Subject: Re: CMJI 18.1
Date: Thu, 9 Jan 2003 14:42:11 +0530
From: "S Morgan" <cmai@del3.vsnl.net.in>
Reply-To: "S Morgan" <smorgan@cmai.org>
To: "Ravi Narayan" <sochara@vsnl.com>

Dear Dr:

Greetings from the Christian Medical Association of India!

Hope you have received the issue of *CMJI* 17.4(Tribal Health).

The theme for our next issue is 18.1 **Caring for my neighbour**. Kindly send in your article for the **Health Advocate** column by **30 January 2003**. Hope you have received tremendous response for the Asia Social Forum held recently.

Looking forward to hearing from you soon.

With regards,

Sumathi Morgan and Rebecca Pandiaraj

RN
10/1/03

To write a reflection on Right to Health care →

RN
13/1/03

Subject: Re: Outline of Chapter
Date: Thu, 16 Jan 2003 18:55:58 -0800
From: chc <sochara@vsnl.com>
To: Vikram Patel <vikpat@goatelecom.com>

Dear Vikram,

Greetings from Peoples Health Movement Secretariat at CHC, Bangalore!

We missed you at ASF though I did mention your book at the Alma Ata Anniversary workshop. I have taken over as the Global coordinator of the PHM from 1st January and just the two week experience of demands and activities needing response or facilitation have given me serious doubts of whether it was wise to have agreed to join your group to evolve this interesting chapter which has its own time schedule and deadlines. Perhaps I should pass it on to Mani Kaliath, one of our team members who may have more time and is the mental health resource person in our team as well. He is a public health physician with long standing experience of CH training and alternative mental health initiatives and experiments and a good replacement.

I wait to hear from you before I pass on the papers or perhaps you could write to Mani as well (email: manicec@pol.net.in).

Sorry about this change but the situation calls for 'realism' not 'romanticism'. Keep in touch.

Best wishes,

Ravi Narayan
Coordinator
PHM Secretariat,
CHC - Bangalore
India

PHM- Article Request file →

RN
16/1/03

Subject: outline of chapter
Date: Mon, 13 Jan 2003 19:15:31 +0500
From: Vikram Patel <vikpat@goatelecom.com>
To: <sochara@vsnl.com>, <naomar@ufba.br>, <leslie_swartz@hms.harvard.edu>, lswartz@hsrc.ac.za

Dear Naomar, Leslie and Ravi

First, thanks to all of you for agreeing to work with me on producing this chapter for the WHO book on mental health promotion. I had earlier sent you the outline of the entire book as proposed by the editors and the brief regarding Chapter 7 which is what we are invited to write.

In the first instance, I had approached each of you because of your rich experience in different regions of the world and in different aspects of health and development. Let me take this opportunity to introduce each of us. Naomar is a social psychiatrist working in Brazil who has worked extensively on social aspects of mental health and, specifically, on issues such as migration and social change. Leslie is a clinical psychologist who has worked extensively on cultural aspects of mental health in South Africa. Ravi is a public health doctor who has been leading a health NGO aimed at improving people' rights and participation in health, and is now the global coordinator of the Peoples Health Movement. I am a psychiatric epidemiologist working in India, with interests in the socioeconomic determinants of mental health. All of us, of course, have many more facets to our work.

We have been asked to prepare a two page outline of what our chapter will cover and submit this to the editors by February 15th. They will send their suggestions by March and our target is to submit our draft chapter by the end of June. I have initiated the process to get us to start thinking about what we will include by preparing a sketchy outline. I have attached this first draft with this message. I am very aware that this is a very tentative, first attempt, and I would be grateful if you could comment on this, adding/ editing/ commenting freely, using the Track Changes function in Word. Please send your comments back to me by the end of January. If any of you wishes to email all of us with general issues or suggestions, please use the 'reply to all' function to this email. I will collate all the suggestions and changes and prepare the next draft by the first week of February and send it back to you for your final comments before submission to the editors.

With regards and best wishes,

Vikram

16/1/03 Ravi

14/1/03
Dear Vikram
We missed you at ASF though I did mention your book at the Alma Ata Anniversary Workshop. I have taken over as the Global coordinator of the PHM from 1st Jan and just the two week experience of demands and activities needing response or facilitation have given me serious doubts of whether it was wise to have agreed to join your group to evolve this interesting Chapter which has its own time schedule and deadlines. Perhaps I should pass it on to Mani Kalliath one of our team members who may have more time and is the most senior person in our team as well

Chapter 7 outline.doc
Name: Chapter 7 outline.doc
Type: Winword File (application/msword)
Encoding: base64

RM 14/1/03
I await to hear from you before I pass on the papers or perhaps you could write to Mani as well (email - ——)
Sorry about this change but the situation calls for 'reaction, not 'romanticism'. Keep in touch. Best wishes Ravi

NOTE THAT ALL TELEPHONE NUMBERS IN GOA ARE CHANGED: ADD A '2' BEFORE THE OLD NUMBER AS SHOWN BELOW

Dr Vikram Patel
Senior Lecturer, London School of Hygiene & Tropical Medicine
Add: Sangath Centre, 841/1 Alto Porvorim, Goa, INDIA 403521

He is a public health physician with long standing experience of CH activities and alternative mental health initiatives and experiments and a good researcher

email: vikpat@goatelecom.com
Tel: 0832-2413527; Fax: +91-832-2415244; Off: +91-832-2414916/ 2417914
Mobile: +91-0-9822132038

Sangath website: www.sangath.com
London School of Hygiene & Tropical Medicine website: www.lshtm.ac.uk

The Mental Health Dimension of Health Promotion:

Concept, Evidence and Practice

(editors: Drs Helen Herrman, Shekhar Saxena and Rob Moodie)

Draft outline of Chapter 7: The situation across countries

Authors:

- Vikram Patel, Senior Lecturer, London School of Hygiene & Tropical Medicine and Chairperson, The Sangath Society, India
- Naomar Almeida Filho, President, University of Bahia, Salvador, Brasil.
- Leslie Swartz, Professor of Psychology, University of Stellenbosch, South Africa.
- Ravi Narayan, Community Health Cell, Bangalore & Global Coordinator, People's Health Movement, India.

The earlier chapters in this book describe the global or universal principles of mental health and health promotion. This chapter will discuss the enormous contrast across countries, especially between developed and developing countries, with respect to the determinants of mental health. The chapter will consider the potential impact of the rapid changes in some of the critical socio-economic influences on mental health in low and middle income countries.

In the first instance, the chapter will briefly review the evidence on determinants of mental health, focusing on disorders which are common and disabling, in particular, common mental disorders (depression and anxiety disorders) and substance abuse. Much of the evidence suggests that both these disorders are largely determined by social and economic factors. The chapter will highlight that global or regional factors such as political instability, gender, violence, globalization of the narcotics trade and criminal activities, large-scale internal and external migration, and economic globalization, will have a major role in modifying these influences which, in turn, may have an unanticipated impact on the mental health of populations. Case examples of the rise in suicide rates in China and Sri Lanka, the rise in alcohol abuse and related deaths in the post-Soviet Union nations, migration, urbanization and mental health in Brazil and India, economic reform and suicide in India, and the rise in substance abuse in some Latin American and African cities will be used to illustrate the practical significance of these changes. The issue of social capital as a determinant of mental health, and the impact of rapid socio-economic change on social capital will also be considered. Two core themes will underline this section: first, that mental health cannot be seen as separate from other aspects of health and development so that the achievement of good physical health and human rights are likely to be the most important aspect of mental health promotion; and second, that the most important difference between developed and developing countries may well be that communities in developing countries have lesser and lesser control and authority over the socio-economic influences on their health and development as the focal point for such macro-decision making moves further away from the individual.

Next, the chapter will consider the practical implications of these influences in terms of potential programs and policies for mental health promotion. We will attempt to review the larger literature on the impact of social and economic development policies in promoting mental health. We acknowledge that it is likely that there will be very little concrete or specific evidence which demonstrates the impact of social and economic development policies and programs on mental health promotion, but evidence from the domain of physical health and other indicators of well being may be used to estimate the impact on mental health. Examples of such programs or policies may include: the impact of urban regeneration; micro-credit schemes; literacy promotion; economic policies aimed at promotion of income equality and protection of the poor; promotion of gender equality; violence and crime prevention programs etc. In situations where evidence is not available for these programs in developing countries, relevant evidence from richer countries will be sought and their applicability to developing countries considered. The discussion will also consider the types of evidence which should be generated in the future to study the impact of various programs and policies on mental health promotion.

Dear Reeena

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

Here is the Health Advocate I promised before leaving for the States. Written in a hurry, it may need a little editing.

THE HEALTH ADVOCATE
February 2003.

WAR OR PEACE: WHAT IS YOUR COMMITMENT?

On 15th February 2003, over a million participated in the largest rally London had seen for decades. Hundreds of thousands marched through Berlin; two lakhs marched through Damascus; thousands joined marches in Bulgaria, Romania, Hungary, Brussels, South Korea, Australia, Malaysia and Thailand; hundreds in Bosnia, Hong Kong and Moscow; and thousands in Amsterdam, Copenhagen, Johannesburg, Tokyo, Dhaka. It was the largest anti-war rally in recent decades.

Earlier many braved the cold in many American cities and many joined similar protests in Delhi and Kolkata and Kerala soon after. The protests were a significant and inspiring message by peace loving world citizens all over the globe. They were not swayed by the pro-war rhetoric of Bush and Blair; nor impressed by the machination of the armament and nuclear transnational corporations all over the world; nor provoked by the demonstration of some leaders or even stereotyping of one of the important religions of the world. Men and women, young and old, school children and college students; farmers and teachers, artists and musicians, disabled and minorities; people of all religions, class and ethnicity joined the protest in an overwhelming grounds well of public opinion. No more war; no more bombs; no more war and bombs for oil rhetoric please!

