Report of PHM Steering / Support group meeting held at YMCA International House, Mumbai on 12th, 13th and 16th January and two additional extended sessions on 18th and 19th January at WSF Venue (Solidarity tent) and Hotel Columbus respectively.

Preamble:

The Third International Health Forum in the Defense of People's Health was organized by the Global Secretariat of PHM and PHM India on 14th and 15th January at the International House, YMCA Mumbai, preceding the World Social Forum from 16th to 21st January also at Mumbai.

Due to some unavoidable constraints, the annual PHM Steering group, usually scheduled in November each year by tradition, was postponed and linked to the Mumbai event. The annual PHM Steering group, therefore, was organized on 12th and 13th of January at the International YMCA.

Due to the unprecedented nature of participation at IHF / WSF, we not only had a full steering group presence ( ), but we also had many members from all over the world, who support the secretariat in separate functions as volunteers () and many country contact points as well ().

The first two days, 12th and 13th, therefore, was a steering / support group and all those in these different categories, other than steering group, were also invited to attend the discussions in a spirit of transparency, as observers / participants.

On 16th, 18th and 19th January, some extended sessions were held to make decisions and evolve a plan for the next year. These meetings were attended primarily by steering group members.

An agenda was sent out in advance of the meetings and a programme overview from 12th – 16th January, was also circulated in which all the steering group agenda points were allotted specific time slots on 12th and 13th January. However, due to delayed arrival of some of the steering group members, sessions were interchanged and some extended sessions were held to increase the participatory nature of the steering / planning exercise and the group addressed some new issues that were brought up during the discussion.

The whole process was very interactive and participatory and the enclosed report written in the order of the original agenda tries to capture the main issues and decisions that were taken.

Since the compilation of the minutes / report took a while, the secretariat team is also appending a follow up report that tracks all the action that has been taken. Overall, the meeting proved to be a great 'battery charger' and 'energizer' and the enthusiasm with which the PHM steering group / support group and country contacts have followed up on their commitments has been most heartening. The PHM is definitely come to stay and

evolving in enthusiasm, content and impact. However, the evolution / mobilization of PHM ~~also~~ continues to show great regional variation and diversity. One of the biggest challenges for PHM is to ensure that all regions / networks / countries are well represented in the evolving initiatives and this puts a special responsibilities on all those who represent these regions that are lagging behind to make an extra effort to evolve circle, initiatives and process in their region as we gear up to ~~PHA – II next year~~ For the next People's Health Assembly in July 2005 in Ecuador.

MEMBERS PRESENT

~~To give clarity to the representation at the steering / support group meeting,~~ The participants have been classified into functional groups.

Steering Group:

a. Network Representatives:

Maria Hamlin Zuniga - Nicaragua (IPHC); Zafrullah Chowdhury, Bangladesh (GK); Prem John, India (ACHAN); Carmelita Canila, Philippines (CI); Evelyne Hong, Malaysia (TWN); Nadia Van der Linde, Netherlands (WGNRR); Olle Nordberg , Sweden (DHF). [Dr. Bala of HAI – AP could not attend)

b. Regional Representatives:

Pam Zinkin (Europe); Sarah Shannon, Hesperian Foundation (USA); Lanny Smith, Doctors for Global Health (USA) (North America); Hugo Icu Peren, Guatemala (Central America and Caribbean); Arturo Quizhpe, Ecuador (South America); David Sanders / Bridget Lloyd , South Africa (Southern Africa); Mwajuma S. Masaiganah, Tanzania (East and Central Africa); Fran Baum, Australia (Pacific Australia and New Zealand); B. Ekbal / Mira Shiva (India); Edelina de la Paz, Philippines (South East Asia); Jihad Mashal, Palestine (Middle East and North Africa). [South Asia, China and West Africa did not have elected regional representatives)

c. Coordinators:

Qasem Chowdhury, GK – Bangladesh (Past coordinator); Ravi Narayan, India (Present Coordinator)

d. Support Group

Andy Rutherford, One World Action – UK (Funding); Unnikrishnan, India (Media); Armando De Negre, Brazil (IHF – WSF); Jose Utrera, Netherland (Public Private Partnership circle); S.S. Prasanna (Website and Communication); Rebecca Zuniga (Translations); Patricia Morton, (GHW)

e. Country Focal Points / Contacts

David Legge (Australia); Julio Monsalvo (Argentina); A.H.M. Nouman (Bangladesh); Anil Kapoor (Canada); Hani Serag (Egypt); Malachi Orondo (Kenya); Mohd. Ali Barzgar (Iran); Mary Sandasi (Zimbabwe); Jagadish

Goburdhun and R.K. Boodhun (Mauritius); Ayyaz Gul (Pakistan for Zafar Mirza); Niranjan Udugamalagala (Sri Lanka for Vinya Ariyaratne); Ghassan Issa (Lebanon)

f. Others Ecuador

Fatemah Afzali, Pedram Rashidi and Rezvan Moghadam (Iran); Alla Shakrollah (Egypt); Bert de Belder (Belgium). Thelma Narayan-TSA-India)

Three sections: a)

For the purpose of easy readability, the report will be devided into PHM Global agenda b) PHM Regional agenda and the latter will focus on reports from regions and plans of action emerging at region. c) Follow up in the phase Feb-April 2004 and Schedule of events

Proceedings/Minutes A: PHM Global Agenda

1 & 2. Introduction and Finalization of Agenda

The meeting on 12th January started at 11.00am with a round of introductions and a review of the agenda and programme overview that had been circulated in the file of documents that was given to all participants. The agenda was accepted without any major changes with the proviso that since some of the participants were coming later on the 12th or after – their presentations will be postponed and accommodated in the programme, whenever feasible.

On a query from Sarah, it was decided to take up campaigns in regional reports or regional reports on capacitation and on the suggestion of Armando, it was decided to introduce a short input into the inaugural session of the Forum on 14th morning, highlighting the earlier health fora and the link with WSF. Ravi suggested that sub-groups of the PHM members present, should meet in regional groupings to discuss regional level issues and campaigns, because PHM would be stronger only as all the regions became stronger and evolved their own activities, framework and initiatives responding to local needs and challenges. The morning of 16th was one possibility for such a meeting.

3. Reports from Regions and Countries (See Section B for further details)

Since, some of the reports from the regions were circulated only some of the main issues and points will be highlighted in a separate document and linked to the regional plans that were discussed during various smaller region group meetings during IHF – WSF.

1. International Health Forum / World Social Forum

a. Dr. Amit Sengupta, Joint Convener of PHM India (Jana Swasthya Abhiyan) and member of the organizing committee of the WSF, gave an overview of the framework of WSF – IV, the background planning and challenges; the major differences in situation / focus from previous WSF and the framework of plenaries, seminars, workshops and street events. The four important panels and seminars on 17th and 18th January and the other 8 health related events at the World Social Forum were also highlighted. (See IHF programme, pp 14 – 17 or on website)

b. Mr. Ravi Narayan gave an overview of the programme for IHF, which included six plenaries on the themes ---------- and the 14 workshops on the theme. (See programme booklet circulated at IHF-WSF or updated programme on PHM website)

This had evolved in an interactive, participatory way with suggestions from the regions and members of the international organization support committee. The suggestions from Latin America, Africa and Philippines and Middle East were particularly useful.

c. He requested All the PHM resource persons present at the meeting were requested to take note of the sessions and roles, which they had been allotted and to participate actively in the next few days to make these sessions / workshops successful in the PHM tradition of listening to voices and testimonies and having panelists respond to the concerns and issues raised by these voices / testimonies. Thanks to the enthusiastic support of Dr. Prem John and others from many regions, these voices and testimonies were strong at IHF and mainly action oriented. He highlighted two challenges for IHF sessions: (a) To move beyond problem / situation analysis to highlight examples of proactive action at various levels. (b) to identify the key concerns and suggestions from each event to feed into a Mumbai Declaration -- a document that would be a definitive output of IHF – WSF and a supplement (as well as 2004 update) on the People's Charter for Health and its concerns. (see separate report of IHF – WSF and updates on the website)

follow up by

were identified (over 20 of them)

Mumbai Declaration

5. Reports from Networks

(see Section B)

While various members reported from regions and country circles, the eight founding / supportive networks that helped to organize the People's Health Assembly and have continued to support the evolving PHM, also reported their main activities and thrust areas.

a. *Third World Network (Evelyne)*

The main contribution of TWN was in spreading the word about PHA and the People's Charter and in focusing on issues relevant to PHM / PCH in TWN publications, especially Resurgence.

A special Alma Ata 25th anniversary feature was included in the July / August 2003 issue. It included the reflections of David Werner, Debabar Banerji and David Sanders; the People's Charter for Health and the statement on Primary Health Care made by PHM at World Health Assembly, May 2003

b. *Women's Global Network for Reproductive Rights (Nadia)*

The main campaign was the Women's Access to Health Campaigns, in which PHM was an international collborator and also many PHM resource persons and articles were involved at different levels, including the Advisory Group set up in August 2003. Copies of the Charter were distributed at all meetings of WGNRR at all levels. This year, the May 28th, campaign will focus on Health for All – Health for Women: What do Health sector Reforms have to do with it, and she requested PHM to join in a big way. In 2003, the focus of the campaign was to

make governments take more responsibility for reproductive rights as well as Primary Health Care. This year, the focus was on Health Sector Reforms and how it improved or enhanced access.

WGNRR also supported actively the Million Signature Campaign and other Alma Ata Anniversary Campaign and was also a co-sponsor of the PHM publication, "Health for All Now – Revive Alma Ata". In October 2003, it organized an Alma Ata Anniversary, Reception in Netherlands. Due to the impact of conservative right wing governments, which aimed to privatise health care disregarding women's rights and access to contraceptives and services. WGNRR has become more proactive in Netherlands and also support the European Social Forum 2003 process (see separate .....).

c. ***International People's Health Council (Maria)***

IPHC has been very actively involved in the organizational work related to PHA – I and to the formation of PHM at international levels as well as the regional promotion of PHM. IPHC has represented PHM actively at national and international events and activities and will continue to do so. IPHC's principle contribution to PHM is its concerns, analysis and perspectives on the "Politics of Health" and its commitment (based on involvement of some of its members with Primary Health Care programmes based in communities) to the Health for All and Primary Health Care goals, reconfirmed on the People's Charter. Recently IPHC has undergone an external evaluation and will soon be evolving the future development of IPHC as response to this evaluation and to the perception of its members of the future directions, which should be taken by IPHC. It would be Pound to continue to participate actively in the development of PHM in the future

Sections

- Conveners of circles should use PHA – Exchange to brainstorm around focus of circle; identify potential members of circle, who respond through the exchange to these circle derived communications; and put out reflections and further communications from the circle. The website can also be designed to have a section for circle discussions (Ravi).

Circles need to be able to accommodate the complexities of members in the context of the quality of the work and need to generate a process that accommodates these complexities. Also since PHM is generating a density of activity plus linkages, we have to be clear how we are going to proceed (Andy).
Are we going round in circles (David Legge)? There is some confusion about the responsibilities and focus of the circles with some overlap. The needs to be clarified by conveners (Delen).

Issue based circles need both depth, wide reach and relevance. A circle may be required to study the issue of newer technologies and their impact on health, eg. Biotechnology, IT,. We need to study positive and negative impacts.

f. Campaigns / Advocacy

Members shared some ideas about campaigns and issue of advocacy relevant to PHM, which should be considered by PHM in regions and supported by some of the issue circles.

- Having been present at WTO and WB meetings, there is need to use the health impact as the measures of effect of all these policies on farmer's livelihoods (Evelyne).
- There is need to write a position paper on the global fund for AIDS, Tuberculosis and Malaria and track its evolution and experience (Evelyne).
- There is need for a campaign strategy to promote comprehensive PHC in this growing world of vertical strategies and evidence based planning. PHM needs to define what is appropriate evidence based for PHC, then collect it through our regional and global networks and put it together as a global evidence base (Fran).
- There is need to study the APAN statement submitted to WHO in May 2003 and the analysis how the global strategy suggested by APAN facts into PHM framework. APAN is planning a Convention and PHM could place this statement in that convention and work with APAN during the next WHA – 2004 (Carmelita)

- There is need to debate on environment and ecological issues related to sustainable development
- There is need to look at the efforts of WTO on agriculture and how they affect farmer's livelihoods (David Legge). [A small sub-group consisting of David Legge, Sarah, Carmelita and Patricia decided to meet to discuss this issue and suggest further action by PHM].
- US is going towards bilateral strategies on trade with different countries. PHM should develop alliances at country, regional and global level to counter these ( )
- FCTC undergoing ratification. PHM should demand that their governments should sign and ratify and implement the framework. There will be a Western Pacific Regional Organization (WHO – WPRO) meeting soon about implementation (Carmelita). [Carmelita was endorsed as PHM representative at the meeting].
- For every campaign, there is need to share information about the issue; get commitment of people and groups to the campaign; and identify strategies at country level (Maria).
- For every campaign, there should be links between local work and international campaigns – this benefits the international campaign, but also helps the campaigns to be used locally to facilitate / mobilize and do strong local advocacy work (Hugo).

Links with other Networks and Movements:

One of the challenges for PHM regional and country level focal points and also the secretariat at global level is to link with other networks and movements to enhance collectivity and solidarity between movements and strengthen the health agenda in all the movements, networks, campaigns and struggles. PHM members are themselves linked to other network and movements. We need to manage these dual or multiple identities effectively. Basically we need to be able to distinguish between the PHM brand and the PHM badge with clarity.

In this process of networking, we need to function with a certain degree of self confidence eg., we are communicating and linking PHM to environmental networks nationally and globally because environmental concerns are a major section of the Charter and these groups were inadequately involved in national and international PHA. A movement by its very definition needs to engage with realities, with other partners and we don't need to wait for approval (Thelma). As we look to the future we need to be inclusive of new organizations (who were not founding members). In terms of bringing in other networks, we need to use the PHA video; share the Charter, give movement web site in meetings of other networks and gradually link with them or link them with PHM (Mwajuma). The Global Health Watch report may be a good way of forming these new linkages in the next year (Patricia).

PHM India (JSA) has increasingly evolved linkages with networks (there are more than 18-20 already working together at national level and their counterparts at state level. In recent years PHM India is also linking with other national campaigns around food, water, TRIPS, tobacco and also involving these campaign groups in PHM India initiatives and campaigns. In some states, members of PHM

the next coordinator (new region) overlapping for three months – around January – March 2005.

It was suggested that a secretariat could have a term of three years with one year overlap with the next secretariat (Abul).

If a secretariat was moved to a region and it was then found not to be able to cope with the new responsibility what could be done (Bood_____). It was noted that such a contingency need not occur in the next secretariat was identified carefully and systematically (Ravi).

h) Some organizational suggestions

While reviewing the evolving organizational structures and framework as outlined in the background papers circulated some ideas and suggestions were made by some of the members about the existing framework and organizational assumptions. These could not be discussed at length but are being listed out to ensure that they are kept in mind as the PHM organization experience evolved and needs review.

- There was need to prevent the movement from becoming too organised and evolving too detailed a framework of rules and regulations. This would bureaucratise and kill the spontaneous spirit of the movement. The movement shoud be issue based campaign oriented and functional capacity especially to emphasis health and social determinants at country and regional level is more important than definitive organizational structure (Ravi).
- Too many issue circles is dividing the group and the problem. We are in a way reproducing the fragmentation that we oppose and thereby creating a barrier. There should be a main frame policy that can guide discussions in individual groups and then a matrix of interconnected issues rather than circles. It is particularly important not to fragment the process and organization so much that we lead to a situation where we loose our capacity to be relevant (Armando).
- One of the assumptions made while designing the thematic circles were that there would be a coming together of these circles –however this did not seem to be happening even though we are all activist. Not only issues but regions should also link and work together. An area where this should be happening urgently is in the issue of privatization of health services. This is happening everywhere and there are negative impacts. We need to build common concerns and strategies over regions (Andy).
- While the issue circles were reaching out to people who are working on those areas it is important to emphasis that the circle connect all its members with PHM is linked to. Also if the circle activity could somehow be linked to a certain degree of activism or action then issue circles would succeed as an idea and a organic structure (Sarah).
- We have circles for regions and each has a specific function –a specific structure for specific needs. We must however integrate all these circles successfully(David Legge).

- While the Charter was clear, it was now necessary to evolve a small booklet describing all aspects of the evolving structures /framework of PHM for easy reference by country level contact persons or focal points (Malachi).
- The steering committee is absolutely serious and important and the way we organize ourselves should be based on what we want to do. It is actions that have vitality rather than merely statements and plans. This vitality groups from local grass roots action –so all PHM initiatives should ultimately support, promote and derive from grass roots action (Pam).
- PHM should be careful not to keep fishing in the same pond – among the already converted. Can the PHM get involved in universities and there we should involve young people in more depth (Julio).

7. PHM Evaluation

A PHA I / PHM evaluation process was started in mid 2002 to assess the impact of PHA-I on individuals who had attended the assembly and also to understand the process of post Assembly follow up in regions and countries in terms of processes, mobilization of circles; Charter translation and distribution; campaigns and PHM inputs into national, regional and international events.

An initial dialogue of the main emerging findings of the evaluation by a three member team lead by Andrew (Health link) was held in May 2003 in London just before the WHA May 2003 in Geneva. Unfortunately, due to unavoidable circumstances and constraints the PHM evaluation report has not yet become available for a wider circulation and debate. While the note on objectives and methodology of the evaluation was circulated as a background paper – the summary of findings could not be accessed so it was a missed opportunity.

Pam and Andy were requested to follow this up with Andrew at the earlier and facilitate prompt action which would greatly help the next project cycle. Ravi shared three findings from the May meeting

(a) that PHA had made a major impact on all those who attended it as an inspirational and energizing experience;
(b) only those who came representing networks / associations or campaign groups and hence had a constituency to share the concerns and perspectives of the Charter did some follow up work including distribution of Charter, publications and some campaign initiatives in their region.

8. PHM Consolidated strategy and budget 2004-2006

a) A note discussed in London by a small representative funding group in 2003 was circulated to the steering group members. This included the following components of an evolving global strategy.

i.
ii.
iii.
iv.
v.

vi.
vii.
viii.

The group went through some parts of this note especially the earlier sections to enhance the collective endorsement of the overall objectives and aims of PHM and thekey thrusts and initiatives in the next 2-3 years.
(see separate document).

b) However, Ravi shared that the group was hampered by two important lacunae in the planning effort and hence the document could not be converted into a logical framework analysis to be sent to funding partners for the next phase.
   (i) There was no feedback or clarity about regional mobilization efforts of PHM; evolution of regional and country level strategies and initiatives and the expectations of support / coordination if any from the global secretariat.
   (ii) There was no clarity about the next People's Health Assembly and its financial requirements.

   It was expected that the present steering group meeting would enhance the clarity of both these constituents of the PHM plan for 2004-2006.

   Some idea of regional needs and requirement;
   Some idea about PHA – II.
   These would then be included in a revised plan of action and logical framework exercise that the funding / planning group of PHM would put together by April –May 2004.

c) The funding – from January 2003 –January 2004

   Ravi and Andy gave a summary of the rather precarious (?innovative) approach of PHM Secretariat to the financial requirements / implications of current ongoing PHM initiatives, coordinated by the secretariat and supported through the fund raising efforts of OWA in UK and Ravi from the Secretariat.

It was summarized as a two pronged process as of now.

i) Scrounging – the balance from PHA – I fund raising efforts (after all the travel grants and organizational costs had been met and the post PHA – II core group meeting held in Dhaka in November 2002) has been scrounged for some of the support to the ongoing initiatives of PHM including some of the secretariat costs.
ii) Friends and neighbours policy –networks and friendly associations / agencies that respect and trust PHM as an evolving movement have responded to the coordinators appeals and have provided small grants and contributions that have been used for specific initiatives. These have included:

   - Christian Aid -12500$ for PHM resource centre in GK;
   - WCC -15000$ for PHM – WHA 2003

- In the months that followed, the Latin American PHM members met a couple of times and wrote to Armando (Brazil) encouraging him to send some sort of written commitment of the local hosting groups at Porto Alegre so that the decision could be finalized and endorsed. However, there was no follow up and over six months of planning time was lost.
- At the beginning of the steering group meeting in Mumbai, there were a few informal discussions between all the participants from the Americas region to sort out this matter since further delay in the decision would jeopardize the planning process further. There was some concern from other regions that the decision from a region should be consensual and the PHM steering group not be faced with the option of selecting from two potential venues from the same region.
- The decision about PHA-II was then finalized in two phases. In Phase I Hugo representing the Latin American region made the following points at the end of the first regional meeting:

    - The Latin American region would like to host the next People's Health Assembly;
    - The region had the capacity and experience to host the Assembly;
    - The Assembly would be hosted in July 2005;
    - He quoted a Latin American proverb –that it does not matter if there is storm, thunder or lightening –we will carry it out to emphasise the interest and the confident resolve of the group from the region to host this important event.

- A few days later, after the arrival of both Arluro and _____ from Ecuador, the proposal of the People's Health and a host of related movements to host the PHA II in Quito Ecuador was placed before the steering group and it was unanimously accepted. It was decided that Arturo Quizhpe would be the organizing committee and would be supported by an International advisory group that would represent different regions and help with all aspects of the planning. This group would be constituted soon –so that it could start the planning and through its regular deliberations it could start the PHA –II planning process.
- It was also decided that the next International Health Forum – IV which would be held next year in January 2005, when the WSF returns to Porto Alegre, Brazil, would be an important complementary and pre PHA-II meeting. Armando, the organizing secretary of this Forum IV would be a member of the International Advisory Committee for PHA – II. The forum could focus on Health Policy changes that are necessary to increase the potential for Health for All, Now. The interesting examples and case studies from Brazilian experience could be highlighted at this forum and the Brazilian experience could be reflected upon by participants from other regions. Policy initiatives from other parts of the world could also be focused upon at the next forum eg., primary healthcare policy endorsements by Karnataka, Orissa state in India and South Australia region in Australia.

10. Regional Capacitation Process

A short paper by Prem about regional capacitation was circulated to all the members in the file of background papers. The paper emphasized that for increased capacity development in different regions and countries it was necessary not only to improve the collectivity and representativeness and effectivity of the existing steering group members and country level contacts but also identify the framework of a capacity building process that includes the identification of new, younger leadership and their sustenance and capacity building.

- One of the challenges for PHM was to build develop capacity in a region with little or no capacity. It was necessary to chose an area with such limited capacity and bring it up to some level (Maria).
- One of the concerns was that if existing capacity especially for networking, information sharing and communication was taken as a necessary criteria for a region to have the qualities to take over the secretariat than regions like Africa would be out of the contention for a long time - may be even up to 20 years before Africa can join the movement fully. Capacity building should be a two-way process. Visits from PHM resource persons from other African region were given a chance to move to other regions tolearn from local processes that would also be effective. Without this two-way process, Africa would be completely excluded. In some regions like in Africa communication was a big problem. More media is privatized so paying for a spot on TV was very costly (Mary Sandasis).
- It was suggested that the next secretariat be chosen based on the potential to build capacity rather than the presence of actual capacity (budget).
- If we needed to grow as a movement then we need to consider the possibility of setting up regional offices or secretariats. This will especially address the needs of other languages (eg., Spanish speaking regions (Armando).
- It was felt that regional offices may actually become the foci of capacity building towards hosting the secretariat in the future (Malachi).
- It was necessary to build capacity in a region by a definitive focus on Human rights and health. This could be done in two ways :

    1. as a distance education programme (being evolved)
    2. as a part of capacity building programme especially of younger recruits and leadership (Armando).

The most important capacity we should be building at regional and country level is to promote the people's Charter and to build a movement by converting the Charter into action and campaigns. Promoting a movement; facilitating a circle-country focused or issue focused; and hosting a secretariat are three very different things and need different capacities. However, the most important capacity to be built is to support movement. While doing s, one must emphasise that it is not making new members or inviting people to join but recognizing those who are already doing the actions / campaigns (that we feel need to be done) as partners and linking them to PHM. All the individuals who are interested must also finally get linked to organizations and movement to be more productive, sustainable (Ravi).

12. Advocacy and Dialogue with WHO

An overview of the history and process of advocacy and dialogue of PHM and WHO was provided by Ravi, who had been convenor of the WHO-WHA circle since 2002. These included in chronology:

- PH Assembly disappointment at Dr. Gro's absence from PHA in spite of invitation and liaison about dates (also UNICEF absence considering WHO/UNICEF were co-facilitators of Alma Ata conference.
- Record of this missing WHO in the PHA report and its interpretation as lack of interest in people's health;
- Specific exhortations to WHO incorporated in the Charter;
- The NCD division of WHO inviting Ravi to present the Charter in a research seminar in April 2001.
- Three in-house lunch time seminars by Ravi at WHO-HQ on PHA and Charter. Distribution of Charter to all staff.
- PHM invited to WHA – May 2001 and interview with DG of six members who represented PHM. DG referred to PHM is report and also announced the WHO – Civil Society initiative. PHM made representations to WHO-CSI.
- Presentation of the Charter by Ravi and Zafrullah at the GFHR Forum 5 in Geneva in November 2001. Demand that Charter be presented at WHA.
- PHM invited to present Charter at WHA – May 2002 as a Technical session. Ravi and Zafrullah present Charter and Maria, Mwajuma and Ellen present evolution of movement in Latin America, Africa and Europe. PHM represented by 32 delegates. Intensive advocacy and media strategy. DG attends session chaired by Filipino Health Secretary but does not make any commitments to further dialogue.
- In the 2003 elections for new DG – PHM plays active part in efforts to make the elections more transparent and participates in debate / dialogue with DG candidates.
- In may 2003 at WHA, 82 participants from 30 countries attend WHA (Alma Ata Anniversary year) and support PHM statement on PHC; support statement of TRIPS with Oxfam, MSFS, etc; support statement on NGO civil society etc., advocacy and lobbying with delegates aster advocacy training by Andrew and Carmelita for all PHM delegates. Beginnings of an effective presence though more quantitative rather than qualitative.
- The new DG designate Dr. Lee meets a small representative PHM delegation and listens to concerns and initiatives including Million signature campaign. Requests PHM to keep WHO aware of the marginalized.
- The informal dialogue with WHO during the present administration has continued and PHM has been invited to engage with WHO on WTO / GATS; the HIV-AIDS 3 by 5 initiative; the reiteration of primary health care; and the dialogue on the recommendations and follow up of the commission on Macroeconomics and Health while many members welcomed these developments. There was a general concerns that we should b e cautious in our expectations and watch the process carefully

looking for policy / strategy change not only public statements and pronouncements and also there was need to track unhealthy trends and organize advocacy strategies to counter them. eg.

- consultants who spoke out against WTO were facing a lot of pressure and found their consultancies being cancelled (Mira);
- business and private enterprises (for profit) were being put under the same categorization as NGOs and this was totally unacceptable (Maria);
- some developments in WHO were not very comforting eg., infant feeding was being merely reduced to an area of information provision and not any more a technical area (Pam);
- the deplorable stake of people's health was partly due to the recent policies of WHO. We need to keep this in perspective –it is therefore people who will bring about this changes by putting pressure on the system from below and not or never the WHO (Prem);
- since WHO is sending a team to IHF-WSF and we have a special session with WHO team –it is at that session that we need to get clarity about WHO's role (Maria);
- GATS and TRIPS were issues that were bridging sectors but the main game was Agriculture. There is need to push the dialogue to include the smallest farmers who were the real losers (David Lege);
- Also there was a continuous struggle within WHO and within International health initiatives to continue legitimizing the neo liberal economic policies and the need to counter them through effective delegitimising strategies – in these battles between legitimizing and delegitimisation –we must not forget the real problems of the people (David Legge);
- Whatever the changes made by the DG at HQ level the impact would be measurable only if there was a shift of policy at regional and country level (Barzgar);
- While there were nice words at the HQ/DG level there is need to monitor the changes in actual functioning / programmes. How do these changes translate into action at region and country level and at field level. Unless there are changes at field / lower levels policies made at higher levels is not enough (Jihad);
- A check list should be prepared to measure WHO's commitment to the concerns of the Charter at global and regional levels (Fran)
- Keeping these caution in mind the process of dialogue should be seen as a strategic opportunity and the dialogue should continue and be particularly focused on a few thrust areas:

- to remind / pressurize WHO of the principles of primary health care and to re-endorse it as policy;
- to pressurize /advocate WHO to shift to a health systems strengthening approach rather than selective marketing of magical bullets through vertical approaches;
- to dialogue with WHO to keep civil society / not for profit NGOs distinct from private sector and corporate sector;
- to dialogue on 3 by 5 initiative for HIV/AIDS but strengthen the primary health care dimensions and the health systems strengthening strategies.
- To continue to share PHMs concerns on Macro economics and Health, various global funds and top down international initiatives.

- The continuing PHM dialogue with PAHO was outlined by Maria. The main context were:
- PAHO is a much older organization than WHO and in this region the new chief of the region ____ Mirta Roses was elected over a WS supported neo liberal candidate.

- PHM was invited by ____ Roses to make a critique of the PHC report;
- PHM (Maria) was invited by PAHO to attend a ministerial meeting as a motivational speaker and she particularly highlighted the role of WTO / trade issues in health;
- Along with governments; civil society organizations and private sector they (PHM & PAHO) were planning a PHC conference in Guatemala.
- The situation in PAHO was strategic and PHM should support the DG to make the region more relevant for primary health care development.

14. Global Health Equity Watch Report

A background note about a Global Health Equity watch had been circulated to all participants. Patricia, a full time worker on the project with medact gave a short summary of the initiative and sought PHM Steering Group endorsement. The initiative had been given the general okay by PHM at the May 2003 meeting in Geneva.

- The Peoples Health movement together with Medact and the Global Equity Gauge Alliance (GEGA) was proposing the development of an annual Global health report to be known as Global Health Equity Watch (GHW)
- The report would be different from other annual health and development reports for the following reasons:
  - Equity and not poverty at the centre of analysis
  - Providing an inclusive platform for civil society
  - Providing a platform for amplifying the 'voices of the unheard'
  - Promote the PHC approach
  - Place health and health inequities within a broader political-economic perspective and a multisectoral perspective
  - Link research and analysis to advocacy.

While the report will primarily be an analytic and evidence based document it will be coupled with descriptive elements of realities on the ground (case studies and testimonies) and on a sound justification of normative principles and values described above

- Approximate size of the Report: 150000 words
- An initial structure and chapter headings of the proposed report was also circulated for comments

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12. Advocacy and Dialogue with WHO

An overview of the history and process of advocacy and dialogue of PHM and WHO was provided by Ravi, who had been convenor of the WHO-WHA circle since 2002. These included in chronology:

- PHAssembly disappointment at Dr Gro's absence from PHA inspite of invitation and liaison chart dates. (also UNICEF absence considering WHO/UNICEF were collaborators of Alma Ata conference
- Record of this missing WHO' in the PHA report and its interpretation as lack of interest in peoples health
- Specific exhortations to WHO incorporated in the Charter
- The NCD division of WHO inviting RN to present the charter in a research seminar in April 2001.
- Three inhouse lunchtime seminars by RN at WHO-HQ on PHA and charter. Distribution of charter to all staff
- PHM invited to WHA-May 2001 and interview with DG of Six members who represented PHM. DG referred to PHM in report and also announced the WHO-Civil Society initiative. PHM made representations to WHO-CSI.
- Presentation of the charter by Ravi + Zafrullah at the GFHR Forum 5 in Geneva in Nov 2001. Demand that charter be presented at WHA
- PHM invited to present charter at WHA-May 2002 as a Technical session. Ravi + Zafrullah present charter and Maria, Mwaguma and Ellen present evolution of movement in Latin America, Africa and Europe. PHM represented by 32 delegates. Intensive advocacy and media strategy. DG attends session chaired by Filipino Health Secretary but does not make any commitments to further dialogue
- In the 2003 elections for new DG -, PHM plays active part in efforts to make the elections more transparent and participates in debate/dialogue with DG candidates
- In May 2003 at WHA, 82 participants from 30 countries attend WHA (Alma Ata Anniversary year) and support PHM statement on PHC; support statement of TRIPS with OXFAM, HSFS etc; support statement on NGO Civil Society etc, advocacy and lobbying with delegates after advocacy training by Andrew and Carmelita for all PHM delegates: Beginnings of an effective presence though more quantitative rather than qualitative
- The new DG designate Dr Lee meets a small representative PHM delegation and listens to concerns and initiatives including Mullion Signature campaign. Requests PHM to keep WHO aware of the misgivings.
- The informal dialogue with WHO during the present administration has continued and PHM has been invited to engage with WHO on WTO/GATS; the HIV/AIDS strategy; the initiative; the reinvention of Primary Health Care and the dialogue on the recommended and follow up of the Commission on Macroeconomics and Health

While many members welcomed these developments there was a general concern that we should be cautious

is our expectations and watch the partners carefully looking for policy / strategy change not only public statements and pronouncements and also there was need to track unhealthy trends and organise advocacy strategies to counter them. e.g

- Consultants who spoke out against WTO were facing a lot of pressure and found their consultancies being cancelled (Marc)
- Business and private enterprises (for profit) were being put under the same categorisation as NGOs and this was totally unacceptable (Marc)
- Some developments in WHO were not very comforting e.g infant feeding was being merely reduced to an area of information provision and not any more a technical area (Pam)
- The deplorable state of peoples health was partly due to the recent policies of WHO. We need to keep this in perspective - it is therefore people who will bring about the changes by putting pressure on the system from below and not or never the WHO (Pam)
- Since WHO is sending a team to IHF-WSF and we have a special session with WHO team - it is at that session that we need to get clarity about WHO's role (Marc)
- GATS and TRIPS were issues that were bridging sectors but the main game was Agriculture. There is need to push the dialogue to include the smallest farmers who were the real losers. (David Legge)
- Also there was a conscious struggle within WHO and within International health institutes to continue legitimising the neo liberal economic policies and we need to counter them through effective delegitimising strategies. In these battles between legitimising and delegitimising action - we must not forget the real problems of the people (David Legge)
- Whatever the changes made by the DG at HQ level the impact would be measurable only if there was a shift of policy at regional and country level. (Berger)
- While there were nice words at the HQ/DG level there is need to monitor the changes in actual functioning / programmes. How do these changes translate into action at region and country level and at field level. Unless there are changes at field/lower levels policies made at higher levels is not enough

(Tabatabai)

11- ~~Global Health Equity Watch Report~~

Dr Anita - presently chairperson of PHM India - a community Health and HFA advocate - long standing made a fervent plea for contextualising the ongoing dialogue with WHO in the larger context of a people unfriendly global order. WHO is merely part of the strategy and often has little capacity to do anything that will make direct impact on peoples life and health. The challenge before PHM is therefore:

- How to reach those millions of people who cannot come to meetings but need to be strongly represented.
- How do we dialogue with people at the grassroots level and how do we identify their needs and their aspirations?
- While governments and politicians do listen to peoples voices and respond to needs - people still fail to see health as priority because it is so mystified and people cannot make the connection between policies and existing realities and needs. In the absence of this awareness at all levels we become hostages to the WB/IMF/US and other imperialist/hegemonistic trends.
- The people are silent and the WHO is vocal - this will not do. Through our efforts we must help the voices of people and the marginalised to be heard by policy makers and respond to their needs. This needs going to the people and increasing their awareness about the situation and the trends and the implications of policies often thrust upon them and in their name. This demystifying and movement building process is crucial and must go hand in hand with strategic and continuing opportunities for dialogue.
- Keeping all the caution in perspective - as expressed by members Ravi noted that these three components of the ~~ongoing~~ strategy

- we have to carefully watch WHO checking how it translates intention into concrete policy and action.
- to increase levels of dialogue including clearly about differences and our disagreements with some of their formulations/analyses
- we have to enhance this dialogue to regional and country levels and also

- A check list should be prepared to measure WHO's commitment to the concerns of the charter at global and regional levels (Fran)
- Keeping these caution in mind the process of dialogue should be seen as a strategic opportunity and the dialogue should continue and be particularly focused on a few thrust areas:
  - To remind/pressurise WHO of the Principles of Primary Health care and to reendorse it as policy
  - To pressurise/advocate WHO to shift to a health systems strengthening approach rather than selective marketing of magical bullets through vertical approaches
  - To dialogue with WHO to keep civil society/not for profit ngos distinct from private sector and corporate sector.
  - To dialogue on 3by5 with chir for HIV-AIDS but strengthen the primary health care dimensions and the health systems strengthening strategies
  - To continue to share PHM's concerns on Macro economics and Health, various global funds and top down international initiatives

- The continuing PHM dialogue with PAHO was cultured by Maria. The main context were
  - PAHO is a much older ~~region~~ organisation than WHO and in this region the new chief of the region Dr Mirta Roses was elected over a US supported neo liberal candidate
  - PHM was invited by Dr Roses to make a critique of the PHC report
  - PHM (Meera) was invited by PAHO to attend a ministerial meeting as a motivational speaker and she particularly highlighted the role of WTO/Trade issues in health.
  - Along with governments, civil society organisations and private sector Rep (PHM & PAHO) were planning a PHC conference in Guatemala
  - The election in PAHO was strategic and PHM should support the DG to make the region more relevant for primary health care development

~~Minutes~~ Report

~~Minutes~~ of the PHM Steering/Support group meeting held at YMCA International House, Mumbai on 12, 13 and 16th February and two additional extended sessions on 18th and 19th February at WSF venue (Solidarity Nesk) and Hotel _____ respectively

Preamble:

~~Introduction:~~

The Third International Health Forum in the Defense of Peoples Health was organised by the Global secretariat of PHM and PHM India on 14 and 15th January at the International House YMCA, Mumbai preceding the World Social Forum from 16-21st January also at Mumbai/Due to some unavoidable constraints the annual PHM steering group, usually scheduled in November each year, by tradition, was postponed and linked to the Mumbai event. The annual PHM steering group, therefore ~~took~~ was organised on 12 and 13th of January at the International YMCA./Due to the unprecedented richness of participation at the IHF/WSF, we not only had a full steering committee presence (out of) but we also had many members from all over the world who support the secretariat in separate functions as volunteers ( ) and many country contact points as well ( )

/The first two days 12 and 13th therefore was a steering/support group and all those in these different categories, other than steering group were also invited to attend the discussions in a spirit of transparency as full members and/or observers/participants/On 16th, 18 and 19th ~~January~~ - Some extended sessions were held to make decisions and evolve a plan for the next year. These meetings were attended primarily by steering group members

An agenda was sent out in advance of the meetings and a programme overview from 12-16th January was also circulated in which all the steering group agenda points were alloted specific time slots on 12th and 13th January. However due to delayed arrival of some of the steering group members sessions were interchanged and some extended sessions were held to increase the participatory nature of the steering/planning exercise and the group addressed some new issues that were brought up during the discussion.

The whole process was very interactive and participatory and the enclosed report written in the order of the original agenda tries to capture the main issues and decisions that were taken.

Since the compilation of the minutes/report took a while, the secretariat team is also appending a follow up report that tracks all the action that has been taken. Overall the meeting proved to be a great battery charger and energiser and the enthusiasm with which the PHM steering group ~~and~~ support group and country contacts have followed up on their commitments has been most heartening. The PHM is definitely come to stay and evolving in enthusiasm content and impact. However the evolution/metabolisation of PHM also continues to show great regional variation and diversity. One of the biggest challenges for PHM is to ensure that all regions/networks/countries are well represented in the evolving initiatives. and this puts a special responsibility on all those who represent these regions that are lagging behind [illegible]

evolve circles initiatives and progress in the [illegible] gear up PHM [illegible] next year

Members Present

To give clarity to the representation at the steering/support group meeting the participants have been classified into functional groups

Steering Group

a) Network representatives Maria Hamlin Zuniga-Nicaragua (IPHC); Zafrullah Chowdhury, ~~Ele~~ Bangladesh (GK); Ram John, India (ACHAN); Carmelita Canila, Philippines (CI); Evelyne Hong, Malaysia (TJN); Nadia Van der Linde, Netherlands (WGNRR); Olle Nordberg Sweden (DHF). (Dr Bela of HAI-AP could not attend)

b) Regional representatives

Pam Zenkus (Europe); Sarah Shannon, Hesperian, USA for Global Health (North America); Arturo Quizhpe, Ecuador (South America)

Hugo Ivan Pereira Cardenas (Central America & Caribbean)

David Sanders, Brigette Lloyd South Africa (Southern Africa); Mwajuma S. Masangano Tanzania (East & Central Africa); Fran Baum & Australia (Pacific, Australia & New Zealand); B. Ekbal / Mira Shiva India (India); Edelina de la Paz, Philippines (South East Asia); Jihad Mashal, Palestine (Middle East & North Africa); (South Asia, China & West Africa elected ~~still do not have~~ regional representatives ~~though South Asia is represented~~)

c) Coordinators

Qasem Chowdhury, GK Bangladesh (Past Coordinator), Ram Narayan India (Present coordinator ~~by Ram in Qasem's absence~~)

Support Group

Andy Rutherford OWA UK (Funding); Unnikrishnan, India (Medic); Armando De Negri Brazil (IHF-USF); Jose Ukera (Public Private Partnership Circle); ~~Hani Sevag Egypt (Newsbrief)~~ S.S Banerjee (Website); Rebecca Zuniga (Translations); Country Focal Points/Contacts ~~Armando de Negri (Brazil)~~

David Legge (Australia); Julio Monsalve (Argentina); A.H.M Nowmee (Bangladesh); Amit Kapur (Canada); Hani Sevag (Egypt); (Bangladesh); Malachi Orondo (Kenya); Mohd. Ali Barzegar (Iran) ~~and Asia~~; Mary Sandasi (Zimbabwe) Jagdish Chaudhuri and R.K. Boodhun (Mauritius) Ayyaz Gul (Pakistan) for Zafar Mirza

Others Nirangen Udugamdagale (Srilanka for Vinya Ariyaratne) Ghana from Rebecca (Lebanon)

Others Pedram Rashidi

Fereneh Afzali & Rezvan Moghadam (Iran) Alla Shakrallah (Egypt) Bart de Belder (Belgium)

For the purpose of easy readability - the report will be divided into PHM-Global agenda and PHM-regional agenda and the latter will focus on reports from regions and plans of action emerging at regions

1/2 Introductions and Finalisation of Agenda

(4)

Introduction

The meeting on 12th January started at 11 am with a round of introductions and a review of the agenda and programme overview that had been circulated in the file of documents that was given to all participants. The agenda was accepted without any major changes with the proviso that since some of the participants were coming later on the 12th or after - their presentations will be postponed and accomodated in the programme whenever feasible.

Once a query from Sarah it was decided to take up campaigns (in regional reports or regional capacitation (Sarah)) and on the suggestion of Armando it was decided to introduce a short input into the inaugural session of the Forum on 14th morning, highlighting the earlier health fora and the links with WSF. Ravi also suggested that subgroups of the PHM members present should meet in regional groupings to discuss regional level issues and campaigns because PHM would be stronger only as all the regions become stronger and evolved their own cultures, frameworks and initiatives responding to local needs and challenges. The morning of 16th was one possibility for such a meeting.

3) Reports from Regions & Countries

Since some of the reports from the regions were circulated only some of the highlights issues and points will be highlighted in a separate document and linked to the regional plans that were discussed during various smaller regional group meetings during IHF-WSF.

separate document

3) International Health Forum / World Social Forum

a) Dr Amit Sengupta - Jt Convenor PHM India (Jana Swasthya Abhiyan) and member of the organising committee of the WSF gave an overview of the framework of WSF IV, the background planning and challenges, the major differences in situation/focus from previous WSF and the framework of plenaries, seminars workshop and skeet events. The four important panels and seminars on 17th and 18th Jan and the other & health related events at the World Social Forum were also highlighted. (See IHF Programme p14-17)

b) Dr Ravi Narayan gave an overview of the programme for IHF which included Six Plenaries on the themes -

and 14 workshops on the themes

This had evolved in an interactive, participatory way with suggestions from the regions, and members of the international organisation support committee. The suggestions from Latin America, Africa and Middle East were particularly useful.

He requested all the PHM resource persons present at the meeting to take note of the sessions and roles which they had been allotted and to participate actively in the next few days to make these sessions/workshops happen in the PHM tradition of listening to voices and testimonies and having panelists respond to the concerns and issues raised by these voices/testimonies.

Thanks to the enthusiastic support of Dr Prem Jain and all these voices and testimonies were shared at IHF from many

He highlighted two challenges for IHF seminars a) To move beyond problem/situation analysis to highlight ~~practical~~ examples of practice action at various levels b) To identify the key concerns and suggestions from each event to feed into a Mumbai Declaration-document that would be a definitive output of IHF-WSF and a supplement (as well as 2004 update) on the Peoples Charter for Health and its concern

(See seperate report of IHF WSF and updates on the website)

5. Reports from Networks

While various members reported from regions and country circles the eight founding/supportive networks that helped to organise the Peoples Health Assembly and have continued to support the evolving PHM also reported their main activities and thrust areas

a) Third world Network (Evelyne)

The main contribution of TWN was in spreading the word about PHA and the Peoples Charter and in focussing on issues relevant to PHM/PCH in TWN publications especially Resurgence.

A special Alma Ata 25th Anniversary feature was included in the July/August/2003 issue. It included the reflections of David Werner, Debabar Banerji and David Sanders on the Peoples Charter for Health and the Statement on Primary Health Care made by PHM at World Health Assembly - May 2003

b) Women's Global Network for Reproductive Rights (Nedra)

The main campaign was the Women's Access to Health campaign in which PHM was an international collaborator and also many PHM resource persons and circles

including the Advisory Group set up in Aug 2003

were involved at different levels. Copies of the charter were distributed at all meetings of WGNRR at all levels. This year's May 28th campaign will focus on Health For All - Health for women - what do Health Sector Reforms have to do with it. ~~is going to be observed as~~ and she requested PHM to join in a big way. In 2003 the focus of the campaign was to make governments take more responsibility for reproductive rights as well as primary health care. This year's the focus was on Health Sector Reform and how it improved or enhanced access. WGNRR also supported actively the Multi-country Campaign and other Alma Ata Anniversary campaigns and was also a co-sponsor of the PHM publication Health for All Now - Revive Alma Ata. In October 2003 it organised

c) ~~IPHC~~ an International Peoples Health Council (Manila) (~~See separate handout~~)

IPHC has been very actively involved in the organisational work related to PHA-I and to the formation of PHM at international level as well as the regional promotion of PHM. IPHC has represented PHM actively at national and international events and activities and will continue to do so. IPHC's principle contribution to PHM is its concerns, analysis and perspectives on the Politics of Health and its commitment based on involvement of some of its members with primary Health care programmes based in communities to the Health for All and Primary Health Care goals reconfirmed in the Peoples Char-

on Alma Ata Anniversary Reception in Netherlands

Due to the impact of ~~conservative right wing~~ Governments which aimed to privatise health care disregarding women's rights and access to contraceptives and services. WGNRR has become more proactive in Netherlands and also supports the European Social Forum 2003 process

(See separate handout)

Recently IPHC has undergone an external evaluation and will soon be evaluating the future development of IPHC in response to this evaluation and to the perception of its members of the future directions which should be taken by IPHC

IPHC looks forward

d) Dag Hammerskjold Foundation (Olle)

DHF had supported the evaluation of PHA particularly in the context of strategy and finances. It had also supported the evaluation of PHA-I and the evolving PHM. DHF was presently bringing out a report titled 'What Next?' which was a sequel to the earlier report 'What Now?' brought out in 1995 which looked at alternative development ideas. The new report would focus on action and strategy in the current global situation.

DHF was also involved with processes to evaluate new technologies in terms of social and environmental implications and the challenge of access by all. Both these initiatives were of relevance to PHM.

A special issue of Development Dialogue' - the DHF journal was also being planned in which some of the earlier background papers (perhaps updated) and the report on the evolving movement and strategy by Ravi and the evaluation findings by Andrew would also be featured.

e) Asian Community Health Network (ACHAN) (Bern)

Efforts were being made gradually to use the already extensive network of ACHAN members to strengthen PHM in various countries of the Asian region. ACHAN-Srilanka had been served (the main focus of the members was on primary health promotion / care). Similar efforts were being planned for Cambodia, Thailand, Indonesia and other countries with very limited resources and other constraints

f) (a) Gonoshasthya Kendra (Savar).

GK has continued as a PHM resource centre even after the secretariat moved to Bangalore. Its main functions are to continue to publish the newsletter and reprint old publications and new ones whenever necessary. The centre continues to get lots of charter endorsements which are being forwarded regularly to the new secretariat for follow up action. It has also been supporting actively the autonomous development of PHM in Bangladesh at the national and regional levels.

g) Consumer International - ROAP (Carmelita)

CI had been supporting PHM through Carmelita whose presence for advocacy training and action at the WHA-May 2003 was particularly valuable. She had also agreed then to be a convenor of the Food & Nutrition circle which would focus on a range of issues - junk foods, sugar lobby, [illegible] and work closely as PHM representative linked to IBFAN, APAN and other networks.

Recently since she is no longer with CI, the secretariat will follow up with CIROAP and explore a replacement for the steering group to continue the linkage with CI.

(b) Health Action International - Asia Pacific

While Bala was not able to attend the continuing support of HAI-AP and its excellent work on the Drug policy issues in which many PHM members in the region were involved, was noted with appreciation. A Special issue of the HAI Journal (Dec 2003) on People's Health Movement was released at IHF-WSF.

6. Organisational Overview and Assessments

This ~~came up as~~ was an important agenda item and various dimensions were discussed in response to agenda 6 and 10 but also came up in different ways during the discussion on most of the other points as well. The meeting was an opportunity and guideline to assess the organisational diagrams that had been circulated at the pre WHA- May 2003 PHM meetings

a) Steering Group

The steering group was still incomplete because three regions — South Asia, China and West Africa did not still have elected/nominated representatives

- South Asia was indirectly represented by Zafrullah Qaseem, Prem, Bala who were in the S.G in other capacities but efforts to get PHM Srilanka, Bangladesh, Nepal, Pakistan, ~~Maldives~~ (PHM Maldives and Bhutan had not yet evolved) to meet at some event and nominate a steering group member to represent the region was necessary
- China - David Legge, who travels to China on other duties had offered to help identify potential resource persons and PHA-I participants to evolve a PHM China. Other members who had contacts were requested to put them in touch with Dr.
- ~~West Africa~~ - WONRR had been requested to get their representative Elmira to be the contact person for the region. All members who had other contacts in the region should put her in touch with them to evolve the regional circle and find more country representatives. Recently there had been enquiries to the secretariat

from Sierra Leone and ______ The secretariat was following this up.

In South East Asia – Deles of Philippines would continue as the regional contact point till more country circles were evolved. ~~and~~

In the Indian region – While Ekbal was directly representing the region, the steering group suggested that a dialogue with PHM-India would explore a role for Mira who is also from the same region and had been asked to continue ~~be~~ in the steering group because of her contribution to PHA-I and the national drug policy, and other issues.

- It was suggested that North Africa be separated from the Middle East as a separate region (Moteccha)

b) Country level circles and regional lists of countries

Ravi mentioned that country level circles with country contact points were increasing (see the website for the latest position). The presence of so many of them at IHEWSF was very heartening. While regional representatives should continue to assist the secretariat in evolving country circles and finding country contact points it was also reiterated that country circle contact points should increase their representativeness in the country by involving more networks, associations, campaign groups, NGOs in the country circle. ~~and~~

There was a question whether Israel should be included in the Middle Eastern region (Hani). It was felt that inclusion of Israel in the present situation when it keeps the danger of so much suffering to neighbouring states was not appropriate. The inclusion of one state may jeopardise the involvement of nearly 20 Arab states.

c) Inter regional efforts to spread PHM and build interregional efforts and initiatives

Ravi highlighted ~~the~~ examples of inter-regional efforts and suggested that PHM would grow faster if there were more of similar efforts

Priority setting and Health Needs assessment

- In East Africa various PHM Steering group members visited in a sort of relay to mobilise for PHM. Qosem (GK) and Mona (IPHC) visited Arusha for a WABA meeting in Oct 2002 when a PHM session was held. Later Ravi Thelma from India visited Kampala, Nairobi, Dar-es Salam enroute to Arusha for the GFHR meeting in Nov 2002. At each of these places there were PHM meetings bringing together NGOs and resource persons from networks and campaigns. This led to the strengthening of the East Africa region and evolving circles in Kenya, Uganda, Tanzania
- Zafrullah, Ravi & Thelma visited USA as special invitees to an International Public Health conference in Berkeley and then visited 10 cities and 8 universities to address PHM meetings. This led to the further development of PHM-USA
- At the World Health Assembly, May 2003, 52 PHM members from 30 countries attended a PHM get together to share ideas and perspectives and attend the WHA to advocate for many concerns of the Charter. Over 67 members came on their own with local/regional support. It was a special Alma Ata anniversary year get-together but it greatly increased the credibility of PHM in WHO and the new DG designate had an informal dialogue with 6 PHM members
- The AIFO (Italy) has been the key promoter/mobiliser for PHM in Italy. AIFO gave the Raoul Follereau Award to PHM at its Biennial meeting in October 2004 and invited three representatives from Asia, Latin America & Africa to receive the award. There were opportunities to share about PHM concerns from the regions and build South-north and South-South solidarity

- The spontaneous response of PHM related groups to the anti-war campaigns and rallies all over the world and the focus on war and health as a PHM global concern was well done.
- The Global Health Forum has been taking note of PHM evolution and the concerns of the charter. In GFHR-Forum 5, in Geneva - the charter was presented (Ravi (India) Zafrullah (Bangladesh)) in December 2004, Geneva; in GFHR Forum 6, Arusha, Tanzania - Nov 2005 there were research inputs in a PHM context by David (South Africa), Zafrullah (Bangladesh), Thelma and Ravi (India). In Forum 7, Geneva, Dec 2003, there were inputs by David (South Africa) Mario (Nicaragua) and Ravi (India) and in GFHR-Forum 8 in Mexico, David represents PHM on the organising committee and David and Ravi have been put on a Task Force to promote Health Systems Research at the Mexico Summit in Nov 2004. (GFHR Forum 8:)
- Zafar Mirza (Pakistan) and Thelma (India) did a lecture tour in Germany in Nov 2003 at the request of Bukopharma Kampagne to promote PHM mobilization in Germany in many cities and with many groups.

d) Secretariat

- Ravi reported in brief the experiences of the secretariat over the last one year which included
  - Shift from GK-Server to CHC-Bangalore on a transitional phase Jan-March 2003
  - Decision to keep PHM secretariat separate from CHC the host-NGO in the Indian region - hence separate accomodation, telephone, and fax.
  - RN and Secretary (Suvidha) being seconded full time from CHC to PHM secretariat from Jan 2003 till Dec 2004 extendable as of now till March 2005 only

d (contd)

- The appointment of a full time communication officer ~~Person with IT/~~ management background who gradually took over the website management from Nand (Ashok Rao) in October 2003

(See separate issues in Item 14 on PHM Communications)

- The decision in GK Sever (Nov 2003) to appoint a separate Technical officer (to help the full time coordinator of the secretariat with day to day activities, planning and response to a large number of technical request that come to the secretariat) was deferred due to non-availability of a specific suitable person However this lacunae was filled by i) support of CHC Technical Team and Fellows ii) Support by various members of the steering group to email referrals of such technical requests
- The efforts at decision making through email communication with steering group members ~~There were some difficulties with this and many~~ expectations from the secretariat team since many steering group members just did not respond to the mail from the secretariat).

(See separate section on decision making and suggestions for improvement post IHF-USF)

- ~~May steering group~~ and many steering group members who did respond felt that the secretariat did not send the collated response (final decision) promptly

(e) Issue based circles

Rani was requested to outline the issue based circles that had been initiated and comment on their functioning

and development

- The WHO-WHA Circle (Convenor – Ron x Zafrullah ~~as co-convenors~~) This was very active and, especially since the presentation of the PH Charter at WHA-May 2002 was beginning to upscale its advocacy strategy with some useful results (see item 12 separate section on Dialogue with WHO). Due to Rao's preoccupation with PHM secretariat he felt that Zafrullah needed to take more proactive role in WHA circle and others should support him as well
- ~~The~~ Poverty and AIDS circle (Convenor Purohit Jogue) (i) This was set up after a dialogue with UNAIDS & Peter Piot and Vecny at the instance of Rao. However this was not very active because it could not find a specific PHM point of action. However now with the dialogue opportunities opening up with the WHO 3X5 initiative and the presence of the WHO 3X5 team and PHM related HIV-AIDS activists from many parts of the world at IHF-WSF (for the Special Plenary and workshop) there was a new opportunity to revive the circle and give it a relevant and challenging focus
- Water & Disaster circle (Convenor Uma x Rachel Berkell) This was a very active circle and had been regularly promoting/catalysing PHM responses to various crisis Palestine, Iraq, water, etc.
- Research Circle (Convenor David Sanders) While some efforts in communication to evolve focus and strategy for this circle had been initiated by David Sanders and PHM was getting involved in making inputs into GFHR and other research forums to provoke greater facilitation of health systems research and research on social determinants the process needs further strengthening

- Women's Health Circle - This was convened by WGNRR and PHM was closely involved with all the campaigns of WGNRR as co-sponsor and active participants. The women's access to health campaign and other activities of WGNRR had been actively supported.
- Three circles have been formed (one continued from the past) and these need further clarity and framework which will evolve in 2004
  - Politics of Health circle - (More IPHC) Its strategy has not yet been shared in the PHM Circle with clarity
  - Macro economics and Health - The role and contribution of Medact and Mike Rowses in particular in the area of Macroeconomics and concerns about CMH report is noted and this circle will be supported as it evolves further
  - The Public Private partnership Circle with ~~items~~ of wemos and Jose Ubera ~~as convenor~~ recognises the continuous and ongoing involvement of wemos in this area and also the recent networks of researchers ~~exploring~~ this topic which has facilitated
- ~~Food~~ Food and Nutrition Circle : at WHA-May 2003 Carmel Vc was invited by PHM to be the convenor of a circle that collates PHM concerns on a range of Food & Nutrition issues including Junk foods, Sugar lobby, infant nutrition, the UNICEF and Mcdonald partnership etc and work closely with IBFAN and APPAN.
- Communication Circle - An effort was made by the secretariat in coordination with Andrew (Health Link) who circulated a paper

While this was seen to steering group it was primarily an effort to bring all those supporting communication efforts of CHC into one, inverarchy circle (See item 14 for further details

Some general points emerged from the overview presented by Ravi

- When the circles are responding to specific events or focused campaign issue they seem to work well
- When the circle evolves primarily as a study circle it is not progressing well. Perhaps there is need to gear up to definitive outputs focused on specific events / initiatives related to the theme of the circle
- Because of limited time and the various other demands on PHFI members energy levels to work through issue based circles is limited

Some interesting discussion about issue based circles and their ~~effectively or ineffectively~~ strengths and weaknesses lead to some interesting observations and questions.

- Many circles are cross cutting and need good evidence, research is crucially important for campaigns (David)
- Circles can be formed spontaneously; individuals with enthusiasm can make it happen; does not need to be endorsed but welcomed (Andy)
- Circles should not be launched with a single point person but a team of individuals. Also one of the role of circles is to find ways of working with other networks and groups who are interested in the same issue (Sarah)
- Lots of groups are already working on these issues and

- There is need to study the APAN statement submitted to WHO in May 2003 and to analyse how the global strategy suggested by APAN fits into PHM frame work. APAN is planning a convention and PHM could place this statement in that convention and work with APAN during the next WHA (2004) (Carmelita)

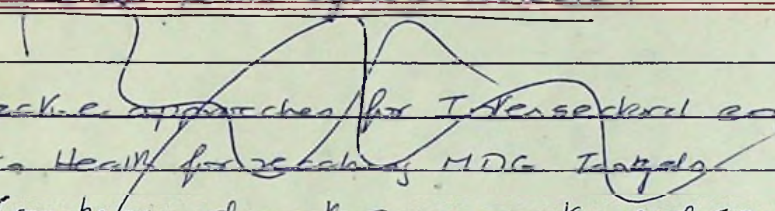
  Meeting the needs of vulnerable ~~populations~~ - Health systems in urban areas; disaster preparedness and relief.

- There is need to debate on environment and ecological issues related to sustainable development

- There is need to look at the effects of WTO on agriculture and how they affect farmers livelihoods (David Legge)
  (A small sub group consisting of David Legge, Sarah Carmelita and Patricia decided to meet to discuss this issue and suggest further action by PHM]
- US is going towards bilateral strategies on trade with different countries. PHM should develop alliances at country, regional and global level to counter these (   )
- FCTC undergoing ratification. PHM members should demand that their governments ~~to~~ should sign and ratify and implement the framework. There will be a Western Pacific Regional organisation (WHO-WPRO) meeting soon about implementation ~~and~~ (Carmelita)
  (Carmelita was endorsed as PHM representative at the meeting)

- For every campaign there is need to share information about the issue; get commitment of people and groups to the campaign; and identify strategies at country level (Mona)
- For every campaign there should be links between local work and international campaigns - this benefits the international campaign but also helps the campaign to be used locally to facilitate / mobilise and do strong local advocacy work (Hugo)

WHO - Task Force ~~on~~ Health Systems Research



Effective approaches for Intersectoral engagement in Health for scaling MDG Targets

(on hunger, domestic energy, water and sanitation)

Therefore the challenge is to make connect and work with Ram around campaigns (Mona)

- Circles need research and analysis skills and also campaigning and advocacy skills. Therefore each circle must also recruit members with this sort of expertise (Ram)
- Circles should put out facts and figures and Ram plans of action from here to there: one page enough but this would greatly help PHM medic team for advocacy (Unni)
- The Global Health Equity watch report may be a good focus for all the circles to come together and work together (Patricia)
- There are issues that are important to regions and so issue based circles and regional circles need to link and respond to realities in the region (Jose)
- In response to Carmelita's question on relation between steering group and circles Ravi clarified from the process paper that country circles group to form regions and regional focal points are members of steering group

Convenors of issue based circles are convenors of circles of PHM members drawn from different regions who are interested in the issue. These convenors are not formal members of the steering group but are ~~to~~ be included as members of the secretariat support group because they support the secretariat in evolving clarity & perspective and PHM responses to specific issue

convenors of circles should
2. Use PHM Exchange to transform ground forums of circle; identify potential members of circle who respond through the exchange to raise circle derived communications; and put our reflections and further communications from the circle. The website can also be designed to have a section for circle discussions (Ravi)

Circles need to be able to accomodate the complexities of members in the context of the quality of the work and need to generate a process that accomodates these complexities Also since PHM is generating a density of activity, status linkages we have to be clear how we are going to proceed (Andy)

Are we going round in circles (Pandlegge) There is some confusion about the responsibilities and forums of the circles with some overlap. This needs to be clarified by convenors (Pelen) depth, understanding and relevance

- Issue based circles need both A circle may be required to study the issue of newer technologies and their impact on health. eg Biotechnology, IT, we need to study positive and negative impacts

(f) Campaigns/Advocacy

Members shared some ideas about campaigns and issues of advocacy relevant to PHM which should be considered by PHM in regions and supported by some of the issue circles

- Having been present at WTO and WB meetings there is need to use the health impact as the measure of effect of all these Policies on farmers livelihoods (Evelyne)
- There is need to write a position paper on the Global fund for AIDS, Tuberculosis and Malaria and track its evolution and experience (Evelyn)
- There is need to support Access to Treatment campaigns at country level (May Sanders)
- There is need for a campaign strategy to promote comprehensive PHC in this growing world of vertical strategies and evidence based planning. PHM needs to define what is appropriate evidence base for PHC, how collect it through our regional and global networks and how it together as a global evidence base (Fran)

PHM India (TSA) has increasingly evolved linkages with networks (there are more than 18-20 already working together at national level and their counterparts at State level. In recent years PHM India is also working with other national campaigns around Food, Water, TRIPS, Tobacco and also involving those campaign groups in PHM India with others and campaigns (Tsunami). In some states members of PHM India are also beginning to influence state health policies (Maharashtra, Rajasthan, Chattisgarh, Orissa, Karnataka) (Kerala)

A consensus from the discussion was articulated by Andy, as key steps towards linking with other networks:

- Check the network if you can (and need to)
- Follow your own judgement and using the PCH as a context
- Mention PHM as you feel appropriate
- Be accountable for the way you use the PHM name or the charter
- Communicate the link established to the secretariat and steering group

h) Shift of secretariat

- Rani shared the fact that CHC had agreed to host the PHM secretariat on behalf of the Indian region till for 2 years, starting Jan 2003 till Dec 2004, extendable till the end of the financial year ie March 2005. He and a secretary had been seconded from CHC for to PHM secretariat for that period. The Communication officer, Reema was also appointed for the same period.

If the secretariat had to be shifted to another region early next year, then it was important to start the process of identifying the next ~~potential~~ region with potential to host the secretariat.

The next region and the potential ~~next~~ coordinator could then work closely with ~~the~~ the Bangalore secretary so that the shift over would be planned and smooth.

A process of selection of the next secretariat could start by the preparation of a note on the secretariat and its responsibilities by Ravi, Ren, Jihad, Sarah and Larry. This could then be circulated end March or Early April so that different regions could review their own potential to host the secretariat.

Ravi clarified that though the Bangalore secretariat had also recently taken over the website from Nand (Costa Rica) because of the availability of Prasanna the communication officer who had an IT/Management background it was not necessary that the secretariat and website be managed by the same team in the future as well. If any region was willing to consider to take over the responsibility of the website, this would be a separate process and a different regional responsibility not linked to the next secretariat.

(The website was discussed further during the session on Communications - See item 14)

It was suggested that if a region was chosen to host the secretariat then someone from that region and the organisation in the region which would actually be hosting the secretariat could spend a few weeks in Bangalore to learn the ropes from the present secretariat (Ren)

- It was also emphasised that as was done during the shift of secretariat from Bangladesh to India - that a period of overlap ~~and coordinatorship~~ was allowed with the outgoing coordinator and the incoming coordinator being coordinators for three months - a similar process would be followed this time as well with Ravi (Bangalore) and the next coordinator (new region) overlapping for three months - around Jan-March 2005.

(8) PHM Consolidated Strategy and budget 2004-2006

a) A note discussed in London by a small representative funding group in ~~October~~ 2003 was circulated to the steering group members. This included the following components of an evolving global strategy

a) i)
b) ii)
c) iii)
d) iv)
e) v)
f) vi)
g) vii)
h) viii)
i)
j)

See handout

The group went through some parts of this note especially the earlier sections to enhance the collective endorsement of the overall objectives and aims of PHM and the key thrusts and initiatives in the next 2-3 years.
(See separate document)

b) However Ravi shared that the group was hampered by this important lacunae in the planning effort and hence the document could not be converted into a logical framework analysis to be sent to funding partners for the next phase

(i) There was no feedback or clarity about regional mobilization efforts of PHM; evaluation of regional and

country level strategies and initiatives and the expectations of support/coordination if any from the global secretariat

ii) b) There was no clarity about the next Peoples Health Assembly. ~~In May 2003 at the PHM General Meeting~~ and its financial requirements it was unanimously endorsed that PHA-II would be in July 2004 at Porto Alegre, Brazil and a ~~four~~ member core committee consisting of Mamta, Armenda, Amir and Mubashir was constituted. They evolved and presented a brief outline and framework of the next PHA-II

It was expected that the present steering group meeting would enhance the clarity of both these constituents of the PHM plan for 2004-2006

(a) Some idea of regional needs and requirements

(b) Some idea about PHA-II

These would then be included in a revised plan of Action and Logical framework exercise that the Funding/Planning Group of PHM would put together by April-May 2004

c) The Funding - From Jan 2003 - Jan 2004

Ravi and Andy gave a summary of the rather precarious (insecure) approach of PHM secretariat to the financial requirements/implications of current ongoing PHM initiatives, coordinated by the secretariat and supported through the fundraising efforts of OWA in UK and RN from the secretariat

It was summarised as a two pronged process as of now

i) Scrounging - The balance from PHA-II fund raising efforts (after all the travel grants and organisational costs had been met and the post PHA-II Core group meeting held in Dhaka in November 2002) has been scrounged for some of the support to the ongoing activities of PHM including some of the secretariat costs.

(ii) Friends and neighbours policy - Networks and friendly associations/agencies that respect and trust PHM as an evolving movement have responded to the various appeals and have provided small grants and contributions that have been used for specific activities. These have included:

- Christian Aid - 12500£ for PHM Resource Centre in GK
- WCC - 15000$ for PHM-WHA-2003
- WEC/AIFO Small grants to support PHM East Africa mobilization
- DHF 15000$ to support PHM secretariat costs
- AIFO 5000£ - Human rights award to PHM - grant used for publication
- Hesperian Foundation - 15000$ grant from Ford Foundation to support secretariat/coordination related travel
- CHC the PHM secretariat hosting organisation in India has covered various office costs, capital equipment - computers and furbiture and the travel advances etc

For IHF WSF - a special fund raising effort by the secretariat specifically for IHF WSF has led to contributions from the following sources.

- Medico International - 5000$
- Action Aid, Bangkok 5000$
- Cordaid Netherlands 12500$
- Misereor, Germany 2500$
- WHO Geneva via IRTAD 12000$
- Physicians for Smoke Free Canada 10000$

While this 'hand to mouth' existence of PHM is very creditable for a movement in the sense there is no wasteful infrastructure development or central largesse that is distributed to regions thereby creating unnecessary centralised dependence it is still probably not the best way to proceed.

A concerted effort has to be made in the next few months to ensure that a core grant to support the main plan of action of PHM for the next phase 2004-2006 is negotiated and then supplemented by the sorts of small grants that have been tapped for specific initiatives and events in the last one year and listed above.

(iii) Regional Funding

A greater clarity has to emerge in the PHM planning and strategy to balance the fund raising by the PHM secretariat supported by the PHM-funders group for the secretariat and global initiatives and the fund raising efforts at the regional and country level to support local, national and regional initiatives. It is also imperative that regions which are better resourced need also to help funding sources to help the secretariat raise resources for global initiatives and needs as well.

AMARI
Hotels and Resorts

24a

Date: Meeting/Theme:

6 (i) ~~Some~~ organisational suggestions

While reviewing the evolving organisational structures and framework as outlined in the background papers circulated some ideas and suggestions were made by some of the members about the existing framework and organisational assumptions. These could not be discussed at length but are being listed out to ensure that they are kept in mind as the PHM organisation experience evolves and needs review

- There was need to prevent the movement from becoming too organised and evolving too detailed a framework of rules and regulations. This would bureaucratise and kill the spontaneous spirit of the movement. The movement should be issue based, campaign oriented and functional capacity especially to emphasis health and social determinants at country and regional level is more important than definitive organisational structure (Ram)

- Too many issue circles is dividing the group and the problem. We are in a way reproducing the fragmentation that we oppose and thereby creating a barrier. There should be a manframe policy that can guide discussions in individual groups and thence matrix of interconnected issues rather than circles. It is particularly important not to fragment the process and organisation so much that we lead to a situation where we loose our capacity to be relevant (Armando)

- One of the assumptions made while designing the thematic circles were that there would be a coming together of these circles - however this did not seem to be happening even though we are all activists. Not only issues but regions should also link and work together. An area where this should be happening urgently is in the issue of privatization of health services

This is happening everywhere and there are negative impacts. We need to build common concerns and strategies over regions (Andy

- While the issue circles were reaching out to people who are working on those areas it is important to emphasis that the circle connect all its members with PHM and all the larger issues PHM is linked to. Also if the circle activity could somehow be linked to a certain degree of activism or action then the issue circles would succeed as an idea and a organic structure (Sarah)
- We have circles for regions and each has a specific function - a specific structure for specific needs. We must however integrate all these circles successfully (David Lesser)

- While the charter was clear it was now necessary to evolve a small booklet describing all aspects of the evolving structures/framework of PHM for easy reference by country level contact persons or focal points (Medeiros)

- The steering committee is absolutely serious and important and the way we organise ourselves should be based on what we want to do. It is actions that have validity rather than merely statements and plans. This validity grows from local grass roots action - so all PHM initiatives should ultimately support, promote and derive from grassroots actions (Penn)
- PHM should be careful not to keep fishing in the same pond - among the already converted. Can the PHM get involved in universities and there we should involve young people in more depth (Julio)

9. Peoples Health Assembly - II

- In May 2003 at the PHM General get together it was unanimously endorsed that the next Peoples Health Assembly II would be held in July 2004 at Porto Alegre in Brazil. A four member core planning committee was constituted ~~with~~ which include Mario (Nicaragua) Armando (Brazil), Amit (India) and Muyumba (East Africa) The group met and prepared a brief outline of the frame work of the next PHA-II which was then circulated for wider dialogue and consideration
- In the months that followed the Latin American PHM members met a couple of times and wrote to Armando (Brazil) encouraging him to send some sort of written commitment of the local hosting groups at Porto Alegre so that the decision could be finalised and endorsed. However there was no follow up and over six months of planning time was lost
- At the beginning of the steering group meeting in Mumbai there were a few informal discussions between all the participants from the Americas region to sort out this matter since further delay in the ~~decision~~ decision would jeopardise the planning process further There was some concern from other regions that the decision from a region should be consensual and the PHM steering group not be faced with the option of selecting from two potential venues from the same region
- The decision about PHA-II was then finalised in two ~~Stages~~ Phases. In Phase I Hugo representing the Latin American region made the following points at the end of the first regional meeting
  - The Latin American region would like to host the next Peoples Health Assembly
  - The region had the capacity and experience to

- The Assembly would be hosted in July 2005
- He quoted a Latin American proverb - that "it does not matter if there is storm, thunder or lightening - we will carry it out" to emphasise the interest and the confident resolve of the group from the region to host this important event

Date: Meeting/Theme:

Start: Finish:

- A few days later after the arrival of both Arturo and ____ from Ecuador the proposal of the Peoples Health and a host of related movements to host the PHA-II in Quito Ecuador was placed before the steering group ~~while the proposal was in Spanish~~ and it was unanimously accepted. It was decided that Arturo Quizhpe would be the organising secretary of PHA-II. He would evolve a local organising committee and would be supported by an International advisory group that would represent different regions and help with all aspects of the planning. This group would be constituted soon - so that it could start the planning and through its regular deliberations it could start the PHA-II planning process

- It was also decided that the next International Health Forum-IV which would be held next year in January 2004, when the WSF returns to Porto Alegre Brazil would be an important complementary and pre PHA-II meeting. Amando the organising secretary of this Forum IV would be a member of the International Advisory committee for PHA II. The forum could focus on Health policy changes that are necessary to increase the potential for Health for All. Now. The interesting examples and case studies ~~experience~~ from Brazilian experience could be highlighted at this forum and the Brazilian experience could be reflected upon by participants from other regions. Policy initiatives from other parts of the world could also be focussed upon at the next forum e.g. Primary Health care policy endorsements by Karnataka, Orissa state in India and (in Kerala.

10. Regional Capacitation process : A short paper by Prem about regional capacitation was circulated to all the members in the file of background papers. The paper emphasised that for increased capacity development in different regions and countries it was necessary not only to improve the collectivity and representativeness and effectivity of the existing steering group members and country level contacts but also identify the framework of a capacity building process that includes the identification of new, younger leadership and their sustenance and capacity building.

Date: Meeting/Theme:
Start: Finish:

- One of the challenges for PHM was to build ~~up~~ develop capacity in a region with little or no capacity. It was necessary to chose an area with such limited capacity and bring it up to some level (Mario)
- One of the concerns was that if existing capacity especially for networking, information sharing and communication was taken as a necessary criteria for a region to have the qualities to take over the secretariat then regions like Africa would be out of the contention for a long time - maybe even upto 20 years before Africa can join the movement fully. Capacity building should be a two-way process. Visits from PHM resource persons from other parts of the world helped to enthuse and change the mood of local people. Similarly if people from the African region were given a chance to move to other regions to learn from local processes that would also be effective. Without this two-way process Africa would be completely excluded. In some regions like in Africa communication was a big problem. More media is privatized so paying for a spot on TV was very costly (Mary Sindeso)

It was suggested that the next secretariat be chosen based on the potential to build capacity rather than the presence of a ~~full~~ capacity (Brigel).

- If we needed to grow as a movement then we need to consider the possibility of setting up regional offices or secretariats. This will especially address the needs of other languages (e.g Spanish speaking regions etc (Armando)
- It was felt that regional offices may actually become the foci of capacity building towards hosting the secretariat in the future (Malachi)

- It was necessary to build capacity in a region by a definitive focus on Human rights and health. This could be done in two ways
  - as a distance education programme (being evolved)
  - as a part of a capacity building programme especially of younger recruits and leadership (Armando)

The most important capacity we should be building at regional and country level is to promote the people charter and to build a movement ~~of action~~ by converting the charter into actions and campaigns. Promoting a movement; facilitating a circle-country focused or issue focused; and having a secretariat are three very different things and need different capacities. However the most important capacity to be built is to support movement. While doing so one must emphasise that it is not making new members, but organising people to join recognising those who are already doing the actions/campaigns (that we feel need to be done) as partners and linking them to PHM
All the individuals who are interested must also finally get linked to organisations and movement to be more productive, sustainable (Ravi)

ravi@phmovement.org

From: TOM fawthrop <tomf70k@yahoo.com>
To: Ravi Narayan <ravi@phmovement.org>
Sent: Saturday, April 01, 2006 6:54 PM
Subject: Re: TomF

Dear Ravi,

I didnt make it to WSF Karachi but trying hard to round off the Cuba doco with visit to earthquake zone to film Cuban medical teams..

would greatly appreciate contact with PHM activists and contacts in Lahore and Islammabad..

hope all is well ,

best

Tom Fawthrop
Thailand
April 1st

4/4/06
Dear Tom
The PHM contacts in Islamabad and Lahore are as follows
Islamabad
Lahor
Best wishes
Ravi

Ravi Narayan <ravi@phmovement.org> wrote:

Dear Tom,

The person who was shooting the DVD video was Dr. Pervez Imam - a doctor film maker whodid it on behalf of the PHM Secretariat but on his own initiative. He is based in Delhi and we are hoping to meet up soon to decide how to go about using all that footage to evolve some good 'teaching documentaries' from PHA2 Cuenca. He stayed back for a few weeks after PHA2 for more shooting and meetings with activists. His email is f20com@yahoo.com and drparvezimam@yahoo.com and his telephonic contacts are Mobile : 0091-98180-29792.

Best wishes,
Ravi

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Section B — 13. Reports from Regions
14. Planning Exercises
15. Communication Strategies
~~16 Decision Making Strategies~~

Section C or B+
17. Schedule of PHM events (as of 15th April)
18. Follow up since IHF WSF

14. Planning Exercise - I — PHM Achievements

The steering group members were invited to write down the key achievements of PHM in the last two years. These were then shared as an assessment of where we are as a movement today. These could be included collected with six key achievements and a few others in the members' own words.

1. Peoples Charter for Health
   - widely disseminated and distributed
   - Successful launch and spreading of charter
   - many translations
   - promoting charter as an inspiration for groups working on health around the world
   - mobilising on the charter and training/communications with communities as an advocacy tool
   - The charter increasingly recognised as a framework for social development work
   - The charter recognised as arising out of a democratic-process of consensus building
2. Peoples Health movement evolution post PHA-I
   - The slow but strong build up of the network with all its diversities transforming PHA to PHM
   - Uniting force for individuals, networks, institutions and NGOs.
   - Gradual strengthening at local, regional and national level
   - Improved networking built with respect to both quantity and quality
   - Persons interacting worldwide through PHM and its communication strategies -

3. The WHO turnaround
   - The dialogue and higher profile of the WHO
   - The breakthrough as an advocacy, lobbying and changing force in the WHO
   - The shake up of the WHO that it now responds to the PHM calls in the area of PHC
   - A force for revitalisation of Comprehensive Primary Health care and Alma Ata principles within WHO.

4. Re endorsement and revitalisation of Alma Ata Declaration and HFA goals

- Establishment that local and national and international groups exist that still have commitment to Alma Ata principles endorsed in the Peoples Charter
- Increased awareness and involvement in Primary health care issues
- The charter as a tool for the revitalisation of Comprehensive Primary Health care / Alma Ata principles within countries
- Development of PHM as an organisation fighting for Health for All Now

5. The PHM Secretariat Leadership

- Excellent work and role of the Secretariat
- Right choice of the International coordinator
- Increasing capacity for communication and joint action (we cannot survive without this)
- improved networking and learning from regions and each others experiences

6. Towards an alternative analysis of World Health

- Encouraging alternative analysis of the worlds economic system and its impacts on health
- Inner, widening and deepening shared critique of neoliberalism of health programme
- Voices of the unheard: encouraging communities to write own stories

- Increasing recognition as the voice of public opinion, with knowledge of what is happening at local level and being taken seriously
- Recognised as a network with concerns against institutions taking decisions on health at international level.

