, which in turn have increased the risk
[redacted]
> infection. Reduced access to health care services has increased the spread
> of sexually transmitted diseases and the vulnerability to HIV infection.
> Further details:
> http://www.equinetafrica.org/newsletter/newsletter.php?id=634
> Edit:
>
http://www.equinetafrica.org/newsletter/admin/admin.php?action=modify&id=634

sochara

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Cc: acc/scn <accscn@who.ch>
Sent: Monday, May 13, 2002 5:00 PM
Subject: PHA-Exchange> World Food Summit five years later

World Food Summit five years later

This is as a follow up to vol. 44.4 of Soc for Intl Dev (SID) journal on 'Food
> Security and Livelihoods', and in order to update you on SID engagement in
> the preparations for the World Food Summit (WFS) five years later review.
>
> The WFS review will take place in Rome on June 10th-13th. The event will be
articulated around a number of plenaries and roundtables, open to country
> delegations as well as 606 representatives from NGOs and civil society
> organisations. Country representatives are already working on the draft
> document of the Declaration which will be issued as the Summit declaration.
> This paper is available on the web at
> http://www.fao.org/worldfoodsummit/practical.htm Comments on the text are
> sought and NGOs/CSOs are invited to express their views.
>
> Organisation of a Multi-Stakeholder Dialogue (MSD) was endorsed by the FAO as a way of facilitating dialogue and enabling civil society representatives to
> convey their views on food security issues to the government delegates. The
> MSD has now been scheduled on Wednesday June 12th at 2.30 pm, with
> voluntary attendance by country delegations.
>
> Parallel to the official Forum, an event organised by NGOs/CSOs will be
> held on June 8th-13th. Among the main themes identified for discussion in the Forum are the right to food, food sovereignty, alternative models of agricultural production and access to resources. Street rallies and other events are expected, with mobilisation
> of peasants, NGOs/CSOS, fisherfolks, agricultural workers, trade unions and
> indigenous peoples of the world calling for food sovereignty.
>
> Planning on all the parallel events is fast advancing; workshops and
> small meetings are being organised in both the official and the NGOs/CSOs
> Fora. Please I look forward to hearing from you at your earliest convenience.
> With warm regards,
Elena Mancusi-Materi
> Society for International Development (SID)
> E-mail:elenam@sidint.org Web:http://www.sidint.org

Feb 15/5

sochara

From: Aviva <aviva@netnam.vn>
To: pha-exch <pha-exchange@kabissa.org>
Sent: Monday, May 13, 2002 4:14 PM
Subject: PHA-Exchange> B. Gates, micronutrients and transnationals

Bruce Cogill at bcogill@smtp.aed.org wrote:

Let them eat Cheez Whiz?

An international consortium led by Bill Gates's charitable foundation plans to address malnutrition around the world by offering economic incentives to Kraft, Procter & Gamble and other food companies to bring fortified processed foods and food commodities to impoverished nations.
The unusual program, funded mostly with $50 million from the Gates Foundation, has signed up Kraft Foods Inc., Procter & Gamble Co., H.J.Heinz and vitamin manufacturers Roche and BASF Corp. Participating companies would add nutrients, such as iron, folic acid and vitamin A, to food products they sell in poor countries and also provide governments and small food producers with technical assistance for fortifying food staples, such as rice, maize meal, wheat flour, oil, sugar, soy sauce and salt.
In exchange, the consortium, called the Global Alliance for Improved Nutrition, or GAIN, would offer companies assistance in lobbying for favorable tariffs and tax rates and speedier regulatory review of new products in targeted countries. The consortium also would give local governments money for initiatives to help create demand for fortified foods, including large scale public relations campaigns or a governmental "seal of approval."
The effort, whose total funding is $70 million over five years, is set to be launched officially Thursday by Mr. Gates at the United Nations General Assembly Special Session on Children. The consortium includes U.N. agencies such as the World Bank, the World Health Organization and Unicef, the governments of the U.S., Japan, Germany and Canada, and global health and nutrition experts. Negotiations with some countries have already begun.
The presidents of Sri Lanka and Zambia are expected to be at the announcement and are considering expanding current food- fortification programs under the new effort.

Facts about vitamin and micronutrient deficiencies in developing countries:
* Two billion people suffer from anemia (mostly iron deficiency anemia)
* One-fifth of maternal deaths are due to severe anemia
* An estimated 200 million children do not get enough vitamin A from their daily diet
* Without supplemental vitamin A, 250,000 would go blind each year
* Close to two billion people do not get enough iodine from their daily diet
* Iodine deficiency is the leading cause of preventable mental retardation in the world
Source: GAIN, USAID

Some experts are troubled by the idea of Bill Gates and multinational food companies teaming up to reach into underdeveloped countries' food systems. Critics dislike helping corporations peddle processed foods that, despite added nutrients, still aren't especially healthy because of their fat, sugar or sodium content. Many see the GAIN program as just a heavy-handed way to ease corporate access to poor markets -- and one that won't do much to counter malnutrition.