Twenty five year ago in 1978, the Alma Ata Declaration on Health for All had clearly noted that

"an acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part should be allotted its proper share."

Twenty two years later, 1995, people from 92 countries gathered at the People's Health Assembly in GK Savar, Bangladesh and noted in the People's Charter for Health that:

"War, violence, conflict and natural disaster devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members.

especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector."

The Charter called on People's of the world to

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression and the research production, testing and use of weapons of mass destruction and other arms.
- Support people's initiatives to achieve a just and lasting peace.
- Demand that the United Nations and individual States end all kinds of sanctions used as an instrument of aggression, which can damage the health of civilian populations...

As members of a health network; as members of an association and followers of a 'peace maker'; what was your response?

Did you join the marches?
Did you email your protest?
Did you talk to your family, your friends, your colleagues, and your associates against war and stimulate them to support peace?
Did you write against the war?
Did you pray for the peace?
Or
Did you remain passive, uninvolved, disinterested, confused and supported the imminent war through your silence?

To live in peace takes a lot of commitment!. To promote a world in which Health for All Now can be a reality needs all of us to be as anti-war as we are anti-disease: as pro-peace as we are pro-health.

Are you going to respond?
Are you going to make your small voice part of a big bang against war?
Whether war takes place or not in the next few weeks, what would have been your commitment?

War or Peace ?
Peace needs You!!

Ravi Narayan
Coordinator
PHM Secretariat
CHC - Bangalore

Main Identity

From: Community Health Cell <sochara@vsnl.com>
To: <reena.luke@cmai.org>
Sent: Tuesday, March 25, 2003 CHC3 PM
Attach: WAR or Peace What is Your commitment(Reena).doc
Subject: The Health Advocate

Dear Reena,

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

The 'Health Advocate' sent on 28th February 2003 is not yet acknowledged. Please do so. We are forwarding it again as a follow up. When is it likely to come out? Should we update it in the context of ongoing war?

Regards,

Ravi Narayan
Coordinator,
PHM Secretariat

Community Health Cell wrote:

Dear Reeena

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Here is the Health Advocate I promised before leaving for the States.
Written in a hurry, it may need a little editing.

Ravi Narayan
Coordinator
PHM Secretariat
Community Health Cell
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

Subject: The Health Advocatte: WAR OR PEACE: WHAT IS YOUR COMMITMENT?
Date: Fri, 28 Feb 2003 13:31:44 +0530
From: Community Health Cell <sochara@vsnl.com>
To: Reena Luke Matai <reena.luke@cmai.org>

Dear Reena

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Ravi Narayan
Coordinator
PHM Secretariat
CHC - Bangalore

WAR or Peace What is Your commitment(Reena).doc	**Name:** WAR or Peace What is Your commitment(Reena).doc **Type:** Winword File (application/msword) **Encoding:** base64

RN
22/3/03

22/3/03

Dear Reena

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RN 28/3/03 We are forwarding it again as a follow up. When is it likely to come out? Should we update it in the context of the ongoing war?

Ram'
PHM Secretariat

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February 2003.

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War or peace
Peace needs You!!

Ravi Narayan
Coordinator
PHM Secretariat
CHC - Bangalore

PHM Secretariat

From: claudio <ravva@netnam.vn>
To: <richard_harris@osumc.edu>
Cc: RAVI <rhmsec@bsnl.net.in>
Sent: Thursday, July 31, 2003 7:48 PM
Attach: Art with Ravi.doc; Art with Ravi Abstr.doc
Subject: Claudio Schultan Urgent - edited por

Dear Richard,
Hope it is not too late. See attached.
I did some last minute editing for better readability as soon as I got last draft from Ravi.
Warm regards,
Claudio

The Peoples Health Movement: A People's Campaign for HEALTH FOR ALL – NOW!

Background

In 1978, in Alma – Ata, the universal slogan ***Health for All by the year 2000*** was coined. At the same time, the famous ***Alma Ata Declaration*** was overwhelmingly approved, putting people and communities at the center of health planning and health care strategies, and emphasizing the role of community participation, appropriate technology and inter-sectoral coordination. The Declaration was endorsed by most of the governments of the world and symbolized a significant paradigm shift in the global understanding of Health and Health care. (WHO – UNICEF, 1978).

Twenty five years later, after much policy rhetoric, some concerted but mostly ad-hoc action, quite a bit of misplaced euphoria; distortions brought about by the growing role of the market economy that affected health, and a fair dose of governmental and international health agencies' amnesia, this Declaration remains unfulfilled and mostly forgotten, as the world comes to terms with the new economic forces of globalization, liberalization and privatization which have made Health for All a receding dream.

The People's Health Assembly in Savar, Bangladesh in December 2000, and the People's Health Movement that evolved from it were both a civil society's effort to counter this global *laissez faire* and to challenge health policy makers around the world with a ***Peoples Health Campaign for Health for All-Now!***

The People's Health Assembly

The Global People's Health Assembly brought together 1450 people from 92 countries, and resulted in an unusual five-day event in which people shared concerns about the unfulfilled Health for All challenge. The Assembly program included a variety of interactive dialogue opportunities for all the health professionals and activists who gathered for this significant event. These events included:

- a rally for Health;
- meetings in which the testimonies on the health situation from many parts of the world and struggles of people were shared and commented upon by multidisciplinary resource persons; (People's Health Movement 2002)
- parallel workshops to discuss a range of health and health related challenges;
- cultural programmes to symbolize the multi-cultural and multiethnic diversity of the people of the world;
- exhibitions and video/film shows; and
- an abundance of dialogue, in small and big groups, using formal and informal opportunities.

The People's Health Assembly was preceded by a series of pre-assembly events all over the world. The most exceptional of these was the mobilization in India. For nearly nine months preceding the Assembly, there were grassroots, local and regional initiatives of people's health enquiries and audits; health songs and popular theater; sub-districts and district level seminars; policy dialogues and translations of national consensus documents on health into regional languages and campaigns to challenge medical professionals and the health system to become more Health for All oriented. Finally, over 2000 delegates converged on Kolkata (Calcutta), mostly coming by five people's health trains, and brought ideas and perspectives from seventeen state

conventions and 250 district conventions. In Kolkata, the assembly endorsed the Indian People's Health Charter after the two days of conferences, parallel workshops, exhibitions, two public rallies for health and cultural programmes. About 300 delegates from this Assembly then traveled to Bangladesh, mostly by bus, to attend the global Assembly. Similar preparatory initiatives, though less intense, took place in Bangladesh, Nepal, Sri Lanka, Cambodia, Philippines, Japan and other parts of the world, including Latin America, Europe, Africa and Australia.

The People's Charter for Health

Finally, at the end of a full year of mobilization and five days of very intense and interactive work in Savar, a ***Global Peoples Health Charter*** emerged which was endorsed by all the participants (People's Health Assembly 2000a). This Charter has now become:

- ⇨ an expression of our common concerns;
- ⇨ a vision for a better and healthier world;
- ⇨ a call for more radical action;
- ⇨ a tool for advocacy for people's health; and
- ⇨ a worldwide rallying manifesto for global health movements, as well as for networking and coalition building.

The significance of this Global People's Charter is multiple:

- ⇨ it endorses Health as a social/economic and political issue and as a fundamental human right;
- ⇨ it identifies inequality, poverty, exploitation, violence and injustice as the roots of ill-health;

- ⇨ it underlines the imperative that Health for All means challenging powerful economic interests, opposing globalization as the current iniquitous model, and drastically changing political and economic priorities;
- ⇨ it tries to bring in new perspective and voices from the poor and the marginalized (the rarely heard) encouraging people to develop their own local solutions; and
- ⇨ it encourages people to hold accountable their own local authorities, national governments, international organizations and national and transnational corporations.

The vision and the principles of the Charter, more than any other document preceding it, extricates Health from the myopic biomedical-techno-managerialist approach it has fostered in the last two decades --with its vertical, selective magic-bullets-approach to health-- and centers it squarely in the more comprehensive context of today's global socioeconomic-political-cultural-environmental realities. However, the most significant gain of the People's Health Assembly and the Charter is that, for the first time since Alma Ata, a Health For All action-plan unambiguously endorses a call for action that tackles the broader determinants of health. These include: ***Health as human right; Economic challenges for health; Social and political challenges in health; Environmental challenges for health; Tackling war, violence, conflict and natural disasters; Evolving a people-centered health sector; Encouraging people's participation for a healthy world.***

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

- combating the negative impacts of Globalization as a worldwide economic and political ideology and process;
- significantly reforming the International Financial Institutions and the WTO to make them more responsive to poverty alleviation and the Health for All Now Movement;
- a forgiveness of the foreign debt of least developed countries and use of its equivalent for poverty reduction, health and education activities;
- greater checks and restraints of the freewheeling powers of transitional corporations, especially pharmaceutical houses (and mechanisms to ensure their compliance);
- greater and more equitable household food security.
- some type of a Tobin tax that taxes runaway international financial transfers;
- unconditionally supporting the emancipation of women and the respect of their full rights;
- putting health higher in the development agenda of governments;
- promoting the health (and other) rights of displaced people;
- halting the process of privatization of public health facilities and working towards greater controls of the already installed private health sector;
- more equitable, just and empowered people's participation in health and development matters;
- a greater focus on poverty alleviation in national and international development plans;
- greater and unconditional access of the poor to the health services and treatment regardless of their ability to pay;

- strengthening public institutions, political parties and trade unions involved, as we are, in the struggle of the poor;
- opposing restricted and dogmatic fundamentalist views of the development process;
- greater vigilance and activism in matters of water and air pollution, the dumping of toxics, waste disposal, climate changes and CO2 emissions, soil erosion and other attacks on the environment;
- militant opposition to the unsustainable exploitation of natural resources and the destruction of forests;
- protecting biodiversity and opposing biopiracy and the indiscriminate use of genetically modified seeds;
- holding violators of environmental crimes accountable;
- systematically applying environmental assessments of development projects and people centered environmental audits;
- opposing war and the current USA – led, blind 'anti-terrorist' campaigns;
- categorically opposing the Israeli invasion of Palestinian towns (having, among other, a sizeable negative impact on the health of the Palestinian people;
- the democratization of the UN bodies and especially of the Security Council;
- getting more actively involved in actions addressing the silent epidemic of violence against women;
- more prompt responses and preventive/rehabilitative measures in cases of natural disasters;