7 Others

- IHF-PHM in Mumbai
- Decision about Peoples Health Assembly - II
-

Planning Exercise II - Movement strengthening - Global agenda
Most of the issues discussed re. organisational strengthening; issue based circles; campaigns and advocacy; PHA-II; Global Health Equity Watch Report etc have been included in the relevant sections in Section A of the Background Material circulated

Planning Exercise III Regional and country strengthening
Due to the enthusiastic level of participation from most regions of the world (with a few exceptions like China Eastern Europe, North and west Africa) the Mumbai meeting provided opportunity for some reflections on regional needs and plans after the initial reports by many regional focal points and country focal points (see Section 13.)
These regional reflections were an initial check list of concerns, options and ideas for follow up by regional with their own regional and country level circles

- It was suggested that a secretariat could have a team of three years with a one year overlap with the next secretariat (AGM)
- If a secretariat was moved to a region and it was later found not to be able to cope with the new responsibility, what could happen? (Brazzaville)

It was noted that such a contingency need not occur if the secretariat

PHM Evaluation was identified carefully and systematically (Rob) and

A PHA-I/PHM evaluation process was started in 2002 to assess the impact of PHA-I on individuals who had attended the assembly and also to understand the process of post-Assembly follow up in regions and countries in terms of processes, mobilisation of circles; charter translation and distribution; campaigns and PHM inputs into national, regional and international events

An initial dialogue ~~compilation~~ of the main emerging findings of the evaluation by a three member team led by Andrew (HealthLink) was held in May 2003 in London just before the WHA May 2003 in Geneva. Unfortunately due to unavoidable circumstances and constraints the PHM evaluation report has not yet ~~been~~ become available for circulation and debate. While the note on objectives and methodology of the evaluation was circulated as a background paper - the summary of findings could not be accessed so it was a missed opportunity.

Pam and Andy were requested to follow this up with Andrew at the earliest and facilitate prompt action which would greatly help the next project cycle.

Rori shared three findings from the May meeting

a) That PHA had made a major impact on all those who attended it as an inspirational and energising experience

b) Only those who came representing networks/associations or campaign groups and hence had a constituency to share the concerns and perspectives of the charter did some follow up work including distribution of charter publications and some campaign activities in their region

P.T.O

From Andy Rutherford

PHM Notes regions

Countries

PHM SG minutes RJ 2011

Australia, New Zealand, and the Pacific

1. Raise profile of PHM in the region
   - by sponsored tours of key PHM people
   - Discussion groups on: Trade & health, ~~GPHC~~ Comprehensive Primary Health Care
2. Use networks in region – New Zealand, South Pacific, PNG
3. Perhaps, Plan a regional conference
4. Local website

(A) →

Strengthening Asia

1. Maximise existing regional networks: ACHAN, IPHC, CIROAP, HAI AP, TWN
2. Contact material ??? and networks directly and distribute materials, initiate dialogue
   - consumer groups in each country
   - health and non-health (and other health related ???)

   e.g. Cambodia & Japan (ACHAN)

3. Utilise existing / already planned activities of networks in the region
   To add a PHM session or agenda for discussion

e.g.
- Feb 9 – 10 meeting of pharmacologists in Indonesia where Deleu (?) is going as a speaker on behalf of HAI AP/PHM April 2004
- June - meeting in Sri Lanka – Dialogue with CMH at regional level
  - communicating for advocacy (PCH as advocacy issue)
- Dec – meeting on safe home delivery in Bangladesh

4. Utilise publications available – TWN publications
   To spread PHM perspectives and expats on movement
   e.g. Resurgence
   HAI-AP Newsletter etc

Europe

1. Develop a plan to strengthen the regional coordination / focal point for ~~support of~~ regional coordination
   No PHM activities
2. Inviting other organisations to take part in the ?? unions, academics, etc.
3. Priority: East European ~~organisation~~ – involve more organisations in their specific regions
3. Develop a circle on:
   - privatisation
   - promote the discussion about the effects of the action on European ~~TNC~~ on health:
     - pharmaceutical
     - financial

Transnational organisations

- water/ electricity

5. PHM sponsored short courses – University based for grassroots leaders on health systems, socio-political determinants of health, primary health care i.e. in universities ~~where ????~~

PHM – ~~MENA~~ region

1. Country movements strengthening in each ~~region~~

2. Invest in capacity building and resource production and ICT for health
3. (~~www.~~?) Advocacy and lobby ~~for ?~~
2. Identified priorities – 7 issues of the region (plan of action)
4. Strengthen networks and the above (?) with involvement of regional networks at community level - based on events, issues, etc

Australia and regional strengthening

1. Tours of sponsored people –Australia and the region
2. Identification of ???
3. Country regional meetings
4. Local website/ listserve
5. Discuss opportunities and resources for key issues e.g. badged ? as PHM

China

1. Recruitment of supporter for Chinese ??
2. Chinese language website
3. Chinese language listserve
4. Call for contributions on key issues

Latin America

1. Establish specific programmes and campaigns (ALCA – Salud, FTAA – Health)
2. Glossary of PHC. Concepts – criteria
3. Strengthen/ promote inter-cultural dialogue –

South Africa

1. Invest resources in cultural communication infrastructure and charter printing and dissemination, in countries where there is already a viable PHM activity.
2. To use planned Southern/ Eastern African PHM /? ? and society meeting s to run module/ course on PHM/ civil society organisation focussed on both knowledge and skills. To use opportunities (regional, national meetings,

regional national networks and sympathetic community based organisations to build PHM.

3. In countries to use Charter to identify key national campaigning issues, i.e. to link key national health issues to global issues to organise campaigns around this to build PHM in African countries.

North America ✓

1. Developing effective regional coordination and communication between the Canadian and US PHM events. Support each others efforts. This may include Health & Trade, Environmental Health and Justice, Tobacco (we do not yet know the priorities.)
2. - Resistance to US Government policy "Regime change begins at home".

- Join campaigns and networks already active
- Promote and facilitate health within the campaigns (give suggestions and plans?)
- Build awareness of the inter-relationship between US policy and Social injustice.
- Encourage the spectrum of grassroots action from the streets to legislation

3. Build the PHM within each country – USA + Canada

Strengthening Campaigns and international advocacy

1. Step up anti-war efforts and build alliances (3 campaigns and 2 events that will be launched tomorrow is a starter)
2. Target non-health summits and be visible in G-8, G-7, etc
3. Target youth groups and students (medical students would be a good starting point)
4. Consider one PHM intervention in a war/ disaster spot every year (Unni can take responsibility)

By Andy Rutherford
(last on 22/04/2004)

ACHEIVEMENTS

1. Charter widely disseminated
2. Recognition that local & national groups exist that still have commitment to People's Charter for Health and Alma Ata Principles
3. Persons interacting world wide

1. The successful launching and spreading of the Charter, translation, wide use
2. The slow but strong build up of the network with all its diversities. Transforming PHA to PHM
3. Emerging dialogue with the WHO

1. Right choice about international coordinator
2. Decision about PHA 2
3. Some break through with the WHO
4. Successful in different countries
5. IHF/PHM in Mumbai

PHM 56 Minutes

1. Translated People's Charter for Health and distributed it, translation into other languages
2. Mobilising on the People's Charter for Health, training communities on communities on advocacy
3. Encouraged communities to write own stories

1. Promoting the People's Charter for Health as an inspiration for groups working on health around the world
2. Having continuity of work based on the People's Charter for Health
3. Getting recognition as a network with knowledge of what is happening at local level, against institutions taking decisions in health at international level.

RN 29/4

1. Uniting force for individuals, networks, institutions, NGOs
2. Advocacy, lobbying and changing force for/in the WHO
3. Awakening involvement on health cars especially PHC issues IHHR
4. A tool for the revitalisation of CPHC/ Alma Ata within countries, WHO
5. Voices of the Unheard
6. Communication and joint action we cannot survive without this.

Spanish in red

1. Strengthening at the local, regional and national level.
2. Voice of public opinion
3. Permanent/ongoing activity Producer and distributor of ??
4. Learning from others experiences

1. Higher profile at the WHO
2. Improved networking

3. Excellent work and role of the secretariat ✓

1. Network built with respect to both quality and quantity ✓
2. Shake up the WHO that it now responds and to the PHM calls in the area of PHC ✓
3. The PCH exists and reaches many and is a framework for social development work ✓

1. WHO turnaround ✓
2. PHM established and growing ✓
3. Inner, widening and deepening shared critique of verticality of ?????? ✓

1. The PCH coming from democratic process of Pha1 and its translation and distribution ✓
2. Developing Pha1 into PHM fighting for Hfa now ✓
3. Encouraging alternative analysis of the world's economic system and its impact on health ✓

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1.

Countries
Australia, New Zealand, and the Pacific
1. Raise profile of PHM
? sponsored tours of key PHM people
? Discussion groups on: Trade & health, CPHC
2. Use networks in region ? New Zealand, South Pacific, PNG
3. Perhaps, Plan a regional conference
4. Local website

Strengthening Asia
1. Maximise existing regional networks: ACHAN, IPHC, CIROAP, HAI AP
2. Contact material ??? and networks directly
- consumer groups in each country
- health and no-health (and other health related ???)
e.g. Cambodia & Japan (ACHAN)
3. Utilise existing / already planned activities
Feb 9 ? 10 meeting of pharmacologists in Indonesia where Defen (?) is going as a speaker on behalf of HAI AP
June - meeting in Sri Lanka
- communicating for advocacy (PCH as advocacy issue)
Dec ? meeting on safe home delivery in Bangladesh
4. Utilise publications available ? TWN publications
Europe
1. Develop a plan to strengthen the regional coordination ? focal point for support of regional coordination
2. Inviting other organisations to take part in the ?? unions, academics, etc. Priority: East European organisation
3. Develop a circle on:
- privatisation
- promote the discussion about the effects of the action on European TNO on health:
? pharmaceutical
? financial
? water/ electricity
PHM sponsored short courses ? University based for grassroots leaders on health systems, socio-political determinants of health, primary health care i.e. in universities where ????
PHM ? MENA region
Country movements strengthening in each region
1. Invest in capacity building and resource production and ICT for health (www, ?) Advocacy and lobby for ?
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Report of
PHM Steering / Support group meeting
held at YMCA International House, Mumbai
on 12th, 13th and 16th January
and two additional extended sessions on 18th and 19th January
at WSF Venue (Solidarity tent) and Hotel Columbus respectively

Slightly larger font

larger box

Preamble:

The Third International Health Forum in the Defense of People's Health was organized by the Global Secretariat of PHM and PHM India on 14th and 15th January at the International House, YMCA, Mumbai, preceding the World Social Forum from 16th to 21st January also at Mumbai.

Due to unavoidable constraints, the annual PHM Steering group, usually scheduled in November each year by tradition, was postponed and linked to the Mumbai event. The annual PHM Steering group, therefore, was organized on 12th and 13th of January 2004at the international YMCA.

Due to the unprecedented nature of participation at IHF / WSF, we not only had a near complete steering group presence but we also had many members from all over the world, who support the secretariat in separate functions as volunteers and many country contact points as well.

The first two days, 12th and 13th, therefore, was a steering / support group and all those in these different categories, other than steering group, were also invited to attend the discussions in a spirit of transparency as observers / participants.

On 16th, 18th and 19th January, some extended sessions were held to make decisions and evolve a plan for the next year. These meetings were attended primarily by steering group members.

An agenda was sent out in advance of the meetings and a programme overview from 12th – 16th January, was also circulated in which all the steering group agenda points were allotted specific time slots on 12th and 13th January. However, due to delayed arrival of some of the steering group members, sessions were interchanged and some extended sessions were held to increase the participatory nature of the steering / planning exercise and the group also addressed some new issues that were brought up during the discussion.

The whole process was very interactive and participatory and the enclosed report written in the order of the original agenda tries to capture the main issues and decisions that were taken.

Send

Since the compilation of the minutes / report took a while, the secretariat team is also appending a follow up report that tracks all the action that has been taken. Overall, the meeting proved to be a great 'battery charger' and 'energizer' and the enthusiasm with which the PHM steering group / support group and country contacts have followed up on their commitments has been most heartening. The PHM is definitely come to stay and evolving in enthusiasm, content and impact. However, the evolution / mobilization of PHM continues to show great regional variation and diversity. One of the biggest challenges for PHM is to ensure that all regions / networks / countries are well represented in the evolving initiatives and this puts special responsibilities on all those who represent those regions that are lagging behind to make an extra effort to evolve regional and country circles and initiatives and process in their region as we gear up for the next People's Health Assembly in July 2005 in Ecuador.

(Released 21st April, 2004)

Members Present
The participants have been classified into functional groups.

Steering Group:

a. Network Representatives:

Maria Hamlin Zuniga – Nicaragua (IPHC); Zafrullah Chowdhury, Bangladesh (GK); Prem John, India (ACHAN); Carmelita Canila, Philippines (CI); Evelyne Hong, Malaysia (TWN); Nadia Van der Linde, Netherlands (WGNRR); Olle Nordberg , Sweden (DHF). [Dr. Bala of HAI – AP could not attend)

b. Regional Representatives:

Pam Zinkin (Europe); Sarah Shannon, Hesperian Foundation, USA and Lanny Smith, Doctors for Global Health, USA – (North America); Hugo Icu Peren, Guatemala (Central America and Caribbean); Arturo Quizhpe, Ecuador (South America); David Sanders / Bridget Lloyd , South Africa (Southern Africa); Mwajuma S. Masaiganah, Tanzania (East and Central Africa); Fran Baum, Australia (Pacific Australia and New Zealand); B. Ekbal / Mira Shiva (India); Edelina de la Paz, Philippines (South East Asia); Jihad Mashal, Palestine (Middle East and North Africa). [South Asia, China and West Africa did not have elected regional representatives)

c. Coordinators:

Qasem Chowdhury, GK – Bangladesh (Past coordinator); Ravi Narayan, India (Present Coordinator)

Support Group

d. Secretariat support:

Andy Rutherford, One World Action – UK (Funding); Unnikrishnan, India (Media); Armando De Negri, Brazil (IHF – WSF); Jose Utrera, Netherland (Public Private Partnership circle); S.S. Prasanna (Website and Communication); Rebecca Zuniga (Translations); Patricia Morton, (GHW) (Andrew Chelley (UK); Nand (Costa Rica) and Claudio (Nelson could not attend)

e. Country Focal Points / Contacts

David Legge (Australia); Julio Monsalvo (Argentina); A.H.M. Nouman (Bangladesh); Atul Kapoor (Canada); Hani Serag (Egypt); Malachi Orondo (Kenya); Mohd. Ali Barzgar (Iran); Mary Sandasi (Zimbabwe); Jagadish Gobardhun and R.K. Boodhun (Mauritius); Ayyaz Gul (Pakistan for Zafar Mirza); Niranjan Udugamalagala (Sri Lanka for Vinya Ariyaratne); Ghassan Issa (Lebanon)

f. Others

Fatemah Afzali, Pedram Rashidi and Rezvan Moghadam (Iran); Alla Shakrollah (Egypt); Bert de Belder (Belgium); Lillian (Uruguay); Thelma Narayan, JSA – (India), Rakhal Gaitonde (rapporteur – India).

For the purpose of easy readability, the report will be divided into three sections – (A) PHM Global agenda; (B) PHM Regional agenda (focus on reports from regions and plans of action emerging at region); (C) Schedule of events and follow up in the phase February – April 2004)

PROCEEDINGS / MINUTES

A. PHM Global Agenda

1 & 2. Introduction and Finalization of Agenda

The meeting on 12th January started at 11.00am with a round of introductions and a review of the agenda and programme overview that had been circulated in the file of documents that was given to all participants. The agenda was accepted without any major changes with the proviso that since some of the participants were coming later on the 12th or after – their presentations will be postponed and accommodated in the programme, whenever feasible.

On a query from Sarah, it was decided to take up reports on campaign in regional reports or regional capacitation and on the suggestion of Armando, it was decided to introduce a short input into the inaugural session of the Forum on 14th morning, highlighting the earlier health fora and the link with WSF. Ravi suggested that sub-groups of the PHM members present, should meet in regional groupings to discuss regional level issues and campaigns, because PHM would be stronger only if all the regions became stronger and evolved their own activities, framework and initiatives responding to local needs and challenges. The morning of 16th was one possibility for such a meeting.

3. Reports from Regions and Countries (See section B for further details)

Since, some of the reports from the regions were circulated only some of the main issues and points will be highlighted in a separate document and linked to the regional plans that were discussed during various smaller region group meetings during IHF – WSF.

4. International Health Forum / World Social Forum

a. Amit, Joint Convener of PHM India (Jana Swasthya Abhiyan) and member of the organizing committee of the WSF, gave an overview of the framework of WSF – IV, the background planning and challenges; the major differences in situation / focus from previous WSF and the framework of plenaries, seminars, workshops and street events. The four important PHM related panels and seminars on 17th and 18th January and the other 8 health related events at the World Social Forum were also highlighted.

b. Ravi gave an overview of the programme for IHF, which included six plenaries and the 14 workshops (see programme booklet circulated at IHF – WSF or updated programme on PHM website).
This had evolved in an interactive, participatory way with suggestions from the regions and members of the international organizing support committee. The suggestions from Latin America, Africa and Middle East and Philippines were particularly useful.

c. All the PHM resource persons present at the meeting were requested to take note of the sessions and roles, which they had been allotted, and to participate actively in the next few days to make these sessions / workshops successful.

d. Thanks to the enthusiastic follow up by Prem and others from many regions, ~~these~~ voices and testimonies (over 20 of them) were strong at IHF and mainly action oriented.

e. Two challenges for IHF sessions were identified: (a) To move beyond problem / situation analysis to highlight examples of proactive action at various levels, (b)

to identify the key concerns and suggestions from each event to feed into a Mumbai Declaration – a document that would be a definitive output of IHF – WSF and a supplement (as well as 2004 update) on the People's Charter for Health and its concerns. (see separate report of IHF – WSF and Mumbai Declaration on the website)

5. Reports from Networks

While various members reported from regions and country circles (see section B), the eight founding / supportive networks that helped to organize the People's Health Assembly and have continued to support the evolving PHM, also reported their main activities and thrust areas.

a. *Third World Network (Evelyne)*
The main contribution of TWN was in spreading the word about PHA and the People's Charter and in focusing on issues relevant to PHM / PCH in TWN publications, especially Resurgence.

A special Alma Ata 25th anniversary feature was included in the July / August 2003 issue. It included the reflections of David Werner, Debabar Banerji and David Sanders; the People's Charter for Health and the statement on Primary Health Care made by PHM at World Health Assembly, May 2003

b. *Women's Global Network for Reproductive Rights (Nadia)*
The main campaign was the Women's Access to Health Campaigns, in which PHM was an international collaborator and also many PHM resource persons and articles were involved at different levels, including the Advisory Group set up in August 2003. Copies of the Charter were distributed at all meetings of WGNRR at all levels. This year, the May 28th, campaign will focus on Health for All – Health for Women: What do Health sector Reforms have to do with it and she requested PHM to join in a big way. In 2003, the focus of the campaign was to make governments take more responsibility for reproductive rights as well as Primary Health Care. This year, the focus was on Health Sector Reforms and how it improved or enhanced access.

WGNRR also supported actively the Million Signature Campaign and other Alma Ata Anniversary Campaign and was also a co-sponsor of the PHM publication, "Health for All Now – Revive Alma Ata". In October 2003, it organized an Alma Ata Anniversary, Reception in Netherlands. Due to the impact of conservative right wing governments, which aimed to privatize health care disregarding women's rights and access to contraceptives and services. WGNRR has become more proactive in Netherlands and also support the European Social Forum 2003 process.

c. *International People's Health Council (Maria)*
IPHC has been very actively involved in the organizational work related to PHA – I and to the formation of PHM at international levels as well as the regional promotion of PHM. IPHC has represented PHM actively at national and international events and activities and will continue to do so. IPHC's principle contribution to PHM is its concerns, analysis and perspectives on the "Politics of Health" and its commitment (based on involvement of some of its members with Primary Health Care programmes based in communities) to the Health for All and Primary Health Care goals, reconfirmed in the People's Charter. Recently IPHC has undergone an external evaluation and will soon be evolving the future

development of IPHC as response to this evaluation and to the perception of its members of the future directions, which should be taken by IPHC. It looks forward to continue to participate actively in the development of PHM in the future.

d. Dag Hammarskjold Foundation - DHF (Olle)

DHF had supported the evolution of PHA particularly in the context of strategy and finances. It had also supported the evaluation of PHA-I, the evolving PHM, and it. DHF was presently bringing out a report titled What Next?, which was a sequel to the earlier report, What Now? – brought out in 1995, which looked at alternative development ideas. The new report would focus on action and strategy in the current global situation.

DHF was also involved with processes to evaluate new technologies in terms of social and environmental implications and the Challenge of access by all. Both these initiatives were of relevance to PHM. A special issue of Development Dialogue – the DHF journal was also being planned in which some of the earlier background papers (perhaps updated) and the report on the evolving movement and strategy by Ravi and the evaluation findings by Andrew would also be featured.

e. Asian Community Health Network – ACHAN (Prem)

Efforts were being made gradually to use the already extensive network of ACHAN members to strengthen PHM in various countries of the Asian region. ACHAN – Sri Lanka had been revived (the main focus of the members was on promotion of Primary Health Care), similar efforts were being planned for Cambodia, Thailand, Indonesia and other countries with very limited resources and other constraints

f. Gonoshasthya Kendra – GK (Qasem)

GK has continued as a PHM resource center even after the secretariat moved to Bangalore. Its main functions are to continue to publish the newsletter and reprint old publications and new ones whenever necessary. The center continues to get lots of Charter endorsements, which are being forwarded regularly to the new secretariat for follow up action. It has also been supporting actively the autonomous development of PHM in Bangladesh at the national and regional levels.

g. Consumer International – ROAP (Carmelita)

CI had been supporting PHM through Carmelita, whose presence for advocacy training and action at the WHA – May 2003 was particularly valuable. She had also agreed then to be a Convener of the Food and Nutrition Circle, which would focus on a range of issue – junk foods, sugar lobby and work closely as PHM representative linked to UBFAN, APAN and other networks.

Recently, since she is no longer with CI, the secretariat will follow up with CIROAP and explore a replacement for the steering group to continue the linkage with CI.

h. Health Action International – Asia Pacific, HAI – AP

While Bala was not able to attend the continuing support of HAI – AP and its excellent work on the Drug policy issues, in which many PHM members in the region were involved, was noted with appreciation. A special issue of HAI journal (December 2003) on People's Health Movement was released at IHF – WSF.

6. Organizational Overview and Assessment

This was an important agenda item and various dimensions were discussed in response to agenda 6 and 10, but also came up in different ways during the discussion on most of the other points as well. The meeting was an opportunity to assess the organizational diagrams and guidelines that had been circulated at the pre – WHA May 2003 PHM meetings.

a. Steering Group:

The Steering Group was still incomplete because three regions – South Asia, China and West Africa did not still have elected / nominated representatives.

South Asia was in directly represented by Zafrullah, Qasem, Prem, Bala – who were in the steering group in other capacities but efforts to get PHM Sri Lanka, Bangladesh, Nepal, Pakistan (PHM Maldives and Bhutan had not yet evolved) to meet at some event and nominate a steering group member to represent the region was necessary.

China: David Legge, who travels to China on other duties had offered to help identify potential resource persons and PHA – I participants to evolve a PHM China. Other members who had contacts were requested to put them in touch with David.

West Africa: WGNRR had been requested to get their representative Elvira to be the contact person for the region. All the members who had other contacts in the region should put her in touch with them to evolve the regional circle and find more country representatives. Recently there have been enquiries to the secretariat from Sierra Leone and Ghana. The secretariat was following this up.

In South East Asia – Delen of Philippines would continue as the regional contact point till more country circles were evolved.

In the India Region – While Ekbal was already representing the region, the steering group suggested that a dialogue with PHM India would explore a role for Mira, who is also from the same region and had been asked to continue in the steering group, because of her contribution to PHA – I and the rational drug policy and other issues.

It was suggested that North Africa be separated from the Middle East as a separate region (Malachi).

b. Country Level Circles and Regional Lists of Countries:

Ravi mentioned that country level circles with country contact points were increasing (see the website for the latest position). The presence of so many of them at IHF – WSF was very heartening,

While regional representatives should continue to assist the secretariat in evolving country circles and finding country contact points, it was also reiterated that country circle contact points should increase their representativeness in the country by involving more networks, associations campaign groups, NGOs in the country circle.

There was a question whether Israel should be included in the Middle Eastern Region (Hani). It was felt that the inclusion of Israel in the present situation, when it was the cause of so much suffering to neighboring states, was not appropriate. The inclusion of one state may jeopardize the involvement of nearly 20 Arab states.

The regional representatives were requested to keep track of all the countries allotted to that region and work towards identifying contact / focal points in all of them. This list was included in the background file.

c. Inter regional efforts to spread PHM and build inter-regional efforts and initiatives:

Ravi highlighted 7 examples of inter-regional efforts and suggested that PHM would grow faster, if there were more of similar efforts.

- In East Africa, various PHM steering group members visited in a sort of relay to mobilize for PHM. Qasem (GK) and Maria (IPHC) visited Arusha for a WABA meeting in October 2002 when a PHM session was held. Later Ravi and Thelma from India visited Kempala, Nairobi, Dar0es Salam enroute to Arusha for the GFHR meeting in November 2002. At each of these places, there were PHM meetings bringing together NGOs and resource persons from networks and campaigns. This lead to the strengthening of the East Africa region and evolving circles in Kenya, Uganda and Tanzania.
- In USA, Zafrullah, Ravi and Thelma were invited as special invitees to an International Public Health Conference in Berkeley and then visited 10 cities and 8 universities to address PHM meetings. This led to the further development of PHM-USA.
- In Geneva, at the World Health Assembly, May 2003, 82 PHM members from 30 countries attended a PHM get together to share ideas and perspectives and attend the WHA to advocate for many concerns of the Charter. Over 67 members came on their own with local / regional support. It was a special Alma Ata anniversary year get-together but it greatly increased the credibility of PHM in WHO and the new DG designate had an informal dialogue with 6 PHM members.
- In Italy, AIFO has been the key promoter / mobiliser for PHM in Italy. AIFO gave the Raoul Follereau Award to PHM at its Biennial meeting in October 2004 and invited three representatives from Asia, Latin America and Africa to receive the award. There were opportunities to share about PHM concerns from the regions and build south-north and south-south solidarity.
- Global anti-war campaigns : The spontaneous response of PHM related groups to the anti-war campaigns and rallies all over the world and the focus on war and health as a PHM global concern was well done.
- The Global Health Forum has been taking note of PHM evolution and involving it in the annual forums.
    - In Forum 5, Geneva, (December 2002) the concerns of the Charter were presented [Ravi (India) and Zafrullah (Bangladesh)]
    - In Forum 6, Arusha, Tanzania (November 2002), there were research inputs in a PHM context by David (South Africa), Zafrullah (Bangladesh), Thelma and Ravi (India). Mwajuma (Tanzania) also attended.
    - In Forum 7, Geneva, (December 2003), there were inputs by David (South Africa) Maria (Nicaragua) and Ravi (India) and
    - In Forum 8 in Mexico (November 2004) David represents PHM on the organising committee and David and Ravi have been put on a Task Force to promote Health Systems Research which will report at the Mexico Ministerial Summit / Forum 8.
- In Germany, Zafar Mirza (Pakistan) and Thelma (India) did a lecture tour in November 2003 at the request of BUKO – Pharma Kampagne to promote PHM mobilization in many cities and with many groups in Germany.

d) Secretariat

- Ravi reported in brief the experiences of the secretariat over the last one year which included:
  - shift from GK-Savar to CHC-Bangalore over a transitional phase January – March 2003.
  - Decision to keep PHM secretariat separate from CHC the host – NGO in the Indian region – hence separate accommodation, telephone and team.
  - Ravi and Secretary (Srinidhi) being seconded full time from CHC to PHM Secretariat from January 2003 till December 2004 extendable as of now till March 2005 only.
  - The appointment of a full time communication officer – Prasanna with IT / management background who gradually took over the web site management from Nand (Costa Rica) in October 2003.

  The decision in GK – Savar (November 2003) to appoint a separate Technical officer (to help the full time coordinator of the Secretariat with day to day activities, planning and response to a large number of technical request that come to the Secretariat) was deferred due to non-availability of a specific suitable person. However this lacunae was filled by (1) support of CHC technical team and fellows (2) support by various members of the steering group to whom email referrals of such technical requests were made

- The efforts at decision making through email communication with steering group members. There were some difficulties with this and many unmet expectation from the Secretariat team since many steering group members just did not respond to the mail from the Secretariat, and many steering group members who did respond felt that the secretariat did not send the collated response (final decision) promptly. (see separate section (No. 14) on decision making and suggestions for improvement post IHF-WSF).

Was not as successful as hoped for.

e) Issue based circles

Secretariat Coordinator was requested to outline the issue based circles that had been initiated and comment on their functioning and development.

- The WHO-WHA circle (convenors – Ravi & Zafrullah)

  This was very active and especially since the presentation of the People's Charter for Health at WHA, May 2002 was beginning to upscale its advocacy, strategy with some useful results (see item 12 separate section on Dialogue with WHO). Due to Ravi's preoccupation with PHM secretariat he felt that Zafrullah needed to take more proactive role in WHA circle and others should support him as well.

- The Poverty and AIDS Circle

  This was set up after a dialogue with UNAIDS Peter Piot and team (Convenor : Dorothy Logie). However, this was not very active because it could not find a specific PHM point of action. However, now with the dialogue opportunities opening up with the WHO 3 x 5 initiative and the presence of the WHO 3 x 5 team and PHM related HIV-AIDS activists from many parts of the world at IHF-WSF (for the 5 special plenary and workshop) there was a new opportunity to revise the circle and give it a relevant and challenging focus.

- Wars, Disaster and Humanitarian circle (Convenors : Unni & Rocelle Bertell)

  This was a very active circle and had been regularly promoting / catalyzing PHM responses to various crisis – Palestine, Iraq war, etc.

- Research Circle (Convenor – David Sanders)

  While some efforts in communication to evolve focus and strategy for this circle had been initiated by David Sanders and PHM was getting involved in making inputs into GFHR and other research forums to provoke greater facilitation of health systems research and research on social determinants the process needs further strengthening

- Women's Health Circle (Convenor – WGNRR)

  This was convened by WGNRR and PHM was closely involved with all the campaigns of WGNRR as co-sponsor and active participant. The women's access to health campaign and other initiative of WGNRR had been actively supported.

  - Three circles have been formed (one continued from the past) and these need further clarity and framework which will evolve in 2004.

    - Politics of Health Circle (Maria – IPHC) : Its strategy has not yet been shared in the PHM circle with clarity.
    - Macro economics and Health – the role and contribution of Medact and Mike Rowsen in particular in the area of macro economics and concerns about CMH report is noted and this circle will be supported as it evolves further.
    - The Public-Private partnership Circle with Jose Utrera of Wemos as Convenor recognizes the continuous and ongoing involvement of wemos in their area and also the recent network of researchers exploring this topic which has facilitated.

  - Food and Nutrition Circle - at WHA – May 2003, Carmelita was invited by PHM to be the convenor of a Circle that collates PHM concerns on a range of Food and Nutrition issues including junk foods, sugar lobby, infant nutrition, the UNICEF and Macdonald partnership, etc., and work closely with IBFAN and APAN.
  - Communication Circle – An effort was made by the Communication Officer of the Secretariat in coordination with Andrew (Health Link) to evolve a communication strategy, starting with a background paper by Andrew and followed up by a strategy paper. It was primarily an effort to bring PHM five communication initiatives into an integrated strategy. (web site, newsletter, email/listserves, exchange and Charter translations/publications). (see item 13 for the details).

Some general points emerged from the overview presented by Ravi:

- When the Circles are responding to specific events or focused campaign issue, they seem to work well.
- When the circle evolves primarily as a study circle, it is not progressing well. Perhaps there is need to gear up to definitive outputs focused on specific events / initiatives related to the theme of the circle.
- Because of limited time and the various other demands on PHM members energy levels to work through issues based circles is limited.

Some interesting discussion about issue based circles and their strengths and weaknesses, lead to some interesting observations and questions.

- Many circles are cross cutting and need good evidence, research is crucially important for campaigns (David).
- Circles can be formed spontaneously; individuals with enthusiasm can make it happen; does not need to be endorsed but welcomed (Andy).
- Circles should not be launched with a single point person but a team of individuals. Also one of the role of circles is to find way of working with other networks and groups who are interested in the same issue (Sarah).
- Lots of groups are already working on these issues and therefore the challenge is to make contact and work with them around campaigns (Maria).
- Circles need research and analysis skills and also campaigning and advocacy skills. Therefore each circle must also recruit members with this sort of expertise (Prem).
- Circles should put out facts and figures and their plans of action from time to time; one page enough but this would greatly help PHM media team for advocacy (Unni).
- The Global Health Equity Watch report may be a good focus for all the circles to come together and work together (Patricia).
- There are issues that are important to regions and so issue based circles and regional circles need to link and respond to realities in the region (Jose).
- In response to Carmelita's question on relation between steering group and circles, Ravi clarified from the process paper that country circles group to form regions and regional focal points are members of steering group.
- Convenors of issue based circles are convenors of circles of PHM member drawn from different regions who are interested in the issue. These convenors are not formal members of the steering group but are included as members of the Secretariat support group because they support the Secretariat in evolving clarify of perspective and PHM responses to specific issue.
- Conveners of circles should use PHA – Exchange to brainstorm around focus of circle; identify potential members of circle, who respond through the exchange to these circle derived communications; and put out reflections and further communications from the circle. The website can also be designed to have a section for circle discussions (Ravi).

Circles need to be able to accommodate the complexities of members in the context of the quality of the work and need to generate a process that accommodates these complexities. Also since PHM is generating a density of activity plus linkages, we have to be clear how we are going to proceed (Andy).
Are we going round in circles (David Legge)? There is some confusion about the responsibilities and focus of the circles with some overlap. The needs to be clarified by conveners (Delen).

Issue based circles need both depth, wide reach and relevance. A circle may be required to study the issue of newer technologies and their impact on health, eg. Biotechnology, IT,. We need to study positive and negative impacts.

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f. Campaigns / Advocacy

Members shared some ideas about campaigns and issue of advocacy relevant to PHM, which should be considered by PHM in regions and supported by some of the issue circles.

- Having been present at WTO and WB meetings, there is need to use the health impact as the measures of effect of all these policies on farmer's livelihoods (Evelyne).
- There is need to write a position paper on the global fund for AIDS, Tuberculosis and Malaria and track its evolution and experience (Evelyne).
- There is need for a campaign strategy to promote comprehensive PHC in this growing world of vertical strategies and evidence based planning. PHM needs to define what is appropriate evidence based for PHC, then collect it through our regional and global networks and put it together as a global evidence base (Fran).
- There is need to study the APAN statement submitted to WHO in May 2003 and the analysis how the global strategy suggested by APAN facts into PHM framework. APAN is planning a Convention and PHM could place this statement in that convention and work with APAN during the next WHA – 2004 (Carmelita)
- There is need to debate on environment and ecological issues related to sustainable development
- There is need to look at the efforts of WTO on agriculture and how they affect farmer's livelihoods (David Legge). [A small sub-group consisting of David Legge, Sarah, Carmelita and Patricia decided to meet to discuss this issue and suggest further action by PHM].
- US is going towards bilateral strategies on trade with different countries. PHM should develop alliances at country, regional and global level to counter these ( )
- FCTC undergoing ratification. PHM should demand that their governments should sign and ratify and implement the framework. There will be a Western Pacific Regional Organization (WHO – WPRO) meeting soon about implementation (Carmelita). [Carmelita was endorsed as PHM representative at the meeting].
- For every campaign, there is need to share information about the issue; get commitment of people and groups to the campaign; and identify strategies at country level (Maria).
- For every campaign, there should be links between local work and international campaigns – this benefits the international campaign, but also helps the campaigns to be used locally to facilitate / mobilize and do strong local advocacy work (Hugo).

g. Links with other Networks and Movements:

One of the challenges for PHM regional and country level focal points and also the secretariat at global level is to link with other networks and movements to enhance collectivity and solidarity between movements and strengthen the health agenda in all the movements, networks, campaigns and struggles. PHM members are themselves linked to other network and movements. We need to manage these dual or multiple identities effectively. Basically we need to be able to distinguish between the PHM brand and the PHM badge with clarity. Some members gave specific suggestions

- In this process of networking, we need to function with a certain degree of self confidence eg., we are communicating and linking PHM to environmental networks nationally and globally because environmental concerns are a major section of the Charter and these groups were inadequately involved in national and international PHA. A movement by its very definition needs to engage with realities, with other partners and we don't need to wait for approval (Thelma). As we look to the future we need to be inclusive of new organizations (who were not founding members). In terms of bringing in other networks, we need to use the PHA video; share the Charter, give movement web site in meetings of

other networks and gradually link with them or link them with PHM (Mwajuma). The Global Health Watch report may be a good way of forming these new linkages in the next year (Patricia).

PHM India (JSA) has increasingly evolved linkages with networks (there are more than 18-20 already working together at national level and their counterparts at state level. In recent years PHM India is also linking with other national campaigns around food, water, TRIPS, tobacco and also involving these campaign groups in PHM India initiatives and campaigns. In some states, members of PHM India are also beginning to influence state health policies (Maharashtra, Rajasthan, Chattisgarh, Orissa, Karnataka) (Thelma).

A consensus from the discussion was then articulated by Andy, as steps towards linking with other networks:

- Follow your own judgement and using the PCH as a context;
- Mention PHM as you feel appropriate
- Be accountable for the way you use the PHM name or the Charter;
- Communicate the link established to the Secretariat and steering group.

b) Shift of the Secretariat

Ravi shared the fact that CHC had agreed to host the PHM Secretariat on behalf of the Indian region for 2 years, starting January 2003 till December 2004, extendable till the end of the financial year ie., March 2005. He and a Secretary had been seconded from CHC to PHM Secretariat for this period. The Communication Officer – Prasanna was also appointed for the same period.

If the Secretariat had to be shifted to another region early next year, then it was important to start the process of identifying the next region with potential to host the Secretariat.

The next region and the potential coordinator could then work closely with the Bangalore secretary so that the shift over would be planned and smooth.

A process of selection of the next secretariat could start by the preparation of a note on the secretariat and its responsibilities by Ravi, Prem, Jihed, Sarah and Lanny. This could then be circulated end March or early April so that different regions could review their own potential to host the Secretariat.

Ravi clarified that though the Bangalore secretariat had also recently taken over the web site from Nand (Costa Rica) because of the availability of Prasanna – the Communication Officer, who had an IT / Management background it was not necessary that the secretariat and website be managed by the same team in the future as well. If any region was willing to consider to take over the responsibility of the web site, this could be a separate process and a different regional responsibility not linked to the next secretariat.
(The web site was discussed further during the session on communications – see item 14).

It was suggested that if a region was chosen to host the secretariat , then someone from that region and the organization in the region which would actually be hosting the secretariat could spend a few weeks in Bangalore to learn the ropes from the present secretariat (Prem).

It was also emphasized that as was done during the shift of secretariat from Bangladsh to India – that a period of overlap was allowed with the outgoing coordinator and the incoming coordination being co-coordinaters for three months – a similar process would

be followed this time as well with Ravi (Bangalore) and the next coordinator (new region) overlapping for three months – around January – March 2005.

It was suggested that a secretariat could have a term of three years with ~~one~~ Mixed year overlap with the next secretariat (Atul).

If a secretariat was moved to a region and it was then found not to be able to cope with the new responsibility what could be done (Boodhun). It was noted that such a contingency need not occur in the next secretariat was identified carefully and systematically (Ravi).

Some organizational suggestions

While reviewing the evolving organizational structures and framework as outlined in the background papers circulated some ideas and suggestions were made by some of the members about the existing framework and organizational assumptions. These could not be discussed at length but are being listed out to ensure that they are kept in mind as the PHM organization experience evolved and needs review.

- There was need to prevent the movement from becoming too organised and evolving too detailed a framework of rules and regulations. This would bureaucratise and kill the spontaneous spirit of the movement. The movement should be issue based campaign oriented and functional capacity especially to emphasis health and social determinants at country and regional level is more important than definitive organizational structure (Ravi).
- Too many issue circles is dividing the group and the problem. We are in a way reproducing the fragmentation that we oppose and thereby creating a barrier. There should be a main frame policy that can guide discussions in individual groups and then a matrix of interconnected issues rather than circles. It is particularly important not to fragment the process and organization so much that we lead to a situation where we loose our capacity to be relevant (Armando).
- One of the assumptions made while designing the thematic circles were that there would be a coming together of these circles –however this did not seem to be happening even though we are all activist. Not only issues but regions should also link and work together. An area where this should be happening urgently is in the issue of privatization of health services. This is happening everywhere and there are negative impacts. We need to build common concerns and strategies over regions (Andy).
- While the issue circles were reaching out to people who are working on those areas it is important to emphasis that the circle connect all its members with PHM is linked to. Also if the circle activity could somehow be linked to a certain degree of activism or action then issue circles would succeed as an idea and a organic structure (Sarah).
- We have circles for regions and each has a specific function –a specific structure for specific needs. We must however integrate all these circles successfully(David Legge).
- While the Charter was clear, it was now necessary to evolve a small booklet describing all aspects of the evolving structures /framework of PHM for easy reference by country level contact persons or focal points (Malachi).
- The steering committee is absolutely serious and important and the way we organize ourselves should be based on what we want to do. It is actions that have vitality rather than merely statements and plans. This vitality groups from local grass roots action –so all PHM initiatives should ultimately support, promote and derive from grass roots action (Pam).
- PHM should be careful not to keep fishing in the same pond – among the already converted. Can the PHM get involved in universities and there we should involve young people in more depth (Julio).

PHM Evaluation

A PHA I / PHM evaluation process was started in mid 2002 to assess the impact of PHA-I on individuals who had attended the assembly and also to understand the process of post Assembly follow up in regions and countries in terms of processes, mobilization of circles; Charter translation and distribution; campaigns and PHM inputs into national, regional and international events.

An initial dialogue of the main emerging findings of the evaluation by a three member team lead by Andrew (Health link) was held in May 2003 in London just before the WHA May 2003 in Geneva. Unfortunately, due to unavoidable circumstances and constraints the PHM evaluation report has not yet become available for a wider circulation and debate. While the note on objectives and methodology of the evaluation was circulated as a background paper – the summary of findings could not be accessed so it was a missed opportunity.

Pam and Andy were requested to follow this up with Andrew at the earlier and facilitate prompt action which would greatly help the next project cycle. Ravi shared three findings from the May meeting

(a) that PHA had made a major impact on all those who attended it as an inspirational and energizing experience;
(b) only those who came representing networks / associations or campaign groups and hence had a constituency to share the concerns and perspectives of the Charter did some follow up work including distribution of Charter, publications and some campaign initiatives in their region.

c)

8. PHM Consolidated strategy and budget 2004-2006

a) A note discussed in London by a small representative funding group in 2003 was circulated to the steering group members. This included the following components of an evolving global strategy.

(A) Goal (B) Objectives / purpose (C) Measurable indicators (D) Means of verification (E) Important assumptions and (F) Specific objectives / initiatives (1. Building strategy for change; 2. Campaigns 3. Alternative People's Health Report (GHEW) 4. Advocacy for Change 5. Reaching the Unreached 6. Building the Movements (G) Funding : Principles and Strategies.

The group went through some parts of this note especially the earlier sections to enhance the collective endorsement of the overall objectives and aims of PHM and the key thrusts and initiatives in the next 2-3 years.
(see separate document).

b) However, Ravi shared that the London discussions were hampered by two important lacunae in the planning effort and hence the document could not be converted into a logical framework analysis to be sent to funding partners for the next phase.
   (i) There was no feedback or clarity about regional mobilization efforts of PHM; evolution of regional and country level strategies and initiatives and the expectations of support / coordination if any from the global secretariat.
   (ii) There was no clarity about the next People's Health Assembly and its financial requirements.

It was expected that the present steering group meeting would enhance the clarity of both these constituents of the PHM plan for 2004-2006.

Some idea of regional needs and requirement;
Some idea about PHA – II.
These would then be included in a revised plan of action and logical framework exercise that the funding / planning group of PHM would put together by April –May 2004.

c) The funding : from January 2003 –January 2004

Ravi and Andy gave a summary of the rather precarious (?innovative) approach of PHM Secretariat to the financial requirements / implications of current ongoing PHM initiatives, coordinated by the secretariat and supported through the fund raising efforts of OWA in UK ~~and Ravi from the Secretariat~~.

It was summarized as a two pronged process as of now.

i) Scrounging – the balance from PHA – I fund raising ~~efforts~~ (after all the travel grants and organizational costs had been met and the post PHA – II core group meeting held in Dhaka in November 2002) ~~has~~ been scrounged for some of the support to the ongoing initiatives of PHM including some of the secretariat costs.

ii) Friends and neighbours policy –networks and friendly associations / agencies that respect and trust PHM as an evolving movement have responded to the coordinators appeals and have provided small grants and contributions that have been used for specific initiatives. These have included:

- Christian Aid – 12500$ for PHM resource centre in GK;
- WCC -15000$ for PHM – WHA 2003
- WCC / AIFO – small grants to support PHM East Africa mobilization
- DHR – 15000$ to support PHM secretariat costs
- AIFO – 5000$ - Human rights award to PHM grant used for publications
- Hesperian Foundation – 15000$ grant from Ford Foundation to support secretariat / coordination related travel
- CHC – the PHM Secretariat hosting organizations in India has covered various office costs, capital equipment – computers and furniture and the rental advances, etc.

iii) For IHF-WSF – a special fund raising effort by the secretariat specially for IHF – WSF has lead to contribution from the following sources :

- Medico International – 5000$
- Action Aid, Bangkok – 5000$
- Cordaid, Netherlands – 12500$
- Misereor, Germany -2500$
- WHO Geneva via WR India -12000$
- Physicians for Smoke Free Campaign -~~10000$~~
- Contributions for CHC, CEHAT, SAMA, VHAI in India

While this 'hand to mouth' existence of PHM is very creditable for a movement in the sense there is no wasteful infrastructure development or central largesse that is distributed to regions thereby creating unnecessary centralized dependence, it is still probably not the best way to proceed.

A concerted effort has to be made in the next few months to ensure that a core grant to support the main plan of action of PHM for the next phase 2004-2005 is negotiated and

then supplemented by the sorts of small grants that have been tapped for specific initiatives and events in the last one year and listed above.

iii. Regional Funding or regional support

A greater clarity has to emerge in the PHM planning and strategy to balance the fund raising by the PHM secretariat supported by the PHM funding group for the secretariat and global initiatives and the fund raising efforts at the regional and country level to support local, national and regional initiatives. It is also imperative that regions which are better resourced need also to tap funding sources to help the secretariat raise resources for global initiatives and needs as well.

9. People's Health Assembly – II

- In May 2003 at the PHM Geneva get together, it was unanimously endorsed that the next People's Health Assembly – II would be held in July 2004 at Porto Alegre in Brazil. A four member core planning committee was constituted which include Maria (Nicaragua), Armando (Brazil), Amit (India) and Mwajuma (East Africa). The group met and prepared a brief outline of the framework of the next PHA-II which was then circulated for wider dialogue and consideration.
- In the months that followed, the Latin American PHM members met a couple of times and wrote to Armando (Brazil) encouraging him to send some sort of written commitment of the local hosting groups at Porto Alegre so that the decision could be finalized and endorsed. However, there was no follow up and over six months of planning time was lost.
- At the beginning of the steering group meeting in Mumbai, there were a few informal discussions between all the participants from the Americas region to sort out this matter since further delay in the decision would jeopardize the planning process further. There was some concern from other regions that the decision from a region should be consensual and the PHM steering group not be faced with the option of selecting from two potential venues from the same region.
- The decision about PHA-II was then finalized in two phases. In Phase I Hugo representing the Latin American region made the following points at the end of the first regional meeting:

  - The Latin American region would like to host the next People's Health Assembly;
  - The region had the capacity and experience to host the Assembly;
  - The Assembly would be hosted in July 2005;
  - He quoted a Latin American proverb –that it does not matter if there is storm, thunder or lightening –we will carry it out to emphasise the interest and the confident resolve of the group from the region to host this important event.

- A few days later, after the arrival of both Arluro and _____ from Ecuador, the proposal of the People's Health and a host of related movements to host the PHA II in Quito Ecuador was placed before the steering group and it was unanimously accepted. It was decided that Arturo Quizhpe would be the organizing committee and would be supported by an international advisory group that would represent different regions and help with all aspects of the planning. This group would be constituted soon –so that it could start the planning and through its regular deliberations it could start the PHA –II planning process.
- It was also decided that the next International Health Forum – IV which would be held next year in January 2005, when the WSF returns to Porto Alegre, Brazil,

Since there was no definite proposal from Porto Alegre, Brazil

would be an important complementary and pre PHA-II meeting. Armando, the organizing secretary of this Forum IV would be a member of the International Advisory Committee for PHA – II. The forum could focus on Health Policy changes that are necessary to increase the potential for Health for All, Now. The interesting examples and case studies from Brazilian experience could be highlighted at this forum and the Brazilian experience could be reflected upon by participants from other regions. Policy initiatives from other parts of the world could also be focused upon at the next forum eg., primary healthcare policy endorsements by Karnataka, Orissa state in India and South Australia region in Australia.

10. Regional Capacitation Process

A short paper by Prem about regional capacitation was circulated to all the members in the file of background papers. The paper emphasized that for increased capacity development in different regions and countries it was necessary not only to improve the collectivity and representativeness and effectivity of the existing steering group members and country level contacts but also identify the framework of a capacity building process that includes the identification of new, younger leadership and their sustenance and capacity building.

- One of the challenges for PHM was to build develop capacity in a region with little or no capacity. It was necessary to chose an area with such limited capacity and bring it up to some level (Maria).
- One of the concerns was that if existing capacity especially for networking, information sharing and communication was taken as a necessary criteria for a region to have the qualities to take over the secretariat than regions like Africa would be out of the contention for a long time - may be even up to 20 years before Africa can join the movement fully. Capacity building should be a two-way process. Visits from PHM resource persons from other African region were given a chance to move to other regions tolearn from local processes that would also be effective. Without this two-way process, Africa would be completely excluded. In some regions like in Africa communication was a big problem. More media is privatized so paying for a spot on TV was very costly (Mary Sandasis).
- It was suggested that the next secretariat be chosen based on the potential to build capacity rather than the presence of actual capacity (Budget).
- If we needed to grow as a movement then we need to consider the possibility of setting up regional offices or secretariats. This will especially address the needs of other languages (eg., Spanish speaking regions (Armando),
- It was felt that regional offices may actually become the foci of capacity building towards hosting the secretariat in the future (Malachi).
- It was necessary to build capacity in a region by a definitive focus on Human rights and health. This could be done in two ways :

    1. as a distance education programme (being evolved)
    2. as a part of capacity building programme especially of younger recruits and leadership (Armando).

The most important capacity we should be building at regional and country level is to promote the people's Charter and to build a movement by converting the Charter into action and campaigns. Promoting a movement; facilitating a circle-country focused or issue focused; and hosting a secretariat are three very different things and need different capacities. However, the most important capacity to be built is to support

movement. While doing s, one must emphasise that it is not making new members or inviting people to join but recognizing those who are already doing the actions / campaigns (that we feel need to be done) as partners and linking them to PHM. All the individuals who are interested must also finally get linked to organizations and movement to be more productive, sustainable (Ravi).

11. Global Health Equity Watch Report

A background note about a Global Health Equity Watch had been circulated to all the participants. Patricia, a full time worker on the project with Medact gave a short summary of the initiative and sought PHM steering group endorsement. The initiative had been given the general okay by PHM at the May 2003 meting in Geneva.

- The People's Health Movement together with Medact and the Global Equity Gauge Alliance (GEGA) was proposing the development of an annual Global Health report to be known as Global Health Equity Watch (GHW).
- The report would be different from other annual health and development reports for the following reasons:

  - Equity and not poverty at the center of analysis
  - Providing an inclusive platform for civil society
  - Providing a platform for amplifying the 'voices of the unheard'
  - Promote the PHC approach
  - Place health and health inequities within a broader political-economic perspective and a multisectoral perspective
  - Link research and analysis to advocacy.

  While the report will primarily be an analytic and evidence based document it will be coupled with descriptive elements of realities on the ground (case studies and testimonies) and on a sound justification of normative principles and values described above.

- Approximate size of the report : 150000 words.
- An initial structure and chapter headings of the proposed report was also circulated for comments.

After the presentation, the following decisions were made:

1. PHM steering group endorsed the idea of the GHEW report;
2. PHM will be a major contributor and the core of the effort working closely with GEGA and Medact as part of an advisory technical committee;
3. we will raise part of the support for the initiative by adding our contribution into our annual budget;
4. ~~the Secretariat (RN)~~ will be the PHM ~~focal point~~ principle for the initiative working closely with the secretariat to be hosted by Medact.
5. PHM will particularly focus on case studies, testimonies of action; voices of the unheard; and regional perspective;
6. David and Abhay will represent PHM in the discussions till a clearer framework of organization and responsibilities emerges.
7. A meeting in March 2004 of all the stakeholders will evolve a framework for action.

Ravi Narayan
No PHM Secretariat coordinator

12. Advocacy and Dialogue with WHO

An overview of the history and process of advocacy and dialogue of PHM and WHO was provided by Ravi, who had been convenor of the WHO-WHA circle since 2002. These included in chronology:

- PH Assembly disappointment at Dr. Gro's absence from PHA in spite of invitation and liaison about dates (also UNICEF absence considering WHO/UNICEF were co-facilitators of Alma Ata conference.
- Record of this missing WHO in the PHA report and its interpretation as lack of interest in people's health;
- Specific exhortations to WHO incorporated in the Charter;
- The NCD division of WHO inviting Ravi to present the Charter in a research seminar in April 2001.
- Three in-house lunch time seminars by Ravi at WHO-HQ on PHA and Charter. Distribution of Charter to all staff.
- PHM invited to WHA – May 2001 and interview with DG of six members who represented PHM. DG referred to PHM is report and also announced the WHO – Civil Society initiative. PHM made representations to WHO-CSI.
- Presentation of the Charter by Ravi and Zafrullah at the GFHR Forum 5 in Geneva in November 2001. Demand that Charter be presented at WHA.
- PHM invited to present Charter at WHA – May 2002 as a Technical session. Ravi and Zafrullah present Charter and Maria, Mwajuma and Ellen present evolution of movement in Latin America, Africa and Europe. PHM represented by 32 delegates. Intensive advocacy and media strategy. DG attends session chaired by Filipino Health Secretary but does not make any commitments to further dialogue.
- In the 2003 elections for new DG – PHM plays active part in efforts to make the elections more transparent and participates in debate / dialogue with DG candidates.
- In may 2003 at WHA, 82 participants from 30 countries attend WHA (Alma Ata Anniversary year) and support PHM statement on PHC; support statement of TRIPS with Oxfam, MSFS, etc; support statement on NGO civil society etc., advocacy and lobbying with delegates aster advocacy training by Andrew and Carmelita for all PHM delegates. Beginnings of an effective presence though more quantitative rather than qualitative.
- The new DG designate Dr. Lee meets a small representative PHM delegation and listens to concerns and initiatives including Million signature campaign. Requests PHM to keep WHO aware of the marginalized.
- The informal dialogue with WHO during the present administration has continued and PHM has been invited to engage with WHO on WTO / GATS; the HIV-AIDS 3 by 5 initiative; the reiteration of primary health care; and the dialogue on the recommendations and follow up of the commission on Macroeconomics and Health. While many members welcomed these developments, There was a general concerns that we should b e cautious in our expectations and watch the process carefully looking for policy / strategy change not only public statements and pronouncements and also there was need to track unhealthy trends and organize advocacy strategies to counter them. eg.
  - consultants who spoke out against WTO were facing a lot of pressure and found their consultancies being cancelled (Mira);
  - business and private enterprises (for profit) were being put under the same categorization as NGOs and this was totally unacceptable (Maria);
  - some developments in WHO were not very comforting eg., infant feeding was being merely reduced to an area of information provision and not any more a technical area (Pam);

- the deplorable stake of people's health was partly due to the recent policies of WHO. We need to keep this in perspective –it is therefore people who will bring about this changes by putting pressure on the system from below and not or never the WHO (Prem);
- since WHO is sending a team to IHF-WSF and we have a special session with WHO team –it is at that session that we need to get clarity about WHO's role (Maria);
- GATS and TRIPS were issues that were bridging sectors but the main game was Agriculture. There is need to push the dialogue to include the smallest farmers who were the real losers (David Lege);
- Also there was a continuous struggle within WHO and within international health initiatives to continue legitimizing the neo liberal economic policies and the need to counter them through effective delegitimising strategies – in these battles between legitimizing and delegitimisation –we must not forget the real problems of the people (David Legge);
- Whatever the changes made by the DG at HQ level the impact would be measurable only if there was a shift of policy at regional and country level (Barzgar);
- While there were nice words at the HQ/DG level there is need to monitor the changes in actual functioning / programmes. How do these changes translate into action at region and country level and at field level. Unless there are changes at field / lower levels policies made at higher levels is not enough (Jihad);
- A check list should be prepared to measure WHO's commitment to the concerns of the Charter at global and regional levels (Fran)
- Keeping these caution in mind the process of dialogue should be seen as a strategic opportunity and the dialogue should continue and be particularly focused on a few thrust areas:
    - to remind / pressurize WHO of the principles of primary health care and to re-endorse it as policy;
    - to pressurize /advocate WHO to shift to a health systems strengthening approach rather than selective marketing of magical bullets through vertical approaches;
    - to dialogue with WHO to keep civil society / not for profit NGOs distinct from private sector and corporate sector;
    - to dialogue on 3 by 5 initiative for HIV/AIDS but strengthen the primary health care dimensions and the health systems strengthening strategies.
    - To continue to share PHMs concerns on Macro economics and Health, various global funds and top down international initiatives and advocate for another Counter Commission on Social Determinants of Health

Dialogue in PAHO region

- The continuing PHM dialogue with PAHO was outlined by Maria. The main context were:
- PAHO is a much older organization than WHO and in this region the new chief of the region Dra Mirta Roses was elected over a WS supported neo liberal candidate.
    - PHM was invited by Dra Mirta Roses to make a critique of the PHC report;
    - PHM (Maria) was invited by PAHO to attend a ministerial meeting as a motivational speaker and she particularly highlighted the role of WTO / trade issues in health;
    - Along with governments; civil society organizations and private sector they (PHM & PAHO) were planning a PHC conference in Guatemala.
    - The situation in PAHO was strategic and PHM should support the DG to make the region more relevant for primary health care development.

(not completed. Section B Follows)

Draft as on 19.04.2003

Report of PHM Steering / Support group meeting held at YMCA International House, Mumbai on 12th, 13th and 16th January and two additional extended sessions on 18th and 19th January at WSF Venue (Solidarity tent) and Hotel Columbus respectively.

Preamble:

The Third International Health Forum in the Defense of People's Health was organized by the Global Secretariat of PHM and PHM India on 14th and 15th January at the International House, YMCA Mumbai, preceding the World Social Forum from 16th to 21st January also at Mumbai.

Due to unavoidable constraints, the annual PHM Steering group, usually scheduled in November each year by tradition, was postponed and linked to the Mumbai event. The annual PHM Steering group, therefore, was organized on 12th and 13th of January 2004at the International YMCA.

Due to the unprecedented nature of participation at IHF / WSF, we not only had a near complete steering group presence ( ), but we also had many members from all over the world, who support the secretariat in separate functions as volunteers () and many country contact points as well ().

The first two days, 12th and 13th, therefore, was a steering / support group and all those in these different categories, other than steering group, were also invited to attend the discussions in a spirit of transparency as observers / participants.

On 16th, 18th and 19th January, some extended sessions were held to make decisions and evolve a plan for the next year. These meetings were attended primarily by steering group members.

An agenda was sent out in advance of the meetings and a programme overview from 12th – 16th January, was also circulated in which all the steering group agenda points were allotted specific time slots on 12th and 13th January. However, due to delayed arrival of some of the steering group members, sessions were interchanged and some extended sessions were held to increase the participatory nature of the steering / planning exercise and the group also addressed some new issues that were brought up during the discussion.

The whole process was very interactive and participatory and the enclosed report written in the order of the original agenda tries to capture the main issues and decisions that were taken.

Since the compilation of the minutes / report took a while, the secretariat team is also appending a follow up report that tracks all the action that has been taken. Overall, the meeting proved to be a great 'battery charger' and 'energizer' and the enthusiasm with which the PHM steering group / support group and country contacts have followed up on

their commitments has been most heartening. The PHM is definitely come to stay and evolving in enthusiasm content and impact. [However, the evolution / mobilization of PHM continues to show great regional variation and diversity. One of the biggest challenges for PHM is to ensure that all regions / networks / countries are well represented in the evolving initiatives and this puts special responsibilities on all those who represent those regions that are lagging behind to make an extra effort to evolve regional and country circles and initiatives and process in their region as we gear up for the next People's Health Assembly in July 2005 in Ecuador.

MEMBERS PRESENT

The participants have been classified into functional groups.

Steering Group:

a. **Network Representatives**:

Maria Hamlin Zuniga – Nicaragua (IPHC); Zafrullah Chowdhury, Bangladesh (GK); Prem John, India (ACHAN); Carmelita Canila, Philippines (CI); Evelyne Hong, Malaysia (TWN); Nadia Van der Linde, Netherlands (WGNRR); Olle Nordberg , Sweden (DHF). [Dr. Bala of HAI – AP could not attend)

b. **Regional Representatives:**

Pam Zinkin (Europe); Sarah Shannon, Hesperian Foundation, USA and Lanny Smith, Doctors for Global Health, USA – (North America); Hugo Icu Peren, Guatemala (Central America and Caribbean); Arturo Quizhpe, Ecuador (South America); David Sanders / Bridget Lloyd , South Africa (Southern Africa); Mwajuma S. Masaiganah, Tanzania (East and Central Africa); Fran Baum, Australia (Pacific Australia and New Zealand); B. Ekbal / Mira Shiva (India); Edelina de la Paz, Philippines (South East Asia); Jihad Mashal, Palestine (Middle East and North Africa). [South Asia, China and West Africa did not have elected regional representatives)

c. **Coordinators:**

Qasem Chowdhury, GK – Bangladesh (Past coordinator); Ravi Narayan, India (Present Coordinator)

d. **Support Group**

Andy Rutherford, One World Action – UK (Funding); Unnikrishnan, India (Media); Armando De Negre, Brazil (IHF – WSF); Jose Utrera, Netherland (Public Private Partnership circle); S.S. Prasanna (Website and Communication); Rebecca Zuniga (Translations); Patricia Morton, (GHW)

c. Country Focal Points / Contacts

David Legge (Australia); Julio Monsalvo (Argentina); A.H.M. Nouman (Bangladesh); Atul Kapoor (Canada); Hani Serag (Egypt); Malachi Orondo (Kenya); Mohd. Ali Barzgar (Iran); Mary Sandasi (Zimbabwe); Jagadish Goburdhun and R.K. Boodhun (Mauritius); Ayyaz Gul (Pakistan for Zafar Mirza); Niranjan Udugamalagala (Sri Lanka for Vinya Ariyaratne); Ghassan Issa (Lebanon)

f. Others

Fatemah Afzali, Pedram Rashidi and Rezvan Moghadam (Iran); Alla Shakrollah (Egypt); Bert de Belder (Belgium); Thelma Narayan, JSA – (India)

For the purpose of easy readability, the report will be divided into three sections – (a) PHM Global agenda; (b) PHM Regional agenda and the latter will focus on reports from regions and plans of action emerging at region; (c) Follow up in the phase February – April 2004 and schedule of events.

Proceedings / Minutes

A. PHM Global Agenda

1 & 2. Introduction and Finalization of Agenda

The meeting on 12th January started at 11.00am with a round of introductions and a review of the agenda and programme overview that had been circulated in the file of documents that was given to all participants. The agenda was accepted without any major changes with the proviso that since some of the participants were coming later on the 12th or after – their presentations will be postponed and accommodated in the programme, whenever feasible.

On a query from Sarah, it was decided to take up reports on campaign in regional reports or regional capacitation and on the suggestion of Armando, it was decided to introduce a short input into the inaugural session of the Forum on 14th morning, highlighting the earlier health fora and the link with WSF. Ravi suggested that sub-groups of the PHM members present, should meet in regional groupings to discuss regional level issues and campaigns, because PHM would be stronger only if all the regions became stronger and evolved their own activities, framework and initiatives responding to local needs and challenges. The morning of 16th was one possibility for such a meeting.

3. Reports from Regions and Countries (See section B for further details)

Since, some of the reports from the regions were circulated only some of the main issues and points will be highlighted in a separate document and linked to the regional plans that were discussed during various smaller region group meetings during IHF – WSF.

4. **International Health Forum / World Social Forum**

a. Amit, Joint Convener of PHM India (Jana Swasthya Abhiyan) and member of the organizing committee of the WSF, gave an overview of the framework of WSF – IV, the background planning and challenges; the major differences in situation / focus from previous WSF and the framework of plenaries, seminars, workshops and street events. The four important PHM related panels and seminars on 17th and 18th January and the other 8 health related events at the World Social Forum were also highlighted.

b. Ravi gave an overview of the programme for IHF, which included six plenaries and the 14 workshops (see programme booklet circulated at IHF – WSF or updated programme on PHM website).
This had evolved in an interactive, participatory way with suggestions from the regions and members of the international organizing support committee. The suggestions from Latin America, Africa and Middle East and Philippines were particularly useful.

c. All the PHM resource persons present at the meeting were requested to take note of the sessions and roles, which they had been allotted and to participate actively in the next few days to make these sessions / workshops

d. Thanks to the enthusiastic follow up by Prem and others from many regions, these voices and testimonies (over 20 of them) were strong at IHF and mainly action oriented.

e. Two challenges for IHF sessions were identified: (a) To move beyond problem / situation analysis to highlight examples of proactive action at various levels, (b) to identify the key concerns and suggestions from each event to feed into a Mumbai Declaration – a document that would be a definitive output of IHF – WSF and a supplement (as well as 2004 update) on the People's Charter for Health and its concerns. (see separate report of IHF – WSF and Mumbai Declaration on the website)

5. Reports from Networks

While various members reported from regions and country circles (see section B), the eight founding / supportive networks that helped to organize the People's Health Assembly and have continued to support the evolving PHM, also reported their main activities and thrust areas.

a. ***Third World Network (Evelyne)***

The main contribution of TWN was in spreading the word about PHA and the People's Charter and in focusing on issues relevant to PHM / PCH in TWN publications, especially Resurgence.

A special Alma Ata 25th anniversary feature was included in the July / August 2003 issue. It included the reflections of David Werner, Debabar Banerji and David Sanders; the People's Charter for Health and the statement on Primary Health Care made by PHM at World Health Assembly, May 2003

b. Women's Global Network for Reproductive Rights (Nadia)

The main campaign was the Women's Access to Health Campaigns, in which PHM was an international collaborator and also many PHM resource persons and articles were involved at different levels, including the Advisory Group set up in August 2003. Copies of the Charter were distributed at all meetings of WGNRR at all levels. This year, the May 28th, campaign will focus on **Health for All – Health for Women: What do Health sector Reforms have to do with it** and she requested PHM to join in a big way. In 2003, the focus of the campaign was to make governments take more responsibility for reproductive rights as well as Primary Health Care. This year, the focus was on Health Sector Reforms and how it improved or enhanced access.

WGNRR also supported actively the Million Signature Campaign and other Alma Ata Anniversary Campaign and was also a co-sponsor of the PHM publication, "Health for All Now – Revive Alma Ata". In October 2003, it organized an Alma Ata Anniversary, Reception in Netherlands. Due to the impact of conservative right wing governments, which aimed to privatize health care disregarding women's rights and access to contraceptives and services. WGNRR has become more proactive in Netherlands and also support the European Social Forum 2003 process.

c. International People's Health Council (Maria)

IPHC has been very actively involved in the organizational work related to PHA – I and to the formation of PHM at international levels as well as the regional promotion of PHM. IPHC has represented PHM actively at national and international events and activities and will continue to do so. IPHC's principle contribution to PHM is its concerns, analysis and perspectives on the "Politics of Health" and its commitment (based on involvement of some of its members with Primary Health Care programmes based in communities) to the Health for All and Primary Health Care goals, reconfirmed in the People's Charter. Recently IPHC has undergone an external evaluation and will soon be evolving the future development of IPHC as response to this evaluation and to the perception of its members of the future directions, which should be taken by IPHC. It looks forward to continue to participate actively in the development of PHM in the future.

d. Dag Hammarskjold Foundation - DHF (Olle)

DHF had supported the evolution of PHA particularly in the context of strategy and finances. It had also supported the evaluation of PHA – the evolving PHM and I. DHF was presently bringing out a report titled What Next?, which was a sequel to the earlier report, What Now? – brought out in 1995, which looked at alternative development ideas. The new report would focus on action and strategy in the current global situation.

DHF was also involved with processes to evaluate new technologies in terms of social and environmental implications and the Challenge of access by all. Both these initiatives were of relevance to PHM. A special issue of Development Dialogue – the DHF journal was also being planned in which some of the earlier background papers (perhaps updated) and the report on the evolving movement and strategy by Ravi and the evaluation findings by Andrew would also be featured.

e. Asian Community Health Network – ACHAN (Prem)

Efforts were being made gradually to use the already extensive network of ACHAN members to strengthen PHM in various countries of the Asian region. ACHAN – Sri Lanka had been revived (the main focus of the members was on promotion of Primary Health Care), similar efforts were being planned for Cambodia, Thailand, Indonesia and other countries with very limited resources and other constraints

f. Gonoshasthya Kendra – GK (Qasem)

GK has continued as a PHM resource center even after the secretariat moved to Bangalore. Its main functions are to continue to publish the newsletter and reprint old publications and new ones whenever necessary. The center continues to get lots of Charter endorsements, which are being forwarded regularly to the new secretariat for follow up action. It has also been supporting actively the autonomous development of PHM in Bangladesh at the national and regional levels.

g. Consumer International – ROAP (Carmelita)

CI had been supporting PHM through Carmelita, whose presence for advocacy training and action at the WHA – May 2003 was particularly valuable. She had also agreed then to be a Convener of the Food and Nutrition Circle, which would focus on a range of issue – junk foods, sugar lobby and work closely as PHM representative linked to UBFAN, APAN and other networks.

Recently, since she is no longer with CI, the secretariat will follow up with CIROAP and explore a replacement for the steering group to continue the linkage with CI.

h. Health Action International – Asia Pacific, HAI – AP (Bala)

While Bala was not able to attend the continuing support of HAI – AP and its excellent work on the Drug policy issues, in which many PHM members in the region were involved, was noted with appreciation. A special issue of HAI journal (December 2003) on People's Health Movement was released at IHF – WSF.

6. Organizational Overview and Assessment

This was an important agenda item and various dimensions were discussed in response to agenda 6 and 10, but also came up in different ways during the discussion on most of the other points as well. The meeting was an opportunity to assess the organizational diagrams and guidelines that had been circulated at the pre – WHA May 2003 PHM meetings.

a. Steering Group:

The Steering Group was still incomplete because three regions – South Asia, China and West Africa did not still have elected / nominated representatives.

South Asia was in directly represented by Zafrullah, Qasem, Prem, Bala – who were in the steering group in other capacities but efforts to get PHM Sri Lanka, Bangladesh, Nepal, Pakistan (PHM Maldives and Bhutan had not yet evolved) to meet at some event and nominate a steering group member to represent the region was necessary.

China: David Legge, who travels to China on other duties had offered to help identify potential resource persons and PHA – I participants to evolve a PHM China. Other members who had contacts were requested to put them in touch with David.

West Africa: WGNRR had been requested to get their representative Elvira to be the contact person for the region. All the members who had other contacts in the region should put her in touch with them to evolve the regional circle and find more country representatives. Recently there had been enquire to the secretariat from Sierra Leone and ----------. The secretariat was following this up.

In South East Asia – Delen of Philippines would continue as the regional contact point till more country circles were evolved.

In the India Region – While Ekbal was already representing the region, the steering group suggested that a dialogue with PHM India would explore a role for Mira, who is also from the same region and had been asked to continue in the steering group, because of her contribution to PHA – I and the rational drug policy and other issues.

It was suggested that North Africa be separated from the Middle East as a separate region (Malachi).

b. Country Level Circles and Regional Lists of Countries:

Ravi mentioned that country level circles with country contact points were increasing (see the website for the latest position). The presence of so many of them at IHF – WSF was very heartening,

While regional representatives should continue to assist the secretariat in evolving country circles and finding country contact points, it was also reiterated that

country circle contact points should increase their representativness in the country by involving more networks, associations campaign groups, NGOs in the country circle.

There was a question whether Israel should be included in the Middle Eastern Region (Hani). It was felt that the inclusion of Israel in the present situation, when it was the cause of so much suffering to neighboring states, was not appropriate. The inclusion of one state may jeopardize the involvement of nearly 20 Arab states.

c. Inter regional efforts to spread PHM and build inter-regional efforts and initiatives:

Ravi highlighted 7 examples of inter-regional efforts and suggested that PHM would grow faster, if there were more of similar efforts.

In the East Africa, various PHM Steering group members visited in a sort of relay to mobilize for PHM. Qasem (GK) and Maria (IPHC) visited Arusha for a WABa meeting in October 2002, when a PHM session was held. Later Ravi and Thelma from India visited Kampala, Nairobi, Dar-es-Salam, enroute to Arusha for the GFHR meeting in November 2002. At each of these places, there were PHM meetings bringing together NGOs and resource persons from networks and campaigns. This lead to the strengthening of the East Africa region and evolving circles in Kenya, Uganda and Tanzania.

Zafrullah, Ravi and Thelma visited USA as special invitees to an International Public Health conference in Berkeley and then visited 10 cities and 8 universities to address PHM meetings. This led to the further development of PHM – USA

At the World Health Assembly – May 2003, 82 PHM members from 30 countries attended a PHM get together to share ideas and perspectives and attend the WHA to advocate for many concerns of the Charter. Over 67 members cam on their own with local / regional support. It was a special Alma Ata Anniversary year get together, but it greatly increased the credibility of PHM in WHO and the new DG designate had an informal dialogue with 6 PHM members.

The AIFO (Italy) has been the key promoter / mobilizer for PHM in Italy at its Bi-annual meeting

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- The AIFO (Italy) has been the key promoter / mobiliser for PHM in Italy. AIFO gave the Raoul Follereau Award to PHM at its Biennial meeting in October 2004 and invited three representatives from Asia, Latin America and Africa to receive the award. There were opportunities to share about PHM concerns from the regions and build south-north and south-south solidarity.
- The spontaneous response of PHM related groups to the anti-war campaigns and rallies all over the world and the focus on war and health as a PHM global concern was well done.
- The Global Health Forum has been taking note of PHM evolution and the concerns of the Charter was presented [Ravi (India) and Zafrullah (Bangladesh)] in GFHR Forum 6, Arusha, Tanzania – November 2002, there were research inputs in a PHM context by David (South Africa), Zafrullah (Bangladesh), Thelma and Ravi (India). In Forum 7, Geneva, December 2003, there were inputs by David (South Africa) Maria (Nicaragua) and Ravi (India) and in GFHR – Forum 8 in Mexico, David represents PHM on the organising committee and David and Ravi have been put on a Task Force to promote Health Systems Research at the Mexico Summit in November 2004 (GFHR Forum 8).
- Zafar Mirza (Pakistan) and Thelma (India) did a lecture tour in Germany in November 2003 at the request of BUKO – Pharma Kampagne to promote PHM mobilization in Germany in many cities and with many groups.

d) Secretariat

- Ravi reprted in brief the experiences of the secretariat over the last one year which included:
    - shift from GK-Savar to CHC-Bangalore over a transitional phase January – March 2003.
    - Decision to keep PHM secretariat separate from CHC the host – NGO in the Indian region – hence separate accommodation, telephone and team.
    - Ravi and Secretary (Srinidhi) being seconded full time from CHC to PHM Secretariat from January 2003 till December 2004 extendable as of now till March 2005 only.

- The appointment of a full time communication officer – Prasanna with IT / management background who gradually took over the web site management from Nand (Costa Rica) in October 2003.

The decision in GK – Savar (November 2003) to appoint a separate Technical officer (to help the full time coordinator of the Secretariat with day to day activities, planning and response to a large number of technical request that come to the Secretariat) was deferred due to non-availability of a specific suitable person. However this lacunae was filled by (1) support of CHC technical team and fellows (2) support by various members of the steering group to email referrals of such technical requests.

- The efforts at decision making through email communication with steering group members. There were some difficulties with this and many unmet expectation from the Secretariat team since many steering group members just did not respond to the mail from the Secretariat, and many steering group members who did respond felt that the secretariat did not send the collated response (final decision) promptly. (see separate section on decision making and suggestions fro improvement post IHF-WSF).

e) Issue based circles

- Ravi was requested to outline the issue based circles that had been initiated and comment on their functioning and development.
- The WHO-WHA circle (convenors – Ravi & Zafrullah)

This was very active and especially since the presentation of the People's Charter for Health at WHA, May 2002 was beginning to upscale its advocacy, strategy with some useful results (see item 12 separate section on Dialogue with WHO). Due to Ravi's preoccupation with PHM secretariat he felt that Zafrullah needed to take more proactive role in WHA circle and others should support him as well.

- The Poverty and AIDS Ciecle

This was set up after a dialogue with UNAIDS Peter Piot and team (Convenor : Dorothy Logie). However, this was not very active because it could not find a specific PHM point of action. However, now with the dialogue opportunities opening up with the WHO 3 x 5 initiative and the presence of the WHO 3 x 5 team and PHM related HIV-AIDS activists from many parts of the world at IHF-WSF (for the 5 special plenary and workshop) there was a new opportunity to revise the circle and give it a relevant and challenging focus.

- War and Disaster circle (Convenors : Unni & Rosclie Bertell)
This was a very active circle and had been regularly promoting / catalyzing PHM responses to various crisis – Palestine, Iraq war, etc.

Section 5

- Research Circle (Convenor – David Sanders)

  While some efforts in communication to evolve focus and strategy for this circle had been initiated by David Sanders and PHM was getting involved in making inputs into GFHR and other research forums to provoke greater facilitation of health systems research and research on social determinants the process needs further strengthen.

- Women's Health Circle

  This was convened by WGNRR and PHM was closely involved with all the campaigns of WGNRR as co-sponsor and active participant. The women's access to health campaign and other initiative of WGNRR had been actively supported.
- Three circles have been formed (one continued from the past) and these need further clarity and framework which will evolve in 2004.

  - Politics of Health Circle (Maria – IPHC) : Its strategy has not yet been shared in the PHM circle with clarity.
  - Macro economics and Health – the role and contribution of Medact and Mike Rowsen in particular in the area of macro economics and concerns about CMH report is noted and this circle will be supported as it evolves further.
  - The Public-Private partnership Circle with Jose Utrera of Wemos as Convenor recognizes the continuous and ongoing involvement of wemos in their area and also the recent network of researchers exploring this topic which has facilitated.

- Food and Nutrition Circle - at WHA – May 2003, Carmelita was invited by PHM to be the convenor of a Circle that collates PHM concerns on a range of Food and Nutrition issues including junk foods, sugar lobby, infant nutrition, the UNICEF and Macdonald partnership, etc., and work closely with IBFAN and APAN.
- Communication Circle – An effort was made by the Secretariat in coordination with Andrew (Health Link) who circulated a paper _____. While this was sent to steering group, it was primarily an effort to bring all those supporting communication efforts of CHC into one interactive circle (see item 14 for further details).

Some general points emerged from the overview presented by Ravi:

- When the Circles are responding to specific events or focused campaign issue, they seem to work well.
- When the circle evolves primarily as a study circle, it is not progressing well. Perhaps there is need to gear up to definitive outputs focused on specific events / initiatives related to the theme of the circle.
- Because of limited time and the various other demands on PHM members energy levels to work through issues based circles is limited.

Secrun 5

Some interesting discussion about issue based circles and their strengths and weaknesses, lead to some interesting observations and questions.

- Many circles are cross cutting and need good evidence, research is crucially important for campaigns (David).
- Circles can be formed spontaneously; individuals with enthusiasm can make it happen; does not need to be endorsed but welcomed (Andy).
- Circles should not be launched with a single point person but a team of individuals. Also one of the role of circles is to find way of working with other networks and groups who are interested in the same issue (Sarah).
- Lots of groups are already working on these issues and therefore the challenge is to make contact and work with them around campaigns (Maria).
- Circles need research and analysis skills and also campaigning and advocacy skills. Therefore each circle must also recruit members with this sort of expertise (Prem).
- Circles should put out facts and figures and their plans of action from time to time; one page enough but this would greatly help PHM media team for advocacy (Unni).
- The Global Health Equity Watch report may be a good focus for all the circles to come together and work together (Patricia).
- There are issues that are important to regions and so issue based circles and regional circles need to link and respond to realities in the region (Jose).
- In response to Carmelita's question on relation between steering group and circles, Ravi clarified from the process paper that country circles group to form regions and regional focal points are members of steering group.
- Convenors of issue based circles are convenors of circles of PHM member drawn from different regions who are interested in the issue. These convenors are not formal members of the steering group but are included as members of the Secretariat support group because they support the Secretariat in evolving clarify of perspective and PHM responses to specific issue.

PROCEEDINGS / MINUTES OF THE STEERING / SUPPORT GROUP MEETING – MUMBAI, JANUARY 2004

SECTION B : REPORTS FROM THE REGIONS AND THE REGIONAL INITIATIVES

13. Report from the Regions

All regional focal points and many of the country focal points reported about issues and initiatives from the regional and country contexts. Some had circulated actual reports, which will be available on the website. In this section, we just list out the key points made to give an overview of the regional challenges of PHM.

