PEOPLE’S HEALTH MOVEMENT
In communities around the world, groups of people have been working together to find creative solutions to their health care problems. To mobilise local and often scarce resources, to put into practice effective, community-based and community-run health care services.

They have been doing this for more than 50 years, or at least from the time that the international health community, particularly under the leadership of the World Health Organization, has been striving to identify practices and policies that can make a difference.

Countries such as Guatemala, Cuba, Bangladesh, India, Mozambique, Tanzania, the Philippines, China and many more provided real life experiences and evidences that underpinned the Primary Health Care (PHC) strategy approved at the 1978 international meeting held at Alma Ata. The Health for All by 2000 AD evolved at this meeting.

In September 2003, nine months from now, the world will reach a milestone – the 25th anniversary of the Alma Ata Declaration on Primary Health Care. It is disappointing to see that the international health community has failed miserably to deliver that promise. That failure is being felt most dramatically in the poorest and most marginalized communities around the world.

Recognizing this, people’s organizations from around the world have begun a new mobilization process to ensure that comprehensive primary health care becomes a reality. Beginning in the late 1990s, in Latin America, Africa, Europe, and throughout Asia, people’s organizations began a process of analysis and mobilization to pull together ideas for a People’s Charter for Health.

In December 2000, nearly 1450 people from 92 countries met in Savar, Bangladesh to review the Charter as a strong call for action. Since then, the Charter has been translated into more than 35 languages, and the People’s Health Movement (PHM) has grown.

This special issue of Contact traces the development of the People’s Health Movement, looks at the key points of the Charter, and highlights some of the initiatives in wide range of regions and countries involved in the PHM. These include Africa, Latin America, Bangladesh, Italy and India. These are just a few examples.

The People’s Health Movement (May 2002) was the largest delegation at the last World Health Assembly in Geneva. A short report on this event is included along with some reflections on ‘Poverty and health’ (Poverty and WHO). The get-together of activists in Geneva from all over the world was also an opportunity to share visions of the future.

Finally, this special issue calls for others to join in the movement and to work together to help put the control of people’s health in people’s hands.

Andrew Chetley & Ravi Narayan
A PEOPLE’S CAMPAIGN FOR
HEALTH FOR ALL – NOW!

Introduction
In 1978, an International Health Assembly at Alma Ata in USSR, (co-sponsored by the World Health Organization; United Nations’ Children’s Emergency Organization; and others) gave the world a slogan Health for All by 2000 AD and endorsed the famous Alma Ata Declaration that brought people and communities to the centre of health planning and health care strategies.

It emphasized the role of community participation, appropriate technology and intersectoral coordination. The declaration was endorsed by all the governments of the world and symbolized a significant paradigm shift in the global understanding of health and health care.

A receding dream
Twenty-two years later and after much policy rhetoric; some concerted but mostly ad hoc action and a lot of governmental and international health agency amnesia; this declaration remains unfulfilled, as the world comes to terms with the new economic forces of globalization, liberalization and privatization.

The PHA meet
In December 2000, a Global People’s Health Assembly, brought together 1453 people from 92 countries. It included a march for health; meetings at which people shared their testimonies on the health situation from many parts of the world. Parallel workshops to discuss a range of health and health related challenges. Cultural programmes to symbolize the multiregional, multicultural and multiethnic diversity of the peoples of the world; and group discussion in small and big groups, using formal and informal opportunities.

Finally, at the end, a People’s Health Charter emerged, which was endorsed by all the participants. This charter has now become an expression of common concerns; a vision of a better and healthier world and a call for radical action.

The PHA meet at Bangladesh was intended to challenge health policy makers around the world. Ravi Narayan reports on this exciting exercise which was intended to remind international bodies and governments of the promises they have failed to keep.

The People’s Health Campaign for ‘Health for All - Now!’ was a platform to share the unfulfilled Health for All challenge.
Thirdly, it underlines the imperative that *Health for All* means challenging powerful economic interests; opposing globalization in its existing inequitous model; and drastically changing political and economic priorities.

Fourthly, it tries to bring in perspectives and voices of the poor and marginalized encouraging people to develop their own local solutions.

Finally, it encourages people to hold accountable their own local authorities, national governments, international organizations and corporations.

The vision and the principles, more than ever before, extricates health from the myopic “biomedical-techno managerialism” of the last two decades and centers it squarely in the context of today’s global socio-economic-political-cultural-environmental realities. However, the most significant gain of the People’s Health Assembly and the Charter is that, for the first time since the Alma Ata Declaration (1978), a *Health For All* action plan endorses a call for action that tackles the broader determinants of health.

This comprehensive view of health action, as we enter the new millennium, is probably the most significant gain of the People’s Health Assembly.

**Other gains**

For the first time in decades, health and non-health networks came together to evolve global solidarity and collectivity in health.

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**Significance of the People’s Health Charter**

The People’s Health Charter endorses health as a socio-economic and political issue and a fundamental human right.

Secondly, it identifies inequality, poverty, exploitation, violence and injustice as the roots of ill-health.

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**‘Health for All’ action plan in the People’s Health Charter**

- Health as human right.
- Economic challenges for health.
- Social and political challenges of health.
- Environmental challenges for health.
- Tackling war, violence, conflict and natural disasters.
- Evolving a people-centred health sector.
- Encouraging people’s participation for a healthy world.
Another significant development was the evolving solidarity which found symbolic expression in various documents at the global level. These indicated that people mattered, and these when taken together represent an unprecedented, emerging, global consensus.

It was not just event oriented, but was preceded by a range of grassroots, local and regional initiatives from the different parts of the world.

The most significant development however, is not what took place before the Assembly, but, what seems to be going on after the December 2000 Assembly. For example, the People’s Health Charter has been translated into several languages which include Dutch, French, Greek, Russian, Ukrainian, German, Nepali, Spanish, Urdu, Japanese, Chinese, Arabic, Finnish, Swedish, Tamil, Sinhala, Kannada, Malayalam, Portuguese etc.

Videos have been made for public education on the events and issues including the ‘BBC – Life Series’ video on ‘The Health Protestors’.

Presentations of the People’s Health Charter, in national, regional and international forum, including the World Health Organization, Global Forum for Health Research (GFHR) and the World Health Assembly have become the norm.

In addition, public meetings/campaigns about taking health to the streets as a ‘Rights issue’ is gaining popularity.