- making a renewed call for a comprehensive, a more democratic People's Health Care that is given the resources needed --holding governments accountable in this task;
- vehemently opposing the commoditization and privatization of health care (and the sale of public facilities);
- independent national drug policies focused around essential, generic drugs;
- the transformation of WHO, supporting and actively working with its new Civil Society Initiative (CSI) making sure it remains accountable to civil society;
- assuring WHO stays staunchly independent from corporate interests;
- sustaining and promoting the defense of effective patient's rights;
- an expansion and incorporation into People's Health Care of traditional medicine;
- changes in the training of health personnel to assure it covers the great issues of our time as depicted in our People's Charter for Health;
- public health-oriented (and not for-profit) health research worldwide;
- strong people's organizations and a global movement working on health issues;
- more proactive countering of the media that are at the service of the globalization process;
- people's empowerment leading to their greater control of the health services they need and get;
- creating the bases for a better analysis and better concerted actions by its members through greater involvement of them in the PHM's website and list-server (pha-exchange);

- fostering a global solidarity network that can support and react out fellow members when facing disasters, emergencies or acute repressive situations.

As we enter the new millennium, this comprehensive view of actions for Health, is probably the most significant contribution of the People's Health Assembly and the evolving People's Health Movement. (Schuftan, 2002).

Significant Gains made by the People's Health Assembly and the Movement:

Noteworthy are the ongoing and growing mobilization process at global level, the Assembly as a historic first gathering and the movement that is evolving. In more detail, the gains include the following:

For the first time in decades, health and non-health networks have come together to work on global solidarity in health. These networks include the International People's Health Council (IPHC); Health Action International (HAI); Consumers International (CI); the Asian Community Health Action Network (ACHAN); the Third World Network (TWN); the Women's Global Network for Reproductive Rights (WGNRR); Gonoshasthya Kendra (GK) and the Dag Hammaeskjold Foundation (DHF). In the last couple of years, new networks like the Global Equity Gauge Alliance (GEGA) and the Social Forum Network are linking with us.

Even at country level, in some regions, this is beginning to happen. In India, for instance, this national collective now includes the science movements; the

women's movements; the alliance of people's movements; the health networks and associations; some research and policy networks and even some trade unions.

Another significant development has been the evolving solidarity PHM has found for its various collective documents at the global level (People's Health Assembly 2000b & c). These have included themes such as:

Health in the era of globalization: from victims to protagonists; The political economy of the assault on health; Equity and Inequity Today: some contributing social factors; The medicalization of Health Care and the challenge of Health for All; *The environmental crisis: threats to health and ways forward*; *Communication as if people mattered: adapting health promotion and social action to the global imbalances of the 21st century.*

Taken together, these documents represent an unprecedented, emerging, global consensus.

At country level also, such consensus documents to support public education and policy advocacy have been upcoming. In India, for instance, five little booklets, now translated into most Indian languages, are now available on the following five themes: What globalization means people's health; Whatever happened to Health for All by the year 2000; Making life worth living by meeting the basic needs of all; A world where we matter: focus on health care issues of women, children, street kids, the disabled and the aged; and, Confronting the commercialization of health care. These booklets have been published by 18 national networks who form the national coordination committee in India and represent unprecedented consensus, the first of its kind in five decades!

The People's Health Assembly itself was an unusual international health meeting expressing and symbolizing an alternative health and development culture of

dialogue and celebration. An extract from the report of two participants in the adjacent box describes this alternative dialogue.

The People's Health Assembly - An Alternative Culture of Dialogue

- The venue was well chosen. GK is one of the most revolutionary and inspiring community-based health programs in the world. The physical and social ambience was fabulous! No five star hotel for this huge forum: instead, a spacious auditorium was built behind a tranquil lake and fields where the GK workers grow food for the community program. Building the auditorium was no easy task. Due to heavy rain and tardy funding, two days before the event the vast structure still had no roof. But miraculously, it was completed at daybreak the morning the Assembly began – thanks for the valiant day and night efforts of 1000 workers.
- But how did the GK team manage to feed 1500 people in this rural setting? Rather than bussing folks to restaurants or trucking in costly catered cuisine, they built a covey of small bamboo sheds and invited women from neighboring villages to come prepare traditional food. The chance to perch out-of-doors on handcrafted bamboo stools, eating chapattis and dhal while trying to communicate with the gracious village women, was one of the high points of the Assembly. It somehow symbolized what we were collectively seeking to achieve: an innovative yet ancient way of transcending the commercial, hierarchical barriers that separate people from one another and their dreams. It brought us down to earth through the common understanding of each and everyone's most fundamental right, above all else – to have enough to eat.
- It was during these communal meals, with six or eight of us activist and progressives from different parts of the world clustered around a table comparing our insights, that some of the most meaningful and potentially transformative interactions of the PHA took place. After attending countless international conferences and fora over many years, this was a marvelous opportunity to chew the fat with so many old friends and fellow warriors for social justice.

- The energy and enthusiasm generated by the PHA was enormous! For all the diversity, the people present had in common a passionate commitment to change. Many were spokespersons for disadvantaged groups valiantly struggling to improve their situations – or at least to survive with dignity – in circumstances that in recent years have become more and more difficult and oppressive. Needless to say, an enormous amount of pain, anger, and frustration was vented. But most important, a great sense of international solidarity emerged.
- 'TO GIVE THE VOICELESS A VOICE' was a foremost goal of the People's Health Assembly. And indeed, the PHA had strong representation from a wide spectrum of marginalized and underprivileged groups, many of whom had never before had a chance to speak at a local council, much less at an international forum. Speakers from all corners of the earth represented everyone: from community health workers to traditional birth attendants, from mother's clubs to a collective of unemployed alcoholics (from Scotland), from tribals to ethnic minorities, from migrant workers to refugees, and from commercial sex workers to activists with AIDS.....
- The PHA was a marvelous forum for sharing experiences and exchanging ideas. Events were enlivened by role plays, music, dancing and poster sessions. Dramatic 'testimonials' of personal hardships – many of which brought tears to the eyes – portrayed the setbacks that people were suffering due to social injustice, unfair laws, and globalization. To give more people a chance to speak out, literally hundreds of relatively small concurrent sessions were held, ranging from women's rights to genetic engineering and everything else under the sun.

(Werner and Sanders, 2000)

Another significant gain has been the translation of the People's Charter for Health into nearly 40 languages worldwide. These include Arabic, Bangla, Chinese, Danish, English, Farsi, Finnish, Flemish, French, German, Greek, Hindi, Indonesian, Italian, Japanese, Kannada, Malayalam, Ndebele, Nepalese, Philippine, Portuguese, Russian, Shona, Sinhala, Spanish, Swahili, Swedish, Tamil, Urdu, Ukrainian and now in the process in Tonga, Lithuanian, Norwegian, Welsh ,Thai, Cambodian, Vietnamese, Pastun, Dhari and Creole. An audio tape in English with Braille titles is also available. All these have been translated by volunteers, committed to the People's Health Movement.

Audio Visual aids including videos for public education, exhibitions, slides, and other forms of communication are coming up. The BBC Life Series video on the Health Protesters was a good example.

The movement itself has evolved a communications strategy which includes a website (www.phmovement.org); the e-list server group for exchange and discussion (pha-exchange@kabissa.org); news briefs (nine since January 2001) and a host of press releases on a wide variety of themes and on special events and crises.

Presentations of the Peoples Health Charter, are constantly taking place in national, regional and international for a which have included the World Health Organization, the Global Forum for Health Research (GFHR – Forum 5 & 6) and the World Health Assembly. The development of a standing relationship between the PHM and WHO is particularly interesting. In April 2001, the very effective and assertive in-house lobbying by a visiting PHM Consultant to a WHO research seminar resulted in the formation of the WHO Civil Society Initiative announced at the World Health

Assembly, in May 2001. Six PHM leaders were invited to meet and dialogue with the Director General. By May 2002, WHO CSI invited PHM to present the People's Charter for Health as a Technical Briefing in the World Heath Assembly. 35 PHM members participated. In May 2003, over 80 PHM delegates from 30 countries attended the Assembly; made statements on Primary Health Care; TRIPS and other issues and were invited to meet the DG designate, who welcomed a greater dialogue with PHM members at all levels so that WHO could be in touch with the realities of the lives of the poor and the marginalized. The Assembly was preceded by a PHM Geneva meeting for the 25th Alma Ata Anniversary, which was attended by some WHO staff, including the PAHO Regional Director. These are all small, but incremental movements towards a critical collaboration of PHM with WHO!

In many countries of the world, emerging country level PHM circles are beginning to organize public meetings and campaigns which include taking health to the streets as a Rights issue. Discussions on the charter by professional associations and public health schools, articles and editorials in medical/health journals are also beginning to increase.

Policy dialogues and action research circles on WHO/WHA; poverty and AIDS; women's access to heath; health research; access to essential drugs; macroeconomics and health; public-private partnerships; food and nutrition security issues are beginning their work.

In short, every day the list of follow-up actions increases.

Conclusion

- To conclude, the People's Health Assembly and the People's Health Movement that has emerged from it has been a rather unprecedented development in the journey towards the Health for All goal. The movement:
    - ⇨ is a multi-regional, multi-cultural, and multi-disciplinary mobilization effort;
    - ⇨ is bringing together the largest gathering of activists and professionals, civil society representatives and the peoples representatives themselves,
    - ⇨ is evolving global instruments of concern and action, and
    - ⇨ is involved in solidarity with the health struggles of people, especially the poor and the marginalized affected by the current global economic order.

