



HEALTH FOR ALL NOW !



REVIVE ALMA ATA !!





GIVE HEALTH A CHANCE!

- A PHM Song

Everybody's talking about
Globalism and localism
Liberalism, conservatism,
Socialism and fascism,
Nationalism and endless rows of
Other '-isms', but

All we are saying is
Give HEALTH a chance;
All we are saying is
Give HEALTH a chance!

Everybody is talking about
Revolution, evolution,
Regulation, transformation,
Integration, separation,
Degradation, concentration,
Corporatisations; endless rows of
Other '-ations'; but

All we are saying is
Give HEALTH a chance;
All we are saying is
Give HEALTH a chance!

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The cover picture of this book shows Endramaya (60), a migrant casual labourer carrying on his back his wife, Lakamma (50), her broken right leg in a plaster cast. The image is a testimony against the ailing Public Health System. (Ref, Page 45). This photograph first appeared in *The New Indian Express*, Bangalore.





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People's Health Movement

WHY ALMA ATA ANNIVERSARY ? - It is to ensure Health For All NOW !

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1. The International Conference on Primary Health Care, co-sponsored by WHO and UNICEF, was held in Alma Ata (USSR) from 6th to 12th September 1978. The Declaration of Alma Ata, finalized on 12th September 1978, was a very radical contribution to a new social paradigm of health care. This year we commemorate the 25th Anniversary of this momentous declaration.
2. The post Alma Ata years have witnessed a wide range of interesting health initiatives. Starting with Primary Health Care Strategies at the Global and country levels, there were other supportive initiatives such as Essential Drugs strategy and the code for Marketing Breast Milk substitutes. Soon the comprehensive strategies were replaced by more selective vertical programmes starting with the expanded programme of immunization and international initiatives like GOBI-FFF, safe motherhood, to more recent ones like RBM and TFI. More recently, another generation of initiatives have evolved including GAVI, MMV, Global fund for AIDS, TB, Malaria and others.
3. The Alma Ata Declaration in 1978 and the Peoples Health Charter, which was a re-endorsement of the Alma Ata principles, at the first Global People's Health Assembly in December 2000 should be used as the framework for analysis to look at the present situation and all the new generation of health initiatives. With the changing visions and roles of international health agencies like WHO and UNICEF who were co-sponsors of the Alma Ata meeting; the growing development of World Bank as a key health player; the effects of neo-liberal economic policies of liberalization, Globalization and privatization; and evolving international instruments of governance like WTO, IPR, GATT , the whole primary health care context has been distorted. Our analysis must be , therefore, both historical and contextual.
4. The changing leadership of WHO and UNICEF over the years including the change in WHO in 2003 must be added to the analysis and this Anniversary opportunity should also be used to discuss the type of International health leadership we have, and what we need.
5. With the evolution of the People's Health Movement and the increasing health concerns in the World Social Forum, this is also an important year to reflect on how PHM, WSF and other such international initiatives can strengthen the struggle for Health for All. While it sometimes easier in our analysis to focus on WHO/ UNICEF/World Bank and national governments - we should also critically evaluate the NGO-civil/society efforts in the last 25 years. We also need to take the responsibility for not becoming an adequate countervailing power to this neo-liberal distortion in the Health For All goals.
6. The People's Health Movement evolving at different levels may be the beginning of a new phase, a new collective commitment. Our reflections in 2003 must lead to sustainable mechanisms of functioning so that the momentum continues and gets deeply, socially rooted.
7. The biggest challenge for all of us in the People's Health Movement is to ensure that the PH Charter does not go the same way as the Alma Ata declaration - forgotten, distorted, selectivised, verticalised, commercialized and ignored. PHM was meant to be a global challenge to this global amnesia. We need to evolve a different strategy this time and use 2003 as a launching pad for it. As we celebrate the Alma Ata Declaration, let us also celebrate the evolution of the People's Charter for Health, two documents that support the struggle for Health for All, Now.

ARE WE READY TO GET INVOLVED?



People's Health Movement

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- Consumers International-Regional Office for Asia and the Pacific (CIROAP)
- Dag Hammarskjold Foundation (DHF)
- Gonoshasthaya Kendra, (GK)
- Health Action International (HAI) - Asia- Pacific - HAIAP
- International People's Health Council (IPHC)
- Third World Network (TWN)
- Women's Global Network for Reproductive Rights (WGNRR)

Regions

- Central America, Mexico and Caribbean
- China
- East and Central Africa
- Europe
- India
- Middle East and North Africa
- North America
- Pacific, Australia and New Zealand
- South Asia (excl. India)
- South America
- South East Asia (excl. China)
- Southern Africa
- West Africa

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The Alma Ata Anniversary Pack

- This collection of statements, reflections and papers is released for use by People's Health Movement members, friends and enthusiasts all over the world to initiate a celebration for the Alma Ata Declaration anniversary particularly around 6-12th September 2003. (These are the actual dates of the meeting in 1978 when the Alma Ata Declaration was passed in an International Conference on Primary Health Care organized by World Health Organization and UNICEF and other organizations and ratified by the majority of the countries of the world.)
- The Declaration is particularly significant to the People's Health Movement because the People's Charter for Health which evolved at the first People's Health Assembly at Gonoshasthaya Kendra (GK) – Savar in Bangladesh on 8th December 2000, endorsed the principles and practice of universal, comprehensive Primary Health Care as outlined in the Alma Ata Declaration.
- Celebrating the Alma Ata Anniversary is therefore a symbolic endorsement of both these consensus documents and an opportunity to express solidarity with the Health for All Now campaign of the Global People's Health Movement.

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TWENTY FIVE YEARS OF PRIMARY HEALTH CARE : LESSONS LEARNED AND PROPOSALS FOR REVITALISATION

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1. PRIMARY HEALTH CARE – FOCUS AND IMPLICATIONS

The strategy of Primary Health Care, advanced by WHO and UNICEF, was declared by 134 states at Alma Ata in 1978 to be the means to achieve Health for All (HFA) by the Year 2000(7). PHC had strong sociopolitical implications. It explicitly outlined a strategy which would respond more equitably, appropriately and effectively to basic health care needs and also address the underlying social, economic and political causes of poor health. Certain principles were to underpin PHC, namely, universal accessibility and coverage on the basis of need; comprehensive care with the emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; intersectoral action for health; and appropriate technology and cost-effectiveness in relation to the available resources(8).

The implications of PHC were recognised, even at the time of the Alma Ata Declaration, to be far-reaching if the strategy were to be properly applied: the principles would have to be translated into changes not merely in the health sector but also in other social and economic sectors as well as in community structures and processes.

2. MIXED PROGRESS IN GLOBAL HEALTH

Over the past 50 years and even over the last 25 considerable gains in health status have been achieved. Globally, life expectancy at birth has increased from 46 years in the 1950s to approximately 65 years in 1995(1) and the total number of young children dying has been restricted to approximately 12 million instead of a projected 17.5 million(2). Substantial control of certain communicable diseases, notably poliomyelitis, diphtheria, measles, onchocerciasis (river blindness) and dracunculiasis (Guinea worm) has been achieved through immunisation and specific disease control programmes(3). and cardiovascular diseases have decreased in males in industrialised countries, partly because of a decline in smoking(4).

Despite these gains, however, there have been setbacks. Although in aggregate terms child mortality and life expectancy have improved in all regions of the world(5) disaggregation of these data reveals that the gap in mortality rates between rich and poor between and within countries has widened significantly for certain age groups. Furthermore, in a number of Sub-Saharan African (SSA) countries, infant mortality rates (IMR) actually increased in the 1980s under the impact of economic recession, structural adjustment, drought, wars and civil unrest and HIV/AIDS(6).

The past two decades have also witnessed the alarming resurgence and spread of old communicable diseases once thought to be well controlled e.g. cholera, tuberculosis, malaria, yellow fever, trypanosomiasis, dengue etc. while new epidemics, notably HIV/AIDS, threaten this century's health gains in many, mostly developing, countries. Many developing countries are also experiencing a double disease burden, with cardiovascular diseases, cancers, diabetes, other chronic conditions and violent trauma replacing communicable diseases in some social groups, but in others co-existing with them.

3. PROGRESS AND REVERSALS IN IMPLEMENTATION OF PHC

Implementation of PHC has been rendered difficult as a result of misinterpretation and of changed context. Misinterpretation was rooted even in the Alma Ata document wherein PHC was defined as both a "level of care" and an "approach": these two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some developed countries and sectors PHC often has been interpreted as primary medical care provided by general doctors, and in developing countries as a cheap, low technology option for poor





people(9). Even in countries which embraced PHC as the key to Health For All (HFA), conservative changes in the 1980s in the political and economic context bedevilled its implementation.

There have, however, been significant successes especially in the 1980s, in implementing PHC, although mainly in the development and extension of particular health programmes, rather than in the facilitation of social development through the promotion of an intersectoral approach and community participation(10).