Conclusion

The People’s Health Assembly process was a rather unusual multiregional, multicultural, and multidisciplinary mobilization effort. Bringing together the largest collection of activists and professionals, civil society representatives and the people’s representatives themselves, to evolve a global instrument of concern and action, and to express solidarity with the health struggles of people, especially the marginalized in today’s inequitous and unhealthy global economic order. A long road lies ahead in the campaign for Health for All. Evolving the charter at the assembly in Bangladesh in December 2000, was only the end of the beginning.

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For those deprived of basic nutrition, health is a luxury

This charter has now become an expression of common concerns; a vision of a better and healthier world
The People’s Health Charter

VISION
☑ A world with equity, ecologically sustained development and peace
☑ A world in which a healthy life for all is a reality
☑ A world that respects, appreciates and celebrates all life and diversity
☑ A world which enables flowering of people’s talents and abilities to enrich each other
☑ A world in which people’s voices guide the decision that shapes our lives

RECOGNISING HEALTH CRISIS
☑ Economic changes affecting people’s health and access to health/social services
☑ Poverty and hunger increasing
☑ Gaps between rich and poor nations widened; inequalities within countries increasing
☑ Large proportion of the population lack access to basic needs (food, water, sanitation, land, shelter and education)
☑ Planetary resources being rapidly depleted
☑ Upsurge of conflicts/violence
☑ The world’s resources increasingly concentrated in hands of few who strive to maximise their profit
☑ New economic/political policies affecting lives, livelihoods, health and wellbeing of people in south and north
☑ Public services deteriorating, unevenly distributed and inappropriate
☑ Privatization undermining access and equity principles

PRINCIPLES
☑ Health is a fundamental human right
☑ Primary health care (1978 Alma Ata Declaration) the basis for policy
☑ Government’s fundamental responsibility to ensure access and quality
☑ People and people’s organisations essential to formulation, implementation, evaluation of health programmes
☑ Political/economic/social/environmental factors are primary determinants of health and must get top priority in policy making
☑ Action at all levels to tackle crisis – individual, community, national, regional and global

TIME TO ACT

The concept of primary health care and Health for All grew out of many grassroot experiences in community-based integral health programmes around the world, as Dr Halfdan Mahler has often reminded us. In Latin America there are excellent examples of these health programmes that began in the mid 60s and continue to be relevant, especially today. The community-based health programmes and the health promoters associated with them have been particularly important in terms of health of the many and varied indigenous communities of the Americas.

We want to celebrate the involvement of community health workers and grassroot movements in the advancement of health. For example, the campaigns for the eradication of smallpox, polio and measles would not have been successful without the active involvement and collaboration of these groups.

After the People’s Health Assembly in Bangladesh, throughout Latin America we have been very active in promoting an awareness of the causes of poverty among grassroot communities. It is in knowing and understanding the causes of poverty that we are better able to organize forces to confront and eliminate
Maria Hamlin Zuniga and Ani Whitby, describe the Latin American process of collective action beyond PHA 2000 stressing dialogue and partnership.

them. The PHM is active in Mexico, Central America, parts of the Caribbean, and in South America, especially in Argentina, Brazil, Ecuador and Peru. In each of these countries and regions, the similarity of causes of poverty and illness are quite identifiable.

Government had created systems that they believed were to the advantage of the people on one hand. On the other, funding for programmes became extremely limited as governments sought huge loans from the World Bank and the IMF for other national projects, for military upbuilding, and even for tourism. They allowed multinational and transnational corporations the use of vast territorial areas for the building of big industries thus dislocating hundreds of communities, stripping forests and increasing pollution, toxic wastes etc.

National debts reached overwhelming limits. The WB and IMF created ‘Structural Adjustments’ in each country, resulting in a large percentage of financial cuts for health and education programmes.

In Peru, the Casas de Salud, community health houses, work together with people on health and education programmes. In Brazil, Christian communities and indigenous movements are working toward people’s health. In Mexico and Central America and the Caribbean, there are community-based health programmes working together in the Regional Committee for the Promotion of Community Health, particularly on the analysis of health care reform processes and Free Trade Agreements. The NGOs and the grassroot organizations in the PHM are dedicated to popular education in health. It is working with the people that we really enter into partnership for action.

With the People’s Charter for Health in hand we spread the ‘Call to Action’ working with the people, incorporating their wisdom to bring about a transformation for a better world, promoting life and health with dignity.

We believe that the centenary of the Pan American Health Organization and the twenty-fifth anniversary of the Alma Ata Declaration provides us with an opportunity. Together we, the health sector workers, universities, civil society organizations and other sectors along with PAHO and our country health ministries, must revisit the holistic concept of comprehensive primary health care and its role in the dramatic situations we are facing in the region and throughout the world. In line with the Alma Ata Declaration and the People’s Health Charter we can work together toward a renewed commitment to truly sustainable healthy human development.

Maria is the Coordinator of the International People’s Health Council and one of the key leaders of the People’s Health Movement in Latin America. Sr. Ani is a popular health educator from Brazil.

E-GROUP ON HEALTH

The Spanish-speaking participants of PHA, mostly from Latin America, set up an electronic list serve to continue to share with one another. It is called Red Latin American Asalud or Latin American Health Network.

FTAA CIRCLE

Health activists have decided to work on building awareness of the effects of the Free Trade Agreement for the Americas (FTAA) on the health of the people. The FTAA goes beyond the WTO!

WSF - BRAZIL

Two people represented the PHA at the Social Forum in Puerto Alegre, Brazil. They were able to distribute the Charter at the Forum and make many contacts at different workshops and events. Julio Monsalvo from Argentina has written an inspiring report that has been translated into English and posted on the PHA Exchange.

Together we must revisit the holistic concept of comprehensive primary health care.
POVERTY AND WHO

‘Poverty is the biggest epidemic for WHO to tackle’ – a message that was oft repeated at the last WHA.

According to Mike Rowson, WHO will have to move beyond the disease-specific approach and advocate comprehensive health strategies.

Participants at the most recent World Health Assembly were beaten over the head with numbers. Information booths in the corridors of the conference building and speeches by WHO staff all highlighted shocking data: X children dying of malaria each year, Y people in developing countries suffering from cardiovascular illness and Z women per minute dying in childbirth. WHO is very much a disease-oriented institution, and the diseases compete with each other for money and attention. Poverty, even though is the most important cause of ill-health, does not receive the same attention in WHO’s work. While poverty and health are among the pillars mentioned in WHO’s corporate strategy, the Poverty and Health team has recently been downsized to just two people.

Poverty cannot be wished away

‘Poverty is being mainstreamed’, is the answer given by WHO’s senior management when they were asked about the consequences of the recent disestablishment of ‘Health in Development’, the department in WHO which previously dealt with poverty. But how can poverty be mainstreamed when there are no staff and budgets to do analytical work, to support the mainstreaming process at WHO’s headquarters, regional and country offices, and to support governments in integrating health in development policies?