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

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Main Identity

From: "Sumathi Morgan" <cmai@del1.vsnl.net.in>
To: <secretariat@phmovement.org>
Cc: <phmsec@touchtelindia.net>
Sent: Monday, January 17, 2005 3:05 AM
Subject: Health Advocate 19.4

Dear Dr Ravi,

Wish you and your team a very happy and a wonderful New Year!

You must be surprised that I did not bother you for so long. So many things happened and the last issue of *CMJI* was getting delayed. Since the country has witnessed the worst disaster, our focus for the 19.4 (Oct-Dec) was shifted from Dalit issues to *The role of Christian Medical professionals in the Disaster Management.*

As you are doing a lot of work regarding this, it was decided to approach you with the request for the write up of *Health Advocate* focussing on this issue of Disaster Management by medical professionals with the backdrop of Tsunami.

Your last write-up on The 'Arcles' or the 'Apollos' Whom do we listen to? was not been used yet. We can use it for our next issue may be with some modifications or as you say.

Since the first issue of the year is already been delayed we are trying to work simultaneously on both the issues.

Looking forward to hearing from you soon.

Regards
Sumathi

19/1/05

Dear Sumathi
Thanks for the mail. The write up will be with you by the end of the week
It may be a good idea to contact CHAI, also Dr Sanjeev Kumar of SIT Shimla and perhaps Thelma of CHC to get short reflections for the special CMJI issue since they are all deeply involved. It will be a good Ecumenical gesture as well
Best wishes
Ravi.

RM
18/1/05

Pls. Article req.

1/18/05

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PHA - Articles

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Effect of Endosulfan on Male Reproductive Development

Habibullah Saiyed,[1] Aruna Dewan,[1] Vijay Bhatnagar,[1] Udyavar Shenoy,[2] Rathika Shenoy,[2] Hirehall Rajmohan,[3] Kumud Patel,[1] Rekha Kashyap,[1] Pradip Kulkarni,[1] Bagalur Rajan,[3] and Bhadabhai Lakkad[1]

[1]National Institute of Occupational Health (Indian Council of Medical Research), Meghani Nagar, Ahmedabad, India; [2]Department of Pediatrics, Kasturba Medical College, Mangalore, India; [3]Regional Occupational Health Research Centre, Bangalore, India

There is experimental evidence of adverse effects of endosulfan on the male reproductive system, but there are no human data. Therefore, we undertook a study to examine the relationship between environmental endosulfan exposure and reproductive development in male children and adolescents. The study population was composed of 117 male schoolchildren (10–19 years of age) of a village situated at the foothills of cashew plantations, where endosulfan had been aerially sprayed for more than 20 years, and 90 comparable controls with no such exposure history. The study parameters included recording of clinical history, physical examination, sexual maturity rating (SMR) according to Tanner stages, and estimation of serum levels of testosterone, luteinizing hormone (LH), follicle-stimulating hormone, and endosulfan residues (70 study and 47 control subjects). Mean ± SE serum endosulfan levels in the study group (7.47 ± 1.19 ppb) were significantly higher ($p < 0.001$) than in controls (1.37 ± 0.40 ppb). Multiple regression analysis showed that SMR scoring for development of pubic hair, testes, penis, and serum testosterone level was positively related to age and negatively related to aerial exposure to endosulfan (AEE; $p < 0.01$). Serum LH levels were significantly positively related to AEE after controlling for age ($p < 0.01$). The prevalence of congenital abnormalities related to testicular descent (congenital hydrocele, undescended testis, and congenital inguinal hernia) among study and controls subjects was 5.1% and 1.1%, respectively, but the differences were statistically nonsignificant. Our study results suggest that endosulfan exposure in male children may delay sexual maturity and interfere with sex hormone synthesis. Our study is limited by small sample size and nonparticipation. *Key words:* endocrine disruptor, endosulfan, luteinizing hormone, male reproductive development, sexual maturity rating, testosterone. *Environ Health Perspect* 111:1958–1962 (2003). doi:10.1289/ehp.6271 available via *http://dx.doi.org/* [Online 22 September 2003]

Endosulfan (6,7,8,9,10,10-hexachloro-1,5,5a,6,9,9a-hexahydro-6,9-methano-2,4,3-benzodioxathiepin-3-oxide) is a broad-spectrum insecticide and acaricide first registered for use in the United States in 1954 to control agricultural insect and mite pests on a variety of field, fruit, and vegetable crops. Technical-grade endosulfan is composed of two stereochemical isomers, α-endosulfan and β-endosulfan, in concentrations of approximately 70% and 30%, respectively. Use data from 1987 to 1997 indicate an average domestic use of approximately 1.38 million pounds of active ingredient per year [U.S. Environmental Protection Agency (U.S. EPA) 2002]. It has been found in at least 162 of the 1,569 current National Priorities List sites by the U.S. EPA (HazDat 2000). In India, it is widely used against a variety of agricultural pests. During 1999–2000, about 81,000 metric tons of endosulfan was manufactured in India, and in terms of tonnage its production was next only to mancozeb (103,000 metric tons) and monocrotophos (95,000 metric tons) (Anonymous 2001).

Oral LD50 (lethal dose sufficient to kill 50% of population) endosulfan in rats is 80 mg/kg, and it has been classified as a moderately hazardous (class II) pesticide [World Health Organization (WHO) 2002]. Neurotoxicity is the major end point of concern in acute endosulfan exposure in human beings and experimental animals. No data are available for subacute or chronic exposure to endosulfan in human subjects; however, the subacute and chronic toxicity studies of endosulfan in animals suggest that the liver, kidneys, immune system, and testes are the main target organs [Agency for Toxic Substances and Disease Registry (ATSDR) 2000].

In recent years, there has been growing concern about toxicity of a number of chemicals, including pesticides, on the male reproductive system (Murray et al. 2001; Sharpe 2001). Reported effects of endosulfan on the male reproductive system in experimental animals have been variable, depending on species, age at exposure, dose, duration of exposure, and study end points. Routine gross and histopathologic examination of the reproductive organs of male mice that consumed doses of 7.3 mg/kg/day for 13 weeks (Hoechst, Unpublished data) or 2.5–5.0 mg/kg/day for 2 years [Hack et al. 1995; Hoechst, Unpublished data; National Cancer Institute (NCI) 1978] revealed no toxic effects. Later on, more detailed studies in adult rats exposed to 2.5, 5, and 10 mg/kg/day endosulfan for 5 days per week for 10 weeks showed reduced intratesticular spermatid counts, sperm abnormalities, and changes in the marker enzymes of testicular activities, such as lactate dehydrogenase, sorbitol dehydrogenase, γ-glutamyl transpeptidase, and glucose-6-phosphate dehydrogenase, providing further evidence of effects on spermatogenesis (Khan and Sinha 1996; Sinha et al. 1995). Exposure of younger animals (3 weeks old) showed marked depletion of spermatid count as well as decreased daily sperm production at a dose of 2.5 mg/kg/day (Sinha et al. 1997), which was earlier seen only at 5 mg/kg/day in adult rats by the same investigators (Sinha et al. 1995). More recent studies have shown that exposure of pregnant rats to endosulfan at 1 mg/kg/day from day 12 through parturition leads to decreased spermatogenesis in offspring (Sinha et al. 2001). Dalsenter et al. (1999) reported similar observations at 3 mg/kg/day but not at 1.5 mg/kg/day, and they attributed this to strain variation (Dalsenter et al. 2003). Thus, experimental studies suggest that endosulfan can affect the male reproductive system and also that these effects are likely to be greater if exposure occurs during the developmental phase.

Environmental exposure to a single chemical over a long period of time is very rare. We came across a situation where endosulfan was the only pesticide that had been aerially sprayed two to three times a year for more than 20 years on cashew nut plantations situated on hilltops in some villages of northern Kerala, India (Figure 1). The population living in the valley had a significant chance of exposure to this pesticide during aerial spray and subsequently through other contaminated environmental media. This population, therefore, provided a unique opportunity to study the long-term health effects of endosulfan. In this article, we report the effects of endosulfan on male reproductive development.

Materials and Methods

Selection of study and control areas. The exposed population was defined as schoolchildren who were permanent residents of the

Address correspondence to H.N. Saiyed, Director, National Institute of Occupational Health, Meghani Nagar, Ahmedabad 380016, India. Telephone: 91-79-268-6351. Fax: 91-79-268-6110. E-mail: saiyedhn@yahoo.com

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The authors declare they have no competing financial interests.

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village situated below the cashew plantations where endosulfan had been sprayed aerially. This village had 12 first-order streams originating from the cashew plantations. Most of the habitations were along the valleys and close to the stream banks. Most of the inhabitants depended on runoff water for irrigation purposes. The control population was selected from schoolchildren of another village situated approximately 20 km away. The population of this village was comparable with the exposed population in socioeconomic status, ethnicity, and occupational characteristics but without any history of aerial endosulfan spray. The control village did not have streams.

Selection of study and control subjects. The main study was carried out to explore the effects of endosulfan exposure on growth and development in 619 schoolchildren of both sexes (5–19 years) and 416 comparable controls. All male children (272 exposed and 135 controls) older than 10 years were asked to participate in a sexual maturity rating (SMR) study; 117 (43%) exposed and 90 (67%) controls participated in SMR examination. For the hormone study, every other student who participated in the SMR study was requested to donate a blood sample.

Study parameters. The study parameters included recording of clinical history in a specially designed pro forma physical examination, assessment of SMR by Tanner's classification (Marshall and Tanner 1969), and estimation of serum levels of testosterone, luteinizing hormone (LH), follicle-stimulating hormone (FSH), and endosulfan residues.