This is a reductionist, single-nutrient techno-fix to a problem that is much more complex. The main reason for

5/17/02

the lack of decent nutritional status is poverty.

The GAIN project is modeled after the billion-dollar global vaccine program to inoculate poor children, also backed by the Gates foundation. The guiding principle is to bring public agencies and private industry together to address grossly inadequate basic health care for the poor resulting from failures of the marketplace. The foundation's approach is to fix problems using market mechanisms. GAIN officials say they hope to encourage national governments to
provide regulatory concessions for fortified foods, thereby reducing the costs for industry.

Patti Rundall, Policy Director
Baby Milk Action, 23 St Andrew's St, Cambridge, CB2 3AX
Work Tel: 01223 464420, Mobile: 07786 523493, Fax: 01223 464417
email: prundall@babymilkaction.org, Websites: www.babymilkaction.org
www.ibfan.org

Baby Milk Action is the UK member of:
The International Nestlé Boycott Committee
INTERNATIONAL BABY FOOD ACTION NETWORK
- 1998 RIGHT LIVELIHOOD AWARD RECIPIENT-

sochara

From: George(s) Lessard <media@web.net>
To: <creative-radio@yahoogroups.com>; <mediamentor@yahoogroups.com>
Cc: <devmedia@listserv.uoguelph.ca>, <pha-exchange@kabissa.org>; <wuscnet@wusc.ca>
Sent: Saturday, May 11, 2002 10:04 PM
Subject: PHA-Exchange> Impact of Media & Communication in Public Health and Biotechnology

Reply to:
Tea Vuku i Rukavina, MD
Andrija tampar School of Public Health
Rockefellerova 4
10 000 Zagreb
Croatia
phone:+385 1 4590 169
fax: +385 1 4684 406
e-mail: tvukusic@snz.hr
[redacted]--- Forwarded message follows -------
Dear all,

My name is Tea Vukusic Rukavina, I'm fellow researcher at the Andrija Stampar School of Public Health, Department of Medical Sociology and Health Economics, Zagreb, Croatia.

I also work asan executive director of the 5th International Conference "Health Insurance in Transition", 26-28 September 2002, Zagreb, organized by Andrija Stampar School of Public Health, Zagreb, Croatia, London School of Economics and London School of Hygiene and Tropical Medicine.

4th International Conference "Health Insurance in Transition" gathered 450 participants from 47 countries all over the world (report is in the attachment).

One of the modules in Conference 2002 is Impact of Media and Communication in P[redacted]lic Health and Biotechnology. Since you representMedia & HealthGroup, we think you might be interested in participating at our Conference.

We would like to strengthen collaboration between media and health care professionals and present basic PR's skills to health care officials, decision makers and researchers.
Public relations are important for successful research. This module is designed also for young journalists who are writing about science and for young researchers who would like to have some basic PR skills. It is important to bring together journalists and researchers, because their close cooperation will produce adequate and true and up to date information to general public. Researchers should know that without good public promotion of their work their funding prospects will be severely damaged, but they should also know that journalists are here also to scrutinize their work which should always be of benefit to their communities.

Feb
15/5

5/17/02

conference, [snipped] at our web site www.dub-conference.org
Sincerely,
Tea Vuku i Rukavina
****

Tea Vuku i Rukavina, MD
Andrija tampar School of Public Health
Rockefellerova 4
10 000 Zagreb
Croatia
phone:+385 1 4590 169
fax: +385 1 4684 406
e-mail: tvukusic@snz.hr

------- End of forwarded message ---------
:-) Message ends, Signature begins (-:
George Lessard, living @ 61.10N 94.05W
Comments should be sent to media@_no_spam_web.net
[Remove _no_spam_ from addresses to e-mail]
"Only those who will risk going too far can possibly
find out how far one can go." T.S. Eliot...
"If you think you are too small to make a difference,
try sleeping in a closed room with a mosquito..." African Proverb
****
ICQ # 8501081
MediaMentor Weblog
http://www.eGroups.com/list/mediamentor
Homepages http://media002.tripod.com
Caveat Lector, Disclaimers & (c) info
http://members.tripod.com/~media002/disclaimer.htm

Semi-random signature quotes follow:
No generalization is true.
-- Alan Dawson

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

Subject: PHA-Exchange> Correction from Claudio
Date: Wed, 24 Apr 2002 09:22:38 +0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

I apologize for a 'faux pax'. The change of PHM's secretariat to Bangalore
in Oct. is not definite yet. A consensus still needs be okayed. The Indian
PHA network - NCC should be considering this possibility at their next meeting in June or July to endorse it; the matter should also be discussed
when the PHMC is constituted in October - November 2002. A final decision
will then be made.
Perhaps on our 16th Meeting at the WCC in Geneva, we can discuss this issue
and the follow-up action.
Claudio

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Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

RN
26/4