The greatest successes in PHC implementation in developing countries have been in respect of its more medically-related elements. For example, in the 1980s coverage of growing children with the six basic vaccinations increased dramatically from below 40% worldwide to over 70% by 1990. Similarly, access to oral rehydration therapy (ORT) for treatment of diarrhoea expanded over the same decade as did improved access to water and sanitation in some parts of the world.

However, the control of both communicable and non-communicable diseases has proved elusive. In particular HIV/AIDS, T.B. and malaria are affecting rapidly increasing numbers of (especially poor) people worldwide. HIV, which now affects over 40 million people, three-quarters of them in sub-Saharan Africa (SSA), has led to declines in life expectancy in a number of countries. The control of these three diseases and of the chronic diseases, which affect increasingly large numbers of poor people, is complex and clearly requires improved living and working conditions, well-functioning health systems and strong intersectoral coordination and community mobilisation.

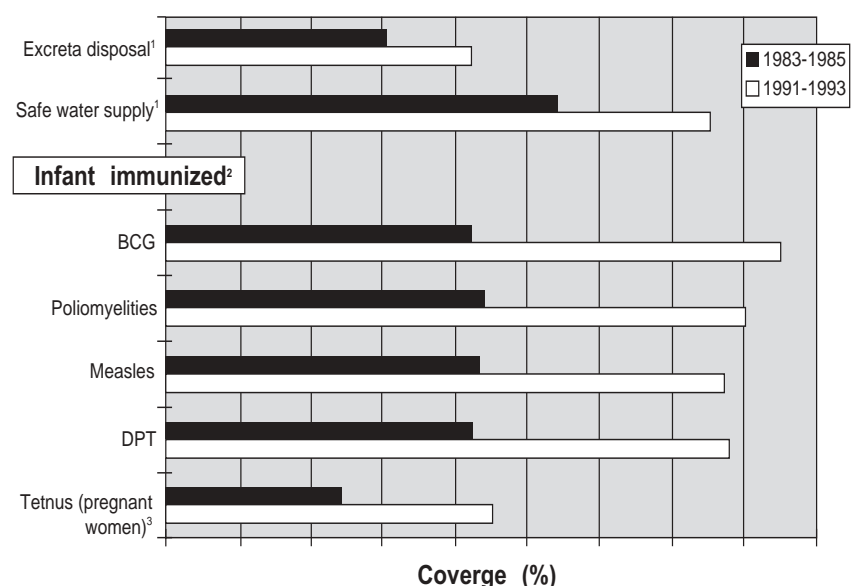
However, it is clear that health systems in most developing countries, and especially in SSA have deteriorated in the past ten to fifteen years. This is most starkly illustrated by the decline in vaccination coverage of young children to well below 1990 levels, despite intensive polio vaccination campaigns and the regular measles vaccination campaigns.

3.1 Progress and Setbacks in Implementing the Programme Elements

Since the early 1980's there has been considerable progress in the coverage of populations with the essential elements (or programmes) of health care.

(Source: WHO 1998B, p 4)

Figure 1. Access to selected elements of primary health care, developing countries, 1983-1985 and 1991-1993



¹ Percentage of population. ² Percentage of children under one year. ³ Percentage of pregnant women.

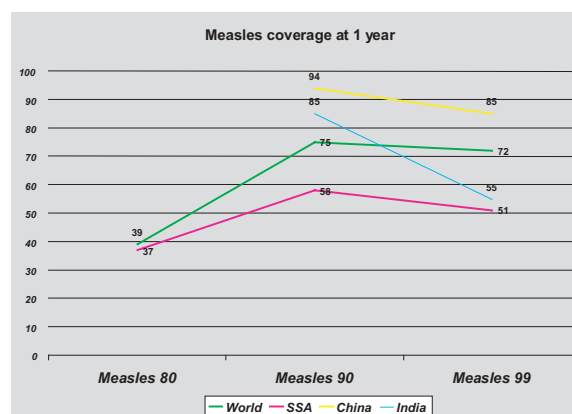
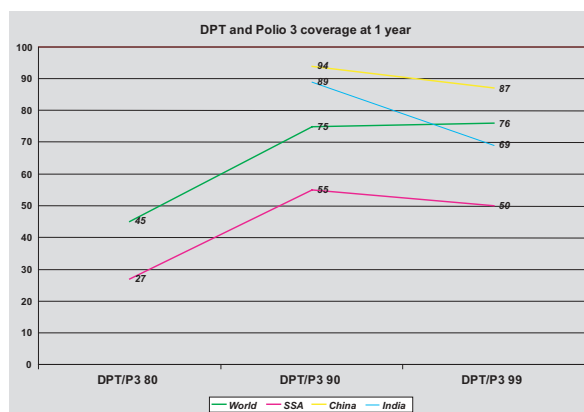
(Source: WHO 1998B, p4)





There has been some progress in improving access to **water supply and sanitation**, although great differences continue to exist between and within countries and social groups.

Child health care provision has increased greatly over the past two decades with the vigorous promotion of certain selected “Child Survival” technologies: growth monitoring, oral rehydration therapy, breastfeeding and immunisation (GOBI). Of these, **immunisation** has shown the most dramatic improvement, with global coverage of children under one year increasing from 20%(11) in 1980 to 80% by 1990. This impressive progress notwithstanding, there remain areas for concern. These include stagnation in immunisation coverage between 1990 and 1993, and declines in coverage in most regions of the world by 1999(12) with the most difficult to reach population being the group experiencing a disproportionate burden of vaccine- preventable disease; the reappearance of diphtheria in the Newly Independent States as a result of vaccine shortage and poor programme management(13); and less than 50% coverage of pregnant women with tetanus toxoid vaccine.



The **nutrition situation** in developing countries remains serious with almost 200 million young children being malnourished and almost a billion people receiving less than their basic daily requirements of energy and protein.

Acute respiratory infection (ARI) and **diarrhoeal diseases** are the two leading causes of death in children under 5 globally with the overwhelming majority of cases occurring in developing countries. Standardised management guidelines have substantially reduced fatality rates but the impact has been less than anticipated due to interrupted and inaccessible supplies of oral rehydration solution, improper usage and an unabated high incidence of diarrhoea as a result of minimally improved environmental hygiene and persisting malnutrition(14). More recently, given that 70% of young child deaths can be attributed to diarrhoea, pneumonia, measles, malaria and malnutrition, clinical guidelines for the **integrated management of childhood illness (IMCI)** have been developed(15).

Maternal health has received far less attention than child health, with levels of **maternal mortality and morbidity** from largely preventable causes in developing (particularly the least developed) countries remaining unacceptably high.

Control of the three most common and serious **communicable diseases**, tuberculosis (TB), HIV/AIDS and malaria has proved elusive. TB is now responsible for over 25% of avoidable adult deaths worldwide(16) with 95% of cases occurring in developing countries; its prevalence has risen sharply over the past decade-and-a-half as a result of HIV infection, deteriorating socio-economic conditions and poor quality control programmes, together with the emergence of multi-drug resistant organisms. The HIV epidemic has spread rapidly to affect over 40 million individuals, mostly in developing countries, especially Sub-Saharan Africa (SSA), and involves predominantly young adults and children born to HIV-infected women. In some SSA countries gains in survival achieved over the past few decades are being reversed by the effects of HIV infection. The malaria situation



remains serious, particularly in SSA where it imposes high mortality and morbidity levels and a major economic burden from lost productivity and escalating treatment costs as antimalarial drug resistance spreads.

Table: Maternal Mortality Rate.

Country groupings	Maternal mortality per 100 000 Live births, 1991	Number of Member States Included, 1991
Developing countries	421	113
<i>Of which least developed</i>	<i>727</i>	<i>37</i>
Eastern Europe	41	8
Developed market economics	34	25
Total	370	146

(Source: Tarimo & Webster 1994, p 39)

Current strategies for control of these diseases are remarkably similar. TB control programmes rely heavily on directly observed short course chemotherapy (DOTS); HIV control has focused on targeted educational activities and early treatment of STDs; and malaria control on early diagnosis and treatment and selected preventive measures – particularly insecticide treatment of bednets - as part of WHO's new "roll back malaria" initiative. While the technologies employed in all three cases have evolved considerably in the past decade, sustained success in combating these diseases is unlikely without well-developed health systems, improved living and working environments secured through anti-poverty measures and coordination with health-related economic and social sectors, and active participation by communities in such control campaigns.

The major **non-communicable diseases** such as cardiovascular disease, cancers, diabetes and mental illness together with violence and injuries contribute significantly to the burden of disease in developed, and, increasingly, in developing countries. Their complex epidemiology requires better clinical management and lifestyle modification but also actions involving a range of sectors and tied to more fundamental measures, for sustainable impact.

Thus it is that the understanding and application of **health education**, one of the elements of PHC, has evolved significantly from a preoccupation with individual behaviour change towards a broader set of activities termed "health promotion", which incorporates individual as well as social action(17).