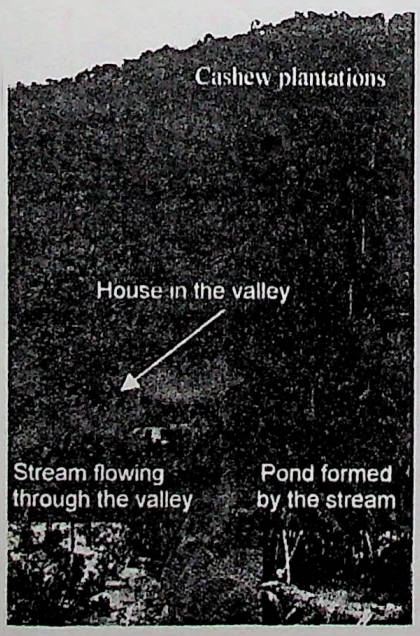

Figure 1. Cashew nut plantations on the hills and houses in the valley. Water streams formed in the hills pass through residential zones in the valley.

Ethical aspects. This study was approved by the ethics committee of the National Institute of Occupational Health. Parents, who were requested to accompany their children at the time of examination, were told the objectives of the study, and a consent form in local language was read aloud to them. The children were examined only after one of the parents gave written consent. In addition, special consent of the child was taken for the SMR study, and only in willing cases were blood samples collected. The SMR examination was carried out by pediatricians observing necessary privacy required for this delicate examination.

Collection, storage, and transport of blood samples. Five milliliters of venous blood were collected from each willing individual between 1000 and 1200 hr on the day of examination and was centrifuged at 5,000 rpm for 5 min in the field laboratory. Serum was separated and stored at −20°C in a nearby hospital. The serum samples were air-shipped under dry ice to the laboratories at National Institute of Occupational Health, Ahmedabad, India. To avoid observer bias, the samples were coded before being handed over for analysis.

Chemicals and standard control materials for analysis of endosulfan in serum samples. All the chemicals and reagents used in the extraction and cleanup of endosulfan residues were highly pure HPLC (high-performance solvents filtered through 0.2-μ filters and packed under nitrogen)-grade obtained from Qualigens Fine Chemicals (Glaxo India Ltd., Mumbai, India) and were checked for any pesticide contamination. Glassware used was free from residue contamination. Standard reference materials of α-endosulfan (99.0%), β-endosulfan (99.0%), and endosulfan sulfate (99.0%) were a gift from M/s Excel Ltd., (Mumbai, India), which is the largest manufacturer of endosulfan in India.

Extraction of residues from serum. Extraction was modified from techniques described in Dale et al. (1966) and U.S. EPA (1980). Briefly, serum (0.5 mL) was pipetted into a graduated stoppered centrifuge tube, 6 mL of hexane was added, and it was rotated in a slow-speed Roto-rac (National Institute of Occupational Health, Ahmedabad, India) for 2 hr. The organic layer was transferred into another graduated tube and was evaporated to dryness under a stream of nitrogen. The final volume was made up with hexane corresponding to the expected concentration of the residue. A suitable aliquot was injected into a gas chromatograph with an electron capture detector. We calculated the recoveries of endosulfan residues, which ranged from 88 to 102%. In addition, fortified samples were studied as a part of quality assurance and quality control.

Instrumentation and quantification. We used a gas chromatograph (model 6890) equipped with a Micro Electron Capture Detector, a capillary column (HP 5, 60 m, 0.25 mm inner diameter, film thickness 0.25 μm; all these items from Hewlett Packard Agilent Plus; Agilent Technologies, Little Fall, DE, USA), and N_2 (ultra high purity, 99.999% grade) as carrier gas for the quantification of endosulfan residues. The initial oven temperature was 80°C with ramp rate of 20°C per min to 200°C. The injector port temperature was 220°C (splitless mode), and detector temperature was 275°C. We quantified the the samples by comparing the peak area of each with those of their respective standards. The retention times of α-endosulfan, β-endosulfan, and endosulfan sulfate were at 38.9, 52.5, and 67.2 min, respectively (Figure 2A,B).

Hormone analyses. We estimated testosterone, LH, and FSH in 50 μL and 100 μL serum samples of study and control subjects using radioimmunoassay kits procured from Immunotech (Marseille, France). We used a Wallac 1470 Wizard autogamma counter (Perkin Elmer, Turku, Finland) to count radioactivity with detection efficiency of 78% for I^{125} and negligible cross talk with other isotopes. Equipment and glassware were segregated to prevent cross-contamination. The hormones were estimated in serial dilutions of serum along with parallel curves to standard. All the samples for hormone estimations were processed in one assay to rule out interassay variations. We performed a linearity study to assess the sensitivity of the hormone assays by serial dilution of a

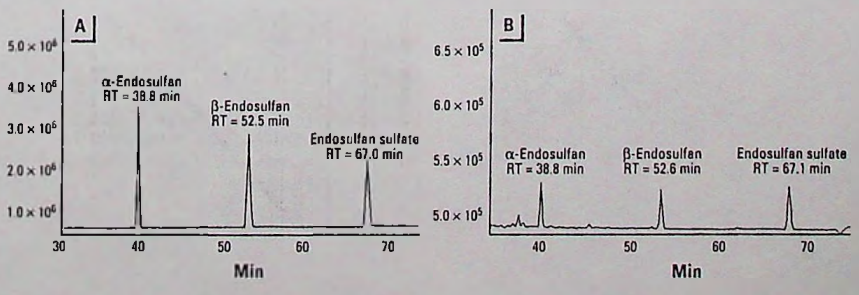

Figure 2. Chromatograms of α-endosulfan, β-endosulfan, and endosulfan sulfate. RT, retention time. (*A*) Standard chromatogram of α-endosulfan, β-endosulfan, and endosulfan sulfate. (*B*) Chromatogram of α-endosulfan, β-endosulfan, and endosulfan sulfate in blood sample of a study subject.

age in study and control individuals. The regression lines indicate that average serum levels for the same age are higher in the study group.

Endosulfan exposure. Endosulfan was detected in serum samples of 78% of the children in the study group and 29% of the children in the control group. Table 4 shows the serum endosulfan levels in the study and control groups. The levels of endosulfan in the study group children are significantly higher ($p < 0.001$).

Discussion

Our study results, after controlling for age, showed significantly lower SMR scores and serum testosterone levels and higher levels of serum LH in the study group compared with controls. To link these changes with endosulfan exposure, we should look at two issues: biologic plausibility of the cause–effect relationship and pathways of endosulfan exposure.

Biologic plausibility. There are reports of testicular toxicity of endosulfan manifested as decreased spermatogenesis and testicular hormone synthesis (steroidogenesis), as evidenced by a decrease in spermatid count in testes and in sperm count in the cauda epididymis and by changes in marker enzymes for testicular steroidogenesis in adult animals (Chitra et al. 1999; Singh and Pandey 1989, 1990; Sinha et al. 1995). These effects were seen at much lower dosages and shorter durations if exposures occurred during the prenatal or prepubertal periods (Dalsenter et al. 1999; Sinha et al. 1995, 1997, 2001). Singh and Pandey (1990) also reported profound decreases in the levels of plasma LH, FSH, and testosterone associated with decrease in testicular testosterone in pubertal rats exposed to endosulfan for 30 days. Thus, our observations of low testosterone levels in male children conform with the animal studies. Lower SMR scores appear to reflect lower serum testosterone levels for age. In our study, it is not possible to confirm disturbed spermatogenesis observed in animal studies.

The higher prevalence of congenital abnormalities related to testicular descent observed in the study group should not be overlooked simply because it failed to achieve statistical significance (which may be due to small sample size), because there is indirect evidence of endosulfan exposure associated with undescended testes in a human population from Spain. Garcia-Rodriguez et al. (1996) reported a higher incidence of hospital admissions to University of Granada Hospital for cryptorchidism from districts near the Mediterranean coast, where there is intensive use of pesticides. A subsequent study reported endosulfan isomers and/or metabolites in adipose tissue of 40% of children who were admitted to the same hospital for a variety of reasons (Olea et al. 1999), indicating that significant endosulfan exposures occurred in the region. In the present study, there is a definite history of endosulfan exposure that is likely to have occurred during the prenatal period.

Pathways of endosulfan exposure in the study population. In our study, we estimated endosulfan residues in biologic and environmental samples. The practice of aerial spraying of endosulfan was discontinued in December 2000. Serum endosulfan residue levels were significantly higher in the study population than in the control group even 10 months after the last aerial spray (October 2001). Moreover, endosulfan residues were detected in water (≥ 0.03 ppb) and pond sediments (≥ 0.3 ppb) only in the study area 1.5 years (June 2002) after the last aerial spray. This signifies that low-level endosulfan exposures continued to occur probably by translocation from the hilltops to the valley in the study area long after the aerial spray. This is supported by the report of Regional Remote Sensing Service Center (RRSSC), Bangalore, India (Nageswara Rao PP. Personal communication). On the basis of analysis of satellite pictures of the study area, the RRSSC reported, "The watershed characteristics are favorable for any aerially sprayed toxicant to reach the soil-water-plant continuum in a very short span of time and get accumulated" (Nageswara Rao PP. Unpublished report). Endosulfan has a half life of 60–800 days in soil (ATSDR 2000). Frank et al. (1982) have also reported that because of its persistence in soil, endosulfan residues were detected in water samples throughout the year (outside the spray season) with storm runoff. The results of several laboratory and greenhouse studies indicate that α- and β-endosulfan are strongly adsorbed to soil (Bowman et al. 1965; El Beit et al. 1981a, 1981b). The study area has an annual rainfall of 140 inches. Twelve first-order streams originate from the cashew plantations. It is likely that endosulfan sticking on the soil is carried by runoff water during most of the year.

We have measured endosulfan levels only once in serum samples. These individual endosulfan measures may or may not accurately reflect the chronic levels and/or levels during critical developmental phases. However, the effect of this would be to decrease power of the study (via an increase in random misclassification of exposure) and thus bias toward the null. We believe that even single estimations of serum endosulfan levels validate that children exposed to endosulfan via aerial spraying do, on average, have higher exposures than children in the control group.