AMERICAS

Maria - Latin America

- The problem of many languages was mentioned.
- The most important problem that was recognised is health and trade. Four governments of Latin America had signed a free trade agreement with USA. It was important to highlight to the people that the governments were in the pockets of Bush. The only way out it seemed was if the proposal was defeated in the US congress.
- There were gaps in the report due to the lack of a good communication system in the region.
- The long history of militancy and revolutionary struggle in the region had a lot to teach the PHM – especially in the field of participatory decision-making.

Lanny – U.S.A.

- Agreed and endorsed what maria said.
- Noted that the PHA exchange was always in English. Some of the experiences of the militant groups in Spanish could not be exchanged with the English reading world and vice-versa.
- The problem was with the server, which was donated to them and had the condition that they would carry things only in English. However now the PHM website had Spanish material and pages (Maria).

Armando – Brazil

- In 2002 the 1st IHF attempted to make a connection with the PHM. The second IHF in 2003 where the PHM was invited was meant to give visibility to the PHM and to connect the Latin American movements with movements in the rest of the world.
- Suggested the setting up of a Social Observatory to do three main things
  - Monitor equity
  - Course on human rights and health
  - Deliberations leading up to an agenda for PHA II (?)

Earlier Draft (incomplete) Section B
RN 29/4/04

- In Brazil this movement led to the inclusion of health as important agenda in the international agenda. Brazil had a universal health care system and was resisting privatisation – going against the grain of the policies of the World Bank and the IMF. It was important to project this example.
- The Brazilian experience should be added to the IHF / PHM agenda as it was a concrete example of what was possible in a developing country with a fairly large population, in today's environment of globalisation.

Sarah – USA

- Launched in Feb / Mar 2003. Coinciding with the trip of Zafrullah, Ravi Thelma.
- There were 5 main issue circles
  - Access to Health in USA
  - Health and War – especially war profiteering
  - Globalisation and health – especially health and trade.
  - Environment health and justice – keeping peoples health over profits
  - Community based action in the USA.

- There were two other important issues highlighted
  i. One was the increasing lack of access of health care to large sections of populations in the US.
  ii. It was the policies of the US government that is the cause of ill health of peoples all over the world.

- The coming year is the electoral year – the first priority of course is to see that Bush was not re-elected – but more importantly to see how we could change US policy.
- Another challenge was coordination with Canada – after they had talked among themselves and come up their own agenda.

Atul - Canada

- The main issues of coordination were – health, trade and environment
- An example may be learnt from Canada that has introduced compulsory licensing of drugs for HIV / AIDS.

AFRICA

Mwajuma – East Africa

- The activities are mainly of South / East and Central Africa.
- There was the launch of the PHM in Kenya in 2003.
- There was an attempt to link with other organisations to address the problem of health for all.
- The movement was merged with a Tanzanian NGO which agreed to donate office space. This was essential as NGO's had to register in Tanzania and new registrations were a problem so it was easier to work from within an already registered NGO.
- An east African office had been set up with a young doctor volunteering to spend three days a week to help (Upendo ~~John~~ Mwingira).

- They were tying up with a youth group in Tanzania in campaigns against drugs.
- A very important issue was the impact of HIV / AIDS. In this connection it was important to learn from the example of Uganda where the infection rate is in fact coming down. However there was very little contact with Uganda.
- They were also connecting up with the African Women's Leadership Organisation.

Bridgett – South Africa

- There were many organisations working separately but not coordinating.
- While previously the civil society in south Africa had united against apartheid / in the struggle against apartheid, however post apartheid the role of civil society in the new South African society was yet to be clearly defined.
- There was need to involve people from the rural areas the academics, trade unions, and the NGO's .
- There was increased participation of community health workers – especially as many of them were being retrenched.
- The special interests of the South African groups were as follows:
    - Globalisation
    - Basic services
    - Poverty with the various sub themes
        - Social security
        - Food security
        - Child support etc
    - HIV / AIDS
        - Equity in access to AIDS drugs
    - Brain drain
    - Demystification of GATS

  In all these issues certain outlooks crossed right through – including Human rights / gender / equity.
- There was also a close association with the Treatment Action Campaign. There was need to discuss how to strengthen the health systems approach to get treatment to reach the patients.
- Challenges for the Future
    - Need to expand to other provinces
    - Health workers campaign
    - HIV / testing and treatment
- There was the problem of stigmatisation of and from health care workers towards patients with HIV / AIDS.
- David Sanders has completed a paper on Health research and Civil Society for the Bulletin Of WHO.

Mary - Zimbabwe

- The particular circumstances under which the NGO movement in Zimbabwe had to function included the repressive laws enacted to paralyse NGO's in Zimbabwe, the REPUBLIC ORDER SECURITY ACT. Under this act you needed permission for more than 5 people to gather together. All NGO's also had to re-register. Thus it was only possible to work with groups already working as new groups were not possible in the present scenario.
- Participation in the treatment access movement.
- The presidential elections where the phm and other organisations got the chance to actually be invited to monitor the elections. This was due to the translation of the charter – so people came to understand the interconnections in health.
- Various innovative ways had come up with to deal with repressive laws. For example with the campaign for AIDS drugs they planned a Cemetry Prayer for which permission was given and a large procession was allowed at the cemetery after the prayer there were speeches that highlighted the fact that many or all of the people who had died could have been saved if they had had access to drugs.
- In spite of all the repressive laws they had managed to arrange 6 public meetings that covered topics like HIV / AIDS, drugs access and prevention of transmission.
- The other obstacles to the functioning of NGO's;
    - ✓ Most of telephones were bugged
    - ✓ Postal system was almost non-functional and sometimes letters never reached.
    - ✓ E-mails also monitored and many never reached.
    - ✓ Some of the NGO's have been infiltrated by government staff so one has to be very careful about who one employs.

Malachi - Kenya

The highlights of the work in the Kenyan region:

- Main activity was lobbying with CBO's and drug organisations
- There was support for the movement from the Kenyan Ports Authority
- There was a very cordial relation with the Kenyan Government
- PHM was registered with the Kenyan Government.
- It was / was attempting to be an umbrella NGO.
- They meet every Wednesday
- In the ICASA meeting the PHM was invited to participate and the Kenyan delegation represented.
- The challenges:
    - ✓ There were nearly 29 million HIV positive people in Africa (?)
    - ✓ There was still not a very strong PHM representation
    - ✓ HIV / AIDS
    - ✓ Lack of IT equipment
- The PHM presence should be strengthened in the African Union, especially on the issues of killings. We need to do this so that our voices may be heard against the genocide.

Jagdish – Mauritius

- PHM was an NGO registered in Mauritius legally.
- Mauritius has taken the Alma Ata declaration as a guiding principle.
- They have a community health fund which supports Primary Health Care Development in the country.
- There is an Institute of health which was doing research on primary health care – funded by the WHO and the UNICEF
- It was ironic that the PHM in Mauritius was trying to the salvage the good work of the governments in the past, especially there efforts to strengthen the primary health care set up.

MIDDLE EAST

Jihad - Palestine

There were specific challenges as a region the first and foremost was the definition of the region as a whole especially as Arabs were all over (and needed to be united)

- Also the problem of language – Arabic, French and English.
- Also various countries had NGO's at different levels of development and this was an impediment.
- There was involvement with NGO's for development – this also ensured connectivity.
- While other regions may be facing lack of access or efficiency this was not a problem in the region – however what was a problem was the continuance of conflict.
- The struggle was represented by a continuum from – access to health (physical) – GATS – and conflict – occupation and war.
- Plan of action – (Cyprus meeting)
    - Commitment of countries towards PHM
    - Launch of the Million Signatures Campaign in Arabic
    - Representatives of the movement met with the regional office in Cairo
    - E-group
- We need to do something for Iraq. It has the worst possible set of experiences – first embargo; then collapse of the health system; and finally war and occupation.

Barzgar - Iran

- The movement in Iran was moving fast, especially after the Alma Ata anniversary program. This was supported by the government allocating money for the meeting, and the presence of senior PHM persons being physically present, this was a great boost.
- There was also the need for a workshop to promote PHM approaches.
- A framework of analysis was also proposed when the events were divided into pre-event \ events \ and post events stages. The pre-event stage was basically about \maintaining\ sustainable development – this was essential to avoid loss during\the event. This included emergency preparedness and the provision of basic minimum needs. Again in the post-event situation there was a highlighting of sustainable development and human centred development.
- Poverty and underdevelopment were the main causes of the extensive death and destruction in the earthquake. However the quake or any crisis was also an opportunity. In Iran this was happening as it is recognised that to get the

assistance to the people who really needed it it was important to get the NGO's involved – it is thus decided to bring all the NGO's under one umbrella. This was to have a unified system of organising the people.

- The basic minimum needs program was seen as a strategy to work with communities.

Hani - Egypt

- THE Cyprus meeting was the first time commitments were made by the various countries attending.. including Egypt
- The meeting with the regional office of the WHO was also highlighted where there were specific decisions especially to build up a partnership.
- More meetings were suggested. Three priorities:
  - Effects of HSR and privatisation
  - GATT and implications on the pharma industry
  - Free trade and its effect on health
  - Malpractice in the medical profession
  - Peoples rights
- Egypt had also got lots of organisations, who wish to take up PHM on their own agendas. These are being involved gradually

AUSTRALIA , NEW ZEALAND AND THE PACIFIC

Fran - Australia

The main activities of the PHM Australia were summarised:

- Spreading the word of PHM
- Teaching / publications
- Working through existing networks – especially political economy group (?)
- South Australia – involved in the relaunch of the primary health care movement Adelaide.
- There was a discussion on how to communicate global issues to the population – it was suggested by the Australians that one strategy was to highlight areas of people to people solidarity.
- Another issue was the draconian laws regards refugees → sub units
- The anti – free trade movement
- Aboriginal health issues.
- Factors that slow us down:
  - How do we make people living in Australia understand that what they do can affect the people all over the world?
  - It was also important to the answer the question – why should we support the PHM rather than any other movement.
- Melbourne conference April 2004 - invited applicants from the phm

EUROPE

Pam - Europe

- Focal point – was elected to be David Woodward.
- The organisation of huge anti-war demonstration in Florence and the biggest anti-Bush demonstration when he came to meet the queen. were significant
- Again language was identified as a problem. in the region
- Italy – there was a good movement
  - Many people signed the charter
  - There was the development and distribution of a PHM calendar.

- BUKO – Germany was active.
- There was also a group active in Netherlands
- The Eastern European countries – especially those under the former Soviet Union were difficult to coordinate except the city of St. Petersburg that had a very active movement especially on the issue of poverty.
- Ukraine had a strong environmental movement especially after Chernobyl.
- Also highlighted were the various resolutions of the British Medical Association that included the statement opening with "This organisation opposed the promotion of the American model of health." (?)
- The environment was one issue where it was felt that the younger groups were willing to get involved.
- Anti-privatisation was also a good campaign platform as the effects were already a reality and were already visible.
- Suggestions / direction
  - The organisation was still not very organised
  - NGO's still don't like working with unions.
  - We need to talk about the brain drain to run our health system
  - We need movements / campaigns that people could join but not loose their identity.

ASIA

Delen – Philippines

- The main activities were:
  - Translation
  - Development of brochure
  - Community based health program – most discussion being at the grass root level
  - Health students association.

- The main circles are:
  - Women's issues
  - Militarization
  - Privatisation
  - Access
- It was pointed out that after 9/11 the Philippines was labelled a terrorist state and the US stationed its army in the country purportedly for security reasons – however it was obvious that this was to control natural resources. In this regard statements were brought out against the US action and also against WTO and its effect on medicines.
- Another issue was how PHC was to be implemented in spite of the government's problems. During the meeting it was very nice to see the seniors and the juniors getting together.
- A meeting in July where Mongolia, Sri Lanka, Japan, Indonesia were invited (supported by health links), will be a good opportunity to grow in the region.
- There was good PHM participation in International Conference against Globalisation and War. Unni helped in media projection. There was a symbolic breaking of the was built by Israel. Also the ***make health not war campaign*** evolved here and Filipino translation of the charter was released.

Nouman - Bangladesh

- Talked about the gradual decentralization of the PHM committees with the development of National then Divisional and then sub-divisional.
- The details of the various issue-based circles is given in the book, prepared especially for IHF – WSF.
- There was concerned about how the issue-based circles were going to coordinate with the geographical circles.
- There was also the translation of the charter and a popular version of the charter
- Noted that the villagers were conceiving of health in rather a different way and were prioritising water, livestock and micro-credit.
- For all the work done a rough break up of the source of funding was as follows:
    - 50% - own funding
    - 25% - local government / partnership
    - 25% - central government / donor.
- The contribution of the other players was absolutely crucial for the success of the program especially for PRSP.
- An important new challenge for the world B^2 = Bush X Blair

Niranjan – Sri Lanka

- 20 organisation were involved in PHM Sri Lanka.
- The main activity was a popularising of the peoples health charter.
- The main health challenges were
    - Privatisation – especially with the planning in the country done by Japanese International Development Agency
    - The country's budget was cut down by 10 – 15%
    - Malnutrition is increasing – and nearly 1/3rd of the preschool children were malnourished.
    - There was concerned that the government was not supporting the indigenous health practitioners
    - There was no powerful pharmaceutical sector in the country.
- The need for formation of a Pharmaceutical or drug bank – this can help the development of the drug industry and production capacity in countries that don't have the production capacity.
- The government did not have a proper sector dealing with the effects of the war. Some people were still living with pieces of shrapnel and that there was no proper mental health services for those affected.

Ayyaz - Pakistan

- Felt that the SAARC regional body should be made use of to promote the people's health movement.
- Felt that a regional getting together was a good strategy.
- Felt the social charter (signed by SAARC) – was an opportunity, as it was rather ambiguous and that the PHM could make it more clear and relevant.
- Need to revitalize PHM Pakistan with inputs from PHM in India and other South Asian neighbors.

Ekbal - India

- There were altogether 18 networks with almost 2000 grassroots level organisations
- All these organisations were already involved in health and were working on various issues such as access to health / drugs / gender / medical education etc.,
- The following were the challenges:
  - The presence of numerous languages
  - The new national economic policy – where the government was moving out of spending on health and education. This was almost completely endorsed by the new health policy.
  - Warned of the internal privatisation of the public sector (internal brain drain from the public to the private sector). (there will be no external manifestations but the haemorrhage will kill)
- Noted the 'model' patents act of the 1970 and how we are now changing / changed to a more TRIPS synch regime.
- The style of PHM campaigns in India was that there were some campaigns that all states did. Some specific campaigns based on local issues were taken up at state level. The National Campaigns were:
  - The right to health
  - Observance of the 25th anniversary of the Alma Ata.
- Noted with concern that GATS will be signed by 2005 and that needs to be taken into account for advocacy by PHM.

14. Planning Exercise

A planning Exercise was conducted in five stages with all steering group members reflecting on each exercise and writing down their idea and suggestions on sheets of paper. They were then shared and discussed. The exercises were on five themes
(a) Achievements of PHM to date, (b) Movement Strengthening (c) Regional and Country Strengthening plans (d) Campaigns and Advocacy (e) Expectations of the Secretariat and Commitments of Support

Planning Exercise I :

a. PHM Achievements

The steering group members were invited to write down the key achievements of PHM in the last two years. These were than shared as an assessment of where we are as a movement today. These could be collated into six key achievements and a few others in the member's own words.

1. **People's Charter for Health:**
   - Widely disseminated and distributed
   - Successful launch and spreading of Charter
   - Many translations
   - Promoting charter as an inspiration for groups working on health around the world
   - Mobilizing on the charter and training / communications with communities as an advocacy tool.

- The charter increasingly recognized as a framework for social development work
- The charter recognized as arising out of a democratic process of consensus building.

2. **People's Health Movement Evolution, post PHA – I**
   - The slow but strong build up of the network with all its diversities transforming PHA to PHM.
   - Uniting force for individuals, networks, institutions and NGOs.
   - Gradual strengthening at local, regional and national level.
   - Improved networking built with respect to both quantity and quality.
   - Persons interacting worldwide through PHM and its communication strategies.

3. **The WHO Turnaround**– from disinterest to active dialogue.
   - The dialogue and higher profile at the WHO
   - The breakthrough as an advocacy, lobbying and changing force in the WHO
   - The shake up of the WHO that it now responds to the PHM calls in the area of PHC.
   - A force for revitalization of comprehensive Primary Health Care and Alma Ata principles within WHO.

4. **Re-endorsement and Revitalization of Alma Ata Declaration and HFA goals**
   - Established that local and national and international groups exists that still have commitment to Alma Ata principles endorsed in the People's Charter.
   - Increased awareness and involvement in Primary Health Care issues.
   - The Charter as a tool for the revitalization of comprehensive Primary Health Care / Alma Ata principles within countries.
   - Development of PHM as an organization fighting for Health for All, Now. symbolised by the signature campaign.

5. **The PHM Secretariat**
   - Excellent work and role of the secretariat
   - Right choice of the International Coordinator
   - Increasing capacity for communication and joint action (we cannot survive without this)
   - Improved networking and learning from regions and each others experiences.

6. **Towards an alternative analysis of World Health**
   - Encouraging alternative analysis of the world's economic system and its impacts on health
   - Inner, widening and deepening shared critique of verticality of health programmes.
   - Voices of the unheard – encouraging communities to write own stories.
   - Increasing recognition as the voice of public opinion with knowledge of what is happening at local level and being taken seriously.

- Recognised as a network with concerns against institutions taking decision in health at international level.

7. **Others**
   - IHF – PHM in Mumbai, Jan 2004
   - Decision about People's Health Assembly – II at Ecuador July 2005

Planning Exercise II :

b. Movement Strengthening and movement

Most of the issues discussed regarding organizational strengthening; issue based circles; campaigns and advocacy; PHA – II; Global Health Equity Watch Report etc., have been included in the relevant sections in Section A of the proceedings / Minutes circulated.

Planning Exercise II :

c. Regional and Country Strengthening

Due to the enthusiastic level of participation from most regions of the world (with a few exceptions like China, Eastern Europe, North and West Africa), the Mumbai meeting provided opportunity for some reflections on regional needs and plans.

These regional reflections are an initial checklist of concerns, options and ideas for follow up by regional focal points with their own regional and country level circles.

d. **Regional initiatives for the future**

A. EUROPE

1. Develop a plan to strengthen the regional coordination – focal point to enhance regional coordination.
2. Inviting other organisations to take part in PHM activities - unions, academics, etc.
3. Priority: East Europe – involve more organisations in that specific region
4. Develop a circle on:
   - Privatisation
   - Promote the discussion about the effects of the action of European Trans National Organization on health
     - Pharmaceutical
     - Financial
     - Water, Electricity.
5. Promote / facilitate PHM sponsored short courses in universities for grass root leaders on health systems, socio-political determinants of health, Primary Health Care etc.

B. SOUTHERN AFRICA

1. Invest resources in cultural communication infrastructure and Charter printing and dissemination, in countries where there is already a viable PHM activity.
2. Use planned Southern / Eastern African PHM and society meeting to run module / course on PHM / civil society organisation focussed on both knowledge and skills.
3. Use opportunities (regional, national meetings, regional / national networks and sympathetic community based organisations to build PHM.

4. In countries to use Charter to identify key national campaigning issues, i.e., to link key national health issues to global issues to organise campaigns around this to build PHM in African countries.

C. NORTH AMERICA

1. Develop effective regional coordination and communication between the Canadian and US PHM events. Support each other's efforts. This may include Health and Trade, Environmental Health and Justice, Tobacco (we do not yet know the priorities).
2. Resistance to US Government policy "Regime change begins at home".
   - Join campaigns and networks already active;
   - Promote and facilitate health within the campaigns (give suggestions and plans);
   - Build awareness of the inter-relationship between US policy and Social injustice.
   - Encourage the spectrum of grassroots action from the streets to legislation.
3. Build the PHM within each country.

D. AUSTRALIA, NEW ZEALAND AND THE PACIFIC

1. Raise profile of PHM in the region
   - By sponsored tours of key PHM people;
   - Discussion groups on : Trade & Health and Comprehensive People's Health Care.
2. Use networks in region – New Zealand, South Pacific, PNG
3. Perhaps, plan a regional conference and / or country regional meetings.
4. Initiate Local website/ List serve
5. Tours of sponsored people to Australia and within region
6. Discuss opportunities and resources for key issues. Eg., Badged as PHM

E. ASIA

1. Maximise involvement and inputs of existing regional networks: ACHAN, IPHC, CIROAP, HAI AP and TWN.
2. Contact networks directly; and distribute materials to all the groups.
   - Focus on consumer groups and health and non-health in each country. Eg., Cambodia & Japan (ACHAN)

3. Utilise existing / already planned activities for adding PHM agenda
   - February 2004 meeting of pharmacologists in Indonesia where Delen is going as a speaker on behalf of HAI AP;
   - April 2004, Dialogue with CMH at regional level in Sri Lanka
   - June 2004, Meeting in Sri Lanka, communicating for advocacy (PCH as advocacy issue)
   - December 2004 – meeting on safe home delivery in Bangladesh
4. Utilise publications available to spread PHM perspectives and reports on the movement. Eg., TWN publications, Newsletter, HAI Newsletter etc.

F. LATIN AMERICA

1.Establish specific programmes and campaigns (ALCA – Salud, FTAA – Health).

1. Produce Glossary of PHC Concepts and criteria.
2. Strengthen / promote inter-cultural dialogue (links between Spanish – Portuguese and English – PHMs)

G. Middle East

1. Promote country circles in each country of the region
2. Invest in capacity building and resource production and ICT for Health including Health.
3. Enhance advocacy and lobby activities
4. Identify the priority for the regions
5. Strengthen the network and increase involvement of these networks at community level, based on specific events and above priority issues.

H. China

1. Recruitment / identification of focal point of China to start mobilization process
2. Chinese language website
3. Chinese List serve
4. Calls for contribution on key PHM issues from that region.

[Any members who have suggestion for these, please sent to PHM Secretariat and copy to David Legge, Austraila].

I. India

Planning Exercise IV :

d. Campaigns and Advocacy

The result of this exercise have been integrated into the earlier section A , item 6 (f).

Planning Exercise V

e. Expectations of the Secretariat and Commitments of Support

The compilation of this exercise to be done by one of the steering committee members has not yet been done and will be circulated as soon as we received it.

15. Decision Making and Communication Process

~~Decision making~~

- Andy commenced with six propositions:
    1. We have enormous collective experience in working in networks
    2. PHM is young and learning and evolving. However there are some issues we know need attention: information sharing, decisions (prompt, strategic), communication (especially between members and secretariat)
    3. Certain projects are underway
    4. Sometimes we need rapid political decisions; sometimes looking for contributions to analyses or suggestions about strategy

- Ravi outlined some history concerning the development of current structures and procedures. Composition: 8 networks and 13 regions, coordinator, ex-coordinator. But patchy representation of regions.
- Yahoo based listserve had been set up to facilitate communication within and across the Steering Group.
- Then followed a long discussion in which different views about problems and difficulties were interspersed with different views about solutions and directions.
- Among the difficulties:
    - Who is on the Yahoo List serve list?
    - Why do some people bounce?
    - Most people don't acknowledge most messages from the Secretariat
    - Some emails call for big decisions and some are simply for information: importance of adequate signposting of the category of message and kind of response needed and relative urgency
    - Some decisions call for a vote in advance; some for consensus in advance; some call for executive action and post-hoc accounting
    - With large group comes the risk of diffusion of responsibility and a paradoxical lack of support to the coordinator
    - Some people reply to Ravi when it might have been more appropriate to reply to the List increasing the secretariat burden to send out these mail to others
- Among the important principles:
    - Clear signposting by sender of the category of message, the kind of response needed and relative urgency;
    - Preparation of documents to support decision-making
    - Possible value of an 'executive' type structure – of a smaller group to help coordinate with rapid decision making
    - Consideration of how to ensure the available technologies are most appropriately used (could include web-phone teleconferencing, bulletin board
    - Fortnightly preparation of a summary of key issues transacted over the last ~~fortnight~~ month (email 'minutes')

Decisions about decisions

- Carmelita undertakes to prepare fortnightly email minutes
- Appointment of executive type group to support Coordinator in urgent decisions and in operational issues. Executive group to include: Maria, Prem, Pam, Brigid (or ~~Mwajuma~~), Delen.
- Exec to draft a set of terms of reference and operating guidelines for interim guidance and subsequent consideration by the Steering Group.
- Sarah offered to prepare draft guidelines about decision-making more generally

17. Communication Strategy

16. Media

Main Identity

From: PHM Secretariat <secretariat@phmovement.org>
To: Hesperian Foundation <hftravel@hftravel.cnc.net>; <sarans@hesperian.org>
Cc: <karutherford@oneworldaction.org>
Sent: Saturday, April 24, 2004 4:33 PM
Subject: Re: Minutes from Strengthening the Movement and Campaign discussions

Dear Sarah,

Greetings from PHM Secretariat (Global)!

I was really surprised to get your methodically classified list for strengthening the movement. I wish you had sent a copy to us when you forwarded it to Andy some weeks ago. We have had to struggle through all sorts of notes (Rakhal's - CHC rapporteur, David Legge's and Andy's). Your lists would have been a great help. I am surprised when you didn't respond to over 5-6 reminders as well. Any way, it came just before section B was despatched. So no one will know about the confusion and it will go very well planned and integrated. I am just working on it and will get back to you on the other points you have raised in the next two days.

Best wishes

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Tel: 00 91 (0) 80 51280009 (Direct) Fax: 00 91 (0) 80 25525372
Website: www.phmovement.org

RHM-SG
Member
RN
29/4

Rada + + advo pg

Main Identity

From: Hesperian Foundation <hftravel@hftravel.cnc.net>
To: PHM Secretariat <secretariat@phmovement.org>
Cc: Sarah Shannon <sarahs@hesperian.org>
Sent: Tuesday, April 27, 2004 9:01 AM
Attach: PHM Strengthening the Movement.doc
Subject: Minutes from Strengthening the Movement and Campaign discussions

Dear Ravi,
Greetings! I am writing from New York where I am doing fundraising and networking visits for Hesperian. The Methodist Church kindly put us up again at the Alma Mathews House where we stayed last March. It brings back memories of our tour! By the way, I had a positive meeting with Larry Cox at the Ford Foundation today, he remains very interested in the PHM and is looking at his budget and also talking with some colleagues to see if there is any possibility for Ford funding for the Fall '04 - Fall'05 to help out with the PHA II, also travel funds for the Secretariat, etc. I will write more to you and to Andy about this after I have a chance to do some further follow up with Larry. (Larry did not have any funds available at all for the Fall'03 - Fall'04 funding year, as all his funds had been committed in 2002 when his budget was cut by more than 60%).

I sent Andy Rutherford -- some time ago -- the summary of the two sections of the planning meeting that I had the responsibility for processing. This was so that he could integrate those two discussions into the rest of the meeting summary he was generating. I had assumed that this is what occurred, and that what he sent you contained these pieces. However, I am sending as an attachment the same write up that I sent to Andy in case he didn't incorporate this content in or if some problem occurred.

Attached are the transcribed and re-grouped/ collated summary of the ideas that were presented for two discussions: Strengthening the Movement and then a more detailed discussion about Campaigns. In some places handwriting was impossible to decipher and I made a note of the person who wrote the un-decipherable content as possible. I did do some organizing of similar ideas together, but did not attempt to edit to deal with any redundancy when several people expressed similar thoughts. I do have the original "papers" that people wrote on, and am happy to either hold on to them or to send them in the mail to you or to Andy.

I will be back in Berkeley on the 29th in case you have any questions.

With best wishes,

Sarah

Sent 27/4/04 about

27/4/04

Dear Sarah
I was really surprised to get your methodically classified list for strengthening the movement & wish you had sent a copy to us when you forwarded it to Andy some weeks ago. We have had to struggle through all sorts of notes (Rakhal's-CHC rapporteur, David Legge and Andy's) Your lists would have been a great help I am surprised when you didn't respond to our 5-6 reminders as well Any way it came just before Section B was despatched so no one will know the confusion and it will go very well planned and integrated. I am just working with on it and will get back to you on the other points you have raised in the next two days Best wishes Ravi

RM 27/4/04 to

Plen - Sh meety

cc Andy

Insert P11 Item b

Strengthening the Movement

Structure, Coordination and Communication:

- Coordination with the Secretariat; with more concrete and responsive steering by the steering committee.
- Steering committee commitment to allocate time for the work.
- Help transition secretariat beyond Asia. Supporting a new region as potential coordinator so that the secretariat can build capacity to take over from Jan 2005.
- Hand over website now to a new region or circle coordination
- Strengthen the structure and effectiveness of the PHM based on the realities of the region.
- Be transparent – issues of governance.
- Active/ full involvement of others in decision making
- Follow-up with and implement today's decision-making discussion.
- Continued commitment to regular correspondence and sharing of views/ opinions.
- Share successful experiences amongst ourselves.
- Transparency in every sense of it.
- Helping to evolve 2-3 year plan
- Involvement of additional delegated people on specific issues, e.g.: media, documentation, communication, work with UN organizations.
- Internalizing the principles of the charter as a part of the work of each of us.
- Taking active part in securing the continuity of the movement (at operational and strategic levels)

Regional Development: Explore

- ~~Allocate~~ resources to Africa regional development.
- Provide support to needy areas.
- Improving capacity of weak regions e.g. Africa.
- ~~A well written and realistic plan for the Africa region.~~ Evolve
- Creative financial resources which include ability to support, strengthening of Africa region.
- Broaden network in Southeast Asia.
- Improve/ support communication for regional/ country/ institutions that don't have access to information.
- Invest proactively in capacity development in regions, especially the weakest.

Advocacy efforts

- More positive policy strategies to move from critique to proposing new directions.
- Regional and country-wide campaigns
- Deeper analysis of the issues: stronger analytical work.
- Influencing national policies and activities for health for the majority.
- Influencing UN agencies, especially WHO.
- Identify global, cross-cutting issues around which peoples' campaigns can be built and nurtured.
- Support campaigns especially "No WTO, No War" to fight for People's Health.

- Representation in policy making forums at the national and international levels to push the charter's agenda.
- Strengthen grassroots activism in conjunction with international advocacy through strategic global campaigns. Greater coordination, planning and focus on campaigns and on the relationship between grassroots activism and international advocacy.
- Use campaigns to strengthen and build relationships with other networks.
- Using the analytic work, select a few (2-3) issues to campaign for globally. Suggestions include: globalization's impact on health (esp. WTO, Trips, Gatts, WB/IMF, PRSPs, overseas aid, etc.)
- Focus advocacy on Health systems/ PHC.
- Perceived lobbying and advocacy activities which are recognized by the PHM as "theirs".
- Contribute to the Global Analysis of health in a globalized world in the Arab context.

Reaching new networks, mobilizing and organizing

- Return to focus of promoting/ advocating sharing the charter with non-health groups, academics, research and policy makers, taking advantage wherever strategic opportunities emerge.
- Build up networks and grassroots XXXXX (Prem?)
- Teaching and learning/ reflection from experience and analysis
- Integrate PHA principles/ PHC in my day to day work and promote this to others: teaching medical students, organizing health workers, education, organizing, mobilizing, communities.
- Involvement of more marginalized peoples e.g. indigenous Australians.
- Work through and use the strength of existing like-minded networks, connecting new with networks.
- Have the charter translated into languages in which it has not been translated in South East Asia (Lao, Bahasa, Indonesian, etc.) — Asia
- To incorporate the People's Health Charter in an undergrad education related to health (i.e. medical, nursing, paramedical, public health, and social sciences).
- Involve other stakeholders, training stakeholders and regions.
- Share achievements and failures.
- More involvement of other institutions, networks and communities.
- A systematic way of supporting the voices of the voiceless to bring their situation more into focus.
- Reach out to many other networks/ individuals while renewing commitments to existing networks.
- Promote and educate about the movement on multiple levels, including health and non-health based conferences, university settings, civic group meetings and writing.
- XXXX and seek to include new groups, communities, movements and people with the PHM through meeting them and specific, XXXXX (Lanny?)
- Widening the ownership of the charter among health and non-health organizations.
- Continuing to share the principles of the charter with others, including those outside of the health sector.
- Appreciation and building on XXXXX activities and for XXXX to see some of their activities to be more PHM activities. (?)

Increase our visibility:

- Make visible the work of the PHM at a community level and a national level.
- Clone Unni for each region to increase publicity and media coverage of PHM.
- Write/ analyze/ publish more popular press.
- Support groups through our publications, e.g. articles in TWR magazine: features, position papers, etc. These materials can be used as campaign materials, to educate people, and as PHM's input on policy initiatives with WHO, UNICEF, etc.
- Utilize TWR's contacts and also PHM contacts to disseminate information.
- More articles written, serious and popular.
- Strengthen the media support to the secretariat and the regions.
- Continue but strengthen the analytic work and it's dissemination in different foms: scientific articles, popular articles, media releases, website.
- IPHC can use the web site actively, draw in other sectors and respond pro-actively. (3 points are condensed)

p 13 item d

Campaigns

GENERAL:
Campaign for WHO's Global Strategy in Nutrition and Prevention of Diseases based on APAN Agenda/ Statement at the WHA 2004. Start lobbying departments of health now until May to build international pressure. Resist pressure of US government on countries to sign trade agreements violating farmer's rights and affecting our food security. This should be linked with other trade issues such as TRIPS. Research on health impacts of trade agreements (e.g. TRIPS, TRIPS+, etc) and research into whether your government is implementing this agreement or not. Resist WTO/ with focus on impact on health -- join networking focusing on this.

Participate in campaigns for the ratification and implementation of the FCTC. There is a regional meeting March 3-5 WPRO; also the intergovernmental working group meeting will be in Geneva in June 2004.

Develop a continuous campaign against privatization of health care. It is taking place around the world, it is a priority for many of the country-level PHM participants (we can exchange experiences), and it allows discussion of globalization (role of the state) linking national elites to international capital, and integrating issues of health care and equity.

Campaign to explain CPHC: in context, and construct a concerted effort to build/ provide evidence of success of CPHC through: stories, research. Adapting this information to context. This effort could be launched with seminars in every region followed by discussion. A publication could be produced to address CPHC in different regions.

PHM needs to make presence at international level and respond to the processes at WTO, World Bank and IMF as well as WHO through press conferences, petitions and press releases, etc.

PHM needs to have position papers on impact on health with case studies and intellectual analysis on "AOA", global Health Fund, HIV AIDS, occupation, etc.

At a national level PHM needs to support national struggles with campaign materials, memorandum to governments, etc. Send letters of support to national groups at meetings, support causes, highlighting their problems with international alerts on hot spots, and focus on issues such as Palestinian refugees, etc.

We need to develop specific campaign circles with links to other activists, and we should limit this to a few, maybe 5. Privatization is a good topic for an international campaign.

To develop campaigns we need to work in coordination at a local, national, regional and global level.

Coordination groups (cross-regional) to focus on developing key messages for selected international campaigns. These messages would then be shared for input. These groups could also support/ inform different advocacy actor such as the WHA circle and the secretariat.

PHM should choose a few strategic issues on which to campaign. Elements to consider in identifying strategic campaigns are: will this bring in new networks to the movement? Will it have impact? Is it cross-cutting? Will it link grassroots activism and concrete policy change suggestions for advocacy work?

Take advantage of the fires generated by social injustice around the world – concerning health issues – and help create awareness of these fires. In other words, promote the voice of the unheard and – in the news flashes at their being heard, ever so briefly – take the long-term advantage of that happening)

Share information on issues, commitment to campaign on an issue, develop response for local and regional campaign in order to implement it. Suggested issues: War and Trade, Militarization (not to war, no to WTO).

INDIA:
In India there are a number of campaigns being carried out by PHM. These include: Right to Health Care Campaign; Right to Food Campaign; Access to Essential Medicines; Health Policies for Primary Health Care --- using evidence based information; and against Tobacco – with an effort now pushing for the ratification of the FCTC including a June 2004 International meeting about the FCTC.

Campaigns are important for linking with other networks. In India links are being made with women's networks, with environmental networks, and with Dalit organizations. There is also an on-going effort called "reaching the un-reached" to bring information about the PHM to academics, students and youth.

AFRICA:
In Africa the crisis is HIV and AIDS. Campaigns currently running in the region are on access to treatment. PHM internationally could assist the region with information and approaches to deal specifically with the issue of pharmaceuticals, patent laws and TRIPS and other trade agreements as these issues should be incorporated into campaigns.

HIV/AIDS demands a CPHC approach. Use HIV/AIDS to show that there can be no solution without 1) confronting economic/social determinants of poverty and vulnerability; 2) rebuilding comprehensive and community-based health systems and confronting health declines from privatization of health and drugs. Campaign addressing WTO, WTO and governments. Link this to grassroots awareness building.

Campaigns (with necessary research to support) on: The impact of culture on women in relation to policy; women's access to health; and in Tanzania and Uganda a campaign can

also be built around the public-private partnership work with WEMOS. Involve PHM in ongoing campaigns.

LATIN AMERICA:
Revive the spirit of Alma Ata through continuing the "Million Signatures Campaign" and through training/ education on the principles of integrated primary health care. Another campaign we are beginning to work on is: Militarization, occupation, War: Resources for Life and No to War. This includes opposition to Plan Columbia. Finally, we care continuing our campaign to oppose the WTO and to the FTAA in particular demanding universal access to medicines, and opposing the privatization of social security systems.

Translate information for cross-regional sharing, and to make it possible for campaign materials to be used throughout the world.

Main Identity

From: David Legge <d.legge@latrobe.edu.au>
To: 'PHM Secretariat' <secretariat@phmovement.org>
Sent: Thursday, February 19, 2004 4:43 PM
Attach: Mins040117PHMSteeringGroup.doc
Subject: Steering Group Meeting minutes

Hi Ravi,

I am very sorry to have taken so long. I finished the minutes during the WSF and then my computer crashed and I have been basically computer-less up until early this week.

Finally herewith the minutes.

Again I am very sorry.

cheers

d

From: PHM Secretariat [mailto:secretariat@phmovement.org]
Sent: Tuesday, 17 February 2004 11:15 PM
To: d.legge@latrobe.edu.au
Subject: Steering Group Meeting minutes

Dear David,
Greetings from PHM Secretariat (Global)!
This is the second SOS for the minutes of the Steering meetings that you so hopefully entered on your laptop on 17th and 18th January. Our rapporteurs have sent in the minutes of 12th, 13th and 16th and Sarah's and Andy's report of the exercises is on its way as well. Prompt follow up will help to keep up the spirit of collectivity and enthusiasm that was generated in Mumbai. I am sure you must be busy with other demands – so forward the minutes without further editing, if necessary. I shall integrate all of this in some practical and sensible way.
Best wishes,
Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Tel: 00 91 (0) 80 51280009 (Direct) Fax: 00 91 (0) 80 25525372
Website: www.phmovement.org
Join the "Health for all, NOW!" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

PHM-SG
Minutes
RN
29/4

Peoples' Health Steering Group – Full Meeting 18/1/2004

Attendance

Andy, Jose, Lanny, Fran, Sarah, David S, Prem, Delen, Ravi, David L, Evelyne, Unni, Hugo, Rebecca, Carmelita, Olle, Zafrulla, Mwajuma, Mary, Patricia, Mira, Maria, Jihad,

Arrangements

Minute taker (DL) appointed. Time keeper (Carmelita) appointed.

Agenda setting

Proposed agenda (for the two day discussion) outlined and discussed.

1. Decision-making and communications processes (~45')
2. Planning exercise, to be conducted in five stages (achievements, movement strengthening, country and regional strengthening, campaigns and advocacy, expectations of secretariat)
3. Networks and linkages
4. Fundraising,
5. Assessment and reflection following IHF

Agenda discussed and adopted.

Need to review Mumbai Declaration noted. Carmelita and Lanny deputed.

Decision making

Andy commenced with six propositions:

1. We have enormous collective experience in working in networks
2. PHM is young and learning and evolving. However there are some issues we know need attention: information sharing, decisions (prompt, strategic), communication (especially between members and secretariat)
3. Certain projects are underway
4. Sometimes we need rapid political decisions; sometimes looking for contributions to analyses or suggestions about strategy

Ravi outlined some history concerning the development of current structures and procedures. Composition: 8 networks and 13 regions, coordinator, ex-coordinator. But patchy representation of regions.

Yahoo based listserve had been set up to facilitate communication within and across the Steering Group.

Then followed a long discussion in which different views about problems and difficulties were interspersed with different views about solutions and directions.

Among the difficulties:

- Who is on the Yahoo Listserve list?
- Why do somepeople bounce?
- Most people don't acknowledge most messages from the Secretariat
- Some emails call for big decisions and some are simply for information: importance of adequate signposting of the category of message and kind of response needed and relative urgency
- Some decisions call for a vote in advance; some for consensus in advance; some call for executive action and post-hoc accounting
- With large group comes the risk of diffusion of responsibility and a paradoxical lack of support to the coordinator
- Some people reply to Ravi when it might have been more appropriate to reply to the List

Among the important principles:

- Clear signposting by sender of the category of message, the kind of response needed and relative urgency;
- Preparation of documents to support decision-making
- Possible value of an 'executive' type structure
- Consideration of how to ensure the available technologies are most appropriately used (could include web-phone teleconferencing, bulletin board
- Fortnightly preparation of a summary of key issues transacted over the last fortnight (email 'minutes')

Decisions about decisions

Carmelita undertakes to prepare fortnightly email minutes

Appointment of executive type group to support Coordinator in urgent decisions and in operational issues. Executive group to include: Maria, Prem, Pam, Brigid (or Mwajuma), Delen.

Exec to draft a set of terms of reference and operating guidelines for interim guidance and subsequent consideration by the Steering Group.

Sarah offered to prepare draft guidelines about decision-making more generally

Planning Exercise

Six stage planning exercise undertaken including achievements, movement strengthening, country and regional strengthening, campaigns and advocacy, expectations of secretariat.

Not completed on 17th; adjourned for completion on 18th.

Separate report to be prepared incorporating the responses of all participants.

Reconvening (18/1/04)

Announcement

Scholarships to IUHPE: Maria, Arturo, Delen (not Unni, ?? Prem),

Arrangements

Timing: need to conclude at 11.00am

Attendance

Andy, Mary, Delen, Arturo, Rebecca, Maria, David S, Thelma, Fran, David L, Ravi, Prem, Mwajuma, Carmelita, Jose, Patricia, Lanny, Evelynne, Jihad, Hugo, Zafrulla, Unni

Thelma here as PHM (India)

Agenda review

Announcements

Complete presentations from yesterday

- expectations of and from secretariat

Process for selection of next secretariat (and website)

Linking with other networks and movements (how rather than who)

Reflections from IHF

Comments on Mumbai

Circles

Focus group on funding

Next steps with WHO

More announcements

Announcements

David Sanders announces two meetings. In June 04 (6-12/3) two meetings in South Africa: International Society for Health Policy (6-8) (Pres Alexis Bennos) jointly with PHA SA on theme "Building progressive partnerships in Public Health" (go to website; put in abstracts).

Following International Society for Equity in Health (ISEQ) (also see website)

David to send an email

Patricia: also meeting on Global Health Watch there abouts

Planning exercise (continued)

Campaigns and advocacy

Evelynne: being present at WB and WTO meetings; farmers livelihoods use the health impact as the measure; position papers on GFATM etc, campaign materials

Mary: supporting access to treatment campaigns at the country level

Maria: sharing of information about the issue; commitment to campaign; identification of strategiees at country level

Hugo: local work on international campaigns, benefits, needed locally, use campaign as a way to facilitate and str advocacy work

Arturo: [environment very noisy]

Fran: comprehensive PHC, world of vertical and evidence-based; what is an appropriate evidence base for PHC; and then collect it; create global framework; and collect data from regions; global evidence base

Carmelita: move to resolution, global strategy, APAN submitted statement to WHO in April 03; have to analyse Global Strategy where it fits into PHM frameworks; 5 mo before May; APAN planing a convention; APAN statement;

US going towards bilateral strategies on trade; PHM to develop alliances at the country, regional and global level, missed the opportunity when Cambodia joined the WTO;

FCTC undergoing ratification; demand govt to sign ratify and implement the Framework; WPRO meeting soon about implementation; Carmelita participating (endorse Carmelita as PHM representative)

DL: WTO Ag on Ag and Farmers' Livelihood; campaign strategies

[Andy: Procedural suggestion: focus on Themes and Circles]

Themes and Circles

Ravi: where the circle is responding to a particular issue it seems to work; study circles do not seem to work so well;

Andy: what are we discussing

David S: would be useful for Ravi to list and indicate which circles are functional

Jose: important to note regional structures should have priority; issues circles organisations of individuals; regional circles will respond to realities;

Ravi: In May 03 we identified circles: WHO (ZC and RN); Poverty and AIDS (dialogue with UNAIDS) – non functional; War and Disaster (Unni and Rosalie Bertell); Macroeconomics (Mike Rowson and Medact as contact); Politics of Helatgh (IPHC); Women's Health active (WGNRR); Food and Nutrition (to work with APAN and IBFAN) – active; Public Private Partnerships (Jose and others, Wemos);

Research Circle (DS, looking for a focus on what to do) linked to GFHR;

Communications Circle (Secretariat in touch with members but they are not working so well together)

Summary: two issues: because of our limited resources (time and other demands) at present the energy level only increases when there are specific opportunities; those which are not linked to strategic opportunities

Patricia: Global Health Watch might provide such a focus

Sarah: one of the roles of circles can be to find ways of working with other networks; a critical function of circles (or at least some circles); communications and research (generic) may not be best dealt with through; how are we going to do our private planning; some of these topics are still in this formative stage; does not make sense for a circle to launch with a single point person; need a team;

David S: some circles are cross cutting; research crucially important; campaigns need to be founded on research

Ravi: not to have one person responsible; but to have one person as focal point; links to GHW useful; limited resources a problem;

Andy: circles can be formed spontaneously; individuals with enthusiasm can make it happen; does not need to be endorsed but welcomed; but nobody reads the papers (see Website)

Prem: research and analysis – campaigning advocay and lobbying specific skills; need to recruit some of this expertise

Unni: facts and figures, on the spot; one page;

Maria: lots of groups already working on all of these issues; eg launching a campaign about sugar tomorrow; so many people working on these issues but contacts not so;

Andy: PHM generating a density of activity plus linkages; how are we going to proceed

DL: going round in circles

Delen: confusion between responsibilities of circles

DL: small groups now?

Ravi; use PHA-Exchange; should talk about process of how not what,

Plan on a group meeting this morning (Ev, Sarah, Carmelita, Patricia, DL) on food, WTO, farmers' livelihood

Carmelita: what is the link between circle and Steering Group?

Ravi: reads from relevant bit of Process Paper;

Andy: Greenpeace varies widely in quality of its work and usefulness as a partner; we need to generate a process which accommodates these complexities

Linking with other Networks and Movements

Ravi: branding and badging; management of dual and multiple identities;

Andy: appoint two volunteers to clarify process

Thelma: we function with a certain degree of self-confidence; communicate; linking with environmental networks, nationally and globally; don't need to wait for approval! a movement by definition has to be based on certain realities; we just engage;

Mwajuma: look to the future; need to be inclusive of new organisations (who were not founding members); in terms of how we bring in other networks; at what point are we

allowed to talk about PHM – depends where you are and how you feel (example about using the PHA video; giving movement website); look forward

Patricia: GHW a good way of forming these linkages

Andy: articulates consensus: check the network if you can (and need to); follow your own judgement; mention PHM as you feel appropropriate; communicate that the link has been made; be accountable for the way you use our name; use the Charter

Thelma: outline the campaigns run with and through PHM (India): Food, TRIPS, PHC, tobacco campaign; Using innovative methods; We are influencing state policies

Unni: keep aware of the use of the Internet

Planning exercise resumed (expectations of and commitments to the secretariat)

Expectations and commitments written and shared.

Andy: summarising. Much was to do with us as a movement rather than specifically about the secretariat. Should have begun this exercise with a resource reality check (includes time).

Ten Reality Points

Ravi offered ten points for consideration.

1. Don't blame technology. The problem of non-response is not due to lack of receipt.
2. Must address the problem of non-representation of certain regions (including Mira's position in the SG which is not understood in the PHM (India). Please clarify what Mira represents.)
3. PHM secretariat started with negative emotions after PHA1. Took a lot of work to bring the alienated networks back. Ill-feelings in the evaluation. Gradually
4. Inheritance of the website. ~~A~~Nand found it very frustrating. Cannot make this website anything but archival; no inputs. Now on sick leave. Don't have unreal expectations of the website. Prasanna has been quite frustrated by lack of response and contribution to the website. Website needs (i) a commitment from members; (ii)
5. Capacity building. Secretariat identified this as top priority. African visiting project. Linked our present coordinators to our networks. Those networks have not been sustained. Rockefeller willing to support PHM in Africa. Must be able to help people who are there. Handicapping Africa by trying lots of outside attempts. But if it doesn't happen from Africa.
6. We have a PHM evaluation. But the evaluator is not responding to anything. Very frustrating. Please can AR and PZ winkle it out.
7. WHO circle needs a new circle coordinator. Need a capacity to respond to their documents. Need a 5-6 member circle who can go to Geneva.
8. Translations and websites and multilingual listserves vital.

9. Network dialectics. Networks need to respond to the five questions (from June email). Why do we have IPHC in privileged position on our letter head?

10. Need constantly different representations in different meetings. Last year RN found that he circulated notices of events but got no response. Last year RN went but not in 2004. If none of you are going to volunteer to travel; to be present and to understand and to represent PHM. From next week, WHO (HIV) wants an input; MSF (Bangkok) wants an input. RN can't travel 52 weeks. Rollback Malaria in Africa in Feb.

Commits self (RN) constant feedback to all of you of responses to communication. Monthly update.

Andy: meeting for 3 days, we should have had this report three days earlier. Must begin our meetings in future with a secretariat report. Ten vital issues have been identified.

Africa

group met yesterday; have produced some notes which will be developed and communicated to Africa and developed for SG consideration.

Clarification of representations and networks.

Maria and Carmelita to produce a draft discussion paper for circulation to SG before the end of Jan.

WHO circle

The circle needs a new coordinator. ZC will give more time to this work. Zafrulla to work with Ravi on sharing the work and taking over the role of liaison with WHO.

RN lists some other considerations associated with WHO.

Website

Needs a different organisation.

DL needs a continuing home with security.

Sarah may be able to find some volunteers. Will investigate.

Process of selection of next secretariat

Process of selection of next secretariat. Prem, Ravi, Jihad, two reps from the Americas to be circulated to SG by end of March. Timetable, process, etc

Mumbai declaration

Carmelita and Lanny, to work with Indian group and make input to final document in the next week or so.

Carmelita. There are real problems with content and structure. Must provide feedback by the end of today, Sunday to Carmelita

Recognition

Andy summed up our collective response to the huge work of Ravi and his colleagues. Unanimous recognition and appreciation.

Evaluation

Andy and Pam to speak with Andrew Chetley about the Evaluation Report.

Membership of SG issues

IPHC and Indian group to address shared problems.

Scheduling of SG meetings

Sarah: Appreciation of Ravi's management of the concurrent SG meeting. But perhaps we should schedule SG meetings for after the events rather than concurrent as this time

Prem: need three clear days for every SG meeting. Andy: perhaps two days. Ravi: it was a problem but saves money. Usually in November.

Setting it up and making it happen!

A Guide for Equity Gauge Design and Implementation

Setting it up and making it happen!
A Guide for *Equity Gauge* Design and Implementation

BACKGROUND

This guide has two primary purposes. The first is to provide existing and potential individual *Equity Gauges* with some guidance in the design, planning and implementation of their strategies and actions. The second is to ensure some commonality around the key principles and concepts of *Equity Gauge* design between different individual gauges - an important requirement for an effective and cohesive global alliance of *Equity Gauges*.

This guide has been developed by a "GEGA core group"[1] funded by the Rockefeller Foundation, and follows field testing in Chile, Uganda, South Africa and Kenya. It also builds on work conducted by the Global Health Equity Initiative (GHEI) and their book, "Challenging Inequities in Health"[2]. Finally, it has benefited from feedback and input of the all gauge members of GEGA.

[1] Core group members responsible for drafting this guide were: David McCoy (Health Systems Trust, South Africa), Meg Wirth (Rockefeller Foundation), Paula Braveman (University of California), Jeanette Vega (), Antoinette Ntuli (Health Systems Trust, South Arica), Davidson Gwatkin (World Bank), Tim Evans (Rockefeller Foundation), Pat Naidoo (Rockefeller Foundation) and Mushtaque Chowdury (BRAC).
[2] Challenging Inequities in Health: From Ethics to Action. 2001. Edited by Tim Evans, Margaret Whitehead, Finn Diderichsen, Abbas Bhuiya and Meg Wirth. New York: Oxford University Press.

SECTION 1: THE PRINCIPLES OF *EQUITY GAUGE* DESIGN AND IMPLEMENTATION

The importance of equity in health and health care is not new. For example, equity was listed as one of the key principles of the 1978 Alma Ata Declaration on Health for All. International health and development agencies, researchers and activists have been pointing to inequities in health and health care between different countries, between rich and poor, and between men and women, for many years.

So what is different or distinctive about an *Equity Gauge*?

The first distinction is that an *Equity Gauge* is an *active* approach to monitoring *and* addressing inequity in health and health care. It moves beyond a mere description or passive monitoring of equity indicators to a set of concrete actions designed to effect real and sustained change in reducing unfair disparities in health and health care. This entails an on-going set of strategically planned and coordinated actions that involves a range of different actors who cut across a number of different disciplines and sectors. It is not a typical health research project or even limited to actions in the public health domain.

The second distinctive feature of an *Equity Gauge* is that it is explicitly based on 3 "pillars of action", each considered to be equally important and essential to a successful outcome, and which should all be represented in both the design and implementation of an *Equity Gauge*. The three pillars are:

- Advocacy
- Public participation
- Measurement and monitoring

An Equity Gauge is therefore an approach consisting of a set of actions, and is not, as the name might suggest, just a set of measurements.

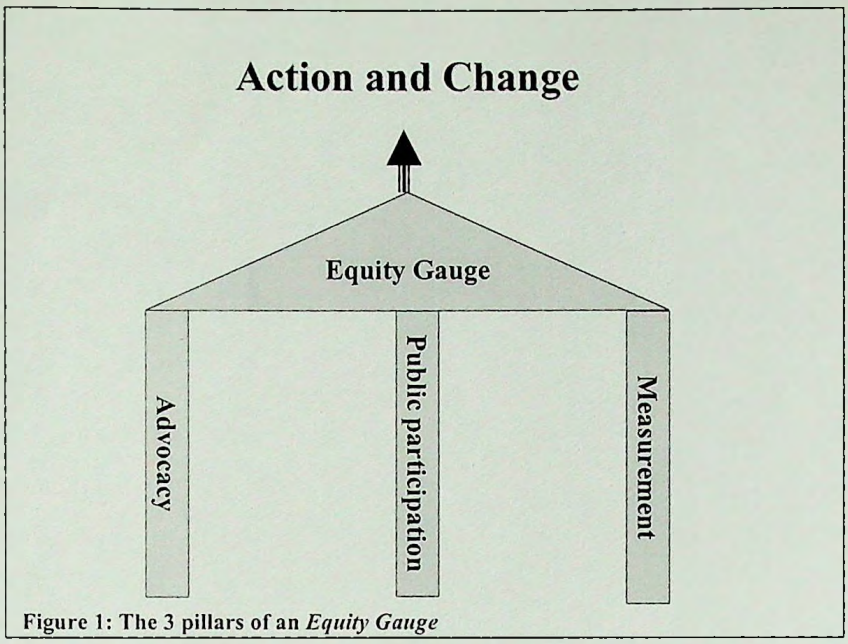


Figure 1: The 3 pillars of an *Equity Gauge*

Although this set of three actions is portrayed as a set of independent pillars (Figure 1), in practice, they overlap and inter-connect with each other. For example, the selection of equity indicators to measure and monitor should be informed by the views of community groups and by a consideration of what would be useful from an advocacy perspective. In turn, the advocacy pillar relies reliable indicators developed by the measurement pillar and may involve community members or public figures.

Another important feature of the three pillar design of the *Equity Gauge* is that they do not relate to each other in any temporal sequence. Often research projects tend to collect information, disseminate it and then undertake advocacy activities in that order. This linear approach to changing policy or affecting change has often been found to be ineffective. In an *Equity Gauge*, the actions of all three of its pillars should be happening concurrently.

Pillar 1: Advocacy

This pillar refers to a broad set of actions designed to lead to real change in levels of inequity in health and health care. Effective advocacy is increasingly being recognised as a challenging and creative skill that researchers, health professionals and public health initiatives should be equipped with. An ideal *Equity Gauge* would incorporate and develop the skills and imagination required to raise the profile of equity in health policy and planning, and to turn data and information into appropriate action.

Advocacy actions can take form in a number of ways:-

- Effective and strategic dissemination of information, education and communication (IEC) materials[3]
- The construction of convincing and effective arguments, policies, proposals and recommendations for improving levels of equity
- Direct engagement and active lobbying of policy makers, decision-makers and other potential change agents
- Empowering the poor and disadvantaged, and their advocates, with knowledge, skills and other resources
- Civil society campaigns and challenges to policies / actions designed, or likely, to lead to greater inequities

An *Equity Gauge* is not expected to engage in all of the types of advocacy actions listed above, as they may not all be appropriate in a given setting. For example, direct challenges by civil society may not be strategic if a more co-operative approach with government is likely to be more effective. What is important is that advocacy should extend beyond a passive and unimaginative dissemination of information on levels of inequity.

The targets of advocacy may also vary from situation to situation. In many instances, ***policy and decision makers*** (the government as a whole, ministers and parliamentarians etc.) will be critical advocacy targets to help ensure that equity is a political priority. The ***civil service*** and ***health sector bureaucracy*** may also be an important target, as it has been found that even in counties with a pro-equity policy environment, inequities may continue to persist because of poor policy implementation. In countries where government is weak, ***donor agencies*** and ***multi-lateral organisations*** such as the World Bank may be important. It is also important to see the ***advantaged and rich sections of society*** as being important targets of advocacy - if redistribution is to occur in pursuit of equity, gaining as much support and understanding from those who are advantaged and privileged may be very important to mitigate potential resistance to redistribution. Finally, there may be other stakeholders with a vested interest in opposing change in favour of equity - for example, private medical insurance companies may oppose attempts to abolish individual risk-rating.

Pillar 2: Public participation

This pillar refers to the involvement of community groups and stakeholders in health policy formulation and health sector reform, as well as the principles of community empowerment (moving away from the notion of the poor being passive beneficiaries of pro-equity and developmental initiatives), bottom-up development and public accountability.

Community groups and stakeholders include the ***general public***, with a particular emphasis on the poor, the illiterate and the impoverished, and the ***community-based organisations (CBOs)*** and ***non-government organisations*** (NGOs) that represent them.

[3] This includes appropriately packaging IEC in different ways for different audience groups.

The rich and powerful members of a society are also stakeholders who must be engaged if inequities are to be reduced through redistribution.

Other important actors include other ***religious organisations***, ***trade union organisations***, ***traditional leaders***, ***women's organisations***, ***civic groups***, ***human rights agencies*** and ***academic institutions***. ***Health workers*** and community health structures such as ***clinic committees*** and ***hospital boards*** might be important group to involve. Finally, ***journalists*** and the ***media*** (print, radio and television) are an important constituency whose participation in an *Equity Gauge* should be encouraged.

In terms of actions, the 'public participation' pillar might include using CBOs to help determine appropriate measures of inequity; facilitating discriminated and disadvantaged community groups to express their health needs in their own words as part of an advocacy strategy; employing 'participatory research' techniques in the measurement and description of inequities; and actively encouraging the media to take an interest in health policy and health systems.

Pillar 3: Measurement

This pillar refers to the identification of inequities that are important for an *Equity Gauge* to describe, measure and monitor.

Part of identifying the inequities that are relevant to an *Equity Gauge* is deciding on the 'population groups' that form the basis of the inequities. This is because measures of inequity have to be framed in terms of comparisons between groups that are 'advantaged' versus groups that are 'disadvantaged. Population groups can be constituted in a variety of ways, and an *Equity Gauge* should identify the most relevant groups for comparison:

- Socio-economic status (e.g. comparing the health status differential between socio-economically advantaged and disadvantaged groups)
- Race, religion, language and / or ethnicity groups
- Gender
- Geography and spatial location (e.g. comparing urban and rural populations, or different states or provinces in a country)
- National origin (e.g. the differential between immigrants / refugees with local nationals)
- Sexual orientation
- Age (the elderly and children are often at a disadvantage in many societies)
- Disability

In addition to comparisons between different population group categories, measures of inequity can be reflected according to various dimensions of health:

- the underlying determinants of health and poverty
- health outcomes
- health financing
- access to health care

- quality of health care
- consequences of ill health

An *Equity Gauge* needs to then determine how it will actually measure these health inequities. While there are hundreds of indicators that can be selected and measured to describe inequity, the point about an *Equity Gauge* is less to do with painting a comprehensive and detailed picture of health inequities, than it is with producing enough data, that is reliable and valid, to influence change.

While the monitoring of equity is typically done through the collection of quantitative indicators, 'inequities in health' can also be described in other ways. For example, the problems that the poor and marginalised experience in accessing health and the devastating consequences of ill health on the socio-economic status of families can sometimes be better described through the use of descriptive or qualitative information. Not only can this describe the situation of inequity and the impacts of inequity, they also provide useful advocacy material.

Using a case study approach to describe the situation of health and health care in a particularly under-resourced and impoverished area can also act as a powerful lens through which health policies and health systems reforms can be evaluated in terms of their impact on improving the health care of the poorest and most marginalised.

In some situations, an *Equity Gauge* may not have to collect new data - if enough data and information of acceptable quality already exists, an *Equity Gauge* might concentrate more on the analysis and use of existing data to support advocacy.

SECTION 2: AN *EQUITY GAUGE* APPROACH TO EQUITY AND HEALTH

There are different definitions of and conceptual frameworks for equity and inequities in health and health care. In order to establish a strong global alliance of *Equity Gauges*, it would be important for Gauges to share underlying principles and theories of equity and health inequalities.

An *Equity Gauge* places health equity squarely within a larger framework of ***social justice***. While some health variations between people are inevitable (most notably the fact that an elderly person will generally have less good health than a younger person), many health inequalities are avoidable and associated with unjust social constructs. It is these inequalities that are unfair, unjustifiable and avoidable that *Equity Gauges* are concerned with.

An *Equity Gauge* perspective therefore means striving towards a world in which disadvantaged population groups (whether defined by age, gender, race-ethnicity, socio-economic class or residence) can achieve their full health potential, as indicated by the health standards of those groups in society who are most advantaged. It calls for affirmative and preferential action to improve the health of those with the poorest health and who face the greatest obstacles to achieving their full health potential.

Placing the *Equity Gauge* within the larger framework of social justice is primarily a moral consideration based on humane and ethical values. It also arises out of the empirical evidence in both rich and poor countries, that health is closely associated with social position, and the underlying political, economic and cultural causes of social position.

Poverty and marginalisation

In all countries and situations, poverty and marginalisation are underlying and fundamental causes of inequities in health. Poverty results in certain groups being unable to access the basic needs of life, and is accentuated by marginalisation through exclusion due to factors of geography, ethnicity, language, race, disability or illness. Part of the answer to redressing health inequities therefore lies in eliminating structural poverty, tackling racism and prejudice and making the opportunities of society more accessible to the excluded. In addition, ill health and its consequences is also a potent generator of poverty, emphasising the importance of health interventions as a means of poverty reduction.

Educational opportunity

In country after country, inequalities in health are robustly associated with educational attainment. Those with higher levels of education enjoy greater life expectancy and lower levels of ill health or disability compared to those with less education. Moreover, education attainment exerts a strong influence on income and standards of living. As a particularly modifiable determinant of health, improved education and literacy levels of disadvantaged and marginalised groups is thought to be an effective strategy for reducing health inequities.

Gender

Gender is a key 'social stratifier' that interacts with other factors like economic class or race because the broad social and economic determinants of health affect men and women differently. For example, occupational roles carrying different health risks may be assigned differently between men and women. Various social and cultural expectations and constraints can also shape the lives of women differently from men.

Health systems and health care

Although factors outside the health sector are key determinants of health inequities, the health sector plays a pivotal role in health equity. Through promoting good health, and providing accessible, appropriate and comprehensive PHC to marginalised groups, health systems can do much to reduce health inequalities. Conversely, and all too often, health systems without a focus on equity have the potential to exacerbate or create health disparities by neglecting the needs of vulnerable populations and ignoring cultural, physical and financial barriers to accessing health care.

SECTION 3: CONTEXTUAL MAPPING

An important aspect of *Equity Gauges* is that they are contextualised. There is no standard formula or recipe for an *Equity Gauge.* An appropriately designed *Equity Gauge* is one that fits the circumstances, needs and conditions of a given country, region or city. This document merely describes the general principles, approaches and characteristics of *Equity Gauges*, However, in order to assist *Equity Gauges* to develop their plans, a set of generic questions on the social, political and economic context have been formulated. By answering these questions, it is hoped that *Equity Gauges* will be stimulated to think through the many complex and challenging issues that are inherent in any initiative designed to impact on equity and promote justice.

3.1 The general state of inequity

This section is designed to sketch out the broad picture of inequity and injustice. It should help to identify and justify the selection of population groups that are to be compared against each in order to describe and quantify inequities in health.

- What is the degree and extent to which your country, region or city is socio-economically stratified? In other words, to what extent are there class divisions, and how large is the differential between these classes? What have been the general trends in socio-economic equity over the past 50 years? Has the country seen increasing or decreasing inequities? What are the underlying causes of this trend?

- Are there any identifiable populations who are socially and politically discriminated against or persecuted? Are any groups marginalised or disadvantaged on the basis of gender, religion, race, language, ethnicity or sexual orientation? If so, who are they, what is the size of these groups, what is the nature of their discrimination / persecution / marginalisation, how severe is it, what evidence is there of this and what are their historical roots?

- Is there a rural-urban divide in terms of wealth and poverty? Are the interests and needs of the rural population adequately represented in government? Is this reflected by inequities in health between the rural and urban populations?

3.2 Government

This section is designed to sketch out the nature of government which may help inform an appropriate advocacy strategy and prompt Equity Gauges *to think how best they can engage with 'government' to promote pro-equity change and action.*

- What is the system of government and electoral representation? Is there democratic representation through fair and free elections? Is there "good and just" governance? Is there a culture of transparent and accountable government?

- To what extent would the government support the objectives of an *Equity Gauge* and be responsive to its findings and recommendations? Is it likely that the *Equity Gauge* will be able to promote equity through an open and constructive dialogue with government?

- Within government, to what extent is health appropriately considered a priority? What proportion of GDP and the government budget is spent on health care and other social sector services? Should advocating for a higher proportion of government spending on the social sector be linked to efforts to reduce inequities in health?

- What health equity issues are on the "radar screen" of policy-makers? What important health equity issues aren't on the agenda but should and could be with reasonable effort in the near future?

- Is there an independent legislature (or other body) with the responsibility, authority and procedures for monitoring the role and performance of the executive arm of government? Could it be persuaded by an *Equity Gauge* to act as advocates on behalf of the poor and marginalised in society? If so, how can they be reached and lobbied?

3.3 Other decision-making and power-brokering institutions

In some countries, the formal structures of government may be weak or disempowered. This section is designed to prompt Equity Gauges to consider other targets for their advocacy strategy.

- To what extent are social, public and economic policy decisions influenced by external agencies such as the WB or IMF? How much of social sector spending comes in the form of external aid / assistance? Is there an externally imposed Structural Adjustment Programme in place, and to what extent does this programme reflect equity concerns? Should donors or multi-lateral agencies be a target for *Equity Gauge* advocacy initiatives?

- Are there other powerful or influential non-governmental institutions that need to be considered as targets for advocacy in favour of greater equity in health? Who might be your allies and who might be your opponents?

3.4 The advocacy and public participation environment

This section is designed to sketch out other aspects of the environment within which an Equity Gauge would operate. It hopes to identify potential collaborators, synergies and levers to an effective advocacy strategy.

Judicial and legal system

- Is there a human rights culture or a commitment to any conventions or declarations on human rights? What international conventions or declarations on human rights (which

could be used as an advocacy lever) is your country, region or city a signatory of? Have these been officially ratified?

- Do individuals and communities have any constitutional or legal rights to their basic social and economic needs? To what extent is recourse to the courts a viable method of advocacy in favour of the poor? Do the poor have access to legal representation? Could this form the basis of an advocacy strategy for the *Equity Gauge?*

- Is there an independent and functional judiciary? How sympathetic is it to the plight of the poor and discriminated? Could it be persuaded to advocate on behalf of the poor and marginalised in society? If so, how can they be reached and lobbied?

Other non-governmental agencies and initiatives

- Is there a vibrant non-government sector in the city, region or country? Are there other groups or initiatives working on human rights, poverty alleviation and social justice who might be potential collaborators of an *Equity Gauge*? For example, if there are groups suffering from discrimination, persecution or a denial of basic human rights, are there efforts, initiatives or movements designed to overcome this?

- Do any of the following groups offer the possibility of working as partners to the *Equity Gauge* or as advocates for improved equity in health: religious organisations, trade unions, women's groups and academic institutions?

The media

- Is there a free press / media? How sympathetic is the press / media to the plight of the poor and discriminated? Does it play a role in upholding fair and accountable government? How can the media be invited to participate in the *Equity Gauge?*

- Is there a growing information and communication gap between the poorer and richer sections of society? To what extent is low literacy a barrier to the poor accessing information? How can IEC from an *Equity Gauge* be best communicated to the poor and marginalised through the mass media?

3.5 Macro-economic environment and public policy

This section is designed to sketch out the broader economic and public policy environment which may help identify some of the underlying causes of health inequities as well as help inform appropriate recommendations for reducing inequities.

- How rich is the country, region or city? For example, is it a high, middle or low income country and what is its GDP? What is the stability and growth of the country's economy? What proportion of total government spending is used on servicing debt re-payments? Is this hampering the capacity of government to strengthen social sector services, particularly those targeting the poor and marginalised?

- What is the ideological / theoretical background of the country's economic and public policy? To what extent is equity a key objective of public policy, and to what extent should economic and public policy be challenged from an equity perspective? For example, to what extent is public sector policy and macro-economic policy neo-liberal and to what extent does the notion of an interventionist welfare state exist?

3.6 The health system

This section is designed to sketch out the health sector in more detail.

- How equitable is the health care sector? What evidence and information currently exists to demonstrate the state of inequity in health?

- To what extent is the health care system horizontally fragmented? For example, is there a two-tier or three-tier health care system? Do the poor and the rich use different health care services / systems?

- What is the size of the private health care sector? Has it grown or shrunk in the country? What effect does it have on the state of inequity or equity in health and health care?

- Have there been any significant health sector reforms in the country over the past 15 years, and what were they? Has this led to a worsening or an improvement in health and health care inequities? Where have these reforms come from? What are the key upcoming issues in health policy-making? Are there any future policies or reform efforts that are being planned, and which may have equity implications?

- Is decentralisation and / or devolution of the health care system happening or being planned? What effect has this had or will have on health inequities?

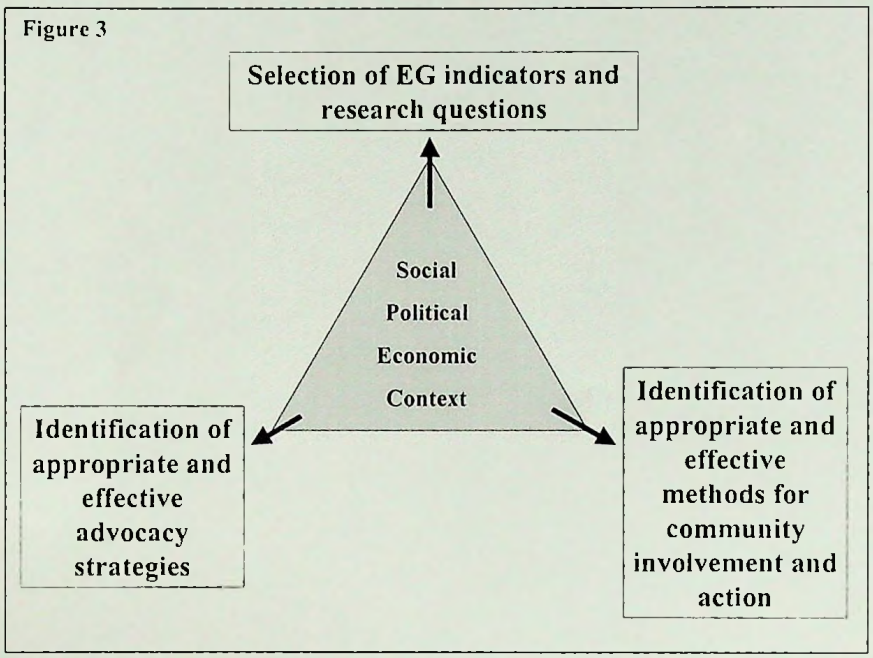
- How is health financing organised and how progressive is it? Have there been changes in the way health care is financed, and have they been more progressive or regressive? Where and how are decisions about health financing made, and should they be a target for *Equity Gauge* advocacy actions?

- To what extent are marginalised groups provided with an opportunity to influence decision-making within the health system? Do clinic committees and hospitals boards offer a formal platform and mechanism within the health system for promoting the needs of the most disadvantaged and marginalised?

SECTION 4: A STRATEGIC PLAN AND DESIGN FOR YOUR *EQUITY GAUGE*

Having conducted a mapping of the context, *Equity Gauges* can now proceed to develop their plans for each of the three pillars accordingly (see Figure 2). The following section of this guide is a guide to developing an Equity gauge plan *on the basis* of the contextual map. Appendix 2 provides an example of what such a plan for a hypothetical country might look like, and is included in this document as a further guide to *Equity Gauges*..

Figure 3



4.1 What inequities will the Equity Gauge focus on?

The population groups

In order to help choose an appropriate focus based on the contextual map, the following table is designed to help *Equity Gauges* to identify and justify their selection of population groups to focus on. *NB. This table is not constructed to be filled in, but merely represents a framework and template to assist Equity Gauge design.*

Categorisation of population groups	Disparities in health outcomes (magnitude of difference between advantaged and disadvantaged group(s))			Size of disadvantaged group (proportion of the overall population that comprises the disadvantaged groups)			Public awareness (degree of public attention paid to health of disadvantaged group		
	High	Moderate	Low	High	Moderate	Low	High	Moderate	Low
Socio-economic:									
Race and / or ethnicity:									
Religion:									
Language:									
Gender:									
Geography and spatial location:									
National origin (e.g. immigrants / refugees versus local nationals):									
Sexual orientation									
Age									
Disability									

Dimensions of health

Having identified the type(s) of population group(s) that are to be the focussed upon, the following table is designed to help *Equity Gauges* determine the dimensions of health inequity that will be focussed upon. *NB. This table is not constructed to be filled in, but merely represents a framework and template to assist Equity Gauge design.*

Dimensions of health Type of Population group (to be filled in)	Underlying health determinants - Socio-economic - Behavioural - Occupational - Education - Environmental	Health status	Health care financing	Access to health care	Quality of health delivery: - e.g. MCH - e.g. communicable diseases - e.g. trauma - e.g. mental Health	The consequences of poor health on social and economic status

4.2 Planning for effective advocacy (Pillar 1)

Based on the contextual mapping exercise and the focus of health inequities identified in the preceding section, the following table is a template framework to assist *Equity Gauges* to map out their advocacy strategy. *NB. This table is not constructed to be filled in, but merely represents a framework and template to assist Equity Gauge planning.*

Advocacy actions	**Actors** Who are your allies and potential partners in pursuing these activities? Who might be your opponents?	**Strategy** What are the key action points, how will they be implemented and which groups will be targeted? How will the media be used?	**Resources required** What resources are available and what additional financial and human expertise are needed?	**Outputs**	**Timeframe**
Effective and strategic dissemination of IEC materials					
Constructing convincing and effective arguments, policies, proposals and recommendations for improving levels of equity					
Direct engagement and active lobbying with policy makers and decision-makers					
Empowering the poor and disadvantaged, and their advocates, with knowledge and other resources					

Civil society campaigns and challenges to policies / actions designed, or likely, to lead to greater inequities					
Other					

4.3 Planning for effective public participation (Pillar 2)

The plan and actions for effective public participation overlaps with the plan and actions for advocacy. The following table may duplicate some information from the table above, but should help to provide a holistic and analytic map of an *Equity Gauge's* public participation strategy. *NB. This table is not constructed to be filled in, but merely represents a framework and template to assist Equity Gauge planning.* Some useful generic questions to consider in the use of this table are:

- What amount and proportion of time and funds will be allocated to working with each community groups and promoting public participation?
- To what extent can your Equity Gauge be influenced by the community's agenda? For example, health service planning and policy are not necessarily priorities for the most marginalised, for whom poverty reduction may be the biggest priority (as well as the most vital contribution to promoting equity in health).
- How will you overcome the potential power imbalance between community groups and academics / professionals?

Community groups	*Rationale and purpose for choosing this community group*	*Involvement with the Equity Gauge*	*Timeframes and outputs*
The general public			
CBOs or community representatives of the poor and marginalised			
CBOs or community representatives of the rich and advantaged			
Civic organisations and consumer groups			
Women's groups			
Religious organisations			
Trade unions			
Traditional leaders			

Health workers - Allopathic public - Allopathic private			
Traditional health practitioners			
Health science students			
Clinic committees, hospital boards etc.			
Media and journalists			
Other			

4.4 Measurement (Pillar 3)

Having selected the types and dimensions of health inequity that your *Equity Gauge* will be focussing on (section 4.1), the following table is designed to elaborate the actual data and actions required to fulfil the measurement pillar of the *Equity Gauge. NB. This table is not constructed to be filled in, but merely represents a framework and template to assist Equity Gauge planning*
Some useful questions to consider when using this table are:

- Why have the following indicators been selected?
- Was / will input from different stakeholders be solicited on the choice of indicators? How meaningful are the selected indicators likely to be to decision-makers and the public? Will information on these indicators be likely to move people to take action?
- Have you considered "participatory" approaches that combine the goal of collecting information with promoting stakeholder involvement?

Selection of quantifiable and measurable indicators

Population group	**Dimension of health**	**Selection of quantitative indicators**	**Source and methodology of data and information**	**Quality and reproducibility of data** Are the selected indicators measurable, of acceptable quality and possible to use over time so that you can evaluate the effects of policies or plans to reduce inequity?

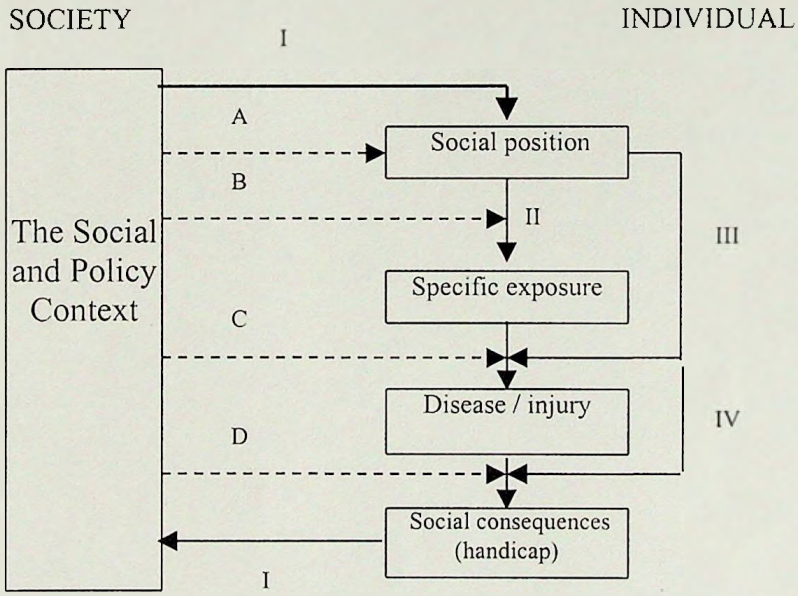
Qualitative data and information

What forms of qualitative data and information will be used in the *Equity Gauge*? Will descriptive case studies, in-depth interviews and focus group discussions form part of the data collecting exercise of the *Equity Gauge?*

Appendix 1: The Diderichsen model

Many analyses of health inequities have used Diderichsen's social determinants framework which consists of four broad mechanisms that play a role in generating health inequities. The way it works is that social stratification (I) leads to a separation of people into different social positions. These differential social positions in turn lead to a differential *exposure* to causes of illness, disease or injury (II), a differential *susceptibility* to causes of illness, disease or injury (III) and a differential *consequence* of illness, disease or injury (IV). These differential social consequences of ill health then have the consequence of reinforcing social stratification, thus setting into place a vicious cycle of increasingly widening disparities.

For example, low income workers are more *exposed* (I) to occupational injuries and unsafe working environments than high income professionals. Or, a malnourished child is more *susceptible* (II) to developing severe respiratory complications following a measles infection, than a well nourished child. And finally, in societies with inadequate social security nets, the *consequence* (IV) of the cost of health care on a poor household can be further or complete impoverishment, and thereby a worsening of social position.