Poverty reduction strategy papers

An example of the need for WHO to put poverty higher on its agenda, is provided by the recent evaluation of the Poverty Reduction Strategy Papers (PRSPs) that were introduced in 1999 by World Bank and IMF. In a PRSP, countries should outline their plans to reduce poverty. PRSPs could potentially become important instruments for health. Firstly, poverty reduction strategies need to be developed with civil society participation. This could provide space to push for national health policies that are equitable and comprehensive. The needs of the grassroots and experiences of
community-based health initiatives could be heard by national policy-makers. Secondly, these strategies provide an opportunity to address health determinants outside the health sector. Economic policies, for example, need to be screened for their effects on people’s health, before being implemented. Thirdly, donors and multilateral institutions promised to support the implementation of PRSPs and ensure sufficient financing. Instead of supporting separate programmes for malaria, HIV/AIDS and other diseases, which risk to compete for resources and attention, donor initiatives should be bundled and integrated through national strategies to help ensure they strengthen instead of fragmenting the health system.

Bring health to the Centre

This potential still needs to materialise. A WHO review shows that health continues to be marginalised and under-resourced in PRSPs, while proposed health sector interventions are in most cases not explicitly pro-poor, and the links between health and other sectors are neglected. Important opportunities for health are therefore missed. One of the reasons is the lack of involvement of ministries of health in the PRSP formulation process, which in most countries is dominated by ministries of finance and planning. Economic targets therefore prevail in the PRSP. Health is treated as a sector costing money, rather than a fundamental human right and a necessary condition for development. A much stronger voice of ministries of health and civil society organisations, is therefore needed to integrate health in the PRSP.

WHO support

WHO support is indispensable, to help governments in developing health systems and negotiate over the health budget, and to analyze the health consequences of other policies. At the international level, WHO should play a leading role and become a health advocate in relation to World Bank and World Trade Organization policies. WHO should work not only with the poverty and health-oriented sections in the World Bank, but also with the sections that believe that neo-liberal policies are the only way to economic growth and that the poor will somehow automatically profit from growth. WHO should start looking at the linkages between economic policies and health outcomes and how they impact on health and equity, still a largely untouched area.

Conclusion

To discuss possible roles and strategies, WHO’s Poverty and Health team and several NGOs organized a seminar on health and PRSPs at the last WHA. Reina Buijs from the Dutch government provided a detailed agenda for WHO country offices, urging them to provide not only technical support but also be an health advocate and fulfil a broker role. This call was supported by civil society representatives arguing that WHO should guide Ministries of Health to ensure that health is integrated in national development plans. Since WHO’s work is guided by its member states, the countries should voice their expectations clearly. This year at the World Health Assembly many nations mentioned poverty as a crucial health problem, though without elaborating on it. It is a challenge for the People’s Health Movement to build on this growing awareness and to push governments and WHO to adopt a poverty agenda that will really make a difference.

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Poverty reduction strategies need to be developed with civil society participation.
AT THE FOREFRONT OF THE STRUGGLE

The analysis made in the People’s Charter for Health (PCH) applies to today’s world every bit as much, as it did 24 months ago — only that the sense of urgency has been heightened. The PCH vision strives for peace, equity, and an ecologically-sustainable development. The health crisis described for most countries in the world in the year 2000 has deepened.

The charter is committed to the points listed out in the Call for Action as they relate to actively influencing the many direct and indirect determinants of health.

The PCH is committed to combating the negative impacts of globalization as a worldwide economic and political ideology and process. Listed high on its agenda, is the reformation of the International Financial Institutions (IFIs) and the WTO to make them more responsive to poverty alleviation and the Health for All -Now movement.

In addition, the Charter places high on its agenda, forgiveness of the foreign debt of least developed countries and use of its equivalent for poverty reduction, health and education activities is another priority area.

The PCH is committed to greater checks and restraints of the freewheeling powers of transnational corporations, especially pharmaceutical houses, greater and a more equitable household food security and some type of a tax that taxes runaway international financial transfers.

It unconditionally supports the emancipation of women and the respect of their full rights and insists that health should be high on the development agenda of governments.

The PCH stresses on:

- The health (and other) rights of displaced people.
- Halting the process of privatization of public health facilities and for greater controls of the already installed private health sector.
- More equitable, just and empowered people’s participation in health and development matters.
- A greater focus on poverty alleviation in national and international development plans.
- Greater and unconditional access for the poor to health services and treatment regardless of their ability to pay.
- Strengthening public institutions, political parties and trade unions involved.
- Opposing restricted and dogmatic fundamentalist views of the development process.
- Greater vigilance and activism in matters of water and air pollution, the dumping of toxics, waste disposal, climate changes and other attacks on the environment.
- Militant opposition to the unsustainable exploitation of natural resources and the destruction of forests.
- Protecting biodiversity and opposing biopiracy and the indiscriminate use of genetically modified seeds.
- Opposing war and the current USA-led, blind ‘anti-terrorist’ campaigns.
- Categorically opposing the Israeli invasion of Palestinian towns.
- The democratization of the UN bodies and especially of the Security Council.
- Getting more actively involved in actions addressing violence against women.
- More prompt responses and preventive/rehabilitative measures in cases of natural disasters.
- Vehemently opposing the commoditization and privatization of health care.
- Independent national drug policies focused around essential, generic drugs.
- The transformation of WHO, supporting and actively working with its new Civil Society Initiative (CSI) making sure it remains accountable to civil society.
- Assuring WHO stays staunchly independent from corporate interests.
- Sustaining and promoting the defense of effective patients’ rights.
- Changes in the training of health personnel to assure it covers the great issues of our time as depicted in our PCH.
- Public health-oriented and not-for-profit health research worldwide. Strong people’s organizations and a global movement working on health issues.
- More proactive countering of the media that are at the service of the globalization process.
- People’s empowerment leading to their greater control of the health services they need and get.
- Fostering a global solidarity network that can support and reach our fellow members when facing disasters, emergencies or acute repressive situations.

The specific actions proposed in the PCH under each of these headings are not to be seen as the content for a collection of fitting slogans or as a wish-list. Eventually, the PHM will have one or more ‘Action circles’ addressing each of these clusters of demands. These circles will interact through email and will network with other groups already working on each of these issues before releasing their conclusions to our list server and the PHM website.