*The final programme element to consider is **Essential Drugs**. While access to essential drugs is much improved approximately two billion people still do not have access to the most important drugs and vaccines(18) and at the same time drugs bills for most countries and their health services are massive, and problems of wastage and irrational drug use remain.*

3.2 Progress and Setbacks in Health Systems Development

In the 1980s there was little recognition of the importance of health systems and almost a decade after Alma Ata the activities of various programmes and institutions continued largely to be piece-meal, poorly coordinated, and unevenly distributed. As a result, the concept of the district health system (DHS) was born(19).

The DHS has been promoted as the unit within which the implementation of primary health care by the health and health-related sectors (public and private), and communities can be best organised and coordinated. District management structures were envisaged as a focus for decentralisation of political power and resources, increased democracy and equity.

Despite efforts over the past ten years or more, there are few countries where district health systems are functioning fully and effectively(20). There are a number of linked reasons for this: these are related ultimately



to the lack of capacity – human and financial – of health services at local levels and an unfavourable broader political and economic environment.

In short, health systems development has been uneven and constrained by fiscal austerity, which has in many countries adversely affected the quantity and quality of human and material resources and logistical support. Efficiency imperatives which have spurred health sector reform and alternative financing approaches in both industrialised and developing countries, have sometimes generated significant innovation but have also often aggravated dysfunctionality and inequity, particularly in developing country health systems(21).

Despite the fact that the successful functioning of health systems depends critically on adequate numbers and competence of personnel who account, in most countries, for approximately 70% of recurrent expenditure on health services, this important area has received inadequate attention in the HFA initiative.

Since 1978 there has been a considerable expansion in health human resources particularly at the “auxiliary” or “paramedical” level in developing countries and, especially in the immediate post-Alma Ata period, in the community health worker cadre. Despite this, many poor countries, especially the least developed, have too few health workers to provide universal coverage and in all countries there continues to be significant maldistribution of, and imbalances between, various types of health workers.

Teamwork is, on the whole, poorly developed(22) and the motivation and competencies of health personnel require considerable strengthening, especially in the non-clinical domains, to implement PHC. Also, greater involvement of traditional practitioners in the health system has been advocated in some countries: achievements in this regard have been limited, with the notable exceptions of China and India where progress largely antedated Alma Ata.

One of the most significant impediments to the successful implementation of PHC, and a major reason for the continued dominance of specialist and hospital-based health care in many countries, has been the substantial failure of most tertiary education health science institutions to adapt their missions and activities to the challenge posed by HFA. Primary health care and public health usually remain marginalised in the formal curriculum and, when present, are often presented in an abstract and theoretical form, with little application to priority health problems and challenges(23).

Further, the training of health professionals mainly at the secondary and tertiary levels of care has meant that health workers are ill-equipped to do primary level work. If health workers are to render comprehensive care at all levels, their practical and theoretical training must be relevant to addressing the needs of the population. It is urgent, therefore, that district-based health teams receive such training(24).

Additionally, important aspects of management of human resources, such as mechanisms to ensure greater retention and improved support and supervision, have been given insufficient attention. This has contributed to demoralisation and loss of personnel and inefficient and low quality service provision in the public health sector of many countries(25).

In summary, then, progress in implementation of PHC in developing countries has been greatest in respect of certain of its more medically-related elements (e.g. immunisation, oral rehydration therapy). This strategy of “selective primary health care” – symbolised in the 1980s by GOBI (Growth monitoring, oral rehydration therapy, breastfeeding and immunization) - has reinforced the “medical model” and de-emphasized equitable social and economic development, intersectoral collaboration, community participation and the need to establish sustainable and decentralised structures and systems. Thus, the mixed progress in global health reflects the uneven dissemination of effective and robust health technologies, although often in a context of declining health systems, and in a situation of widening disparities in wealth and widespread poverty, resulting in diminished access for many to the basic needs of food, water, sanitation and housing. Acceleration of pre-existing economic, social and political interdependence has resulted in globalisation, characterised



by such instruments of economic integration as Structural Adjustment Programmes and sweeping regulation of trade which threaten the economic sovereignty of poorer nations and in the short run have aggravated inequities(26) (27).

4. PROPOSALS FOR THE REVITALISATION OF PRIMARY HEALTH

CARE

4.1 Equitable social investment

In charting the way forward in a world where wealth and health are becoming rapidly and increasingly polarised it is important to reaffirm the centrality of equitable, broad-based and gender-sensitive development and social sector investment in achieving substantial and durable health improvements. This is illustrated by the striking success that has been achieved in social development and health by a few poor countries, notably Sri Lanka, Costa Rica, Cuba, China and Kerala State in India. In these countries mortality and malnutrition rates are much lower and life expectancy much higher than in other countries of similar wealth and, indeed, many much richer countries. An authoritative study of these countries by the Rockefeller Foundation attributed their impressive achievements to a political commitment to equity, secured through strong movements of civil society or social revolution(28). In all cases this resulted in the provision of universal education and an emphasis on primary health care, as well as the assurance of adequate diets through a combination of land reform and consumer food subsidies. That greater equity has been achieved and is associated with better social statistics, whatever the aggregate wealth of a country, is evidenced by the fact that these poor countries have much lower Gini coefficients (an index of relative equality) than neighbouring states.

4.2 Implementing healthy policies and comprehensive programmes

In synergy with equity-oriented social sector investment, a strategy to revitalise PHC requires the complementarity of "bottom-up" comprehensive health programme development and "top-down" policy development and planning. Successful implementation depends on the creation of a facilitatory environment through advocacy, community mobilisation, capacity-building and organisational change backed up by financing and legislation.

Policy development needs to involve those sectors, agencies and social groups critical to achieving better health. Steps include advocating health objectives as integral to socio-economic development, and engaging different sectoral partners and community structures in such a consensual process, which may benefit from setting agreed-upon goals and indicators of progress. Implementation requires functional intersectoral structures, and often laws as well as management instruments and equity-based financing(29).

PHC implementation has often been predominantly facility-based and focused on the curative and preventive components of comprehensive care, while the health promotion movement has stressed the broader social components. The divide between these two initiatives requires urgently to be bridged. Health promotion through Healthy Cities initiatives as well as a focus on other settings, including health districts, can advance the development of healthy policies(30). The success of such multifaceted initiatives depends on organisational change within (especially) government and an openness to the positive potential of community groups.

Whereas health promotion activities commence with a multisectoral focus, programmes originating around diseases or health problems start from a health care response. By addressing priority health problems comprehensively through a combination of rehabilitative, curative, preventive and promotive actions a set of activities common to a number of health programmes will be developed as well as a horizontalised infrastructure. The principles of comprehensive programme development apply to all health problems.

**Comprehensive Primary Health Care for some common diseases :
a summary framework of priority interventions**

DISEASE	INTERVENTION			
	Rehabilitative	Curative	Preventive	Promotive
Diarrhoea	Nutrition Rehabilitation	Oralrehy dration Nutrition support	Education for personal and foodhygiene Breastfeeding Measles Immunization	Water Sanitation Household Food Security Improved child Care
Pneumonia	Nutrition Rehabilitation	Chemotherapy	Immunisation	Nutrition Housing Clean Air
Measles	Nutrition Rehabilitation	Chemotherapy	Immunisation	Nutrition Housing
Tuberculosis	Nutrition Rehabilitation	Nutrition Support Chemotherapy Nutrition Support	Immunization Contacts (tracing)	Nutrition Housing Ventilation
Cardiovascular Disease	Weight loss Graded exercise Stress control	Drug treatment Supportive therapy	Nutrition education Increased exercise Treat hypertension Smoking cessation	Nutrition policy Tobacco control Recreational facilities

Programme design should be based on an assessment of the seriousness of the problem, analysis of its multifaceted and multilevel causation and of the resources that can be mobilised to address it. Minimum or core service components such as the IMCI (Integrated Management of Childhood Illness) guidelines, protocols for clinical management of common diseases etc. should be integral to such comprehensive programmes and replicated at different levels of the health system, including in hospitals(31).

Such programmes need to be integrated into decentralised district systems. This inevitably requires transformation of both management systems and practice. A primary requirement is appropriate and usable health information for planning programmes and monitoring their implementation(32). Where such information is lacking, health systems research – which may be fostered in working relationships with academic departments of public health – may assist decision-making(33).

Most district level health personnel will be based in sub-district facilities such as health centres and clinics. Health centres should be the focal point for comprehensive PHC : personnel teams will therefore need a combination of clinical skills and skills in participatory programme development(34). Their success can be enhanced by working with and through community health workers: the role of this cadre needs to be re-examined, given their undoubted historical and potential contribution.

Since equity is core to the policy of HFA and current socio-economic and health sector trends are aggravating inequities, capacity to monitor equity in health and health care needs to be strengthened(35).