What is also important about this model is that each of the mechanisms described above can be countered by specific pro-equity policies or by a modification of the social context. These are to influence and modify the pattern and extent of social stratification (A), to preferentially decrease exposures amongst the poor and vulnerable (B), to preferentially decrease differential susceptibility amongst the poor and vulnerable (C) and to prevent unequal social consequences (D).

Subject: Equity Gauge
Date: Thu, 29 Nov 2001 14:58:14 +0200
From: "David McCoy" <hstmccoy@ct.stormnet.co.za>
To: sochara@vsnl.com

Dear Ravi Narayan,

I am writing to you on David Sanders' recommendation.

I am a public health doctor working for an NGO in South Africa. I am also part of a group of people who are trying to establish a global movement around the issue of equity and health, based on based projects called "Equity Gauges".

An "Equity Gauge" is defined as an active approach to monitoring inequity in health and health care, based on three clearly defined "pillars of action":

* Advocacy and action to reduce inequity
* The measurement and description of inequity in health and health care
* Public participation and community involvement in measurement and advocacy

At the present moment there are 11 such "Equity Gauges" in various countries across the world, mostly in Africa. These are being sustained by grants from the Rockefeller Foundation.

The reason for this e-mail is to ask if you would be able and willing to participate in a meeting to help us develop our programme of work in the field of advocacy and action around reducing health inequities.

David Sanders felt that you would bring valuable insights in the challenge of lobbying, campaigning and advocating at both a country and regional level.

Most of the Equity Gauge projects are being managed by public health professionals who do not have that much experience in advocacy, and we are therefore looking to develop their capacity in this "pillar of action.

The meeting I refer to will be held in february (week of the 11th) in Kampala. Representatives from 11 Equity Gauge projects from across the world will be present at the meeting, including a number of senior representatives from multi-lateral and donor agencies.

We would be able to pay for your travel costs and time should you come.

I look forward to hearing from you. Attached is a document that gives further background to what it is we are trying to accomplish.

Yours sincerely,

Dr. David McCoy
Health Systems Trust
509 Premier Centre
451 Main Road
Observatory 7925
Cape Town

Forwarded to Abhay on 8/2/02
8/2/02

South Africa

Tel: 021-4476330
Fax: 021-4476302
Cell: 083-3013681
E-mail: hstmccoy@ct.stormnet.co.za

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

---- File information -----------
File: EG Manual draft 3.doc
Date: 8 Aug 2001, 20:34
Size: 141312 bytes.
Type: Unknown

EG Manual draft 3.doc	**Name:** EG Manual draft 3.doc **Type:** Winword File (application/msword) **Encoding:** BASE64

Subject: Re: Meeting
Date: Fri, 30 Nov 2001 16:08:15 +0200
From: "David McCoy" <hstmccoy@ct.stormnet.co.za>
To: Community health cell <sochara@vsnl.com>

Dear Ravi,

Many thanks for your e-mail. I think you would be a great addition to the meeting in Kampala. I would be pleased if you would formally diarise the dates.

There are now things left to do. First is to arrange for your travel and visa requirements. Someone called Pat Naidoo will be in touch with you about this.

The second will be to discuss your input. This might be best done through a phone call in the first instance. Is this possible?

There are some other people involved in the meeting who will also be there as "advocacy experts". They are Dorothy Logie (Jubilee 2000), Mike Rowson (Medact), Monica Naggaga (Oxfam) and Mark Heywood (Treatment Action Campaign and AIDS Law Project).

Look forward to hearing from you again
Dave

Date sent: Fri, 30 Nov 2001 17:44:30 +0530
From: Community health cell <sochara@vsnl.com>
To: hstmccoy@ct.stormnet.co.za
Subject: Meeting

> *Dear Dr. David McCoy,*
>
> *Greetings from Community Health Cell, Bangalore. Thanks for the invitation to be a resource person on Advocacy and community Health Action at your meeting on Equity Gauges'. For the present the week starting 11th February seems convenient, and I confirm my availability. I look forward to hearing more about the meeting its scope and structure - so that it would help me to decide how I could contribute.*
>
> *I am a Public Health Professional with training at the London School of Hygiene and Tropical Medicine and the All India Institute of Medical Sciences. I was an academic / researcher and a faculty member of the Department of Community Medicine at St. John's Medical college, Bangalore for a decade and also an overseas lecturer of the School. In 1984, along with a small group of colleague, we quit our faculty positions to initiate a centre working with NGOs peoples movement, civic society and more recently governments and universities on Community Health Action and Health Policy Advocacy. Its been 17 years in this exciting work and the high point was the Peoples Health Assembly in Calcutta (2500 Health and Development Activists and Professionals in India) and the Global Assembly in Bangladesh 1500 participants from 92 countries. We are all now lobbying with the People's Health Charter which evolved at this assembly.*
>
> *You can access our centres website for more information.*
> *web site address: www.geocities/sochara2000.*
>
> *With best Wishes,*
>
> *Dr. Ravi Narayan,*

> *Community Health Advisor.*
> *CHC*
>

Dr. David McCoy
Health Systems Trust
509 Premier Centre
451 Main Road
Observatory 7925
Cape Town
South Africa

Tel: 021-4476330
Fax: 021-4476302
Cell: 083-3013681
E-mail: hstmccoy@ct.stormnet.co.za

Subject: Kampala meeting
Date: Fri, 14 Dec 2001 10:39:23 +0200
From: hstmccoy@ct.stormnet.co.za
To: sochara@vsnl.com

Dear Ravi,
I have been having some problems with my e-mail so you may have already responded to my previous e mail. I just wanted to conform your attendance at the Kampala meeting and to make sure that you don't have problems with arranging flights and visas.

I thought it would also be useful to talk on the phone - would this be possible.

Dave
PS. David Sanders will be coming to the meeting as well and is looking forward to seeing you there!

Subject: GEGA Workshop in Uganda - Invitation
Date: Sat, 22 Dec 2001 01:11:22 +0300
From: "Dr. Pat Naidoo" <rpillay@imul.com>
To: sochara@vsnl.com

Dear Dr. Ravi Narayan,
Greetings!
Thanks for agreeing to participate in the GEGA workshop Advocacy pillar agenda. I am looking forward to meeting and working with you in Uganda.
Please find attached you invitation to the workshop from Dr. Fred Wabwire, the director of IPH which is hosting the workshop.
Please dont hesitate to get in touch with me if you require any further information.

Best wishes for the holiday season and for the new year.

Look forward to seeing you in Uganda,

Regards,

Pat Naidoo
GEGA Workshop Coordinator

Invitation Dr. Ravi Narayan.doc	**Name:** Invitation Dr. Ravi Narayan.doc **Type:** Winword File (application/msword) **Encoding:** base64

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26/12

MAKERERE UNIVERSITY
P.O. Box 7072 Kampala Uganda
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Tel: 256-41-532207/543872/543437
Fax: 256-41-531807

INSTITUTE OF PUBLIC HEALTH
OFFICE OF THE DIRECTOR

18th December 2001

Dr. Ravi Narayan
Community Health Advisor
Community Health Cell
email: sochara@vsnl.com

Dear Dr. Narayan,

RE: Rescheduled Global Workshop on Health Equity, February 2002

I am pleased to invite you as a resource panellist, to attend the Global Equity Gauge Workshop (GEGA) hosted by Makerere University Institute of Public Health. The workshop will be held at the Imperial Botanical Beach Hotel in Entebbe, Uganda between February 10th-16th, 2002.

I believe the conference will greatly benefit from your presence and input and we look forward to a very productive and fruitful meeting.

A number of countries from Asia, Africa and Latin America that make up the GEGA will make scientific presentations on the status of their equity gauges at the workshop. In addition, the workshop will serve to cater the Gauge specific technical needs identified by the individual country gauges.

The objectives of the workshop are:

1. To bring together experts, international researchers and donor agencies in the area of health equity to discuss health equity and its assessment.
2. To critically examine the design of existing equity gauges and to see how each of them can be supported and strengthened appropriately.
3. To advocate for the establishment of health equity gauges as a means of monitoring equity in health and health care

4. To develop consensus on the core concepts of the equity gauges i.e. advocacy, measurement and community participation and their use in narrowing equity gaps within and between countries

The workshop format will provide for an in-depth discussion on the various technical aspects of Health Equity as they pertain to active monitoring, evaluation and implementation within various contexts.

The workshop will also attempt to develop standardised tools for the design, implementation and evaluation of health equity gauges and it also hoped that key strategic issues including long term co-ordination and funding for GEGA and the way forward for Equity Gauge Initiatives will be discussed.

My Institute and will provide for your accommodation and all meals during your attendance at the Workshop. We can also make all the necessary arrangements for your travel to Uganda. Alternatively, you are free to make your own travel arrangements, if you so prefer. You would however need to let us know as soon as possible (before January 7) if you require us to arrange your travel and if you choose to make your own arrangements, please let us have your itinerary as soon as possible. Please note also, that there is a ceiling for reimbursement of travel expenses for participants who make their own travel arrangements. This is based on the lowest, most direct round-trip economy class fare available from your port of embarkation to Uganda. Our travel co-ordinator, Juddy Otti, will be able to provide you with more specific details regarding this ceiling and you are kindly advised to check with her regarding any clarifications you may require. She can be reached on e-mail as follows:

"Ms. Annette N. Kironde att: Juddy Otti" <afrique@infocom.co.ug>

We look forward to your presence and participation at the Uganda Workshop.
Please let me know, at your earliest convenience, if there is anything further I can do to help.

Sincerely yours,

Dr. Fred Wabwire-Mangen
Director, Institute of Public Health

Subject: Re: Greetings
Date: Fri, 04 Jan 2002 14:39:09 +0300
From: "Dr. Pat Naidoo" <rpillay@imul.com>
To: Community health cell <sochara@vsnl.com>

Hi Ravi,
Sorry to hear that you've been having some difficulties with your health, I wish you well and a speedy recovery. I'm still hopeful that you will be able to attend our meeting. I was so looking forward to meeting and working with you. Dave McCoy is organizing the advocacy pillar sessions so it is his call regarding the resource participants for this pillar, although at this stage I don't foresee any difficulties regarding an alternative person from People's Health Movement if this is necessary. In order to facilitate the travel and other logistics in time we would need to confirm this fairly soon though. Dave would probably talk with you soon on the phone about this.

In any case lets stay in touch and I wish you a speedy return to health.
Best wishes for the new year,

W[redacted] regards

Pat Naidoo

At 16:00 28/12/01 +0530, you wrote:
>
>
>*Dear Dave and Pat,*
>
>*Greetings from Community Health Cell.*
>
>*Apologies for the delay in replying to your recent emails but an attack*
>*of my recurrent spondylosis problem has resulted in some temporary*
>*dislocation of my work including some travel restrictions. This setback*
>*has injected an uncertainty about my participation at your workshop -*
>*which I am still really looking forward to attend. I should know in a*
>*weeks time after physiotherapy etc how the condition progresses. While*
>*wishing you all best wishes for the New Year, I must apologise for this*
>*sudden uncertainty. We could chat on the phone around 3 - 5th January*
>*to make a final decision (my residence number is 0091 - 80 - 5533064 and*
>*office 0091-80-5531518). In case I am unable to attend would you*
>*consider another colleague from the Peoples Health Movement Mobilization*
>*process in India - with a similar background replacing me. There are*
>*several in mind but I did not want to approach them till I have a*
>*tentative okay from you on this.*
>
>*Regards,*
>
>*Ravi Narayan*
>*Community Health Advisor,*
>*CHC*
>
>
>

RN
7/1/02

Subject: Greetings
Date: Fri, 28 Dec 2001 16:00:36 +0530
From: Community health cell <sochara@vsnl.com>
To: rpillay@imul.com, hstmccoy@ct.stormnet.co.za

Dear Dave and Pat,

Greetings from Community Health Cell.

Apologies for the delay in replying to your recent emails but an attack of my recurrent spondylosis problem has resulted in some temporary dislocation of my work including some travel restrictions. This setback has injected an uncertainty about my participation at your workshop which I am still really looking forward to attend. I should know in 4 weeks time after physiotherapy etc how the condition progresses. While wishing you all best wishes for the New Year, I must apologise for this sudden uncertainty. We could chat on the phone around 3 - 5th January to make a final decision (my residence number is 0091 - 80 - 5533064 and office 0091-80-5531518). In case I am unable to attend would you consider another colleague from the Peoples Health Movement Mobilization process in India - with a similar background replacing me. There are several in mind but I did not want to approach them till I have a tentative okay from you on this.

Regards,

Ravi Narayan
Community Health Advisor,
CHC

Subject: Re: Dr. Ravi's address
Date: Wed, 09 Jan 2002 16:49:30 +0300
From: "Dr. Pat Naidoo" <rpillay@imul.com>
To: Community health cell <sochara@vsnl.com>

Hi Ravi,
Many thanks for your note.
Please find attached the tentative agenda for the Uganda Workshop
I'll have our travel person send you the tentative itinerary for your travel
If you need to reach her directly she can be reached on email as follows:
Juddy otti c/o "Ms. Annette N. Kironde" <afrique@infocom.co.ug>

Look forward to hearing from you

Regards,

Pat Naidoo

At 13:29 09/01/02 +0530, you wrote:
>*Dear Dr. Pat Naidoo,*
>
>*Greetings from Community Health Cell - Bangalore!*
>
>*Further to your discussion you had with Dr. Ravi Narayan today, please*
>*find his office and residence address and phone numbers :*
>
>*Office :*
>
>*Dr. Ravi Narayan,*
>*Community Health Cell,*
>*367, 'Srinivasa Nilaya'*
>*Jakkasandra I Main,*
>*I Block, Koramangala,*
>*Bangalore - 560 034,*
>*Karnataka,*
>*India.*
>
>*Telephone : 091 - 80 - 553 15 18,*
>*091 - 80 - 552 53 72*
>
>*Telefax : 091 - 80 - 552 53 72*
>
>*e-Mail : sochara@vsnl.com*
>
>Residence :
>
>*Dr. Ravi Narayan,*
>*# 326, 5th Main Road,*
>*Ist Block, Koramangala,*
>*Bangalore - 560 034.*
>
>*Telephone : 553 3044*

>
>Thanking you,
>
>V.N. Nagaraja Rao
>
>
>
>

Uganda Workshop Programme.doc	**Name:** Uganda Workshop Programme.doc **Type:** Winword File (application/msword) **Encoding:** base64

Global Equity Gauge Alliance
Technical Workshop for Equity Gauges

February 11th to the 15th 2001

Draft Programme

The workshop aims to:

- Strengthen participants understanding of the concept of Equity as well as a Framework for Equity Gauges;
- Strengthen participants awareness of the place and scope of advocacy, public participation and monitoring and measurement within an Equity Gauge;
- Provide a forum for undertaking some strategic planning for the Global Equity Gauge Alliance (GEGA);
- Create an opportunity for Equity Gauges to exchange ideas and information.

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9.30am	Setting the Context for the Workshop *Dr. Tim Evans and Ms. Antoinette Ntuli*
10.00am	Plenary: A Framework for Equity *Dr. Paula Braveman and Dr. Jeanette Vega*
11.00am	Break
11.30am	Plenary: A Framework for an Equity Gauge *Dr. David McCoy*
1.00pm	Lunch
2.00pm	Plenary: Individual Gauge Presentations - *Chile and South Africa*
2.45pm	Group Discussion: Framework for Equity and an Equity Gauge
4.00pm	Tea
4.15pm	Plenary: Feedback from small groups
5.30pm	Day Ends

Tuesday February 12th:
Plenary: Strengthening the Three Pillars of an Equity Gauge

0830:	Introduction to Advocacy (*Dr. David McCoy*)
0840:	Working at the level of the community *(Dr Ravi Narayan)*
0910:	Using the law and community mobilisation – the experience of TAC and the AIDS Law Project in South Africa *(Mark Heywood)*

RN
10/1

0940: Working through information, pressure and lobbying – the experience pf Jubilee 2000 and Medact (Dorothy Logie)

1000: Tea

1030: Introduction to Measurement: *Dr. Jeanette Vega*

1040: Concepts of Equity and the implications for measurement. Theoretical frameworks for health inequalities pathways *Margaret Whitehead*

1110: How to select the indicators to measure Equity: Selection criteria for Health status, health care and socioeconomic indicators. Level of aggregation. *Paula Braveman*

1145: Introduction to Public Participation: *Antoinette Ntuli / Mushtaq Chowdury*

1200: Why participation is a vital component of promoting Equity *(Susan Rifkin)*

1230: Case Study: *Abbas Bhuiya*

2.00pm Plenary: Individual Gauge Presentations - *Nairobi, Cape Town and Ecuador*

3.15pm Tea

3.30pm Parallel Sessions

Advocacy and Public Participation	Measurement
Question-Answer session based on plenary inputs to be facilitated by presenters. • What is 'advocacy' and 'public participation' – what are their differences and what are their synergies? • Developing consensus on definitions of "community", "participation" and "empowerment".	*Group Exercise* • Outline of the conceptual framework being used in each gauge (alternatives models can be considered to do this) • What are the indicators being used or considered in each gauge? *Guided discussion* Limitations and strengths of using different sources of information (primary vs secondary, individual vs aggregate, qualitative vs quantitative, etc) based on gauge sources and approaches

5.30pm Day Ends

Wednesday February 13th

8.30am Parallel sessions

Advocacy	*Public Participation*	*Measurement*
Case study: Mount Frere - *David Sanders* Policy Maker – a tool to help develop an advocacy strategy – *Hilary Brown*	*Group work:* Examining assumptions about the critical role of participation Sub-themes: Does participation promote sustainability? Does participation ensure capacity building? *Facilitated discussion:* Examining issues around power and control. Sub-Themes: How do attitudes and behaviours of professionals promote or inhibit participation? What are the causes and consequences of manipulation by a participatory approach?	*Lecture:* "Measuring the size of the Gap" *Norberto Dachs / Adam Wagstaff* *Group Exercise* What measures will be used in each specific gauge and why? *Lecture:* Qualitative aspects of Health Equity measurement *Timothy Evans*

1.00pm Lunch

2.00pm Plenary: Individual Gauge Presentations - *Thailand, Bangladesh and China*

3.15pm Tea

3.30pm Parallel Sessions

Advocacy	*Public Participation*	*Measurement*
Case study: Uganda Oxfam - *Monica Naggaga* Group Work – three gauges to work on plans for their own individual Equity Gauges and to use these as a basis for developing skills Skills for advocacy – using the media *(1 hour)*	*Group work:* Assessing participation and facilitating changes for wider participation. Sub themes: Experiences of assessment and how to develop assessment tools to reflect local situations. Identification of key factors that promote participation and review of factors as possible indicators for participation in an Equity Gauge Developing Criteria for Public Participation - who would Equity Gauges want to involve, and for what ends?	*Group Exercise:* Discussion of the qualitative techniques being considered to collect information in each gauge? *Lecture:* Measurement of household expenditures for health care (Adam Wagstaff and Martin Valdivia) Group Exercise: Putting together your gauge – summary of the theoretical framework and complete methodology for measurement in each gauge.

5.30pm Day Ends

Thursday February 14th

8.30am Plenary: Individual Gauge Presentations - *Uganda, Zambia and Zimbabwe*
10.30am Field Trip: organised by Ugandan Institute of Public Health

Friday February 15th

8.30am Plenary: A Global Equity Gauge Alliance – The Way Forward

- Update on GEGA activities: September 2000 to September 2001
- Key Strategic Issues from the parallel sessions – (presentations from resource people)
- Examples of how individual Gauges might have a global impact
  Monitoring Immunisation in Bangladesh - *Mr. Mushtaque Chowdury*
  Training for Equity – *Dr. Jeanette Vega*

Plenary Discussion: Strategic Vision of GEGA

12.30pm Closure and vote of thanks: Ugandan Institute of Public Health
1.00pm Lunch

Subject: Reservations for KAMPALA
Date: Wed, 9 Jan 2002 17:14:21 +0530
From: "Suchi" <suchi@travelexchange-india.com>
To: <ashokaiyar@yahoo.com>, "Community health cell" <sochara@vsnl.com>

ATTN:Dr.Ravi Narayan

This is in reference to Mr.Ashok Aiyer `s telephone call enclosing
the reservation made for your trip to Kampala.
Visa requirements for Uganda

1) Applicant should have a valid passport [minimum 6 months)
2) Two Visa forms
3) Three passport photographs
4) return confirmed ticket
5)Covering letter from community health center mentioning purpose of visit
6)Vaccination certificate for cholera and yellow fever
7) Invitation from Kampala
8) Sufficient funds to support self in Kampala
9) Consulate in Delhi and time taken 5 working days.

Fare for the routing
RS 41756+TAXES RS 6000 ON KENYAN AIRLINES

To Abhay
as an attachment
with communication
of 15/1/02
RN
15/1
Sent
on 15/1/2002
rahul

Record Locator: MQD0ZS

NARAYAN, RAVIDR
Frequent Flyer Numbers

Phones

Type	City	Phone
Travel Agent	(MAA)	TRAVEL EXCHANGE REF SUCHI
Travel Agent	(MAA)	TRAVEL EXCHANGE REF SUCHI

Itinerary

RN
10/1/02

1 9W - Jet Airways Flight Number: 442 Booking Code: M # Seats: 1
Date: 10 February - Sunday
From: BLR - Hindustan Arpt, Bangalore India
To: BOM - Chhatrapati Shivaji Airport, Mumbai India
Departs: 8:30 PM Arrives: 10:05 PM
Status: HK - Confirmed Sell Type: S - Super guaranteed sold

2 KQ - Kenya Airways Flight Number: 201 Booking Code: Q # Seats: 1
Date: 11 February - Monday
From: BOM - Chhatrapati Shivaji Airport, Mumbai India
To: NBO - Jomo Kenyatta Intl, Nairobi Kenya
Departs: 3:10 AM Arrives: 6:45 AM
Status: HK - Confirmed Sell Type: O - Secure sold

3 KQ - Kenya Airways Flight Number: 410 Booking Code: Q # Seats: 1
Date: 11 February - Monday
From: NBO - Jomo Kenyatta Intl, Nairobi Kenya
To: EBB - Entebbe Airport, Entebbe Uganda
Departs: 7:30 AM Arrives: 8:40 AM
Status: HK - Confirmed Sell Type: O - Secure sold

4 KQ - Kenya Airways Flight Number: 413 Booking Code: Q # Seats: 1
Date: 15 February - Friday
From: EBB - Entebbe Airport, Entebbe Uganda
To: NBO - Jomo Kenyatta Intl, Nairobi Kenya
Departs: 3:10 PM Arrives: 4:20 PM
Status: HK - Confirmed Sell Type: O - Secure sold

5 KQ - Kenya Airways Flight Number: 200 Booking Code: Q # Seats: 1
Date: 15 February - Friday
From: NBO - Jomo Kenyatta Intl, Nairobi Kenya
To: BOM - Chhatrapati Shivaji Airport, Mumbai India
Departs: 5:20 PM Arrives: 2:00 AM Saturday
Status: HK - Confirmed Sell Type: O - Secure sold

6 9W - Jet Airways Flight Number: 411 Booking Code: M # Seats: 1
Date: 16 February - Saturday
From: BOM - Chhatrapati Shivaji Airport, Mumbai India
To: BLR - Hindustan Arpt, Bangalore India
Departs: 6:40 AM Arrives: 8:15 AM
Status: HK - Confirmed Sell Type: S - Super guaranteed sold

e: Greetings

Subject: Re: Greetings
Date: Thu, 10 Jan 2002 08:23:13 +0200
From: hstmccoy@ct.stormnet.co.za
To: Community health cell <sochara@vsnl.com>
CC: Pat Naidoo <rpillay@imul.com>

Dear Ravi,

It was good talking to you on the phone, and its made me hope even more that you will be able to make the trip out to Kampala!

I am attaching the draft programme agenda. As you will see, the day of the field trip is in fact thursday and NOT wednesday. So if you needed to cut your trip short, you could miss the 4th and 5th day quite conveneintly.

I have inserted into the programme the three ideas we had about inouts from yourself. Two of which you say you would already have prepared, and the one using the example of India's different states being something you might need to prepare. I hope I'm not being over-demanding!

In any case, we will talk again on saturday. In the meantime I hope that Pat will be able to find suitable travel arrangements for yourself.

With best wishes,
Dave

David McCoy
Health Systems Trust
Tel: 021-4476330
Fax: 021-4476302

To Alshaj → as an attachment with communication of 15/1/02 RN 15/1

Sent on 19/1/2002 alshaj

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

---- File information ----------
File: Uganda Programme2.doc
Date: 9 Jan 2002, 23:44
Size: 37376 bytes.
Type: Unknown

Uganda Programme2.doc	**Name:** Uganda Programme2.doc **Type:** Winword File (application/msword) **Encoding:** BASE64

RN 10/1/02 RN 10/1

Global Equity Gauge Alliance
Technical Workshop for Equity Gauges

February 11th to the 15th 2001

Draft Programme

The workshop aims to:

- Strengthen participants understanding of the concept of Equity as well as a Framework for Equity Gauges;
- Strengthen participants awareness of the place and scope of advocacy, public participation and monitoring and measurement within an Equity Gauge;
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1230: Case Study: *Abbas Bhuiya*

2.00pm Plenary: Individual Gauge Presentations - *Nairobi, Cape Town and Ecuador*

3.15pm Tea

3.30pm Parallel Sessions

Advocacy and Public Participation	**Measurement**
Question-Answer session based on plenary inputs to be facilitated by presenters. • What is 'advocacy' and 'public participation' – what are their differences and what are their synergies? • Developing consensus on the meaning of "community", "participation" and "empowerment".	*Group Exercise* • Outline of the conceptual framework being used in each gauge (alternatives models can be considered to do this) • What are the indicators being used or considered in each gauge? *Guided discussion* Limitations and strengths of using different sources of information (primary vs secondary, individual vs aggregate, qualitative vs quantitative, etc) based on gauge sources and approaches

5.30pm Day Ends

Wednesday February 13th

8.30am Parallel sessions

Advocacy	*Public Participation*	*Measurement*
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  Training for Equity – *Dr. Jeanette Vega*

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RN
10/1

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Advocacy	*Public Participation*	*Measurement*
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  Training for Equity – *Dr. Jeanette Vega*

Plenary Discussion: Strategic Vision of GEGA

12.30pm Closure and vote of thanks: Ugandan Institute of Public Health
1.00pm Lunch

Dear Dave, Pat and David,

Greetings from Community Health Cell!

Further to all the telephonic conversations we have had over the last few weeks and the email dialogue, this is to confirm that Dr. Abhay Shukla, a public health professional and activist, who is presently with the Centre for Enquiry into Health and Allied Themes (CEHAT) in Pune, Maharashtra, and a colleague of the medico friend circle (mfc) will stand in for me at the Workshop because as of now my recovery from acute cervical spondylosis has not been good enough to ensure my definitive participation and I felt the uncertainty was not good for the workshop organisation.

I have noted the three 'inputs' that David would like me to have made (a) Micro level case study (b) Building Coalitions (c) Adjusting the advocacy strategy to the political environment. I have discussed these with Abhay and I am quite confident that he will make these inputs rather well, since his recent advocacy / campaign with the Peoples Health Assembly mobilization process in Maharashtra has been among the most effective. He also builds on other experiences of advocacy and campaigning. We both are going to be in touch as he evolves these inputs. David has been kind enough to suggest that I should continue to keep the option of participation if the condition improves, which I shall do. However if I do not make it, I still look forward to the proceedings and would like to keep in touch.

I do not know if you are aware of the International Poverty and Health Network (IPHN), which some of us have initiated after attending some WHO policy meetings on Equity and Sustainability. We hosted the South Asian Dialogue of IPHN in November 1999. It has a emailed newsletter and website (e-Mail : richardson.v@healthlink.org.uk Website : http://www.iphn.org) It would be nice for both your equity guage network and IPHN to link up. Shall send you some more materials of IPHN separately.

Keep in touch.

With best wishes,

Yours sincerely,
RN
Ravi Narayan,
Community Health Advisor,
Community Health Cell.

P.S : Dr. Abhay Shukla's address and other details for communication are as follows :

Dr. Abhay Shukla,
B-1, Nilgiri Apartments,
Karve Nagar,
Pune – 411 052.
0091 –
Phone : (020) 5465936 CEHAT-(off) – 020-4443225
e-mail : abhayshk@hotmail.com / abhayseema@vsnl.com

0091-20 –

Sent on (6/1) 2002

Dear Abhay,

Further to our telephonic conversation over the weekend, I am forwarding the last message from David McCoy, which gives the three small presentations that I was supposed to make :

a) Micro level case study;
b) Building coalitions;
c) Adjusting the advocacy strategy to the political environment.

In (a) I would add socio-economic-cultural as well not only political.

David McCoy of Health Systems Trust in Cape Town, South Africa is coordinating this 'pillar: of the Workshop and would have got in touch with you by now. If not please get in touch hstmccoy@ct.stormnet.co.za and Pat Naidoo - rpillay@imul.com is in charge of travel and local arrangements in Kempala and will also be getting in touch with you.

After seeing the programme, I felt you would be the best replacement for me, especially because of the PHA campaigns that you have so effectively mobilized. We could dialogue around item 'c' but items 'a' and 'b' should not be a problem for you – since it is in line with all your recent work.

I am also sending you an itinerary which my travel agent had forwarded to me a few days ago. It has one set of options on Kenya Airways plus all other requirements as well. Pat could make alternative arrangements from their side as well. You can follow this up when he calls.

I am glad that you are able to stand in for me. The doctor has suggested two months of restriction on travel to ensure relief from symptoms. Hence there is a good chance I will not be able to make. Anyway, we shall be in touch.

All the best,

RN

Ravi.

C.C. : (1) David McCoy (2) Pat Naidoo.

Sent on 17.1.2002

Subject: Uganda Meeting
Date: Tue, 15 Jan 2002 13:25:32 +0530
From: Community health cell <sochara@vsnl.com>
To: hstmecoy@ct.stormnet.co.za, rpillay@imul.com, lmartin@uwc.ac.za

Forwarded to Abhay Shukla Cehat-Pune

forwarded 17/01/02 au

Dear Dave, Pat and David,

Greetings from Community Health Cell!

Further to all the telephonic conversations we have had over the last few weeks and the email dialogue, this is to confirm that Dr. Abhay Shukla, a public health professional and activist, who is presently with the Centre for Enquiry into Health and Allied Themes (CEHAT) in Pune, Maharashtra, and a colleague of the medico friend circle (mfc) will stand in for me at the Workshop because as of now my recovery from acute cervical spondylosis has not been good enough to ensure my definitive participation and I felt the uncertainty was not good for the workshop organisation.

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Keep in touch.

With best wishes,

Yours sincerely,

Ravi Narayan,
Community Health Advisor,
Community Health Cell.

P.S : Dr. Abhay Shukla's address and other details for communication are as follows :

Dr. Abhay Shukla,
B-1, Nilgiri Apartments,
Karve Nagar,
Pune - 411 052.
Phone : 0091- 20 - 5465936 CEHAT (Off.) 0091 - 20 - 444 3225
e-mail : abhayshk@hotmail.com / cehatpun@pn3.vsnl.net.in

Subject: **Re: Uganda Meeting**
Date: Wed, 16 Jan 2002 16:36:24 +0200
From: hstmccoy@ct.stormnet.co.za
To: hstmccoy@ct.stormnet.co.za, rpillay@imul.com, lmartin@uwc.ac.za, Community health cell <sochara@vsnl.com>

Dear Ravi,

I haven't been able to contact Abhay by phone. I think I may have taken down the number wrongly. Wpuld you mind re-sending it to me.
Thanks
Dave

> *Dear Dave, Pat and David,*
>
> *Greetings from Community Health Cell!*
>
> *Further to all the telephonic conversations we have had over the last few weeks and the email dialogue, this is to confirm that Dr. .*

Sent email Requesting Dr-AS to Send CVs/Dr-Dave... his Contact numbers/Fax.
17/1/2002

Forwarded to Abhay Shukla of CEHAT -Ravi

forwarded 17/01/02

Subject: kampala meeting
Date: Sun, 13 Jan 2002 17:57:53 +0200
From: hstmccoy@ct.stormnet.co.za
To: tnarayan@vsnl.com, Community health cell <sochara@vsnl.com>
CC: Antionette Ntuli <ant@healthlink.org.za>

Dear Ravi,

I will join you in being an optimist and continue to hope that you will be able to join us in Kampala. I am however glad that your physician is helping make sure that you safeguard your own health first and foremost.

Thankyou very much for arranging to have Abhay stand in for you.

If you are still able to come, we would only be too pleased to have both of you there.

In terms of reimbursement, we are able to provide some compense. We have budgeted for a daily rate of up to a limit of US$400 for the 5 days of the meeting. If you are unable to come but have spent a significant amount of time contributing to the presentations that Abhay will be making, then please make out an invoice to the Health Systems Trust.

I will in the meantime make contact with Abhay.

I hope your neck gets better, and I look forward to meeting you in Kampala or somewhere else one of these days.

Dave
David McCoy
Health Systems Trust
Tel: 021-4476330
Fax: 021-4476302

RN 15/1/02

RN 15/1/02

Subject: Kampala meeting
Date: Sun, 13 Jan 2002 17:57:53 +0200
From: hstmccoy@ct.stormnet.co.za
To: Cehatpun@pn3.vsnl.net.in
CC: tnarayan@vsnl.com, Community health cell <sochara@vsnl.com>, Pat Naidoo <rpillay@imul.com>

Dear Abhay,

I have just spoken with Ravi about your agreement to participate in the meeting in Kampala. Many thanks for this. I look forward to meeting with you.

I understand that you and Ravi have already been discussing the three themes / presentations. Attached is a draft programme which will give you a rough idea of the programme in Kampala. I will contact you by telephone (91-20-5465936) to discuss the programme in due course.

In the meantime, Dr Pat Naidoo will be sending you a formal invitation to the meeting which is required for your visa application. He will also be arranging your travel arrangements with you. Should you have a preference for your travel itinerary you could forward him the details.

We are only able to provide economy class travel, but we are able to reimburse you and your organisation for the five days of the meeting up to a maximum daily rate of US$400.

Many thanks once again.

I will call you by telephone in the week

Dave

David McCoy
Health Systems Trust
Tel: 021-4476330
Fax: 021-4476302

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

---- File information ----------
File: Uganda Programme2.doc
Date: 9 Jan 2002, 23:44
Size: 37376 bytes.
Type: Unknown

Uganda Programme2.doc	**Name:** Uganda Programme2.doc **Type:** Winword File (application/msword) **Encoding:** BASE64

RN 15/1/02

Subject: Re: Kampala meeting
Date: Mon, 21 Jan 2002 17:01:35 +0530
From: cehat <cehatpun@vsnl.com>
To: hstmccoy@ct.stormnet.co.za
CC: Community health cell <sochara@vsnl.com>, Pat Naidoo <rpillay@imul.com>

Dear David,
Greetings!

I am sorry for the delay in responding to your e-mails. The reason is because I was in the field last week and returned to office just today.
I have gone through the programme and also had some discussion with Dr. Ravi Narayan about the workshop. The idea of the Equity Gauge does seem interesting and could be a very effective tool to advocate for the right to health care and healthy living conditions. The effort of bringing together health professionals from all over the world to develop a common strategy in this regard is indeed commendable.
As far as my participation is concerned, I could definitely contribute to the Micro-level case study on advocacy / building coalitions, drawing upon our work of developing health movements in the context of various peoples movements. 'Adjusting the advocacy strategy to the political environment' is a somewhat broader issue where perhaps I could share the PHA process in India and how it has evolved in a few different states.
My major constraint is that I need to reach back to Mumbai on 14th Feb. morning for a meeting and presentation with the Global health council and other participants from various parts of the country. So I may have to leave from Uganda on 13th afternoon to return. My travel agent has informed me that there is a flight from Entebbe to Dubai at 4 pm and a connecting flight from Dubai to Mumbai which would enable me to reach Mumbai on 14th morning. However any other flight schedule which enables me to reach Mumbai on 14th Feb. morning is fine.
Regarding coming, I can follow the same itinerary from Mumbai as that planned for Ravi. I would go from Pune (where I am based) to Mumbai by bus. Then I could leave Mumbai by Kenya Airways on 11th Feb at 3.10 am, and via Nairobi reach Entebbe on 11th morning at 9.40 am.
Although I would be interested in all the sessions, there seems to be no presentation expected from my side after 13th noon. So I hope such an arrangement should be OK.

Please inform me whether such a schedule could be worked out. Also, given this, how I should go about obtaining the visa, tickets and other details. Kindly try to reply by 23rd noon since I will be going out for a couple of days on 23rd afternoon. You are welcome to phone me at home (91-20-5465936) or office (91-20-4443225) if necessary.

I do look forward to participating in and contributing to the workshop and interacting with all of you,
With regards,

Abhay Shukla,
CEHAT

RM
22/1/02

RM
22/1

Subject: Re: Kampala meeting
Date: Mon, 21 Jan 2002 17:01:35 +0530
From: cehat <cehatpun@vsnl.com>
To: hstmccoy@ct.stormnet.co.za
CC: Community health cell <sochara@vsnl.com>, Pat Naidoo <rpillay@imul.com>

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With regards,

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RN
22/1/02

RN
22/1

hstmccoy@ct.stormnet.co.za wrote:

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> ---
>
> Name: Uganda Programme2.doc
> Uganda Programme2.doc Type: MSWORD File (application/msword)
> Encoding: BASE64

Subject: Re: Kampala meeting
Date: Fri, 25 Jan 2002 13:07:41 +0530
From: cehat <cehatpun@vsnl.com>
To: hstmccoy@ct.stormnet.co.za
CC: narayan@vsnl.com, Community health cell <sochara@vsnl.com>, Pat Naidoo <rpillay@imul.com>

Dear David,
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I was in the field last week and returned to office just today.
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RN 29/1/02

RN 29/1/02

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CEHAT

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> I will call you by telephone in the week
>
> Dave
>
> David McCoy
> Health Systems Trust
> Tel: 021-4476330
> Fax: 021-4476302

Subject: advocacy programme for Kampala meeting
Date: Sun, 3 Feb 2002 23:29:35 -0200
From: hstmccoy@et.stormnet.co.za
To: cchat <cchatpun@vsnl.com>, kazim@netactive.co.za,
Logie-Dorothy-DPHM-BHB <dorothy.logie@borders.scot.nhs.uk>,
"Lynette Martin" <lmartin@uwc.ac.za>
CC: "Mark Heywood" <heywoodm@law.wits.ac.za>, "Brown, Hilary" <HBrown@rockfound.org>,
"Dr. Pat Naidoo" <rpillay@mweb.com>, Community health cell <sochara@vsnl.com>

Dear friends,

Please find attached a programme for the Kampala meeting in which I hope you will be able to see now / where you will fit into the broader programme.

I have arranged the programme partly to accommodate people's travel arrangements. As you can see we have 1 hr 20 mins of plenary time, and 5 and a half hours of small group time. By 'small group' I mean about 20-30 people.

FARM POISONS TO THE FORE

I would like to suggest that all the advocacy presenters (Dorothy, Abhay, Sipho, David and Hilary) meet with me on monday evening to discuss the programme. If necessary we can still change the programme, as there is the flexibility to move presentations between the plenary and small group sessions. Ideally I would like as many inputs to be made in the plenary, but this can only be done by reducing the amount of time per plenary input.

A question I would have is whether to make time in the plenary for Sipho to present as well.

The small group sessions will be a mix of inputs and discussion, and then using the inputs and discussions as a basis for participants to raise issues about their advocacy plans vis a vis their Equity Gauge projects.

I haven't budgeted a time for the small group inputs, and would be grateful if you could indicate to me now much time you would like. For David Sanders and Sipho, I would also like to ask if your inputs are best done as one presentation, or whether there are parts of your overall input that could be broken up into parts.

For example the Treatment Action Campaign experience incorporates a range of dimensions ranging from public campaiging, using the media, building coalitions and applying the law to effect change and government action.

Please do not hesitate to contact me if you have any suggestions or thoughts. I am certainly looking forward to the inputs and discussions.

Many thanks

Dave

RN 6/2

subpoena 1/2/2002

Global Equity Gauge Alliance
Technical Workshop for Equity Gauges

February 11th to the 15th 2001

Draft Programme

The workshop aims to:

- Strengthen participants understanding of the concept of Equity as well as a Framework for Equity Gauges;
- Strengthen participants awareness of the place and scope of advocacy, public participation and monitoring and measurement within an Equity Gauge;
- Provide a forum for undertaking some strategic planning for the Global Equity Gauge Alliance (GEGA);
- Create an opportunity for Equity Gauges to exchange ideas and information.

Monday February 11th

8.30am	Welcome *Ugandan Institute of Public Health*
9.30am	Setting the Context for the Workshop *Dr. Tim Evans and Ms. Antoinette Nuli*
10.00am	Plenary: A Framework for Equity *Dr. Paula Braveman and Dr. Jeanette Vega*
11.00am	Break
11.30am	Plenary: A Framework for an Equity Gauge *Dr. David McCoy*
1.00pm	Lunch
2.00pm	Plenary: Individual Gauge Presentations - *Chile and South Africa*
2.45pm	Group Discussion: Framework for Equity and an Equity Gauge
4.00pm	Tea
4.15pm	Plenary: Feedback from small groups
5.30pm	Day Ends

Tuesday February 12th:
Plenary: Strengthening the Three Pillars of an Equity Gauge

0830:	Introduction to Advocacy (*Dr. David McCoy*)
0840:	Working through information, pressure and lobbying -- the experience of Jubilee 2000 and Medact (*Dorothy Logie*)
0915:	Micro-level case study: Advocacy / building coalitions, and developing health movements in the context of various peoples

movements. *(Dr Abbay Shukla)*

1000: Tea

1030: Introduction to Measurement: *Dr. Jeanette Vega*

1040: Concepts of Equity and the implications for measurement. Theoretical frameworks for health inequalities pathways *Margaret Whitehead*

1110: How to select the indicators to measure Equity. Selection criteria for Health status, health care and socioeconomic indicators. Level of aggregation. *Paula Braveman*

1145: Introduction to Public Participation: *Antoinette Ntuli / Mushtaq Chowdury*

1200: Why participation is a vital component of promoting Equity *(Susan Rifkin)*

1230: Case Study: *Abbas Bhuiya*

2.00pm Plenary: Individual Gauge Presentations - *Nairobi, Cape Town and Ecuador*

3.15pm Tea

3.30pm Parallel Sessions

Advocacy and Public Participation	**Measurement**
Question-Answer session based on plenary inputs plenary presenters (Abbay, Dorothy, Susan, Abbas) • What is "advocacy" and "public participation" – what are their differences and what are their synergies? • Developing consensus on the meaning of "community", "participation" and "empowerment".	*Group Exercise* • Outline of the conceptual framework being used in each gauge (alternatives models can be considered to do this) • What are the indicators being used or considered in each gauge? *Guided discussion* Limitations and strengths of using different sources of information (primary vs secondary, individual vs aggregate, qualitative vs quantitative, etc) based on gauge sources and approaches

5.30pm Day Ends

Wednesday February 13th

8.30am Parallel sessions

Advocacy	*Public Participation*	*Measurement*
Adjusting the advocacy strategy to the political environment – *Abhay Shukla* Case study: Mount Frere - *David Sanders* Policy Maker – a tool to help develop an advocacy strategy – *Hilary Brown*	*Group work:* Examining assumptions about the critical role of participation Sub-themes: Does participation promote sustainability? Does participation ensure capacity building? *Facilitated discussion:* Examining issues around power and control Sub-Themes: How do attitudes and behaviours of professionals promote or inhibit participation? What are the causes and consequences of manipulation by a participatory approach?	*Lecture:* "Measuring the size of the Gap" *Norberto Dachs / Adam Wagstaff* *Group Exercise* What measures will be used in each specific gauge and why? *Lecture:* Qualitative aspects of Health Equity measurement *Timothy Evans*

1.00pm Lunch

2.00pm Plenary: Individual Gauge Presentations - *Thailand, Bangladesh and China*

3.15pm Tea

3.30pm Parallel Sessions

Advocacy	*Public Participation*	*Measurement*
Case Study: The Treatment Action Campaign – *Sisonke Mthathi* Lobbying and dialogue with decision-makers – *Dorothy Logie* Discussion on planning an advocacy strategy based on one of the existing country gauges	*Group work:* Assessing participation and facilitating changes for wider participation. Sub themes: Experiences of assessment and how to develop assessment tools to reflect local situations. Identification of key factors that promote participation and review of factors as possible indicators for participation in an Equity Gauge Developing Criteria for Public Participation – who would Equity Gauges want to involve, and for what ends?	*Group Exercise:* Discussion of the qualitative techniques being considered to collect information in each gauge? *Lecture:* Measurement of household expenditures for health care (Adam Wagstaff and Martin Valdivia) Group Exercise: Putting together your gauge – summary of the theoretical framework and complete methodology for measurement in each gauge

5.30pm Day Ends

Thursday February 14th

8.30am Plenary: Individual Gauge Presentations - *Uganda, Zambia and Zimbabwe*
10.30am Field Trip: organised by Ugandan Institute of Public Health

Friday February 15th

8.30am Plenary: A Global Equity Gauge Alliance – The Way Forward

- *Update on GEGA activities: September 2000 to September 2001*
- Key Strategic Issues from the parallel sessions – (presentations from resource people)
- Examples of how individual Gauges might have a global impact
  Monitoring Immunisation in Bangladesh - Mr. Mushtaque Chowdury
  Training for Equity – *Dr. Jeanette Vega*

Plenary Discussion: Strategic Vision of GEGA

12.30pm Closure and vote of thanks: Ugandan Institute of Public Health
1.00pm Lunch

RN
4/2

Subject: Re: GEGA workshop
Date: Fri, 1 Mar 2002 16:20:26 +0200
From: hstmccoy@ct.stormnet.co.za
To: abhay shukla <abayscma@pn3.vsnl.net.in>
CC: Antionette Nnuli <ant@healthlink.org.za>, Community health cell <sochara@vsnl.com>

Dear Abhay,

I'm glad to hear that you have arrived safe and sound in India.

Thankyou very much for the contributions you made to the workshop. I thought you made a real difference to getting the group to understand many important issues about the politics of health.

I really think that your presentation about fitting one's advocacy strategy to the socio-political context (using 4 examples) should be written up into an article for wider dissemination. Can GEGA commission you to write such an article??

In any case, Health Systems Trust have been mandated to play a leadership and secretariat role for the development of GEGA, and we would like to explore ways in which you / Ravi can become formally associated with GEGA, as well as to explore the potential for connections between GEGA and the People's Health Assembly.

Please keep up your good work, and doing it in such a friendly and positive manner!! We will proceed with the invoice.

Dave

PS. Ravi - thank you for making it possible for abhay to join us!!

> *Dear David,*
> *Greetings!*
>
> *Hope this mail finds you fine. Sorry for the delay in writing - I was in the field and returned just yesterday. I first of all wish to thank you for giving me the opportunity to attend the stimulating sessions and interactions that I had during the GEGA workshop. I do hope that the subsequent sessions during the GEGA consultation were also informative and productive. Hope you would have recovered from the exhaustion of organizing the event by now!*
>
> *I look forward to reading the report of the workshop including the plan of future action. Although in India we are not directly part of the GEGA process, we do look forward to keeping in contact and learning from this important process, using some of the tools in our situation and also contributing our experiences and perspective wherever relevant. Please include my e-mail address in the final participant list that is circulated, since it was inadvertently left out of the list circulated during the workshop. Do convey my congratulations and regards to Pat Naidoo and other organisers who made it a fruitful and pleasant experience. I will also be writing to David Sanders separately.*
>
> *I am attaching a brief invoice for my consultancy and local travel (Pune-Mumbai and Mumbai-Pune) with respect to the workshop. I have also given my bank details as you had suggested. Please let me know if any modifications are required or additional information needs to be given. I can send the same by fax if necessary.*
>
> *I hope rest is fine at your end. It would be interesting to see how the international determinants of intra-national inequity get addressed during further application of the causes, and also how the massive global inequities, being exacerbated by the processes of inequitous globalisation are included while addressing inequity in*

RN 4/03

3/4/02 8:24 AM

RN 4/3/02

3/4/02 8:29 AM

> this important process. Please do keep me informed about further
> developments.
>
> With warm regards,
> Yours sincerely,
>
> Abhay Shukla
>
>

Dr. David McCoy
Health Systems Trust
Tel: 021-4476330
Fax: 021-4476302

cc. Abhay Shukla

15/3

Dear David

Thanks for the copy of the correspondence between Abhay and you of 1st March. I am really glad that Abhay made a good contribution and his inputs were meaningful and relevant for the process. He has been in touch as well greatly appreciating the opportunity and experience.

He has also written about the article and I have agreed to work with him on it. It seems a good idea to evolve a formal association with GEGA and both of us could do it as CEHAT (Abhay) and CHC (Ravi) since both these are Health Policy Research groups or alternatively we could associate as PHA (India) and PHA (Global). We in CHC are evolving a new project from April 2002 entitled the Peoples Health Watch. More about it when the proposal is ready for a peer review. There is a possibility that we may relocate the organisational responsibility of the Peoples Health Movement at International level from Oct 2002. So the PHM/PHA link is also feasible.

Presently I am rather busy organising the Technical briefings in WHO - Assembly May 2002 of the Peoples Health Charter to all the delegates. Some aggressive lobbying has resulted in getting 90 minutes fixed and I am convenor of the WHO/WHA circle in the PHA. Are any of the GEGA partners likely to attend WHA-May 2002 in Geneva?

3/4/02 8.29 AM

Subject: Re: Greetings from Ravi CHC
Date: Fri, 15 Mar 2002 16:29:53 +0200
From: hstmccoy@ct.stormnet.co.za
To: Community health cell <sochara@vsnl.com>
CC: abhay shukla <abavsema@pn3.vsnl.net.in>, "Antoinette Ntuli" <ant@healthlink.org.za>

Dear Ravi,

Thanks and all this sounds great. As far as the WHA meeting is concerned, I am not aware if anyone from GEGA is attending, but I think we should be there. I would certainly like to go, and I will discuss this with other members of the GEGA steering committee. If you think it would be useful for GEGA to be there, could you let us know??

As far as institutional linkages are concerned, it sounds like PHA (India) would act as an umbrella for both CEHAT and CHC, and would therefore make sense from that angle.

As for the artcile, I look forward to it. Would it be useful if we were to formally "commission" you and Abhay to write this and include a budget for its purposes as well??

Regards,
DAve

> *Dear David*
>
> *Thanks for the copy of the correspondence between Abhay and you of 1st March. I am really glad that Abhay made a good contribution and his inputs were meaningful and relevant for the process. He has been in touch as well, greatly appreciating the opportunity and experience. He has also written about the article and I have agreed to work with him on it. It seems a good idea to evolve a formal association with 'GEGA' and both of us could do it as CEHAT (Abhay) and CHC (Ravi) since both of these are Health Policy Research groups interested in Equity and Health. Or alternatively we could associate as PHM (India) and PHA (Global).*
>
> *We in CHC are evolving a new project from April 2002 entitled the 'People's Health Watch'. More about it when the proposal is ready for a peer review. There is a possibility that we may takeover the organizational responsibility of the People's Health Movement at international level from October 2002. So the PHM/PHA link is also feasible. Presently I am rather busy organizing the technical briefing in WHO- Assembly May 2002 of the People's Health Charter to all the delegates. Some aggressive lobbying has resulted in getting 90 minutes for it and I am convener of the WHO/WHA Circle in the PHA. Are any of the GEGA partners likely to attend WHA-May 2002 in Geneva?*
>
> *Best wishes*
>
> *Ravi*
> *Community Health Cell, Bangalore*

Dr. David McCoy
Health Systems Trust
Suite 509, 5th Floor
Premier Centre
161 Main Road
Observatory, 7925
Cape Town

RN 16/3

RN 16/3

Subject: [Fwd: PHM contacts in Thailand]
Date: Tue, 24 Sep 2002 18:26:41 +0530
From: Community Health Cell <sochara@vsnl.com>
To: abhayseema@vsnl.com
CC: ctddsf@vsnl.com, gksavar@citechco.net, achan2000@vsnl.com

Dear Abhay,

Greetings from Community Health Cell!

Please write to Dr.Qasem (PHM Secretariat - Savar) and Dr.Prem John of Asian Community Health Action Network about THAI contacts. I am forwarding your letter to both of them but please contact directly as well.

I shall confirm with Srinath Reddy about ASF and participation in the Right to Health Care workshop since I shall be in Trivandrum (25-27th September) for the India Clinical Epidemiologists Network Annual Meeting. I am speaking on a alternative Research Framework using the PH Charter and Dr.Ekbal is speaking on GATTS, as guest speakers. Sundar's outline has just come in - of ASF health related activities. We all need to add further details to it.

Best Wishes,

Ravi Narayan
CHC / PHM

Equity Gauge file
RN
4/10/02
PHM- Asia
Thailand

Subject: PHM contacts in Thailand
Date: Tue, 24 Sep 2002 09:12:07 +0530
From: "Abhay Seema" <abhayseema@vsnl.com>
Reply-To: "Abhay Seema" <abaysema@pn3.vsnl.net.in>
To: <sochara@vsnl.com>
CC: <ctddsf@vsnl.com>

Dear Ravi and Amit,
Greetings!
As you know, a process of developing 'Health equity gauges' in various developing countries is underway, which is trying to document health inequity and supporting advocacy efforts to bring about greater equity in health care and health determinants. I am involved in supporting this process (yet to start in India) and Thailand is one of the countries where public health academics have developed an equity gauge. However, they are yet to develop linkages with grassroots groups, people's organisations or PHM groups who could tap this information and expertise, for advocacy. So it would be useful if you could forward any addresses of health groups or even non-health community organisations / advocacy groups who may be involved in PHM / WSF activities and might be interested in collaborating with the Equity Gauge in Thailand.
Amit, since you were recently in Thailand for ASF, I thought you would have WSF / PHM contacts there, which you could send. Ravi, you would also be aware of PHM groups in Thailand. Even if you know of some 'link contacts' who could help identify other relevant groups in Thailand, it would be useful.
Incidentally, Thailand has recently developed a system for universal health care coverage which might be a useful model for us to study in the context of Right to Health Care in India.
I think we should go ahead with the process of contacting speakers for the 'Right to Health Care' workshop during ASF now. I will circulate a draft programme and list of speakers soon.
Hope rest is fine at your end.
With warm regards,
Abhay

PS: Amit, please forward to me Srinath Reddy's e-mail address so I can confirm with him about his participation in the ASF workshop. I had talked to him briefly on the phone when I was in Delhi and he was positive, but you should also

talk to him.

Let's all join the fight, for health as a basic right!

Abhay Shukla
B-1 Nilgiri Apartments, Karvenagar, Pune 4110052
Maharashtra, India
Phone: 020-546 5936
e-mail: abhayseema@vsnl.com

Subject: PHM contacts in Thailand
Date: Tue, 24 Sep 2002 09:12:07 +0530
From: "Abhay Seema" <abhayseema@vsnl.com>
Reply-To: "Abhay Seema" <abaysema@pn3.vsnl.net.in>
To: <sochara@vsnl.com>
CC: <ctddsf@vsnl.com>

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I think we should go ahead with the process of contacting speakers for the 'Right to Health Care' workshop during ASF now. I will circulate a draft programme and list of speakers soon.
Hope rest is fine at your end,
With warm regards,
Abhay

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Let's all join the fight, for health as a basic right!
Abhay Shukla
B-1 Nilgiri Apartments, Karvenagar, Pune 4110052
Maharashtra, India
Phone: 020-546 5936
e-mail: abhayseema@vsnl.com

RM 24/9/02 Ravi

Sent 24/9/02 Ravi

24/9/02

Dear Abhay

Please write to Dr Qasem (PHM secretariat-Savar) and Dr Prem John of Asian Community Health Action Network about THAI contacts. I am forwarding your letter to both of them but please contact directly as well

I shall confirm with Srinath Reddy about ASF and participation in the Right to Health Care workshop since I shall be in Trivandrum (25-27th Sept) for the Indic Clinical Epidemiologists Network Annual Meeting. I am speaking on a alternative Research Framework using the PH Charter and Dr Ekbal is speaking on GATTS, as guest speakers Sundari and have just come in-of ASF health related activities. We all need to add further details to it. Best wishes

Ram

cc. Dr Qasem
Dr Ram John
Dr Amit Sengupta

Community Health Cell

From: Community Health Cell <sochara@vsnl com>
To: Claudio Schuftan <aviva@netnam.vn>; Abhay Shukla <abhayshk@hotmail.com>
Sent: Monday, February 17, 2003 4.04 PM
Subject: Hello

Dear Lexi,

Thelma and I met Pat Naidoo in Kempala (not the local guage) and had a very good dialogue with David and colleagues in Nairobi (the local urban guage). We were very impressed with the work in Nairobi. Abhay Shukla (PHA-India / CEHAT) who stood in for me at the Makerere meeting has been invited to be on a GEGA committee so he keeps in touch with me on this. At the Asia Social Forum in Hyderabad in January he made a special presentation on GEGA at the workshop on Taking the PHM Forward. We look forward to getting some idea about your meetings in different parts of the world this year since it's the Alma Ata Declaration anniversary year and we could think of three small additions in each of your GEGA meetings this year with at least one or two PHM resource persons attending each of these meetings (a) A presentation on PHM (b) launch of signature campaign (c) A short discussion on how GEGA-PHM could collaborate.

We have announced PH Assembly – II in Porto Allegre in July 2004. By that time GEGA should have evolved a meaningful relationship with PHM constituents. Lets work towards it proactively. I shall request Claudio Schuftan who manages the PHM exchange to put you on the list. By the way, since we lost corresponded I have become the Coordinator of the PHM Secretariat which has now moved to CHC Bangalore for 2-3 years.

Best wishes,

Ravi Narayan,

PHM / CHC.

PHM-GEGA →

RN
18/2/03

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

Community Health Cell

From: Alexandra Bambas <lexi@hst.org.za>
To: Community Health Cell <sochara@vsnl.com>
Sent: Thursday, February 13, 2003 6:44 PM
Subject: RE: PHM - GEGA

Dear Ravi and Thelma,

I do hope all is well with both of you--congratulations on your launch of the Million Signature Campaign!

I am (very belatedly!) following up with you on a couple of issues. My apologies for not getting back to you sooner--we have been very busy making preparations for the next round of activities in the Gauges, and for planning our global efforts in training, advocacy, and collaboration.

First, I wanted to find out whether you were able to meet with any of the Gauges during your visit to Nairobi. I suspect that this activity was not as organised as it could have been, from our end...

Also, I know that you had intended to be at GEGA's Makerere meeting last February (I had not come on board at that time), specifically to work with us on advocacy issues. There may be upcoming opportunities to pick up on this line of work, which I would be very interested in discussing with you. Given the structure of our organisations, it seems there would be possibilities for linking both at the country and international levels. I am fairly familiar with the activities of the individual Gauges at this point, and, as the Coordinator, also have a broad overview of the organisation and the directions we are moving in.

Please let me know if you would like to discuss areas of mutual cooperation. I look forward to hearing from you!

Best wishes,

Lexi

RN 14/2/03 Ravi

****

Alexandra Bambas, PhD, MPH
Coordinator of the Global Equity Gauge Alliance
Health Systems Trust
PO Box 808
Durban, KwaZulu-Natal
South Africa 4000

email: lexi@gega.org.za

14/2/03

Dear Lexi

Thelma and I met Pat Naidoo in Kampala (not the local gauge) and had a very good dialogue with David and colleagues in Nairobi (the local urban gauge). We were very impressed with the work in Nairobi. Abhay Shukla (PHA-India/CEHAT) who stood in for me at the Makerere has been invited to be on the GEGA committee so he keeps in touch with me on this. ← At the Asia Social Forum in Hyderabad in January he made a special presentation on GEGA at the workshop on Taking the PHM Forward.

We look forward to getting some idea about your meetings in different parts of the world this year since it is the Alma Ata Declaration anniversary year and we could think of ~~two~~ three small additions to each of your GEGA meetings this year with atleast one or two PHM resource persons attending each of these meetings c) A presentation on [illegible] b) A short discussion on how GEGA-PHM could collaborate c) [illegible] campaign

Sent on 7/2/03 [illegible]

We have announced PHA Assembly II in Porto Alegre in July 2004. By that time GEGA should have evolved a meaningful relationship with PHM constituents. Let's work towards it proactively. In the [illegible] exchange. I shall request Claudio Schuftan who manages the PHM exchange to enlist you.

By the way since we coordinated PHM secretariat for 2-3 years and now moved to [illegible]. A new secretariat has become [illegible] which is [illegible] closer to Bangladesh [illegible] 100% concentrated on CHC.

Best wishes
Ravi Narayan
PHM/CHC
cc Thelma
cc Abhay Shukla
– Claudio Schuftan

PHM Secretariat

From: Lynette Martin <lmartin@uwc.ac.za>
To: sabhayshetty@hotmail.com; <phmsec@touchtelindia.net>
Sent: Monday, March 31, 2003 6:55 PM
Subject: Re: GEGA Meeting in Nairobi

Dear Abhay,

I do not think it is necessary for Ravi to be there if it is difficult for him. Ravi should just send us any information he would like to include.

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
Cell: 082 202 3316

>>> "PHM Secretariat" phmsec@touchtelindia.net 03/26/03 01:12PM >>>

RN 1/4/03

Dear Abhay

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

PHM-GEGA

It was nice chatting to with some news, the other day. Hope you were able to meet Jose Urrera. The travels are becoming too much and I have to consider some only if really important. I am the key note speaker in the PHM - Sri Lanka (9th to 9th April 2003) meetings - then onto Delhi for JSA - NCG. Does GEGA really require my presence especially when you and Ravi are already there and linked to it? Perhaps we can evolve a potential linkage email dialogue between the three of us and you both present it on 16th. I shall consider only if you both think its really crucial!! Perhaps you need to let me know why?

RN 1/4/03.

PHM - GEGA

4/1/03

Main Identity

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Abhay Shukla <abhayshk@hotmail.com>
Cc: David Sanders <lmartin@uwc.ac.za>
Sent: Wednesday, March 26, 2003 CHC4 PM
Subject: GEGA Meeting in Nairobi

Dear Abhay

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

It was nice catching up with some news, the other day. Hope you were able to meet Jose Utrera. The travels are becoming too much and I have to consider some only if really important. I am the key note speaker in the PHM – Sri Lanka (7th to 9th April 2003) meetings – then onto Delhi for JSA – NCC. Does GEGA really require my presence especially when you and David are already there and linked to it? Perhaps we can evolve a potential linkage email dialogue between the three of us and you both present it on 16th. I shall consider only if you both think its really crucial!! Perhaps you need to let me know why?

Best wishes,

Ravi Narayan

Coordinator

PHM Secretariat

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

RN
27/3/03

Main Identity

From: Abhay Seema <abhayseema@vsnl.com>
To: Community health cell <sochara@vsnl.com>
Cc: <secretariat@phmovement.org>
Sent: Thursday, March 20, 2003 CHC11 PM
Subject: GEGA meeting in Nairobi

Dear Ravi,
There is a GEGA coordinating committee meeting (including representatives from all the country gauges) from 16 to 18 April in Nairobi. There is a plan to invite on 16th selected representatives of other networks to develop collaborations, I have strongly suggested your name as coordinator of the global secretariat of PHM (see below), with the idea that we should strengthen GEGA's links with PHM at country and international levels. One particularly interesting activity is the Global Health Equity Watch planned by GEGA.
I suppose Lexi will contact you formally shortly, do block the dates.
More later about this and JSA matters,
Abhay

----- Original Message -----
From: Abhay Seema <abhayseema@vsnl.com>
To: Alexandra Bambas <lexi@hst.org.za>
Cc: Pat Naidoo <PNaidoo@rockfound.org>; Abbas Bhuiya <abbas@icddrb.org>; Antoinette Ntuli <ant@healthlink.org.za>; Banza Baya <bayabanza@hotmail.com>; David Acurio <Aldes@etapa.com.ec>; David McCoy <David.McCoy@lshtm.ac.uk>; David Sanders <dsanders@uwc.ac.za>; Jeanette Vega <jeanvega@terra.cl>; Mushtaque Chowdhury <mc2218@columbia.edu>; Paula Braveman <pbrave@itsa.ucsf.edu>; Pierre Ngom <pngom@aphrc.org>; Rene Loewenson <rene@tarsc.org>; Siriwan Grisurapong <shsgs@mahidol.ac.th>; TJ Ngulube <chessore@zamnet.zm>
Sent: Friday, March 14, 2003 10:59 AM
Subject: Re: External partners and the GEGA meeting in Nairobi

> Dear All,
> I would strongly recommend inviting Ravi Narayan, who is now the Coordinator
> of the Global Secretariat of the People's Health Movement. Linking GEGA with
> PHM in multiple countries, and also at the global level in the context of
> the Global Health Equity Watch could give significant boost to advocacy
> activities of Gauges and of GEGA, which would definitely be positive. I feel
> Ravi Narayan is one of the best persons to help build such collaborations,
> David Sanders and myself would of course also help in building such linkages
> with PHM.
> Contact e-mails of the Global PHM secretariat and for Ravi are:
> secretariat@phmovement.org
> phmsec@touchtelindia.net

>
> Regards,
> Abhay Shukla
>
>

cc David Sanders

26/3/03

Dear Abhay
It was nice catching up with some news, the other day. Hope you were able to meet Jose Ukkola. The travels are becoming too much and I have to consider some only if really important. I am the keynote speaker in the PHM-Srilanka 2nd/4th April meetings — then onto Delhi for JSA-NCC. Does GEGA really require my presence especially when you and Rene are already there and linked to it. Perhaps we can evolve a potential linkage framework through email dialogue between the three of us and you both present from 16th. I shall consider only if you both think it's really crucial!!

Perhaps you need to let me know why? Best wishes
Ravi
PHM Secretariat

3/21/03

From: [redacted]
To: [redacted]
Cc: [redacted] David Sanders <dmartin@uwc.ac.za>
Sent: [redacted]
Subject: [redacted]

Dear [redacted],

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

Thanks for your invitation to attend the GEGA planning meeting. Apart form the short notice(even though Abhay had spoken to me about it last week), I discover that our annual family holiday is from 13th to 18th April 2003 and its too late to make any changes. Since Abhay and David will be attending - PHM is strongly represented and I shall plan a framework of a PHM – GEGA Collaboration through an email dialogue. We meet in Geneva on [redacted] for a PHM policy/strategy meeting. Can some of you join if you are [redacted] the week [redacted] or the following week?

Best wishes

[redacted]
Coordinator, People's Health Movement Secretariat (Global)
CHC-Bangalore
[redacted]
[redacted]
[redacted]

[redacted] campaign in the 25th anniversary year of the Alma Ata declaration. Visit www.TheMillionSignatureCampaign.org

RN
1/4/03

PHM-GEGA

4/1/03

Main Identity

From: Alexandra Bambas <lexi@hst.org.za>
To: Ravi Narayan <secretariat@phmovement.org>
Cc: David Sanders <dsanders@uwc.ac.za>, Abhay Shukla <abaysema@pn3.vsnl.net.in>
Sent: Friday, March 28, 2003 CHC9 PM
Subject: GEGA meeting in Nairobi

Dear Dr. Narayan,

As Abhay has mentioned to you, we would very much be interested in having your participation in the upcoming GEGA planning meeting in Nairobi, April 16-18. In particular, we would hope you could participate on the first day of the meeting, when we will be discussing our plans for developing our Global Health Equity Watch as well as other global advocacy initiatives.

The Global Health Equity Watch will be an effort to bring out particular equity issues related to supra-national processes. Although the specific topics of the Watch have not yet been decided, we have been talking about addressing issues of PRSPs, trade agreements, MDGs, and/or regional agreements, linking these processes to their impact on the health of the poor and on the health of those in the South and East. In the next months, GEGA will also be initiating Regional Networks to support health equity as well as curricula and training courses to support pro-equity monitoring, policy, and support for community empowerment, always with an aim to support voices from the South and East.

We would very much appreciate your input so that we might plan our activities and approaches to be as supportive to PHM as possible, and we would make time at the meeting not only for discussion, but also for you to present any PHM efforts that you think might be of particular interest to GEGA.

RN 31/3

cc David Sanders
Abhay Shukla

I do realise this is short notice, for which I apologize, but I hope that you will consider attending the meeting.

In any case, we look forward to strengthening our ties to PHM in the future.

Best regards,
Lexi Bambas

Alexandra Bambas, PhD, MPH
Coordinator of the Global Equity Gauge Alliance
Health Systems Trust
PO Box 808
Durban, KwaZulu-Natal
South Africa 4000

email: lexi@gega.org.za

RN 31/3/03

Best wishes
Ravi Narayan
coordinator
PHM Secretariat
Global

31/3/03

Dear Lexi

Thanks for your invitation to attend the GEGA planning meeting. Apart from the short notice (even though Abhay had spoken to me about it last week) I discover that our annual family holiday is from 13th to 18th April 2003 and its too late to make any changes. Since Abhay and David will be attending - PHM is strongly represented and I shall plan a framework of PHM-GEGA collaboration through an email dialogue

PHM - GEGA

We meet in Geneva on 16/17th May for a PHM policy/strategy meeting. Can some of you join if you are attending the World Health Assembly in the following...

From: Alexandra Bambas <lexi@hst.org.za>
To: PHM Secretariat <phmsec@touchtelindia.net>; David Sanders <dsanders@uwc.ac.za>; Abhay Shukla <abaysema@pn3.vsnl.net.in>
Cc: Antoinette Ntuli <ant@healthlink.org.za>; Paula Braveman <pbrave@itsa.ucsf.edu>; David McCoy <David.McCoy@lshtm.ac.uk>
Sent: Monday, April 07, 2003 2:32 PM
Subject: RE: GEGA Meeting in Nairobi

Dear Ravi, David, and Abhay,

I hope this note finds you all well. Following up on Ravi's email of last week, I am hoping we might be able to get your thoughts on particular areas of GEGA work that are of interest to PHM, and how we might move towards a coordinated collaboration. At the Nairobi meeting, we are planning to meet with representatives from Indepth and the Millennium Development Project, and will also meet with Wemos in the coming month, to discuss areas of possible overlap and specifically some work on PRSPs.

I've included below a short summary of some of the resources/activities that may be useful in discussing collaboration with PHM, and some very preliminary thoughts, and would be happy to hear your thoughts, so that we might have further discussion with the Gauges in Nairobi on what might be feasible for them.

Dear Lexi
Just received your

1) the monitoring and advocacy work developed by our Gauges; there is now a wealth of equity-sensitive information made available by the Gauges, as well as a number of advocacy initiatives being pursued; we are currently collecting this information, and will hopefully have an overview assembled soon of cross-cutting themes among the Gauges;

2) a specific regional initiative in Africa, in cooperation with Equinet, to support Parliamentary Portfolio Committees on Health in a number of countries by linking them with technical resource personnel in their own countries, with teams from other countries, and with SADC officials, in order to address policy issues at the national and regional levels;

3) a recent initiative to develop curricula for training in Assessing and Monitoring health equity, advocating for pro-equity policy, and working with communities;

4) the Global Equity Gauge Watch, which is currently being defined and discussed, and will possibly look at the impact of macro level forces on health equity;

RN 7/4/03

5) our emerging initiative to build regional networks on health equity in Latin America, Africa, and Asia to support sharing of information as well as support collaboration for Equity Gauge-type projects.

People's Health Movement / International People's Health Council
Contacts: Ravi Narayan, Abhay Shukla, David Sanders, Maria Zuniga

RN 7/4/03

PHM - GEGA

Likely areas of collaboration: Dissemination, technical support for advocacy, possible advocacy cooperation

focus
PHM provides a Southern/Eastern voice for health promotion focused on health as a human right, community based care, and people-centered approaches to policy and development. The organisation is a loose network of partners from countries all over the world, and includes regional chapters that engage more focused advocacy initiatives. PHM is generally critical of privatisation efforts, of World Bank/IMF-led initiatives and actions, and of other neoliberal oriented efforts.

Overlap with GEGA
Because PHM is a very large and diverse organisation, identifying specific areas of overlap is a little difficult. But in general, there are many general issues, including health inequalities; strengthening of health systems, including human resources; and macro influences on health equity. It would be useful to hear more about PHM's specific advocacy campaigns (existing and upcoming) to see how we might support them through the information the Gauges have collected.
More specifically, GEGA and the Gauges may be able to effectively link with groups within PHM, and getting a better sense of target groups and their projects within the organisation would be useful also.

potential value of collaboration
PHM has a large constituency, is well-known and respected in general, and has ongoing relations with various organisations that GEGA may also want to connect with, including WHO (Civil Society Initiative) and Wemos, which would provide additional opportunities for networking and mutual support. Additionally, PHM's capacity to launch advocacy initiatives and to disseminate information could be helpful to our efforts. The networking function of PHM, both through listserves and through meetings, would be additional opportunities for GEGA to network with specific groups and to promote the Equity Gauge Strategy.
(Abhay: do you have comments in relation to your experience at the Asian Social Forum, or on other aspects of this discussion?)
As GEGA grows, and as we are able to collect lessons and data, there may be opportunities to provide an evidence base to PHM work and advocacy initiatives, especially if we were to approach such efforts through a planned strategy incorporating other groups collecting data on equity.
Links with smaller groups within PHM, such as regional networks and even individual members/institutions, could also provide support while feeding into our own goals for capacity building.

Thanks very much, and I look forward to hearing back from you.

Best regards,
Lexi

****

Alexandra Bambas, PhD, MPH
Coordinator of the Global Equity Gauge Alliance

Health Systems Trust
PO Box 808
Durban, KwaZulu-Natal
South Africa 4000

email: lexi@gega.org.za

-----Original Message-----
From: PHM Secretariat [mailto:phmsec@touchtelindia.net]
Sent: Tuesday, April 01, 2003 9:06 AM
To: lexi@hst.org.za
Subject: GEGA Meeting in Nairobi

Dear Lexi,
Greetings from People's Health Movement Secretariat at CHC, Bangalore!
Thanks for your invitation to attend the GEGA planning meeting. Apart form the short notice(even though Abhay had spoken to me about it last week), I discover that out annual family holiday is from 13th to 18th April 2003 and its too late to make any changes. Since Abhay and David will be attending - PHM is strongly represented and I shall plan a framework of a PHM - GEGA Collaboration through an email dialogue. We meet in Geneva on 16th-17th May 2003 for a PHM policy/strategy meeting. Can some of you join if you are attending the World Health Assembly on the following week?
Best wishes,
Ravi Narayan
Coordinator, People's Health Movement Secretariat
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org

4/7/03

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Alexandra Bambas <lexi@hst.org.za>
Cc: <abaysema@pn3.vsnl.net.in>; David Sanders <lmartin@uwc.ac.za>; Eric Ram <eric_ram@wvi.org>
Sent: Tuesday, April 08, 2003 2:04 PM
Subject: Re: GEGA Meeting in Nairobi

Dear Lexi,

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

I meet Abhay in Delhi on 11th April and will discuss some of the ideas with him. If your briefing document arrives by then perhaps I may be able to focus on 'specifics' as well.

1. I am writing to Eric Ram of (ex-World Vision) who organized a series of reflections on a Global Health Watch in which I was actively involved for many years. He will forward some reports of a project proposal that did not get followed up due to unavoidable circumstances but would definitely be helpful to GEGA especially when it looks at the determinants of Global Inequity and critiques international initiatives from a Equity perspective.

   Hope we can follow all this up more concretely in Geneva meeting, building on your reflections in Nairobi on the 16th.

2. As a General principal I believe we should try and link our PHM contacts to each of your country gauges so that PHM members advocacy / campaign's experience compliments the GEGA – Equity measurement experience, thereby linking 'evidence' to campaigns in a creative way.

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
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PHM GEGA→
12
16/4/03

----- Original Message -----
From: Alexandra Bambas
To: PHM Secretariat
Sent: Tuesday, April 01, 2003 2:31 PM
Subject: RE: GEGA Meeting in Nairobi

4/8/03

Dear Ravi,

From: Alexandra Bambas <lexi@hst.org.za>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Tuesday, April 01, 2003 2:31 PM
Subject: RE: GEGA Meeting in Nairobi

cc Abhay Shukla
David Sanders

Dear Ravi,

I understand that the short notice was a bit of a problem (though a family holiday sounds like fun in any case!). I very much welcome an email dialogue on possible collaboration. I would be able to send you a briefing document on our activities by next week, if that would be helpful, although I would also welcome any comments or questions you have in the meantime.

P.T.O. →

Thanks very much for the invitation to the strategy meeting in Geneva--I'll get back to you as soon as I can talk with others.

Kind regards,
Lexi

(1)

Dear Lexi, I meet Abhay in Delhi on 11th April. and will discuss some of the ideas with him. If your briefing document arrives by then perhaps I may be able to focus on specifics as well. I am writing to Eric Ram (ex World Vision) who organised a series of reflections on a Global Health watch in which I was actively involved for many years. He will forward some reports of a project proposal that did not get followed up due to unavoidable circumstances but would definitely be helpful to GEGA especially when it looks at the deliverables of Global Inequity and critiques/alternatives from a International Equity perspective. Hope we can follow all this up more concretely in Geneva meeting building on your reflections in Nairobi on the 16th

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From: PHM Secretariat [mailto:phmsec@touchtelindia.net]
Sent: Tuesday, April 01, 2003 9:06 AM
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Subject: GEGA Meeting in Nairobi

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Ravi 5/4/03

Ravi 3/4/03

PHM - GEGA

(2) As a General principle I believe we should try and link our PHM contacts to each of your country groups so that PHM members advocacy/campaign experience complements the GEGA-Equity measurement experience thereby linking 'evidence' to campaigns is a creative way. Best wishes Ravi Narayan Please

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Eric Ram <eric_ram@wvi.org>
Cc: David Sanders <lmartin@uwc.ac.za>; <abaysema@pn3.vsnl.net.in>; Alexandra Bambas <lexi@hst.org.za>
Sent: Friday, April 11, 2003 12:27 PM
Subject: GEGA Meeting in Nairobi

Dear Eric,

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

PHM is gradually getting linked in a collaboration way with a Global Equity Guage Alliance (GEGA). I believe this group (included David Sanders from South Africa and Abhay Shukla from India) may have the structure, energy and resources to take our Global Health Watch forward. Can you please forward the reports and summaries (whatever is possible through email) to David (lmartin@uwc.ac.za), Abhay (abaysema@pn3.vsnl.net.in) and Lexi Bambas (of GEGA – lexi@hst.org.za)) so that we can continue the dialogue? In May, we may be able to set up a small meeting to take this cross-fertilization process forward. Did you get my earlier communication?

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat(Global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
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PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Alexandra Bambas <lexi@hst.org.za>; David Sanders <lmartin@uwc.ac.za>; <abaysema@pn3.vsnl.net.in>; <David .McCoy@lshtm.ac.uk>
Sent: Thursday, April 17, 2003 6:51 PM
Subject: Fw: GEGA Meeting in Nairobi

Dear David, Lexi, Dave, Abhay and others,

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

I returned from the PHM Sri Lanka meetings and the PHM – India (National Coordination Committee meeting) in Delhi (where I had just a few minutes with Abhay about GEGA – Nairobi meeting over breakfast) and saw the dialogue on 'values". I think it's a very pertinent point but having been a coalition builder for years, I would like to straightaway caution that we need clarity between 'values' and 'ideological positions', since values can unite when they are shared and 'ideological positions' especially if they are strong and inflexible can divide. Our discussions to explore clarity in this area must focus on shared values and respecting diversities in ideological positions.

I have suggested that GEGA and PHM could continue the dialogue in Geneva on the 18th (Sunday). WEMOS may organize a workshop for PHM participants on WTO / GATTS etc but we can find time during the day. On 17th, we shall also flag PHM – GEGA linkage at the PHM strategy meeting (agenda point – linkages with other networks).

Will someone be able to attend the Geneva events, in addition to David, who is also IPHC / PHM? Perhaps Lexi, Abhay and some one else who can make it!

Best wishes,

Ravi Narayan
Coordinator
PHM Secretariat (Global)

PHM-GEGA
RN
21/4

P.S: Prof. Hans Rosling email is Hans.Rosling@phs.ki.se. Abhay knows the context in which this is being sent.

Dr. Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034

4/21/03

PHM Secretariat

From: Alexandra Bambas <lexi@hst.org.za>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <abaysema@pn3.vsnl.net.in>; <phmsec@touchtelindia.net>; <dsanders@uwc.ac.za>
Cc: <ant@healthlink.org.za>; <pbrave@itsa.ucsf.edu>
Sent: Tuesday, April 08, 2003 2:11 AM
Subject: RE: GEGA Meeting in Nairobi

Dear Dave and David,

Thanks for raising the issue of values, as it is one that the Gauges themselves occasionally raise, and also comes out indirectly (for example, in our discussion last week about the Drop the Malaria Tax Campaign). I don't want to take the discussion here too far from our original task of discussion with Ravi, but perhaps it is also useful to look at the issue a bit early on in our discussions (part of the pain of a growing organisation).

The question of values doesn't just relate to the values of the Gauges themselves--it also relates to how GEGA and the Gauges are able to position themselves in terms of cooperative relationships and securing a space for "classy advocacy." For instance, if we want to be able to work with groups like MDP and Indepth, it is important, as Dave notes, for our conclusions (that is, our advocacy message) about what works and what doesn't to be (as much as possible) evident from the empirical data with which we are working, along with some general values (e.g. basic tenets of democracy and democratic societies, and of human development). Couching the issues in these terms can often lead to conclusions/arguments that are, in essence, contra a neoliberal agenda without necessarily forcing neoliberal vs anti-neoliberal stances.