Finally, it is important to discuss and resolve the following weaknesses of the study. First is nonparticipation in SMR study: 57% of the exposed and 33% of the control participants did not agree to undergo SMR examination. However, growth-related end points (height, weight, and skin-fold thickness) were

Table 3. Summary of the multiple regression analysis for serum testosterone levels against age, history of AEE, and serum LH levels.

Dependent variable	Age		Exposure		LH	
	b	SE	*b*	SE	*b*	SE
Testosterone	0.37**	0.06	−0.62**	0.21	1.09**	0.20

No. of observations: study = 67; control = 46. Overall $R^2 = 0.61$. **$p < 0.001$.

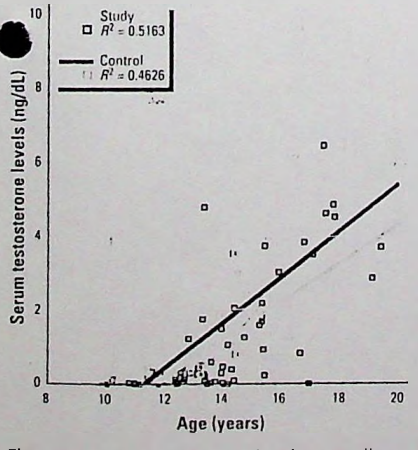

Figure 6. Serum testosterone levels according to age and AEE.

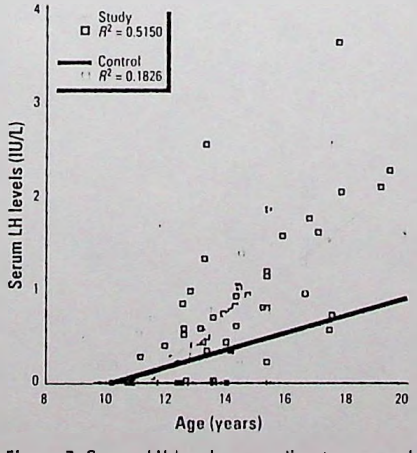

Figure 7. Serum LH levels according to age and AEE.

Table 4. Mean ± SE levels (ppb) of serum endosulfan in study and control subjects.

	Control ($n = 45$)	Study ($n = 70$)
α-Endosulfan	0.87 ± 0.23	4.24 ± 0.74**
β-Endosulfan	0.40 ± 0.17	1.77 ± 0.36**
Endosulfan sulfate	0.10 ± 0.08	1.47 ± 0.33**
Total endosulfan	1.37 ± 0.40	7.47 ± 1.19**

**$p < 0.001$.

To
The Editor
Down To Earth

Dear Ms Sunita Narain,

I found your article on the endosulphan very comprehensive and well investigated. Since you mentioned the visit of Mr Ganesan to CHC I would like to add something more from that interaction. The conversation was basically around the industries concern about the 'misinformed activists' campaign against endosulphan, which was a 'relatively safe pesticide alternative' today. As a health training and policy action group committed to community health concerns and action initiatives, I informed him that we were neither anti-industry or anti-pesticide per se but pro people's health and our concerns and interests were around 'evidence' of dangers to community health of any nature. Also as an Occupational Health consultant I have been interested in this issue ever since I did a large ICMR study on Occupational Health hazards of tea plantation workers including pesticide hazard.
I requested him to provide us with all the information the association/industry had about endosulphan, which he promptly gave me in a note with questions and answers on endosulphan.

Over the last few months two of our younger team members Dr Anur Praveen and Dr Rajkumar Natarajan have done a detailed literature review. I am sending this to you as our commitment to public education so that your readers can decide whether this is ignorance of an industry or a deliberate misinformation campaign.
At the end of last month we facilitated a very interesting three day Community Health Environment Skill Share (CHESS), where over 100 professionals and activists gathered from all over the country to share their concerns about pesticides, mines, industrial hazards and other environmental hazards and explore ways and means of studying them and collecting health evidence. We had the unique privilege of a presentation by Dr Sayed, Director of National Institute of Occupational Health who summarised the findings of their study on endosulphan in Kasargod, which has been submitted to the National Human Rights Commission. The findings not only substantiate the literature review we have compiled in CHC but is a sound, scientific, evidence based contribution to the controversy. As a contribution to people's science I think Down To Earth should formally write to NHRC and NIOH (on behalf of your readers and the affected victims of the endosulfan disaster) to release this report and make it a public document to support the right of information.
The ICMRs ethical guidelines for bio medical research on human subjects (2000) highlights that "researchers have a responsibility to make sure that the public is accurately informed about results without raising false hopes or expectations."

Regards,

PHM – Articles sent

Dr Ravi Narayan
Community Health Cell Adviser, CHC, Bangalore
sochara@vsnl.com

INDUSTRY VERSUS SCIENCE – IGNORANCE OR MISINFORMATION

Compiled by Dr Anur Praveen and Dr Rajkumar Natarajan (CHC)

Questions	Answers (What the Industry provided us*)	What we have to say..... (The actual facts)
What is Endosulfan?	Endosulfan is a popular insecticide used worldwide in more than 60 countries including USA, Japan, many European and Asian countries. It is recommended for control of insect pests in a variety of field and plantation crops such as Cotton, Vegetables, Wheat, Paddy, Mango, Cashew, Tobacco, Coffee, Tea, Sugarcane, Spices, etc., Agricultural scientists call Endosulfan as a "selective insecticide" as it has a very low toxicity towards beneficial insects such as honeybees and insect predators/parasites and crop pests. It is therefore considered to be the most ideal insecticide for use in IPM (Integrated Pest Management) systems. * Note provided by Mr Ganesan of Pesticide Manufacturers Association	- Endosulphan is an organochlorine pesticide belonging to the same family (cylodiene sub group) as Aldrin, Endrin, Dieldrin, Heptachlor, Chlordane and Mirex all of which are Persistent Organic Pollutants (POPs) and banned by the International POPs Convention Treaty. (Quijano. R. F., International Journal of Occupational Health, 2000) - Endosulfan itself is banned in Germany, Singapore, Norway, Sweden and Belize. Its use in rice fields is not allowed in Bangladesh, Indonesia, Korea and Thailand. - Its use is severely restricted in USA, UK, Japan, Russia, Australia, Great Britain, Finland, Netherlands, Denmark, Sri lanka, Thailand, and Kuwait. (Hoeshcst, 1991; IRPTC, 1993; PRC, 1994) - Latest data reveal it is highly toxic to bees, aquatic animals and other wildlife. It is moderately to highly toxic according to scale of Hodge and Sterner(1956). - It is easily absorbed in the body following ingestion, inhalation and skin contact. (IPCS, WHO-EHC 40, 1984.) - There is no authority or reference quoting endosulfan as a selective or ideal insecticide. - Acute intoxication or systemic toxicity causes neurological manifestaitions like irritability, restlessness, muscular twithicng, seizures, cyanosis, pulmonary oedema and death. (IPCS, WHO-EHC 40, 1984 and Gosselin. R. Et al, Toxicoloogy of

		Commerical Products, 1984.)
2. Does endosulfan belong to the insecticide group ' Chlorinated Hydorcarbons" similar to DDT?	No. Insecticides of Organo chlorine group contain mainly the elements Carbon, Hydrogen and Chlorine. Whereas, Endosulfan additionally contains oxygen and sulphur in a functional sulphite group. Hence, in 1986, WHO reclassified Endosulfan as sulfurous ester of a chlorinated cyclic diol. In he handbook of International Union of Pure and Applied Chemistry (IUPAC), Endosulfan is designated as sulphite.	Endosulfan is a Persistent Organic Pollutant belonging to the organocholrine group and cyclodiene sub group. It belongs to the same family as Aldrin, Endrin, Dieldrin, Heptachlor, Chlordane and Mirex all of which are Persistent Organic Pollutants (POPs) and banned by the International POPs Convention Treaty. (Quijano. R. F., International Journal of Occupational Health, 2000) Although endosulfan is classified as sulphurous acid ester of chlorinated cyclic diol by WHO, it is still an organochlorine and its degenerated product endosulfan sulfate is very persistent and as toxic as the parent compound.(ASTDR, US Dept of health & human Services, 1993)
3. How does WHO rank endosulfan for its toxicity?	The UN body WHO has classify pesticides as follolw. Class Ia : Extemely Hazardous Class 1b : Highly Hazardous Class II : Moderately Hazardous Class III : Slightly Hazardous Endosulfan comes under the Class II "Moderately Hazardous" pesticide.	WHO basis for Class II (moderately hazardous) is based on LD 50 value taken from company generated* acute toxicity rate . (Quijano. R. F., International Journal of Occupational Health, 2000) **This data was challenged because the lab that did theses tests was charged with fraudulent practice.* In India, endosulfan is classified as an **"extremely hazardous"** pesticide (ITRC, 1989) According to USEPA, endosulfan is classified as **"extremely hazardous"** - class I b (US Environmental Protection Agency, Consolidated Chemicals List, 2nd February, 1990) EXTONET classified it as a highly toxic chemical. (European union, 1998)