A prerequisite for the realization of HFA is sufficient numbers and effective performance of health personnel in all phases of health systems development. The PHCA needs to strongly inform both curriculum and content in all the health sciences as well as the process of, and choice of venues for, learning. Learners at undergraduate and postgraduate level need to be equipped with a broader range of competencies than hitherto has been the case(36). Expansion of continuing education and training is urgent if system change is to be achieved in the near future. Relevance will be enhanced through problem-oriented and practice-based approaches, preferably involving multidisciplinary teams. To give effect to such changes, teaching staff in many countries also require urgent strengthening of knowledge and skills(37). Retention of personnel in the public sector is increasingly difficult during the current economic crisis. Urgent attention needs to be given to implementing measures – incentives and regulations - to halt this loss from the public health sector of precious human resources(38).

5. CONCLUSIONS

It is clear that progress towards Health for All has been uneven. Gains already achieved are under threat from a complex and accelerating process of globalization and neoliberal economic policies which are impacting negatively on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes that have reduced substantially the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilizing roles – which are the keys to its sustainability – have been neglected, not only in the discourse but also in implementation.

In terms of implementation, the challenge is to revitalize Primary Health Care by drawing together the best of the PHC experience and the best of the HP initiative as well as important associated activities such as those around Local Agenda 21. Here the lessons learned in implementing Healthy Cities projects need to be applied more widely.

The time is long overdue for energetically translating policies into actions. The main actions should centre around the development of well managed and comprehensive programmes involving the health sector, other sectors and communities. The process needs to be structured into well-functioning district systems which require, in most countries, to be considerably strengthened, particularly at the household, community and primary levels. Here comprehensive health centres and their personnel should be a focus of effort and investment and the reinstatement of community health worker schemes should be seriously considered.

The successful development of decentralised health systems will require targeted investment in infrastructure, personnel and management and information systems. A key primary step is capacity development of district personnel through training and guided health systems research. Such human resource development must be practice-based and problem-oriented and draw upon, and simultaneously reorientate, educational institutions and professional bodies.

Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here partnerships with NGOs and expertise in various aspects of community development is crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. Here the identification of well-functioning organs of civil society, whether or not they presently are active in the health sector, needs to be urgently pursued.

In promoting the above move from policy to action, WHO has to play a much bolder role in: advocating for equity and legislation to facilitate its achievement; pointing out the dangers to health of globalization and liberalisation; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive PHC programmes are developed; entering into





partnerships with and influencing other multilateral and bilateral agencies and donors as well as non-governmental organisations and professional bodies towards a common vision of PHC; and arguing for major investment in health, especially in human resource development, without which HFA will remain a mere statement of intent.

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REFERENCES

1. World Health Organisation (WHO) (1998B). Health for All in the Twenty-first Century. (Document A51/5). Geneva: World Health Organisation
2. UNICEF. (2001). State of the World's children, Oxford: Oxford University Press.
3. Tarimo, E. and Webster, E.G. (1994). Primary Health Care Concepts and Challenges in a changing world: Alma-Ata revisited. (Current Concerns SHS Paper number 7, WHO/SHS/CC/94.2). Geneva: World Health Organisation, p 61.
4. World Health Organisation (WHO) (1998A), World Health Report 1998 – Life in the 21st Century: A Vision for All. Geneva: World Health Organisation, p 56 - 7.
5. World Bank. (1993). World Development Report: Investing in Health. Oxford: Oxford University Press, p 2.
6. Commonwealth Secretariat (1989). Engendering adjustment for the 1990s. London: Commonwealth Secretariat Publications.
7. Source: WHO and UNICEF, Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 September 1978.
8. Adapted from Tarimo & Webster (1994), op. cit., p 3.
9. Tarimo & Webster (1994), op. cit., p 88.
10. WHO (1998A), op. cit., p 145.
11. WHO (1992), cited in Tarimo & Webster (1994), op. cit., p 43.
12. Sanders D, Dovlo D, Meeus W, Lehmann U. 2002, "Public Health in Africa". Chapter in: Beaglehole R. Ed. Global Public Health: A new era. Oxford University Press, Oxford.
13. WHO (1995), cited in Tarimo & Webster, (1994), op. cit., p 44.
14. Werner, D. & Sanders, D. (1997). Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto: Health Wrights, pp 36-40.
15. WHO/CHS/CAH/98.1A. Management of childhood illness in developing countries: Rationale for an integrated strategy. Geneva.
16. WHO (1993), cited in Tarimo & Webster (1994), op. cit., p 46.
17. Ashton, J. & Seymour, H. (1988). The New Public Health: the Liverpool Experience. Milton Keynes: Open University Press.
18. Tarimo & Webster (1994), op. cit., p 52.
19. Tarimo, E. (1991). Towards a District Health System: organizing and managing district health systems based on primary health care. Geneva: World Health Organisation.
20. Tarimo & Webster (1994), op. cit., p 32.
21. WHO (1998A), op. cit., p 147.
22. WHO (1988), cited in Tarimo & Webster, (1994), op. cit., p 54.
23. White, K.L. (1991). Healing the Schism: Epidemiology, Medicine and the Public's Health. Heidelberg: Springer-Verlag. cited in Zwi, A., Zwarenstein, M., Tollman, S. & Sanders, D. (1994) 'The introverted medical school – time to rethink medical education?', South African Medical Journal, 84(7), pp 424-426.
24. Flahault, D. & Roemer, M.I. (1985). Leadership for primary health care: levels, functions, and requirements based on twelve case studies. Geneva: World Health Organisation (Public Health Papers, No. 82) cited in Tarimo & Webster (1994), op. cit., p 55.
25. Bassett, M.T., Bijlmakers, L. & Sanders, D. (1997). 'Professionalism, Patient Satisfaction and Quality of Health Care: Experience during Zimbabwe's Structural Adjustment Programme', Social Science Medicine, 45 (12), pp. 1845 – 1852.
26. Speth, J.G.. UNDP, 29/06/94, quoted in the Social Summit Seen From the South, P 31. Norwegian Summit for Environment and Development, 1995, cited in Werner & Sanders, (1997), op. cit, p 87.
27. United Nations Development programme (UNDP). (1997). Human Development Report, 1997. New York: Oxford University Press.



28. Halstead, S.B., Walsh, J.A., & Warren, K.S. (eds.) (1985). Good health at Low Cost. Conference Report. New York: Rockefeller Foundation.
29. World Health Organisation (WHO) (1998E). Health 21 The Health for all Policy for the WHO European Region – 21 Targets for the 21st Century. 18 June EUR/RC48-10, p.36.
30. Baum, F. (1998). The New Public Health: An Australian Perspective. Melbourne: Oxford University Press.
31. Sanders, D. (1997) "Success factors in community-based nutrition programmes", cited in: Food and Nutrition Bulletin, Volume 20, Number 3, September 1999, pages 307-314.
32. Vaughan, J.P. & Morrow, R.H. (eds) (1989). Manual of Epidemiology for District Health Management. Geneva: World Health Organisation.
33. Smith, D.L. & Bryant, J.H. (1988). 'Building the infrastructure for Primary Health Care: An overview of vertical and integrated approaches', Soc. Sci. Med., 26(9), pp 909-917.
34. World Health Organisation (WHO) (1997A). Improving the Performance of Health Centres in District Health Systems. (WHO Technical Report Series 869). Geneva: World Health Organisation, p.24.
35. World Health Organisation (WHO)(1998D). Final Report of Meeting on Policy-orientated Monitoring of Equity in Health and Health Care. Geneva, 29th September – 3rd October 1997. (Document WHO/ARA/98.2). Geneva: World Health Organisation
36. Flahault, D. & Roemer, M.I. (1985), op. cit. cited in Tarimo & Webster (1994), op. cit., p 52.
37. World Health Organisation (WHO) (1996C). Reviewing and Reorienting the Basic Nursing Curriculum. Copenhagen: WHO Regional Office for Europe.
38. Tarimo & Webster (1994), op. cit., p 55.

REFLECTIONS ON TWENTY-FIFTH ANNIVERSARY OF THE ALMA ATA DECLARATION

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The Alma Ata Declaration on Primary Health Care of 1978 (1), which was endorsed by all the countries of the world, make a major watershed in the concepts and practice of public health as a scientific discipline. Expectedly, the vision that was endorsed at Alma Ata is the outcome of the power equations that had been shaping within and between countries of the world during the preceding years. India's vision in 1938 of entrusting "people's health in people's hands" (2) during the anti-colonial struggle and the emergence in the course of the famous Long March of the Chinese vision of developing rural health cooperatives, with the 'Barefoot Doctor' as the centerpiece (3), are instances of socio-political conditions within individual countries which had earlier inspired such pathbreaking endogenous thinking in public health. Incidentally, the two countries contained an overwhelming majority of the unserved and underserved people of the world.

Equally expectedly, when the power equation massively swung in favour of a few rich countries of the world, the poor were made to 'forget' the idealism contained in the solemn declarations made by them earlier. Significantly, the changes that have occurred in China during the past two decades has virtually wiped out the rural health cooperatives, leaving vast masses of the poor to their fate. It is a profound irony that fearing backlash from the poorest of the poor, the Chinese authorities have sought assistance from the World Bank to revive health cooperatives for this limited population. India too suffered a similar fate though, presumably because of some degree of commitment to democracy, the damage to the endogenously developed public health system was not as sweeping as in the case of China.