I think the more sensitive area will be at the national level: ensuring that GEGA's advocacy activities and collaborations don't affect Gauges' relationships with government in specific countries, which can sometimes take suspicious views of activities.

Finally, GEGA's positioning has implications in terms of defining future Gauges and affiliate groups--that is, who we would want to feel comfortable in adopting the Equity Gauge Strategy, which could very well be quite a broad group.

I think there are some positions/principles that GEGA could take that would meet the approval of all the Gauges (and that would not be very controversial, in themselves), including (but not limited to) support for
1) transparent and accountable government, including regional and global governance (implications for state responsibility for monitoring and releasing information related to broad policy effects)
2) human development and opportunities for all (with implications for prioritising the needs of the worst-off)
3) universal access to basic needs (e.g. water/sanitation, education) and primary health care (perhaps no need to adopt a monolithic view of how such

17/4/03

Dear David, Lexi, David Abhay and others

I returned from the PHM Srilanka meetings and the PHM India (National Coordinating Committee) meetings in Delhi (where I had just a few minutes with Abhay about GEGA-Nairobi meeting over breakfast) and saw the dialogue on 'values'. I think it's a very pertinent point but having been a coalition builder for years I would like to straighvacy caution that we need clarity between 'values' and 'ideological positions'

Needs urgent reply

Since values can unite when they are shared and 'ideological positions' especially if they are strong and inflexible can divide. Our discussions to explore clarity in this area must focus on shared values and respecting diversities in ideological positions.

RM 16/4

4/8/03 I have suggested that GEGA and PHM could continue the dialogue in Geneva on the 18th (Sunday). WEMOS may organise a workshop for PHM participants on WTO/GATTS etc but we can find a meeting the day. On 17th we also plan PHM-GEGA linkage at the

PHM - GEGA be able to attend, in addition to Generic events
Will someone else is also IPHC/IPHM
Pls Daniel who
Best wishes
Ravi Narayan
PHM Sec

RM
8/4/03

models in terms of their effects)

Or are these too broad to be satisfying? Of course, the tension will always come in the interpretation of the data, and drawing lines about when standards are satisfied, but perhaps laying out the principles to which the organisation subscribes is a start. Perhaps we could draft a proposal for GEGA principles for discussion/revision/adoption at the meeting? This would obviously help ground our discussions with other groups, too, and support consistency in our approach.

-Lexi

-----Original Message-----
From: David McCoy [mailto:David.McCoy@lshtm.ac.uk]
Sent: Monday, April 07, 2003 9:35 PM
To: lexi@hst.org.za; David McCoy; abaysema@pn3.vsnl.net.in; phmsec@touchtelindia.net; dsanders@uwc.ac.za
Cc: ant@healthlink.org.za; pbrave@itsa.ucsf.edu
Subject: RE: GEGA Meeting in Nairobi

Dear David,

I left out values because I assumed common values. I know the wemos, IPHC, PHM and medact positions fairly well, but you are right in pointing out that the gega alliance is much more of a diverse group of people who may not subscribe to an anti-neoliberal ideology.

It's something we need to discuss as gega - I personally feel that gega needs to be bound by some common values or have a fairly common understanding of political and economic theory.

But I also think we should be arguing as much from a non-ideological perspective ..... i.e. use empiricism and logic to show the fundamental contradictions between neo-liberalism and equity / social justice.

But thanks for the amber light .....

Paula, antoinette, abhay ... what assumptions can we make about gega's positioning re: neo-liberalism, the state, democratic accountability, health as a public good and the inherent market failure characteristics of health care?

Dave

>>> "David Sanders" <dsanders@uwc.ac.za> 04/07/03 18:53 PM >>>
Dear Dave,

Thanks for this. I think it would be useful to have a discussion along the lines you suggest. However, as one of those associated with the initiation of the IPHC and PHM and now with GEGA, there is an important dimension you have left out. That is the dimension of "values" or, dare I say "ideology".
In my view IPHC and PHM are founded on an explicitly anti -neoliberal ideology. But I don't think GEGA as an alliance (and still less the Millenium Development Project and INDEPTH) necessarily subscribes to such values. Nor should it necessarily- altho some of us within GEGA might believe that health equity cannot be achieved in a neoliberal-dominated world. So, the issue of values needs to be taken into account when we explore WHAT KIND of collaboration/synergy is possible or desirable.

I hope you don't mind such words of caution/scepticism from an old (and probably time-expired) lefty!
Regards and see you in Nairobi,
David.

>>> "David McCoy" <David.McCoy@lshtm.ac.uk> 04/07/03 03:32PM >>>
Dear Ravi, David and Abhay,

First of all, greetings to you all! Lexi, your e-mail has listed a range of topics that I also wanted to discuss in Nairobi, and it's good to discuss these a little by e-mail before we meet. All the more so given that Ravi will not be able to join us.

As background, I should mention that over the couple of last two months I have been doing a consultancy with "Health Counts" (which consists of Medact and Wemos) to develop some ideas on a Novib-funded IPHC-Health Counts project on 'globalisation and health'. This has included the following activities:
- Assessing IPHC's organisational and communication strategy, which includes its relationship to PHM (I had been hoping to discuss this with Ravi in Nairobi). This will be leading into a set of IPHC and PHM meetings in May.
- Assessing the broader NGO environment to identify an appropriate niche for IPHC-Health Counts (which has also been of use in my GEGA capacity).
- Developing some ideas around analysis, communication and advocacy strategies on: 1) trade / GATS / WTO; 2) health sector reform / structural adjustment / PRSs; 3) Global health governance (WHO; PPIs). This is being done together with Medact, IPHC and Wemos. It's work in progress at the moment.

All in all, my impression is that GEGA, PHM, IPHC, Wemos and Medact share a number of values and interests that we really should attempt to

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David Sanders <imartin@uwc.ac.za>; <David.McCoy@lshtm.ac.uk>; <lexi@sirian.hst.org.za>; <abaysema@pn3.vsni.net.in>
Sent: Thursday, April 24, 2003 3:33 PM
Attach: participation form.doc
Subject: PHM GEGA

Dear Dave, Lexi, David, Abhay,

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

I heard about the hiccough at GEGA meeting from Abhay (telephonically and email) and Dave (email). Not surprising, because some of the National gauges could have seen Global Equity guage as raising broader issues that might affect relationship with funders and international agencies!! But perhaps we should just be patient and not too judgmental.

Lexi could make a short presentation on 17th and we could all meet on 18th morning informally with all our 'hats', somewhere in Geneva. Any suggestions? WEMOS has organized a workshop on WTO and Public Health in the afternoon, which may be interesting for you all as well. Our last communication III sent to potential participation enclosed.

Best wishes,

Ravi Narayan

Coordinator,

PHM Secretariat (Global)

RN 23/4

Communication – Iii April 22, 2003

PHM GENEVA-2003 > PHM GEGA

Dear PHM Geneva 2003 participants and PHM friends,

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

4/24/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <ant@hst.org.za>; <lexi@sirian.hst.org.za>; <phmsec@touchtelindia.net>
Cc: <lexi@hst.org.za>; David McCoy <David.McCoy@lshtm.ac.uk>; <abaysema@pn3.vsnl.net.in>; <lmartin@uwc.ac.za>
Sent: Wednesday, April 23, 2003 8:33 PM
Subject: Re: Fw: GEGA Meeting in Nairobi

Ravi,

Greetings.

If you have had an opportunity to talk with Abhay you will know that there was a slight hiccough at the GEGA meeting in Nairobi, because a substantial number of people felt uncomfortable about GEGA running a 'Global Health Equity Watch' project. We are not entirely sure what the reason(s) for this was (there are many theories!), but are still hopeful that there will be a change in mind.

I also discussed some other options with David Sanders and Abhay. We all feel that there is value in setting up a Global Health Equity Watch, and that if GEGA is not willing to convene this, we should then discuss some other alternatives. In any case, it is something that we would like to continue to discuss in Geneva.

Abhay and I felt that it would be good to discuss such ideas on the 18th. I could present some ideas to start off a discussion, and depending on what happens within GEGA, I may either wear a GEGA hat or a medact hat.

As for more general GEGA-PHM links, Lexi is better placed to present the country-level work on the 17th.

best wishes
Dave McCoy

>>> <lexi@sirian.hst.org.za> 04/20/03 15:56 PM >>>
Dear Ravi,

Thanks very much for the clarification between values and ideologies--very appropriate and helpful. I'm sure we'll continue to have these discussions...

I would be happy to attend the May PHM meeting in Geneva, as I have additional business in the area.

Looking forward to seeing you there!

-Lexi

24/4/03

Dear Dave, Lexi, Devd, Abhay
I heard about the hiccough at GEGA meeting from Abhay (Telephonically & mail) and Dave (e mail) Not surprising because some of the National groups could have seen Global Equity Guage as raising broader issues that might affect relationship with funders and international agencies!! But perhaps we should just be patient and not too judgemental. Lexi could make a short presentation on 17th and we could all meet on 18th morning informally with all our hats! Any suggestions? 24/4/03
Geneva. WEMOS has organised a workshop on WTO & Public Health in the afternoon, that may be interesting for you all as well

RM 24/4/03 Ravi

PHM. GEGA

Our last communication III sent to potential participants enclosed. Best wishes Ravi

DGS Send this to all except David Sanders

PHM Secretariat

From: <abhayseema@vsnl.com>
To: <phmsec@touchtelindia.net>
Sent: Wednesday, April 23, 2003 8:54 PM
Subject: Global Health Equity watch

Dear Ravi.
Dave McCoy's e-mail more or less summarises what happened in Nairobi. I would just like to realistically comment that it would be better not to count on GEGA to host a Global watch in the near future. However, given Dave's initiative and the interest from the rest of us PHM-wallahs, some way should be found to go ahead with the idea (including accessing funding) and a discussion in Geneva would definitely be useful to move towards this objective.
Regards,
Abhay

David.McCoy@lshtm.ac.uk wrote
Ravi,

Greetings,

If you have had an opportunity to talk with Abhay you will know that there was a slight hiccough at the GEGA meeting in Nairobi, because a substantial number of people felt uncomfortable about GEGA running a 'Global Health Equity Watch' project. We are not entirely sure what the reason(s) for this was (there are many theories!), but are still hopeful that there will be a change in mind.

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best wishes
Dave McCoy

RN
24/4/03

PHM - GEGA

RN
24/4

4/24/03

PHM Secretariat

From: <lexi@sirian.hst.org.za>
To: PHM Secretariat <phmsec@touchtelindia.net>
Cc: Alexandra Bambas <lexi@hst.org.za>; David Sanders <lmartin@uwc.ac.za>; <abaysema@pn3.vsnl.net.in>; <David.McCoy@lshtm.ac.uk>
Sent: Sunday, April 20, 2003 8:27 PM
Subject: Re: Fw: GEGA Meeting in Nairobi

Dear Ravi,

Thanks very much for the clarification between values and ideologies--very appropriate and helpful. I'm sure we'll continue to have these discussions...

I would be happy to attend the May PHM meeting in Geneva, as I have additional business in the area.

Looking forward to seeing you there!

-Lexi

RN 2114

Quoting PHM Secretariat <phmsec@touchtelindia.net>:

> Dear David, Lexi, Dave, Abhay and others,
>
> Greetings from People's Health Movement Secretariat at CHC, Bangalore!
>
> I returned from the PHM Sri Lanka meetings and the PHM - India (National
> Coordination Committee meeting) in Delhi (where I had just a few minutes
> with Abhay about GEGA - Nairobi meeting over breakfast) and saw the dialogue
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> builder for years, I would like to straightaway caution that we need clarity
> between 'values' and 'ideological positions', since values can unite when
> they are shared and 'ideological positions' especially if they are strong
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> the 18th (Sunday). WEMOS may organize a workshop for PHM participants on WTO
> / GATTS etc but we can find time during the day. On 17th, we shall also flag
> PHM - GEGA linkage at the PHM strategy meeting (agenda point - linkages with
> other networks).
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> Will someone be able to attend the Geneva events, in addition to David, who
> is also IPHC / PHM? Perhaps Lexi, Abhay and some one else who can make it!
>

RN 21/4/03

PHM - RN GEGA

4/21/03

DGS - Add to paper

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <lexi@hst.org.za>; David McCoy <David.McCoy@lshtm.ac.uk>; <abaysema@pn3.vsnl.net.in>; <phmsec@touchtelindia.net>; <dsanders@uwc.ac.za>
Cc: <ant@healthlink.org.za>; <pbrave@itsa.ucsf.edu>
Sent: Tuesday, April 08, 2003 5:53 PM
Subject: RE: GEGA Meeting in Nairobi

Dear all,

Please see below message about WB report 2004.

Something else for discussion? Also something that GEGA should respond formally to. I suspect that the WB's strategy fro making services work for people is by "unburdening the public sector of the emplyed and the rich so that the public sector becomes a service for the poor; promoting market incentives for companies to reach the poor; targeting the poor etc. But little on redistribution; cross-subsidisation; risk pooling; etc.

World Development Report 2004:
Making Services Work For Poor People: e-Discussion
E: Discussion from April 14 - May 30, 2003

WB-PHM file →

During a 7-week period from April 14, 2003 through May 30, 2003, the World Bank and Public World will co-host a moderated electronic discussion on the forthcoming WDR 2004: "Making Services Work for Poor People". The e-discussion is an opportunity for a wide range of stakeholders from government, business, and civil society to exchange views about the content and main ideas of the draft report.

RN 16/4

Each of the seven weeks will have its own theme:

DeS
To send Mohan comments and reports & Conveying meeting
Discuss

Week 1: Overview of "Making Services Work for Poor People"
Week 2: What accounts for success and failure in serving poor people, and what are the obstacles to overcoming failures and building on successes?
Week 3: Is the draft report imbued with the values, informed by the principles and aiming for the goals that are required to make services work for poor people?
Week 4: What changes are required that would lead policy makers to produce policies that are more beneficial to poor people?
Week 5: What changes are required in the relationships between policy makers and service providers that would lead to the latter meeting the needs of poor people more effectively?
Week 6: What changes are required to enable poor people to exercise more influence over the decisions and behavior of service providers so that their needs are more fully and effectively met?
Week 7: Does the WDR rise to the challenge it sets itself? How can donors, governments and other actors rise to its challenge?

Please read our announcement which further defines the role of this e-discussion and weekly topics, as well as "rules of engagement", and details on availability of the comments and draft in various langugages.
The World Bank and Public World Announce e:Discussion on "Making Services Work for Poor People"

If you would like to request a printed version (in English) of the public draft, please send an email

RN 9/4/03

PHM - GEGA

DeS 16/4

to: world_dev_report@worldbank.org with the words "e:discussion" in the subject line.

* * * *

This message from the Pan American Health Organization, PAHO/WHO, is part of an effort to disseminate information
related to Equity, Health inequality; socioeconomic inequality in health; socioeconomic health differentials. Gender,
Violence, Poverty, Health Economics, Health Legislation, Ethnicity, Ethics, Information Technology and Virtual Libraries,
Research & Science issues.

PAHO/WHO Website: http://www.paho.org/English/HDP/

EQUIDAD List - Archives - Join/remove: http://listserv.paho.org/Archives/equidad.html

4/9/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Cc: <lexi@hst.org.za>; <mikerowson@medact.org>; <abayasema@pn3.vsnl.net.in>
Sent: Thursday, May 29, 2003 8:29 PM
Attach: GHEW proposal.doc
Subject: GHEW

Dear Ravi and David,

Greetings and I hope you both had safe trips back home.

Please find attached a document on the global health (equity) watch idea we discussed in geneva.

I've written the document so as to help ensure that we are all operating from the same understanding - it can also be used as a template for sharing with other organisations and as a funding proposal.

I have indicated in the document what I consider to be the next steps for the next six weeks or so, and would be grateful for your quick feedback (you can skip the first two pages of introductory comments)

Note:

1. The document is headlined by PHM, GEGA and Health Counts (which is Medact + Wemos)

2. The budget is incomplete - I need some help with this

3. The suggested chapter headings / structure of the document are open to discussion and change

I look forward to hearing back from you soon

All the best

Dave

5/30/03

Peoples Health Movement
Global Equity Gauge Alliance
Health Counts[1]

Concept Note for the Development of an Annual Global Health Equity Watch

Background

Every day 30,000 children die of preventable causes. The HIV/AIDS epidemic continues to escalate, with the situation in sub-Saharan Africa already tragic, and large parts of Asia about to follow suit. Worldwide, poverty at the country, local and household level remains the biggest underlying cause of morbidity and premature death. 1.2 billion people, mostly women and children, live on less than US$1 a day[2].

Added to this are ever-growing inequities. While the poor are getting poorer, and the sick are getting sicker and dying earlier; the healthy are getting healthier, and the rich are living longer and consuming more. The world's 25 richest people have income and assets worth US$474 billion - more than the entire GNP of Sub-Saharan Africa[3].

In spite of the economic growth and technological advances of the last forty years, for millions of people, this has not resulted in *any* development. Trickle down has not worked, and worst still, the social and economic development of some seems to have come at the cost of impoverishment to others.

In spite of growths in agricultural productivity, in some parts of Africa and Asia there is famine, and across then world, 214 million people are so under-nourished that they cannot work or care for themselves.[4]

In the health sector, while the top 10 U.S. drug companies made profits of $37 billion in 2001[5], millions of people are unable to access even the most basic PHC drugs, let alone have access to affordable anti-retroviral treatment.

The resounding failure of the global community to achieve "Health for All by the Year 2000" has been met with barely a whimper. (what about PHM - mention as exception)

At a time in which the state of health within countries is increasingly affected by supra-national and global forces, most disappointing has been the lack of leadership shown by the World Health Organisation. Instead of pointing to the need for a drastic and profound re-think of global strategies to ensure equitable development and health for all, it has become a small player on the global health and development policy stage (increasingly dominated by the World Bank). Even the World Trade Organisation and the International Monetary Fund have potentially

[1] Health Counts = Medact + Wemos.
[2] African Poverty at the Millennium, World Bank, Washington DC, 2001.
[3] Data from Forbes, GNP of Sub-Saharan Africa was US$315 billion in 1999.
[4] FAO. 2002. The state of food insecurity in the world. FAO: Rome.
[5] Public Citizen. April 2002. Pharmaceuticals Rank as Most Profitable Again.

become more significant health policy players by virtue of the impacts of trade policies and broader public sector policies on health and health care.

The Alma Ata declaration which enshrined the principles of equity, social medicine, appropriate technology, access to comprehensive health care and sound public health approaches to disease prevention and management, has virtually disappeared from the WHO agenda, and when it does reappear, it is apparent that the conceptual meaning of the 'PHC Approach' is no longer understood by WHO, who frequently confuse it with primary level care.

Instead, WHO has become increasingly tied up with vertical disease-based approaches and questionable econometric, number-crunching exercises. Others have pointed to its support of the flawed analysis and recommendations of the Commission on Macro-economics and Health, and the increasing influence of the corporate and private sector.

The World Bank on the other hand has continued to foist discredited, neo-liberal solutions to global development and poverty alleviation. Rather than supporting the development of public health systems, they have promoted the fragmentation of health systems and increasing privatisation. Health sector liberalisation with an increasingly under-funded resourced public sector safety-net for the poor remains the stock solution - in spite of its glaring failures. On top of this, market-based reforms of the public sector are offered as solutions to many of the bureaucratic inefficiencies that result from demoralised, under-skilled and under-paid civil servants.

Poverty Reduction Strategies which were supposed to herald a new democratic and participatory approach to development have turned out to be 'old wine in new bottles', and many of the lessons from the World Bank's own internal assessments of its failures have not been heeded.

Meanwhile, year after year, the world is treated to a new set of commitments, goals and targets for development and health - the latest being the millennium development goals. While making grand pronouncements on debt relief, trade reform, aid and HIV/AIDS, the truth is that overseas development assistance has declined, whilst the trade and investment environment have become even more unfriendly to the development aspirations of poor countries. The commercial imperatives of rich-country companies and multi-national corporations have consistently taken precedence over social development, poverty alleviation, equity and economic fairness.

Although corrupt, inefficient, unethical and undemocratic government within many developing countries are major hinderances to equitable development which require local solutions, the social, economic and political contexts within which such governments have become established also have external global contributory and causal factors.

In response to the situation described above, people from all over the world have been partaking in a variety of grassroots "struggles for health". More and more health workers realise that the principles of the Alma Ata Declaration no longer guide health sector development - neither within the World Health Organisation, nor within most governments. More and more communities and academics are noting how the international economic system and globalisation is perpetuating poverty and increasing inequities. The lack of credible and effective global public health leadership has become increasingly evident.

As a consequence, in the year 2000, the Peoples Health Assembly was convened in Bangladesh to reaffirm the principles of the Alma Ata Declaration, including the right of people to health, and to call upon the World Health Organisation and other international institutions to take up the challenge of improving the health of the poor more effectively and appropriately.

Following this landmark event, a broad network of progressive health organisations and civil society groups (including citizens groups, NGOs, research institutions and trade unions) have come together as the Peoples Health Movement in order to promote more equitable and accountable health sector development, within a more just international economic and political order.

← Mention the Charter

In order to support a more equity-oriented approach to global health, the Peoples Health Movement has endorsed the annual publication of a "Global Health Equity Watch" which would present a progressive, people's perspective on developments in the health sector globally.

Although WHO produces an annual health report, and other UN agencies such as UNICEF and UNAIDS produce periodic and regular world reports; and although the World Bank produces its World Development Report once every two years, these inadequately reflect the views and perspectives of the Peoples Health Movement, progressive health non-government organisations and many international public health academics.

This document spells out a proposal to fill this current gap in the analysis and promotion of global health.

← It builds on Global Health watch

Niche of the Global Health Equity Watch

- The Global Health Equity Watch would represent an alternative world health report, which would analyse and report on developments in the health sector globally annually from:

An equity and redistribution perspective - this stands in contrast to the poverty reduction approach which emphasises the poor and the marginalised, without relating them to the rich and powerful.

A public sector / counter-neoliberal perspective - this stands in contrast to the dominant development discourse amongst the multi-lateral development agencies and OECD countries.

A PHC Approach perspective - this stands in contrast to the vertical, disease-based approach to health systems development, and emphasises the social and public health approach to health systems development.

A Political Economy perspective - this stands in contrast to the tendency for global health problems to be described in isolation of the global political economy - one of the purposes of this document will be to highlight the political economy as a central public health issue.

- Civil society perspective - this stands in contrast to the publication of annual health reports by UN agencies. It also allows the performance of the official global health and development institutions (such as the UN agencies - WHO, UNICEF and UNAIDS; the global PPIs; and the World Bank) to become the subject of an annual health report.

GHEW Strategy

The idea is not to base GHEW on new research and new analysis - there are many NGOs, progressive groups and academics who have done the research and analysis - the Global Health Equity Watch will provide a platform for the compilation of this work under a broad civil society / PHM banner.

The idea is that the chapters would be written by an eclectic group of different individuals and NGOs.

The document would be primarily an analytic document that is targeting global and national policy makers and the World Health Organisation, and which could be used to support the advocacy activities of progressive health and development groups around the world. It should avoid rhetorical argument, and base its arguments on a mix of explicit normative principles, sound argument and evidence.

A platform that is shared by a number of networks and NGOs would also result in a process of mutually beneficial learning, synthesis and analytic integration, as well as joint advocacy. In particular, GHEW would be an opportunity to develop strategic alliances between PHM and progressive health NGOs, with those organisations and institutions whose expertise are in the fields of international finance, macro-economic policy, trade international relations, global governance and agriculture.

It would therefore try and be inclusive of progressive networks and NGOs (the more NGOs and networks that we can get to contribute to, and be associated with GHEW, the more weight it will carry); and of all geographic regions (if this is to an 'alternative world health report', then we would want contributions and input from all regions of the world).

GHEW Management

Medact and GEGA to act as coordinating secretariat for GHEW, in close consultation with PHM Research and Macro-economic Circle members. Their responsibilities will be to:

- finalise lay-out and structure of the document
- define detailed chapter outlines
- identify and commission chapter authors / contributors
- set up an editorial committee
- fundraise
- manage the finalisation and publication of the report

Funding and Budget

GEGA will provide some seed funding for SHEW

Managing editor(s)	1 FTE @ $45,000 per year for 12 months	$45,000
Office and administrative support	Including printing, computer, telephone, fax and other office costs	$6,000
Honoraria for authors and contributors	$500 x 25	$12,500
Lay-out		?
Printing and publication		?
Launch and PR		?
TOTAL		

Way Forward (next 6 weeks)

- Agree on institutional collaboration and relationships between Medact, GEGA and PHM.
- Circulate proposed structure of report for comment.
- Invite suggestions about potential authors
- Finalise budget
- Develop a funding proposal
- Begin to identify donors / funders who might want to support this, and seek expressions of interest from them

Timeframes

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Initiate fundraising activities	✓	✓											
Finalise structure of report		✓											
Finalise detailed briefs for each chapter			✓	✓									
Confirm agreement from authors / contributors					✓	✓							
First draft of chapters								✓					
Second draft of chapter										✓			
Final draft											✓		
Ready to print												✓	
Finance list of endorsing & affiliated NGOs and networks											✓		
Go to print												✓	
Launch													✓

Structure and Lay-Out of the Report

The Global Health Equity Watch will consist of a compilation of chapters on various global health issues. Each chapter should be able to stand on its own, but together, represent a comprehensive overview of the key global health issues from the perspectives described earlier.

Each chapter might, if appropriate, culminate in a set of recommendations and "demands" from the PHM, which would provide some basis for on-going monitoring.

Action points
Issues of concern
For advocacy and lobbying

Where appropriate, and as much as possible, there would be case studies and testimonies from the ground (collected through the PHM Network).

Approximate size of the report: 100,000 words

A detailed structure and lay-out of each chapter of the report will be developed. An initial set of proposed chapter headings for discussion are laid out below:

Suggested Structure and Lay-out of GHEW
For Discussion

SECTION A: The International Political Economy of Health

A1: Overview and introduction

Introduce the socio-economic determinants of health

Overview of the distribution of wealth / health / health care resources; and the growing inequities. Describe growth in poverty levels (counter WB assertion that poverty declining and that poverty reduction and efforts at global development are generally moving in the right direction)

Sketch how economic and health resources are generated, controlled and distributed. Introduce:

- Unfairness of current trading systems
- Declining levels of ODA
- Unfairness of debt and inadequate debt relief
- Dominance of political economy by OECD countries / US / EU
- Capture of power and influence by corporate sector
- Declining levels of democratic accountability at a general global level

Argue that a new international political economy is necessary for improvements in health, and for reductions in health inequities. This is a priority public issues for health professionals, health workers and global health institutions such as the WHO to prioritise.

The following chapters in Section A will argue these points in greater detail.

A2. Development and Social Sector Policy and Ideology

Summarise the overall picture / trends re: development policy and economic growth strategies; the debate on ideological models; and the current pre-eminence of neo-liberal ideologies and approaches. This would include a critique and summary of the policy convergence among WB, IMF and bilaterals.

Provide evidence and arguments of how this is inappropriate for developing countries, and how Washington Consensus policies have generally been unsuccessful in LDCs.

Another increasingly dominant policy / approach within development and social service delivery is the new public management – the promotion of market-based, private solutions to public sector management. Describe extent to which this is being promoted and critique.

A3. World Bank and IFIs

- Critique of World Development Report
- Critique of WB governance
- Recommendations

A4. Critique of PRSPs (using selected case studies)

- What are they
- How are they being managed?
- What is their orientation?
- Who is monitoring the process?
- How is health being reflected within them?

A5. Trade

Describe how trade is currently unfair, and trade policies and structures are part of the poverty trap that many poor countries are in. Describe to whom and to where the benefits of trade accrue. Describe the double-standards being applied re: subsidies and tariffs.

Describe Free Trade Agreements, and their impact (or likely impact) on health, as well as GATS and its impact on health.

Describe the campaign to reform trade and to mitigate the harmful effects of GATS.

A6: Trans-national corporations and conglomerations

Describe the concentration of economic power and profits amongst fewer and fewer TNCs. Describe the lack of adequate systems for the national and global regulation of TNCs and the taxation of profits. Describe their influence on national and global governance.

A7. Global economic governance

Topics:

- governance of trade at a global level (i.e. the World Trade Organisation) - fundamentally unfair, non-transparent and built on non-humanitarian objectives.
- governance of the WB and its secrecy - links to TNCs.
- decline in influence of UNCTAD, UNDP
- limited progress towards appropriate and effective civil society engagement.

A8. Liberalisation of basic services - water and electricity

- Explain importance of basic utilities to health
- Describe trends in terms of coverage, access and utilisation (including inequities in consumption)
- Describe trend and effects of liberalisation in these sectors

A9. Agriculture and food security

Describe state of hunger and malnutrition, and efforts to address this problem
Critique of agri-business, GMOs, TRIPS

Critique of UN / donor / FAO approach to household food security
Propose alternative strategies
Nutrition from a health sector perspective - what is to be done?

A10. Militarism and health

- Effects of military expenditure / opportunity costs
- Effects of war, violence and conflict
- Highlight ... Afghanistan Iraq, Congo, Columbia and Palestine / Israel
- Describe nuclear weapons threats

Section B: The health sector and health programmes

B1. Overview chapter on health inequities trends

Globally, inter-regional and in-country

Use Hans Rosling data

B2. The liberalisation and privatisation of health

- Describe the trend
- Discuss what is wrong with the state

B3. Global health governance

- World Health Organisation
- UNAIDS
- UNICEF

B4. GPPIs in health

- Focus on GFATM?
- Discuss the global verticalisation of health interventions

B5. The PHC Approach

- Illustrate how the PHC Approach is misunderstood and misapplied
- Describe what it really is about
- Link PHC Approach to organisational and health systems issues

B6. Access to medicines and the pharmaceutical industry

- TRIPs and the implementation of the Doha agreement

- Accelerated access initiative
- Involvement and influence of pharmaceutical industry within WHO

B7. Health personnel
- Inequitable distribution - brain drain etc.
- What is being done about this
- Point out failure of rich countries to adopt ethical and fair positions

B8. Breastfeeding and the baby food industry | Nutrition, Food Security | APPAN

B9. Health research

Progress on the 10:90 gap
Inequities within the global health research community

B10 International Institutions (critique from a Political Economy | PHC perspective)
i) GAVI
ii) MMV
iii) Macro-economic Commission in Health R
iv) Critique of WHO-DG address
v)

Case studies a) Problem
b) Towards solution — community level
— campaign level

Link exercise to PHD. II
bringing together document

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <david.mccoy@lshtm.ac.uk>
Cc: David Sanders <lmartin@uwc.ac.za>; Alexandra Bambas <lexi@hst.org.za>
Sent: Friday, June 06, 2003 6:07 PM
Subject: GHEW Concept Review

Dear Dave,

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

I just got time to review your GHEW concept paper. I think its very well done and the main objectives, potential, framework and linkages are well outlined. I have the following comments at this stage:

a. Mention PHM and Charter as exception to the 'whimper' on page one.
b. There is corruption and mismanagement in developed countries as well and as the recent US revelations of MNCs and government's are being exposed, our comment on corruption should be addressed to both North and South countries. The North is not corrupt and the South is corrupt' is an old stereotype which does not hold good any longer (reference page 2).
c. Before the endorsement of the watch – mention the charter for health again and take a small quotation relevant to GHEW (see below). Then talk about endorsement by PHM (page 3).

- Health is primarily determined by the political, economic, social and physical environment.

- A large proportion of the world's population still lack access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

- Build and strengthen People's organization to create a basis for analysis and action.

PHM-GEGA=GHEW
RN
9/6/03

d. As a bridge building / coalition developing effort for the future a mention of the Global Health Watch (NGO Forum for Health), Global Health Chart (Centre for International Health, Karolinska) as other initiatives which we can link with. I was involved with both.
e. I have some ideas on the budget – so in any circulation for comment to a larger group at this stage -- this can be left out for the time being.
f. Regarding structure and lay out, a few thoughts:

i. What all would you include in GPPI? Thelma says there are 80 of them now!!

ii. Macro-economic Commission on Health Report and our critique must be mentioned separately.

iii. Breast Feeding and Baby Food Industry should be replaced by Food and Nutrition Security. The recently formed APAN "Alliance for People's Action in Nutrition", has circulated a document on PHM exchange which has this broader understanding.

iv. We should mention box items of studies and case studies which focus on problems analysis and action / campaigns (this will tap the PHM potential)

g. Link – GHEW to PHA – II, as an important backgrounder for the event and for future action

For follow up:

a. Send it to all concerned – a larger circle for ideas suggestions – minus the budget.

b. Once you have David, mine, GEGA, Medact views on budget, we can send another supplementary communication about it

Hope you received the PHM Geneva report. GHEW is mentioned in section 6.

Best wishes,

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

6/9/05

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>, <rmartin@uwc.ac.za>
Sent: Tuesday, June 03, 2003 10:02 PM
Subject: Global health equity watch

Dear Ravi and David,

Please can I nudge you for some feedback on the GHEW concept paper. I would like to get moving on this as soon possible.

thanks

Dave

RN 4/6/03

RN 4/6/03

Dear Dave

Greetings from the PHM Secretariat. I just got time to review your GHEW concept paper. I think it's very well done and the main objective, potential, framework and linkages are well outlined. I have the following comments at this stage:

a) Mention PHM and Charter as exception to the 'whimper' on page one

b) There is corruption and mismanagement in developed countries and as the recent US revelations of MNCs and governments are being exposed, our comment on corruption should be addressed to both North and South countries. The North is not corrupt and the South is corrupt is an old stereotype which does not hold good any longer (reference page 2)

c) Before the endorsement of the watch – mention the Charter for health, and take a small relevant quotation to GHEW again. Then talk about endorsement by PHM (page three)

d) As a bridge building/coalition developing effort for the future a mention of the Global Health watch LNGO Forum for Health project); Global Health Chart (Centre for Int Health, Karolinska and other initiatives which can be linked into and built upon – would be useful. I was involved with both.

PHM Secretariat

From: Lynette Martin <lmartin@uwc.ac.za>
To: <David.McCoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>
Cc: <lexi@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Friday, June 06, 2003 4:59 PM
Subject: Re: GHEW

Dear Dave,

Thanks for this. It is a very good first stab and quite comprehensive.

Since I am in a rush this will be a brief first comment. I can give more later when I have thought about it more.

1) The background is generally fine but needs some tweaking. For example, I do not think we can say that there has been "no development". We need for example to be able to explain the success of the "Asian tigers".

2) Suggested structure:
Most of the necessary chapters are there, however I would rearrange them somewhat. For example, following the overview chapter, I would start with what is currently in chapter A6, i.e. TNCs and their growth over the past 3 or 4 decades, situating this within trends in the global economy.

I would then order the chapters as you have and include in A2 an account of the experience of Structural Adjustment programmes and give examples of countries whose social policies have been pro-poor and where real advances have occurred.

After the chapter on Global Economic Governance I think we need a chapter on "Politics and power globally". We obviously need to relate the changes in the global economy to those in global politics.

The sectoral chapters A8-A10 are fine but we need also to fit in education and possibly housing.

In section B I would shift up the chapter on "The PHC approach" to after B1. I would also expand this to give an overview of international health policy's evolution from the 1960s. We need then to have quite a lot of material on health systems (including local case studies) and I would say that the chapter on "health personnel" needs to be linked to this or come soon after it.

Obviously there is a lot more detail to be added in each chapter. Notably however we need to say something about education and training of health personnel in that chapter and of the focus within health research in that chapter.

I hope this helps. I will continue to think about the structure.

In terms of the budget I am sure that you should include more for commissioned chapters and also for research, travel and overheads.

Best regards,
David Sanders

RN
9/6/03

PHM - EGA → GHEW

RN
9/6/03

6/9/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>, <lmartin@uwc.ac.za>
Cc: <lexi@hst.org.za>; <mikerowson@medact.org>, <abaysema@pn3.vsnl.net.in>
Sent: Sunday, June 08, 2003 1:34 AM
Subject: Re: GHEW

Dear all,

I have received feedback now from Ravi, David and Mike. I will re-work this into a second draft early next week and send back.

In terms of funding:

Mike has agreed to approach the Dag Hammarskjold Foundation.

I will pass this by Christina Zarowsky at IDRC and Tim Evans at Rockefeller.

I would like to raise small amounts of money from some of the larger development NGOs such as World Development Movement, Christian Aid and Oxfam.

Any other suggestions?

PHM-GEGA/GHEW Inchve →

Many thanks again for all the feedback

RN 9/6/03

dave

>>> "Lynette Martin" <lmartin@uwc.ac.za> 06/06/03 12:28 PM >>>
Dear Dave,

Thanks for this. It is a very good first stab and quite comprehensive.

Since I am in a rush this will be a brief first comment. I can give more later when I have thought about it more.

1) The background is generally fine but needs some tweaking. For example, I do not think we can say that there has been "no development". We need for example to be able to explain the success of the "Asian tigers".

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RN 9/6/03 lm

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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
Cell: 082 202 3316

>>> "David McCoy" <David.McCoy@lshtm.ac.uk> 05/29/03 04:59PM >>>
Dear Ravi and David,

Greetings and I hope you both had safe trips back home.

Please find attached a document on the global health (equity) watch idea we discussed in geneva.

I've written the document so as to help ensure that we are all operating from the same understanding - it can also be used as a template for sharing with other organisations and as a funding proposal.

I have indicated in the document what I consider to be the next steps for the next six weeks or so, and would be grateful for your quick feedback (you can skip the first two pages of introductory comments)

Note:

1. The document is headlined by PHM, GEGA and Health Counts (which is Medact + Wemos)

PHM Secretariat

From: Alexandra Bambas <lexi@hst.org.za>
To: Ravi Narayan <secretariat@phmovement.org>; Abhay Shukla <abaysema@pn3.vsnl.net.in>
Sent: Tuesday, June 10, 2003 2:20 PM
Subject: GEGA/Equinet project on parliamentary alliances in Southern Africa

Dear Abhay,

I'm sure you know about GEGA's project, in coordination with Equinet, to put together a project to work with parliamentarians to support pro-equity legislation in countries in Southern Africa, working both at the national level and at the regional level through SADC, the regional governance body.

We are looking for a case study of a successful struggle by parliamentarians to influence national policies that affect health equity, with a view to inspiring the participants as to the possibilities. If you have any ideas of countries from the Asian region that might provide a good case study, and who we might contact, it would be extremely helpful in our planning.

I am about halfway through my first pass at your draft of the Advocacy paper--hope to be done at the end of this week, including Gauge references. In any case will send by Sunday.

Thanks, and best to you.
Lexi

****

Alexandra Bambas, PhD, MPH
Coordinator of the Global Equity Gauge Alliance
Health Systems Trust
PO Box 808
Durban, KwaZulu-Natal
South Africa 4000

email: lexi@gega.org.za

PHM-GEGA

RN
11/6/03

RN
11/6/03 fax

PHM. GEGA

PHM Secretariat

From: <abhayseema@vsnl.com>
To: David McCoy <David.McCoy@lshtm.ac.uk>
Cc: lexi@hst.org.za ;phmsec@touchtelindia.net <lexi@hst.org.zaphmsec@touchtelindia.net>
Sent: Wednesday, June 11, 2003 10:03 AM
Subject: Re: GHEW

Dear Dave,
Sorry for the delayed response, overall the structure looks good, though it has definitely come a long way from our initial idea of a 'Global Gauge'!
Some general comments and suggestions:

1. Section A is well conceptualised overall but Section B (Health sector) seems to trail off and has certain gaps

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PHM-GECA
-GHEW

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12/6

****

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12/6/03

PHM - GECA / GHEW

6/12/03

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Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org
****

6/12/03

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <david.mccoy@lshtm.ac.uk>; mikerowson <mikerowson@medact.org>; <sapaysema@pn3.vsnl.net.in>; <ant@healthlink.org.za>; David Sanders <lmartin@uwc.ac.za>; Alexandra Bambas <lexi@hst.org.za>
Sent: Friday, June 20, 2003 5:32 PM
Subject: Consultative process for GHEW

Dear Dave, Mike, Abhay, Antoinette, David, Lexi,

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

I have read all the current mail and exchange of ideas on GHEW. I am in the middle of a detailed 3 year project proposal for PHM and log frame exercise, so my reply will be brief.

i. I endorse Abhay and Antoinette's idea for a GHEW committee.

ii. It's quite okay to have MEDACT as secretariat and logistical coordinator including receipt of funds and its disbursal.

iii. Regarding the dialectics about slimmer / and more focused report and or a larger canvas. I would tend to agree with Dave and support his well thought out ~~arrangements~~ arguments. The Charter is as wide as you, can get and this GHEW publication will be a sort of back up evidence for it.

We could have a section A, which is focused and exhaustive on certain chapters. And another section B, which has some evidence on all the remaining issues (or as much as we can collect in the time constraint).

Year to year, we can shift these chapters into section A and B.

iv. An editorial board, which includes expert on science / lay communication would be helpful to prevent it from becoming too heavy reading. It must be 'Reader Friendly'.

v. David as PHM member is okay. I have enough responsibility as coordinator of PHM Secretariat to give adequate time as process evolves. So someone else can represent PHM.

I shall be on the e-group and will send ideas from time to time.

Best wishes,

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

RN
24/6/03

PHM Secretariat

From: Antoinette Ntuli <ant@healthlink.org.za>
To: Mike Rowson <mikerowson@medact.org>; <lexi@hst.org.za>; Abhay Seema <abhaysema@pn3.vsnl.net.in>
Cc: David McCoy <david.mccoy@lshtm.ac.uk>; LYNETTE MARTIN <LMARTIN@uwc.ac.za>; <phmsec@touchtelindia.net>
Sent: Thursday, June 19, 2003 12:40 AM
Subject: Re: Consultative process for GHEW

Dear Colleagues,

Its great that this initiative is going forward and that such a dynamic group of organisations is coming together to work on it. I think that it is critical that we pay careful attention to inter-organisational process and responsibilities from the outset to ensure that we promote an effective working relationship that strengthens the outcomes of the work rather creating distractions. To do so is clearly challenging given the geographic spread and complexity of the individual organisations.

As a principle I think we need to be fostering genuine shared ownership and responsibility for the GHEW and I would support Abhay's suggestion of a Steering/Management committee for the work which has two representatives from each of the organisations. As I like Abhay, I am happy for Medact to function as the secretariat so long as the work is managed by a ctte that is representative.

If there is agreement with the suggetsion of such a ctte, then I think the organisations should be asked to nominate two reps asap so that the group can start functioning.

Antoinette

On 19 Jun 2003, at 9:22, Abhay Seema wrote:

> Dear Mike,
> It is good to know that Medact would be able to facilitate initial fund-raising and formulation of the concept for the GHEW, and is supporting Dave for this. However, as far as coordinating the actual preparation, finalisation and publication of the report is concerned, it is important that a mutually agreed on, collective process is adopted. It is not necessary to mention that besides the definite contribution of Health Counts (Medact & Wemos) in developing the idea, the initial concept of a GHEW has originated in GEGA, and that the international network of PHM would be both a source of ideas and information, and a key forum for dissemination of the report. You have already mentioned the importance of 'ownership' by all the collaborating organisations. Keeping the collaborative nature of this entire venture in mind, it would be preferable for each of the organisations / networks involved (GEGA / PHM / Health Counts) to nominate say two persons each for a 'GHEW committee' which would be in regular correspondence over e-mail about the funding proposals, structure, contributors, and progress of work regarding the report.
> This group may also form the editorial board for the report. With such

20/6/03

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i) I endorse Abhay and Antoinettes idea for a GHEW committee

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iii) Regarding the deadlines chair slimmer and more focussed report and or a larger canvas I would tend to PHM-GEGA / GHEW agree with Dave and support his well thought out arguments. The charter is as wide as you can get and thus GHEW Publication will be a sort of backup evidence for it

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PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <ant@hst.org.za>; <lexi@hst.org.za>; <mikerowson@medact.org>; <abavsema@pn3.vsnl.net.in>
Cc: <phmsec@touchtelindia.net>; <LMARTIN@uwc.ac.za>
Sent: Thursday, June 19, 2003 3:31 PM
Subject: GHEW

Thanks Mike for raising the issue of institutional relationships and coordination.

I would like to add a couple of thoughts from my perspective (which includes sitting with a foot in Medact and a foot in GEGA) + some background.

The need for one organisation to coordinate fundraising is primarily logistical - to avoid the possibility of different organisations approaching the same funder with the same proposal. In terms of other things to coordinate under one roof: a) if we are going to commission work from other organisations and individuals it would be good to ensure some standardisation of contracts; b) financial management for the purpose of donor reporting.

Presently, in addition to Medact being prepared to put some money into supporting my time to do this work, GEGA has also done likewise. But the firm intention is for GEGA, PHM and medact to be producing the report jointly and in concert with a range of other contributing and endorsing NGOs.

In terms of coordination of the actual technical and intellectual work for the final publication of the report, I would envisage that if Medact is to act as a the fulcrum for the logistical coordination of GHEW, it would work through and with an editorial committee that is inclusive of GEGA, PHM (and Wemos?)

From the technical / intellectual perspective, the key task is to come to some agreement and
consensus about the scope, purpose, structure, size and style of the document as this may influence the kind of organisational approach to publishing GHEW.

Mike is concerned that the suggested format is too bulky and bitty, and would prefer a more slimmed down and tighter version of maybe 4-5 chapters, covering a narrower scope of issues and building the report around a key theme.

I on the other hand would prefer to see GHEW as a broader amalgam of different chapters raising the full range of international health issues - and where some of the chapters act as stand-alone chapters.

The sections are structured to allow the report to a) incorporate political and economic analysis (i.e. to make the clear point that the politics of global governance and the global economic order are public health issues and central to global health inequities); b) raise the

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PHM. GEGA / ~~GHEW~~ GHEW

profile of the different sectoral influences on health (e.g. environment; militarism; housing; education' water and electricity etc.); and c) raise the key issues around the global health sector and health policy.

This is undoubtedly a very broad range of issues and topics to raise in a single document, and some of the chapters would inevitably be relatively superficial.

However, part of the rationale for this is to make the point that the problems of international health and global health inequities need to be tackled at all three levels – politics and economics; non-health sector impacts on health; and health policy and programmes – and that WHO and health associations and health professionals all over the world need to engage much more with this comprehensive agenda rather than on disease-based, technocratic and health service solutions.

The second rationale for a deliberately broad scope is so that GHEW can support coalition building and linkages between progressive health NGOs with those NGOs that deal more specifically with the political economy of develoment (eg. the bretton woods institutoins) and with other sectors (arms trade; environment etc). I think this is one of the ends to which GHEW is a means.

The third rationale is to come up with a report that can be used in different ways by different groups for different purposes. It becomes akin to a yearly reference document that can be used to help buttress arguments and campaigns on a range of issues, and not a report that is too centred on one theme. (I have the annual south african health review as a template in
mind)

The fourth rationale is to see this as an annual report where several of the same chapter headings are repeated every year because we want to monitor what is happening – a report which is centred around a core theme that changes each year would lose some of the potential for annual monitoring across a range of public health issues and the potential for the report to
be used for institutional watching and advocacy.

The potential downside of this approach is that the report could become 'bitty and fragmented' and appear as a series of disjointed chapters; that it would entail much more coordination and management; and that there may not be a central key message at the launch of the report.

The former approach would require a much more slimmed down set of writers and editors for the report: whilst the latter would require more writers, editorial work and coordination.

I think we can look to reducing and rationalising the overall number of chapters so that GHEW does not feel disjointed, but I think we need to keep the original conception of GHEW as a platform for multiple analyses and perspectives.

Now at the moment there is an informally constituted group consisting of Mike, Ravi, David Sanders, Lexi, Ant, Abhay and myself who have been discussing the concept paper. (Wemos are still deciding if they would like to be part of this group).

Is there a need at this stage to draw in a few other heads and perspectives to help us think through the scope, purpose, structure, size and style of the document – which is a very important strategic decision to make soon.

I HAVE NOW SEEN ABHAY AND ANT'S RESPONSES

Can I now suggest the following:

Secretariat for GHEW - redact

GHEW Management committee - (Two from lexi, ant, abhay, paula) + (mike) + (david and ravi from PHM) + myself + ?wemos

GHEW Reference group - a group of people we can bounce ideas off to get additional perspectives and views

Thanks for this and sorry for the long e-mail

Dave

6/20/03

PHM Secretariat

From: Abhay Seema <abhayseema@vsnl.com>
To: Mike Rowson <mikerowson@medact.org>; <lexi@nst.org.za>; <ant@hst.org.za>
Cc: David McCoy <david.mccoy@lshtm.ac.uk>; LYNETTE MARTIN <LMARTIN@uwc.ac.za>; <phmsec@touchtelindia.net>
Sent: Thursday, June 19, 2003 9:22 AM
Subject: Consultative process for GHEW

Dear Mike,
It is good to know that Medact would be able to facilitate initial fund-raising and formulation of the concept for the GHEW, and is supporting Dave for this. However, as far as coordinating the actual preparation, finalisation and publication of the report is concerned, it is important that a mutually agreed on, collective process is adopted. It is not necessary to mention that besides the definite contribution of Health Counts (Medact & Wemos) in developing the idea, the initial concept of a GHEW has originated in GEGA, and that the international network of PHM would be both a source of ideas and information, and a key forum for dissemination of the report. You have already mentioned the importance of 'ownership' by all the collaborating organisations.
Keeping the collaborative nature of this entire venture in mind, it would be preferable for each of the organisations / networks involved (GEGA / PHM / Health Counts) to nominate say two persons each for a 'GHEW committee' which would be in regular correspondence over e-mail about the funding proposals, structure, contributors, and progress of work regarding the report. This group may also form the editorial board for the report. With such a consultative group guiding the process, I personally feel it would be fine for Medact to act as a 'Secretariat' for GHEW, and for Dave to work as a key facilitator for the entire process. It would be a good idea for people from all the networks involved to make suggestions about what kind of collective framework would be best to support the process. My compliments to the Medact group for carrying forward this key initiative.
Regards,
Abhay

Abhay Shukla
B-1 Nilgiri Apartments, Karvenagar, Pune 411052
Maharashtra, India
Phone: 020-546 5936
e-mail: abhayseema@vsnl.com
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

----- Original Message -----
From: Mike Rowson
To: lexi@hst.org.za ; ant@hst.org.za ; LYNETTE MARTIN ; phmsec@touchtelindia.net
Cc: David McCoy ; abayseema@bn3.vsnl.net.in ; Ellen Verhoul ; Marian Stoffers
Sent: Wednesday, June 18, 2003 10:39 PM
Subject: GHEW

RN 2011

Dear Friends

Just wanted to touch base with you all about how GHEW is progressing, and some institutional issues. Dave has been working on the proposal here, and although we are having some debate about the final form of the publication, I think we are getting nearer to sending it out to funders. As you know, this has been proposed as a joint GEGA/PHM/Medact/?Wemos publication, but we haven't yet been clear about where the actual nitty-gritty of putting the publication together would be carried out.

If it is acceptable to you, I would like to propose that the co-ordination, both of fundraising, and eventually,

RN 19/6/03

PHM. GEGA / GHEW

PHM Secretariat

Page 1 of 4

PHM Secretariat

From: Mike Rowson <mikerowson@medact.org>
To: Antoinette Ntuli <ant@healthlink.org.za>; <lexi@hst.org.za>; Abhay Seema <abaysema@pn3.vsnl.net.in>
Cc: David McCoy <david.mccoy@lshtm.ac.uk>; LYNETTE MARTIN <LMARTIN@uwc.ac.za>; <phmsec@touchtelindia.net>
Sent: Thursday, June 19, 2003 2:42 PM
Subject: Re: Consultative process for GHEW

Dear Abhay and Antoinette

Thanks for your comments and I do agree that a committee is essential, to make sure this is a proper collaboration. Let's see if there are any further comments from others and then think about its composition.

mike

----- Original Message -----
From: "Antoinette Ntuli" <ant@healthlink.org.za>
To: "Mike Rowson" <mikerowson@medact.org>; <lexi@hst.org.za>; "Abhay Seema" <abaysema@pn3.vsnl.net.in>
Cc: "David McCoy" <david.mccoy@lshtm.ac.uk>; "LYNETTE MARTIN" <LMARTIN@uwc.ac.za>; <phmsec@touchtelindia.net>
Sent: Wednesday, June 18, 2003 8:10 PM
Subject: Re: Consultative process for GHEW

> Dear Colleagues,
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> outcomes of the work rather creating distractions. To do so is
> clearly challenging given the geographic spread and complexity of
> the individual organisations.
> As a principle I think we need to be fostering genuine shared
> ownership and responsibility for the GHEW and I would support
> Abhay's suggestion of a Steering/Management committee for the
> work which has two representatives from each of the organisations.
> Like Abhay, I am happy for Medact to function as the secretariat so
> long as the work is managed by a ctte that is representative.
> If there is agreement with the suggestion of such a ctte, then I think
> the organisations should be asked to nominate two reps asap so
> that the group can start functioning.
> Antoinette

PHM Secretariat

From: Mike Rowson <mikerowson@medact.org>
To: <lex@hst.org.za>; <ant@hst.org.za>; LYNETTE MARTIN <LMARTIN@uwc.ac.za>; <phmsec@touchtelindia.net>
Cc: David McCoy <david.mccoy@ishtm.ac.uk>; <abayaema@pn3.vsnl.net.in>; Ellen Verheul <ellen.verheul@wemos.nl>; Marjan Stoffers <marjan.stoffers@wemos.nl>
Sent: Wednesday, June 18, 2003 10:39 PM
Subject: GHEW

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If it is acceptable to you, I would like to propose that the co-ordination, both of fundraising, and eventually, of implementation, are carried out at Medact. Of course this would still mean lots of partnership working, and in particular, if we proceed with the report, a sense of combined ownership being present. I don't want it to seem like Medact is running away with this report! And in truth, our capacity to do it alone will be limited. We forsee that most of the document will be written by people outside of Medact, and that we will play a tying together role. Both Dave and I are also conscious of the fact that we need to work closely with Southern institutions and networks to get the thing written, and to support capacity there.

As we have Dave here at the moment, we have decided to pay him a day a week for the next three months to take forward the fundraising, and further formulation of the concept. I hope this is OK. But if you have any objection to Medact as an organisation taking the lead role in future implementation, please let me know. We are quite happy to step aside!

Best wishes
Mike

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment

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www.medact.org
Registered Charity 1081097
Company Reg. No. 2267125

RN 2016

March 2003: Medact's work on Iraq, including report on likely health and environmental consequences of conflict, available at www.medact.org

RN 19/6/03

PHM. GEGA/GHEW

PHM Secretariat

From: Abhay Seema <abhayseema@vsnl.com>
To: David McCoy <David.McCoy@lshtm.ac.uk>
Cc: <lexi@hst.org.za>; <phmsec@touchtelindia.net>
Sent: Wednesday, June 11, 2003 12:10 AM
Subject: Re. GHEW

Dear David,
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RN 17/6

Abhay Shukla
B-1 Nilgiri Apartments, Karvenagar, Pune 411052
Maharashtra, India

RN 17/6/03

PHM - GEGA / GHEW -

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <abhayseema@vsnl.com>
Cc: <lexi@hst.org.za>; <phmsec@touchtelindia.net>
Sent: Wednesday, June 11, 2003 3:57 PM
Subject: Re: GHEW

Thanks Abhay
very useful and just on time!

>>> abhayseema@vsnl.com 06/11/03 05:33am >>>

Dear Dave,
Sorry for the delayed response, overall the structure looks good, though it has definitely come a long way from our initial idea of a 'Global Gauge'!
Some general comments and suggestions:

1. Section A is well conceptualised overall but Section B (Health sector) seems to trail off and has certain gaps

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RM 12/6/03

PHM - GHEA / GHEW

PHM Secretariat

From: Abhay Seema <abhayseema@vsnl.com>
To: PHM Secretariat <phmsec@touchtelindia.net>, David McCoy <David.McCoy@lshtm.ac.uk>; <lmartin@uwc.ac.za>
Cc: Alexandra Bambas <lexi@hst.org.za>; mikerowson <mikerowson@medact.org>
Sent: Monday, June 30, 2003 11:58 PM
Subject: Re: GHEW management and technical advisory committee

Dear Ravi,
It is good that you have agreed to participate in the Managing committee! That would ensure representation from the PHM secretariat. Now I can escape Dave's arm-twisting!

In this context, my understanding is that the Managing committee is a body consisting of organisational representation from the main collaborating organisations (GEGA, Medact and PHM). However the Technical advisory group should include key individuals suited to giving technical inputs for the GHEW, whether directly representing GEGA / Medact / PHM or not. If we limit the TAG to strict representation by the collaborating organisations, we may miss out on the inputs of certain individuals. So it may be better to select the members of the TAG as individuals, (perhaps many happening to be from GEGA / Medact / PHM networks) but not insist on each TAG member to represent an organisation.
Regards,
Abhay
****

Abhay Shukla
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Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org
****

RN 1/7

----- Original Message -----
From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <abayseema@pn3.vsnl.net.in>; <lmartin@uwc.ac.za>
Cc: Alexandra Bambas <lexi@hst.org.za>; mikerowson <mikerowson@medact.org>
Sent: Monday, June 30, 2003 4:58 PM
Subject: Re: GHEW management and technical advisory committee

RN 1/7/03

> Dear Dave, David, Abhay, Mike, Lexi,
>
> On further reading through all the evolving organizational and technical
> dialectics, I will reconsider my suggestions and would agree to be on the
> management committee, which will perhaps be strengthened by the hat, which

PHM - GEGA/GHEW

PHM Secretariat

From: Abhay Seema <abhayseema@vsnl.com>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>; <imartin@uwc.ac.za>
Cc: Alexandra Bambas <lexi@hst.org.za>; Mike Rowson <mikerowson@medact.org>
Sent: Sunday, June 29, 2003 11:54 AM
Subject: Re: GHEW management and technical advisory committee

Dear Friends,
I agree with Dave's overall conceptualisation of a Management committee and a Technical advisory group. However, I have a few comments and clarifications:

1. All persons on the Management committee belong to one or more networks / organisations. Would'nt it be appropriate for each person to be formally endorsed by the organisation which s/he primarily represents in this committee, before the names are finalised? This is significant because GHEW is an organisational collaboration between GEGA, Medact and PHM. Individual members of the Management committee (which is an organisational /managerial, not just technical body) represent particular organisations, besides of course their personal interest in the activity. (Correct me if I'm mistaken).

2. I personally feel I would not be able to participate in the Management committee because of serious time constraints on my side. I am now managing the National secretariat of PHM-India and am centrally involved in developing a national campaign on Right to Health Care in India, besides various ongoing activities at local and state levels. However, I might be able to give inputs on the Technical advisory group if appropriate. I definitely feel this is an important initiative which needs to be carried ahead, and so I have been giving and would try to continue to give suggestions and inputs as time permits.

3. The specific and distinct roles of the Management committee (MC) and Technical advisory group (TAG) need to be made a bit more clear. Dave's description of the TAG seems OK, we need a similar role description of the MC.

4. An overall comment about the structure of the report is that it seems to have become too broad ranging and ambitious. It may be a good idea to start small and then grow year by year as the idea receives a broader range of support and contributors. I would recommend pruning of sections A and B, and that we focus on section C with an explicit statement of our limitations at this stage in being able to cover all areas, even though we recognise them as being significant.

PHM-GHEW
RN 30/6/03

With regards,
Abhay

Abhay Shukla
B-1 Nilgiri Apartments, Karvenagar, Pune 411052

Maharashtra, India
Phone: 020-546 5936
e-mail: abhayseema@vsnl.com
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org
****

----- Original Message -----
From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net> ; <lmartin@uwc.ac.za>
Cc: <lexi@hst.org.za> ; <mikerowson@medact.org> ; <abayseema@pn3.vsnl.net.in>
Sent: Friday, June 27, 2003 11:29 PM
Subject: GHEW management and technical advisory committee

Dear all,

I would like to follow up on some of the earlier discussions about institutional arrangements. As I understand it we are agreed that there will be a GHEW Management Committee. I would like to also propose that we set up an technical advisory committee to help with the conceptualisation and production of the document.

As far as the management committee is concerned we have:
David McCoy (Medact / GEGA)
Mike Rowson (Medact / PHM)
Lexi Barnbas (GEGA)
Abhay Shukla (GEGA / PHM)
David Sanders (GEGA / PHM)

Is this sufficient and agreed-upon representation of the management committee? We are unsure about wemos participation at this present moment.

As far as a technical advisory group is concerned, I would like to suggest:
- main functions: over the next three months to provide advice on the structure and lay-out of the document; later on possibly to help with writing of sections and editing of the report
- want a broad range of skills and expertise, especially to compliment the public health and health policy expertise that already exists in the management committee
- want geographical representation
- their names may also strengthen a GHEW funding proposal
- no more than ten people?

Any comments on the above?

PHM-GHEW

If not, can we suggest some names of people to approach as technical advisors?

In the meantime, I received feedback from Mike and Ravi on the discussion about the structure of the report. I am working on a revision, and get this

RJ
30/6

PHM Secretariat

From: hariprem <hariprem@eth.net>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Saturday, June 28, 2003 7:40 AM
Subject: Re: [PHM_Steering_Group_02-03] Evolving a plan of action and overall strategy for PHM - Communication - II

Dear Ravi,

Documents received and under study!

Regards

Prem

----- Original Message -----
From: PHM Secretariat
To: PHM_Steering_Group
Sent: Friday, June 27, 2003 7:01 PM
Subject: [PHM_Steering_Group_02-03] Evolving a plan of action and overall strategy for PHM - Communication - II

COMMUNICATION - II DATE:

PHM-AC HAN

RN
30/6/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Cc: <lexi@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Friday, June 27, 2003 11:29 PM
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- their names may also strengthen a GHEW funding proposal
- no more than ten people?

Any comments on the above?

If not, can we suggest some names of people to approach as technical advisors?

In the meantime, I received feedback from Mike and Ravi on the discussion about the structure of the report. I am working on a revision, and get this out to you soon on Monday (hopefully the structure will now be in a shape that we are all happy to begin to share with potential funders and others)

thanks

dave

PHM-GHEW

RN
30/6/03

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <abaysema@pn3.vsnl.net.in>; <lmartin@uwc.ac.za>
Cc: Alexandra Bambas <lexi@hst.org.za>; mikerowson <mikerowson@medact.org>
Sent: Monday, June 30, 2003 4:58 PM
Subject: Re: GHEW management and technical advisory committee

Dear Dave, David, Abhay, Mike, Lexi,

On further reading through all the evolving organizational and technical dialectics, I will reconsider my suggestions and would agree to be on the management committee, which will perhaps be strengthened by the hat, which I presently wear, coordinator, PHM secretariat. I also plan to build a little support for GHEW project in our evolving PHM budget. Abhay can share the PHM responsibility by being on the Technical advisory group (TAG). For other members of the TAG I suggest a more careful selection keeping gender and geographical representation in mind. I would suggest Niclas (DHF), Nadine Gassman(Mexico) and Claudio Schuftan (Vietnam). The first two helped the PHA-I background papers and the third person has a strong health rights approach. These are just suggestions, others may have views.

I have included an announcement about GHEW evolving process in our last steering group communication. They will now await a proposal from Dave when it has reached a stage for wider distribution!!

Best Wishes
Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
367 "Srinivasa Nilaya"
Sakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org
----- Original Message -----
From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <abaysema@pn3.vsnl.net.in> ; <phmsec@touchtelindia.net> ; <lmartin@uwc.ac.za>
Cc: <lexi@hst.org.za> ; <mikerowson@medact.org>
Sent: Sunday, June 29, 2003 6:34 PM
Subject: Re: GHEW management and technical advisory committee

Thanks for this Abhay

I think the role of the Management Committee is to make the key strategic and financial decisions (partly on the basis of the advice we might get from the advisory group). The Secretariat (medact) would carry out most of the management functions but the Management Committee is where I would see key strategic decisions are made.

PHM-GECA-GHEW >

RN
3/7/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <abaysema@pn3.vsnl.net.in>; <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Cc: <lexi@rst.org.za>; <mikerowson@medact.org>
Sent: Sunday, June 29, 2003 6:34 PM
Subject: Re: GHEW management and technical advisory committee

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I think the role of the Management Committee is to make the key strategic and financial decisions (partly on the basis of the advice we might get from the advisory group). The Secretariat (medact) would carry out most of the management functions but the Management Committee is where I would see key strategic decisions are made.

I support your suggestion that it would be important for individuals to be on the Management Committee with one organisational hat on, and for this individual to have the mandate of that organisation.

Therefore, can I suggest:
David McCoy (Medact)
Mike Rowson (Medact)
Lexi Bamidas (GEGA)
A.N. Other (GEGA)
Abhay Shukla (PHM)
David Sanders (PHM)

How is that? Abhay, can I twist your arm to stay on the management committee? I think it's vital for either you or Ravi to be on the committee - someone close to the PHM secretariat which is based in India.

In terms of structure of the report, there seems to be a dialectical process going on. I agree with the feeling that it has become too cumbersome, and will pass on a new version early next week which I hope will look more manageable and concise.

Thanks again

Dave

P.S. I have included an announcement about GHEW evolving process in our last steering group communication They will now await a proposal from Ravi ← Best wishes Ravi ← There when it has reached a stage for wider dissemination!

more careful selection keeping gender and geographical representation in mind. I would suggest Nicolas (DHF) Nadine Gasman (Mexico) and Claudio Schuftan (Vietnam) The first two helped the PHA-I - background papers and the third person has a strong Health Rights Approach. These are just suggestions - others may have views.

>>> abhaysema@vsnl.com 06/29/03 07:24am >>>

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I agree with Dave's overall conceptualisation of a Management committee and a Technical advisory group. However, I have a few comments and clarifications:

1. All persons on the Management committee belong to one or more networks/ organisations. Would'nt it be appropriate for each person to be formally endorsed by the organisation which s/he primarily represents in this committee, before the names are finalised? This is significant because GHEW

30/6/

Dear Dave, Da
Abhay, Mike, Lex
On further reco
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evolving organi
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strengthened
by the net, whic
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PHM Secretaria
I also plan to
build a little supp
for GHEW project
our evolving PHM
budget. Abhay ca
share the PHM
responsibility by be
on the TAG. For other m
of the TAG I suggest c

PHM Secretariat

From: mikerowson <mikerowson@medact.org>
To: <phmsec@touchtelindia.net>; <smartin@uwc.ac.za>; David McCoy <David.McCoy@lshtm.ac.uk>
Cc: <ant@hst.org.za>; <lexi@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Friday, July 04, 2003 5:11 PM
Subject: Re: GHEW

Dear Friends

Thanks Dave, for the new structure. Just a couple of suggestions:
(a) I am not sure about the overlaps between section B1-B3. I think they are a bit repetitive, and I'd get rid of the section on social sector policy, as we can get most of what we need into a broader "political economy" section or into the following section on health policy.

(b) I am also unsure about whether to tackle so many subjects in section D. Whilst I realise this can be helpful in drawing in different NGOs etc. into this report, I feel it will also make it all a bit unwieldy. I would just focus on one or two issues, of crucial policy importance in 2004, maybe tied to a global conference.

I would be interested to hear your thoughts.
mike

RN
5/7/03

---------- Original Message ----------
From: "David McCoy" <David.McCoy@lshtm.ac.uk>
Date: Wed, 02 Jul 2003 13:12:48 +0100

>Dear all,
>
>Here is the revised version of the GHEW report structure. As I mentioned earlier it has changed in an attempt to be more coherent and slimmed down. I have also separated out a section at the end for monitoring and advocacy - the section that will contain our "institutional watches" and "demands".

>we are reasonablyhappy with this, I would like to begin to share this more formally with a broader group of people? Perhaps to thelist of potential technical advisory group members that we need to generate. So in addition to commenting on the structure of the report, can I ask again for any further suggestions on:
>- potential advisory committee people
>- potential authors / academics to write chapters
>- potential individuals / groups we want to endorse and support the final product and be invited to act as reviewers of draft chapters
>
>Thanks
>
>Dave

GHEW

RN
07/07

RN
2/7

7/8/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>; <imarun@uwc.ac.za>
Cc: <ami@hst.org.za>; <lexi@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Wednesday, July 02, 2003 5:42 PM
Attach: Report Structure.doc
Subject: Re: GHEW

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Thanks

Dave

RN
3/7/03

PHM - GEGA / ~~GHEW~~ GHEW

To
Dr TN/CMF

Heres a plan of the PHM-GEGA joint initiative called Global Health Equity Watch. It will be an alternative World Health report - published as background paper prepared for PHA-II in Porto Alegre in July 2004. Please send any comments or suggestions to focus it better on PHM/Charter concerns

Thanks

RN
1/8/03

SUMMARY OF CHAPTER HEADINGS

Preface

Introduction

SECTION A: INTRODUCTION TO GLOBAL HEALTH INEQUITIES

A1. Health in a Divided World (Socio-economic, health and health systems inequities)

SECTION B: THE POLITICAL ECONOMY OF HEALTH, DEVELOPMENT POLICY AND HEALTH SYSTEMS

B1. The Politics and Economics of Poverty – A Global Public Health Priority

B2. Failing Prescriptions - Social Sector Policy and Ideology

B3. Health Policy: The Privatisation Agenda

B4. Where are our doctors? The Global Brain Drain of Health Personnel

B5. Big Pharma and the Future of Accessible Medicines

B6. Global Heath Leadership

SECTION C: BEYOND THE HEALTH SECTOR

C1. Agriculture and food security (long)

C2. Water (short/medium)

C3. Militarism and health (medium)

C4. Environment (medium)

C5. Gender and Women's Access to Health Care and Reproductive Rights (medium)

SECTION D: MONITORING AND ADVOCACY SECTION

This section will consist of a number of sub-sections each of which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and at the same time inform the advocacy and lobbying actions of a global progressive health movement committed to a just world and health for all. There would be a number of sections, for example:

- Trade and WTO
- ODA
- HIPC initiative
- IMF
- Global political and economic governance

- WB Watch
- WHO and other international health agencies
- GATS and Health Watch
- Global medicines watch
- Global health research watch
- Donor watch

	Suggested individuals or NGOs to co-author or endorse chapter
Preface	Nelson Mandela / Desmond Tutu / Graca Machel
Introduction Why have an alternative world health report. Why a focus on equity. Structure and purpose of report	GEGA/PHM/Medact
SECTION A: INTRODUCTION TO GLOBAL HEALTH INEQUITIES	
A1. Health in a Divided World (Socio-economic, health and health systems inequities)	
Introduce the socio-economic and political determinants of health and how socio-economic inequities affect health inequities	WDM Oxfam
Overview of the distribution of wealth (poverty) / health (ill health and mortality) / health care resources. Provide historical overview of socio-economic development and equity since WW2 and describe the current concentration of economic wealth amongst rich nations and fewer and fewer TNCs, and the existing levels and distribution of poverty	SCF GEGA / Equitap
Describe trend of growing inequities within rich countries as well as within in poor countries.	
Describe health inequities globally, inter-regional and in-country – emphasise HIV/AIDS, TB and malaria, but also of childhood killers, trauma and violence related health.	
There are many reasons for this picture, but this section of the report will highlight the political and economic causes at a global level, with the understanding that poverty will not be addressed without inequities being reduced.	
Describe the state of health care in relation to the state of health, and the way health systems can determine health inequities	
Describe health care and health systems inequities globally, inter-regional and in-country - incorporate a case study on the collapse of African health systems.	
SECTION B: THE POLITICAL ECONOMY OF HEALTH, DEVELOPMENT POLICY AND HEALTH SYSTEMS	
B1. The Politics and Economics of Poverty – A Global Public Health Priority	
Explain and summarise key global trends that are relevant to the current picture of growing inequities and the poverty traps that many poor countries are in. Highlight: ➢ Unfairness and effect of the global trading system (including double standards re tariffs and subsidies)	• Norecna Hurtz • George Monbiot • Naomi Klein

➢ Effect of protectionism and subsidies amongst rich countries ➢ Declining levels of ODA, inequitable distribution of aid amongst developing countries and poor quality ODA (tying of aid; donor uncoordination; appropriateness of aid; linkage to privatisation policies) ➢ Burden of debt and inadequacy of debt relief ➢ Effect of global financial system on macro-economic stability and development in poor countries ➢ Capture of the wealth of natural resources by small numbers of people ➢ Policies which transfer assets from sovereign debtors to international creditors ➢ Impact of Washington Consensus policies on development and equity Describe the political processes that underpin the current global economic structure and system and highlight issues about global economic and political governance. These issues include the accountability of global governance institutions to civil society and the democratic deficit; lack of transparency and accountability; corporate control and influence; lack of power of developing countries in the face of increasing economic and financial globalisation and concentration of political and economic power amongst rich nations and corporate sector; the elevation of the rights of foreign creditors over those of citizens. Relate these issues to (each as a sub-section): • International financial system; • Regulatory structures and systems for trade - WTO • Regulatory structures and systems of TNCs • IMF • UN • Intellectual property rights regime Emphasise the link between all of this with health and that unless the underlying socio-economic determinants of poverty are addressed and unless countries are adequately resourced to ensure effective health systems, we will not deal with the 30,000 preventable childhood deaths a day, the HIV and TB epidemics etc. Conclude that there is a need for: ➢ Reform of global economic and political institutions ➢ Much greater transfers of resources and wealth from rich to poor ➢ Bold and radical departure from business as usual ➢ Global health institutions such as WHO and other health associations and organisations to elevate the political economy of health as a public health priority.	• Susan George + staff and fellows of Transnational Institute • Martin Khor and Chakravarthi Raghavan (Third World Network)
B2. Failing Prescriptions - Social Sector Policy and Ideology Describe the current (neo-liberal) economic theories and ideology that underpins the general social sector development discourse, and the influence of WB, IMF and OECD. Describe the growing privatisation agenda and the policy convergence among WB, IMF and bilaterals. Make link between the privatisation agenda in the social sector with the global political economy. Explain the effects of such policies on poverty alleviation and inequity.	Citizens Network on Essential Services (Nancy Alexander and Tim Kessler)

Contrast with examples of countries whose social policies have been pro-poor and where real advances have occurred. Include sub-sections: • Critique of the current World Development Report • Critique of selected PRSPs • Extent of and the effects of the privatisation of basic services (water and electricity) on health, poverty and inequities	Patrick Bond (South Africa) WEED - German NGO working on privatization of water. Bretton Woods Project and BIC Public Services International Research Unit (PSIRU)
B3. Health Policy: The Privatisation Agenda Overview Overview of development of international health systems policy since the 1960s. Describe the heterogeneity of health systems, but the growing worldwide trend of a shrinking public sector. Describe the demise of the principles of the PHC Approach and how it is misunderstood and misapplied. Report on the growing emergence of selective primary health care and the global verticalisation of health interventions in contrast to the development of coherent health policy and health systems development. Privatisation Describe the trends on the privatisation of health care. Describe trends in public health budgets and health care expenditure', declining public health budgets and rise in out-of-pocket expenditure. Describe the lack of regulation of the private medical care in developing countries and the growth of the private medical insurance industry. Describe the various forms of privatisation incl. cost recovery mechanisms, user fees and subcontracting of services to NGOs, and critique the targeting of services approach (as opposed to strong universal care systems). Emphasise also how public sector budget cuts lead to 'de facto' privatisation. Describe the policies, ideologies, reforms and forces that are contributing to this and raise the issue of increased inequities, inefficiencies, segmentation of health systems and weakening public health capacity. Make reference to WB and WHO positions in this regard. Review evidence about the performance of the private for-profit sector in terms of efficiency and effectiveness, as well as their	Mike Rowson Fran Baum Ravi Narayan Davin Sanders David Woodward Andrew Green / Charles Collins Abhay Shukla John Hilary / WDM (Jessica Woodroffe and Claire Joy) / Sarah Sexton Maureen Mackintosh

impact on equity. In contrast, discuss the evidence that exists to suggest that universal public sector state services are inherently inefficient and inequitable – will need to tackle some of the WB papers and views on this directly. Built on case studies – for example, describe what is happening in a number of countries (for example, India, Mexico, South Africa, Australia, Malaysia, USA and one East European country), and then propose an appropriate health sector reform package. Describe Free Trade Agreements and GATS, and their impacts (or likely impacts) on increasing privatisation, increasing health systems inequities and weakening government regulatory capacity. The new Public Management Another increasingly dominant policy / approach within development and social service delivery is the new public management – the promotion of market-based, private solutions to public sector management. Describe extent to which this is being promoted and critique its appropriateness for the delivery of social goods and services such as health care (develop a box summarising the reasons why health and health care require the state and are failed by the market and market-based reforms of the public sector).	
B4.Where are our doctors? The Global Brain Drain of Health Personnel Indicators to monitor the equitable distribution and availability of health personnel Describe the central importance of health personnel to functioning health systems, and the picture of global health personnel inequities. Describe the aggressive recruitment of health personnel from the south. In short, the political economy of health personnel availability and training. Describe efforts underway to address this problem, including the Rockefeller / WHO initiative. Describe what WHO, ILO and other UNagencies are doing. Describe some of the other stakeholder positions. Monitor development and implementation of policies to mitigate the global brain drain	Equinet-HRH network Rockefeller – WHO team members
B5.Big Pharma and the Future of Accessible Medicines Describe the multi-billion dollar pharmaceutical industry in relation to global health and world poverty Report on progress with respect to: • TRIPs and the implementation of the Doha agreement • Accelerated access initiative • Regulation of the pharmaceutical industry • Progress towards EDP implementation Describe the efforts of the pharmaceutical industry to remain non-transparent, to inflate their research and developments costs, as well as to promote a deregulation of the market whilst strengthening their capacity to protect patents and to fix prices.	MSF, HAI and TAC

Describe progess re. development of pharmaceutical manufacturing capacity in developing countries Set out an agenda of action for WHO, including distancing itself from the influence of the pharmaceutical industry and calling for a international famework for the transparent regulation of the pharmaceutical industry as well as the development of generic manufacturing capacity in developing countries	
B6. Global Hoth Leadership The whole concept of global health governance needs to be described and explained in relation to many of the earlier chapters. It should point to a lack of global public health leadership in addressing the underlying determinants of poverty and disease; inadequate mechanisms for civil society engagement and participation; dangers of GPPIs etc This chapter will include a critique of some of the key health sector specific multi-lateral agencies: • World Health Organisation • UNAIDS • UNICEF It will look at overall performance; the extent to which a broad public agenda is acknowledged and supported; the extent to which there has been adequate civil society engagement especially with developing country civil society, the extent to which they have been compromised by corporate interests etc It should build on some concrete case studies including: • involvement and influence of pharmaceutical industry within WHO • breastfeeding, the state of play re. infant feeding code and the influence of baby food industry on health policy agencies • the tobacco control initiative + WHO's desire to stand up to the sugar and food industry ... positive examples of health leadership	
SECTION C: BEYOND THE HEALTH SECTOR	
C1. Agriculture and food security (long) • Describe state of hunger and malnutrition, and growing inequities in food consumption • Increasing oligopolisation of food industry • Critique of agri-business, GMOs and TRIPS-related developments • Comment on the weakening of public distribution systems for food security (e.g. various forms of rationing and food subsidies) under neoliberal regimes • Report on unfair agricultural subsidies and dumping Critique of UN / donor / FAO approach to household food security. Critique WHO's approach and performance related to food security, agriculture, nutrition. Report on WHO's recent battles with the sugar and food industry. Make mention of the millennium development project's background paper.	Tim Lang is Professor of Food Policy at Thames Valley University. Alliance for People's Action in Nutrition Vandana Shiva

Propose alternative strategies Emphasise the importance of this as a health issue. Determine some key recommendations that we can ask health associations and health-related NGOs, as well as the global health institutions such as UNICEF and WHO to advocate for, and which GHEW can monitor on an annual basis.	
C2. Water (short/medium) Explain importance of basic utility services (water, sanitation and electricity services) to health, emphasising again the importance of addressing the broader determinants of health. Describe the global situation in terms of coverage, access and utilisation (including inequities in consumption). Review, assess and critique the current state of international treaties and conventions related to water and energy.	
C3. Militarism and health (medium) • Report on trends related to military expenditure and its direct and indirect effects on development and health (describe inequitable distribution of the consequences of war and conflict) • Report on trends related to the effect of war, violence and conflict on health • Describe on-going threats of nuclear weapons and its impact on health • Case studies (possibly from Bosnia, Sri Lanka, Afghanistan, Iraq, Sierra Leone, Congo, Columbia and Palestine / Israel) o What is happening from a health perspective o What have been the post war responses to reconstructing the health system Brief summary of what is happening in the UN and the various other weapons control treaties and conventions. Construct this as a report card of progress and failure – naming and shaming of perpetrators and problem countries. Emphasise the importance of this as a health issue. Determine some key recommendations that we can ask health associations and health-related NGOs, as well as the global health institutions such as UNICEF and WHO to advocate for, and which GHEW can monitor on an annual basis.	Medact / IPPNW Centre for Humanitarian Dialogue (Human Security and small arms project) Saferworld - independent foreign affairs think tank has two research programmes: Arms and Security, and Conflict Prevention Federation of American Scientists - Arms Sales Monitoring Project - works for transparency, accountability and deep reductions in global conventional weapons production and trade. Case studies: The Regional Centre for Strategic Studies in Sri

	Lanka Regional Human Security Center in Jordan Institute for security Studies in South Africa
C4. Environment (medium) Report on the continued and growing threats to health from environmental degradation and pollution: • global warming • ozone depletion • water pollution from pesticides, sewage etc • deforestation Make link between poverty, environmental degradation and health. Introduce concept of ecological debt. Summary of what is happening in the UN and through the Commission for Sustainable Development. Describe the shortcomings of the current system of global economic governance in protecting the environment as well as the weakness of the international regulatory system to identify and punish environmental offenders. Construct a short report card of progress and failure related to the various treaties and conventions -- naming and shaming of perpetrators and problem countries Relate this back to the health community. What should they be doing? What should WHO be doing? For example, has it spoken out against the failure of the Kyoto protocol from a public health perspective?	Bank Information Centre (BIC) has been working on the multilateral development banks from an environmental perspective. The Center for International Environmental Law – NGO that provides environmental legal services, as well as policy research, advocacy, education and training Friends of the Earth Greenpeace
C5. Gender and Women's Access to Health Care and Reproductive Rights (medium) Highlight the specific needs and challenges to addressing women's health. Describe the progress that has been made since Cairo, but highlight the fact that while the world is long on bold policy statements and declarations, it is short on changing the lives of millions of women who suffer from discrimination and a lack of adequate health care. Provide what data there is to demonstrate the health inequity between men and women. Make the link between the collapse of health systems to women's health. Make the link to broader social and cultural issues, and describe attempts to empower and liberate women through health care. Critique the role and effectiveness of international and multi-lateral agencies to address this issue.	Womens Global Network for Reproductive Rights
SECTION D: MONITORING AND ADVOCACY SECTION	

This section will consist of a number of sub-sections each of which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and at the same time inform the advocacy and lobbying actions of a global progressive health movement committed to a just world and health for all. There would be a number of sections, for example:

Trade and WTO

- In terms of trade, concrete issues to monitor might include the rich country tariffs and subsidies, and the removal of appropriate protectionist barriers in poor countries. This might include a 'report card' of the fairness of the Cancun talks.
- In terms of WTO, highlight the need for reform of purpose, governance and accountability.