Twenty-four months after PHA 2000, our challenge remains the same, though more urgent. It still calls for the same actions and makes the same demands made in our People’s Charter for Health. But for this challenge to materialize in concrete, concerted actions, each of you needs to get involved more.

Claudio Schuffan, MD is a pediatrician originally from Chile now living in Vietnam. He was one of the members preparing the PHA2000 and now moderates the PHM listserv E-mail: pha-exchange@kabissa.org

Greater and unconditional access for the poor to health services and treatment regardless of their ability to pay.
Africa with its many health problems finds the ‘Charter’ to be a useful instrument to break the silence about the health issues. An update by Mwajuma Saidy Masaignah

In Kinshasa, Zaire, a trained health worker enters field data on a solar-powered laptop microcomputer at the School of Public Health.

TOWARDS A HEALTHY WORLD

AFRICA

The three major aims of PHM in Africa are:

- Reflect on the PHA and see how the People’s Charter for Health could be used to strengthen activities and systems in Africa and start a campaign for greater support for comprehensive Primary Health Care.

- Identify key health issues that are important and affect the people in Africa.

- Strengthen the People’s Health Movement in Africa.

A range of diseases

HIV/AIDS is a serious problem for health in Africa, but not the only problem. It is important to look at the context and ensure that sufficient resources are available to prevent and treat other leading diseases like: TB, ebola fever, malaria, typhoid fever, cholera, and measles.

Apart from these, some hospitals retain mothers after delivery due to their failure to pay. They wait for relatives to come and bail them out. Sometimes this takes from one week to even more than a month’s period.

The social, political and economic determinants that are impacting our health negatively need to be considered and were identified as:

- Structural Adjustment Programmes (SAPs).

- Trade Related Intellectual Rights (TRIPs).

- Gender insensitivity – increased disparity in access to health with health systems tending to be gender blind.

- Conflicts and wars.

Introduction

We believe that the key link in this process is the need to develop shared partnerships with local and national governments, to complement their work and strengthen their ability to provide services that the people need. Already in many African countries the vast majority of care for patients suffering from HIV/AIDS is being done in poor households mainly by women who receive little or no assistance from the health and welfare services. Governments should give peoples’ organizations, including the PHM, recognition and representation at decision-making fora where issues affecting health are discussed, and to facilitate their recognition and support from national and international donors as channels for resources to facilitate the process of grassroot involvement.
● Gender violence.
● Lack of basic infrastructure – transport, deterioration in health systems including lack of quality services.
● Environmental issues – including water and sanitation, deforestation and natural disasters.
● Corruption.
● Cultural beliefs and practices that contribute to poor health and increase the risk of diseases and those that strengthen healthy behaviours.

Breaking the silence
We have found out that communicating the issues expressed in the Charter is a way of breaking the silence around many of these health concerns. Strengthen peoples’ ability to be involved in the process of both contributing to and demanding the development and strengthening of relevant and effective health services.

The role of PHM in Africa
It must become a strong unifying force, helping to bring together many people and organizations involved in effective initiatives to improve health.

The issue of re-use of female condoms is unacceptable by Africa and suggests that other means be sought. After all, rural women cannot afford to buy a condom that costs almost a dollar. We outrightly condemn this with vigour and dignity.

The People’s Charter for Health should take into consideration the issues that concern the youth and the aged.

Every government should provide obstetric services that ensure that no woman can get HIV transmission at childbirth - (there should be universal precautions in deliveries, as well as all aspects of health care). HIV/AIDS is only one of the many diseases that affect Africa. Therefore, there should be a re-orientation where funding goes, and in this case, grassroot funding is of vital importance.

Support of Global PHM
PHM needs global recognition by international institutions and governments in order to operate and access funding, and thus Africa calls for immediate global recognition of PHM.

Our situation in Africa does not guarantee a Right to Health. Thus we should work towards a change of attitude of our governments to respond to people’s health needs and create space where people can play an active role by activating local actions. The people of the developing world deserve and have a right to share the resources that the rich countries lavishly enjoy. It is time now to demand, and we demand it. It is no more time for rhetoric; we need actions.

Mwajuma is the Convenor of the East and Central Africa Circle for PHM activities in Kenya, Tanzania and Uganda and shared the above message at the briefing session on the People’s Health Charter at the World Health Assembly in Geneva in May 2002.

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“Primary Health Care was and still is, the correct pathway for us all. Holding this meeting in East Africa is bringing the agenda home. Let’s listen to these communities. How many times do we allow them to be part of their development? Genuine people-centred initiatives must be strengthened to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.”

Dr Upunda, Chief Medical Officer Ministry of Health, Tanzania, April 29, 2002.
Milestones

The first meeting on the People’s Health Assembly, during the WHA was two years ago, in the NGO lounge in the basement of the Palais. And because nobody knew where that room was, we had to put up papers with arrows showing people the way. We were busy for two days to get official permission to have our meeting announced in the Journal. Last year it was much better. There was an official room, an announcement in the Journal and even a meeting with the Director General. Now WHO organized a technical briefing on the People’s Health Movement and the Charter. In that sense, a lot has been achieved: we have the possibility to share our views with delegates and the WHO Secretariat, and I think that is very important to start with.

In a way we in Europe are somewhat backward, compared to what has been done in other regions. In most countries, we have not yet come far in terms of mobilising our constituencies, or health professionals. But things are starting, like in Italy where the PHM has fallen on fertile ground. Many organizations and networks also outside the health sector have endorsed the chapter and it was published in medical journals. In St Petersburg, in the Russian Federation, the PHM has brought civil society together for the first time. The Charter has been translated and discussed on the website in Ukraine.

We know we share a vision and a common goal and it is easier to find each other and look beyond the single issues. And we know we have something to defend in Europe: our relatively accessible health systems that are increasingly made subject to market forces, for instance under the General Agreement on Trade in Services (GATS) of the World Trade Organization. We are asking for a full assessment of the potential risks for access to health services and the ability to regulate national health sectors. It is important that health ministries make sure that access to health services is not traded away.
A need for change

We have a special position in Europe, since our governments and the EU are the biggest donors in health. We want our governments to finance and support comprehensive health policies, and avoid putting up vertical programmes that end up competing with each other in terms of money and human resources. We want our governments to support and respect national decision-making processes in developing countries. We want WHO to do much more to support developing countries in strengthening health systems as a part of national poverty reduction strategies. These strategies should respond to people's needs. The proliferating 'Global Health Initiatives' should be aligned to these national strategies, instead of the other way round.