HIGHLIGHTS OF THE ALMA ATA DECLARATION

1. Health is considered as a fundamental right. The state has the responsibility to enforce this right.
2. Instead of starting with various types of health technologies and considering people as almost passive recipients for them, the Declaration sought to reverse the relationship by considering people as the prime movers for shaping their health services. It sought to straighten the capacity of the people to cope with their health problems, which they have developed through ages.
3. It also visualized a wider approach to health by straightening such intersectoral areas as ensuring adequate supply of potable water, environmental sanitation, nutritive food and housing.
4. It called for social control of the health services that are meant to strengthen people's coping capacity.
5. It considered health as an integral whole, including promotive, preventive, curative and rehabilitative components. Any concept of 'selective care' was considered antithetical to the concept of Primary Health Care (PHC).
6. Health services ought to cover the entire population, including the unserved and the underserved.
7. Those aspects of traditional systems of medicine, which are proven to be efficacious of which are the only one accessible to the people ought to be used in providing PHC.
8. Choice of Western medical technology should conform to the cultural, social, economic and epidemiological conditions. Particular care is to be taken to use only essential drugs in generic forms. Ivan Illich, in his book, 'Limits to Medicine' (4) had stated (perhaps a little exaggeratedly) how even in the rich countries 'medicine had become a threat to the people' through what he called medicalisation of life, mystification of medicine, professionalisation of medicine, increasing incidence of medical, social and cultural iatrogeneses,



among others. Later, studying the rapid market driven technological developments, he has pointed out the powerful trends in making practice of medicine as a bigger organizations in the form of 'conglomerates (conglomertisation) (personal communication). More recently, noting that the doctor in the US have lost so much of their say in the market driven medical practice that John McKinley and Lisa Marceau (5), have pronounced the 'end of the golden age of doctoring'. The PHC approach ensures that such anomalies do not creep in the practice of medicine.

It may be underlined that PHC is a PROCESS. Even the most rudimentary forms of home remedies or use of a village bonesetter could form the starting point of development of PHC. Mahatma Gandhi had recognized such limitations of the deprived sections of the population. In his programme of 'Constructive Work', he had included very simple but effective methods of rural sanitation and use of naturopathy to protect and promote the health of rural populations in India.

EVOLUTION OF THE ALMA ATA DECLARATION

Overthrow of colonial rule and rising aspirations of the liberated people, starting of democratic forms of government in some of the newly independent countries, initiation of the cold war and information of the Non Aligned Movement (NAM), have been some of the major factors which contributed to creation of conditions which tended to impel the new rules in these countries and the newly formed international organizations to pay attention to some of the urgently needed problem facing them. International organizations such as WHO and UNICEF bilateral agencies came forward to contribute to improvement of health status of the people in the needy countries. Availability of the so called silver bullets tempted these organization to launch special 'vertical' or 'categorical' programmes against some of the major scourges such as malaria (DDT and synthetic antimalarials), tuberculosis (BCG vaccination), leprosy (dapsone), filaraisis (hetrazan) and trachoma (aureomycin). It took them quite some time to realize that these vertical programmes were not only very expensive but they also failed to provide the expected results. These programme also hindered the growth of integrated health services. This impelled them to advocate integration of health services, then promotion of basic health services, then going to individual countries to promote country health planning and later, country health programming. In the mid – 1970s WHO got together with the World Bank to link activities with poverty reduction programmes. A World Health Assembly resolution in 1977 (6), aiming for a programme of Health for All through PHC by 2000 AD (HFA 2000/PHC), set the stage for the calling of the International Conference for PHC at Alma Ata in 1978.

POST ALMA ATA SCENARIO

There were exponential changes in the power equations between and within the countries of the world from the early 1980s. Events such as the end of the cold war, enfeebling of the NAM, rapidly increasing influence of the Bretten Woods institutions, brought about a sea change in the national and international commitment to HFA-2000 PHC. As early as in 1979, the rich countries launched what they called Selective Primary Health Care (SPHC) on the basis of virtually no scientific data (7). Apparently to rub in the power of the syndicate of the rich countries and the ruling elite of the poor countries, the two sponsors of the Alma Ata Conference – WHO and UNICEF – were made to tow the line laid down by it. An active effort was made to thoroughly was out the ideas generated by the Declaration to make 'space ' for patently unscientific market driven agenda for health for the poor countries of the world. It was a massive assault on the intellect of public health workers; those who confirmed to the laid down line were rewarded and those who dared to disagree were simply ostracized (8). Public Health was once again put on its head, with people once again becoming hapless recipients of pre-fabricated, market driven, technoentric and scientifically very questionable programmes imposed by international agencies.

The International Monetary Fund demanded and got compliance for fundamental structural adjustments in the economy of dependent countries. Their impact on health and health services for the poor was devastating.





It meant drastic cuts on the already pathetically inadequate public supported health budgets. They created space for rapid growth of the private sector in magical care. There was also pressure for cost recovery for services provided by some of the publicly funded health agencies. Their pressure to globalize poor countries on grossly unequal and iniquitous terms turned them into bonded laborers in the global village dominated by the syndicate. The World Trade Organization (WTO) added its bit by forcing patent laws in many poor countries to subserve the interests of the drug-manufacturing giants.

Substituting scientific reasoning and well researched conclusions, for use of brute force, the syndicate let loose a virtual torrent of international health initiatives on the poor countries. As admitted even by the government of India in its Health Policy pronouncement of 2002, these initiatives have not only been highly expensive, but they have also further decimated the general health services. Worse still, they have fallen far short of the objective for which they were launched. The Universal Immunization Programme, the Global Programme for AIDS, the Global Tuberculosis Control Programme, the Pulse Polio Programme for polio eradication and the Leprosy 'Elimination' Programme, are examples of the major initiatives taken during the last decade and a half. Despite pouring billions of dollars, the syndicate-inspired initiatives are becoming a menace to the health and health services of the world's poor (9). In what has turned out to be a desperate bid to regain some credibility for itself, WHO managed to interest some of the top economist of the world to join a Commission on Macroeconomics and Health (CMH) to study macroeconomics of health services for the poor people of the world and make its recommendations (10). Interestingly, it included the former finance minister to India and the present leader of the opposition in the upper house of the parliament. Dr. Manmohan Singh and the president of the Mitsubishi Bank. The Report is being analysed at some length as it provides a documentary evidence of the poor level of the scholarship of the members and the secretariat (11). The Report of the Commission is ahistorical, apolitical and atheoretical. It has adopted a selective approach to conform to a preconceived ideology. It has ignored the earlier work done in this field. It has pointedly ignored such major developments in the health services as the Alma Ata Declaration. This of attitude of developing massive blindspots in their vision has brought the quality scholastic work to almost the rockbottom level. It is not surprising that the CMH has developed a tube vision in making recommendations on so important a subject. Their emphatic recommendation for perpetuating vertical programmes against major communicable diseases like Tuberculosis, AIDS and Malaria on the grounds that vertical programmes have proved to be convenient in a number of ways to the 'donors' lets out the real motivations for undertaking such an almost openly ideology driven agenda. This is a serious danger signal for scholars of the world who would like to have a scientific attitude towards programme formulations for the poor to get the maximum returns from the limited resources.

WHAT IS TO BE DONE?

A struggle for HFA-2000/PHC has to be a part of the long and very formidable struggle to have a just world order. The focus of the struggle has to be in individual countries. Like minded groups from individual countries will have to join together to form a global movement. Some first, very tentative steps have already been taken:

1. After having their own National Health Assemblies, delegates from a large number of countries got together at Dhaka in December 2000 to form the People's Health Assembly to adopt a People's Health Charter. To carry forward the struggle for health it has formed People's Health Movement which has set up branches at continental, national and sub-national levels.
2. The inaugural meeting of a World Social Forum (WSF) was held in Brazil in 2002. Concern for health of the poor is an important component of the activities of the WSF. As a prelude to the second WSF, a meeting of the European Social Forum which was attended by two or three hundred thousand delegates was recently held at Florence. An Asian Social Forum will be held at Hyderabad during January 2-7 2003.



3. A great deal of credit is due to anti-capitalist activists for organizing sustained demonstrations against extremely heavy odds to register their protest at major conclaves of rich countries in different parts of the world – starting from Seattle and then covering cities like Gothenburg, Barcelona, Davos, Calgary, Doha, Genoa and Melbourne.
4. Another line of struggle will be to use scientific critiques as a weapon to resist imposition of the syndicates' agenda on the poor and to offer an alternative one (8). To 'remind' them about the Alma Ata Declaration is one such example.