ODA

- Provide detail of good and bad performers.
- Develop donor country case studies (possibly a mix of good performers and bad performers) – to look at quantity, quality, conditionality and politicisation of aid
- G8 report card

HIPC initiative

- Describe the lack of progress related to debt cancellation as well as the inappropriate / unfair conditionalities.

IMF

Global political and economic governance

- Regulation of global financial and capital markets
- Recommend and monitor progress towards policy proposals such as Tobin tax
- An effective global tax system

WHO and other international health agencies

Assess their positions and actions on the political and economic issues listed above (include absence of such issues in macro-economic commission on health).

WB Watch

Develop a critique of the World Bank which can be used to make specific demands of the Bank and to monitor the Bank – this can be tracked in subsequent GHEWs. Include issues related to governance, transparency and policy (possibly the other MDBs?)

WHO and other international health agencies

Assess their views, positions and actions on issues raised in C1 and C2. For example, WHO's position on privatisation within health care systems + critique WHO's position and policies with regard to GATS and FTAs.

GATS and Health Watch

Development Initiatives – they compile an annual review of all ODA

- Kees Biekehart, TNI Fellow working on aid impact
- David Sogge. Works on development aid and aid policy in Southern Africa
- North-South Institute - independent institute that conducts research on Canada's relations with developing countries and its foreign aid programs.

Anne Pettifor – works on debt relief and HIPC

Global medicines watch Global health research watch Progress on the widely publicised 10:90 mismatch between the allocation of research funds and the burden of disease. Donor watch Although the WB is probably the biggest influence on health systems policy / health sector reform, bilateral donors can be influential at the country level. Therefore important for there to be a greater "donor assessment" within the health care sector to determine how well aid is being used to support appropriate health systems development and equity. Also how are donor countries choosing between different countries? How much aid is recycled back to home country consultants? To what extent are trade objectives and religious agendas being promoted through donor programmes?	
APPENDICES : VOICES FROM THE GROUND	
End with something positive that talks about various alternatives (the PHM network can provide many examples) and which illustrates the vision envisaged in the People's Health Charter. Identify and promote good models and countries which have continued to strengthen universal health care systems	PHM

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: Abhay Seema <abhaysema@pn3.vsnl.net.in>
Sent: Wednesday, July 02, 2003 4:39 PM
Subject: Re: Clarification from Ravi

Dear Abhay,

Greetings from PHM Secretariat!

I must apologies for perhaps a careless note that caused some confusion. I think you read more into my note than was intended. I think you are a excellent care member of the TAG, whether you represent GEGA or PHM is your decision. The careful selection was in the context of two facts:

i. Out of a 6 member group presently in GHEW, we have 1 woman and 5 males so we need to strengthen gender balance.
ii. We are basically from South Africa, UK and India. So we need geographical balance.
iii. When I mentioned careful selection, I was not meaning that we all were not carefully selected, but only meant that from a larger number of suggestions we may make to include people other than those already in the core group - we need to keep gender and geography in mind.

I am sorry if you were upset with any implication of the letter. It was not at all intended.

Apologies all the same. I hope this note puts all in context.

Best wishes.

PHM-GEGA GHEW
RN
3/7/03

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org
----- Original Message -----
From: Abhay Seema <abhayseema@vsnl.com>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Tuesday, July 01, 2003 12:04 AM
Subject: Clarification from Ravi

> Dear Ravi,
> I am writing this mail only to you, unlike the other one which is addressed
> to all in the GHEW 'core group'. This is because I wanted a clarification

PHM Secretariat

From: Abhay Seema <abhayseema@vsnl.com>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Tuesday, July 01, 2003 12:04 AM
Subject: Clarification from Ravi

Dear Ravi,
I am writing this mail only to you, unlike the other one which is addressed to all in the GHEW 'core group'. This is because I wanted a clarification about your statement -

'Abhay can share the PHM responsibility by being on the Technical advisory group (TAG). For other members of the TAG I suggest a more careful selection keeping gender and geographical representation in mind.'

1. If you feel that my being on the TAG is not a careful selection, (this is implied by the above statement, but I am not sure if you mean this) please let me know.
2. If you did not mean this, then this should be clarified by you to the group explicitly.
3. Historically, my involvement in GHEW dates since nearly a year back, from the initial discussions on this issue in GEGA. I first presented a paper on a 'Global Gauge' in September last year in the GEGA Coordinating Committee. Since then, Dave and myself were nominated by the GEGA CC to work on developing this. Both of us have consistently pushed for such a Global Gauge within GEGA (against significant resistance) and to some extent it is as a continuation of such earlier processes that the GHEW is materialising now.
4. I have pointed out in my other mail my opinion, that unlike the Managing committee, which is an organisational body, the Technical advisory group need not consist only of organisational representation from three organisations. Rather the TAG could consist of various individuals suitable for giving technical inputs for GHEW.
5. In any situation, if it is decided that the TAG would consist of organisational representation, I would definitely not expect to represent PHM. I am seriously considering keeping away from any major responsibility in GHEW (as it is, time is a very major constraint), but if it is decided by the GEGA CC that I should participate in the TAG on behalf of GEGA, I might agree.

I hope you would clarify the issues I have raised at the earliest.
Regards,
Abhay

Abhay Shukla
B-1 Nilgiri Apartments, Karvenagar, Pune 411052
Maharashtra, India
Phone: 020-546 5936 5451413
e-mail: abhayseema@vsnl.com 2325
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org

Dear Abhay
I must apologise for perhaps a careless note that caused some confusion. I think you read more into my note than was intended. I think you are an excellent core member whether you represent GEGA or PHM in your of the TAG. The careful selection was in the context of two facts
i) Out of a six member group presently in GHEW - we have 1 woman and 5 males so we need to strengthen gender balance.
ii) We are basically from South Africa, UK and India. So we need geographical balance.
iii) When I mentioned careful selection I Personal was not meaning PHM - that we all were not carefully selected but only meant that from a larger number of suggestions we may make to include people other than those already in the core group - we need to keep gender and geography in mind

RN 1/7/03

I hope this note puts it all in context

I am sorry if you have upset with any implication of the letter. It was not at all intended and I am all the same

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Cc: <ant@hst.org.za>; <lex@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Tuesday, July 08, 2003 5:47 PM
Subject: Re: GHEW

Hi David,

I have been focussing mainly on the structure and content of the report, and haven't revised my original list of individuals / organisations to invite as collaborators. I was also waiting for further suggestions and additions - I also want to generate some more southern names - especially from east asia, south east asia, middle east and latin america. I will definitely add your suggestions with the next iteration of the GHEW report structure.

In terms of participatory comprehensive modles - are you suggesting making the appendix a chapter?

And as for advisory group - have you any particuair people you have in mind?

Dave, I will be in SA for the next ten days or so - I'll call to see if we can meet to discuss face to face.

Thanks for your feedback

dave

>>> "Lynette Martin" <lmartin@uwc.ac.za> 07/08/03 09:39 AM >>>
Dear Dave,

RN
10/7/03

I am broadly in agreement with the structure but still feel that some key thinkers/authors have been left out from important sections. I wonder whether you received my earlier email on this?
E.g. Section B3, I suggested Allyson Pollock on privatisation of health services. Section D Ron Laponte on DDA watch.

Regarding advisory group members: we clearly need some representation from GEGA, PHM.

PHM - GEGA / GHEW

Lastly, we need a section/chapter on more participatory comprehensive models that are working. This should not just be an appendix. Examples could include Cuba, Thailand, BRAC, TEHIP, Jan Khed etc.

RN
9/7/03

Regards,
David Sanders

Prof David Sanders/Lynette Martin
School of Public Health
University of the Western Cape

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <david.mccoy@lshtm.ac.uk>
Cc: David Sanders <drmartin@uwc.ac.za>
Sent: Thursday, July 10, 2003 3:41 PM
Subject: Fw: GHEW

Dear Dave,

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

I fully endorse David's suggestion about Primary Health Care and integrated development models, but also good examples of training for health action and good health campaigns as well. Jamkhed in India is a relevant but old model of the 1970/1980. We have three generations after Jamkhed all the way to Arogya Iyakkam (Tamil Nadu) and Arogya Sathi (Madhya Pradesh), which are third generations models in India. I have lot of compilation on these and will contribute to that section. Also Asian models.

Also there are good examples from Iran, Uganda, Mauritius and many Latin American modules. I am particularly keen on action models not on just good analysis, so you can count on me and CHC team / PHM secretariat team to strengthen that part of the GHEW report. We could have a separate section or even have it as box items in many of the other Chapters. I think you should send the plan around to a wider audience now. We mentioned it in the last PHM Secretariat - Communication III. A copy is enclosed. Refer to it and mark the report plan to PHM Steering group soon.

Extract from Communication - III, 4th July 2003:

Item IX: "A strategy and process paper from a PHM - GEGA / MEDACT Joint initiative on the Global Health Equity Watch Report which will become an evidence based background document for the next PHA - II.

[David McCoy and Mike Rowson have been working on the project and will report to the Steering group soon].

Best wishes,

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

PHM Secretariat

From: Lynette Martin <lmartin@uwc.ac.za>
To: <David.McCoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>
Cc: <ant@hst.org.za>; <lexi@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Tuesday, July 08, 2003 2:31 PM
Subject: Re: GHEW

Dear Dave,

I am broadly in agreement with the structure but still feel that some key thinkers/authors have been left out from important sections. I wonder whether you received my earlier email on this?
E.g. Section B3, I suggested Allyson Pollock on privatisation of health services, Section D Ron Labonte on DDA watch.

Regarding advisory group members: we clearly need some representation from GEGA, PHM.

Lastly, we need a section/chapter on more participatory comprehensive models that are working. This should not just be an appendix. Examples could include Cuba, Thailand, BRAC, TEHIP, Jamkhed etc.

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

Rec 10/7/03 RN
Rec 9/7/03 Lm

>>> "David McCoy" David.McCoy@lshtm.ac.uk 07/02/03 02:12PM >>>
Dear all,

Here is the revised version of the GHEW report structure. As I mentioned earlier it has changed in an attempt to be more coherent and slimmed down. I have also separated out a section at the end for monitoring and advocacy - the section that will contain our "institutional watches" and "demands".

If we are reasonablyhappy with this, I would like to begin to share this more formally with a broader group of people? Perhaps to the list of potential technical advisory group members that we need to generate. In addition to commenting on the structure of the report, can I ask again for any further suggestions on:

have it as box items as many of the other chapters. I think you should send it around to wider audience

(D)

10/7/03

Dear Dave

I fully endorse Davids suggestion about comprehensive models We need these not only for primary health care and integrated development models but also good examples of training for health action and good health campaigns as well. Jamkhed in India is a relevant but old model of the 1970/80". We have three generations after Jamkhed all the way to Arogya Ikkem in Tamilnadu and Arogya Sakhi (Madhya Pradesh) which are third generation models in India. I have lot of compilation on these and will contribute to that section. Also Asian models' Also there are good examples from Iran, Uganda, Mauritius and many Latin American models. I am particularly keen on action models not on just good analysis

So you can count on me and CHC team/PHM secretariat keen to strengthen that part of the GHEW report. We could have a separate section or even

Best wishes
For PHM - GEGA / GHEW
I we mentioned it in the last PHM-SEC communication-IV. A copy is enclosed. Refer to it and make the report more pleasing to PHM steering group

- potential advisory committee people
- potential authors / academics to write chapters
- potential individuals / groups we want to endorse and support the final product and be invited to act as reviewers of draft chapters

Thanks

Dave

PHM Secretariat

DGS
Send letter & Dave to all of them
Sent 14/7/03 fa

From: Antoinette Ntuli <ant@healthlink.org.za>
To: <phmsec@touchtelindia.net>; <imartin@uwc.ac.za>; David McCoy <David.McCoy@isntm.ac.uk>; <mikerowson@medact.org>
Cc: <lex@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Sent: Thursday, July 10, 2003 6:11 AM
Subject: Re: GHEW

Greetings Friends,
Thanks very much to Dave for the work that has gone into the initial thinking re the structure and content for the GHEW.
It looks wonderfully exciting. I suspect that the time needed to raise funds, commission, review, edit and print a publication of this breadth will be substantial and I think we will need to make some planning and decisions re timelines before we are able to finalise the suggested contents.

Are we wanting to produce a comprehensive GHEW annually? If so we probably need to be working with at least an 18 month timeline from planning to publication.

Alternatively we could produce the GHEW annually with some core issues covered every year and then some issues that we might want to cover more intermittently?

Or do we want to produce a once off very comprehensive GHEW which would be slimmer in subsequent years?

I personally would like to think of the GHEW as an annual publication and would suggest that for sustainability we dont try to cover everything every time. This would mean us making some hard choices about what we leave out of this stimulating outline.
What do others think?
Antoinette

On 4 Jul 2003, at 7:41, mikerowson wrote:

> Dear Friends
>
> Thanks Dave, for the new structure. Just a couple of suggestions: (a)
> I am not sure about the overlaps between section B1-B5. I think they
> are a bit repetitive, and I'd get rid of the section on social sector
> policy, as we can get most of what we need into a broader "political
> economy" section or into the following section on health policy.
>
> (b) I am also unsure about whether to tackle so many subjects in
> section D. Whilst I realise this can be helpful in drawing in
> different NGOs etc. into this report, I feel it will also make it all
> a bit unwieldy. I would just focus on one or two issues, of crucial
> policy importance in 2004, maybe related to a global conference.
>

PHM - GHEW / GEGA

RN
11/7/03 fa

> I would be interested to hear your thoughts.
> Mike
>
>
> ---------- Original Message ----------
> From: "David McCoy" David.McCoy@lshtm.ac.uk
> Date: Wed, 02 Jul 2003 13:12:48 +0100
>
> >Dear all.
> >
> >Here is the revised version of the GHEW report structure. As I
> >mentioned earlier it has changed in an attempt to be more coherent
> >and slimmed down. I have also separated out a section at the end for
> >monitoring and advocacy - the section that will contain our
> >"institutional watches" and "demands".
> >
> >If we are reasonablyhappy with this, I would like to begin to share
> >this more formally with a broader group of people? Perhaps to thelist
> >of potential technical advisory group members that we need to
> >generate. So in addition to commenting on the structure of the
> >report, can I ask again for any further suggestions on: - potential
> >advisory committee people - potential authors / academics to write
> >chapters - potential individuals / groups we want to endorse and
> >support the final product and be invited to act as reviewers of draft
> >chapters
> >
> >Thanks
> >
> >Dave
> >
> >
> >
>
> --
> ---------------------------
> Mike Rowson
> Executive Director
> Medact
> 601 Holloway Road
> London N19 4DJ
> United Kingdom
> T: +44 (0)20 7272 2020 F: +44 (0)20 7281 5717
> Mb: +44 (0)7703 214469
> www.medact.org
> Challenging barriers to health
> Registered Charity 1081097
> ---------------------------
> --

Antoinette Nruli
Director, HealthLink
Chair, GEGA Co-ordinating Committee

PHM Secretariat

From: Alexandra Bambas <lexi@hst.org.za>
To: David McCoy <David.McCoy@lshtm.ac.uk>; <ant@healthlink.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Cc: <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Sent: Thursday, July 17, 2003 2:17 PM
Subject: RE: Fw: GHEW

Hi to all,

Sorry I've been a bit out of sight lately, but I have been keeping up with the discussion. I do have a couple questions and comments.

Antoinette suggests that Dave serve in an ex-officio capacity, but my understanding is that that would preclude him from really representing MedAct, at least if there were a "voting" situation. Perhaps this is too formal a way to look at it, but it seemed unclear to me. Ant also mentioned a MedAct/Wemos combination for 2 representatives on the management group, but Mike seemed to suggest that Wemos' participation is not clear yet.

I very much agree with those who have tried to place an emphasis on "hearing the unheard"--this is something that will set the document apart, and gets to the heart of the problem we are suggesting persists--still too much top-down dictates.

In terms of a theme, I agree with Dave that we should use the opportunity to bring out why an alternative world health report is necessary, which suggests (to me) that we need to focus on the need for institutional leadership that better attends to public interest and the policies/strategies that are being promoted within them, for instance highlighting issues related to PRSPs and the MDP. Presumably if we were able to increase attention to these process issues, there would be implications for the various sectors and activities within them.

Dave said:
"A second point. If we go with the structure and scope of the report as outlined earlier, then we accept GHEW as a platform for supporting a broad report on global public health - a major theme might in this context be better reflected as an issue we cover in greater depth rather than an issue that excludes others). Does that make sense?"

Sorry, Dave, I didn't get that.

A few comments on the proposal itself:
In section C, I would suggest that gender and women's access to health care and repro rights sounds like a health issue to me--would this be better placed in A1? If it were a chapter on Gender in general, it would make more sense to put it in Section C.

Also, I think keeping a chapter in section C on education and housing would

PHM- GHEW

RN 17/7/03

RN 24/7/03

inequalities inequities in health, but as sectors they also more structually

resemble the health sector in ways than some of the other sectors addressed in Section C. It would also allow us to highlight much of the work different groups (including the Equity Gauges) have been doing, which was part of the incentive for the GHEW.

B1. Is it possible to put the focus not only on poverty, but on "development" and "inequity/inequality"? I realise that they are tied together and would be addressed in the chapter, but I think it would be good to bring them out explicitly as as the Global Public Health Priorities.

I think we should strongly consider defining (and making explicit in the text) what we mean by an inequity, including an operational definition, if we are going to use that language, and try to be consistent throughout. I know this is tough, but I think it would serve the document, and us, well if we can do it. By the way, I would say the same for "poverty". For instance, in the proposal there are places where poverty and inequity are used rather interchangably, which I think will weaken the analysis. If we decide this is important to do, it would be better done at the outset, and agreed to by authors, reviewers, etc. so that they can incorporate the language usage in their chapters and edits.

Levi

-----Original Message-----
From: David McCoy [mailto:David.McCoy@lshtm.ac.uk]
Sent: Wednesday, July 16, 2003 7:03 PM
To: ant@healthlink.org.za; lexi@hst.org.za; mikerowson@medact.org; vysema@pn3.vsnl.net.in
Cc: David McCoy; phmsec@touchtelindia.net; lmartin@uwc.ac.za
Subject: Re: Fw: GHEW

Dear all,

I am keen to move on now beyond the conceptual stage. I am happy with Antoinette's summary of the GHEW management and advisory structures.

In terms of the structure of the report I will take it that we are agreed on:

1) the Four Broad Sections of GHEW (SEctions A, B, C and D)
2) that Section C will consist of no more than 5 chapters which may alter each year, and which will allow us to develop a common front with NGOs from other sectors such as the environment and peace groups
3) that section B is focussed on health policy, and the chapters may also change from year to year.
4) that Section D will consist of a set of issues that we can monitor each year and use as benchmarks of progress and for advocacy

I am sure that there will be different opinions on how this structure could

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <david.mccoy@lshtm.ac.uk>; Alexandra Barnbas <lexi@hst.org.za>; mikerowson <mikerowson@medact.org>; <ant@healthlink.org.za>
Cc: David Sanders <dmartin@uwc.ac.za>; <abayserma@pn3.vsnl.net.in>
Sent: Thursday, July 17, 2003 3:33 PM
Subject: GHEW

Dear All,

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

In response to Dave's / Mike's / Antoinette's Communications on GHEW and communication strategy for year one (18th July 2003), I am still making efforts to send you some background papers on a Global Health Watch initiative (idea) that I participated in for around 3 years, 1998-2000 – which did not get beyond the conceptual clarity and feasibility project stage due to unavoidable reasons. Dr. Eric Ram, Geneva, who facilitated this will forward these documents to you shortly. Many of these reasons and issues were debated even then. Sometimes history can be a good teacher as well. Acknowledge it when you receive them.

I am presently preoccupied with PHM – 3 year project log frame and the imminent NCC / NWG meting of PHM – India and a tentative South Asian informal dialogue as well next week.

For PHM viewpoint, in addition to mine, David's and Abhay's, I think you may need Marie's (iphc@cablenet.com.ni) , Bala's (bala@haiap.org), Olle's (olle.nordberg@dhf.uu.se) and Claudio's (aviva@netnam.vn) views to start with. Alternatively, you can also send a communication to us to put on Steering group yahoo list, which will reach the first three among others.

Best wishes,

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

PHM-GHEW
RN
22/7

PHM Secretariat

From: mikerowson <mikerowson@medact.org>
To: mikerowson <mikerowson@medact.org>; Alexandra Bambas <lexi@hst.org.za>; <abaysema@bn3.vsnl.net.in>; <ant@healthlink.org.za>; PHM Secretariat <phmsec@touchtelindia.net>; Antoinette Ntuli <ant@healthlink.org.za>
Cc: <david.mccoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>; <martin@uwc.ac.za>
Sent: Wednesday, July 16, 2003 3:47 PM
Subject: Re: Fw: GHEW

Dear Ant and others

Thanks Ant for this valuable advice. I have been looking at the SAHR and it looks very good - not sure how you get such an ambitious document out every year. It looks like a hell of a lot of work.

Yes, I agree that the task is now to get on with the fundraising. Dave should lead on that, with support from myself at Medact, but if anyone has any useful contacts we could utilise, please do let us know. Hopefully we should get the proposal sorted within the next week or so when Dave gets back to London. I will send some more thoughts to him.

I have recently discussed the GHEW with Wemos, who are also enthusiastic about it, but together I think we still have some profound issues about content, which need to be discussed separately. I get the feeling that at some point a physical meeting would be useful, but we'll need to raise some money for that. In the meantime, I think we should tweak the proposal slightly to emphasise that this report won't simply be about excellent analysis but will also include "voices" and seek to try and bring a sense of reality to international health policy debate. An associated communication strategy could also centre on this theme, particularly as any launch would probably be linked with the next PHA, and I presume one of the objectives of that will be to "hear the unheard". What do others think about this?

Incidentally, I still think we need to settle on a major theme for the report (which will make communication of the message clearer), and I think we should do that before we send of any proposal. Maybe Dave you could start a brief e-mail debate on this?

mike

---------- Original Message ----------
From: "Antoinette Ntuli" <ant@healthlink.org.za>
Date: Tue, 15 Jul 2003 21:27:23 +0200

>Greetings to All.
>A few more thoughts on GHEW which stem from my experience of
>editing the South African Health Review, and are an attempt to
>clarify my own understanding of how we should now move forward
>with the project.
>We are going to need one person who is the co-ordinator of the
>project - presumably this will be Dave? Dave will sit in an ex officio
>capacity on the management team and the Advisory Board.
>The management team, comprising two reps from Medact/Wemos,
>GEGA will be responsible for strategic decision making,

RM
17/7/03
PHM - GEGA / GHEW

PHM Secretariat

From: Antoinette Ntuli <ant@healthlink.org.za>
To: mikerowson <mikerowson@medact.org>; Alexandra Bambas <lexi@hst.org.za>; <abaysema@pn3.vsnl.net.in>; <ant@healthlink.org.za>; PHM Secretariat <phmsec@touchtelindia.net>
Cc: <david.mccoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Sent: Wednesday, July 16, 2003 12:57 AM
Subject: Re: Fw: GHEW

Greetings to All,
A few more thoughts on GHEW which stem from my experience of editing the South African Health Review, and are an attempt to clarify my own understanding of how we should now move forward with the project.
We are going to need one person who is the co-ordinator of the project - presumably this will be Dave? Dave will sit in an ex officio capacity on the management team and the Advisory Board.
The management team, comprising two reps from Medact/Wemos, PHM, and GEGA will be reponsible for strategic decision making, fundraising, publication and dissemination.
The Advisory Board will provide technical support and may be a more fluid body than the management team, pulling in individuals as necessary. The Advisory Board will play an important role in commissioning and editing of contributions. It may be necessary to have on individual who takes a leadin working with Dave to co-ordinate each of the four sections.
We are going to need to achieve a delicate balance between inclusivity, encouraging ownership of the report by as wide a range of groups and organisations as possible, and exercising editorial and quality control.
We need to put in place a system whereby each chapter is peer reviewed by at least one expert in addition to members of the Advisory Board. When we request contributions we need to have a clear contract which gives us the right not to include substandard work, and indicates that if agreed deadlines are not met then this may risk work being excluded.
With regard to contents, Section A,B and D are core and we will perhaps want to exercise tighter editorial control than in Section C. I think we should expect that the contents of section C will vary considerably from year to year, and perhaps we should aim to have a maximum of four or five chapters in that section each year.
I think there is now some urgency to develop what we have into a funding proposal and to start to raise funds. The tielines are already tight.
Antoinette

Antoinette Ntuli,
Director, HealthLink
Chair, GEGA Co-ordinating Committee
2731-307-2954 (tel)
2731-304-0775 (fax)
ant@hst.org.za
www.hst.org.za

RM 17/7/03

PHM-GEGA / GHEW

(D) 17/7/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <ant@healthlink.org.za>; <lexi@hst.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>
Cc: David McCoy <David.McCoy@lshtm.ac.uk>; <phmsec@touchtelindia.net>; <dmartin@uwc.ac.za>
Sent: Wednesday, July 16, 2003 10:32 PM
Subject: Re: Fw: GHEW

Dear all,

I am keen to move on now beyond the conceptual stage. I am happy with Antoinette's summary of the GHEW management and advisory structures.

In terms of the structure of the report I will take it that we are agreed on:

1) the Four Broad Sections of GHEW (SEctions A, B, C and D)
2) that Section C will consist of no more than 5 chapters which may alter each year, and which will allow us to develop a common front with NGOs from other sectors such as the environment and peace groups
3) that section B is focussed on health policy, and the chapters may also change from year to year.
4) that Section D will consist of a set of issues that we can monitor each year and use as benchmarks of progress and for advocacy

I am sure that there will be different opinions on how this structure could be modified, but I would appreciate having some mandate to now move on with engaging donors and potential advisory group members etc.

I am a little bit unclear about the idea of a major theme.

Thinking through about a communication strategy, a main issue I would want to publicise in Year 1 is about the whole concept of an alternative world health report, and the reasons why we have felt this necessary.. ie. counter neoliberal; bringing reality to the policy debate; global institutions needing to be watched and held accountable; the need to make the political economy feature more strongly as a public health issue; the need to revitalise the spirit and principles of Alma Ata in the light of a pro-private sector consensus amongst key global players etc.

In other words I think the report itself would be an important story in itself (and why the process of maximising support and endorsement for the report will be important). Because this is the first year there should be an emphasis on the underlying reasons for what we are doing.

A second point. If we go with the structure and scope of the report as outlined earlier, then we accept GHEW as a platform for supporting a broad report on global public health - a major theme might in this context be better reflected as an issue we cover in greater depth rather than an issue that excludes others). Does that make sense?

With the South African Health Review .... we don't have a major theme each year, but we do pick out certain key chapters for extra attention.

The strength about the South African Health Review is that it provides a menu of different issues and topics that people can choose to read and act upon. This doesn't however constrain us from

Dear All
In response to Dave's / Mike's, Antoinette's kick off debate on GHEW and communication strategy for year one (16th July 2003), I am making still making efforts to send you some background papers on a Global Health Watch idea that I participated in for around 3 years 1998-2001 - which did not get beyond the conceptual clarity and feasibility project stage due to unavoidable reasons.
Many of these reasons and issues were debated even then. Sometimes history can be a good teacher as well. Acknowledge Bil when you
PHM - GHEA/GHEW
receive them
Recently preoccupied with PHM 3 year project log frame and the imminent NCC/NWG meeting of PHM India and

RN
18/17/6/03

For PHM viewpoint in addition to mine Dave's & Abhay I think Best wishes to ... Ravi ... a South Asian informed dialogue as well next week

being able to highlight a few key issues that we want to target the press and media with.

Okay, there's some debate kicked off!

thanks,

Dave

PHM Secretariat

From: David McCoy <DavidMcCoy@medact.org>
To: <phmsec@touchtelindia.net>
Cc: <patita_au@yahoo.com.au>; <mike@medact.org>
Sent: Wednesday, July 23, 2003 10:29 PM
Attach: GHEW proposal.doc; Dear PHM Steering Committee.doc
Subject: GHEW

Dear Ravi

I am attaching a letter to send out to the PHM Steering Committee as you suggested. Attached is also the latest and modified version of the concept note (shorter – it has the PHM, medact and GEGA logos etc.)

Who exactly is on the Steering Committee? is there anyone not on it who you feel should also see this?

I noticed that ollie nordberg is on the steering committee - should we approach him slightly differently? i.e. as a funder? I know that Mike has had some contact with him about GHEW.

Also how do you forsee GHEW fundraising synergising with PHM fundraising in general? I want to approach certain funders quite soon but want to avoid any miscommunication with funders that PHM, GEGA and medact are already in contact with.

We also have someone at Medact who is currently working as a volunteer - her name is Patricia Morton and she will be helping me on this - so her name will be popping up.

I hope you and your family are well

best wishes

dave

RM
24/7/03 Lon

PHM - GHEW

7/24/03

Dear PHM Steering Committee,

At the World Health Assembly, the Peoples Health Movement endorsed an idea put forward by GEGA and Medact to produce an 'alternative world health report'. After some weeks of discussion by a small group of individuals representing the organisation we have developed a concept note that we want to use to begin a process of wider consultation with other NGOs and with funders.

I am attaching the concept note and I would value your input and thoughts. In particular I would value any suggestions about people who would be able to contribute either as chapter authors, or as chapter reviewers. We are looking for two types of authors – authors who will be able to provide a rigorous and evidence-based analysis of the themes and topics, and secondly, authors who will be able to provide case studies and be expressions of the 'voices of the unheard' (these will be 'boxes' embedded within the various chapters as outlined at the present moment).

We are looking for the chapters to be co-authored by more than one author with the intention of reflecting as much progressive consensus as possible, and with the intention of ensuring that the authors do not reflect a northern bias. Therefore individuals, academics and NGOs from the South who you feel have some expertise that could contribute to a particular chapter would be especially welcome.

The chapters in Section C of the report relate to issues that are mainly outside of the health sector, and we are therefore looking for suggestions of people and NGOs who are working on issues related to the environment, agriculture, food security, gender etc.

I am hoping to have a list of authors and co-authors by mid-September.

I look forward to hearing from you

Thankyou very much

Dave (McCoy)

Dr David McCoy
DavidMcCoy@medact.org
(GHEW Coordinator)

People's Health Movement

GEGA

Global Equity Gauge Alliance

Introducing the Global Health Equity Watch – an alternative World Health Report for the future

Background

Every day 30,000 children die of preventable causes. The HIV/AIDS epidemic continues to escalate, with the situation in sub-Saharan Africa already tragic, and large parts of Asia about to follow suit. Worldwide, poverty at the country, local and household level remains the biggest underlying cause of morbidity and premature death. 1.2 billion people, mostly women and children, live on less than US$1 a day[1].

Added to this are ever-growing inequities. The poor are getting poorer, and the sick are getting sicker and dying earlier; the healthy are getting healthier, and the rich are living longer and consuming more. The world's 25 richest people have income and assets worth US$474 billion - more than the entire GNP of Sub-Saharan Africa[2].

In spite of the economic growth and technological advances of the last forty years, and the fact that some countries, notably the asian tiger economies, have managed to demonstrate remarkable rates of development, for millions of people, standards of living have not improved. Worst still, the social and economic development of some has come at the cost of the impoverishment of others.

The resounding failure of the global community to achieve "Health for All by the Year 2000" has been met with barely a whimper (apart from the efforts of the Peoples Health Movement to revitalise the Alma Ata Declaration with a Peoples' Health Charter).

Meanwhile the global health institutions of the UN system have become increasingly weak. The World Health Organisation, for example, has become an increasingly small player on the global health and development policy stage which is dominated by the World Bank. Even the World Trade Organisation and the International Monetary Fund have potentially become more

[1] African Poverty at the Millennium, World Bank, Washington DC, 2001.
[2] Data from Forbes; GNP of Sub-Saharan Africa was US$318 billion in 1999

significant health policy players by virtue of the impacts of trade policies and broader public sector policies on health and health care.

The Alma Ata declaration which enshrined the principles of equity, social medicine, appropriate [illegible] health care and sound public [illegible]

[illegible] it is apparent that the conceptual meaning of the "PHC Approach" is no longer understood by WHO, who frequently confuses it with primary level care. Instead, WHO has become increasingly tied up with vertical disease-based approaches and questionable econometric, number-crunching exercises. Others have pointed to its support of the flawed analysis and recommendations of the Commission on Macro-economics and Health, and the increasing influence of the corporate and private sector.

The World Bank on the other hand has continued to foist discredited, neo-liberal solutions to global development and poverty alleviation. Rather than supporting the development of public health systems, they have promoted the fragmentation of health systems and increasing privatisation. Health sector liberalisation with an increasingly under-funded public sector safety-net for the poor remains the stock solution - in spite of its glaring failures. On top of this, market-based reforms of the public sector are offered as solutions to the bureaucratic inefficiencies that result from demoralised, under-skilled and under-paid civil servants.

Year after year, the world is treated to a new set of commitments, goals and targets for development and health - the latest being the millennium development goals. While making grand pronouncements on debt relief, trade reform, aid and HIV/AIDS, the truth is that overseas development assistance has declined, whilst the trade and investment environment have become even more unfriendly to poor countries. The commercial imperatives of rich-country companies and multi-national corporations have consistently taken precedence over social development, poverty alleviation, equity and economic fairness.

Although conflict, corruption, inefficient, unethical and undemocratic government within many countries are a hinderance to equitable development that requires local action, the establishment of such governments often have external global contributory and causal factors.

In response to the situation described above, more and more health workers realise that the principles of the Alma Ata Declaration no longer guide health sector development. More and more communities and academics are aware of how the international economic system and globalisation is perpetuating poverty and increasing inequities; and the lack of credible and effective global public health leadership has become increasingly evident.

In response to this situation, the Peoples Health Movement together with Medact and the Global Equity gauge Alliance, have proposed the development on an alternative World Health Report (to be known as the Global Health Equity Watch).

WHO produces an annual health report, and other UN agencies such as UNICEF and UNAIDS produce regular world reports on particular health topics. The World Bank produces a World Development Report once every two years and the UNDP produce an authoritative Human development report every year. In addition, academics and NGOs produce many documents describing and discussing the state of global health. How would the Global Health Equity Watch add value to this existing body of literature? What would be the characteristics and values of an 'alternative world health report' that would make an alternative world health report worth

investing in? The following section describes the purpose, characteristics and need for an alternative world health report.

2. Purpose, characteristics and need for an alternative world health report.

The Global Health Equity Watch would represent an 'alternative world health report' that:

- Places equity and not poverty at the centre of its analysis – this stands in contrast to the more common emphasis on targeting the poor and the marginalised without relating them to the rich and powerful. We believe that any significant improvement in the health of the poor and the marginalised will only be possible through an explicit commitment to reducing the gaps and disparities between the rich and the poor; and between the powerful and the marginalised.

- Amplifies the 'voices of the unheard' – this stands in contrast to reports that are produced using technocratic language and inaccessible formats. We want to produce a report that is accessible, grounded in reality and which reflects the voices of the poor and the marginalised.

- Provides a non-neoliberal perspective – this stands in contrast to the dominant development discourse amongst the multi-lateral development agencies and OECD countries. We believe that governments and the public sector have a social obligation *and* are able to provide basic social services in way that promotes equity and ensures effectiveness and efficiency. The gradual dismantling of the state has led to greater inequities, and we seek to promote policies that will support the establishment of public sector bureaucracies that work effectively and efficiently, rather than diminishing their role.

- Promotes the PHC Approach – we believe that the principles of the 1978 Alma Ata Declaration remain relevant, credible and sound. The Global Health Equity Watch will work towards explaining the on-going meaning, relevance and importance of these principles.

- Promotes health systems development in contrast to vertical, disease-based interventions – in recent years, there has been a growing tendency to address certain particular diseases rather than addressing the core fundamental components of functional health care systems.

- Places health squarely within a broader political economy perspective – this stands in contrast to the tendency for global health problems to be described in isolation of the unfairness of the global political economy. We believe that the politics and economics of health should be a central public health priority of all health workers concerned about the poor state of global health.

- Places health and the reduction of health inequities squarely within a multi-sectoral perspective – in addition to placing health and health inequities within the context of the political economy, the Global Health Equity Watch will promote a description of the links between health and other sectors such as the environment, international finance, agriculture and food security, war, housing, land rights, conflict and education. This will lead to a process of mutually beneficial learning, analytic integration and joint advocacy amongst different NGOs.

- Provides a civil society perspective to the state of global health - this stands in contrast to the publication of reports by UN and other multi-lateral institutions and also allows the performance of such institutions to be the subject of annual monitoring and reporting. In addition, the report will seek to express the views of people from the South.

- Links research and analysis to advocacy - the Global Health Equity Watch will do more than just describe the state of health and inequity. It will provide recommendations and encourage advocacy actions that will help ensure that real change in favour of justice and redistribution takes place and that governments and the relevant international institutions are held more accountable to those who are marginalised and impoverished.

While the report will primarily be an analytic and evidence-based document grounded with some descriptive elements of reality on the ground, it will also be explicitly based on a sound justification of the normative principles and values described above.

3. Management

The production of the report will be managed and coordinated by the three organisations listed above. They will be guided by an advisory technical committee. Because the three sponsoring organisations are mainly located within the health sector, they will develop partnerships with organisations from the non-health sectors to ensure that the report adequately reflects a multi-sectoral approach to health. Efforts will be made to make the process as inclusive as possible.

4 Structure and Lay-Out of the Report

The Global Health Equity Watch will consist of a compilation of chapters (some with discrete with sub-sections) on various global health issues, supplemented with testimonies from the ground and the voices of people who are traditionally unheard. The idea is not to commission new research. Many NGOs and academics have done the research and analysis for which the Global Health Equity Watch will provide a platform for further dissemination and popularisation. It will also provide an opportunity for the analysis to be complimented with "stories from the ground" and an advocacy agenda. Only in some instances will it be necessary to commission some primary research.

The idea is that the chapters would be written by an eclectic group of experts and NGOs, representative of all regions of the world. For each chapter, a lead author will be identified and asked to coordinate the inputs and perspectives from other experts in the field, representing as many regions of the world as possible. Each chapter will also have designated reviewers.

The approximate size of the report: 150,000 words.

The suggested structure and chapter headings of the report are shown in the following section:

Structure and Chapter Headings of the Global Health Equity Watch

FORWARD

INTRODUCTION

SECTION A: INTRODUCTION TO GLOBAL HEALTH INEQUITIES

A1: Health in a Divided World (Socio-economic, health and health systems inequities)

SECTION B: THE POLITICAL ECONOMY OF HEALTH, DEVELOPMENT POLICY AND HEALTH SYSTEMS

B1. The Politics and Economics of Poverty and Inequity - A Global Public Health Priority

B2. Failing Prescriptions - Social Sector Policy and Ideology

B3. Health Policy: The Privatisation Agenda

B4. Where are our doctors? The Global Brain Drain of Health Personnel

B5. Big Pharma and the Future of Accessible Medicines

B6. Global Public Health Leadership - Making it Visible, Effective and Progressive

SECTION C: BEYOND THE HEALTH SECTOR

C1. Agriculture and Food Security

C2. Water

C3. Militarism, War and Conflict

C4. Environment

C5. Gender and Women's Access to Reproductive Rights

SECTION D: MONITORING AND ADVOCACY SECTION

This section will consist of a number of sub-sections each of which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and at the same time inform the advocacy and lobbying actions of a global progressive health movement committed to a just world and health for all. There would be a number of sections, for example:

- Trade and WTO
- ODA
- HIPC initiative
- IMF
- Global political and economic governance
- WB Watch
- WHO and other international health agencies
- GATS and Health Watch
- Global medicines watch
- Global health research watch
- Donor watch

Compiled by David McCoy
July 2003
Please send comments and feedback to: DavidMcCoy@medact.org

PHM Secretariat

From: Lynette Martin <lmartin@uwc.ac.za>
To: <David.McCoy@lshtm.ac.uk>
Cc: <ant@healthlink.org.za>; <dext@hst.org.za>; <mikerowson@medact.org>; <abayseme@on3.vsnl.net.in>; <phmsec@touchtelindia.net>
Sent: Tuesday, August 05, 2003 7:58 PM
Subject: Re: GHEW update

** High Priority **

Dear Dave,

Thanks for this : it looks good.

One very small point. I feel that in Section 2 "Features of the Global Health Equity Watch", line 1, the word "alone" should be inserted after "poverty". This is so that we should not be misunderstood as thinking that poverty in itself is not important.

Regards,
David Sanders

Prof David Sanders/Lynette Martin
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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

RM 7/8/03

>>> "David McCoy" <David.McCoy@lshtm.ac.uk> 08/01/03 05:40PM >>>
Dear all,

This is an update of where we are at present.

1. General structure and outline of report finalised - although what we end up in x months time is likely to be quite different from what we have now!

2. A five page funding proposal with budget and short workplan has been drafted (see attached). Mike is going to work on this this weekend and next week we hope to start sending it out to potential donors.

3. A list of potential donors is being generated by Patricia Morton (who is working with us in the Medact office). I think we are going to need to target non-government donors / foundations plus some of the larger NGOs.

RM 7/8/03

PHM. GHEW

In terms of the next steps:

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <ant@healthlink.org.za>; <lexi@hst.org.za>; David McCoy <David.McCoy@lshtm.ac.uk>; <mikerowson@medact.org>; <abavsema@pn3.vsnl.net.in>
Cc: <ohmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Sent: Friday, August 01, 2003 9:10 PM
Attach: Funding Proposal.doc
Subject: Re: GHEW update

Dear all,

This is an update of where we are at present.

1. General structure and outline of report finalised - although what we end up in x months time is likely to be quite different from what we have now!

2. A five page funding proposal with budget and short workplan has been drafted (see attached). Mike is going to work on this this weekend and next week we hope to start sending it out to potential donors.

3. A list of potential donors is being generated by Patricia Morton (who is working with us in the Medact office). I think we are going to need to target non-government donors / foundations plus some of the larger NGOs.

In terms of the next steps:

1) Each of the chapters now needs to be turned into a more fleshed and carefully constructed brief + a workplan of who we are going to approach as a lead author(s) + potential collaborators to try and reflect a global dimension + who we can approach to act as reviewers and soundboards. Each chapter effectively needs a workplan and strategy of its own, and we will need assisstance with this.

2) Follow-up with donors is essential as it will not be possible to sustain the required level of activity without funding. Immdiate contact with certain donors should be possible within the next week (Dag Hamm, IDRC, RF .... amyone else?)

3) Suggestions from the broader PHM network about potential authors and contributors

4) We need an institutional CV for each of the three organisations (PHM, GEGA and Medact), which would the names of people and individuals associated with the organisations - this will be attached to the funding proposal. Lexi and Ravi - do you have something ready and to hand for GEGA and PHM? I would guess at no more than half a page each.

Thanks to you all

Dave

RN 4/8/03

RN 4/8/03

PHM - GHEW

RN

People's Health Movement

GEGA

Global Equity Gauge Alliance

Funding Proposal for an annual Global Health Equity Watch

1. Introduction

Every day 30,000 children die of preventable causes. The HIV/AIDS epidemic continues to escalate, with the situation in sub-Saharan Africa already tragic, and large parts of Asia about to follow suit. Worldwide, poverty at the country, local and household level remains the biggest underlying cause of morbidity and premature death. 1.2 billion people, mostly women and children, live on less than US$1 a day.

Added to this are ever-growing inequities. The poor are getting poorer, and the sick are getting sicker and dying earlier; the healthy are getting healthier, and the rich are living longer and consuming more. The world's 25 richest people have incomes and assets worth US$474 billion - more than the entire GNP of Sub-Saharan Africa.

Year after year, the world is treated to a new set of commitments, goals and targets for development and health - the latest being the millennium development goals. While making public commitments on debt relief, trade reform, aid and HIV/AIDS, the reality is that overseas development assistance has declined, and the trade and investment environment has become more unfriendly to poor countries.

The failure of the global community to achieve "Health for All by the Year 2000" has been met with barely a whimper. The 1978 Alma Ata declaration which enshrined the principles of equity, social medicine, appropriate technology, access to comprehensive health care and sound public health approaches to disease prevention and management, has virtually disappeared from the international health agenda, and when it does appear, it is often confused with primary level care.

Meanwhile the global health institutions of the UN system have become increasingly weak. The World Health Organisation, for example, has become an increasingly small player on the global health and development policy stage which is now dominated by the World Bank. Even the World

Trade Organisation and the International Monetary Fund have potentially become more significant health policy players by virtue of the impacts of trade policies and broader public sector policies on health and health care.

The international health policy agenda is increasingly dominated by a narrow and inappropriate neo-liberal paradigm that is effectively promoting the increased fragmentation of health systems, increasing privatisation and a weaker and smaller public sector. In turn, market-based reforms of the public sector are offered as solutions to the bureaucratic inefficiencies that result from demoralised, under-skilled and under-paid civil servants.

In response to this situation, the Peoples Health Movement, together with Medact and the Global Equity Gauge Alliance, have proposed the development on an annual global health report to be known as the Global Health Equity Watch. In order to distinguish this from the many other annual health and development reports that are produced, especially by the various multi-lateral institutions, the following section describes the particular features of such a report.

2. Features of the Global Health Equity Watch

- Place equity and not poverty at the centre of its analysis – this stands in contrast to the more common emphasis on targeting the poor without relating them to the rich and powerful.

- Provide an inclusive platform for civil society – this stands in contrast to the publication of annual world reports by UN and other multi-lateral institutions. Instead, this report will aim to capture the perspectives and spirit of civil society and the NGO sector, including a critique and assessment of the performance of the global and international institutions affecting health worldwide.

- Provide a platform for amplifying the 'voices of the unheard' – in contrast to the technocratic publications of many reports, this report will aim to be reflective of the voices of the poor.

- Promote the PHC Approach – this stands in contrast to the dominant neo-liberal discourse amongst the multi-lateral development agencies and OECD countries.

- Place health and health inequities within a broader political economy perspective – this stands in contrast to the tendency for global health problems to be described in isolation of the unfairness of the global political economy. The report will promote the idea that the political economy of health should be a central public health priority of all health workers.

- Place health and health inequities within a multi-sectoral perspective – the report will explicitly link health to other sectors such as the environment, international finance, agriculture and food security, war, housing, land rights, conflict and education.

- Links research and analysis to advocacy – the report will provide recommendations and encourage advocacy actions that will help ensure that real change in favour of justice and redistribution takes place and that governments and the relevant international institutions are held more accountable to those who are marginalised and impoverished.

While the report will primarily be an analytic and evidence-based document, it will be coupled with some descriptive elements of reality on the ground and on a sound justification of the normative principles and values described above.

3. Structure and Lay-Out of the Report

The Global Health Equity Watch aims to promote an inclusive participation of civil society and non-government organisations within the constrains of having a coherent and well written report.

The intention is for the Global Health Equity Watch to consist of a compilation of chapters (some with discrete with sub-sections) on various global health issues, supplemented with testimonies from the ground and the voices of people who are traditionally unheard.

The idea is not to commission new research. Many NGOs and academics have done the research and analysis in which case the Global Health Equity Watch will provide a platform for the further dissemination and popularisation of this work. Only in some instances will it be necessary to commission some primary research.

Chapters would be written by different authors, and a special effort will be made for the authors to be representative of all regions of the world. Each chapter would also have designated reviewers.

The approximate size of the report: 150,000 words.

The suggested structure and chapter headings of the report are shown below. It is envisaged that the precise scope and size of the report will change slightly from year to year.

Structure and Chapter Headings of the Global Health Equity Watch

Forward

Introduction

Section A: Introduction to Global Health Inequities

A1: Health in a Divided World (Socio-economic, health and health systems inequities)

Section B: The Political Economy of Health, Development Policy and Health Systems

B1. The Politics and Economics of Poverty and Inequity – A Global Public Health Priority

B2. Failing Prescriptions - Social Sector Policy and Ideology

B3. Health Policy: The Privatisation Agenda

B4. Where are our doctors? The Global Brain Drain of Health Personnel

B5. Big Pharma and the Future of Accessible Medicines

B6. Global Public Health Leadership – Making it Visible, Effective and Progressive

Section C: Beyond The Health Sector

C1. Agriculture and Food Security

C2. Water

C3. Militarism, War and Conflict

C4. Environment

C5. Gender and Women's Access to Reproductive Rights

C6. Education and housing

Section D: Monitoring And Advocacy Section

This section will consist of a number of sub-sections which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and inform the advocacy of a global progressive health movement committed to a just world and health for all. There would be a number of sections, that may include:

- WTO
- HIPC initiative
- Bretton Woods Institutions
- Development Assistance Committee of the OECD
- WHO and other international health agencies
- GATS
- Pharmaceutical industry

4. Management

The production of the report will be managed and coordinated by the Peoples Health Movement, the Global Equity Gauge Alliance and Medact, with Medact acting as the secretariat.

An advisory technical committee will be established to act as a sounding board to the three organisations.

An editorial committee will be established to help shape and review each chapter and make sure that they are adequately reflective of the 'voices of the unheard' from different parts of the world.

5. Budget

Administrative and managing editor[1]	0.8 F.T.E. @ $30,000 / yr for 12 months	24,000
Technical and Senior Support to Editorial Process[2]	0.8 F.T.E. @ $40,000 / yr for 8 months	$21,333
Office and administrative support[3]	Includes printing, telephone, fax, postage, stationery etc.	$10,000
Honoraria for contributing authors, advisors and contributors[4]	$800 x 36	$28,800
Printing and publication of hard copies of reports	@ $20 per report	$30,000
Dissemination of reports	@$4 per post	$6,000
Launch and PR[5]		$5,000
Sub-total		$125,133
Contingency	@ 10% of sub-total	$12,000
Total		$137,133

Notes to budget

1. Post-graduate professional whose job will be to coordinate the production of the individual reports and facilitate the process of editorial and peer review. The person will also liaise between the three coordinating NGOs and the various other NGOs who will be invited to participate in supporting the publication of the report. The job will start off being part-time and become full-time in the lead up to the finalisation of the report.
2. Senior members of Medact, GEGA and the Peoples Health Movement
3. Based at Medact office
4. Many of the people who will be approached to act as authors, co-authors and reviewers will be asked to contribute in their own time. It is expected that participation in the production of GHEW will be mutually beneficial to the work of all participating individuals and organisations.
5. The intention is to formally launch the report at an appropriate global event, possibly at the second Peoples Health Assembly that is being held in Porto Allegre in July next year.

6. Timeframe

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July
Finalise structure and content of individual chapters	3	3										
Fundraise	3	3	3									
Commission chapters		3	3									
Commission testimonies and voices from the ground		3	3									
First draft of chapters						3						
Second draft of chapters								3				
Final draft of chapters									3	3		
Lay-out and publication											3	
Launch												3

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>
Cc: <mike@medact.org>
Sent: Friday, August 08, 2003 8:31 PM
Attach: Funding proposal.doc
Subject: GHEW

Dear Ravi

thanks for sending out the e-mail to the PHM secretariat. I did however notice that there was only one other person on the e-mail list other than Jeni, mike and myself.

I am attaching the final version of the funding proposal which has been greatly improved by Mike as well as the final budget. Have you had a chance to think about the fundraising strategy, and if so, are you happy that we pursue funding directly with funders who you may also be engaging with?

On the point of funding I also wanted to ask if PHM has any bridging funds available to support the project until we get additional funding. The GEGA funding is limited and it may take a while for funders to kick in.

Many thanks

Dave

RN 11/8/03 fm

PHM - GHEW

8/11/03

IGNORE

People's Health Movement

Global Health Equity Watch

Funding proposal

Introduction

Global civil society does not participate strongly and consistently in international health advocacy. Whilst high-profile success has recently been achieved with the campaigns on access to medicines and the past twenty years have seen extremely significant achievements due to pressure from campaigners (for example, on breastfeeding and smoking), there is a striking lack of involvement and pressure from health campaigners on broad health and health systems issues. Where such pressures exist, they are inadequately drawn upon by the institutions of global health governance – notably the World Health Organisation – whose legitimacy and accountability to the world's population would be enhanced by more vigourous engagement with civil society.

A fragmented, disease- and issue-specific approach to health dominates research, advocacy and governance agendas. Calls on policy-makers to address fundamental causes of ill-health and failing health systems are weak and unco-ordinated: a dangerous situation in a world where these issues need to be addressed more than ever.

To highlight these problems the People's Health Movement, the Global Equity Gauge Alliance and Medact – each with excellent technical expertise in research and advocacy – propose to mobilise a fragmented global health community around values which stress the need to tackle the fundamental causes of ill-health and inequity in our societies. The vehicle for this advocacy is the publication of an annual **Global Health Equity Watch** – in effect an alternative World Health Report – which will combine outstanding research and policy analysis with a commitment to bringing the views of poor and vulnerable groups to the attention of international and national policy makers.

The Global Health Equity Watch will be used – rather like the UNDP's *Human Development Report* – to shift the health policy agenda away from a technocratic approach to delivering health, to one that recognises the important political, social and economic barriers which prevent the achievement of better health. We want the Watch to be a tool which:

- Legitimises and strengthens the calls for a broad approach to health amongst policy-makers, health professionals, campaigners, researchers and others concerned with health.

- Can be used by advocates to strengthen their existing work whilst drawing them into broader debates about international health and in the process creating a more vibrant global civil society in health.

- Acts as a reality-check on those formulating health policy by providing a forum which magnifies the voice of the poor and vulnerable and those who work with them.

We intend to release the Watch with maximum publicity at the 2nd People's Health Assembly which will take place in Porto Allegre, Brazil in July 2004. The rationale, values and contents of the Watch are sketched below.

Background

Every day 30 000 children die of preventable causes. The HIV/AIDS epidemic continues to escalate, with the situation in sub-Saharan Africa already tragic, and large parts of Asia about to follow suit. Worldwide, poverty remains the most important underlying cause of morbidity and premature death. Over a billion people, mostly women and children, live on less than US$1 a day, and this number has grown over the past twenty years.

Perversely, growing poverty exists with growing wealth. The world's 25 richest people now have incomes and assets worth US$474 billion – more than the entire GNP of Sub-Saharan Africa. In both developing and developed countries we have witnessed increasing inequalities in income over the past two decades, coupled with the persistence of other types of disparity and social division such as gender and ethnic inequalities.

The failure of the global community to achieve 'Health for All by the Year 2000' is the result of this situation. New targets – such as the Millennium Development Goals – have come to the fore more recently. However, whilst overseas development assistance declines, and the trade and investment environment becomes even more unfriendly to poor countries, there is a great danger that these objectives too will not be met, increasing cynicism and discontent in the world.

The global health institutions of the UN system have become increasingly weak. The influence of the World Health Organisation has declined in a global policy arena which is now dominated by the World Bank, International Monetary Fund and World Trade Organisation. As a result, international health policy is dominated by a market-led development paradigm which is leading to fragmentation of health systems, privatisation and a gross lack of emphasis on the underlying causes of ill-health.

To counter these trends, the People's Health Movement, Medact and the Global Equity Gauge Alliance, have proposed the development of an annual global health report to be

known as the Global Health Equity Watch. The following section describes its objectives and values.

Objectives and values of the Global Health Equity Watch

The Watch will strive to achieve the following objectives which flow from the value base and strategic goals of the co-ordinating organisations.

- We want to work to invigourate the international health policy agenda. The Watch will aim to capture the perspectives and spirit of civil society, and bring in the 'voices of the unheard', as a contrast to the technocratic and dry nature of many other assessments of the global health situation. We aim to re-connect global civil society with the institutions of global health governance.

- We will promote human rights as the basis for health policy, as a corrective to the market-led policy agenda which tends to fragment and exclude.

- We will place health and health inequities within a broader political economy perspective. There is a tendency for global health problems to be described in isolation from the unfairness of the global political economy. The Watch will promote the idea that the political economy of health should be a central public health priority of all health workers.

- We will place health and health inequities within a multi-sectoral perspective. The Watch will explicitly link health to other sectors such as the environment, international finance, agriculture and food security, war, housing, land rights, conflict and education.

- We will link research and analysis to advocacy. The Watch will provide recommendations and encourage advocacy actions that will help ensure that real change in favour of justice and redistribution takes place and that governments and international institutions are held more accountable to those who are marginalised and impoverished.

Structure and Lay-Out of the Report

The Global Health Equity Watch aims to promote substantial participation of civil society (and others concerned with international health) within the constrains of having a coherent and well written report.

The intention is for the Global Health Equity Watch to consist of a compilation of chapters (some with discrete with sub-sections) on various global health issues, supplemented with testimonies from the ground and the voices of people who are traditionally unheard. The idea is not to commission new research. Many NGOs and academics have done the

research and analysis in which case the Global Health Equity Watch will provide a platform for the further dissemination and popularisation of this work.

Chapters would be written by different authors, and a special effort will be made for the authors to be representative of all regions of the world. Each chapter would also have designated reviewers. The approximate size of the report will be 150 000 words. The suggested structure and chapter headings of the report are shown below. It is envisaged that the precise scope and size of the report will change slightly from year to year.

Structure and Chapter Headings of the Global Health Equity Watch

Foreword by eminent global personality

Introduction by the co-ordinating organisations

Section A: Introduction to Global Health Inequities
A1: Health in a divided world: socio-economic, health and health systems inequities

Section B: The Political Economy of Health
B1: Politics and economics of poverty and inequity – a global public health priority
B2: Health policy: the privatisation agenda
B3: Where are our doctors? The global brain drain of health personnel
B4: Big Pharma and the Future of Accessible Medicines
B5: Global public health leadership – making it visible, effective and progressive

Section C: Beyond The Health Sector
C1: Agriculture and food security
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C3: Violent conflict
C4: Environment
C5: Gender
C6: Education
C7: Housing

Section D: Monitoring And Advocacy Section
This section will consist of a number of sub-sections which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and inform the advocacy of a global progressive health movement committed to a just world and health for all. There would be a number of sections that may include:

- WTO
- Debt relief

- Bretton Woods Institutions
- Aid trends
- WHO and other international health agencies
- GATS
- Pharmaceutical industry

Management

The production of the report will be managed and coordinated by the Peoples Health Movement, the Global Equity Gauge Alliance and Medact, with Medact acting as the secretariat.

An advisory technical committee will be established to act as a sounding board to the three organisations.

An editorial committee will be established to help shape and review each chapter and make sure that they are adequately reflective of the 'voices of the unheard' from different parts of the world.

Budget

Item	Description	Total
Administrative and managing editor[1]	0.8 FTE @ $30,000/yr for 12 months	$32,000
Technical and Senior Support to Editorial Process[2]	0.6FTE @ $40,000/yr for 8 months	$27,500
Office and administrative support[3]	includes printing, telephone, fax, postage, stationery etc	$10,000
Honoraria for contributing authors and advisors[4]	$800 x 36	$28,800
Printing and publication of hard copies of reports	[redacted]	$37,500
Dissemination of reports	[redacted]	$8,000
Launch and PR[5]		$5,000
Sub-total	@ 10% of sub-total	$125,133
Contingency		$12,000
Total		$157,533

Notes to budget

1. Post-graduate professional whose job will be to coordinate the production of the individual reports and facilitate the process of editorial and peer review. The person will also liaise between the three coordinating NGOs and the various other NGOs who will be invited to participate in supporting the publication of the report. The job will start off being part-time and become full-time in the lead up to the finalisation of the report.
2. Senior members of Medact, GEGA and the Peoples Health Movement
3. Based at Medact office
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5. The intention is to formally launch the report at the 2nd People's Health Assembly that is being held in Porto Allegre in July next year.

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Second draft of chapters								3				
Final draft of chapters									3	3		
Lay-out and publication											3	
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The Global Equity Gauge Alliance

The Global Equity Gauge Alliance, an international network of health equity-promoting teams, was created to participate in and support an active approach to monitoring health inequalities and promoting equity within and between societies.

The Alliance currently includes 11 member-teams, called Equity Gauges, located in 10 countries in the Americas, Africa and Asia. Seven teams address health equity at the country level (Chile, Zambia, Zimbabwe, South Africa, Bangladesh, China, and Thailand), and four teams focus on inequalities at the local level (El Tambo Ecuador, Ouagadougou Burkina Faso, Nairobi Kenya, and Cape Town South Africa). Equity Gauges use a 3-pronged approach of Assessing and Monitoring health equity, Advocating for pro-equity policy and programs, and engaging actions to support Community Empowerment to address health inequities.

GEGA includes more than 70 active members working with the Gauges, and many additional partners directly involved in the work of the Gauges, including research institutions such as the African Population Health Research Council, Kenya; University of the Western Cape, South Africa; Harvard University, USA; University of Ouagadougou, Burkina Faso; University of Beijing, China. Social and health development NGOs involved in Gauge work include Alternatives for Social Development, Ecuador; BRAC, Bangladesh. Political bodies include the Parliamentary Committee on Health, South Africa; the Urban Slums Development Project of the Nairobi City Council, Kenya. GEGA is also currently working in collaboration with a number of donors; bilateral aid groups; local, national, and regional governance bodies; and development, advocacy, and technical organisations.

GEGA is developing opportunities for training and capacity development to support pro-equity decisionmaking and planning, and links with a number of other organisations to coordinate equity analysis and support.

The GEGA Secretariat is currently housed within Health Systems Trust, Durban, South Africa.

Coordinating Committee:

Antoinette Ntuli (Chair), Director of HealthLink, Health Systems Trust, South Africa
David Sanders, Dean of the School of Public Health, University of the Western Cape, Cape Town, South Africa
Jeanette Vega, Director of the Institute of Epidemiology and Public Health Policy, Universidad de Desarrollo, Santiago, Chile

David Acurio, Director of Aldes, Cuenca, Ecuador
Banza Baya, Director, Unité d'Enseignement et de Recherche en Démographie, (UERD), University of Ouagadougou, Ouagadougou, Burkina Faso

David Omollo Owuor, African Population and Health Research Council, Nairobi, Kenya
TJ Ngulube, Director of the Centre for Health, Science, and Social Research (CHESSORE), Lusaka, Zambia

Rene Loewenson, Director of Training and Research Support Centre (TARSC), Harare, Zimbabwe; Chair of Equinet

Mushtaque Chowdhury, BRAC, Dhaka, Bangladesh
Siriwan Grisurapong, Professor, Mahidol University, Bangkok, Thailand
Yuanli Liu, Professor, Harvard University, Boston, U.S.

Full-time Secretariat Personnel:
Alexandra Bambas, PhD, MPH, Coordinator of GEGA
Qamar Mahmood, MBBS, MSc, Assistant Coordinator of GEGA

Consultants:
Paula Braveman, Director, Center on Social Disparities in Health, Professor of Family and Community Medicine, University of California, San Francisco, U.S.
David McCoy, former Director of Research for the Health Systems Trust (HST), South Africa; presently UK-based consultant to Equinet and HST
Abhay Shukla, Center for Enquiry into Health and Allied Themes (CEHAT), India

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>
Cc: <mike@medact.org>
Sent: Friday, August 08, 2003 10:05 PM
Subject: Re: Some important Follow-up

Please ignore earlier version of the funding proposal -t here was a minor mistake which has been corrected
thanks
dave

RN
11/8/03 fm

SSI/ DGS - Please check which one is correct?

RN
11/8/03

PHM. GMEW

PHM Secretariat

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Sent: Friday, August 08, 2003 10:05 PM
Attach: Funding proposal.doc
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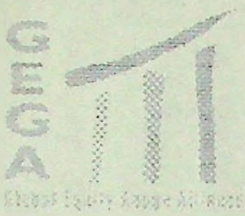
RM
11/8/03

PHM - GHEW



People's Health Movement

Global Health Equity Watch

Funding proposal

Introduction

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To highlight these problems the People's Health Movement, the Global Equity Gauge Alliance and Medact – each with excellent technical expertise in research and advocacy – propose to mobilise a fragmented global health community around values which stress the need to tackle the fundamental causes of ill-health and inequity in our societies. The vehicle for this advocacy is the publication of an annual **Global Health Equity Watch** – in effect an alternative World Health Report – which will combine outstanding research and policy analysis with a commitment to bringing the views of poor and vulnerable groups to the attention of international and national policy makers.

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Dissemination of reports	1,500 copies @$4 per post-out	$6,000
Launch and PR[5]		$5,000
Sub-total	@ 10% of sub-total	$125,133
Contingency		$12,000
Total		$157,333

Notes to budget

1. Post-graduate professional whose job will be to coordinate the production of the individual reports and facilitate the process of editorial and peer review. The person will also liaise between the three coordinating NGOs and the various other NGOs who will be invited to participate in supporting the publication of the report. The job will start off being part-time and become full-time in the lead up to the finalisation of the report.
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3. Based at Medact office.
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Lay-out and publication											3	
Launch												3

The Global Equity Gauge Alliance

The Global Equity Gauge Alliance, an international network of health equity-promoting teams, was created to participate in and support an active approach to monitoring health inequalities and promoting equity within and between societies.

The Alliance currently includes 11 member-teams, called Equity Gauges, located in 10 countries in the Americas, Africa and Asia. Seven teams address health equity at the country level (Chile, Zambia, Zimbabwe, South Africa, Bangladesh, China, and Thailand), and four teams focus on inequalities at the local level (El Tambo Ecuador, Ouagadougou Burkina Faso, Nairobi Kenya, and Cape Town South Africa). Equity Gauges use a 3-pronged approach of Assessing and Monitoring health equity, Advocating for pro-equity policy and programs, and engaging actions to support Community Empowerment to address health inequities.

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GEGA is developing opportunities for training and capacity development to support pro-equity decisionmaking and planning, and links with a number of other organisations to coordinate equity analysis and support.

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Rene Loewenson, Director of Training and Research Support Centre (TARSC), Harare, Zimbabwe; Chair of Equinet

Mushtaque Chowdhury, BRAC, Dhaka, Bangladesh
Siriwan Grisurapong, Professor, Mahidol University, Bangkok, Thailand
Yuanli Liu, Professor, Harvard University, Boston, U.S.

Full-time Secretariat Personnel:
Alexandra Bambas, PhD, MPH, Coordinator of GEGA
Qamar Mahmood, MBBS, MSc, Assistant Coordinator of GEGA

Consultants:
Paula Braveman, Director, Center on Social Disparities in Health; Professor of Family and Community Medicine, University of California, San Francisco, U.S.
David McCoy, former Director of Research for the Health Systems Trust (HST), South Africa; presently UK-based consultant to Equinet and HST
Abhay Shukla, Center for Enquiry into Health and Allied Themes (CEHAT), India

PHM Secretariat

From: patricia morton <patita_au@yahoo.com.au>
To: <phmsec@touchtelindia.net>
Sent: Tuesday, August 12, 2003 8:00 PM
Subject: GHEW

Dear Ravi

We are currently preparing proposals for GHEW. The only thing missing is an institutional cv from PHM. It need only be one page. Is it possible for you to send me one in the next couple of days.

Much Appreciated
Kind Regards
Patricia Morton

http://search.yahoo.com.au - Yahoo! Search
- Looking for more? Try the new Yahoo! Search

PHM-GHEW

RN
13/8/03

PHM Secretariat

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PHM-GHEW

RN
13/8/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <phmsec@touchtelindia.net>
Sent: Tuesday, August 12, 2003 2:16 AM
Subject: institutional CV

Dear Ravi

Greetings to you

Do you have a short, one-page institutional CV for the Peoples health Movement that we can add to our funding rpoposal. I have one for GEGA [redacted], and just need one from PHM now

thanks

dave

Action taken PHM - GHEW.

SSP - Can you prepare one

RN
12/8/03

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: <patila_au@yahoo.com.au>; David McCoy <david.mccoy@lshtm.ac.uk>; mikerowson <mikerowson@medact.org>
Cc: <ant@hst.org.za>; David Sanders <dmartin@uwc.ac.za>; Olle Nordberg-DHF-Sweden <olle.nordberg@dhf.uu.se>; Andy Rutherford <arutherford@oneworldaction.org>; Alexandra Barnbas <alex@hst.org.za>
Sent: Thursday, August 28, 2003 3:52 PM
Attach: Phm-cv.doc
Subject: GHEW

Dear Dave, Mike, Patricia,

Greetings from PHM Secretariat (Global)!

Apologies for the delay in replying to some of the specific questions you have all asked in the context of PHM participation in the GHEW initiative. I have been rather constrained by the demands of the Alma Ata Anniversary initiatives, the pack of materials circulated recently, the evolving Iran meeting and other pressures on my time. Hope you received the Alma Ata Pack.

1. I enclose a page on PHM as requested.
2. I propose to put in part of the GHEW budget in our larger budget around 50 to 60000$, and show it as PHM contribution to the initiative. This way it will help Medact, GEGA and others to raise part of the funds independently as contribution to the overall budget without being constrained by the PHM funding process, which will take its own time. When the funds are received (Andy Rutherford operates the PHM account in UK), they can be transferred to Medact or we can reimburse specific costs to specific individuals or NGOs directly on your advice. To be realistic, our contribution would come in for Honoraria, printing disseminations and PR nearer to end of the process.
3. I would suggest that you contact Andy Rutherford (arutherford@oneworldaction.org) at One World Action to discuss this matter and also the possible overlap of funding agencies, which you have enquired about in your letter. He has a lot of experience and probably knows whom to tap, for what, and how.
4. As you know there are two or three specific events in the next 6 months, which will become opportunities for interactive dialogue / planning of the GHEW report.

   i. The Alma Ata Anniversary meeting in Teheran between 20th – 23rd October is scheduled to have 2 days of Alma Ata discussion and 2 days of PHM Steering / Support Group discussion and you may have seen that GHEW is one of the six items on the agenda.

   ii. The International Health Forum in Mumbai on 14th / 15th January 2004, preceding the WSF 16th – 21st January 2004. I am going to suggest smaller group meeting for planning etc., on 13th January and GHEW could be one such for the planning / advisory committee). Accommodation and other arrangements will be taken care off.

PHM-GHEW

RN
29/8/03

You all have to find travel grants to Teheran and Mumbai or build it into the project (at least for one or two of you as a core project team – See also para 8).

iii. Another opportunity will be Geneva at Forum 7 of Global Forum for Health Research, 2nd – 7th December 2003. David Sanders, Marie and I will definitely be there, since we have been invited to make specific inputs, but there will be many other and usually a host of researchers from all over the world – some of whom you may want to interact with during the forum.

Just keep all this in mind as you plan the road map for GHEW.

5. We have no funds to support the project (bridge funds) you have mentioned, since the PHM is still surviving on what was available for PHA – I and the next project cycle is just evolving, 2003-2005. I have been raising small donations and grants for specific events and initiatives - a very risky way of doing it but I also believe that a 'movement' cannot be centrally funded but supported in various decentralized ways by all those who feel the movement is relevant.

6. I think it's a good idea to contact Dag Hammarskjold Foundation. Olle Nordberg (olle.nordberg@dhf.uu.se), the Director is on the PHM Funding group and is also joining us in Teheran. They were very helpful in facilitating the Analytical group and the Background papers for PHA – I in Bangladesh.
7. As a rule it may be better to go to 3-4 agencies and get a contributory support of 25-30% of the costs (a sort of co-funding arrangement) rather than negotiating the whole amount, which may be seen as quite large). If each of the participating group – PHM, GEGA and Medact – were to raise 50-60000$ each, it may seem more feasible. However, please dialogue with Andy and Olle, they know the funding scene better.
8. I do notice that you have not built in a little travel support to ensure that Dave or Mike can reach meetings that may have opportunities to dialogue with a larger member of GHEW contributors and help the evolution, integration and process. It's not always possible on relying on the meeting or conference organizers to include a travel grant for this purpose. Of course, if Medact, GEGA and PHM already have a travel line in the overall budget, this could be tapped, whenever such a contingency is required.
9. Since David and Abhay are already GEGA and Mike is Medact (we consider all of them PHM as well), we will need to choose from Bala, Claudio, Fran, Olle, Thelma, David Woodward and others with policy / research orientation to represent PHM in the advisory – technical / editorial committees. Can we leave this decision to the Teheran meeting? In the meanwhile show me and David in the project proposal if you need to get on with the job of fund raising.
10. I hope this answers most of your questions and has been helpful. I think Dave and Mike should seriously locate some travel grant to reach Teheran to take this process further. I shall also try and see if there are ways of making at least one of them a resource person or special invitee and tap some funds in Iran itself. Zafrullah and I are visiting Teheran for a planning meeting at Dr. Banzgar's request. Have you seen the tentative programme? Any comments?

Best wishes

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#357 "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

People's Health Movement

The People's Health Movement (PHM) is a growing coalition of health activists and health professionals, NGO's and civil society organizations, academics and researchers and networks, associations and people's organizations that endorse the **People's Charter for Health** – a consensus document that arose out of the People's Health Assembly in December 2000 when 1453 participants from 92 countries met to discuss the Health for All Challenge.

Objectives

The objectives of the Assembly and the Movement, which evolved beyond it are:

- **Promote Health for All** as an equitable, participatory and inter-sectoral movement and as a Rights Issue
- **Promote government and other health agencies** to ensure universal access to quality health care, education, social services according to people's needs and not people's ability to pay
- **Promote the participation of people and people's organization** in the formulation, implementation and evaluation of all the health and social policies and programs
- **Promote health along with equity and sustainable development** as top priorities in local, national and international policymaking.
- **Encourage people to develop their own solution to their local health problems.**
- **To hold accountable local authorities, national governments, international organizations and corporations to the health for all commitment**

The People's Health Movement is coordinated by a global secretariat now located in Bangalore, India which is supported by a steering group consisting of the representatives of

- 8 organizations and Networks that cosponsored the first Assembly: Asian Community Health Action Network (ACHAN); Consumers International (CI); Dag Hammarskjold Foundation (DHF); Gonoshasthaya Kendra (GK); Health Action International – Asia Pacific (HAI – AP); International People's Health Council (IPHC); Third World Network (TWN); Women's Global Network for Reproductive Rights (WGNRR) and thirteen regional focal points representing members in the regions of South Asia; India; South East Asia; China; Middle East and North Africa; East and central Africa; Southern Africa; West Africa; Europe; North America; Central America; Mexico and Caribbean; South America; Pacific; Australia and New Zealand and the past and present coordinators.

  The movement is operationalized through Geographical circles at country and regional level and Issue based dialogue circles that are linked though local and country level campaigns.

  PHM secretariat facilitates communication between members through advocacy and campaigns; website; a discussion group called PHA Exchange; Media releases; publications including a News Brief; and through the PHM participation in various conferences, policy dialogues and other events supported by PHM volunteers all over the world.

  Presently Dr. Ravi Narayan is the full time coordinator of the People's Health Movement Secretariat (Global) and can be reached at the following address.

  PHM Secretariat,
  C/o CHC,
  # 367, "Srinivasa Nilaya", Jakkasandra I Main, I Block Koramangala, Bangalore – 560034.
  INDIA. Tel: 00 91 (0) 80 5128009 (Direct): Fax: 00 91 (0) 80 5525372
  Email: secretariat@phmovement.org

  For more details visit our website www.phmovement.org

RN 29/8/03

Application to Sida for grants for the period July 2003 to December 2004 for continuation of two linked projects

1. Trendalyzer

Free software for visualisation of development statistics

Applicant: Gapminder AB

and

2. World Development Chart (WDC) & World Health Chart (WHC)

Provision of free time series of digital data on world development powered by Trendalyzer

Applicant: A Swedish University network in collaboration with WHO and UN co-ordinated by the Division of International Health, Karolinska Institutet.

Compiled by Hans Rosling July 16, 2003[1]

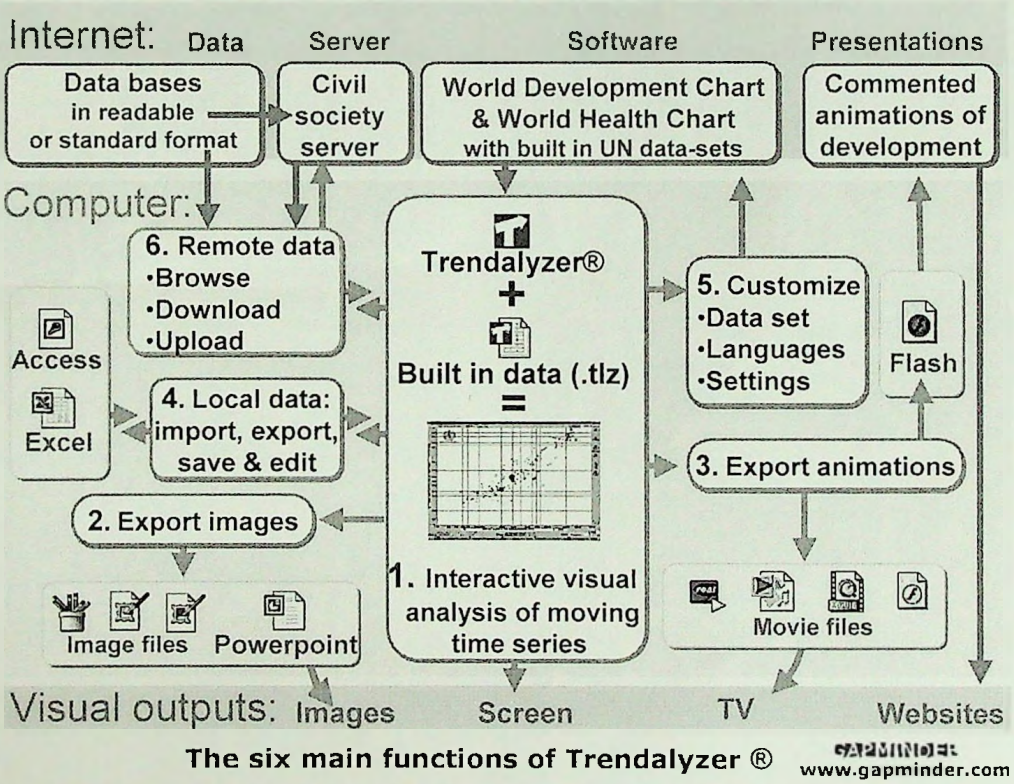

Figure 1. Conceptual model of the six main functions of the free Trendalyzer software

[1] This application is a reconstruction of a former version lost due to computer theft on June 7.

CONTENTS

Annexes:

1. Travel report by Martin Ejerfeldt from project teams visit to UN in NY on March 10-13 2003.
2. Mail from Jan Vandermoortele UNDP/UNDG & report from UNDG Re-Cap meeting with project team during UN tour March 10-14, 2003
3. Invitation from Michael Marmot on collaboration with Amartya Sen and Emma Rothscild at Trinity Collage, Cambridge University.
4. Annual report from Gapminder AB 2002.
5. Report from Gapminder Share holder meeting April 28, 2003; with annexes.
6. Economical report from KI for World Health Chart grant for Jan-June 2003.
7. "Improving Statistics for Measuring Development Outcomes" at WB June 4-5, 2003.

EXECUTIVE SUMMARY

BACKGROUND: UN has defined 8 Millennium Development Goals (MDGs) and 48 indicators for monitoring of goal achievements at national and global level. The MDG initiative requires increased use and improved understanding of development statistics to guide global and national governance. Annual data for most development indicators are available for almost all countries for the past decades. Each year UN Statistic Division, World Bank Development Data Group, UNDP, WHO, UNICEF and other UN-organisations add the last years free national statistics to their growing time series of development indicators. In spite of a similar basic structure (Country/Indicator/Year) the numerical data sets are provided by several agencies in many different digital formats.