Finally we want our governments to be coherent in their policies. We cannot allow our governments to support health for all objectives in the World Health Assembly and at the same time promote liberalisation of the trade in health services in negotiations under the World Trade Organization. We do not want our governments saying they promote universal access to health services on the one hand and at the same time support World Bank strategies that promote commercialisation of health care and full cost charging to the patients.

WHO's task

We call upon our ministries of health and development to look beyond the health sector, and make sure that health interests are not undermined by other policies made in other departments. We want WHO for example, to start looking at the evidence on the sometimes disastrous impact of economic policies on health and act upon it. We as civil society organizations, want to work with WHO on these issues, for we realise it is a huge task. And we want WHO to take the lead. We, therefore expect our governments and WHO members to make sure that WHO at all levels will move 'full speed' ahead. Such a health alliance can be very powerful (as we saw in the last WTO Ministerial meeting in Doha), where governments stated that patent rights of pharmaceutical industry should not limit access to life saving drugs. But this has to be implemented and there is much more to be done, with a lot of urgency.

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STRUGGLE FOR TOMORROW

Beyond 2000

After the international conference in December 2000, national level health activists, civil societies, professional groups of different social strata, NGOs, trade unions, women’s organizations, different community representatives of the country joined together in the health campaign programmes from grassroots level to policy-making level.

The PHM Bangladesh Chapter, conducted 15 committee meetings on different health agendas.

In addition, the PHM Bangladesh Chapter, gained momentum to tackle the determinants of the health ruins left by SAP and the globalization process, by responding vigorously to the most challenging national, political and social spillovers.

The ‘bottom-up’ approach; lessons from unheard people based on their understanding on health care systems; and realization of the community in designing the programmes of the movement were prioritized through their participation. Awareness building, ‘people to people’ contact at community level, networking of small social forums at the grassroots level are some of the work done during last few months.

Further, the People’s Health Charter has been translated and printed in ‘Bangla’ by the Global Secretariat, after the International Conference. A shorter but popular Bangla version was also prepared by PHM Bangladesh chapter.

National convention

As a follow-up, the PHM Bangladesh Circle conducted its Second National Convention where more than 500 representatives from civil societies, policy makers, social forums, NGOs, women’s organizations, human rights institutes, health activists, trade unions, journalists and campaigners participated. The meeting held at Dhaka in May this year was attended by the Health Minister Dr Khandoker Mosharraf Hossain along with other representatives from the Ministry of Health.

The Convention focused on two issues: ‘Globalization and Health’ (presented by Dr Dipak Kumar of Proshika) and ‘PRSP and Health’ (presented by B.K. Adhikary of Development Organization of the Rural Poor (DORP)). The convention concluded on the note that a national committee with representatives from different communities and professionals would be formed.

Structurally, Bangladesh circles have a different format. These include;

1. Geographical circle: Division, District, Sub-District, Union, Village.


3. Issue-based Circle: Issues like acid violence, pollution, child trafficking, river erosion, torture, road safety etc.

Strategy

It was decided that a two-way strategy would be adopted.

♦ The ‘bottom-up’ at the community level which included the ‘health village’ and stakeholders, through their involvement and participation.

A mother and her sick child waiting for help at the community health centre.
Strong networking, advocacy and lobbying at the top level to bridge the gap in between the 'top-down and bottom up' approach.

PHM Bangladesh advocates that primary health care services should be cheap, available, and affordable. They also insist that all activities should be transparent and to be accountable to achieve this social goal.

Action Plan

- To disseminate message of health issues to the root level as much as possible

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HEALTH CRISIS

In Bangladesh the health and nutrition scenario is grim. Twenty-six percentage of the population have no access to basic health care facilities, 56% of children under 5 years are underweight and suffer from malnutrition. More than 94% of the children are victims of different grades of Protein-Energy-Malnutrition (PEM), about 70% of the children and women suffer from iron deficiency anemia, and 25% of the maternal death are associated with anemia and hemorrhage. About 30 to 40 thousand children go blind every year due to Vitamin-A deficiency. Bangladesh dietary average is 2000 calories as against FAO recommended intake of 2310 calories per day.

About 57% of the population has no access to proper sanitation. Thirty-five million people are drinking tube well water with arsenic contents in 59 districts out of 64 districts in the country.

Health crisis: governments in dilemma

During the last decade, government’s budgets for health care have been decreasing gradually. In addition, the available budget is also focused on donor-driven policies. Most of the government’s health budgets go to city areas for salary and low quality infrastructure development, while the poor in the rural areas receive little. Very few hospitals and health care services were built during the last decade under government initiatives. Health care services are left in the hands of private sector beyond the capacity of common people. Thereby, commercialization of health services has been viewed according to ability to pay and not according to the peoples’ needs.
Jana Swasthya Sabha – A Pre Assembly mobilization process in India

The People’s Health Assembly in Savar, Bangladesh, was preceded by a series of pre-assembly events all over the world. The most significant of these was the Jana Swasthya Sabha (National Health Assembly mobilization). In India, from April to November 2000 at Kolkata, India, on 30th November and 1st December.

- Eighteen national networks came together after 50 years of Independence as a significant symbol of national collectivity and solidarity. These included all the key health networks, the people’s science movements, the women’s movements, the environmental movements and others.

- These networks published five booklets collectively on all the key concerns in health. These included: What Globalization does to People’s Health; Whatever happened to Health For All by 2000 AD: Making Life Worth Living (basic needs and intersectoral issues); A World Where We Matter (health care issues of women, children and marginalized sections of society); Confronting Commercialization of Health Care.

- A range of grassroots, local and regional initiatives took place all over India. These included: people’s health enquiries and audits; Kalajatras—health songs and popular theatre; policy dialogue; block-level seminars; translation of the consensus national booklets into all the regional languages; campaigns to challenge medical professionals to become more Health for All oriented.

- This led up to 250 district conventions that covered representatives from over 1000 community development blocks in the country and was followed by 17 state conventions.

- Then 2500 health activists and professionals boarded five ‘people’s’ trains to reach Kolkata for the National Assembly. The trains did not just transport health activists but also became travelling workshops and opportunities to increase health awareness during the journey, at many stations, with slogans and songs.

- At the Kolkata assembly, delegates endorsed an Indian People’s Health Charter, apart from spending two days together collectively sharing their commitment to the Health for All campaign. They participated in parallel workshops; sub conferences; exhibitions; a march for Health; a public rally; and cultural programmes celebrating national diversity and cultural plurality.

- Lastly, the Jana Swasthya Sabha has now become the Jana Swasthya Abhiyan (People’s Health Movement in India) which is continuing its work at national and state levels mobilizing people for health campaigns on a variety of issues including Health as a Right, Right to Food, Campaign against female foeticide, Violence against Women, Commercialisation of Medical Care and Irrational Therapeutics.