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REFERENCES

1. World Health Organization :Primary Health Care: Report of the International Conference on Primary Health Care, Alma Ata, USSR, September 6-12, 1978, Geneva, WHO, 1978.
2. National Planning Committee, Sub-Committee on National Health: Report, Bombay, Vohra, 1948, 3. K.W. Newell: Health By the People, Geneva, WHO, 1975.
3. I. Illich : Limits To Medicine, Bombay, Rupa, 1977
4. J.B.McKinley and L.D. Marceau: End of the Golden Age of Doctoring, International Journal of Health Services, Vol. 39, pp. 379-416, 2002.
5. WHO Resolution WHA 32-33 in Handbook of Resolutions and Decisions, Vol.2 (1973-1984), WHO, Geneva, 1985.
6. D. Banerji: A Manipulated Programme, Economic and Political Weekly, Vol. 15, pp 151-54, 1980.
7. D. Banerji: Reflections of an Indian Scholar, International Journal of Health Services, Vol.33, pp. 163-169, 2003.
8. D. Banerji: A fundamental Shift in the Approach to International Health by WHO, UNICEF and the World Bank: Instances of Practice of Intellectual Fascism and Totalitarianism in Some Asian Countries, International Journal of Health Services, Vol. 29, pp 227-59, 1999.
9. World Health Organization: Report on Macroeconomics and Health: Investing in Health for Economic Development, Geneva, WHO, 2001.
10. D. Banerji: Report of the Commission on Macroeconomics and Health: A Critique, International Journal of Health Services, Vol. 32, pp 733-54, 2002.



THE ALMA ATA DECLARATION AND THE GOAL OF "HEALTH FOR ALL" 25 YEARS LATER – KEEPING THE DREAM ALIVE

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In 1978, a potential breakthrough in global health rights took place at an international conference organized by the World Health Organization (WHO) and UNICEF in Alma Ata, USSR (now Almaty in Kazakhstan). In the so-called "Alma Ata Declaration", 134 countries subscribed to the goal of "Health for All by the Year 2000". They affirmed the World Health Organization's broad definition of health as "a state of complete physical, mental and social well being".

To approach Health for All. The world's nations, together with WHO, UNICEF and other major funding organizations, pledged to work towards meeting people's basic health needs through a comprehensive, remarkably progressive approach called "Primary Health Care" (PHC). Principles and methods garnered from the barefoot doctors methodology in China and from experiences of small struggling Community Based Health Programs in the Philippines, Latin America and elsewhere. The link of many of these enabling initiatives to social transformation movements helps explain why the concepts underlying PHC have been both praised and criticized for being "revolutionary".

The social and political Implications of the Alma Ata Declaration and PHC

Perhaps the most politically charged aspect of PHC as proposed at Alma Ata was its all inclusive equity-oriented approach. The Declaration stresses the need for a comprehensive strategy that not only provides basic health services for all, but that also addresses the pervasive underlying social, economic and political causes for poor health. It links health to a strongly participatory strategy that has since become known as "people centered development". Support documents for the Declaration state that:

"The purpose of development is to permit people to lead economically productive and socially satisfying lives. . . .

Since Primary Health Care is the key to attaining an acceptable level of health by all, it will help people to contribute to their own social and economic development. It follows that Primary Health Care should be part of the overall development of the society

These documents not only emphasize that Health for All will require structural change in the direction of greater socioeconomic equity, but they anticipate the opposition to this revolutionary strategy within the existing power structure

"It can be seen that the proper application of Primary Health Care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it will greatly influence community organization in general. Resistance to such change is only to be expected".

To overcome such opposition, and to give people a stronger voice in the decisions that determine their well being, the Declaration calls for strong popular participation.

Resistance to Primary Health Care

Sadly, the year 2000 has come and gone, and the goal of Health for All in some ways seems farther than ever from being reached. 2003, the 25th anniversary of the Alma Ata Declaration, provides an occasion to analyze what went wrong and to strategize what action is needed to advance in earnest toward Health for All.





While a few health indicators have improved modestly since 1978, for billions of the poorest people, health and quality of life have actually deteriorated. This is partly because of the decreasing access to costly health services. But it is also because the world's neediest people have been increasingly marginalized by the dominant model of economic development.

As foreseen, the comprehensive, social-change-fostering concept of Primary Health Care has been resisted by the powerful decision makers at national and international levels. Historically, from the late 1970's to the present, this resistance can be looked at in terms of four interrelated attacks.

Four Assaults on Primary Health Care

- 1. Selective Primary Health Care – introduced in the late 70's.** The comprehensive approach to PHC with its emphasis on equity and its call for a model of socioeconomic development conducive to Health for All, was quickly undermined by experts at John Hopkins School of Public Health, who claimed it was too complex and too costly. Instead, they advocated Selective Primary Health Care, focusing on a few “cost effective”, top-down technological fixes “targeting” high risk groups. UNICEF quickly adopted this selective approach, which in practice focused mainly on oral rehydration therapy and immunization. While these so-called “twin engines” of the Child Survival Revolution did succeed in somewhat reducing child mortality, they did discouragingly little to reduce poverty, hunger, or children's quality of life. For this, a comprehensive approach is needed that confronts the root causes.
- 2. Structural Adjustment Programs – introduces in the early 1980s.** In the 1960s and 70s the governments and banks of the North loaned a vast amount of money to poor countries in the South to promote a model of development that replaced rural peasants and urban workers with fossil fuel consuming machines. This brought large profits for foreign investors and massive joblessness and increased poverty for the many. When poor countries began to default on their loans, the World Bank and IMF stepped in with bailout loans. These were tied to structural adjustment programs (SAPs). These required debt-burdened countries to reduce public spending, including that for health and education, to free up money to keep servicing their debts to the Northern Banks. Whereas the Alma Ata Declaration has called for increased government spending on health, SAP's pressured the poor countries to reduce and privatize public services. “Cost recovery” schemes (with introduction of “user fees”) placed health services out of reach for many poor families. As a result in some countries child mortality, sexually transmitted diseases and rates of tuberculosis drastically increased. In terms of the pursuit of Health for All, this was a giant step backwards.
- 3. World Bank's takeover of Third World Health Policy – in the 1990s.** Prior to the 1990s the World Bank invested almost nothing in health. But in the 1990s the Bank discovered that *poor health reduces worker productivity*, thus impeding economic growth (of big industry). So over a few years the Bank increased its investment in health to where, by the late 1990s, it was spending on the health sector three times as much as the entire WHO Budget. In terms of guiding Third World health policy, this has relegated WHO to second place, not only because of the Bank's greater spending, but because it can tie its health reform “recommendations” to urgently needed (or strongly desired) loans. In its 1993 World Development Report, titled *Investing in Health*, the Bank spells out its health policy recommendations. These are essentially a free market version of selective health care. Governments should determine which health interventions to support according to their cost effectiveness in terms of keeping workers on the job. Persons who cannot contribute to the economy – such as elderly and severely disabled persons – are ranked as of lower “value” and therefore merit little or no public assistance. Another dehumanizing step backwards in terms of Health for All!
- 4. The Mcdonaldization of WHO and UNICEF – in the 2000's.** Partly because of shortage of funds, and partly because of influence of corporate gifts, in the last few years both WHO and UNICEF have entered into an increasing number of “partnerships” with transnational corporations, including drug and junk food companies. An example is UNICEF's recent plan with fast – food giant, Mcdonalds. On its promotion





McDonalds will include UNICEF public health messages and boost sales of Big Macs by announcing that part of the purchase price goes to UNICEF. In Nigeria UNICEF has made a similar agreement with Coca Cola. Such compromises with industries that promote conducive to obesity, heart diseases, stroke and diabetes are not conducive for Health for ALL. Partnerships with other pre-packaged mass-produced food with endorsement by WHO or UNICEF. Even if these costly foods have improved nutritional content, they are still a threat to health. If poor families spend their limited money to buy them rather than cheaper staple foods (like Maize and beans), the end result is more undernourished children.

The Alma Ata declaration called for combating the underlying social and structural causes of poor health. To the contrary, these new partnerships by UNICEF and WHO with transnational corporations further entrenches and legitimizes the forces that put healthy profits before people.

Corporate rule as a threat to world health.

All of these four "assaults" on Primary Health Care as conceived in Alma Ata are manifestations of the dominant "free market" paradigm of development. As undemocratic as it is unsustainable, it promotes economic growth of the rich regardless of the human and environmental cost.

That the current model of economic development driven by a deregulated market system is dangerous to health, is evident when we consider the impact of its biggest industries. In economic terms, the world's three biggest industries are: 1) military/arms. 2) Illicit drugs, and 3) oil. All three of these colossal industries poses far-reaching dangers to the sustainable well being of humanity and the planet. Yet because the money proffered by these industries strongly influences who gets elected to public office, it undermines democratic process. It impedes humanity from taking decisive steps to rein in the biggest emerging global threats to human health such as global warming, the pending Third World War, the deepening poverty of one third of humanity, the global pandemic of crime and violence and the disempowerment that leads to terrorism. Rather than confront the underlying causes of these globalized threats to health, the world's chieftains – with their ties to the arms, drugs and the oil industries – use the current crises as a pretext to systematic role-back of civil rights, public services and rein in on corporate greed.