"World Development Indicators" from World Bank and "UN Common Data Base" are the main global data sets with long time series in standardized formats for hundreds of variables from all countries. These data sets are sold at prices of 100 to 275 USD, but only attracts a few thousand buyers in spite of the co-existence of (1) data sets with long time series, (2) free yearly updates from countries, (3) UN's focus on MDG and (4) an ongoing "IT revolution". We think this can be changed!

The key to successful sharing of digital information is free software for user-friendly visualisation. Prominent examples are Explorer, Netscape, Acrobat Reader and Google. An explosion of free sharing of genetic information among scientists is based on the free software on the Gene Bank servers. The same can be done for development statistics whose use will explode when a click of the mouse automatically turn selected information from free data servers into understandable animations on the users computer screen! The software solution for this should be freely provided.

***Our Vision** is to improve the understanding of development by providing a free software system that makes the number of users of development statistics increase from thousands to millions!*

Project phase one (Nov 1999 to June 2001) We developed a software with WHO that turned built-in time series of health data into easily understandable moving graphics. A beta-version (300 A4 pages of code) called World Health Chart (WHC) 2001 (www.whc.ki.se) got positive comments from 10,000 testers, but they also requested additional functions. With WHO we concluded that a stand-alone computer program was needed with the following six functions:

1. Interactive visual display of time series as animated graphics with options to split national averages into data for provinces, gender, and other sub-units, access to data sources and uncertainty estimates, as well as several additional interactive user "goodies".
2. Export of created images to Power Point and other common image software.
3. Export of created animations to Flash and other major animation software.
4. Import of data from Excel and Access for comparison with the built-in data set.
5. Production of National and Topic "Charts" for distribution of special data sets to identified user groups by adding new built-in data sets and customisation of languages, settings, and interfaces.
6. Browsing the Net for data and downloading & uploading of datasets in standardized format.

Project phase two (July 2001 to June 2003). We developed the free software Trendalyzer® with above listed functions 1 to 5 and used it to make animations in Flash for the Human Development Report 2003 (www.undp.org/hdr2003/). Trendalyzer2003 (1,500 A4 pages of code) is now available for testing (www.trendalyzer.com). It will be provided as World Development Chart (WDC) 2003 with a built in data set from the UN common database. Collaboration with UN and the new MX-version of the Flash has expanded the concepts for the Trendalyzer software system

THE AIM is to convert boring development statistics into enjoyable interactive moving graphics by

1. Trendalyzer software for download (.exe), with built in data sets as regularly updated World Development Chart, World Health Chart, World Education Chart etc.

2. Trendalyzer software for interactive web display (.swf) of development statistics in moving graphics from UN and other Data Providing Agencies.

3. Trendalyzer software system in Flash components (.fla) with open source code for use by others interested in composing software systems for visualisation of time series statistics.

4. Search of time series of development statistics for visualisation on a web site linked to a "Civil Society Server" with possibility to download and upload documented time series.

EXECUTIVE SUMMARY continued

Target users are:
Various groups concerned with global and national development, public officials researchers, policy makers, students, politicians, activists, journalists, other professionals and user groups in the civil society that formerly did not access global, national and local digital development statistics.

PLANS FOR JULY 2003 TO DECEMBER 2004:
Software development will continue as "extreme programming" (as games are made). This means stepwise definition of requirement specification by continuous interactions between software developers at Gapminder and test pilots at Universities, UN and the Web. Pragmatic changes from Director to Flash programming with intention to eventually provide the whole Trendalyzer software system in Flash components with open source code.
Networking with UN and universities will facilitate improved provision of free development statistics with documentation of collection and editing methods as well as systematic provision of uncertainty estimates.

Output by December 2003:
WDC2003 with tested, revised, and debugged **Trendalyzer2003** and UNCDB data, promoted.
Specialised Charts with Trendalyzer2003 done with WHO, UNAIDS, UNESCO & selected countries.
Trendalyzer2004 (.swf) tested for web based visualisation of UN Common DataBase.
Development of **Trendalyzer2004** in Flash (.fla) for providing both executable (.exe) and web based (.swf) versions.
Planning of a Civil Society Server (CS-server) with an international university network.
Examples of documentations of collection & editing methods, and estimations of uncertainty ranges.

Output by June 2004:
WDC2004 with tested, revised, and debugged executable version of **Trendalyzer2004(.exe)**.
UN Common DataBase visualised on the web using **Trendalyzer2004(.swf)**.
Specialised Chart versions promoted with UN-organisations and a few countries.
Start of a Civil Society Server with an international university network.
Documentation of collection & editing and display of uncertainty ranges for variables on CS-server.

Output by December 2004:
Debugged and revised Trendalyzer2004 (open code components in .fla) for promotion.
Expanded Trendalyzer use as downloadable Chart versions (.exe) and as visualised databases(.swf).
Further development of CS-server and linking to some other servers.
Plans for systematic quality certification and uncertainty estimates with UN and university networks.

Output in Coming Years:
A 100 to 1000-fold increase of the number of interactive web- and computer users of free digital development statistics compared to the present thousands that buy commercially provided data sets.
Increased use of national digital development statistics in a number of countries and by a number of international organisations for monitoring of development and MDG and for policy analysis.
Facilitation of evidence-based research on global development issues.
Contribute to a growing system for quality certification of time series of development statistics resulting in provision of understandable and well-defined uncertainty intervals to users.

1. Background

United Nations has defined 8 Millennium Development Goals (MDG's) as well as 48 development indicators for national and global monitoring of the fulfilment of these goals. This set of goals reflects the contemporary view that favourable development is composed of different dimensions that reciprocally reinforce each other. The multidimensional concept is only useful for policy if specific indicators are used to monitor each dimension of development. Time series data for the 48 MDG indicators and for other relevant development variables are available for most countries for the last 20 to 40 years. The success of UN's MDG focus will depend on increased access, use and understanding of development statistics. We do not think this will be achieved by "business as usual", i.e. by selling major data sets of development statistics at a high price to a small group of professionals. Almost none of the world's students use these digital data sets during their university training. The available digital development statistics of countries and the world need to be in the hands of many and to be displayed in ways that many can understand. Fortunately the Internet and new IT tools now enable us to make development statistics as understandable and enjoyable as the daily weather forecasts on TV.

Students, activists, politicians, journalists, planners, researchers and decision-makers need to view and understand time series of development statistics, especially those assessing past trends and future options for national and world development. Many millions of those sharing the need to view development have access to TV and computer screens, but the data is only available in the databases of a few professionals. We think the time is ripe for the development of a free software system that enables the development data on the servers of the few to interactively move in understandable ways on the screens of the many! We call our attempt Trendalyzer®, a free software system composed from Flash components with open source codes.

1.1 Millennium Development Goals (MDG)

In September 2000, a total of 191 nations adopted the Millennium Declaration of the United Nations. It sets the agenda for the 21st Century for peace, security and general development concerns in the areas of human rights, environment, and governance. The Declaration mainstreams a set of inter-connected development goals into a global agenda. The goals contained in the Millennium Declaration have been merged into the eight "Millennium Development Goals" (MDGs).

1.1.1 United Nations Development Group, UNDG

The UNDG has been assigned the responsibility to support UN Country Teams in their efforts to assist national governments to implement and report on the Millennium Declaration, especially with regard to the MDGs. UNDG is chaired by the Administrator of the United Nations Development Programme (UNDP). The Executive Committee that leads UNDG is comprised of the heads of UNDP, UNICEF, UNFPA, and WFP. UNDG also includes: the Department of Economic and Social Affairs (DESA), United Nations Drug Control Programme (UNDCP), United Nations Human Settlements Programme (UN-HABITAT), United Nations Office for Project Services (UNOPS), United Nations Fund for Women (UNIFEM), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Conference on Trade and Development (UNCTAD), World Health Organization (WHO), International Fund for Agricultural Development (IFAD), United Nations Educational, Scientific and Cultural Organization (UNESCO), the Food and Agriculture Organization (FAO), the regional commissions, the High Commissioner for Human Rights and the Special Representative of the Secretary-General for Children in Armed Conflict. The UNDG Executive Committee is comprised of: UNDP, UNICEF, UNFPA, WFP, and other

entities participating as warranted by their interests and mandates. The Office of the Spokesman of the Secretary-General and the United Nations Fund for International Partnerships (UNFIP) participate in UNDG as observers.

The MDG process offers an opportunity to provide coherent development statistics from the UN system. Through this process and other initiatives such as the Paris21 programme of OECD and the work by the Development data group of the World Bank it is recognized that development statistics need and can be better used (Annex 7).

To gain optimal credibility an international collaboration is needed for development of systematic methods for quality certification of development statistics. Such a system must be based on documentation of both collection and editing methods used to generate each number. An uncertainty estimate of each numeric value for each indicator for each country and year would greatly facilitate a wider use of the data. Christopher Murray at WHO has started such methodological development for several health indicators and other data providers can benefit from this development. Eric Swanson at the World Bank has suggested the formation of one international group for the assessment of each variable (Annex 7). These are promising initiatives.

1.2 New IT resources

The global flow of information on the Internet has exploded in the last decade. The reasons are the free provision of software for web browsing. It may have been forgotten how "Internet Explorer" and "Netscape" rapidly became widely used. They were provided free of charge. Exchange of documents with combinations of texts and illustrations in pdf format has also exploded in recent years. The reason is that pdf-files can be read on most computers due to the free provision of the Acrobat Reader software, which today is installed on new computers. The provision of free software for visualisation of information was part of commercial strategies. The exchange of music exploded on the Internet due to the availability of the free Napster software with which the end user could easily turn MP3 files into music. The e-mail exchange through hotmail and yahoo are prominent examples of free provision of software on web servers. Free provision is the rule, rather than an exception, for those that want to reach the millions via Internet. A late example is the efficient search engine of Google that is freely provided to all Internet users. In contrast to these global successes based on free provision of information and software the numerous attempts to sell digital information via the Internet or on CD became market failures.

The process for successful explosion of information sharing on the Internet is straightforward: - new user-friendly software is either made available on a web server or as a downloadable programme. This software attracts increasing numbers of information users, - this makes information producers upload more information in the standard format, -which in turn attracts more users, and so the snowball rolls faster and faster. Trendalyzer, or a similar attempt, may be the software needed to initiates effective Internet sharing of development statistics within and between countries.

In molecular sciences a similar explosion of free information exchange of genetic information from all organisms has been made possible by the Genbank software system. This system today makes detailed genetic information freely available to all researchers in the world as a global public good. It expanded rapidly in the last 5 years by linking several servers for DNA sequences into one system. These were the DataBank of Japan, the European Molecular Biology Laboratory, and the US GenBank server at NCBI. DNA data for 100,000 species is now daily up- and downloaded freely on these servers as global public goods. The 2002 Nobel Prize in Medicine was awarded for the discovery of the genes that regulate cell death and organ formation in all species. The Nobel laureate John E. Sulston attributed the discovery to the free provision of gene information as global public goods through the Genebank software system.

Publicly funded statisticians can share information about development in the same effective way as publicly funded molecular scientists share information about genes! It is in fact strange that UN and Breton Wood organisations claims ownership of compiled National Development Statistics and sell the datasets. This correspond to how biotechnology companies claim ownership and sell genetic information from crops originating from all continents.

1.3 Contemporary provision of global development statistics.

Discussions about our common global future have not been much based on evidence. Ideology-generated assumptions appear to be more common regarding the present state of the world as well as for development trends and determinants. The works of Amartya Sen, the Global Burden of Disease study by Christopher Murray and Allan Lopez, the study on Macroeconomics and Health lead by Jeff Sachs and the international collaboration on climatic change are important parts of a move towards more evidence based assessment of global development. Another example is the book "The skeptical environmentalist" by Björn Lomborg. It triggered a confusing debate that typically did not differentiate well between the numeric evidence provided and the conclusions drawn. There are still several objections against the use of numeric evidence as one component is assessment of world development. However, we think that the above examples represent an ongoing paradigm shift that is driven by the very fact that a growing amount of data on global and national development is becoming available in growing time series with gradually improving quality. This data has been generated by a number of different collection and editing methods and is unfortunately still made available in a countless number of different digital formats, mostly without the "metadata" which describes the source and nature of the data items.

"Improving Statistics for Measuring Development Outcomes" was the title of a meeting at the World Bank on June 4-5, 2003. The meeting included the major international stakeholders for development statistics. Several valuable recommendations regarding data collection and statistical systems emerged from the meeting (Annex 7), but less emphasis was put on how to increase the use of development statistics. Trendalyzer was presented at the meeting by UNDP, and it was found that this software is complementary to other international efforts being made to improve the monitoring of MDG.

The IT revolution has so far only had limited effects on the use of development statistics. The most comprehensive data sets are still being sold on CDs or as a few numbers at a time being made accessible on web pages. Sometimes development statistics are made available free as .pdf files or in free excel files of different formats but it remains cumbersome for users to merge data sets and compare time series of data from different sources. We believe this is the main reason why updated social, economic and environmental data still has a limited impact on how the future of the world is viewed and debated. Digital data is still used in very limited ways, if at all, when world development is taught in schools and universities. The explosion of development statistics on the Internet is yet to come!

Time series of the main development indicators are being compiled at country level by National Statistic Agencies and at international level by several UN organisations and Breton Wood institutions. A leading provider of comprehensive global development data sets is the World Bank that sells a CD called World Development Indicators (WDI) with visualisation software owned by World Bank. Annual updates of the web version and the CD sell some thousand copies at prices of 100 and 275 USD, respectively. The other main provider of data sets on world development is UN Statistic Division that provides data from the UN common database (UNCDB). Web accesses to selected numeric values from this dataset are sold at a prize of 100 USD. UNCDB does not find more buyers than WDI. UN population division provide selected numeric values for important variables free, but the population data is not yet available in user-friendly graphic formats. UNICEF also provides selected numbers free of charge from www.childinfo.org. UN organisations also provide the

numeric information about MDG fulfilment at both international and national level in conventional static graphs. Our projects aim to offer more enjoyable, user-friendly ways of using statistics for improved understanding of the complex dimensions of development.

Specialized UN organizations still mostly distribute data in yearbooks (on paper) or as pdf-files. At best the data sets can be freely downloaded as excel files from websites. However, in these excel files the numeric data is organized in different patterns. Using only Excel, time series data with country/indicator/year can be organized in 3x3x3=27 different patterns! The different ways data are made available make it cumbersome for the majority of potential users to compare indicators, countries, and time periods. It takes a dedicated researcher to make comparisons across data sets. When statistical agencies distribute their numerical data in digital format they often do so on a CD with special software that works relatively well for their own data-sets, but the differences in software and data format complicate combination with data sets from other providers. A powerful free software for effective exchange and visualization of existing numerical data on national and global development can change this. Our attempt to provide such software may not be the only one. Others may provide user-friendlier software. But our aim is to either succeed in providing the software that can multiply use of development data, or to stimulate others to do so. **But why has this not already been done?**

1.3.1 Yearbook tradition

The tradition to publish and sell yearbooks is strong in agencies providing statistics. This tradition makes agencies keep new IT-tools and data sets secret until special release-date. The old book concepts as well as sales of data sets as *products* on CD or via the net do not at all utilize the effectiveness and the dynamism of free Internet distribution.

1.3.2 Software for professionals

International and National Agencies tend to make software for their own professionals and for those with similar skills. Such software is often very useful for the intended user group and constitutes a valuable tool for production of conventional graphic illustrations of new data. However, across the world most of the computer experience of the young generation that are interested in Millennium Development Goals comes from playing interactive computer games. They would be able to use digital development statistics directly from data servers in interactive and visual ways.

1.3.3 Untapped new IT resources

IT technology and software continues to develop very fast, thereby proving that it always remains difficult to imagine what we have not yet seen. Existing IT-tools for development statistics tend to produce digital versions of what already existed on paper or adopt conventional interfaces from statistical programs. They do not utilize new opportunities to create automatic digital links from huge data sets to understandable and visual screen interfaces. Nor do they use new possibilities to display change over time as motion, or to enable users to select data interactively by mouse clicks in the graphic interface. Those involved may have limited experience of advanced interactive software environments, i.e. of computer games. The game sector today leads the interactive software design and programming and hosts the world elite of programmers and interaction designers.

1.3.4 Data ownership

Most National Statistical Agencies understandably claim "data ownership". The UN and international agencies receive development statistics free of charge from countries. When they have copied, compiled and edited the national data in a "global" Excel sheet they also consider their organisation as "owner" of the global data sets. The income from the sale of the global data set is often expected to finance the competent statisticians that compiled and

edited the data sets. These qualified professionals perform data quality assessment during the editing process, and are making documentation about editing methods more available to users, but rarely provide full documentation on how each number has been generated. Although the quality assessment and standardisation of format constitute an added value the cost of doing the global compilation is marginal compared to the costs for primary data collection and editing at country level. We are convinced that if global development statistics can be made available and used by the millions it will be easy to find public funding for the few highly professional staff that will continue to be needed in the statistical system at national and global level.

The concept of selling development statistics emerged in many countries and at international level more than 10 years ago. We claim that it has now been by-passed by the IT and Net revolutions. The modern visualisation software has increased the potential effectiveness of digital information sharing so much that the old concept of selling digital products to end users needs to be reassessed. The core of digital development statistics should be regarded as a global public good; both for its value in the political and democratic process as well as for its critical role in creating equal economic and trade opportunities. In relation to the present emphasis on objective monitoring of development it appears as if the international and national statistical systems are under funded (Annex 7). Sale of data does not seem to have solved this problem, whereas a multiplication of the number of users may improve the public funding.

1.4 The Vision

Contribute to effective sharing of development statistics on the Net by providing free software for enjoyable interactive visualisation of time series!

Our vision is based on ides generated in discussions with Sida and WHO in 1999 and 2000 as well as from pilot testing of different software versions at Karolinska Institutet and other Universities. We also received very valuable inputs from the Development Data Group at the World Bank during a visit in 2000 and from the Paris 21 Programme at OECD during visits in 2001. We are also influenced by continuous requests from students that the data collection methods that generated the data in the first place need to be fully documented in ways that are accessible to all users.

In 2002 and 2003 the Swedish government expressed strong support for our projects. However, both the government and Sida suggested that the scope should be widened from world health to world development, including the monitoring of the millennium development goals. It was suggested that the collaboration should include UNDP and other UN organisations. This coincided with the thinking of the project team. Following the finalisation in June 2001 of the first beta version called World Health Chart 2001, the project has focused on development of a generic stand-alone software called Trendalyzer that has been programmed using the program compilator Director and the language Lingo. For reasons given later, the work is now being programmed in Flash MX, a new and excellent improvement of earlier software.

2. Project Milestones

The idea for this project was generated when teaching global health at Karolinska Institutet (KI) in 1996. Ola Rosling did the first software prototype in the fall of 1998, and improved it during 1999. The first year of development with testing in courses at KI and in external

lectures was done without any external funding. Table 1 shows the two project phases since the first external funding was received in November 1999. The first phase delivered a multimedia like product called World Health Chart 2001 with a built in (mainly WHO) data set. The second phase delivered a beta version of a stand-alone "generic software" for visualisation of time series data as moving graphics called Trendalyzer.

Table 1 Project milestones for first two phases and plans for the third phase

	Phase one
1999 Nov	World Health Chart project starts with WHO and Sida support
2001 June	Beta version of World Health Chart 2001 provided on www.whc.ki.se **(10 000 downloads)**
	Phase two
2001 July	Trendalyzer/World Health Chart(WHC) & World Development Chart(WDC) projects start
2003 June	Beta version of Trendalyzer (25 June) provided on www.trendalyzer.com
2003 July	Provision of web pages in flash from Trendalyzer for UN Human Development Report 2003
2003 July-	Provision of WDC2003 beta version for internal testing

2.1 Phase one, World Health Chart 2001

The first phase resulted in the planed provision of the beta version of World Health Chart 2001 for download and testing from <www.whc.ki.se> in June 2001. Without any active promotion this has resulted in 9 500 downloads at a gradually increasing rate. The web testers have provided many useful comments that have been introduced into the development of Trendalyzer. WHC2001 has been extensively used in training at KI and a number of other universities. It has proven to be a useful tool for lecturing. It has been presented in the Swedish Science radio and shown in Swedish Television News in prime time.

With limited information and no funds spent on promotion we got 6 500 downloads in Sweden of the beta version of World Health Chart 2001. Internationally we got an additional 3000 downloads. Sweden has about 1% of the world's computer users. From this we estimate that the number of users worldwide can be increased more than 100 times if it is made known that global development data sets are provided as global public goods with user-friendly software.

In spite of many downloads we have recognised that many potential users hesitate to download free software. It is now clear to us that the Trendalyzer software system will get several-fold more users if the visualisation of development statistics can also be made with full interaction on web sites. This is the main reason why programming is being switched to the new program compilator Flash MX that presently is revolutionising interactive visual IT design.

Most users expressed the need for a stand-alone software or a web display rather than a download of a multimedia like product such as WHC2001. It also became clear that the project would benefit from a widening of the focus from health to all forms of development data. The aim of the second phase was thus to produce the software Trendalyzer based on the extensive user testing of the version from phase one.

2.2 Phase two, Trendalyzer 2003

The discussions with Chris Murray and his group at WHO in 2000 and 2001 as well as our wide testing of the beta version indicated that our way to present development statistics in moving graphics is something genuinely new. From the feedback of the users of the phase one World Health Chart, we believed that what was needed was a stand-alone program with the functions summarised in Table 2:

Table 2. The main 6 functions of the Trendalyzer software system shown in Figure 1.

1. Interactive visual display of time series on the screen interface. IN the default display one country will be a bubble that simultaneous can display name of the bubble and time as movement and four development indicators as size of bubble, colour of bubble, position on x and y axis's. This chart interface can display the wanted indicators and changes over time through clicking user-friendly buttons on the screen
2. Export of images into **PowerPoint** or other image software. In these software the generated graphs can de further edited for display or other forms of distribution and publication.
3. Export of animation to **Flash** files that are the dominating animation tool on the Internet. The graphics generated by Trendalyzer in Flash files can be further edited or directly displayed on WebPages or sent to other computers.
4. Import and export of data from **Access** and **Excel** files in addition to the built – in data files that are distributed with the Trendalyzer software in customised format
5. Customisation of the software into National and Topic Charts with other data-sets, default settings and language. This will be done for distribution of National or Topical development charts powered by Trendalyzer.
6. Browsing for time series on Internet servers for visualisation or download of the data. It will also be possible to search for data and to upload data on a Civil Society Server that can complement data servers of International and National data providing agencies. In other words to provide a Google/Napster like function for development statistics.

Trendalyzer2003 was produced with the compilator programme Director from Macromedia. Code was written in the programming language Lingo. Functions 1 to 5 in Table 2 are included in the Trendalyzer2003 version that is now uploaded on www.trandalyzer.com for the first period of testing. These five functions will be debugged and interfaces improved based on gradually expanded testing and use during the fall of 2003. A data set compiled at Karolinska Instituted will be built in to turn the version into a World Development Chart 2003 during this testing period. The second phase implies a considerable change in aim of the project. The volume of the software best explains the increased ambitions. WHC2001 contained about 300 A4 pages of code, whereas the present Trendalyzer version contain about 1500 A4 pages of code.

Table 3 Major project presentations, discussions & meetings in the first half of 2003

January 8	Inauguration lecture at the course of International Health at Helsinki University
February 6	Presentation at regional meeting for Ministers of Health, Khartoum, Sudan
February 13	Presentation at ICT day at DESO/Sida
March 3-4	Project presentation & discussions with the Swedish Prime Minster and the Minister of Education & Research at meeting for researchers at Harpsund.
March 10-13	UN tour in New York hosted by Jan Vandermoortele, UNDP/UNDG
March 14	Closing key-note speech at the Swedish Conference in Public Health
Mach 17-19	Visit to UNAIDS for joint planning of Trendalyzer usefulness
March 28	Planning meeting at Centre for International education, Stockholm University
April 3	Discussions with Marcus Storch, vice chairman of Nobel Foundation
April 11	Project team one-day meeting at Gapminder in Malmö
May 15	Key note lecture at the Swedish Conference in nursing science
May 19	Meeting with Dept of Epidemiology & Historic Demographic *database*, Umeå
June 5	Meeting with Sakiko Furruda at KI on Trendalyzer for Human Dev. Rep. 2003
June 8	Presentation at workshop on Mobility Regimes at Institute for Future Studies
June 12	Key note lecture at Nordic Conference on Sustainable Development, Min Educ.
June 25	Key note lecture at World Technology Summit, San Fransisco
July 2	Presentation at UN/ECOSOC meeting in Geneva

2.2.1 Project collaborations with UN in 2003

During the spring of 2003 the advancement of Trendalyzer 2003 enabled extensive contacts to be made for future promotion of the software system. Both Sida and the Swedish government suggested in 2002 that the scope of the project should be widened from monitoring of world health to include all millennium development goals and general monitoring of development. To achieve this it was suggested that the collaboration also should include UNDP. At meetings in Copenhagen and Stockholm in the fall of 2002 UNDP expressed great interest in collaborating with the project. This was confirmed when Jan Vandermoortele at UNDP/UNDG hosted a one-week tour by the project team and the Sida desk officer Martin Ejerfeldt (Annex 1) at UN organisations in New York in March 10-13, 2003. We received especially valuable inputs from Garret Jones and Howard Dale at UNICEF, from Saikiko Furuda and Haishan Fu at Human Development Report and by Robert Johnston and Zoltan Nagy at UN Statistic Division. These professionals and the Administrator of UNDP, Mark Malloch Brown, shared our vision.

They all emphasised that Trendalyzer will be complementary to the IT developments at these UN organisations, especially by its capacity to provide digital development statistics to a wide range of user groups. UNDP represented the project and showed a version of World Development Chart at a June meeting at the World Bank (Annex 7). As requested by the Human development report editor Sakiko Furuda Gapminder made animations of this years report messages for the launch on July 8. They are available at http://www.undp.org/hdr2003/flash.html The files were used around the world, including Stockholm, for the launch of the report.

2.2.2 Project extension to Education and Economy in 2003

Through initiative from Anders Frankenberg at the Education Unit in DESO/Sida the project has extended collaborations to the Institute of International Education at Stockholm University regarding data sets for Education. This turned out to be an excellent idea as Prof Albert Tuijnman had extensive international experience of development of data sets for Education. He is also adviser on MDG goals in Education to UN and had a highly skilled group of researchers that are motivated to develop a World Education Chart with UNESCO. Unfortunately the planning of this component has been delayed as Prof. Tuijnman has taken a position in Luxembourg but he continues to lead a research group at Stockholm University that will develop a UNESCO collaboration based on Trendalyzer. The present head of the Institute for International Education and UNESCO has confirmed their interest to collaborate with Prof Tuijnmans group.

Prof Christer Gunnarsson at the dept of Economic History at Lund University is likewise planning for collaboration with UN, World Bank and OECD for provision of historical data sets from high-income countries with economic indicators together with those from middle- and low-income countries provided by World Bank.

2.2.3 Interest by Swedish government

At a two-day meeting at Harpsund in March the Trendalyzer and World health Chart project was thoroughly presented for the Prime Minster and the Minister of Education & Research. They expressed great interest on behalf of the government and confirmed the usefulness of viewing time series as moving graphics for policy makers. The suitable organisational form for developing and providing Trendalyzer software system as global public goods was discussed. The Prime Minister had no alternative suggestion to software development in a Company. He kindly invited the project to make a presentation for the whole government in the fall of 2003 with the aim to discuss wider application of Trendalyzer for public statistics.

3. Aim

The overall aim is to improve understanding and monitoring of development, by increased use of development statistics as enjoyable interactive moving graphics, generated by a free Trendalyzer software system in Flash (.fla open code) that enables:

1. **Trendalyzer software for download (.exe)**, with built in data sets as regularly updated World Development Chart, World Health Chart, World Education Chart etc.
2. **Trendalyzer software for interactive web display (.swf)** of development statistics in moving graphics from UN and other Data Providing Agencies.
3. **Trendalyzer software system in Flash components (.fla) with open source code** for use by others interested in composing software systems for visualisation of time series statistics.
4. **Search of time series of development statistics** for visualisation on a web site linked to a "Civil Society Server" with possibility to download and upload documented time series.

3.1 Users groups

Those concerned with national and global development; professionals and researchers, policy makers, students, activists, journalists, other professionals and various user groups in the civil society that formerly did not access global, national and local digital development statistics.

4. Plans for July 2003 to December 2003

Software development will continue as "extreme programming" (as games are made). This means stepwise definition of requirement specification by continuous interactions between software developers at Gapminder and test pilots at Universities, UN and elsewhere.

4.1 Effect of Macromedias software for program compilation

In 1998 Macromedia (www.macromedia.com) launched Director 6 and later version 7. This software from Macromedia made this project possible. The reason was that Director 6 made it possible to make visualisation software much faster than in conventional C++ programming. It is estimated that this software increased the productivity 10 times compared to conventional programming in C++. The reason why one programmer in 2 years could make World Health Chart 2001 (using Director 6) was this effectiveness. When starting in 1999 and when continuing to develop Trendalyzer in 2001 all other program compilators available were considered. Neither in 1999 nor in 2001 was there any software that enabled a production of moving graphics produced from data sets to be made available interactively on web pages (this included Flash version 5).

It was never clear if it would at all be possible to make Trendalyzer as a stand-alone software as fast as planned with Director. It was a high-risk endeavour, but it turned out to be possible, although more debugging still remain to be done. However, the initial wish to make development statistics available interactively on web pages through direct reading of data bases is in 2003 possible to achieve by programming in Flash MX.

In the late fall of 2002 Macromedia launched the Flash MX version. It considerably increased the speed by which interactive graphics can be programmed. When Trendalyzer2003 was almost ready in Director in the end of 2002, Gapminder realized that Flash MX would enable much faster advancement, probably by a factor of five. Flash MX with its language Action Script constituted a higher level of programming, and contained more ready-made graphic components. This posed a frustrating challenge to the project team during some months, (as it seemed the whole system would need to be rewritten in this new language). However, Director MX version was launched by the turn of the year, and this new

version allows combinations of DirectorMX and FlashMX components in the same software system. Trendalyzer 2003 will thus be debugged in its Director version, but all new programming for Trendalyzer 2004 will be done in Flash MX. The advantages of Flash MX are given below in table 4.

Software produced in Flash requires a special reader on the users computor if it is used for visualisation on a web page. The good with Flash is that most modern computers have a Flash reader installed. In the last year the new Flash version make it possible to make the Trendalyzer software system available in both an executable (.exe) and web-usable format(.swf), using programme components made in Flash MX in the open source code format (.fla). Another growing advantage is that large functional components of Flash code is becoming available as global public goods on www.flashcomponents.net

Table 4: Comparison of Director MX and Flash MX.

Aspects of the programmes	Director MX	Flash MX
Reader	Few have reader on computer	Most have reader on computer
Size of reader	Bigger	Smaller but better
Language	Lingo	Action Script
Development speed	Fast	> 5 times faster
Developers community	Constant	Fast growing
Annual license cost	1 500 USD	500 USD

The vision of these projects seemed far-reaching some years back, but we are now sure they will become a reality. It will be through a much less rigid software system than anyone of us could imagine in 1999. The software components can be recombined by advanced users or used as an old-fashioned computer program by less advanced users. The components will also become global public goods in themselves. It should be noted that these components also could be used as building blocks in software systems that are commercially produced as well as used for data sets that are sold commercially. The reason is that the overall aim is to increase use and understanding of development data, be it as global public good or as a commercial product.

4.2 Project team at Gapminder in the fall of 2003

The basic principle of extreme programming and the fast advances in visualisation software makes it irrelevant to make detailed hour by hour work plans as done in earlier applications. For August to December 2003 the composition and division of tasks in the software developing team is as follows:

Person	Main area of responsibility
Mattias Lindberg	Debugging and revisions of Trendalyzer 2003
Jakob Malmros	Design of colour function in Flash for Trendalyzer 2004
Martin Öhman*	Design of icon function in Flash Trendalyzer 2004
Jörgen Abrahamsson	Design of calculator & chart functions in Flash for Trendalyzer 2004
Johan Nystrand	Programming to link data bases to Trendalyzer
Ola Rosling	Co-ordination and innovation of software system structure
Anna Rönnlund Rosling	Flash output design and Tutorial and Help functions + administration

* Live and works mostly in Stockholm

4.2 Main collaborations in the fall of 2003

Table 4. Meetings planned for the Fall of 2003

UNDP/UNDG, Human Development Report
WHO and UNAIDS
The Swedish government, invitation by the Prime Minister
The Swedish/French commission for Global Public Goods, invitation by Minister for International Development
UN statistics Division, New York
Institute for Future Studies
Cambridge University
Stanford University
UNESCO
Inter-American Development Bank (IDB), Washington
Vanguard conference on new visualisation technology, Phoenix, Arizona 4-5 Dec, Vanguard Technology Transfer Institutet

The fall will be a very intensive period with gradual spread of the Trendalyzer software system and maintaining the collaborations started during the first part of the year. A timetable is yet to be laid. Most important are the connections with UNDP/UNDG, Human development Report and UN Statistical division that will be given highest priority. Likewise the change of senior staff in collaborating clusters at WHO make it necessary to start the fall by re-establishing the collaboration with WHO. Plans for work with UNAIDS were already established in the spring of 2003. The HIV time series are the most requested by users but data have a considerable uncertainty range. The time series are also recalculated each time a new value appears so that HIV variables are optimal for attempts to define collection and editing method in ways that enable estimation of uncertainty.

4.4 Project team at KI in the fall of 2003

Marie Reilly, who since joining this project has been promoted to Professor of Biostatistics at KI, provides the statistical expertise. Christian Ahlstedt will continue as research assistant, and will be assisted by Mattias Strand who joined the project during the summer of 2003 on a KI fellowship for summer research students. Hans Rosling continues as project co-ordinator and Asli Kulane, in charge of IHCAR's course programme will also participate extensively with planning and monitoring the pilot testing in courses. Several other researchers at IHCAR will also participate with provision of data sets as part of other ongoing projects.

A special effort to test the Trendalyzer software for local MDG monitoring will be made by Prof Vinod Diwan during his period as guest professor in India, where he is organising development monitoring down to village level in a pilot area outside Bohpal. As part of a Danida project, health centres and health administrations have been supplied with new computers and the use of Trendalyzer visualisation of the time series generated will be implemented in the fall of 2003.

In addition to WDC2003, it is foreseen that an updated health data set and the Trendalyzer 2003 version will be provided as a World Health Chart 2003. It will also be tried to apply the Trendalyzer 2004 system as first suggested by James L. Duppenthaler, Statistician at WHO and in charge of the WHOSIS statistical web system.

4.5 Output by December 2003:

One of the major delays in Trednalyzer2003 was due to a bug found in the Excel, from which Trendalyzer imports data. Numeric data cannot be read by available database readers on the

first row in the excel sheets. This bug also exists in the last Excel version, and several in the programmer community know it. The bug cannot be solved without access to the source code of Excel. At the World Technology Summit in San Francisco a high representative of Microsoft offered assistance to Gapminder in solving this problem. Counting on this assistance from Microsoft a **World Development Chart, WDC2003** with tested, revised, and debugged **Trendalyzer2003** and an expanded UNCDB data set will be ready for promotion during the early or mid fall 2003.

Specialised Charts with Trendalyzer2003 in a yet to be decided form will be done with WHO, UNAIDS, UNESCO, either as a separate chart version for each organisation or as contributions to a joint World development Chart. This depends on the final attitude and motivation in the different UN organisations /Annex 7).

Development of **Trendalyzer2004** in Flash (.fla) for making both .exe and .swf versions will be done during the fall of 2003. Trendalyzer2004 (.swf) will be first tested for web-based visualisation of the UN Common DataBase. This will be done during the fall of 2003 to allow for revisions based on comments from the highly professional partners at UN Statistic Division. If successful, Trendalyzer may perhaps also access the WHOSIS data base at WHO.

The planning of a Civil Society Server (CS-server) with an international university network and joint examples of how documentations of collection & editing methods, and estimations of uncertainty ranges can be done will be an issue of collaboration between Gapminder and KI teams, and also hopefully teams in Education at Stockholm University and in economics at Lund University.

5. Plans for January 2004 to December 2004

Before the requisition of funds for the first and second half-year of 2004 detailed work plans and expected outputs will be submitted to Sida. For the time being it is not meaningful to make more detailed plans than as specified in the foreseen outputs given below.

5.1 Output by June 2004:

WDC2004 with tested, revised, and debugged **Trendalyzer2004(.exe)** for promotion.
UN Common DataBase visualised on the web using **Trendalyzer2004(.swf)**.
Specialised Chart versions promoted with UN-organisations and a few countries.
Start of a Civil Society Server with an international university network.
Documentation of collection & editing and display of uncertainty ranges for variables on CS-server.

5.2 Output by December 2004:

Debugging and revised Trendalyzer2004 (fla) for promotion.
Expanded Trendalyzer use as downloadable Chart versions (.exe) and as visualised databases(.swf).
Further development of CS-server and linking to some other servers.
Plans for systematic quality certification and uncertainty estimates with UN and university networks.

5.3 Output in Coming Years:

A 100 to 1000 fold increase in the number of interactive web- and computer users of free digital development statistics compared to the present thousands that buy commercial data sets.
Increased use of national digital development statistics in a number of countries.
A growing system for quality certification of time series of development statistics resulting in provision of understandable and well-defined uncertainty intervals to users.

6. About Gapminder

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Gapminder is registered as a limited company, (Aktiebolag in Swedish) for invention, development and provision of free software that visualise global, national and local development. The company's vision is to compensate for market and institutional failures in providing cutting edge IT solutions for information and education on development in the public sector and civil society. Software development is done in collaboration with universities, UN organisations, public agencies and non-governmental organisations. Six software developers are presently working at Gapminder and one is attached as a consultant, having his own formal company and being based in Stockholm.

It all started in 1998 from an idea to enhance the understanding of world health. We developed a prototype software showing time series of health statistics as moving graphics combined with visualisation of varying human life conditions by 360° photo panoramas from homes, schools and health facilities. From the prototype software emerged the Dollar Street project with Save the Children Fund in Sweden and the World Health Chart project with WHO. Gapminder developed the free software Trendalyzer within the World Health Chart project. Collaboration with United Nations Division of Statistic and UNDP, started in 2003 with the aim to visualise fulfilment of millennium development goals with a World Development Chart powered by Trendalyzer.

The initiators Ola Rosling, Anna Rönnlund Rosling and Hans Rosling own Gapminder together with the Karolinska Institutet, the medical university in Stockholm. It is organised as a limited company, but do not pay any dividend on the capital. Ten percent of the shares were sold to Karolinska Institutet for 1 SEK to mark that the involvement of this medical university was not for profit but for transparency, stability, and advice. KI benefit from an early benefit in teaching and research software developed by Gapminder and from the experience of forming companies for production of global public goods.

The funding for Gapminder is by grants from non-commercial sources such as Sida, WHO, Save the Children Fund and UNDP. Being a producer of global public goods, Gapminder benefit from free and creative inputs from pilot-testers and other end-users in many institutions and organisations. Gapminder trademark product names to prevent others from claiming ownership. Gapminder will not seek patents, costly processes that impede intensive external user testing during software development. Patents are also largely irrelevant and offer no additional advantage for free Gapminder will not bid on tenders to do commissioned work for delivery of specified products or software adaptations according to predefined requirements specifications. However, the company will accept non-commercial funding for joint non-commercial endeavours with external partners with common interest in developing visualisation software as global public goods.

6.1 Why a company?

The development and provision of Trendalyzer software system has benefited from the flexibility and effectiveness of being done by a company. The advantage of being organised as a company is related to the need for fast purchase of hardware, software updates and plug-inn's as well as flexibility in long and short time employment and affiliation of partners. The

clarity in laws and rules for taxation, bookkeeping and audit are the advantages of being a company, compared to alternative organisational forms such as foundation, association, or project within government agency or university.

to consult the most experienced advisers possible we have asked several persons about the organisational form. The decision to maintain Gapminder as a company is based on consultations with Hans Wigzell, the president of Karolinska Institutet, Jan Lindsten the secretary general of the Royal Academy of Science (elect), and Marcus Storch former CEO of AGA, and now vice chairman of the Nobel Foundation. These experts on interlinks between public and private sector in Sweden recommended Gapminder to be organised as a company, as the Swedish law clearly allows companies to operate without generating profit on the capital and to receive grants from public sources. The Prime Minister also agreed that a company appeared as a good organisational form and he invited us to continued discussions about future collaborative mechanisms between the public sector in Sweden and UN organisations to specify in detail the future tasks and assignments of Gapminder.

Jan Kleerup, the leading expert at Ernest & Young was asked whether a company can receive a grant from a public institution like Sida without paying VAT(moms) (http://www.ey.com/GLOBAL/content.nsf/Sweden/VAT_Services_Branscher_Finans).
He said that was no problem, and compared to Almi bolagen (http://stockholm.almi.se) that receives grants from Nutek without paying VAT(moms). Gapminder will keep the activities linked to development and provision of the Trendalyzer software system separate in bookkeeping and in reporting to tax authorities. As an independent grant (oberoende bidrag) without direct reciprocal product or service being delivered to Sida there will be no need to pay VAT on this grant. Gapminder will report to Sida as required and specified in contract.

6.2 Gapminder owners and board.

As can be seen from Annex 5 the ownership of Gapminder has been changed based on the above considerations. Anna and Ola Rosling have sold 10% each of the shares to Hans Rosling and Karolinska Institutet for 1 SEK, respectively. This is to mark that this is not a commercial investment but a way to offer Karolinska Institutet full transparency into the activity and economy of Gapminder as well as to enable Hans Rosling to participate as owner in the running of the company. Hans Roslings participation in Gapminder thus follow regular proceedings when a researcher forms a company based on ideas generated at the University. It now remains for Hans Rosling to report to Karolinska Institutet how he handles university and company tasks, and the earlier type(???) of conflict of interest disappears.

The present board is lead by Anna Rosling Rönnlund, software designer, Gapminder. E-mail: anna@gapminder.com and includes Ola Rosling, Software inventor & designer, Gapminder. E-mail: ola.rosling@gapminder.com, Hans Rosling, professor of international health at Karolinska Institutet, Folke Meijer, Karolinska Institute Holding AB, Karolinska Institutet. E-mail: Folke.Meijer@kab.ki.se and from the staff Jörgen Abrahamsson, Gapminder, jorgen@gapminder.com.

7. Budget for July 2003 to Dec 2004

We apply for the following budgets for the two linked projects and will appreciate if Sida can sign separate contracts with Gapminder and KI. We are also grateful if funds can be transferred once every six months period. Economic and activity reports will likewise be submitted for six month periods from Gapminder and KI, respectively.

7.1 Budget for Gapminder

The budget for Gapminder is calculated for the next 6-month period. It is in a similar range as the last six month period when 1082 000 SEK were transferred to Gapminder and KI

separately paid for the NY visit and some other travel costs from Gapminder. The end of the parental leaves for two of the team members explains the slightly higher budget. The estimates for each cost item is on the same levels as the last half-year. The employed software developers do not have a fixed number of weekly work hours. This is partly due to preferences and partly to the character of the project. They are paid for an average of 40 working hours per week at 158 SEK per hour, including compensation for holidays. The employers' tax (LKP) for this type of company is only 33%. Software development benefits from teamwork, but going beyond 7 persons requires costly managerial structures. Therefore Gapminder continues with the present effective team size.

Presented budget is based on full time work by five software developers during the half July 2003 to December 2004. This implies that test versions done with partner organisations like the animations of the Human Development Report 2003 is covered by additional external grants as well as some of the testing in courses and other events. The applied budget for the core development and provision of Trendalyzer will be handled separately from the other smaller activities and grants at Gapminder. The two travels to UN in New York and to Sida and university partners in Stockholm are also exclusively for the development of Trendalyzer. The costs for external consultations include highly specialised programming for linking Trendalyzer to other software's, this may be solved by free service from Microsoft. The program license costs correspond to the Macromedia products Director and Flash that are used to compile and programme Trendalyzer. The plug inns are available programme scripts written in Lingo and Action script available at low costs from the web. Careful documentation of payment is needed for inclusion in Gapminder free software. Equipment is a low estimate for the need for hardware renewal. Overhead includes rent, security, other office costs, internal and external administrative service. That the application concerns a grant is supported by the effectiveness that can be assess by recalculating the budget into cost per hour including all overheads, even for consultant, travel and other non salary expenditure. The salary cost and overhead is 1 270 770 SEK divided by 4400 hours gives 289 SEK per hour.

Budget for Gapminder for July to December 2003

Timlön inkl. semester	158
LKP 33%	52
Lönekostnad/timme	210
Arbetade timmar/månad	160
Lönekostnad per månad	33 622
Antal personer	5
Lönekostnad / mån	168 112
Arbetade mån / halvår	5,5
Total lönekostnad / halvår	**924 616**
Resor till NY 2*10 000	20 000
Resor till Sthlm 10*2500	25 000
Resor totalt	**45 000**
Extern konsult 400SEK*200	80 000
Program licenser 10x5000, Plug-ins 5 x 2000, utrustning 44 230	104 230
Totalt konsult & utrustning	**184 230**
Totalt halvårskostnad	1 153 846
Overhead 30%	346 154
Grand total Juli-Dec 2003	1 500 000
TOTALT 200307- 200412	4 500 000

7.2 Budget for KI July 2003 to Dec 2004

Budget KI for July to December 2003

Salary	**months**	**cost**	
Statistician, 20%	6	12 000	72 000
Research assistant, 100%	6	30 000	180 000
Total salary			**252 000**
Travel	**number**	**cost**	
Geneva	2	8 000	16 000
NY & Washington	2	14 000	28 000
Malmö/Lund	4	2 000	8 000
Total travel			**52 000**
Consumables and services			**21 926**
Subtotal			**325 926**
overhead 35%			114 074
Total			**440 000**
TOTALT 200307- 200412			**1 320 000**

7.3 Budget for other partners for July 2003 to Dec 2004

The Department of Economic History at Lund University and the Institute for International Education at Stockholm University will apply for separate budgets for implantation of their components of the network collaboration.

7.4 Budget for continuation in 2005 and beyond.

It is understood that following completion of the third phase in December 2004 Gapminder will not apply to the Health Unit of Sida for any further funding for continued development and provision of the Trendalyzer software system. Gapminder defiantly plan to apply for other public and non-commercial funding for the continued provision of the software, but given its wide application that funding should come from appropriate sources. This organisational form for provision of software as global public goods and the sources of sustainable funding will be the focus of the discussion with the Swedish Government in the fall of 2003.

The Division of International health at Karolinska Institute may submit an application for continued support for further development of World Health Chart or the health component of a World Development Chart.

PHM Secretariat

From: Hans Rosling <Hans.Rosling@phs.ki.se>
To: PHM Secretariat <phmsec@touchtelindia.net>; <ola.rosling@gapminder.com>; <vinod.diwan@phs.ki.se>
Sent: Sunday, September 07, 2003 3:06 PM
Subject: Re: attachment

Dear Ravi,
With resources I mean software and person time and travell cost if we need to meet. That is collaborating projects with back to back financing. Since Gapminder is finances by the Swedish government to provide public goods that how we are interested to work. We are producing flash modules that can be assembled in different ways for visualization of time series and other statistics.

Ew 8/9/03

DGS -
Please send this to Dave McCoy and Mike Rawson
RN
8/9/03

Via this we are now using the MDG euphoria to make UN provide the data sets as public goods. The mentality from the privatizations in the 90ies when statistical offices started to sell public data is so wrong now when IT can make them freely available. It is an irony that the good old public statistical beureu of sweden wants to sell data and software and we therefore need to form a privatre company tyo get government grants and provide free software for free data.

It will all boil down to how well the software will function but knowing what google and others can to something big can be done with development data. You can contribute a lot by
1. demanding free data
2. providing alternative data that question the sources and uncertainty of official data and especially that shows the disparities within countries by spitting into regions (your classical India map) and income group, gender, ethnic group etc.

Vinod diwan is trying to get local development data from an ondian state displayed in powerful ways.

PHM-GHEW
PHM-Sweden
RN
8/9/03

>Dear Hans,
>
>Greetings from PHM Secretariat (global)!
>
>Thanks for the attachment with plans for Trendalyzer and WHC / WDC. It was most impressive. I have forwarded this to my two PHM colleagues - Dave McCoy and Mike Rowson - and they will send you the plans for GHEW. When you mentioned contribute to resources - did you mean a financial support (small grant) or contribution of information? Shall get back to you with details about the Bangladesh PHM training linkage soon.
>
>Looking forward to your colleagues joining the Mumbai meeting.
>
>Best wishes,
>
>Ravi Narayan

RN
8/9/03 fax

PHM.

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <david.mccoy@lshtm.ac.uk>; mikerowson <mikerowson@medact.org>
Sent: Thursday, September 04, 2003 1:49 PM
Attach: Application tlz-vrde who18aug2003+langREV.doc
Subject: GHEW

Dear Dave and Mike

Greetings from PHM Secretariat (Global)!

I have been in touch with Hans about a whole of PHM related matters including GHEW. He has replied mentioning that he would put some resources at our disposal whatever that means (monetary or information!). He has sent the latest project proposal on WDC / WHC and Trendalyzer, which is self-explanatory. Would you like to send him the GHEW document as well?

Did you get the one page CV of PHM, some thoughts on PHM financial contribution and my suggestion on the road map for GHEW with potential skypes at Teheran, Geneva and Mumbai. Do acknowledge.

skypes
halls

Best wishes,

Ravi Narayan

PS: Following are the quotes on GHEW from me and Hans:

My letter: The Global Health Watch Project has got a shot in the arm by a collaborative proposal put forth by People's Health Movement; Global Equity Guage Alliance; and Medact - UK for a Global Health Equity Watch. Which in the initial stages will be a report we put together as an alternative World Health report and background paper to the next People's Health Assembly. Would you be interested to be involved and support the process? The arranged marriage between GHC and PHW is till to take place. How is GHC progressing? Do keep us in touch about it.

PHM-GHEW
RN
5/9/03

Hans's reply: The Global Health Equity Watch sounds good but we would rather put
resources at disposal than participate as I read it. Since we spoke we have found it not to be within reach to make development statistics accessible & understandable interactive visualizations directly on the web without need to down load. We have just got funded for the coming 18 month and work directly with UN statistics division. There is a need to demand that UN make their 6000 development variables freely available ad global public goods. I attach our full project document for the next 18 months for your information and look forward to learn more or get similar document for Global Health Equity Watch.

Dr. Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
GHC-Hangzhou
#367 "Shuvasa Niloya"

PHM Secretariat

From: Hans Rosling <Hans.Rosling@phs.ki.se>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Monday, September 01, 2003 3:21 AM
Subject: Re: PHM Events

Dear Ravi,
1+2= I copy this to Vinod Diwan and Birger Forsberg so that they can get into direct contact with you.
3=The Global Health Equity Watch sounds good but we would rather put resources at disposal than participate as I read it. Since we spoke we have found it not to be within reach to make development statistics accessible in understandable interactive visualizations directly on the web without need to down load. We have just got funded for the coming 18 month and work directly with UN statistics division. There is a need to demand that UN make their 6000 development variables freely available ad global public goods. I attach our full project document for the next 18 months for your information and look forward to learn more or get similar document for Global Health Equity Watch
4= that sounds interesting for our master students in public health. I have a first group of five making a one year period with us in international health during this academic year. Could you send me info on the possibility of collaboration with the Bangladesh institution.

At 16:30 2003-08-28 +0530, you wrote:
>Dear Hans,
>
>Greetings from PHM Secretariat (Global)!
>
>Thanks for your prompt response.
>
>1. We look forward to Vinod Diwan joining WSF meeting. Ask him to be in touch with us and send him the framework so that he can participate in the framework development.
>2. Regarding Birger Forsberg, it is a lucky coincidence. Thelma has been the consultant for the Karnataka Government for the last two years evolving the Integrated Health Nutrition and Population Project and also to other projects of the state and I had completed a study for the government task force on Externally Funded Health Projects in Karnataka in the context of

RN
1/9/03

RN
1/9/03

PHM - WSF (India)

PHM Secretariat

From: Hans Rosling <Hans.Rosling@phs.ki.se>
To: PHM Secretariat <phmsec@touchtelindia.net>
Sent: Monday, September 01, 2003 3:22 AM
Attach: Application tlz-wdc-whc16aug2003+langREV.doc
Subject: Re: attachment

Dear Ravi
Here is the attachment with plans for Trendalyzer and world health development chart for next 18 months.
See also the homepage www.gapminder.com.

RN
1/9/03 Rn

RN
1/9/03

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: David McCoy <David.McCoy@lshtm.ac.uk>
Cc: mikerowson <mikerowson@medact.org>
Sent: Monday, September 15, 2003 9:55 AM
Subject: Re: GHEW

Dear Dave,

Greetings from PHM Secretariat (Global)!

Thanks for the response finally.

1. The Teheran meeting is now postponed to 29th / 30th November and 1st December 2003. Hope one of you can join if I raise the grant, if not we meet in Geneva, then Mumbai.
2. Its good to have Fran and Maria on the committee. At some later date once the administrative aspects including funding is well underway. I shall be a little more low key and suggest Thelma's more active involvement since as a Public Health Policy Researchers and activist. She may have more to contact Vibuke at the compiling and editing levels. She is presently quite pre-occupied with a Fellowship scheme that CHC has been granted, which means 4 undergraduates and 2 post-graduates spending 6 months - 1 year with us understanding Community Health Theory and praxis. An exciting, but time consuming new initiative.

Hope Mike and you receive Han's proposal on CHC.

PHM-GHEW

RN
15/9/03

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata
declaration visit www.TheMillionSignatureCampaign.org
----- Original Message -----
From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <mikerowson@medact.org>; <phmsec@touchtelindia.net>
Sent: Friday, September 05, 2003 4:41 PM
Subject: Re: GHEW

> Dear Ravi
>

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <mikerowson@medact.org>; <phmsec@touchtelindia.net>
Sent: Friday, September 05, 2003 4:41 PM
Subject: Re: GHEW

Dear Ravi

Many thanks for your earlier e-mails. They were most useful. Some quick responses.

1. We will be in touch with Andy Rutherford and Ollie about coordinating fundraising, and note your intention to incorpoate a GHEW line item into the PHM budget. We have sent out the funding proposal to a couple of donors already.

2. Re: Tehran meeting. Mike is unable to attend the meeting, and I am unlikely to be able to attend. However, I don't think that will be a problem. We will prepare a set of documents and discussion points which you and David could use to discuss GHEW in our absence. If Tehran is not possible, then one of us will look to attend in Geneva or Mumbai.

3. In order to strengthen the funding proposals, we have approached both Maria and Fran to ask if they would mind having their names mentioned. We selected maria and Fran because of the need to balance the already heavy presence of African, Asian, US and European-based individuals. Both have written back to say that they would like very much to contribute as much as possible in an active role. I think their regional links as well as their willingness suggests that we should incorporate them as part of the 'coordinating committee'. If you are happy with this, I will then proceed to write a short e-mail to update everybody (ourselves + david sanders, abhay, paula braveman, fran, maria, lexi and antonette) about where we are with GHEW at this present moment.

4. Re: Hans Rosing ..... we see his project as being very complimentary to the Watch, and he could make a useful contribution to Chapter 1. Mike will be contacting him shortly.

I hope you're well - look forward to hearing from you

Dave

>>> "PHM Secretariat" <phmsec@touchtelindia.net> 09/04/03 09:19am >>>
Dear Dave and Mike,

Greetings from PHM Secretariat (Global)!

I have been in touch with Hans about a whole of PHM related matters including GHEW. He has replied mentioning that he would put some resources
at our disposal whatever that means (monetary or information!). He has

12/9/03

Dear Dave
Thanks for the response finally.
(i) The Tehran meeting is now postponed to 29/30 November. Hope one of you can join if I raise the grant if not we meet in Geneva-then Mumbai
(ii) Its good to have Fran and Maria on the committee. At some later date once the administrative aspects including funding is well underway - I shall be a little more low key and suggest that Maria, more active involvement since as a Public Health Policy researcher and activist PHM - GHEW she may have more to contact at the compiling and editing levels. She is presently quite preoccupied with a fellowship scheme that CHC has been granted which means 4 undergrads and 2 postgrads spending 6mths-1yrs with us understanding Community Health Theory & praxis. An [illegible]

Hope Mike & you received news with the Hans proposal on (GHC) Bedrusha
R.N.

Seen
15/9/03

RN
8/9/03

RN
8/9/03

PHM Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <ionc@cablenet.com.ni>; <olle.nordberg@dhf.uu.se>; <fran.baum@flinders.edu.au>; <lexi@gega.org.za>; <ant@hst.org.za>; <maria@iphcglobal.org>; <pbrave@itsa.ucsf.edu>; <mikerowson@medact.org>; <patriciamorton@medact.org>; <arutherford@oneworldaction.org>; <abaysema@pn3.vsnl.net.in>; Ghassan <afodafro@scs-net.org>; <phmsec@touchtelindia.net>; <lmartin@uwc.ac.za>
Sent: Sunday, October 26, 2003 5:12 PM
Subject: Global Health Watch update

Dear friends,

Please accept apologies for an update that is long overdue. A few quick notes to keep you abreast of where we are and what we are doing, mainly through the medact office.

1. Name change - after feedback from various quarters, there seems to be a general feeling that the title Global Health Watch would be better and mpore catchy than Global Health Equity Watch.

2. Funding - this is the main area that is being focussed on. A funding propsal has been developed and sent out to various donors (IDRC, Rockefeller, Rockefeller Brothers, Ford, Soros Foundation, SIDA, Charles Stewat Mott Foundation, Macarthur Foundation). Rockefeller has turned us down but we are following up on others.

3. Funding from NGOs - we have received some funding from wemos in holland, which is adding to the amounts that GEGA has put in thus far. We are planning to approach some of the bigger development and health NGOs to see if they would be interested in co-funding (e.g. oxfam, save the children, christian aid, greenpeace, friends of the earth etc.).

RN 30/10

Most of the NGOs that will be approached will be UK-based - if you have NGOs in other parts of the world whom you might think would be sympathetic, there is a ready-made funding proposal that you could use to solicit funds etc. Even if it's a small amount of money, the final report will be strengthened if we can show that a large number of NGOs have actively supported its publication.

4. Chapter briefs - we have been working much more slowly on developing the briefs for each of the proposed chapters. This would be followed by a process of identifying authors and formally commissioning articles + organising a review / advisory panel for each chapter.

5. "Voices" - The funding received from Wemos has been ear-marked primarily to enhance the report's reflection of voices from the ground. In order to make this compone t of the report manageable, we have chosen to focus in on two areas:
- the privatisation and commercialisation of health, water, sanitation and electricity services
- the struggle for health amongst indigenous peoples
We have already begun sending out out information through various networks to alert people to this initiative, and to begin to collect testimonies. As far as the indigenous people's health is concerned, we hope to be working with and through the indigenous people's rights networks that include organisations such as Survival International, Minority Rights Group etc.

RN

6. Patricia Morton .... will be coordinating the "voices" work and is also helping to coordinate our fundraising efforts. She is based at the medact office and you will be hearing much more from her in the coming weeks.

Many thanks and best wishes from the GHW team in London,

Dave, Mike and Patricia

DGS/SSP

Please put on screen, group mail

RN 18/11

RN 27/10/03

PHM - GHEW

10/27/03

PHM Secretariat

From: PHM Secretariat <phmsec@touchtelindia.net>
To: <patriciamorton@medact.org>
Sent: Wednesday, November 12, 2003 12:11 PM
Subject: Re: Global Health Watch update

Dear Patricia,

Greetings from PHM Secretariat (Global)

Thanks for your note. We shall circulate it to PHM Steering group, PHM Exchange and the PHM India Yahoo groups. I met Mike and Dave in London, during my recent visit to London 22nd - 26th October 2003 and heard about the focused task that you are embarking on. I have suggested that you consider participating in the WSF in Mumbai, since the Health Forum preceding it on 14th - 15th January will be giving opportunities for so many, similar, testimonies from all over the world. You will also meet may representing voices of the unheard and can built the process from there. A separate communication on WSF and the International Health Forum follows.

Best wishes,

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

----- Original Message -----
From: Patricia Morton <patriciamorton@medact.org>
To: <iphc@cablenet.com.ni>; <olle.nordberg@dhf.uu.se>; <fran.baum@flinders.edu.au>; <lexi@gega.org.za>; <am@hst.org.za>; <maria@iphcglobal.org>; <pbrave@itsa.ucsf.edu>; <mikerowson@medact.org>; <patriciamorton@medact.org>; <arutherford@oneworldaction.org>; <abaysema@pn3.vsnl.net.in>; Ghassan <afodafro@scs-net.org>; <phmsec@touchtelindia.net>; <martin@uwc.ac.za>; David McCoy <David.McCoy@lshtm.ac.uk>
Sent: Wednesday, October 29, 2003 9:17 PM
Subject: Re: Global Health Watch update

Dear All

PHM-UK | GHEW
WSF

RN
13/11/03

11/12/03

PHM Secretariat

From: Patricia Morton <patriciamorton@medact.org>
To: <iphc@cablenet.com.ni>; <olle.nordberg@dhf.uu.se>; <fran.baum@flinders.edu.au>; <lexi@gega.org.za>; <ant@hst.org.za>; <maria@iphcglobal.org>; <pbrave@itsa.ucsf.edu>; <mikerowson@medact.org>; <patriciamorton@medact.org>; <arutherford@oneworldaction.org>; <abaysema@pn3.vsnl.net.in>; Ghassan <afedafro@scs-net.org>; <phmsec@touchtelindia.net>; <jmartin@uwc.ac.za>; David McCoy <David.McCoy@lshtm.ac.uk>
Sent: Wednesday, October 29, 2003 9:17 PM
Attach: Global Health Watch Flyer.doc
Subject: Re: Global Health Watch update

Dear All

We have recently sent out a call for testimonies for the 'Voices of the Poor' part of the Global Health Watch. The following is an e-mail and attached is a flyer that have been sent out to various networks and organisations who are concerned with privatisation of health systems and utilities.

It would be appreciated if you could assist us with this endeavour by sending this information out to organisations/networks/individuals you think could contribute.

Much Appreciated
Patricia Morton

Dear Friends

Medact, together with the People's Health Movement and GEGA, is planning the publication of the Global Health Watch, a report providing a civil society view on the state of the world's health (see accompanying flyer).

In preparation for this report, Medact is calling for testimonies from civil society on the different issues covered by the report. We will launch this call in several waves: firstly, we are looking for testimonies on the effects of the marketization of:

1. Health care provision in the developing world. Issues we are particularly interested in are:
 the effects of privatisation and commercialisation on access to health care and the quality of health care. For example, has privatisation led health providers to see health care as a business rather than a public service? Has it resulted in an increase in user fees? Have profit-motives led to an increase in unethical practices such as using cheaper drugs that do not work?
 ways in which advocacy has improved access to health services (such as report cards for public services; participatory budgeting; and health consumer protection groups).

2. Water, sanitation and electricity services.
 What is the effect of privatisation on access to these services? How does reduced access to water, for example, affect the poor? What is the effect on cost and quality of these services?

RM 30/10/03 Sm

PHM, GHEW | WSF

RJ 31/10

10/25/03

The testimonies will feed into and support arguments put forward in the publication. They will also be organised thematically and geographically and available for public access on the web. Testimonies should be no more than 800 words in length.

We hope that the Global Health Watch will form a mechanism to express and amplify civil society's concerns about the increase in marketisation and commercialisation of key public services and goods. Join us in this venture by helping us collate the testimonies of the poor. Please e-mail Patricia Morton at patriciamorton@medact.org

With many thanks

Patricia Morton
For the Global Health Watch team

Dear Patricia (1)

Thanks for your note. We shall circulate it to PHM steering group, PHM Exchange and the PHM-India yahoo groups. I met Mike and Dave in London during my recent visit to London 22-24th Oct 2003 and heard about the forthcoming task that you are embarking on. I have suggested that you consider participating in the WSF in Mumbai since the Health Forum preceding it on 14-15th January will be giving opportunities for so many similar testimonies from all over the world. You will also meet many representatives the press
Voices of the unheard and can build from there
A separate communication about WSF and the International Health Forum follows

Best wishes
Ravi Narayan

10/25/03

Global Health Watch

Global civil society has not adequately participated in international health advocacy. Although high-profile success has been achieved with some campaigns, most notably around access to medicines and breastfeeding and certain diseases, there has been a striking lack of involvement and pressure from health campaigners on broader public health and health systems issues. In addition, disparities in health between the rich and the poor have grown at alarming rates both within and between countries, leaving society and the public health movement with a large humanitarian and moral challenge.

The increasingly global dimensions of poverty, disease and health policy require a much more vigorous input from public health experts, civil society and non-government organisations. The People's Health Movement, the Global Equity Gauge Alliance and Medact therefore propose to mobilise a fragmented global health community through the publication of an annual **Global Health Watch**. This publication will be used to shift the health policy agenda away from a technocratic approach to delivering health, to one that recognises the important political, social and economic barriers which prevent the achievement of better health.

We want the Watch to strengthen the calls for a broad approach to health amongst policy-makers, health professionals, campaigners, researchers and others concerned with health and to act as a reality-check on those formulating health policy by providing a forum which magnifies the voice of the poor and vulnerable and those who work with them.

The Watch will consist of a compilation of chapters on various global health issues written by NGOs and academics. Stories, experiences and analysis direct from poor communities will be threaded through the chapters and enable those who are traditionally unheard to voice their concerns on global health issues.

The Global Health Watch team is now looking both for authors to write chapters and for stories and experiences from around the world. For more information on the areas we are covering, go the Medact website www.medact.org

Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom
Tel: +44 20 7324 4733
Fax: +44 20 7324 4734
www.medact.org

October 2003

PHM Secretariat

From: Naveen <navthom@yahoo.co.uk>
To: PHM Secretariat (Global) <phmsec@touchtelindia.net>
Sent: Thursday, November 13, 2003 3:10 PM
Subject: [G & H] Global Health Equity Watch

Dear Ravi,

This is a mail sent out by Patricia Morton on the Globalisation and Health e-group. For your information.....

Best wishes
naveen

----- Original Message -----
From: Patricia Morton
To: globalizationandhealth@topica.com
Sent: Tuesday, November 11, 2003 5:14 PM
Subject: [G & H] Global Health Equity Watch

Dear Friends

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In preparation for this report, Medact is calling for testimonies from civil society on the different issues covered by the report. We will launch this call in several waves: firstly, we are looking for testimonies on the effects of the marketization of:

RM 14/11/03

1. Health care provision in the developing world. Issues we are particularly interested in are:

- the effects of privatisation and commercialisation on access to health care and the quality of health care. For example, has privatisation led health providers to see health care as a business rather than a public service? Has it resulted in an increase in user fees? Have profit motives led to an increase in unethical practices such as using cheaper drugs that do not work?
- ways in which advocacy has improved access to health services (such as report cards for public services; participatory budgeting; and health consumer protection groups).

2. Water, sanitation and electricity services

- What is the effect of privatisation on access to these services? How does reduced access to water, for example, affect the poor? What is the effect on cost and quality of these services?

The testimonies will feed into and support arguments put forward in the publication. They will also be organised thematically and geographically and available for public access on the web. Testimonies should be no more than 800 words in length.

We hope that the Global Health Watch will form a mechanism to express and amplify civil society's concerns about the increase in marketisation and commercialisation of key public services and goods. Join us in this venture by helping us collate the testimonies of the poor. Please e-mail Patricia Morton at patriciamorton@medact.org

RM 14/11/03

PHM. GHEW

WSF

11/14/03

With many thanks

Patricia Morton
Global Health Watch

Global Health Watch

Global civil society has not adequately participated in international health advocacy. Although high-profile success has been achieved with some campaigns, most notably around access to medicines and breastfeeding and certain diseases, there has been a striking lack of involvement and pressure from health campaigners on broader public health and health systems issues. In addition, disparities in health between the rich and the poor have grown at alarming rates both within and between countries, leaving society and the public health movement with a large humanitarian and moral challenge.

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We want the Watch to strengthen the calls for a broad approach to health amongst policy-makers, health professionals, campaigners, researchers and others concerned with health and to act as a reality-check on those formulating health policy by providing a forum which magnifies the voice of the poor and vulnerable and those who work with them.

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The Global Health Watch team is now looking both for authors to write chapters and for stories and experiences from around the world. For more information on the areas we are covering, go the Medact website www.medact.org

October, 2003

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment

Medact
United Kingdom
T. +44 (0) 20 7272 2020
F. +44 (0) 20 7281 5717
www.medact.org
Registered Charity 1061097
Company Reg. No. 2287126

March 2003: Medact's work on Iraq, including report on likely health and environmental consequences of conflict, available at www.medact.org

The Globalization and Health list is a discussion group, an information source, and to subscribe, send a blank message to: globalizationandhealth-subscribe@topica.com To send a message: globalizationandhealth-post-topica.com

PHM- Secretariat(Global)

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <mikerowson@medact.org>; <patriciamorton@medact.org>; <phmsec@touchtelindia.net>
Cc: <lexi@gega.org.za>; <ant@hst.org.za>
Sent: Saturday, November 22, 2003 7:08 PM
Subject: Re: PHA-Exchange> Global Health Watch

Dear Ravi
Thanks for this message. I hope the meeting in Iran goes well. I will not be able to attend the meeting due to work commitments here, but we have resolved that Patricia will represent the GHW secretariat and be able to report on progress and make useful links and contacts. I am not sure if Lexi is planning to go.

acco

In the meantime we are continuing with out fundraising efforts and identifying organisations and individuals to write chapters. More later

Best wishes
Dave

>>> "PHM Secretariat" <phmsec@touchtelindia.net> 11/11/2003 12:36:51 >>>
Dear Mike, Patricia, Dave,

Greetings from PHM Secretariat (Global)!

Further to my recent communication, this is to encourage once again all three of you to attend the International Health Forum, 14th - 15th January 2004 and the World Social Forum, 16th - 21st January 2004 (at least till 18th for health events in WSF), since they would be a great opportunity to listen to testimonies from a wide variety of civil society participants from
all over the world. You will notice that in the tentative programme (enclosed) that we have already begin to show testimonies in all the sessions.

RN 24/11/03

If you can raise some travel support and make it to Mumbai, then we will definitely be able to cover your local accommodation and meals etc. PHM is trying to raise travel grants, but for now most of the applications are focused on participants from developing countries / LDCs etc.

Dave may qualify, because of South African passport, but we may have a little more problems for UK based PHM delegates. Lets all try to explore alternative sources. Perhaps GEGA could support one travel and GHEW / MEDACT
project could support one travel and we could cover one.

PHM India has launched a Right to Health Care campaign and as part of this process, there are case studies and stories of denials of Right to Health Care being documented in many states.

Prem and Hari John of ACHAN (premjohn9141@hotmail.com and hariprem@eth.net) have also volunteered to support identification and facilitation of testimonies for the IHF / WSF health events.

RN 24/11/03 for PHM. GHEW

The events will also be an opportunity to brainstorm about GHEW and add a stronger collective planning dimension to the whole initiative. Do give it serious consideration and let me know your thoughts on this as soon as possible, so that we can include your names in the tentative participants list and get on with formalities such as registration in the events, etc,.

PHM - Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <ant@hst.org.za>; <czarowsky@idrac.ca>; <smhatre@idrc.ca>; <patriciamorton@medact.or>; <mikerowson@medact.org>; <phmsec@touchtelindia.net>
Sent: Friday, December 05, 2003 9:36 AM
Subject: Global Health Watch

Dear Christina and Sharmila,

It was good seeing you in Johannesburg. This e-mail is a follow-up on the GHW discussions, and I am copying to Antoinette (GEGA), Mike Rowson (Medact), Patricia Morton (Medact), Ravi Narayan (PHM) and Andy Rutherford (PHM).

First of all, we are really pleased that you are keen on supporting the Global Health Watch, pending agreement through the proper IDRC channels. This is going to be a really exciting development that will really challenge the current neoliberal and dsisease-focussed orthodoxy, and give a rigorous / academic voice to the progressive social movements through the lens of health and health equity.

Anyway, following the meeting we had in Johannesburg, I am writing to confirm that we will:

1. Provide you with more detail on the plans for each of the chapters we envisage having , as well as the authors and institutions we have approached to contribute to the document. We will also indicate where we would like some advice and suggestions from you (e.g. there may be places where IDRC-funded research could feed into the report - e.g. MIMAP and MSP).
2. Provide you with a detailed budget, especially for the next few months. As I mentioned the bulk of the budget in the proposal that we sent to you earlier is made up of printing and publication costs, and for coordination costs.
3. Let you know what the response has been from other funders.

In terms of your suggestion that IDRC may also be able to support the GHW through a co-publishing arrangement, would it be possible for you to provide us with a little more detail? What would be the implications of such an arrangement in terms of making the document available electronically for free; providing the document at cost to targeted audiences; copyright etc. We will probably need to discuss this option in a little more detail.

I hope you are both back home safe and well from your travels. .

Keep well!!

Dave
x

RN 8/12/03 for

PHM GHEW.

RN 8/12

RN 8/12

PHM - Secretariat

From: PHM - Secretariat <secretariat@phmovement.org>
To: Mike <mikerowson@medact.org>
Sent: Tuesday, December 09, 2003 12:03 PM
Subject: Re: [PHM_Steering_Group_02-03] PHM steering committee

Dear Mike,

Greetings from PHM Secretariat (Global)!

We managed charters from all sorts of sources and had a good stall at GFHR. More details in a separate communication. You and David McCoy have not yet confirmed your participation at the Mumbai Health Forum and WSF. We have even tentatively show you in the programme as facilitators of sessions. Do reply as soon as you can. We have registered Patricia and Lexi already.

Best wishes,

Ravi Narayan

----- Original Message -----
From: Mike
To: PHM-Secretariat(Global) ; pamzinkin
Cc: chetley.a@healthlink.org.uk ; uque@bluemail.ch ; marjan.stoffers@wemos.nl ; gksavar@citechco.net ; simb@comset.net ; cfischer@bukopharma.de ; woodwarddavid@hotmail.com ; sunil.deepak@aifo.it
Sent: Monday, December 01, 2003 1:06 AM
Subject: Re: [PHM_Steering_Group_02-03] PHM steering committee

I'm afraid we only have a handful at Medact
mike

PHM GHEW
IHF

RN
12/12/03

----- Original Message -----
From: pamzinkin
To: PHM-Secretariat(Global)
Cc: chetley.a@healthlink.org.uk ; uque@bluemail.ch ; marjan.stoffers@wemos.nl ; mikerowson@medact.org ; gksavar@citechco.net ; simb@comset.net ; cfischer@bukopharma.de ; woodwarddavid@hotmail.com ; sunil.deepak@aifo.it
Sent: Sunday, November 30, 2003 7:59 PM
Subject: Re: [PHM_Steering_Group_02-03] PHM steering committee

Dear Ravi
Have only just got your email message. Problems with computer, server. Marjan at Wemos was going to do distribution as I have no resources for this but I don't think she has many copies. Qasem was the source of the Charters. Medact and Healthlink may have a few. As I am only email sec. I have very few. David Woodward is the focal point.
The charters in other languages are available on the website of phm. The translators are not likely to have 50 hard copies or the means of sending them, certainly not by tomorrow. We really have to budget and plan these things as it will arise again.. (Agenda item in Mumbai).
I have some electronic versions of translations (there are 30 not 40) and I could forward these to either Allyson or Eugenio if the web site does not lend them. Can whoever has the means of printing the charters in other languages help?
Pam.

PHM- Secretariat(Global)

From: Mike <mikerowson@medact.org>
To: PHM-Secretariat(Global) <secretariat@phmovement.org>; pamzinkin <pamzinkin@gn.apc.org>
Cc: <chetley.a@healthlink.org.uk>; <uque@bluemail.ch>; <marjan.stoffers@wemos.nl>; <gksavar@citechco.net>; <simb@comset.net>; <cfischer@bukopharma.de>; <woodwarddavid@hotmail.com>; <sunil.deepak@aifo.it>
Sent: Monday, December 01, 2003 2:36 PM
Subject: Re: [PHM_Steering_Group_02-03] PHM steering committee

I'm afraid we only have a handful at Medact
mike

RN
8/12

----- Original Message -----
From: pamzinkin
To: PHM-Secretariat(Global)
Cc: chetley.a@healthlink.org.uk ; uque@bluemail.ch ; marjan.stoffers@wemos.nl ; mikerowson@medact.org ; gksavar@citechco.net ; simb@comset.net ; cfischer@bukopharma.de ; woodwarddavid@hotmail.com ; sunil.deepak@aifo.it
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RN
2/12/03

PHM - Steering Group

9/12/03

Dear Mike
We managed charters from all sorts of sources and had a separate sheet of GFIIR. More details in a separate communication. You and Dave Haccoy have not yet confirmed your participation at the Mumbai Health Forum and WSF. We have even Venkately show you in the programme as facilitators of sessions. Do reply as soon as you can. We have reprinted Petition and Letter already
Best wishes
Ravi

RN
9/12/03

RN
3/12/03.

PHM - Secretariat

From: Patricia Morton <patriciamorton@medact.org>
To: abay <abaysema@pn3.vsnl.net.in>; PHM-Ravi <phmsec@touchtelindia.net>; Rowson <mikerowson@medact.org>; McCoy <David.McCoy@lshtm.ac.uk>; HST <ant@hst.org.za>; Lynette Martin <LMARTIN@uwc.ac.za>
Sent: Monday, December 22, 2003 7:41 AM
Attach: Spending sheet for global health watch December 2003.xls
Subject: Budget for Global Health Watch

Dear All

Here is an account of funds recieved and spent (please ignore that in the GHW update).

Best Regards
Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment

Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom
T +44 (0) 20 7324 4739
F +44 (0) 20 7324 4734
www.medact.org
Registered Charity 1081097
Company Reg. No. 2267125

RN
23/12/03

PHM-Goa
UK

RN
23/12/03

Global Health Watch project

Activity	Activity cost (US$)
Patricia (project co-ordinator's) salary (Oct - December)	6200
Patricia's salary (Jan - March)	8900
Flight and expenses to World Social Forum	1700
Honoraria for authors	3500
Administrative overheads and support costs for Medact	3500
Honoraria for authors	4600
Administrative overheads and support costs for Medact	1600
	30000

Resources committed to

Donor	Amount (US$)
Wemos	6200
Exchange	17600
Wemos	6200
Total	**30000**

PHM - Secretariat

From: PHM - Secretariat <secretariat@phmovement.org>
To: Patricia Morton <patriciamorton@medact.org>
Sent: Tuesday, December 23, 2003 12:52 PM
Subject: Re: Global Health Watch Update

Dear Patricia,

Greetings from PHM Secretariat (Global)!

i. Thanks for the update on GHEW initiative. At the PHM Steering and Support group meeting on 13th January, there is a slot for the GHEW initiative, which we hope that you will present.

ii. Please note that more than half of your advisory committee - Fran, Maria, Olle, Lexi, Andy, David, possibly Andrew will be at Mumbai, 13th to 18th January, if not longer. So the opportunity cost of a detailed discussion must be explored. We are still hoping Dave and or Mike will change their minds and attend.

iii. we need to strengthen Southern and Asian participation in the Advisory Committee and IHF - WSF will be an excellent opportunity to identify Southern Authors as well.

iv. I was surprised to note that your communication for case studies was not mentioned in the update. Prem and I just recently put together a potential of 40 case studies / testimonies that may be part of the IHF programme. The tentative list is enclosed. Perhaps you could help prem coordiante the testimonies and later get permission from the testimony givers (those you think are relevant to GHEW) to give persmission to use them).

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat (Global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
I Block Jakkasandra, I Block Koramangala
Bangalore-560034
Tel: 00 91 80 51280009 (Direct)
Fax: 00 91 80 5525372
website: www.phmovement.org
Join the "Health for all, NOW" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

IHF-WSF
DK (GHEW)

RN
29/12

----- Original Message -----
From: Patricia Morton
To: Lynette Martin ; Chetley ; McCoy ; PHM-Ravi ; abay ; Rutherford ; Rowson ; Braveman ; IPHC ; HST ; Bambas ; Baum ; Nordberg
Sent: Monday, December 22, 2003 7:34 AM
Subject: Global Health Watch Update

Dear All

Here is an update of the progress of the Global Health Watch. We welcome your comment on the various

12/23/03

PHM - Secretariat

From: Patricia Morton <patriciamorton@medact.org>
To: Lynette Martin <LMARTIN@uwc.ac.za>; Chetley <chetley.a@healthlink.org.uk>; McCoy <David.McCoy@lshtm.ac.uk>; PHM-Ravi <phmsec@touchtelindia.net>; abay <abaysema@pn3.vsnl.net.in>; Rutherford <arutherford@oneworldaction.org>; Rowson <mikerowson@medact.org>; Braveman <pbrave@itsa.ucsf.edu>; IPHC <maria@iphcglobal.org>; HST <ant@hst.org.za>; Bambas <lexi@gega.org.za>; Baum <fran.baum@flinders.edu.au>; Nordberg <olle.nordberg@dhf.uu.se>
Sent: Monday, December 22, 2003 7:34 AM
Attach: Global Health Watch Update1 (1).doc
Subject: Global Health Watch Update

Dear All

Here is an update of the progress of the Global Health Watch. We welcome your comment on the various activities.