- To integrate more NGOs, civil societies, journalists, social and cultural organizations, trade unions, tribal and indigenous populations, fisher folk community and other grass rooted social institutes

- To hear the experiences of unheard people of different communities and professions living at different socio-economic and social conditions.

- Assess the degree of health care facilities available provided by governmental institutions and non-governmental organizations at the remote area

- Assessing capacities and understanding of the people on health care problems living in severe economic hardship and poverty

- To evaluate sustainable process of health care systems presently existing in the country

- Find possibilities of alternative health policies in the rural and urban areas affordable to common population

Conclusions

PHM Bangladesh circle shall continue to implement programmes to achieve health rights, justice and social equality through awareness programmes, conducting workshops, mass mobilization, and campaign and advocacy programmes in the days to come.

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in the prison of Bologna. Since then it has grown as a federation of more than 60 groups spread all over Italy. Each group has a democratic structure and nominates delegates to AIFO general assembly. The groups are organized in provincial and regional coordinations and involve thousands of persons including about 570 officials. AIFO supports health care projects dealing with leprosy, primary health care and disability. At the same time, in Italy the AIFO groups are involved in advocacy, awareness raising, teachers training courses etc., on issues related to intercultural living, development education, emigration, etc. (For details log on to: www.aifo.it.)

Activities related to PHA

Translation & printing of the Charter: In July 2001, the Charter was translated in Italian and 1500 copies were printed. An edited version of the Charter was printed in AIFO’s monthly magazine in Italian in September 2001. In December 2001, AIFO used the Charter as the theme for its calendar for 2002. Since then, the Charter has been in many

The whole initiative has grown and multiplied in different forms.
other forums – like as annex to the magazine of Italian workers union, as a supplement with a monthly magazine Vita in the Italian Journal of Paediatricians etc. The Charter was also put on the AIFO web page in both Italian and English versions.

People supporting the Charter in Italy: Till the beginning of May 2002, there were already more than 6600 signatures for support of the Charter including from some Parliamentarians, some well known Italian personalities, many university professors, many organizations including NGOs as well as many Catholic congregations and institutes.

A large number of signatures were collected in January 2002, when AIFO carried out a massive information campaign in 250 city squares all over the country, during which AIFO group volunteers sold honey produced at a cooperative of disabled persons and asked people to sign the Charter.

About 700 signatures have been collected through individuals who saw the Charter and wrote back to AIFO saying that they wanted to support it. A detailed analysis of different persons signing the Charter is being carried out.

Networking: The Charter has been seen as part of the struggle in which many other organizations and movements are involved like, ‘Cancel the Debt’ campaign ‘Anti-mine’ campaign, ‘healthy cities’ campaign, ‘Anti-globalization’ forums, ‘Essential Drugs’ campaign etc. Thus different organizations like Doctors for Environment & Italian Health Watch have decided to include the Charter in their activities.

Organization of specific events: In October 2001, AIFO organized an international workshop on Poverty & Development, during which the Charter was also presented.

In November 2001, the biannual AIFO National Conference was organized in Assisi, which focused on PHA Charter.

Dr Halfdan Mahler and Dr Mira Shiva were invited to speak.

Future plans: It has been decided to create some thematic email discussion groups, which should come out with a final document expressing their position about each theme. The themes include – nutrition and health; military budgets, wars and health; women and health; children and health; health and equity. For each thematic group, a promoter will contact and involve persons interested in joining the thematic group.

On the World Health Day 7 April 2003, it may be possible to launch a post card campaign about ‘Give a day of war to peace and health’, asking people to send post cards to government to ask that one day’s defence budget be committed to health needs of homeless
people. It remains to be seen if similar campaign can also be carried out in other European countries or other countries where PHA activities are present.

AIFO has also presented a Development Education project related to PHA charter to European Commission for funding. If the idea of this project is approved, this would provide more funds for doing awareness-raising work with the Charter in Europe – some of the ideas include printing the Charter in comic book form for school children, preparing an interactive CD-ROM on the Charter, organizing an international meeting on Charter in October 2003 etc.

Finally a newsletter called Condivisione (Sharing) is being planned, to provide an instrument to different persons involved in this initiative in Italy to share their experiences and ideas.

Other activities: A doctor in Sardinia island recently informed that she had already organized different meetings with the local medical council on the Charter.

Another group in Naples involved in the thematic group on Health and Nutrition, have invented a boardgame called Nutritionometer, which should introduce the concepts of healthy eating in school children. The city council of Naples has agreed to cover the costs for distribution of this teaching game to 350 classes of school children. With each game, each class will also receive a copy of the Charter.

It is true that such initiatives are ‘un-coordinated’ but hopefully, these will lead to strengthening of the PHA movement in Italy.

Dr Sunil Deepak, Medical Advisor, AIFO, Italy. Address: AIFO, Via Borselli 4 – 640135 Bologna, Italy Email: sunil.deepak@aifo.it

A world where health is a non-negotiable human right which is in the hands of people. And the needs of the least in the community must form the priority. The movement sees the strength and health of the community as that of the poorest and weakest member. Community can only be strong and healthy when the poorest and weakest is strong and health. This is for me, the aim of PHM.

Eva Ombaka, EPN

Dr Mira Shiva addressing the conference
LESSONS LEARNED - A CASE STUDY
THE ‘AROGYA IYAKKAM’ INITIATIVE

This is the synopsis of a community initiative to improve child health and nutrition in Tamil Nadu, India which was one of the case studies at the People’s Health Assembly in India. Balaji and Kalpana outline the key aspects.

Background
This programme was started in May 1999, and is being implemented in roughly 500 villages in 10 blocks in Tamil Nadu, India. Supported by UNICEF, the programme is executed by the NGO - Tamil Nadu Science Forum. The programme has three main aims:

- Improve the use of primary health care services;
- Improve children’s health and nutritional status; and
- Organise and empower women around their health needs.

The programme organised village health committees (VHCs), which selected local health activists. These voluntary health activists were trained together, and more intensively in the field, in talking to mothers about nutrition and diseases, and to pregnant women about nutrition, delivery, breast-feeding and other health matters. The VHCs also met to read and discuss health books, and helped the health activist to promote nutrition and health education.

The main strategies used to address child health are:

At the family level
- Identify children at risk by weighing each child
- Constantly follow up each child at risk and assist families to prevent malnutrition or reverse it by appropriate health education and better use of existing health services

At the community level
- Strengthen Primary Health Care and Tamil Nadu Integrated Nutrition Programme (TINP) services through advocacy
- Make child malnutrition the most important index of health for local planning, and sensitize panchayat members about its significance.