In sum, far from progressing toward Health for All, humanity may currently be on a collision course toward Health for no one. It is time to collectively wake up and change course.

How can we get back on the road to Health for All?

Some say Primary Health Care has been tried and failed. But in truth, it has never been tried – certainly not on a large scale, in the comprehensive form advocated in Alma Ata.

It is even clearer today than 25 years ago, that the main *determinants of health are social, economic and political*. Resources exist to provide adequate food and basic health services to everyone. A small fraction of what is spent on arms could provide the necessary health care and food for everyone on who now lack them.

What is necessary is the political will. The Alma Ata Declaration insisted on putting health – or rather the decisions that determine health – back in the hands of people and communities. If the world's people had a clear understanding of the dangers to their health that are looming, and the way the world's top decision makers have sold out to the interests of big money, they might very well take organized action. They would join the growing movements for election finance reforms, so that leaders could be elected who put the human needs before corporate greed. They would begin to participate more fully in the decisions that affect their health and their lives – and the well being of generations to come.





There are positive signs that such an awakening is taking place. Examples include:

- In many countries, growing groups of activists have begun to protest the unhealthy and unaccountable adjustment policies and trade agreements of the international financial institutions and the World Trade Organization.
- AIDS activists have partially succeeded to demanding the people's right to low-cost generic versions of patent medicines
- Watchdog groups are having an impact. For example, a joint letter to UNICEF from non-governmental organizations criticizing UNICEF for partnering with McDonalds has helped UNICEF to reconsider its questionable liaisons with fast-food giants and other industries
- Citizens groups in the US have pressurized Congress to regulate the influence of corporate "soft money" in public elections, opening the way to more democratic and healthy policies.
- Protests in and around the world are exposing the oil interests, weapons profits and political expediency that hide behind the proposed Attack on Iraq.

Also highly important, especially at the global level, are the *international conditions that are forming around concerns of sustainable health and development*, which bring together grassroots movements and watchdog groups from many countries and from many sectors. The global forces behind the dominant inequitable paradigm of development have grown so powerful and well coordinated, that only through coordinated global movement from the grassroots is the likelihood of getting back on the path toward sustainable Health for All.

In the health sector (but reaching out beyond it to every sector affecting health) two important coalitions are the international People's Health Council and the People's Health Movement Information on how to become involved with these initiatives is available through:

In Sum, the concept of Primary Health Care as advocated in the Alma Ata Declaration – with its emphasis on equity, strong participation and addressing the underlying social, economic and political causes of poor health, is as valid today as it was 25 years ago. And even more urgently needed!

David Werner has spent more than three decades working to help poor farming families in the mountains of western Mexico to protect their health and rights. Project Piaxtla, the villager-run program to which he has been a facilitator and advisor since 1965, has contributed to the early conceptualization and evolution of Primary Health Care. The three main books he has written and illustrated – *Where There Is No Doctor*, *Helping Health Workers Learn*, and *Disabled Village Children* – are among the most widely used in the field of community-based health care and community based rehabilitation. He has worked in more than 50 countries- mostly in the Third World- helping to facilitate workshops and training programs, and as a consultant. In recent years, David Werner has become increasingly involved in social, political, and economic factors, local to global, that affect disadvantaged people's health and lives. David has received several awards for his ground-breaking work, including the World Health Organization's first International Award in Health Education in 1985





"FUZZY WORDS, SHARP BULLETS' MEDIA, GLOBALIZATION AND HEALTH

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There is an image that has been haunting me in my sleep for the past many months now. It is an image from the first wave of bombing raids carried out by US warplanes in the town of Basra in southern Iraq.

In this image there is a tired, broken Iraqi father who is lifting up the limp body of his dead 10 year old daughter from the rubble of his bombed out home. If one could freeze all the tragedy possible, anywhere, within one human lifetime- this would be the image to capture it. A distraught father with his dead daughter.

Now what do health, media or globalization have to do with this image and the incident it represents?

Before I get to that, I want to make a confession. For quite some time now I have had a problem in understanding even the simplest of terms - very common words like health, media and globalization for example.

Maybe this is because, as a journalist for nearly two decades, I have been reading too many newspapers that lie and watching too many television talk shows that distort all reality. Or yet again, it may be because of that image of the Iraqi father and his dead daughter that has been haunting me, forcing me to search for meaning beyond mere words. Whatever the reason for my confusion, let me try to understand and clarify the these three terms one by one, in the context of the times we live in.

First, let us take the word 'health'. For years together, as a journalist and as a citizen with some minimum education I always thought health was all about biology, medicine, doctors, hospitals. Makes sense, doesn't it? Ill health is caused by disease. Bacteria or viruses cause disease. At worst, ill health can be caused by the poor behavior of individuals. (Those who smoke, drink too much and do too little exercise go to heaven early!). And all these problems in turn can be treated with medicine prescribed by doctors in their hospitals. Maybe I never really gave the subject of health much attention, but that was the simple understanding I had on the subject for a long time.

All that was till I had the good fortune of attending the first People's Health Assembly in Dhaka, Bangladesh in the winter of 2000 as a journalist helping out with their media work. It was there while listening to the hundreds of health activists from around the globe, reading the papers they presented and talking to many of them that I realized two very simple things.

First of all your, my or anyone's health is not a mere function of our individual behavior alone but also the behavior of entire societies. It is a direct function of the politics, economics, ecology and culture of the world we live in.

Before anyone gets me wrong let me make it clear that I do believe that individual behavior is still a very important determinant of individual health. One cannot absolve individuals of responsibility and blame every misfortune that befalls the individual on society at large

And yet can anyone tell me what precisely was the problem with the individual behavior of that young Iraqi girl that she had to die at such a tender age and the way she did?

It is quite obvious that young girl there had to die because neither she, nor her father, were really a match for the firepower of the world's only remaining superpower. But maybe she had to die because someone very powerful, very far away, at a very safe distance thought she could one day grow up, become a mother and give birth to a 'terrorist'. Could it be also possible that she had to die because she as an Iraqi citizen was



sitting on top of the world's second largest reserves of oil and there are too many petroleum junkies in the United States who need this indispensable narcotic of modern civilization?

These are the kind of questions that come to my mind when I see an image like that from Basra. War, it is clear, is the biggest threat to public health anywhere. And make no mistake, the times we live in is all about war and conflict- with really no end in sight soon. So when you think health, please think about the impact of war on the health of the individual and how we can bring about peace to an increasingly violent world.

But where do war and conflict really come from ? Is it just about the faults of human nature or the differences between religions or nationalism and fundamentalisms of different kinds ? These are all surely ingredients that catalyze conflict in different parts of the world, but I would like to bring your attention to the one perpetual source of violence throughout human history- the quest for control and consumption of resources.

These could be natural resources- food, forests or fossil fuel as in the case of the US occupation of Iraq. Yet again, the conflict could be for control and domination of human resources. In the old days monarchs used to repeatedly rally their people to war for capturing slaves from their neighboring countries. In the modern age the role of the 'monarch' has been neatly taken over by 'multinational' corporations. And the term 'slaves' has been replaced by 'cheap labour' from the Third World.

And it is this process by which feudal control over global resources has been replaced by corporate control that brings us to that much publicised word 'globalisation'. I have always felt that there really can't be a fuzzier word possible in the dictionary than this term 'globalisation'. Think about it carefully and you will see it really means nothing on its own.

After all, we all know that the globe, the planet Earth exists and has been around for a long time. (it will hopefully be around a little longer). People across the oceans, forests, mountains and entire continents have always traveled across the face of the planet- in search of better habitats, resources, experience or just for their own enjoyment. All of human kind, any anthropologist will tell you, migrated out of Africa- which was truly the motherland of our entire species.

And yet there are those who today claim that they are going to 'globalise' the 'globe'. That would be like making an apple more of an apple or adding to Mona Lisa's smile to make her look more attractive.

There is a reason for this lack of clarity behind the word 'globalisation'. The word obfuscates the fact that we are not really one 'globe' at all and that there are many planets within this one planet Earth that all of us are supposed to inhabit.

There is the glittering golden planet of the bold and the beautiful, the rich and the powerful, the masters of our universe. The small minority who control most of the wealth on planet Earth, who make the policies that run the economic, political and military systems of our world - and who decide the fate, life and death of the millions.

There is also a silver planet run by those who will do anything to serve their masters on the golden planet and aspire to join them at some point of time. These are dubious managers, generals, advertising and public relations professionals who spend all the time polishing and protecting the gold of their Godfathers.

And finally there is the planet of iron, rusting away, inhabited by a majority of the world's population. The people who work, who consume the least, and with whose sweat and blood the other two planets thrive and survive. And these are the very people- the people who make the globe spin on its axis- to whom the virtues of 'globalisation' are being preached to by those from the planets of gold and silver.

In order to 'globalise' they are told to give up their land, water, forest and minerals to the global corporations. They are told to leave their fate and that of their families to the mysterious market, which is manipulated by global bankers and investors. They are told to tighten their belts- (which are often around their necks)- and promised that globalisation will bring them a 'shining' future.