Season's Greetings and Best Wishes for the New Year

Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment

Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom
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www.medact.org
Registered Charity 1081097
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RN 23/12/03

RN 23/12/03 fa

PHM-GHWA

23/12/03

Dear Patricia
(i) Thanks for the update on GHEW initiative. At the PHM steering and support group meeting on 13th Jan there is a slot for the GHEW initiative, which we hope that you will present.
(ii) Please note that more than half of your advisory committee - Fran, Maria, Olle, Lexi, Andy, David, possibly Andrew will be at Mumbai 13-18th Jan if not longer. So the opportunity cost of a detailed discussion must be explored. We extend still hopes Dave and/or Mike will change their mind and attend.
(iii) We need to strengthen the more Southern and Asian participation in the Advisory committee and IHF WSF will be an excellent opportunity to identify Southern Authors as well as for case studies
(iv) I was surprised to note that your communication was not mentioned in the update. Prem and I just recently put together a potential of 40 case studies/Testimonies that may be part of the IHF programme. The tentative list is enclosed. Perhaps you could help Prem coordinate the testimonies and later get permission from the testimony givers (those you think are relevant to GHEW) to give permission to use the...

Best wishes
Ravi

12/23/03

Global Health Watch Update

Chapter briefs and authors

Attached is a table giving a full update on progress with the development of chapter briefs and the commissioning of authors. Highlights include:

- Survival International have agreed to take the lead on a chapter on indigenous people's health
- The Municipal Services Project have tentatively agreed to take a lead on the water chapter. There has also been interest shown by Water Aid.
- Mickey Chopra from University of Western Cape is discussing the nutrition chapter with Phillip McMichael (Cornell University) and Tim Lang about the nutrition chapter
- Public Services International have been approached to write for the chapter on privatisation of health services. In terms of chapters, there has been a decision to include a chapter related to disabled people and to mainstream gender through the report.

We are still looking for advice and recommendations on other authors – especially people who are from the South.

Funding

Funding provided and received:

- HealthLink (UK) - £10,000
- WEMOS - £10,000
- GEGA - £3,000

Dag Hammarskjold - has promised us some in-kind support.

IDRC have given a verbal undertaking to fund GHW

Soros Foundation – recent phone conversation indicates a genuine interest. They want more detail on our post-publication advocacy strategy.

Other organisations are yet to get back to us.

Thus far, funds have been allocated to support the secretariat and the part-employment of Patricia Morton.

Publication

Zed Books has proposed a very affordable publishing deal. IDRC have also proposed a joint publication proposal. Both offers are being investigated.

Advocacy

In light of the enthusiasm for the Global Health Watch, we are proposing the idea of launching the initiative at the International Health Forum in Mumbai in January. Apart from creating anticipation and demand for the report, we are hoping to recruit southern based authors or at least tap into networks of southern based CSOs and potential authors. Patricia Morton will be present at that

meeting, but we need to know who else will be able to support her with the launch of the report.
please respond to this item

We are currently in the process of putting together an advocacy plan which will include activities to create demand for the report as well as how we will use the report to influence global health policy. Informal discussions with certain allies in WHO suggest that the report could be used to strengthen the hand of progressive elements within WHO. There is a tentative plan to meet with Tim Evans in January (this will be brokered by Jeanette Vega).

There is a proposal to hold a meeting with other NGOs in June at the time of the GEGA meeting to discuss potential advocacy opportunities.

Timeframes

We are setting the date for the final draft of the report at June 30 and we plan to launch the report in October.

Project management

The organisational management of GHW is as such: Dave and Mike are providing day to day coordination and leadership, with the support of Patricia who is working almost full-time on this. There is a steering committee consisting of representation from the three organisations. There is also a broader advisory group consisting of the following people: Fran Baum (PHM); Maria Zuniga (IPHC/PHM); Paula Braveman (GEGA); Ollie Nordberg (DAG); Andy Chetley (Healthlink/Exchange); Lexi Bambas (GEGA); Antionette Ntuli (HST/ GEGA); David Sanders (PHM); Andy Rutherford (One World Action); Marjan Stoffers (Wemos); Paula Braveman (GEGA).

An e-mail discussion list will be set up for the advisory group to ease communication.

Each chapter will have a reference / advisory group set up.

We are proposing a steering committee meeting in February with representatives from Medact, Gega, PHM and possibly also some of you from the advisory group. There may be some travel money available for this. ***Please respond***

Secretariat

From: "PHM - Secretariat" <secretariat@phmovement.org>
To: "Mike" <mikerowson@medact.org>; <patriciamorton@medact.org>; "David McCoy" <david.mccoy@lshtm.ac.uk>
Sent: Thursday, January 08, 2004 13:38
Subject: Re: Budget for Global Health Watch

Dear Mike, Patricia, Dave and friends.

Greetings from PHM Secretariat (Global)!

Could you send a summary of GHEW proposal for the Steering group meeting? We lost all the earlier versions in a hard disck crash on New Year. Patricia can update the group on the latest situation at the time it features on the PHM agenda on 13th January.

A range of 40 testimonies have been facilitated. So GHEW will have good inputs in this area.

Best wishes,

Ravi Narayan
----- Original Message -----
From: "Mike" <mikerowson@medact.org>
To: "Antoinette Ntuli" <ant@healthlink.org.za>; "abay" <abaysema@pn3.vsnl.net.in>; "PHM-Ravi" <phmsec@touchtelindia.net>; "McCoy" <David.McCoy@lshtm.ac.uk>; "HST" <ant@hst.org.za>; "Lynette Martin" <LMARTIN@uwc.ac.za>; "Patricia Morton" <patriciamorton@medact.org>
Sent: Thursday, January 08, 2004 00:04
Subject: Re: Budget for Global Health Watch

> Apologies - my mistake - the money did not come through Medact so wasn't reflected in the original statement. It is now (see attached).
>
> Best wishes
> Mike
> ----- Original Message -----
> From: "Antoinette Ntuli" <ant@healthlink.org.za>
> To: "abay" <abaysema@pn3.vsnl.net.in>; "PHM-Ravi" <phmsec@touchtelindia.net>; "Rowson" <mikerowson@medact.org>; "McCoy" <David.McCoy@lshtm.ac.uk>; "HST" <ant@hst.org.za>; "Lynette Martin" <LMARTIN@uwc.ac.za>; "Patricia Morton" <patriciamorton@medact.org>
> Sent: Monday, January 05, 2004 11:20 AM
> Subject: Re: Budget for Global Health Watch
>
>
> > Dear Patricia,
> > I believe that GEGA Contributed funds in the initial stage of

Secretariat

From: "Mike" <mikerowson@medact.org>
To: "Antoinette Ntuli" <ant@healthlink.org.za>; "abay" <abayserna@pn3.vsnl.net.in>; "PHM-Ravi" <phmsec@touchtelindia.net>; "McCoy" <David.McCoy@lshtm.ac.uk>; "HST" <ant@hst.org.za>; "Lynette Martin" <LMARTIN@uwc.ac.za>; "Patricia Morton" <patriciamorton@medact.org>
Sent: Thursday, January 08, 2004 00:04
Attach: Spending sheet for global health watch December 2003.xls
Subject: Re: Budget for Global Health Watch

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Best wishes
Mike

----- Original Message -----
From: "Antoinette Ntuli" <ant@healthlink.org.za>
To: "abay" <abayserna@pn3.vsnl.net.in>; "PHM-Ravi" <phmsec@touchtelindia.net>; "Rowson" <mikerowson@medact.org>; "McCoy" <David.McCoy@lshtm.ac.uk>; "HST" <ant@hst.org.za>; "Lynette Martin" <LMARTIN@uwc.ac.za>; "Patricia Morton" <patriciamorton@medact.org>
Sent: Monday, January 05, 2004 11:20 AM
Subject: Re: Budget for Global Health Watch

> Dear Patricia,
> I believe that GEGA Contributed funds in the initial stage of conceptualising the Global Health Watch. These are not reflected in the statement you attached. Please could you amend the statement to reflect GEGA's contribution.
> Many thanks
> Antoinette
>
> On 22 Dec 2003, at 15:41, Patricia Morton wrote:
>
> > Dear All
> >
> > Here is an account of funds recieved and spent (please ignore that in the GHW update).
> >
> > Best Regards
> > Patricia Morton
> > Global Health Watch
> >
> > Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment
> >
> > Medact
> > The Grayston Centre
> > 28 Charles Square

8/1/04

Dear Mike, Patricia, Dave + friends

Could you send a Summary of GHEW proposal ~~adaptation~~ for the Steering group meeting. We lost all the earlier versions in a hard disc crash on New Year. Patricia can update the group on the latest situation at the time & features on the PHM agenda on 13th Jan.

A range of new testimonies have been facilitated so GHEW will have good update on this area

Best wishes
Ravi.

Resources committed to Global Health Watch project

Donor	Amount (US$)	Activity	Activity cost (US$)
Wemos	6200	Patricia (project co-ordinator's) salary (Oct - December)	6200
Exchange	17600	Patricia's salary (Jan - March)	8900
		Flight and expenses to World Social Forum	1700
		Honoraria for authors	3500
		Administrative overheads and support costs for Medact	3500
Wemos	6200	Honoraria for authors	4600
		Administrative overheads and support costs for Medact	1600
GEGA	5000	Fee for initial concept development. Paid directly from GEGA to Dave McCoy	5000
Total	**35000**		**35000**

Secretariat

From: "PHM - Secretariat" <secretariat@phmovement.org>
To: "Mike Rowson" <mikerowson@medact.org>
Cc: "David McCoy" <david.mccoy@lshtm.ac.uk>; "Patricia Morton" <patriciamorton@medact.org>; "Antoinette Ntuli" <ant@healthlink.org.za>; "David Sanders" <LMARTIN@uwc.ac.za>; "Ravi Narayan" <phmsec@touchtelindia.net>; "Abhay Shukla" <abaysema@pn3.vsnl.net.in>
Sent: 21 January 2004 14:56
Subject: Re: Global Health Watch Steering Group Meeting

Dear Dave

Greetings from PHM Secretariat (Global)!

I am just recovering from a very exhausting but exciting four weeks - the build up to IHF / WSF and the whole event as well. As mentioned at the steering group meeting, we had sessions on 12th, 13th, 16th, 17th, 18th as well. I am suspending travel for the next few months for health reasons and other commitments and also to widen the opportunity and involvement of steering and other PHM members to such events and initiatives. I hope David and Abhay can participate. So PHM is represented in London. Keep Pam and Andy involved. I am sure Qlle will join. If you need more South / Asian representation, we can explore possibilities but count me out. 2004 ending with IHF - WSF has proved to be too much. I shall send you comments on Chapters etc as soon as I recover and complete a host of pending commitments. Patricia will report on all that took place in Mumbai. There were plenty of strong testimonies and lots and lots of contact.

Best wishes

Ravi Narayan

----- Original Message -----
From: Mike Rowson
To: Antoinette Ntuli ; David Sanders ; Ravi Narayan ; Abhay Shukla
Cc: David McCoy ; Patricia Morton
Sent: Monday, January 19, 2004 4:06 PM
Subject: Global Health Watch Steering Group Meeting

Dear Friends

As you will have seen from previous e-mails we are progressing well with the Global Health Watch. We are almost at the critical stage of commissioning materials and planning advocacy, and we now need a meeting of the steering group organisations to do some steering!

We would like to plan a meeting for the second week in March - i.e. sometime between 8th and 12th March. The meeting should last two full days and will be held here in London. We will discuss both content matters and plan an advocacy strategy during that time. Gega has very kindly offered to put the money up front for travel to this meeting, although hopefully outside funders will be able to cover these costs eventually.

We will also invite some other participants (including funders and supporting NGOs) to contribute at certain points in the meeting.

Please let me know at your earliest convenience if these dates are possible. If not, please let me know if there are any other times in March that would be possible for you.

With very best wishes
Mike

Secretariat

From: "Mike Rowson" <mikerowson@medact.org>
To: "Antoinette Nuall" <ant@healthlink.org.za>; "David Sanders" <LMARTIN@uwc.ac.za>; "Ravi Narayan" <phmsec@itouchtelindia.net>; "Abhay Shukla" <abaysema@pn3.vsnl.net.in>
Cc: "David McCoy" <david.mccoy@lshtm.ac.uk>; "Patricia Morton" <patricia.morton@medact.org>
Sent: 19 January 2004 18:06
Subject: Global Health Watch Steering Group Meeting

Dear Friends

As you will have seen from previous e-mails we are progressing well with the Global Health Watch. We are almost at the critical stage of commissioning materials and planning advocacy, and we now need a meeting of the steering group organisations to do some steering!

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With very best wishes
Mike

Mike Rowson
Executive Director
Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom
T: +44 (0)20 7324 4735 (direct)
T: +44 (0)20 7324 4739 (main)
F: +44 (0)20 7324 4734
Mb: +44 (0)7703 214469
www.medact.org

PHM - GHEW

21/1/04

Dear Dave

I am just recovering from a very exhausting but exciting four weeks - the build up to IHF-WSF and the whole event as well. As mentioned at the steering group meeting - we had sessions on 12, 13, 16, 17, 18th as well. I am suspending travel for the next few months for health reasons and other commitments and also to widen the opportunity and involvement of steering and other PHM members

RN
21/1/04

has proved to be too much. I shall send you comments on chapters etc as soon as I recover and complete a host of pending commitments. Patricia will separately all that took place in Mumbai - There were plenty of sessions and testimonies and lots and lots of conked beer

To such events and initiatives I hope Dave and Abhay can perhaps be so PHM is represented. In London keep Ravi and Andy involved. I am sure Ollie will join. If you need more South/Asian representation we can explore possibilities but count me out 2004 ends with IHF WSF

Secretariat

From: "David McCoy" <David.McCoy@lshtm.ac.uk>
To: <ann@healthlink.org.za>; <mikerowson@medact.org>; <abayserma@on5.vsnl.net.in>; <phmeeo@louchielincia.net>; <LMARTIN@uwc.ac.za>
Cc: <patriciamorton@medact.org>
Sent: 20 January 2004 02:21
Subject: Re: Global Health Watch Steering Group Meeting

Thanks Mike

I would like perhaps to add that we must have this meeting in march if we are to meet deadlines and expectations. Therefore if anyone can't make the meeting they could perhaps nominate someone in their place.

As Mike mentioned we hope to invite some external people along as well. These include:
Ollie Nordberg - because Dag Hammarskjold want to support GHW
Christine Zerowsky - because we want IDRC to support GHW and have had some positive interest expressed by her.
Wemos - because they have put in some money
Healthlink International - because they are going to put in some money

We are also going to approach the big development and health NGOs in the UK to support and fund:
- SCF (verbal agreement to put in £5000)
- Oxfam
- Christian Aid
- World development Movement
- Action Aid

Finally I think that we need to have some latin american, middle east and far east representation. Perhaps not for this meeting, but we need your help and advice on who to approach.

dave

PHM GMEW

RJ
21/1/04

Secretariat

From: "David McCoy" <David.McCoy@lshtm.ac.uk>
To: <ant@healthlink.org.za>; <mikerowson@medact.org>; <abaysema@pn3.vsnl.net.in>; <phmsec@touchtelindia.net>; <LMARTIN@uwc.ac.za>
Cc: <patriciamorton@medact.org>
Sent: 20 January 2004 02:21
Subject: Re: Global Health Watch Steering Group Meeting

Thanks Mike

I would like perhaps to add that we must have this meeting in march if we are to meet deadlines and expectations. Therefore if anyone can't make the meeting they could perhaps nominate someone in their place.

As Mike mentioned we hope to invite some external people along as well. These include:
Olle Norberg - because Dag Hammarskjold want to support GHW
Christina Zarowsky - because we want TDRC to support GHW and have had some positive interest expressed by her.
Wemos - because they have put in some money
Healthlink International - because they are going to put in some money

We are also going to approach the big development and health NGOs in the UK to support and fund:
- SCF (verbal agreement to put in £6000)
- Oxfam
- Christian Aid
- World development Movement
- Action Aid

Finally I think that we need to have some latin american, middle east and far east representation. Perhaps not for this meeting, but we need your help and advice on who to approach.

PHM-GHEW

RN 2011

dave

Secretariat

From: "Mike Rowson" <mikerowson@medact.org>
To: "PHM - Secretariat" <secretariat@phmovement.org>
Cc: "David McCoy" <david.mccoy@lshtm.ac.uk>; "Patricia Morton" <patriciamorton@medact.org>; "Antoinette Ntuli" <ant@healthlink.org.za>; "David Sanders" <LMARTIN@uwc.ac.za>; "Ravi Narayan" <phmsec@touchtelindia.net>; "Abhay Shukla" <abayseme@pn3.vsnl.net.in>
Sent: 21 January 2004 16:33
Subject: Re: Global Health Watch Steering Group Meeting

Dear Ravi

Sorry to hear that you are not well - give yourself plenty of time to recover. We'll miss having you over, but we'll keep you in close touch by e-mail. Glad to hear that WSF has gone well.
mike

Best wishes

Mike

----- Original Message -----
From: PHM - Secretariat
To: Mike Rowson
Cc: David McCoy ; Patricia Morton ; Antoinette Ntuli ; David Sanders ; Ravi Narayan ; Abhay Shukla
Sent: Wednesday, January 21, 2004 9:28 AM
Subject: Re: Global Health Watch Steering Group Meeting

Dear Dave

Greetings from PHM Secretariat (Global)!

I am just recovering from a very enhausting but exciting four weeks - the build up to IHF / WSF and the whole event as well. As mentioned at the steering group meeting, we had sessions on 12th, 13th, 16th, 17th, 18th as well. I am suspending travel for the next few months for health reasons and other commitments and also to widen the opportunity and involvement of steering and other PHM members to such events and initiatives. I hope David and Abhay can participate. So PHM is represented. In London, keep Pam and Andy involved. I am sure Cile will join. If you need more South / Asian representation, we can explore possibilities but count me out. 2004 ending with IHF - WSF has proved to be too much. I shall send you comments on Chapters etc as soon as I recover and complete a host of pending commitments. Patricia will report on all that took place in Mumbai. There were plenty of strong testimonies and lots and lots of contact.

Best wishes

Ravi Narayan

----- Original Message -----
From: Mike Rowson
To: Antoinette Ntuli ; David Sanders ; Ravi Narayan ; Abhay Shukla
Cc: David McCoy ; Patricia Morton
Sent: Monday, January 19, 2004 4:06 PM
Subject: Global Health Watch Steering Group Meeting

PHM - GHEW

Dear Friends

RN
22/1/2004

Secretariat

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <mikerowson@medact.org>; <secretariat@phmovement.org>
Cc: <ent@healthlink.org.za>; <patriciamorton@medact.org>; <abaysema@pn3.vsnl.net.in>; <phmisec@touchtelindia.net>; <LMARTIN@uwc.ac.za>
Sent: 21 January 2004 16:20
Subject: Re: Global Health Watch Steering Group Meeting

Dear Ravi
Thanks for the e-mail and I hope you enjoy a well deserved list. We look forward to your feedback re: authors and chapters list. Please let have some names of people we can approach. As Mike says, we will keep you in touch. It's essential that the PHM are centrally involved in the production and dissemination of the report.

June this year in South Africa, there are another series of meetings being held. The International Society for Equity and Health and the International Association of Public Health Association are having back to back meetings, in addition to Eqiunet and GEGA meetings. GEGA are hoping to use at least one of the days over that period for GHW. I hope you'll be rested by then and available to join us for that.

Best wishes
Dave

>>> "PHM - Secretariat" <secretariat@phmovement.org> 01/21/04 9:28 AM >>>

Dear Dave,

Greetings from PHM Secretariat (Global)!

I am just recovering from a very exhausting but exciting four weeks - the build up to IHF - WSF and the whole event as well. As mentioned at the steering group meeting, we had sessions on 12th, 13th, 16th, 17th, 18th as well. I am suspending travel for the next few months for health reasons and other commitments and also to widen the opportunity and involvement of steering and other PHM members to such events and initiatives. I hope David and Abhay can participate. So PHM is represented. In Lonon, keep Pam and Andy involved. I am sure Olle will join. If you need more South / Asian representation, we can explore possibilities but count me out. 2004 ending with IHF - WSF has proved to be too much. I shall send you comments on Chapters etc as soon as I recover and complete a host of pending commitments. Patricia will report on all that took place in Mumbai. There were plenty of strong testimonies and lots and lots of contact.

Best wishes

RM
22/1/04

PHM - GHW

21/01/2004

Secretariat

From: "Abhay Seema" <abhayseema@vsnl.com>
To: "Antoinette Ntuli" <ant@healthlink.org.za>; "David Sanders" <DMARTIN@uwc.ac.za>; "Mike Rowson" <mikerowson@medact.org>
Cc: "Ravi Narayan PHM Sec" <phmsec@touchtelindia.net>; "Patricia Morton" <patriciamorton@medact.org>; "Dave Work" <Dave.McCoy@haringey.nhs.uk>; "David McCoy" <david.mccoy@lshtm.ac.uk>
Sent: 27 January 2004 23:38
Subject: Re: Global Health Watch steering group

Dear Mike,
I can make it only by 12th March, since I have a prior committment here, fixed long back, on the 10th of March. In general, I am quite involved in the Right to Health Care campaign emerging here, so I may not be able to give much time for GHW in the coming months. As another option, I would like to know if it will be appropriate if instead of me, one of my colleagues from among the national organisers of PHM-India attends the meeting. It would be someone who has knowledge and interest in global health issues, and would be willing to contribute on an ongoing basis to the GHW as a member of the advisory committee. Do let me know if I should explore this option, otherwise I can try to make it on or after 12th March. I have discussed this briefly with Ravi Narayan, and I think it will be good to keep him in the discussion loop.
With regards,
Abhay

RN
28/1/04

----- Original Message -----
From: Mike Rowson
To: David Sanders ; Abhay Shukla
Cc: Antoinette Ntuli ; David McCoy ; Dave Work ; Patricia Morton
Sent: Monday, January 26, 2004 7:16 PM
Subject: Global Health Watch steering group

Dear David and Abhay

Could you please confirm whether you will be able to attend? Antoinette can make the second week of March, but Ravi has given up travelling for the moment, so it would be very helpful Abhay if you could come with your PHM hat on.

Thanks

Mike

>>>>

Dear Friends

As you will have seen from previous e-mails we are progressing well with the Global Health Watch. We are almost at the critical stage of commissioning materials and planning advocacy, and we now need a meeting of the steering group organisations to do some steering!

We would like to plan a meeting for the second week in March - i.e. sometime between 8th and 12th

RM
28/1/04 for

PHM - ~~GHW~~ GHEW

March. The meeting should last two full days and will be held here in London. We will discuss both content matters and plan an advocacy strategy during that time. Oega has very kindly offered to put the money up front for travel to this meeting, although hopefully outside funders will be able to cover these costs eventually.

We will also invite some other participants (including funders and supporting NGOs) to contribute at certain points in the meeting.

Please let me know at your earliest convenience if these dates are possible. If not, please let me know if there are any other times in March that would be possible for you

With very best wishes
Mike

Mike Rowson
Executive Director
Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom
T: +44 (0)20 7324 4735 (direct)
T: +44 (0)20 7324 4735 (main)
F: +44 (0)20 7324 4734
Mb: +44 (0)7703 214469
www.medact.org

Main Identity

From: Patricia Morton <patriciamorton@medact.org>
To: <ghw@hst.org.za>
Sent: Friday, January 30, 2004 4:56 PM
Attach: Concept document-Oct 2003.doc
Subject: [ghw] Concept Document

Dear All

As requested by many of you whilst in Bombay, here is the latest version of the concept document. Please note that the chapter headings keep changing. I will send out a list of them and proposed authors for each, for your comment, very soon.

Best Regards
Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment.

Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom
T: +44 (0) 20 7324 4739
F: +44 (0) 20 7324 4734
www.medact.org
Registered Charity 1081087
Company Reg. No. 2287125

RN
13/2/04 fax

Pharm. Grégoire

SSP DGS pls do the needful
Please mark to Steering Group and Amit/Pbhoj/Thelma in JSA at this stage
RN
13/2/04

213 04

People's Health Movement

Medact

Global Health Watch

Introduction

Global civil society does not participate strongly and consistently in international health advocacy. Whilst high-profile success has recently been achieved with the campaigns on access to medicines and the past twenty years have seen positive achievements due to pressure from civil society (for example, on breastfeeding and smoking), there is a striking lack of involvement and pressure from health campaigners on broad health and health systems issues. Where such pressures exist, they are inadequately drawn upon by the institutions of global health governance – notably the World Health Organisation – whose legitimacy and accountability to the world's population would be enhanced by more vigorous engagement with civil society.

A fragmented, disease- and issue-specific approach to health dominates research, advocacy and governance agendas. Calls on policy-makers to address fundamental causes of ill-health and failing health systems are weak and uncoordinated: a dangerous situation in a world where these issues need to be addressed more than ever. In addition, the growing disparities in health care consumption between the rich and the poor have grown alarmingly within and between countries, leaving society and the public health movement with a major ethical and moral challenge.

In response to this, the People's Health Movement, the Global Equity Gauge Alliance and Medact – each with excellent technical expertise in research and advocacy – propose to mobilise a fragmented global health community around values which stress the need to tackle the fundamental causes of ill-health and inequity in our societies. The vehicle for this advocacy is the publication of an annual **Global Health Watch** which will combine outstanding research and policy analysis with a commitment to bringing the views of poor and vulnerable groups to the attention of international and national policy makers.

The Global Health Watch will be used to shift the health policy agenda away from a technocratic approach to delivering health, to one that recognises the important political, social and economic barriers which prevent the achievement of better health. We want the Watch to be a tool which:

- Legitimises and strengthens the calls for a broad approach to health amongst policy-makers, health professionals, campaigners, researchers and others concerned with health;

- Can be used by advocates to strengthen their existing work whilst drawing them into broader debates about international health and in the process creating a more vibrant global civil society in health;

- Acts as a reality-check for those formulating health policy by providing a forum which magnifies the voice of the poor and vulnerable and those who work with them.

The rationale, values and contents of the Watch are sketched below.

Background

Every day 30,000 children die of preventable causes. The HIV/AIDS epidemic continues to escalate, with the situation in sub-Saharan Africa already tragic, and large parts of Asia about to follow suit. Worldwide, poverty remains the most important underlying cause of morbidity and premature death. Over a billion people, mostly women and children, live on less than US$1 a day, and this number has grown over the past twenty years.

Perversely, growing poverty exists with growing wealth. The world's 25 richest people now have incomes and assets worth US$474 billion – more than the entire GNP of Sub-Saharan Africa. In both developing and developed countries we have witnessed increasing inequalities in income over the past two decades, coupled with the persistence of other types of disparity and social division such as gender and ethnic inequalities.

The failure of the global community to achieve "Health for All by the Year 2000" is the result of this situation. New targets – such as the Millennium Development Goals – have come to the fore more recently. However, whilst overseas development assistance declines, and the trade and investment environment becomes even more unfriendly to poor countries, there is a great danger that these objectives too will not be met, increasing cynicism and discontent in the world.

The global health institutions of the UN system have become increasingly weak. The influence of the World Health Organisation has declined in a global policy arena which is now dominated by the World Bank, International Monetary Fund and World Trade Organisation. As a result, international health policy is dominated by a market-led development paradigm which is leading to fragmentation of health systems, privatisation and a gross lack of emphasis on the underlying causes of ill-health.

To counter these trends, the People's Health Movement, Medact and the Global Equity Gauge Alliance, have proposed the development of an annual global health report to be known as the Global Health Equity Watch. The following section describes its objectives and values.

Objectives and values of the Global Health Watch

- We want to invigorate the international health policy agenda by capturing the perspectives and spirit of civil society, and bringing in the 'voices of the unheard'. We aim to re-connect global civil society with the institutions of global health governance and offer a contrast to the technocratic and dry nature of many other assessments of the global health situation.

- We will promote human rights as the basis for health policy, as a corrective to the market-led policy agenda which tends to fragment and exclude.

- We will place health and health inequities within a broader political economy perspective. There is a tendency for global health problems to be described in isolation from the unfairness of the global political economy. The Watch will promote the idea that the political economy of health should be a central public health priority of all health workers.

- We will place health and health inequities within a multi-sectoral perspective. The Watch will explicitly link health to other sectors such as the environment, international finance, agriculture and food security, war, housing, land rights, conflict and education.

- We will link research and analysis to advocacy. The Watch will provide recommendations and encourage advocacy actions that will help ensure that real change in favour of justice and redistribution takes place and that governments and international institutions are held more accountable to those who are marginalised and impoverished.

Structure and Lay-Out of the Report

The Global Health Watch aims to promote substantial participation of civil society (and others concerned with international health) within the constraints of producing a coherent and well written report.

The intention is for the Global Health Watch to consist of a compilation of chapters (some with discrete with sub-sections) on various global health issues, supplemented with testimonies from the ground and the voices of people who are traditionally unheard. The idea is not to commission new research. Many NGOs and academics have done the research and analysis: the Global Health Watch will provide a platform for the further dissemination and popularisation of this work.

Chapters will be written by different authors, and a special effort will be made for the authors to be representative of all regions of the world. Each chapter would also have designated reviewers. The approximate size of the report will be 100,000 words. The suggested structure and chapter headings of the report are shown below. It is envisaged that the precise scope and size of the report will change slightly from year to year.

Structure and Chapter Headings of the Global Health Watch

Foreword by eminent global personality

Introduction by the co-ordinating organisations

Section A: Introduction to Global Health Inequities
A1: Introduction

Section B: The Political Economy of Health and Health Programs
B1: Politics and economics of poverty and inequity- a global public health priority
B2: Health policy: the privatisation agenda (including JPPIs)
B3: The global brain drain of health personnel
B4: Big Pharma and the Future of Accessible Medicines
B5: Responding to treatment access and beyond

Section C: Beyond The Health Sector
C1: Nutrition and the right to food
C2: Water and Sanitation
C3: Violent conflict
C4: Environment
C5: Education
C6: Disabilities
C7: Indigenous People

Section D: Monitoring And Advocacy Section
This section will consist of a number of sub-sections which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and inform the advocacy of a global progressive health movement committed to a just world and health for all. There would be a number of sections, that may include:

- Trends in financial flows to developing countries
- Trends in health and key health-related expenditures in low-income countries
- Assessment of actions of
  - WHO and other international health agencies
  - World Trade Organisation
  - International Monetary Fund and World Bank
  - Private Sector (e.g. pharmaceutical industry

Note: Gender issues will be mainstreamed through the report.

Management

The production of the report will be managed and coordinated by the People's Health Movement, the Global Equity Gauge Alliance and Medact, with Medact acting as the secretariat. An editorial committee will be established to help shape and review each chapter and make sure that they are adequately reflective of the 'voices of the unheard' from different parts of the world.

Advocacy Strategy

To achieve its greatest impact, the co-ordinating organisations are proposing an advocacy strategy with three primary goals:

- To increase the accountability and responsiveness of the World Health Organisation (WHO) and other global health institutions to the opinions and ideas of global civil society;
- To legitimise and strengthen our core message: that equity, the centrality of effective and inclusive public health systems and broad public health issues need greater recognition in the health policy arena at both the global and national level
- To encourage greater involvement of CSOs in the determination of international health policy, with a particular emphasis on strengthening representation of the poor

The activities planned to realise these goals are as follows and combine a mixture of activities at national and global level.

The process of producing the Watch will in itself be a part of the advocacy strategy. We aim to involve a diverse range of NGOs, CSOs and individuals from both developed and developing world in the writing the report (emphasising the fact that health is a broad cross-cutting issue). The Watch will also be 'pre-launched' at the World Social Forum in Mumbai in January 2004, and it will be further promoted to attract attention and involvement before the report is published. A notice about the report has already been published on many different listserves, websites and e-lists. Post-publication, we will encourage CSOs to use the Watch to strengthen their own positions in the particular areas of health and development that they work in.

Simultaneous launch of the Watch in as many countries as possible. We will be asking local NGOs, CSOs, academics and others to help organise a simultaneous launch of the published report in as many countries as possible. Both GEGA and the Peoples Health Movement are already networks of country-based individuals and organizations that are capable of covering a large number of countries. The aim will be to get strong media coverage, putting pressure on WHO and other global health and development institutions to respond to the report. The precise timing of the launch of the report has not been finalised, but it may be linked to a particular event, possibly around the time of the publication of WHO's World Health Report.

Campaign around central recommendations. Apart from encouraging advccacy around the recommendations made in specific chapters of the Watch, the co-ordinating organisations will also develop a campaign around a number of cross-cutting recommendations related to the goals above and recurring themes. The campaign will aim to exert influence on WHO and other global health institutions through national governments and a broad coalition of CSOs. Organisations at the national level will be encouraged to take the report to representatives of their national governments.

Dialogue with decision makers. It is hoped that the Watch will be used as the basis for CSOs and NGOs to initiate and stimulate dialogue and discussion with international and country-level decision-makers whenever they have the opportunity. For this reason, an underlying strategy will be to seek formal and explicit endorsement of the report or specific chapters from as many individuals and NGOs as possible so that there will be a broad sense of ownership of the report.

Promotion and distribution. In collaboration with a leading publisher with good distribution networks in the developing world (Zed Books), we will subsidise the publication of the Watch in poorer countries at a cheaper price. The Watch will also be available for free on the World Wide Web.

Reaching different language groups will be a challenge, and we are planning to develop shortened versions of the report in languages other than English for dissemination to grassroots organisations and other civil society groupings.

Main Identity

From: PHM Secretariat <secretariat@phmovement.org>
To: <phm_steering_Group_02-03@yahoogroups.com>
Sent: Thursday, February 12, 2004 3:05 PM
Subject: Fw: Global Health Watch

Dear Friends,

Greetings from PHM Secretariat (Global)!

Dave McCoy of GHW initiative has sent the enclosed letter requesting PHM to consider being the main umbrella under which GHW is promoted. He has raised some other issues and suggestions as well. Please send me your responses to this, including how your region could be better represented or involved in this global initiatives.

Best wishes,

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Tel: 00 91 (0) 80 51280009 (Direct) Fax: 00 91 (0) 80 25525372
Website: www.phmovement.org

PHM-GHW

RN
13/2/04

Main Identity

From: PHM Secretariat <secretariat@phmovement.org>
To: David McCoy <David.McCoy@shirm.ac.uk>
Sent: Thursday, February 12, 2004 3:03 PM
Subject: Re: Global Health Watch

Dear Dave,

Greetings from PHM Secretariat (Global)!

I am circulating your letter to the PHM Steering group to get an overall sense of endorsement from the larger body of some of the ideas you have suggested.

1. In principle, PHM may be willing to provide the umbrella under which this initiative could be announced and promoted. But lets hear from Steering Group meeting members first.
2. GHW would be a good and potential background document for both the next Health Forum (January 2005) and the next People's Health Assembly (July 2005) though it may be a better idea not to make the direct link to these events yet, since your schedule is rather ambitious with an effort to complete it earlier this year.
3. I think regional representation keeping geography and gender is important but we must show a spirit of voluntarism rather than nominations. Also we should try to focus on those with the sorts of background and linkages that can truly address the needs and complexity of the exercise. You have listed out some functions, which are relevant. Before we include names arbitrarily perhaps we should consider whether they can actually play this role.
4. Since the next meeting is already announced - go ahead with it and the process of collective planning and consultation can begin.
5. Finally a word of caution. As long as I am the secretariat Coordinator, I would not like to represent any particular region, but support the logistics and administration of the initiative on behalf of PHM globally. Perhaps some one like Thelma or Mira could represent South Asia. They have a good policy sense and contacts and would help the gender balance as well.

I shall collate the responses and send the required communication, hopefully before the UK meeting (but only if I get a prompt response from Steering Committee members).

Best wishes,

Ravi Narayan

Main Identity

From: David McCoy <David.McCoy@ishm.ac.uk>
To: <ant@nst.org.za>, <mikerowson@medact.org>, <secretariat@pnmovement.org>
Sent: Tuesday, February 10, 2004 3:26 AM
Subject: Global Health Watch

Dear Ravi, Mike and Antoinette,

Greetings. Ravi, I hope you are well and have recovered from the exertions of Mumbai.

Things are going well with the Global Health Watch (GHW). We have raised some finances through Mike's contacts with some of the UK based NGOs. The design of the report is slowly taking shape.

In the past few weeks we have come into more contact with other NGOs about the report, and the kinds of questions they have been raising has been illuminating. I want to share some thoughts about this with you.

If we are agreed on the idea that this report needs to represent a vehicle for a wide range of NGOs, CBOs etc to be able to campaign for social justice and better health for all, then we are going to have been very careful about how we market the report to the broader NGO / CBO community. We have to avoid as much as possible any opportunity for NGO rivalry to divert energy and attention, and we need to minimise the possibility of the report being criticised for having been produced through an illegitimate process.

I have been feeling more and more as though PHM must form the main institutional umbrella for the production of the report, with GEGA and Medact providing the secretariat and technical functions. The PHM forms the only really global network with the legitimacy to produce an alternative world health report, particularly with its strong roots in the South. NGOs are more likely to support the report as a PHM product, rather than as a joint report of Medact, GEGA and PHM. For this reason I feel that we should be projecting the report much more as a product of PHM, with GEGA and Medact playing a less visible role. (the exception to this might be when approaching donors - for example, GEGA will be approaching SIDA to help fund GHW, and would therefore need to project itself more firmly in this regard)

Mike and I touched on this issue very briefly last week, but perhaps we need to take the current marketing of GHW and the process required to ensure its legitimacy a little more seriously now. My feeling is that the production of the report will be a waste of time unless we able to generate a much bigger mass of support for its production.

If this is to happen I feel that we need to generate a greater involvement and interest in GHW amongst the wider PHM network.

The composition and role of the steering committee / advisory group is important in this regard. I think that we need to have much wider PHM representation on this group, representing not just particular areas of expertise, but also individuals from different parts of the world. At present we have the following PHM individuals playing some kind of an advisory / technical role:

South Asia - yourself, Abhay and Amit Sengupta

- RN

10/2

RN
10/2/04

Southern Africa * David Sanders
Middle East * Samimeh Jabbour

I feel that we now need to identify people from:
North America * possibly, Ron Labonte or Paula Braveman
South America * possibly Armando Norberto Dachs
Central America * possibly Maria
South East Asia * possibly Chan Chee Khoon
Australasia * possibly Fran Baum or David Legge
North Africa * ??
Far East - ??
West Africa - ??
East Africa - ??
Carribean - ??
Central Europe - ??

While expanding the membership of the advisory / steering group carries some risks, I think it will in the long-term prove to be important.

The function of these individuals would be to:
- advise on authors' content of report
- facilitate production of case studies to feed into the report
- raise general awareness about the production of the report in their respective regions
- approach sources of funding in their particular regions
- take responsibility for the translation of the report into local languages
- take responsibility for launching the report in their respective regions and developing local advocacy strategies
- build connections between health and non-health NGOs around the core themes and messages of the report at a local level

How do you all feel about this? If you agree then I think it would be necessary for you Ravi to provide some communication about GHW from PHM specifically, rather than it coming from Modact or GEGA.

It now looks as though the advisory committee will meet on march 18th and 19th. I am not suggesting that all members of an expanded advisory committee should attend, but it would be nice to have a sense that the GHW has a stronger global-wide foundation by the time we do meet.

I hope, Mike and Ant, you don't mind me raising these questions and issues by e-mail.

Thanks

Dave

PS. I forgot to mention that there is a further group of GHW 'supporters' (funders, certain NGOs and individuals) who are also lending support and their advice to the process.

2/10/04

Main Identity

From: Jihad Masna <jihad@snabeka.net>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Cc: <PHM-MENA@yahoogroups.com>
Sent: Friday, February 13, 2004 1:51 PM
Subject: RE: [PHM_Steering_Group_02-03] Fw: Global Health Watch

Dear Friends,
We have agreed in the region to work on that, we all should be involved.
Jihad

-----Original Message-----
From: Maria Hamlin Zuniga [mailto:iphc@caplenet.com.ni]
Sent: Thursday, February 12, 2004 4:07 PM
To: PHM_Steering_Group_02-03@yahoogroups.com
Subject: RE: [PHM_Steering_Group_02-03] Fw: Global Health Watch

Agreed. As you can observe IPHC is already involved in this. I am preparing a response to Dave about issues he raised with me.
Maria

From: hariprem [mailto:hariprem@eth.net]
Sent: jueves, 12 de febrero de 2004 7:33
To: PHM_Steering_Group_02-03@yahoogroups.com
Subject: Re: [PHM_Steering_Group_02-03] Fw: Global Health Watch

RN
16/2/04

RN
16/2/04

PHM - GEGA

GHW

Main Identity

From: Evelyne Hong <ehong28@yahoo.com>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Friday, February 13, 2004 11:32 AM
Subject: Re: [PHM_Steering_Group_02-03] Fw: Global Health Watch

Dear Ravi & friends,

Thanks for your msg of 12 Feb re GHW Initiative. Good idea. Can we make sure PHM representatives of the advisory group are also active or linked to grassroots or movements in their countries or regions. Also, more gender balance. I suggest Delen de la Paz for South East Asia.

Cheers
Evelyne

--- PHM Secretariat <secretariat@phmovement.org> wrote:
> Dear Friends,

RM
16/2/04

PHM – Steering group
GHW

Main Identity

From: Ranjeeni <ranjeeni@eth.net>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Thursday, February 12, 2004 7:03 PM
Subject: Re: [PHM_Steering_Group_02-03] Fw: Global Health Watch

Dear Ravi,

This is a logical task for us and we should be involved in it.

Prem

----- Original Message -----
From: "PHM Secretariat" <secretariat@phmovement.org>
To: <phm_steering_Group_02-03@yahoogroups.com>
Sent: Thursday, February 12, 2004 3:05 PM
Subject: [PHM_Steering_Group_02-03] Fw: Global Health Watch

> Dear Friends,
>
> Greetings from PHM Secretariat (Global)!
>
> Dave McCoy of GHW initiative has

RN
13/2/04

PHM - GHW
GHW

RN
13/7

Main Identity

From: Mike Rowson <mikerowson@medact.org>
To: <ghw@nst.org.za>
Sent: Thursday, February 19, 2004 9:36 PM
Subject: Re: [ghw] Recent conversation with head of Social Watch

Dear Friends

Thank you Samer for this very useful response. You raise an issue which is going to emerge over the next few weeks and months. I'm not sure I know the answer to your questions. Here is my first response

(1) Ownership: yes, I guess Medact and GEGA are organisations who associate themselves with PHM. However, having the report coming simply under the umbrella of PHM does not avoid the problem of ownership - the same questions would be asked by other organisations who would want to be seen to back the report. Secondly, I think the fact that there are other organisations working alongside PHM enhances the legitimacy of the report and helps to stand it up. We need the report (or at least its central recommendations) to be as widely backed as possible. I think also that, given the shared origins of the report, it is right to acknowledge the contribution of Medact and Gega in some way. We need to be open with each other (and other NGOs) on how this is done. Our aim should of course be to make "ownership" as wide as possible - we should not be seen to act in an exclusionary way.

(2) The future: I haven't got that far yet - I'm leaving that up to Pati However, the issue will certainly raise its head soon about whether GHW is a separate entity even this time (this is related to the questions of ownership)

We need to begin discussing these issues even before the March meeting, so thank you Samer for raising them now. I hope others will respond
best wishes
Mike

RM
20/2/04 fax

PHM - GHW

Main Identity

From: David McCoy <David.McCoy@lshtm.ac.uk>
To: <secretariat@phmovement.org>
Sent: Friday, February 13, 2004 5:49 PM
Subject: Re: Global Health Watch

thanks ravi - it's difficult making sure that the process is right, and fitting in between an organisation that pays you and a movement you feel part of. I certainly see the GHGA and mediact work on the watch as being part of fulfilling the PHM's aims. So at the march meeting I will wear two if not all three hats!

Your message below actually says it should be okay to authorise David Sanders, Amit and Armando and whoever else has a direct PHM [illegible] to represent us. I presume the "not" is a typo error?

>>> "PHM Secretariat" <secretariat@phmovement.org> 02/13/04 11:14 AM >>>
Dear Dave,

Greetings from PHM Secretariat (Global)!

I agree that the way I put it in my response

Urgent
RN
16/2/04

Please send corrected format for record

RN
16/2/04

RN
16/2/04/Lm

PHM – GHGA

Dear Dave 17/2/04

The line should read 'a direct PHM nor' and not 'a direct PHM, nor'. A typo error in the earlier paragraph ~~I am sure Dave, Am~~ In your case you I suppose 'ear' is 'wear'.

Best wishes

Lm
17/2/04

RN

Main Identity

From: PHM Secretariat <secretariat@phmovement.org>
To: <David.Mccoy@lshtm.ac.uk>
Sent: Friday, February 13, 2004 4:44 PM
Subject: Re: Global Health Watch

Dear Davé

Comments from PHM Secretariat (Global)

I agree that the way I put it in my response may have pushed the PHM - Umbrella more than you had originally requested. In principle, whether for process of promotion (rather than 'marketing, we have to be careful about alternative connotations to words). PHM backs the GHW report.

I think it should be okay to authorise David Sanders, Amit and Armando and whoever else has a direct PHM, not to represent us at the London meeting and a more detailed communication to PHM Steering group and member could be sent after that meeting - once the framework process and time lines have greater consensus. Please remember whether you, Mike and Antoinette were GEGA, MEDACT or any other hats, we also consider you PHM.

Best wishes.

Ravi Narayan
Coordinator, People's Health Movement Secretariat (global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Tel: 00 91 (0) 80 51280009 (Direct) Fax: 00 91 (0) 80 25525372
Website: www.phmovement.org
Join the "Health for all, NOW!" campaign in the 25th anniversary year of the Alma Ata

Main Identity

From: David McCoy <David.McCoy@ishtm.ac.uk>
To: <secretariat@phmovement.org>
Cc: <ant@hst.org.za>; <mikerowson@medact.org>; <patriciamorton@medact.org>
Sent: Thursday, February 12, 2004 10:47 PM
Subject: Re: Global Health Watch

Dear Rani

Thanks for your e-mail. I hope you are well!

The question of PHM acting as the umbrella organisation is a bit of a tricky one. Both Mike and Antoinette are sensitive to the importance of anything marketed as an alternative world health report as having legitimacy. At the same time GEGA and Medact's investment would need to be recognised. The issue really arises when it comes to projecting the report to a wider audience and when it comes to asking for involvement and contributions from other NGOs.

For example, when we meet with london-based NGOs next month to promote the Watch, I would like to be able to say that I work for GEGA, and that GEGA is working as part of the broader PHM, which is the veiucle that provides for legitimacy and an umbrella under which other NGOs which shared values can participate.

In terms of timeframes, I think that aiming to launch the report in January 2005 is probably more realistic. So it could dovetail with the next PHA.

I agree entirely about the need to rely on voluntarism, rather than nominations. I have been in touch with Sammer Jabbour and he has, for example, volunteered to act as a Middle East hub / champion. Armando has done likewise for South America. I think that David S has done so for for Southern Africa and Fran for Australia. A call from you for volunteers will help. Otherwise, do you have anyone you could suggest we approach ourselves.

I take your point about you keeping a global hat, and not one that is regional. Abbay has got Amit Sengupta to step in for him, and he will be coming to london. Sammer, David S. and Armando have confirmed attendance as well.

We DO need to keep an eye on the gender balance - thanks for the alert!

Mike and Antoinette - your views on this?

Dave

RM
13/2/04

13/2/04

Dear Dave
I agree that the way I put it in my response may have pushed the PHM-umbrella more than you had originally requested. In principle whether for process or promotion (rather than 'marketing'; we have to be careful about all encroachive connotations to words) PHM backs the GHW report-
I think it should be okay to authorise David Sanders, Amit and Armando and whoever else has a direct PHM hat to represent us at the London meeting and a more detailed communication to PHM Steering Group and members were GEGA, Medact or any other hats we also consider your PHM
Best wishes
Rani

PHM - GHW

Copied be sent after Rich meeting - once the framework process and time lines have greater consensus. Please remember whether you Mike, and Antoinette

Main Identity

From: Maria Hamlin Zúniga <iphc@cablenet.com.ni>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Thursday, February 12, 2004 7:36 PM
Subject: RE: [PHM_Steering_Group_02-03] Fw: Global Health Watch

Agreed. As you can observe IPHC is already involved in this. I am preparing a response to Dave about issues he raised with me.
Maria

From: hanprem [mailto:hanprem@eth.net]
Sent: jueves, 12 de febrero de 2004 7:33
To: PHM_Steering_Group_02-03@yahoogroups.com
Subject: Re: [PHM_Steering_Group_02-03] Fw: Global Health Watch

Dear Ravi,

Take it to logical conclusion and we should be involved in it.

Hans

----- Original Message -----
From: "Ravi Narayan" <ravi.narayan@btinternet.com>
To: <PHM_Steering_Group_02-03@yahoogroups.com>
Sent: Thursday, February 12, 2004 2:57 PM
Subject: [PHM_Steering_Group_02-03] Fw: Global Health Watch

> Dear Friends,

RN
13/2/04

PHM - GHW

RN
13/2/04

PHM-GHW

Main Identity

From: Samer Jabbour <sjabbour@aub.edu.lb>
To: <ghw@hst.org.za>
Sent: Thursday, February 19, 2004 3:34 AM
Subject: RE: [ghw] Recent conversation with head of Social Watch

Dear Patricia,

I am just getting around to my unanswered emails after a week's travel and I take this opportunity to thank you for your efforts and to greet all others in the group. In service of engaging in a dialogue with everyone on this list, I will share a few thoughts after going quickly through some of the material and emails that have been circulated. Like others maybe on this list, I am looking forward to our meeting in March to clarify some of the issues regarding GHW. A couple of such issues:

1. Ownership: For some reason, I originally thought that GHW (or Alternative Health Report) would be a product of PHM (under whose umbrella many, if not all, of us gather), but would be unique in terms of engaging many individuals and organizations, especially considering the plans for issuing it periodically. The background document indicates that PHM is a partner on this effort with two other organizations, Medact and GEGA. I have great respect and admiration for these two organizations (and the people who work in them!) and I understand that they have been instrumental in coming forth with this idea and carrying it forward to this stage. However, as these organizations are also part of PHM, I wonder about the rationale for a three-owner arrangement vs. putting the whole effort under one umbrella, i.e. PHM (even if it's coordinated temporarily or permanently at Medact or GEGA) so that there is one address for GHW, now and in the future. I am thinking of the following scenario: How would we address the situation where other organizations (national or international NGOs or networks) feel that they would like to be co-sponsors of GHW, on equal grounds with Medact or GEGA? We all agree that it would be great to have broad participation in this effort but such requests from other organizations would create a dilemma for us. Having one umbrella under which GHW can be placed, like PHM, would help us avoid such a dilemma. Issues of ownership are tricky as they touch sensitivities, whether they are expressed or unexpressed. Again I reiterate my appreciation for the efforts of Medact and GEGA which would be acknowledged however this issue is settled.
2. Future outlook: I wholeheartedly agree with the implication of your message that GHW should be something that starts today and continues in the future and that we need to think about this future now. I know the SW model in a limited way only and their contribution and experience would be very valuable for GHW. However, I am not clear as to what would be good for GHW, i.e. whether GHW should become an entity (like SW is) or a periodic publication of the existing collaboration. I understand that the two options are not mutually exclusive but the difference is there and maybe this can be added to the agenda for discussion next month. GHW is more specific, in terms of range of topics and issues, than SW and thus lends itself more easily to coordination within existing organizations than SW which requires the separate entity that it has today.

I am probably coming late in this process (as a lot of work seems to have gone into this) and these issues may have already been discussed, so I apologize but the aim of these crude first thoughts is to enter with others in discussions leading to the March meeting.

In peace,
Samer

Samer Jabbour, MD, MPH
American University of Beirut
Van Dyck Hall
Beirut, Lebanon
Tel: +961-1-374 374
x4040 (Sec), x4042 (Direct)

To ji + RN

To reply about GHW

RN 19/2/04

PHM - GHW

-----Original Message-----
From: ghw-bounces@hst.org.za [mailto:ghw-bounces@hst.org.za] On Behalf Of Patricia Morton
Sent: Wednesday, 18 February, 2004 4:13 PM
To: ghw@hst.org.za
Subject: [ghw] Recent conversation with head of Social Watch

Dear All

I spoke to Roberto Bissio, head of Social Watch earlier this week who was very supportive of the Global Health Watch and said that they would be interested in working/ sharing information with us. Social Watch's aims and objectives are very similar to the Global Health Watch and their approach very much involves civil society at a national and local level. As they have been around for nearly 10 years, I think we can learn a lot from them. See www.socwatch.org.uy/en/portada.htm for lots more information.

Roberto said that there is a good chance that someone from their European Social Watches (Germany or Italy) or from Canada (from the North South Institute) will be able to come to our March meeting. The North-South Institute are particularly interested in health issues (HIV and Repro health). The following is some information I got out of my phone conversation with him.

I asked about local advocacy and national groups and how they are engaged in the running of Social Watch. He said that the SW started with a small group of national groups that were part of the national assembly, now there are 60 national coalitions. He said it was important to start off with a small number of groups in terms of just getting the initiative off the ground. He also said that the national groups are basically recognised as the foundation of the network. The national groups legitimise the work of SW and greatly increase the impact of the international report (they can say they represent a coalition of 60 countries). It is also useful for national lobbying, national groups can say that the national report features in an international publication.

SW does not fund national groups, they have to make their own applications for funding. There are cons in terms of coordination but the pros are a sense of ownership (national groups can join and pull out of SW as they wish). I did not ask about where these national groups get their funding from (but their website does say that initially NOVIB funded 33 national initiatives!). This arrangement also creates a sense of accountability of the global secretariat to the national groups. In terms of campaigning at a national level this sense of ownership has been v important. An interesting development has been that some of the national groups now produce their national reports for international distribution (the Brazilian one is produced in three languages). He said there is no constitution for SW but there are guidelines for national groups to join.

The Social Watch was originally funded by NOVIB which was heavily involved in the set up and formed part of the steering group. Although having this bulk funding was a great assistance to starting off, this caused a problem in terms of NOVIB dominating. Their funding now comes from the Ford Foundation, Christian Aid and a small amount from UNDP. Roberto said that it was very important for Social Watch that they maintained various sources of funding.

He said that translation of the report is challenging. It is the bulk of the product on expenses. They now produce the report in English and Spanish. They translate the report at the secretariat from original languages (French Portuguese and Arabic) into Spanish and English. I think that is what he said.

In terms of report themes, he said that there is tension between the international campaign trying to determine a theme for the annual reports and the interests of the national groups.

In terms of international advocacy, he said it is hard to judge what the impact has been. He says that they are taken seriously. The report is launched at the UN and taken to WB and IMF meetings in

2/19/04

Washington among meany others. The UN is more sympathetic than the WB.

There are several other Watches that have emerged or been planned since SW. Habitat Watch is being planned and will have strong collaboration with SW. Sustainability Watch and Indigenous People's Watch are other watches that are being planned. I mentioned that it would be useful for us to use SW's national groups/networks for GHW. He said that this was possible particularly as many have interests in health issues (HIV, repro health).

Roberto is circulating the details of the March meeting to some national groups (in Europe and Canada) to see who is interested - it may be better than having the secretariat in the end to see how it works from a national perspective.

Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment.

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www.medact.org
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Company Reg. No. 2267125

Main Identity

From: David McCoy <David.McCoy@ishtm.ac.uk>
To: <ghw@inst.org.za> <mikerowson@medact.org>
Sent: Friday, February 20, 2004 5:26 AM
Attach: Concept document-Feb 2004.doc
Subject: [ghw] Re: GHW

Dear all,

Thanks again to Samer for raising important points for discussion. I want to add to his and Mike's comments, as well as to raise another issue.

Firstly, the issue of ownership. There are perhaps a number of sub-texts to the issue of ownership and inclusiveness.

There is first the issue of management and coordination of the process of producing the Watch - there will need to be a balance between wide participation and a clear mandate located somewhere and with somebody(ies) to drive the process to its conclusion. I think that at this stage it should clearly be Medact, GEGA and PHM doing that, through the steering committee and with some ground rules that we can agree to. The gat value of the PHM is that it is a network, and in this way is able to bring in a fairly wide constituency of individuals to be represented on the steering committee. However, we would have to, for the purpose of organisational efficiency, limit the steering to a manageable number.

Then there will need to be a way in which we can be inclusive of as many NGOs and individuals over and beyond those represented on the steering committee. This will be done to some extent through the commissioning of authors, and by identifying reference groups for the different chapters etc. In addition, we can seek the formal endorsement of other NGOs and individuals; not to mention funding contributions.

Finally, there is the issue of how the Watch is projected. My personal inclination would be to have the Watch attributable to as many NGOs and CSOs as possible. All should be listed as contributors and co-owners of the report. Mention should be made of medact and gega's role, but I would vote against the Watch being 'branded' as a product of the three founding organisations. Perhaps we should consider the development of a logo for the watch itself, rather than for the organisations involved.

In order to catch up with this new thinking, the concept document has been re-written to reflect these important points. I am attaching it to this e-mail and it would be good to get feedback on this before the march meeting.

PHM - GHW

RN
20/2/04

2/20/04

Now for the second issue. I have only just finished reading the latest world health report, and the new regime in geneva has undoubtedly meant that the environment in which the Watch was conceptualised has changed. The new world health report does make strong statements about equity, the PHC Approach and various macro-economic issues. We therefore need to think carefully about how we position the Watch in relation to WHO, and how we respond to the new positions being taken by WHO.

The new version of the concept document has also taken this into consideration. I think it would be useful if we can all have a quick look at the new world health report before the march meeting.

Thanks to all for listening and I hope we can keep this discussion going.

Best wishes to you all

David

2/20/04

Prasanna - PHM Communications

From: "Prasanna - PHM Communications" <prasanna@phmovement.org>
To: "Patricia Morton" <patriciamorton@medact.org>
Sent: Saturday, February 21, 2004 9:20 AM
Subject: Re: Photos of IHF

Hi Patricia,

Just y'day I recd. some of the IHF/WSF photos in the digital form from Andreas. Will put it up shortly on the web. I am yet to optimise the size of the photographs as they are very huge and it took me ages to download with my dial-up connection. Will get back to you with the photos soon. Any deadlines?

Best Wishes
Prasanna Saligram
Communications Officer, People's Health Movement Secretariat(Global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
Jakkasandra 1st Main, I Block Koramangala
Bangalore-560034
Tel: 00 91 (0) 80 51280009 (Direct) Fax: 00 91 (0) 80 25525372
Website: www.phmovement.org
Join the "Health for all, NOW!" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

----- Original Message -----
From: Patricia Morton
To: Prasanna - PHM Communications
Sent: Monday, March 01, 2004 3:55 PM
Subject: Photos of IHF

Dear Prasanna

I wondered if you had any photos of the International Health Forum which we could use for our medact newsletter. If you do we need them asap.

Thankyou very much.

Patricia Morton
Global Health Watch

PS: did you recieve my bits for the webpage??

PHM - GHW
Medact

21/02/04

RN
2/3/04

Main Identity

From: Patricia Morton <patriciamorton@medact.org>
To: <secretariat@phmovement.org>
Sent: Monday, March 01, 2004 7:52 PM
Subject: photos of IHF and WSF

Dear Ravi/PHM staff

I wondered if by any chance you had some photos of the IHF and WSF that would be available digitally, for our medact newsletter. I took some, but they were not great.

Thankyou very very much
Regards
Patricia

Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment

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Registered Charity 1081097
Company Reg. No. 2267125

RM
2/3/04

Phew –

Main Identity

From: Patricia Morton <patriciamorton@medact.org>
To: PHM-Raw <phmsec@bucknellindia.net>; <secretariat@phmovement.org>; <webmaster@phmovement.org>
Sent: Monday, February 23, 2004 6:56 PM
Subject: Website

Dear PHM,

I would like to add the Global Health Watch to the PHM website. Can someone at the PHM secretariat do this.

Thankyou very much.

Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty, and the environment.

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RN
24/2/04

SSP → Reply sent PHM/ Bellonde please correspond directly and do needful

PHM – GHW

RN
24/2/04

Main Identity

From: Patricia Morton <patriciamorton@medact.org>
To: GHW mailing list <ghw@hst.org.za>
Sent: Wednesday, February 25, 2004 7:45 PM
Subject: Re: [ghw] Concept document- Latest Version

Dear All

In light of Amit's very useful comments, it would be good to have the steering committee's opinion on the following letter, prepared to go on to PHA-Exchange as a start to some regular discussion on the GHW on this e-list. Dave has suggested that it come from the steering group itself. If possible, could you please make your comments in the next couple of days so we could send it out asap.

Thanks
Patricia

Dear Friends,

At the World Health Assembly in May 2003, the Peoples Health Movement, GEGA and Medact discussed the need for civil society to produce its own 'Alternative' World Health Report. It was felt that the WHO reports were inadequate, and furthermore, that there is a report that monitors the performance of the global health institutions themselves. It was also felt that the dominant neo-liberal discourse in public health policy also needed to be challenged by a more people-centred approach that highlights social justice.

PHM-GHW

RN 26/2/04

An 'Alternative World Health Report' based on rigorous analysis would also form a useful platform for the strengthening of advocacy and campaigns to promote equitable health for all. In this sense the report should be seen as a means to an end.

This idea of an alternative world health report has since developed into an initiative called the 'Global Health Watch'. In January 2004, the initiative was presented at the International Health Forum in Mumbai and we are now attaching for your consideration, the latest concept document. We plan to launch the Global Health Watch in May 2005.

Till now the Global Health Watch has been supported by the Peoples Health Movement, Medact and GEGA. However, we now need to widen the network of collaborators and supporters to this initiative.

We are looking to members of this list to:

- Comment on the concept document: link
- Stimulate discussion about what key messages should be contained in the

RN 26/2/04 for

PHM-GHW

report
- Develop local platforms for the use of the report in 2005 when it is published

We look forward to hearing some of your views and comments.

Yours Sincerely
Global Health Watch Steering Committee

2/26/04

Main Identity

From: McCoy Dave <Dave.McCoy@haringey.nhs.uk>
To: <ghw@hst.org.za>
Sent: Wednesday, February 25, 2004 7:05 PM
Subject: RE: [ghw] Concept document- Latest Version

Dear Amit

Thanks for this message. You make some excellent points ..... and timely as well. We have just been drafting a message to put out onto the PHA mailing list where we want to invite comment about the Global Health Watch, as well as about some of the topics that will be covered in the Watch. In this way we hope to catalyse much greater ownership of the Watch and allow tha Watch to act as a platform for a more vibrant discussion about key issues for civil society and NGOs in the health sector to engage with.

For example, in the run up to the publication of the report, it would be great if the PHM network could facilitate some discussion and debate about how we position ourselves vis a vis the new orientation of the WHO. Or to discuss how we strengthen to good bits about the WHO and how we target its weaknesses for advocacy.

We will circulate the message for the PHA mailing list to the GHW steering group first, and then send it out from all of us, if there are no objections.

Best wishes

David

RN
26/2/04 for

Phan - GHW

RN
26/2/04

Main Identity

From: <ctddsf@vsnl.com>
To: <ghw@hst.org.za>; GHW mailing list <ghw@hst.org.za>
Sent: Wednesday, February 25, 2004 6:23 PM
Subject: Re: [ghw] Concept document- Latest Version

Dear All,

Just a brief reaction to the GHW concept document that has been circulated. I think it reads very well, and captures the key concerns. If I may add a few small suggestions:

1) When we refer to CSOs, NGOs, etc. it would be appropriate to also specifically mention "movements". The PHM, while being a network of CSOs, NGOs and other organisations, is above all a movement. I understand that the distinction between movements and NGOs/CSOs is not always clear, and may not exist in many contexts. But going by our experience in India, it would be useful to specifically talk of movements as part of the PHM process and the process of putting together the Global Health watch report.

To give back RN for reply

2) Two small specific suggestions on the note:

a) When we say " ...the diminished capacity and role of national governments..." can we also add "and the erosion of sovereign decision making space"

b) Instead of saying "...as a corrective to the market-led policy agenda..." can we say "as an alternative to market-led policy agenda..."

3) A suggestion for the proposed structure of the Watch:

Two special chapters are proposed on Indigenous people and Disabled people's right to health. Can we, instead, have a section that talks about the "marginalised and the right to health care". To elaborate: imperialist globalisation today is leading to the accelerated marginalisation of those ~~who are already marginalised, the most vulnerable are facing the most savage~~ attacks on their health rights. This includes the indigenous people and the disabled, but also in many settings: women, children, the aged, and other traditionally marginalised sections like ethnic or religious minorities, dalits (in India and other parts of S.Asia), etc. It might be useful, especially when we focus the report on health inequities to have a section with substantive focus on this aspect.

RN 26/2/04

Finally some reactions to the issue raised by friends in this discussion list, regarding the long-term view of the Global Health watch and its relation to the PHM (this is not necessarily in the context of the concept note).

RN 26/2/04 for PHM-GHW

I think we need to take note of the very loose organisational structure that the PHM has and which we have consciously promoted. In such a situation it would be very difficult for the PHM as an "organisation" to administer the Global Health Watch. So it makes sense for organisations like Medact and GEGA to play the co-ordinating role that it is playing at the moment. The PHM can add value to the enterprise by bringing in perspectives and insights that are truly global and also by using its extensive network to publicise the report, and by making its impact felt at regional, country and local levels.

In order to facilitate this process, it would be necessary over time to consciously bring in concerns of the PHM -- which would means concerns of the large number of organisations, which form the PHM. This is not going to happen overnight (possibly much of this will not happen for the first report in 2005), and would require a process where PHM constituents discuss the concept of the Global Health Watch and also suggest ways in which they can enrich the report. This will, I presume, involve a discussion within the PHM -- maybe also the activation of a separate "circle" in PHM to initiate this process. Even relatively minor things like discussions within country PHM constituents about suggested authors/editors/issues from that country/region would be useful in enhancing a sense of involvement with the Report by PHM constituents. If this can be ensured the PHM can be better placed to "own" the Report.

I think that in some way there may be a concern that the Global Health Watch should not be "institutionalised" and thereby loose its vitality. These are early days and such a danger, is at best, just a theoretical possibility -- but a possibility nonetheless that we would need to guard against. The best safeguard in this regard would, of course, lie in the ability of the PHM to play a proactive role in the preparation of the Report.

Hope the above adds some substance to our discussions.

With warm regards to all,

Amit Sen Gupta
Jana Swasthya Abhiyan (PHM - India

At 05:22 PM 2/24/04 +0000, Patricia Morton wrote:
>Dear All
>
>See, attached, the latest version of the GHW concept document. This version has incorporated comments from some of you and from IDRC (who are looking like they will fund the GHW). Changes have been to emphasise the role of the PHM and to spell out the advocacy strategy a bit more.
>
>Please let us know what you think.
>
>Regards
>Patricia

>
>
>Patricia Morton

Main Identity

From: PHM Secretariat <secretariat@phmovement.org>
To: <ghw@hst.org.za>
Sent: Wednesday, February 25, 2004 4:48 PM
Subject: Re: [ghw] Concept document- Latest Version

Dear Patricia,

Greetings from PHM Secretariat (Global)!

Just out of interest. Could you send me the latest GHW mailing list, so that we can identify all those who have PHM linkages already even if they are wearing other hats and send you names, for regions not adequately representated.I think the latest version is evolving well in an interactive way. Specific comments follows after I do a more relaxed review.

Best wishes to you, Dave and Mike

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Join the "Health for all, NOW!" campaign in the 25th anniversary year of the Alma Ata declaration visit www.TheMillionSignatureCampaign.org

Main Identity

From: Patricia Morton <patriciamorton@medact.org>
To: GHW mailing list <ghw@hst.org.za>
Sent: Tuesday, February 24, 2004 10:52 PM
Attach: Concept document-Feb 27 2004.doc
Subject: [ghw] Concept document- Latest Version

Dear All

See, attached, the latest version of the GHW concept document. This version has incorporated comments from some of you and from IDRC (who are looking like they will fund the GHW). Changes have been to emphasise the role of the PHM and to spell out the advocacy strategy a bit more.

Please let us know what you think.

Regards
Patricia

Patricia Morton
Global Health Watch

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment

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25/2/04

PHM – GHW

Dear Patricia
Just out of interest could you send me the latest GHW mailing list so that we can identify all those who have PHM linkages already even if they are wearing other hats and send you names for regions not adequately represented. I think the latest version is evolving well in an interactive way. Specific comments follows after I do a more relaxed review

2/25/04

Best wishes
to you, Dave & Mike
Ron
PHM-Geneva

People's Health Movement

GEGA

Global Equity Gauge Alliance

Global Health Watch

Mobilising the global health and social justice movement around an *alternative* World Health Report

Introduction

Global civil society does not participate strongly and consistently in international health advocacy. Whilst there have been some high-profile successes due to pressure from civil society, (for example with campaigns to improve access to medicines and to regulate the promotion of infant formula), there is a striking lack of involvement and pressure from civil society on broad health and health systems issues.

With the failure of the global community to achieve "Health for All by the Year 2000", new targets - such as the Millennium Development Goals – have come to the fore. However, whilst overseas development assistance declines, and the trade and investment environment become even more unfriendly to poor countries, there is a great danger that these objectives too will not be met, increasing cynicism and discontent in the world.

A fragmented, disease- and issue-specific approach to health dominates advocacy as well as research and governance agendas, under-emphasising the underlying causes of ill-health. Meanwhile, disparities in health care consumption between the rich and the poor are growing alarmingly within and between countries, leaving society with a major political, social and moral challenge.

The values that underpin the goal of health equity and the PHC Approach are often undermined by development policies emphasising efficiency at the expense of fairness; market forces at the expense of planning based on population needs; and selective approaches to disease-eradication at the expense of more comprehensive strategies for achieving health. In addition, the diminished capacity and role of national governments, particularly of poor countries, has further undermined the notion of social solidarity and inclusive health systems.

Although there has been a recent and welcome shift by the World Health Organisation to highlight global inequity and reassert the principles of the Primary Health Care Approach, constant pressure from civil society is needed to hold national policy-makers and international organizations accountable to declared values and to address the fundamental causes of ill-health and failing health systems. To be effective, civil society voices must be well informed, evidence-based, and united on fundamental issues.

In response to this, the People's Health Movement, with the support of the Global Equity Gauge Alliance and Medact, propose to mobilise a fragmented global health community around values which stress the need to tackle more effectively the fundamental causes of ill-health and health inequity in our societies. The vehicle for this is the **Global Health Watch**, an initiative that will combine outstanding research and policy analysis, a commitment to bringing the views of poor and vulnerable groups to the attention of international and national policy makers and a more effective civil society advocacy movement.

We want the Watch to be an initiative that:

- Amplifies the calls for a broad, multi-sectoral approach to health by explicitly and concretely linking health concerns to the environment, international finance, agriculture and food security, war, housing, land rights, conflict and education.

- Strengthens the capacity and accountability of the world's global health institutions to provide technical and value-based leadership in the struggle to attain adequate health for all.

- Creates a more vibrant global civil society in health by strengthening the links between socially conscious non-government and civil society organisations across all regions of the world, based on shared values.

- Provides a forum for magnifying the voice of the poor and vulnerable and those who advocate for them;

- Shifts the health policy agenda away from technocratic approaches, to one that also recognises the political, social and economic barriers to better and more equitable health; and

- Promotes human rights as the basis for health policy, as a corrective to the market-led policy agenda which tends to fragment and exclude.

Institutional framework of the Watch

The People's Health Movement (PHM) is an organised network of civil society and grassroots organisations that developed out of the international gathering of the first

People's Health Assembly in Bangladesh in December 2000. At that meeting, delegates from all over the world reaffirmed their commitment to the strengthening of health care systems that are equitable, sustainable and locally appropriate, as well as to the view that health is a human right. This has since been encapsulated in a People's Health Charter, which has been translated into several different languages.

As a global network, with its base firmly rooted in developing countries, the PHM is a vehicle that can act as a unifying umbrella for a wide range of individuals, organisations and community-based organisations engaged in struggles and efforts to improve health and social justice globally.

Medact is a UK-based charity with a health professional membership that has been active in highlighting the harmful effects of globalisation, poverty, environmental degradation and war on health and equity. GEGA, a network of projects mainly in the South that primarily addresses in-country health inequities, has committed itself to tackling the global determinants of health disparities within and between countries. Together with PHM, they have helped to provide the impetus around the development of the Global Health Watch.

In keeping with the organisational philosophy of the People's Health Movement, the aim is now to promote the involvement of as many NGOs and individuals as possible in the development and use of the Watch as an advocacy tool. The efforts to ensure this widespread involvement and the shared ownership of all those who participate in the development of the Watch and / or endorse its contents will strengthen global civil society's engagement with global health policy, and are as important as the actual production of the report.

A central feature of the workplan to produce the Watch is therefore the process of forging and strengthening linkages between CBOs, NGOs and academics; between constituencies in the South and the North; and between the progressive health sector and other progressive social and environmental movements and organisations.

Aims of the Watch

1) The regular production of an alternative world health report

The Global Health Watch will regularly be produced as an alternative world health report that is coherent, rigorous and written to support civil society's capacity to promote a more socially conscious and equitable health agenda. To be effective, the report's credibility as a reliable source of sound evidence is crucial. At the same time, the report will serve as a forum for civil society perspectives, testimonies from the ground and the voices of people who are traditionally unheard. The report will consist of a compilation of chapters on various health issues. Generally, the Watch will not commission new research but will rely on research and analysis already done by NGOs and academics, providing a platform for the further dissemination and popularisation of this work.

Chapters will be written by different authors from various regions of the world. Each chapter would also have designated reviewers, thus expanding the network of contributors to the text. An editorial committee will oversee the report production, ensuring the overall quality of the material, the coherence of the report as a whole, and that it reflects the 'voices of the unheard' from different parts of the world. There will be a set of recommendations at the end of each chapter and the opening chapter will draw out the main themes of the report and put forward over-arching recommendations. A dedicated editor will be hired to support individual contributors in producing material of adequate quality, and finalising and copy editing the report.

The approximate size of the report will be 100,000 words and the suggested structure and chapter headings of the report are shown below. It is envisaged that the scope and size of the report will change somewhat each time to accommodate emerging issues while preserving a critical core that remains consistent over time

2) Advocacy

In addition to the production of a report, the Watch incorporates an advocacy strategy that aims to:

- Increase the responsiveness of global health institutions to the opinions and ideas of global civil society;
- Legitimise and strengthen our core message: that equity, the centrality of effective and inclusive public health systems and broad public health issues need greater recognition in both global and national health and development policy agendas; and
- Encourage greater involvement of civil society organisations in the determination of international health policy, with a particular emphasis on strengthening representation of the poor and their advocates.

The activities planned to realise these goals combine a mixture of activities at national and global level.

The process of producing the Watch. By involving a diverse range of NGOs, CSOs and individuals from both developed and developing worlds in the writing the report, the core messages of the Watch will be filtered and communicated through a wide range of formal and informal networks and information channels.

Pre-launching the report. In order to raise the level of expectation and demand for the Watch, it will be 'pre-launched'. The Watch was presented and discussed at the World Social Forum in Mumbai in January 2004, and will be presented to a broad group of health, development NGOs, CSOs and trade unions as well as the press at a meeting in London in March 2004. In addition various notices about the report have already been disseminated through different list-serves, websites and e-lists.

Simultaneous launch of the Watch. We plan to launch the published report at the time of the World Health Assembly in May 2005. We will also be asking local NGOs, CSOs, academics and others to help organise a simultaneous launch of the report in as many countries as possible. Both GEGA and the People's Health Movement are already networks of country-based individuals and organizations that are capable of covering a large number of countries.

Campaign around central recommendations. Apart from encouraging advocacy around the recommendations made in specific chapters of the Watch, a campaign around a number of the cross-cutting recommendations will aim to exert influence on global and national health institutions through national governments and a broad coalition of NGOs/CSOs. Organisations at the national level will be encouraged to take the report to representatives of their national governments and to use it to strengthen their own positions in advocating for equity in the areas of health and development that they work in. A key global health institution that the Watch will engage with is the World Health Organisation, and participating organisations will be encouraged to raise the main and chapter recommendations from the Watch with WHO.

Dissemination. In addition to hard copy distribution of the report, the Watch will also be available without charge on the World Wide Web. The report as a whole and individual chapters will be available in easily downloadable format to facilitate advocacy .

Reaching different language groups. We will develop shortened versions of the report initially in Portuguese and Spanish for dissemination to grassroots organisations and other civil society groupings. We will explore avenues for the translation of the document into other languages.

Proposed structure and lay-out of the Watch

Foreword
Introduction
Executive Summary and Overview
A summary of the report, linking the chapters, drawing out the main themes and ending with major recommendations.
Section A: Politics and Economics of Health
A1: Politics and economics of poverty - a global public health priority *Describes the mechanics of the global political economy that keeps people and countries poor; covers trade, global financial systems, debt and their linkages to health.*
A2: Approaches to health care *An overview of the relevance of the PHC approach today, and how health policies are influencing the shape of health care in ways that diverge from the principles of Alma Ata. This includes some commentary on the role and effects of GPPPs.*

A3: Health Policy: the privatisation agenda *Describes the processes of commercialisation and privatisation of health care, the resulting problems and the appropriate government and non-government responses. Describes the weaknesses and shortcomings of the marketisation and commercialisation of health care.*
A4: The global brain drain of health personnel *Describes the effect of migration of health personnel, the underlying forces of economic and political globalisation and suggests ways to address the problem. Critiques the lack of effective action to tackle this urgent health priority.*
A5: Big Pharma and the funding of R&D for medicines *Describes the multi-billion dollar pharmaceutical industry in relation to global health and world poverty and the influences of this industry on health policy. Sets out an argument about the need for more fundamental reform of R&D and the need for excessive profit-making from medical care to be regulated.*
A6: Responding to treatment access and beyond *A critique of 3x5, the Global Fund and the World Bank's treatment programmes, in the context of the overall progress towards combating the HIV/AIDS epidemic.*
A7: Genomes and health *The unravelling and exploitation of the human genome leads to important questions in the health sector from an ethical and equity perspective. This chapter further explores the unclear inter-face between commercial health care and public health, and for accountable governance of the future development of this industry at the international and national level.*
Section B: Beyond the Health Sector
B1. Nutrition and the right to food *Focus of this chapter is still to be defined*
B2: Water and Sanitation *Covers the commodification of water and control of water rights by private companies, looks at case studies from around the globe, discusses responses from UN and recommendations from water NGOs.*
B3: War, the new militarism and public health *Focus of this chapter is still to be defined*
B4: Environment *Focus of this chapter will be on making the connections between health and global warming; and thereby between politics, economics, development paradigms and environmental justice with health.*
B5: Education *Focus of this chapter is still to be defined*
Special chapter: Indigenous people, land and health
Describes the relationship of indigenous people to land and discusses the underlying health effects of displacement of these communities.
Special chapter: Disabled people's rights and health
Focus of this chapter is still to be defined
Section C: Monitoring Section *This section will highlight a few key advocacy targets and institutional case studies, so that the Watch evolves over time into a tool that monitors the performance of key actors, institutions and policy processes.*
Debt cancellation / HIPC process
ODA quantity and quality – include an in-depth case study of one bilateral donor
World Bank monitor – what are the strengths and weaknesses of the World Bank and the key recommendations for change.
IMF monitor – what are the strengths and weaknesses of the IMF and the key recommendations for change.
WTO monitor – what are the strengths and weaknesses of the IMF and the key recommendations for change.
WHO monitor – what are the strengths and weaknesses of the WHO and the key recommendations for change.
UNICEF monitor – what are the strengths and weaknesses of UNICEF and the key recommendations for change.
FAO monitor – what are the strengths and weaknesses of FAO and the key recommendations for

change.
Foundation monitor –private philanthropic foundations have been playing a greater role in the development of health policies and programmes in recent years. In order to develop some assessment of their role and effects, it is proposed that an in-depth case study of one Foundation be developed.
Cross-cutting themes ◦ it is expected that the 'voices of the unheard' will be incorporated throughout the report in the form of short case studies and testimonies. ◦ It is expected that the issue of gender will be mainstreamed throughout the report.

Main Identity

From: María Hamlin Zúniga <maria@iphcglobal.org>
To: <ghw@hst.org.za>
Sent: Thursday, February 26, 2004 10:29 PM
Subject: RE: [ghw] Concept document- Latest Version

Hi friends,
I have been following the discussion and want to make my contribution. However it is impossible at this moment. I hope to send my ideas and comments early next week. I hope that will be ok.
I am swamped right now and under pressure to get some items finished before Monday.
Hope you all understand.
Cheers,
Maria

-----Original Message-----
From: ghw-bounces@hst.org.za [mailto:ghw-bounces@hst.org.za] On Behalf Of McCoy Dave
Sent: miércoles, 25 de febrero de 2004 7:36
To: 'ghw@hst.org.za'
Subject: RE: [ghw] Concept document- Latest Version

Dear Amit

Thanks for this message. You make some excellent points ..... and timely as well. We have just been drafting a message to put out onto the PHA mailing list where we want to invite comment about the Global Health Watch, as well as about some of the topics that will be covered in the Watch. In this way we hope to catalyse much greater ownership of the Watch and allow tha Watch to act as a platform for a more vibrant discussion about key issues for civil society and NGOs in the health

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