The activists were given intensive training in child health and nutrition to:

- Analyse the combination of factors that led to particular cases of malnutrition;
- Identify those factors that can be
addressed individually and socially; discuss with the family about the child’s risk factors and the importance of addressing those factors; and reinforce the initial message by repeated visits at the family level as well as through cultural programmes and village-level meetings.

Programme principles
The interaction between the health activist and the mother is central to the programme, and is based on principles derived from experience:

Respect: The mother and pregnant woman are seen as intelligent people coping with difficult conditions, and not as ignorant people who will not listen to sensible advice.

Understanding: The focus is therefore, on understanding why a mother does not follow advice, rather than blaming her for not doing so. She already has a world-view, formed by her own experiences and what she has learned from her community. That world-view guides her health practices for herself and her child. The advice she is given by the programme often differs from her own information; to succeed, one must integrate this advice with her world-view, by discussing in detail why it makes sense and how it can be adopted within the limits of her resources.

Skilled and patient negotiation: This kind of dialogue is difficult, time-consuming and requires considerable skill and confidence on the part of the person giving the advice. Training the activist in dialogue takes time; she must learn not only to advise, but to counter arguments and elaborate ways in which advice can be adopted in a resource-poor setting. The activist needs support from a group of trainers who visit her regularly, provide her work with legitimacy and constantly encourage and provide her with further training.

Peer discussion and reinforcement: One-to-one sessions between the activist and mother are complemented by group meetings called by the activist to discuss specific issues (e.g. feeding the colostrum). In such a meeting, a mother will invariably say she has fed the baby with colostrum and the baby is healthy; this can be used as “proof of concept” to convince others. This kind of negotiation with a larger group also requires skill, and often the block-level trainers help the activist to conduct such discussions.

Preliminary results on child malnutrition: As part of programme activities, children aged under five were weighed at the beginning of the programme and again roughly 1.5 years later (in October-December 2000). Of 7133 children weighed during both periods, the percentage of children with a ‘normal’ weight increased from 34.5% to 45.8%. The percentage of ‘grade 1’ children increased by 1.3 percentage points, while the percentage of children in grades 2-4 decreased by 12.6 points.

If one compares each child’s status at both times of measurement, one finds that 34.9% of children improved their category, while 13.5% deteriorated; the remainder stayed in the same category. That is, there was a net categorical improvement among 21.4% of the children.

These results underscore the programme’s impact, in that the nutritional status of a under-fives is not static in the absence of positive interventions in their favour. Rather, one expects their nutritional status to worsen. In areas of the State where the programme is not being implemented, one finds that the overall nutritional status of children aged under five deteriorates over a 1.5-year-time period; indeed this pattern is commonly found throughout India.

Organisational insights
Explanations for these positive results can be found in the actions of the health
activist, the programme’s design and operations place great emphasis on motivating her and making her effective:

When measuring the activist’s work, she is not blamed for children who are malnourished or in poor health. The emphasis is rather on measuring her work, i.e. talking to mothers and pregnant women. If health condition of children have worsened, the reasons are sought in her training or in programme design. Sometimes there are underlying factors beyond her control, such as diarrhoea epidemics.

Some tips

- The activist is always praised in front of the mothers. To boost her respect in the village and her self-confidence, village meetings are organised in which she is honoured and called to talk to the village community. These measures gain her respect locally and motivate her to work harder.

- An egalitarian and intensive relationship between the trainers, and the activists is important. The motivation of these trainers, and their willingness to meet with mothers, often over a period of days, are crucial to providing the activist with a good example as well as the skills she needs.

- The activists’ voluntary status is important to their motivation. The activists and the village understand that the work is done for the sake of improving children’s nutrition.

- To ensure that the focus of the activist is on actually meeting mothers and pregnant women, administrative tasks such as report writing and maintaining records are kept to a minimum. The trainer is responsible for monitoring the programme, and is primarily responsible for administrative tasks; the activist is asked to maintain only one page from which all relevant data are gathered.

While the preliminary results will need to be independently verified, they suggest that this programme might provide a viable model to reduce child malnutrition. More time will be required to determine how long it takes to raise a community’s capacity sufficiently to address malnutrition without ongoing support from an NGO; and to determine the cost of this model.

There are three further considerations relating to sustainability and replicability. First, the model requires supportive primary health care and nutritional services, which have traditionally been provided by the State. These services need to be reinforced. Second, this model is predicated upon intensive outreach counselling and personal relations.

While resource constraints play a role in malnutrition, much of child malnutrition can be explained by behaviours. Poor feeding practices are common, and the in-home management of illness can be much improved.

These problems can only be addressed through a dialogue that intensively and repeatedly seeks to ensure that the right behaviour has been understood and is being practised. There does not appear to be a shortcut or substitute for this approach.

Third, the community’s involvement is important: it provides support to the activist and examples of positive behaviour for others.

Balaji and Kalpana are Health Activists involved with the Tamilnadu Science Forum and the People’s Health Movement in Tamilnadu and India. E-mail: kb@eth.net
TRADE FOR PEOPLE, NOT PEOPLE FOR TRADE

The right to food, health, education, work and an adequate standard of living are part of the internationally recognized framework of human rights standards. That makes them a legal obligation rather than just a policy option. A global campaign launched in December by the Geneva-based Ecumenical Advocacy Alliance (EAA) argues that the universality of these obligations fundamentally challenges notions of competition and efficiency, which accept that in the global marketplace, some people and communities may lose these basic entitlements.

Launched in Geneva, Switzerland on World Human Rights Day, the three-year campaign wants to ensure that international human rights, social and environmental agreements take precedence over trade agreements and policies. Or, as its slogan says that trade is for people, not people for trade.

The EAA is a global network of more than 85 churches, development agencies, and related organizations on all continents, including the World YWCA, the World Council of Churches, Bread for the World, and many others. It represents a constituency of hundreds of millions of people. "As institutions, and as members of civil society, we believe we have both the obligation and the power to speak for justice and change the rules of global trade," considers EAA board member Dr Musimbi Kanyoro.

Speaking at a press briefing on the campaign, Kanyoro, secretary general of the World Young Women’s Christian Association (YWCA), argued that economic injustice, spearheaded by "trade rules that are not fair and don't put people first", are "brutally ripping the global community apart."

Why churches?