4. What is the fate of endosulfan in the environment? & 5. Is use of endosulfan safe for man and environment?	Degradation and dissipation of Endosulfan is rather fast from all compartments of the environment (soil, water, air and organisms). In Indian conditions, dissipation of total Endosulfan residues occurs to the extent of 95% within 28 days after application. On most fruits and vegetables 50% of Endosulfan residues is lost within 3-7 days after application. In soil, it is degraded by microorganisms. It is practically insoluble in water. The half line of Endosulfan in water is estimated to be 4 days. At the recommended rate/s and method/s of application, Endosulfan is safe to man and environment and is unlikely to lead to any user or public health problems. Studies and reviews by WHO/FAO and US show that Endosulfan does not have carcinogenic/mutagenic /teratogenic effects. Endosulfan does not cause endocrine disruption. Endosulfan enjoys good user safety record, though used in a variety of situations worldwide.	**Fate in Environment-** In soil- The time taken for the concentration of endosulfan sulfate to reduce to half its concentration in soil is 60- 800 days (Stewart and Cairns, Journal of Agricultural Food Chemicals, 1974) Endosulfan was found in soil after 3 years of usage. (Rao DMR, Murthy AS, Journal of Agricultural Food Chemicals, 1974) Concentration of endosulfan in sediment is 32,000 times greater than in the water column.(NRCC,1975) In water- The time taken for the concentration of endosulfan to reduce to half its concentration in water in 3-days – 5 months depending upon pH of water, 0_2 (dissolved in water) and pollution in water. (NRCC, 1975) Endosulfan has been found in groundwater at deep soil layers upto 20 days after spraying. (Paningbatan EP et al, The Phillipine Agriculturist, 1991.) Endosulfan is lethal to fish, even at acceptable levels in water bodies. (IPCS, WHO-EHC 40, 1984) In air- Endosulfan has been carried over long distances and found in air and snow samples in Arctic regions. (Gregor and Grummer, 1989) Endosulfan bioaccumulates in aquatic species like fishes, (Naquvi SM, Vaishnavi C, Comp Biochem Physiol C, 1993; Fernandez Casalderrey A, et al, Comp Biochem Physiol C, 1991; IPCS, WHO-EHC 40, 1984) Kingfishers that fed on fish which were killed or incapacitated by endosulfan aerial spray died. (Douthwaite, 1982)

		Endosulfan and its residues have been found in foods like vegetables, crops and infant foods. (Pordrebarac DS, 1984, Bureau of Plant Industry Phillipines, 1995) **Safety of endosulfan for man and environment-** No chemical pesticide is completely safe!! There has been no studies on to prove the toxicity of endosulphan as it is ethically and legally not permissible to perform tests on humans with pesticides. However, sufficient proof is available on the mutagenic , carcinogenic, teratogenic and geno toxic effects on animals. Naturally, these studies are used to predict the possible effects on human beings. **Endocrine disruption-** Endosulfan has reproductive and endocrine disrutping effects leading to reproductive toxicity and changes in reproductive organs. (Soto A, Colborn. T, Van Saal F. S., Environmental Health Perspectives, 1994) **Mutagenicity (Cancer causing)** A 1992 study concluded that endoulfan could act as a tumour promoter. (Fransson-Steen R, et al, Carcinogenesis, 1992) It has produced high rates of lymphosarcoma (cancer of lymph nodes)(Industrial Biotest, 1965) **Genetic defects (genotoxicity)** Endosulfan has caused damaged to genes, chromosomes and cell cycle kinetics. (Yaquan Lu, et al, Environmental Health Perspectives, 2000; ASTDR, 1993) **Birth defects** Low birth weight and adverse behavioral

		effects have been noted on the offspring of exposed rats. Endosulfan may produce both maternal and developmental toxicity in humans. (ASTDR, 1993) **Nervous system:** Acute intoxication or systemic toxicity causes neurological manifestations like irritability, restlessness, muscular twitching, seizures. Long term effects of exposure to endosulfan have caused seizures and mental retardation. (ASTDR, 1993) **Immunotoxicity-** This is the most sensitive endpoint of endosulfan toxcity and humans are at risk of adverse immune effects. . (ASTDR, 1993) **In environment-** Endosulfan is lethal to fish, even at acceptable levels in both fresh water and sea water. (IPCS, WHO-EHC 40, 1984) Endosulfan has been proven toxic for terrestrial birds and organisms like beetles, mallards, kingfishers. (IPCS, WHO –EHC 40,1984, Hudson et al, 1972) The National Wildlife Federation US states that endosulfan is extremely toxic to wildlife and acutely toxic to bees. (NWF, 1987) The Danish government has classified endosulfan as acutely toxic to birds. (Hanson OC, Ecotoxicological Evaluation of Endosulfan, 1993) Toxicity of endosulfan in roots and leaves have been reported. (IPCS, WHO-EHC 40, 1984)

WHOEHC: World Health organization Environmental Health Criteria
IPCS: International Program on Chemical Safety
ATSDR: Agency for Toxic Substances and Disease Register, Atlanta
ITRC: Industrial Toxicology Research Centre

Main Identity

From: "Sumathi Morgan" <smal@del1.vsnl.net.in>
To: "PHM - Secretariat" <secretariat@phmovement.org>
Sent: Thursday, February 24, 2005 4:04 AM
Subject: Re: for Health Advocate

Dear Dr Fred,

Thank you for the materials you have sent. We will place the Apples or the Apostles whom do we begin to? article for this issue along with the materials you sent now.

Thank you once again.
Regards,
Sumathi

----- Original Message

RM
25/2/05

RM
26/2/05

Phm - Article req
Conf1

2/23/05

Main Identity

From: "PHM - Secretariat" <secretariat@phmovement.org>
To: <benny.benjamin@rediffmail.com>
Sent: Thursday, February 24, 2005 2:56 PM
Subject: from CHC

Dear Dr. Benny

This is just to remind you to send us a CV or bio-data of your father Late Dr. V. Benjamin, so that we can use it to write a few obituries in CMJI, HFM, NMJI and others. Abraham Joseph has also talked to me at the funeral about the same. So do send me what you can.
Thanks for the books and the wonderful picture of your late father with your sister gave us. The photograph with his characteristic smile is in the main CHC office and reminds us of his guiding and inspiring presence.

best wishes

Rev. Narayan

PHM-CHC → NMJI obituary
Late Dr VBS—CV

RN
1/3/05

Main Identity

From: "PHM - Secretariat" <secretariat@phmovement.org>
To: "Anant Bhan" <anant.bhan@utoronto.ca>
Cc: "Claudio" <claudio@hcmc.netnam.vn>; "rakhal gaitonde" <subharakhal@rediffmail.com>; "Community Health Cell" <chc@sochara.org>
Sent: Tuesday, April 05, 2005 4:45 PM
Subject: Re: Urgent: Article on PHM

Dear Anant

Greetings from PHM Secretariat (Global)!

I have been swamped by global mail ever since I returned after a 10 day trip to Chile and Ecuador. Go ahead and write an article. You can get Rakhal, Claudio and perhaps Thelma to join you in the article.We could discuss at the Steering Group meeting. Claudio is the best bet for such papers, since he coordinates the PHM Exchange and has access to all the documents.

Best wishes

Ravi

PHM-Article (Fellow

RN
7/4/05

Main Identity

From: "Anant Bhan" <anant.bhan@utoronto.ca>
To: <secretariat@phmovement.org>; <ravi@phmovement.org>
Sent: Wednesday, March 30, 2005 10:01 AM
Subject: Urgent: Article on PHM

Dear Dr. Ravi,

Greetings from Toronto!

Hope that you are doing well. I am doing fine - busy with course, but now it is entering the final stage, and I will be returning in end June to India.

We were exploring writing an article on the PHM for a major medical journal at the IHF before the WSF in Mumbai and there were preliminary discussions over email with Rakhal and Vikram Patel which I had about it, but it did not happen.

I got in touch with the editors of PLOS Medicine (www.plosmedicine.org) which is a new peer reviewed and open access high quality medical journal. As you can see from their mail below they are very interested in having an article on PHM for their July 2005 issue to coincide with the PHA-II. This is an excellent oppurtunity for us to further publicize the work of the PHM in the global health arena and also raise our concerns on the present global health structures.

I need to get back to them immediately as the time lines are tight- so I would need a quick response from you:-

1) I hope this is fine with PHM, I wanted to check with you before I proceeded with this.
2) Do yo have any suggestions on who else might be interested in working with me on this- we will have to do this over email, and within the next three-four weeks so it has to be folks who can spare that kind of time.
3) As is evident from the mail, they would prefer authors from developing countries

Please do let me know what you think, so that I can get back to the editors as soon as possible.

Thanks and please convey my regards to everybody in the CHC/PHM family

Best,
Anant

5/4/05

Dear Anant
I have been swamped by global mail ever since I returned after a 10 day trip of Chile & Ecuador. Go ahead and write an article. You can get Rakhal, Claudio and perhaps Thelma to join you in the article we could discuss at the S.G meeting. Claudio is the best bet for such papers since he coordinates the PHM exchange and has access to all the documents

----- Original Message -----
From: Gavin Yamey
To: Anant Bhan
Sent: Tuesday, March 29, 2005 6:45 PM
Subject: Article on PHM

Dear Anant,

The timing of your suggestion is excellent, as it would be great for us to publish something in our July issue to coincide with the People's Health Assembly.

The only problem (not a big problem) is that we are publishing your essay in June, and we would be reluctant to have two sole authored pieces from you in two consecutive issues. Would you be able to ask 2 or 3 co-authors on board from PHM—ideally based in developing countries themselves? This would also make for a broader and more inclusive piece.

The best format would be a "Health in Action" article. These are about 1000-1500 words, with up to 20 references. The idea is that you take readers through the following issues:

*Why was PHM needed: what was the background? What problem was PHM trying to address?
*What is PHM: what does it do? How does it work?
*What kind of impact and successes has PHM had? Give specific and concrete examples. For example,

RN 30/3/05 VM

PHM RS 30/3/05 Best wishes Ravi cc Claudio, Rakhal 3/30/05

what did the last People's Health Assembly achieve?
*What are the difficulties and challenges facing PHM?
*The future: where is PHM heading?

You can see some examples of Health in Action articles at:
http://dx.doi.org/ 10.1371/journal.pmed.0020046
http://dx.doi.org/ 10.1371/journal.pmed.0020011

For us to get this into the July issue, and allowing time for peer review, we'd need the piece in four weeks' time. Is this possible?