In answer to the question "Why are the churches taking up the issue of trade?" Prof. Dr Christoph Stückelberger of the EAA’s trade strategy group told journalists that it is "because the biblical standards for economics, including the trade of goods and services, are justice and taking the side of the poor."

'This vision,' said Stückelberger, "should not be reduced to mere equality of opportunity for all to compete without hindrance. That has only helped those who already have access to political and economic power to gain more power and a greater share of the world’s resources, and to create power elites that suppress others."

The campaign acknowledges that "trade is a basic social activity", and that it "can contribute to the common good". But it argues that "trade on unequal terms is damaging, creates and maintains inequities, and can lead to violence, conflict and environmental destruction." It holds that "trade should be a means to share the bounty of the earth and the fruits of human labour, yet too often is a force that causes poverty, despair, injustice and death."

Campaign plan

The campaign will advocate for trade rules and policies that recognize the right to food, ensure sustainable agriculture, promote greater self-reliance in developing countries, guarantee access for all to essential services, and allow for regulation of transnational corporations. Its action plan covers: mass mobilization, including use of a global petition; local advocacy initiatives; and lobbying with international institutions by experts from North and South.

Each participating church and organization will take up the common campaign agenda in its own context with its own government, as well as working together to impact international institutions.

This plan has been shared with both World Trade Organization (WTO) director general Supachai Panitchpakdi and UN high commissioner for Human Rights Sergio Vieira de Mello, and both have agreed to meet with the EAA. It has also been sent to all governmental representatives and observers to the WTO, and to all ambassadors to Switzerland.

The plan of action and the petition are available on the EAA website at http://www.e-alliance.ch/trade.html.
THE COURAGE TO CHANGE

Christ calls us to walk a new path, and we can’t always see where it leads. Yes, it’s risky, and it can be frightening. Living openly calls for both courage and discernment, to risk mistakes and misunderstandings.

It scares me, Lord, the thought of so much change. At times, I’m petrified, a hunted creature, crouched mute in long grass, the only sound the pulse beat in my head. And when I get the chance I run for cover, hoping I won’t be noticed. Praying that change may pass by silently on hawk’s wings, its shadow sliding softly out of vision. And leaving me to breathe again. Life just as it was. Uninterrupted, undisturbed. It doesn’t work that way. Your world, my world, so solid to the touch, is constant change. Growth, and renewal. And if it weren’t, where would I be? My only hope is in the change you’ve worked in me. Are working. Renewing me each day, and, hopefully, moulding that quiet transformation which makes me, slowly, more like you. I welcome that. At least, I do in my best moments. I see the need, and though I sometimes feel the pain, the outcome’s sure. Lord, help me find the courage to adventure, the willingness to take the risks that living for you brings. And let me know the joy of walking close to you, my ever-changing, yet unchanging Lord.

by Eddie Askew

This booklet has an overview of the PHA and its view on world health. It specifically focuses on factors affecting health and challenges the inequitable and unhealthy global model of development.

People’s Health Assembly - Discussion Papers: prepared by PHA drafting group.

This booklet includes five key discussion papers by PHA Activists for the PHA 2000 and covers the political economy of the assault on health; equity and inequity today; medicalization of health, the environmental crisis; communication as if people mattered.

Voices Of the Unheard – Testimonies from People’s Health Assembly by PHM 2000.

This booklet shares people’s testimonies from Tanzania, Ecuador, UK, Bangladesh, New Zealand, India, Palay, Australia, Brazil, Zimbabwe and Guatemala that were presented at the People’s Health Assembly, GK Savar, December 2000.

What Globalization does to People’s Health – A people’s health assembly booklet (1) by PHA National Coordination Committee – Jan Swasthya Sabha, India, 2000.

This booklet is part of a 5 booklet series has been brought out by the PHM India Movement for guiding district and state seminars. It focuses briefly on understanding what Globalization is all about and how it affects the health of the poor.


This booklet briefly dwells on an understanding of primary health care and the making and the unmaking of the Alma Ata Declaration. It focuses on the war against malaria and tuberculosis as case studies of distortions from the primary health care module.

Making Life Worth Living! A people’s health assembly booklet (3) by PHA National Coordination Committee, Jan Swasthya Sabha, India, 2000.

This third booklet in the series focuses on meeting the basic needs for all and the inter-sectoral issues in health care including civic basic amenities like water, sanitation and housing, basic education and livelihoods and securing people’s livelihoods.

A World Where We Matter – A people’s Health Assembly booklet (4) by PHA National Coordination Committee, Jan Swasthya Sabha, India, 2000.

This fourth booklet of the series looks at health issues of women, children and the marginalised sections of society including street children, differently abled and the uncared aged.

Confronting Commercialization of Health Care! A People’s Health Assembly booklet (5) by PHA National Coordination Committee, Jan Swasthya Sabha, India, 2000.

This booklet contains a brief introduction to the ethical and professional dimensions and quality of care implications of the growing thrust to privatize all health care services. It has special focus on rational medical care and medical ethics.

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ANNOUNCEMENTS

Want to stay in contact with the People’s Health Movement? We certainly would be very glad you did. Do two things:

1. Periodically visit PHM’s website and see what’s new www.phmovement.org

2. Join our active listserver and receive informative emails 3-4 times a week and post your OWN news and comments to share with 600 others in the list.

Write directly to pha-exchange@kabissa.org and ask to join, OR write to the list’s moderator at aviva@netnam.vn asking for the same. If you do both things, we still ask you to share hard copies of the materials you find of interest with those organizations and individuals who do not have access to the internet and email services. JOIN THE NETWORK. STAY ABREAST. MAKE A DIFFERENCE. DIVIDED WE BEG; UNITED WE DEMAND! Claudio

Announcing the relaunch of the People’s Health Movement website. Please visit the site at www.phmovement.org and encourage others to also visit the site.

Among the new features are:

* the full text of Voices of the Unheard - the testimonies of the people from the PHA
* copies of the Charter in several languages (and more are being added)
* access to all of the background papers and issue papers from the PHA

We would also like to ask any people on the PHA-Exchange list who are interested in and have experience of working on communication, media and website activities to join the PHM Communications Working Circle. Again, simply send us an e-mail to: communications@phmovement.org

LETTERS

Dear Editor,

We have read Contact 175 with great interest, especially the article of ‘Breakfast to Break Barriers’ from Mr Leonardo Villegas Zamorano, who describes his therapeutic community for drug addicts.

We are involved in rehabilitating alcoholics and home brewers at community level, by prayer, counselling and organization of self-help groups who develop small scale income generating projects.

M.W. Tarus, Secretary, Kenya Anti Alcohol Programme

Contact deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing.

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