I look forward to hearing from you,

Sincerely

Gavin Yamey

From: Anant Bhan [mailto:anant.bhan@utoronto.ca]
Sent: Friday, March 25, 2005 12:20 PM
To: Gavin Yamey
Subject: Re: Peer Review Report Attched

Dear Gavin,

Thanks for your mail, and for pointing out the article on the PHM GHW.

I was working as a trainee in community health and as a technical volunteer with the global secretariat of the Peoples Health Movement which is based in Bangalore, India for some time, and that helped me develop linkages within the movement.

The PHM is an innovative grassroots movement and they are suggesting some interesting alternatives to the global health order.

Take care and have a nice weekend,
Anant

> ----- Original Message -----
> **From:** Gavin Yamey
> **To:** Anant Bhan
> **Sent:** Wednesday, March 23, 2005 7:21 PM
> **Subject:** RE: Peer Review Report Attched
>
> Dear Anant
>
> Thanks for this suggestion, which I will share with my colleagues.
>
> The PHM did contribute to an article in our launch issue, on the Global Health Watch, at http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0010003 But it may still be good to have a piece about the PHM itself. I'll get back to you.
>
> Best wishes
>
> Gavin

Main Identity

From: <davidmccoy@xyx.demon.co.uk>
To: "Lynette Martin" <lmartin@uwc.ac.za>; <fran.baum@flinders.edu.au>; <claudio@hcmc.netnam.vn>; <d.legge@latrobe.edu.au>; <secretariat@phmovement.org>; <ctddsf@vsnl.com>
Sent: Tuesday, March 08, 2005 5:33 PM
Subject: Re: VERY URGENT! Chapter

Dear all - just by way of addition, YES please send me comments by sunday morning to have best chance of your comments being acted upon. I'm sorry for the short turnaround time, but as you know we have been working flat out on getting several chapters completed in time for the publisher's deadline.

The chapter is over 17,000 words long - so bear in mind the fact that we cannot extend the length.

Thanks again!!

Dave

lmartin@uwc.ac.za wrote:
> ** High Priority **
> Dear Ravi, David, Claudio, Amit, Fran,
> I am attaching the latest (near-final) version of the proposed chapter
> for Global Health Watch on Health Systems. Dave McCoy has been working
> very hard and long to pull this together. As you may know, both the
> process and content/emphasis have resulted in much controversy. While I
> have made extensive comments on several occasions and believe that the
> chapter now is MUCH improved from earlier versions, I still have some
> reservations about it. Nonetheless, it needs to soon go to the printers
> (March 12 is the deadline). I have only just received this version and
> am forwarding it now to all of you in the hope that you will be able to
> make comments and get them to Dave McCoy (to whom I am copying this
> request as soon as possible.
> Best regards,
> David Sanders
>
> Prof David Sanders/Lynette Martin
> School of Public Health
> University of the Western Cape
> Private Bag X17
> Bellville, 7535
> Cape, South Africa
> Tel: 27-21-959 2132/2402
> Fax: 27-21-959 2872/959 1224
> Cell: 082 202 3316
>

PHM - Article

RN
22/4/05

Main Identity

From: "UNNIKRISHNAN P.V. (Dr)" <unnikru@yahoo.com>
To: "PHA Global" <pha-exchange@kabissa.org>; <pha-ncc@yahoogroups.com>; <PHA-Europe@yahocgroups.com>; "IPHCWORLDWIDEY" <IPHCWORLDWIDE@yahoogroups.com>
Sent: Tuesday, April 26, 2005 2:26 PM
Subject: [pha-ncc] 'Asiafrica: Linking the Two Continents') focuses on news, information around the HIV/AIDS pandemic in Asia and Africa

FYI:

-----Original Message-----
From: IPS Asia-Pacific [mailto:ipsasia@ipsnews.net]
Subject: asiafrica

'Asiafrica: Linking the Two Continents') focuses on news, information around the HIV/AIDS pandemic in Asia and Africa, linkages between them and lessons that the two regions can learn from each other. A follow-up project from the XV International AIDS Conference in Bangkok, Thailand, this initiative is coordinated by Inter Press Service (IPS) Asia-Pacific, supported by the Rockefeller Foundation. IPS Asia-Pacific and IPS Africa are cooperating on this project.

http://ngo.c.topica.com/maadrDyabgmn4bpfCYdb/

Below are the first features, and watch out for more....

*****

PHM-HIV-AIDS circle
RN
29/4/05

INDIA
Deadly Mix: Drugs, HIV and Insurgency at the Border
by Ranjit Devraj, Churachandpur

Perhaps no place on earth deserves free anti-retroviral drugs (ARVs), which helps slow the spread of HIV/AIDS, more than this remote district of 240,000 people in the north-east Indian state of Manipur, just on the porous India-Burma border.

http://ngo.c.topica.com/maadrDyabgmn5bpfCYdb/

ZIMBABWE
Secrets and Silence Around AIDS
by Kudzai Makombe, Harare

As AIDS affects a growing number of women and girls in sub-Saharan Africa, a timely novel -- entitled 'Secrets of a Woman's Soul' has been released by first-time Zimbabwean author Lutanga Shaba.

http://ngo.c.topica.com/maadrDyabgmn6bpfCYdb/

CHINA
Children Orphaned by AIDS Battle Double Stigma
by Antoaneta Bezlova, Beijing

The 2001 scandal in central China's Henan province – over the huge

RN
27/4/05

4/27/05

number of poor people becoming infected with HIV through the sale of their blood – forced a slow, painful change in Beijing's complacent attitude toward an emerging AIDS crisis.

http://ngo.c.topica.com/maadrDyabgmn7bpfCYdb/

Other Resources:

Training Manual for the Media: Gender, HIV/AIDS and Rights

The manual was developed by an experts group and tested in two IPS journalists training workshops in South Africa and Jamaica. Download pdf version of the manual.

The Language of HIV/AIDS: A Tool for Journalists/Newsrooms

This tool was prepared for a briefing for journalists by IPS-Asia Pacific, ahead of the production of the 'TerraViva' conference newspaper edition at the XV International AIDS Conference, Bangkok, Thailand, July 2004. Download pdf file.

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IPS Asia-Pacific is the regional headquarters of Inter Press Service (IPS) news agency. The World Service is available at www.ipsnews.net For feedback on this page, pls write editors@aidsasiafrica.net or ipsasia@ipsnews.net

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Main Identity

From: "Anant Bhan" <anant.bhan@utoronto.ca>
To: "PHM - Secretariat" <secretariat@phmovement.org>
Sent: Tuesday, April 19, 2005 7:49 PM
Subject: Re: Important: Request for information about PHM

Dear Dr. Ravi,

Thanks a lot for the materials- very useful!

I will send the draft article to you for comments soon.

Best wishes,
Anant

RM
20/4/05

Re PHM2 - Article
RM
22/4/05

Main Identity

From: "PHM - Secretariat" <secretariat@phrnovement.org>
To: "Anant Bhan" <anant.bhan@utoronto.ca>
Sent: Tuesday, April 19, 2005 6:03 PM
Attach: Perspective on Global Development and Technology.doc; NarayanSchuftan.doc; WHO Case study.doc
Subject: Re: Important: Request for information about PHM

Dear Anant

Greetings from PHM Secretariat (Global)!

Please check the PHM website and I am requesting Srinidhi to send you two articles that answer some of your questions. An article by Claudio Schuftan and myself in a recently published book on Globalization and Health from Berkeley and some comments by the editors and authors in the same book (other articles on the PHM in the global context). We also enclose a case study on PHM and WHO which documents a changing relationship of 'total ignoring' to 'active engagement'. You can send me a draft of your article to comment upon nitty gritty.

Alternatively send it also to Claudio who manages our PHM Exchange (claudio@hcmc.netnam.vn) and he can also comment and peer review the article.

Best wishes

Ravi

PHM - Article
Anant

RN
2/5

4/19/05

Main Identity

From: "Anant Bhan" <anant.bhan@utoronto.ca>
To: "PHM - Secretariat" <secretariat@phmovement.org>; <ravi@phmovement.org>
Sent: Tuesday, April 19, 2005 12:23 AM
Subject: Important: Request for information about PHM

Dear Dr. Ravi,

As you know, I am presently writing a short article on PHM to be probably published in medical journal in its July issue to coincide with the 2nd Peoples Health Assembly in Ecuador to be held in July. In discussion with the editor, we want to focus on the following:-

Health in Action article- 1000-1500 words, taking the readers through the following issues:-
*Why was PHM needed: what was the background? What problem was PHM trying to address?
*What is PHM: what does it do? How does it work?
*What kind of impact and successes has PHM had? Give specific and concrete examples. For example, what did the last People's Health Assembly achieve?
*What are the difficulties and challenges facing PHM?
*The future: where is PHM heading?

I know you are very busy, but I request you to send me your thoughts and ideas on these topics about PHM and also any other suggestions for the article. Also I would appreciate any documents relevant to the article that you can email to me.

I am working on a very short time line as the editors want the article to reach them by the end of this month, hence I request you to kindly reply to this request at the earliest possible for you.

Thanks a lot in advance.

Anant Bhan
PHM- India/Canada

P.S. I wrote to Rakhal, Dr. Thelma and Claudio. Rakhal said no, Claudio has sent me some stuff, and Dr. Thelma has not yet replied to me. I wrote to Vikram Patel and he has said yes.

RN
19/4/05

Alternatively send it also to Claudio Schuftan who manages our PHM Exchange ( ) and he can also comment and peer review the article
Best wishes
Ravi

19/4/05
Dear Anant
Please check the PHM website and I am requesting Srinidhi to send you two articles that answer some of your questions. An article by Claudio Schuftan and myself in a recently published book on Globalisation and Health from Berkeley and some comments by the editors and authors in the same book (other articles on the PHM in the global context) We also enclose a case study on PHM and WHO which documents a changing relationship of 'total ignoring' to active engagement'. You can send me a draft of your article to comment upon nitty gritty.

4/19/05