Well, we have all seen what this 'shining' future looks like for our planet's workers. It means 'shining' the shoes of the rich in the hope that one day that pair of shoes will be their own. That day will never come for the workers of the world through globalisation- for what is sold to them as a dream is in reality the darkest nightmare.

All I can see in globalization is the continuation of colonization by other means but for the same purpose- the looting of local resources, the destruction of indigenous livelihoods, the bankrupting of entire national economies, the loss of sovereignty of the developing world. And every time the people of the world try to improve their lives, even by following the rules of the marketplace, the globalisers find new ways to increase their own wealth and keep the vast majority in poverty. Poverty, which by itself is the mother of all health problems.

At this point I would like to say something which is important for all movements of social justice to consider. And that is the fact that while extreme poverty is harmful to the health of people this is equally true of extreme prosperity. Today we see the rich, not only in the developed countries but also in our own societies, killing themselves with their obscene wealth. Think of all the things that the rich have to do to keep themselves on top of our societies. The moral stress they undergo while exploiting the poor, the psychological stress they get worrying about preserving their wealth and the physical stresses of consuming more than what is humanly possible- all these together kills them everyday. So it is my belief that it is the duty of the social movements around the world not only to fight for justice for the poor but also consciously save the rich by taking away their wealth. The rich will resist of course, but we have to do what is in their best interests.

Coming back to 'globalisation'- it is often claimed by the mainstream media that the anti-globalization movement only criticizes and does not provide any alternatives? Is there an alternative and what does that look like?

That was the second thing I learnt from the People's Health Assembly in Dhaka and from the People's Health Movement in general. That it is possible to have a clear and simple alternative to the approach of globalisation- that is workable, viable and in the interests of the majority of the people on this planet.

The alternative proposed by the People's Health Movement is that the health and well being of the individual should be at center of all policy making everywhere. The logic is very clear. Health should be at the center of everything human societies do precisely because everything that human societies do affects the health of all its members. And mind you, here we are talking about not just the physical condition of the individual human being but also their economic, social and spiritual health.

Every time a government anywhere formulates policy on anything trade, finance, defence, agriculture- it should do so only after asking the simple question- how will this policy affect the health of individual citizens in that country.

That is an important point, mainly because this simple question is never asked and what we in the People's Health Movement are suggesting is still an unfulfilled dream. The fact is that the health of the people today is not even at the periphery of concerns that drives policy makers who run our globe. What is at the center of their concerns is money and profits. Nothing else really matters for the would-be masters of our universe as long as their cash-counters keep ringing.

And in fact in our time we see a complete distortion and misuse of the basic concepts of medicine by the global elites.

A few years ago when I first heard the term 'surgical strikes' used to describe the bombing of Kosovo in Yugoslavia I did not think very much about it. But surgical is a medical term and surgery is a procedure that is meant to save lives. So why is the US army using this term to describe a process that is meant to kill people?

This misuse of medical terms has only increased under the so called War on Terror launched by the United States since September 11. So now we have US leaders calling for the 'wiping out' of terrorists, US army commanders talk of 'detecting and destroying' terrorists. People dubbed as 'terrorists' are compared to snakes, deadly bacteria and microbes and the promise is made to 'cleanse' the world of terrorism as if it was a disease or an epidemic of some kind.



Make no mistake about it- in the eyes of the imperialists all those who resist imperialism are really nothing more than microbes. And this is where the global media plays a crucial role in the de-humanisation of all those who resist and preparing the ground for massacres and genocide by the imperialists.

So what exactly is the 'media' all about? As someone who is a media person let me offer you an insight and some clues from what I know about the global media. To begin with, as a journalist, working for both newspapers and television for many years, I can tell you very honestly that the global media does not deal with the truth at all.

As many of you would already have noticed much of the global media is used by powerful vested interests to promote their point of view, distort realities and fool ordinary people into accepting their sorry fate as the best possible deal they can ever get. In other words the global media is nothing but a sophisticated lying machine. There are many reasons why the media lies constantly, but I will not go into that now.

However, I have to warn of you of a strange new trend in recent times. The role of the global media as a mouthpiece of the establishment has actually diminished. This is not because the media has become more truthful in its reporting of realities but because the establishment no longer needs to make a pretence and is willing to launch an open and brazen attack on the rights of the people everywhere. The masters of the golden planet have already fired the media from its pitiful role as a messenger.

Let me put it this way. For a long time now the Emperor has been quite naked in the eyes of many of us. But the global media acted as the Emperor's mask and hid his truly ugly face from the view of the world's people. Today, the Emperor has thrown even this mask aside because he is desperate and willing to do anything- murder, massacre, genocide- to keep his Empire together.

That is what we see in Afghanistan, in Iraq and in the entire so-called War on Terror throughout the globe. The brazen invasion of sovereign nations, the blatant violation of all human rights, the pillage and plunder of resources from weaker societies and above all the willingness to use extreme violence and devastating force to achieve these ends.

I will give you an example of what I am trying to say. A couple of years ago, I like many of you, heard the US President George W. Bush claim on television that he is going to send a strong 'message' to terrorists everywhere in the world. Soon after that US armed forces invaded Afghanistan and took over that country, killing thousands of innocent people in the process.

Again, earlier this year I heard Little Bush say that he is going to send a strong 'message' to dictators everywhere. Soon after that the US air force started pounding Iraq with bombs of every description, and have now occupied the country, once again killing thousands of civilians as well as poorly armed soldiers.

From this I can conclude only one thing that communicating a 'message' does not mean sending an email or a letter or newspaper report or a television picture anymore. In the dictionary of US imperialism communication has always been about sending bullets, bombs and missiles to make their point to those who dare to defy them. And that is truer today than ever before.

That is why I believe that the smokescreen of the global media has been dispensed with and the real messages in our times come from the armed forces of the imperialist powers. While their words have become fuzzier, their bullets have become sharper and that is where the impact of their propaganda comes from. This is the ugly reality we have to wake up to. The sooner we stand up and resist the closer we will be to creating a better world.

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PALESTINE: HEALTH AND DEVELOPMENT AT TIMES OF UNCERTAINTY

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It is not only a coincidence that The Union of Palestinian Medical Relief Committees (UPMRC) celebrate 25 years of commitment to the protection of a basic human right to receive efficient and quality health care at the time of commemorating The 25 Anniversary of The Alma Ata Declaration. UPMRC was influenced by the Alma Ata Declaration and therefore was founded on the same principles and values. The UPMRC has fought to ensure these principles are implemented in Palestine, combating at many times the restrictions imposed by occupation. Our overall objective is to protect and promote the health of Palestinian people under occupation, thus we have sought to achieve this objective by focusing on Primary Health Care.

Part of this dream came true, translated into changes in the health sector affecting much of the community structures and processes implementing much of Alma Ata's principles, yet at the same time failing to achieve our national dream of independence. Our arduous attempts have produced many successes; however, these are only achievements that have assisted in establishing a viable health care system and have not been able to rise above the current emergency situation. Unfortunately, as long as the current repressive ideals are imposed upon the Palestinian people then the health care system will continue to face new and increasingly frustrating health issues.

The Politics of Health in Palestine

It is difficult to avoid talking about the current political situation, because it has had such short and long-term implication on the health of population. We are currently experiencing the third year of the continuous restriction on the movement of people and goods in Palestine (West bank and Gaza), which has had adverse effects on the health care system and the provision of health services.

The ongoing plan to erect the separation wall (Berlin Wall) inside the land of the West Bank will not only further inhibit the movement within OPT, it is also resulting in massive destruction that is affecting the lives of hundreds of thousands of Palestinians; all of which is coinciding with the continued deterioration of the socioeconomic conditions of the Palestinian families, poverty, and unemployment at its highest levels. This situation imposes the need for a new direction of strategies to help alleviate the impact on the health and daily lives of Palestinians. The intensity of the current emergency situation has shifted the emphasis away from developing the health care system and towards focusing on the emergency needs of the population.

The movement of people is also restricted by the geographic division of the Palestinian territories. The geography of Palestine is comprised of two non-contiguous areas—West Bank, and Gaza strip—is characterized by varied demographic socio-economic conditions and even different legal pounds.

Not only are these two regions separated but also the last three years of conflict has left the country shattered into hundreds of isolated Bantustans, due to the implementation of the Israeli military siege and closure, leaving the whole society vulnerable. This in turn exacerbates the existing difficulties facing the Palestinian people.

- Gaza strip is considered to be the most densely populated area in the world, with a population growth that is still one of the highest in the region at 4.63





- The demographic change in the population pyramid, where Palestinians are one of the youngest populations in the world, at 51% of the people under 18. This phenomenon is reflected in the character of what problems and content of health planning in the country.
- GDP was estimated by the World Bank at 1710 US\$ per capita per year. This has been cut in half during the last 3 years, while in contrast we continue to live and spend at the same level of the average Israeli family out of necessity, all the while having ten times less income.
- Poverty remains at 62% in the West Bank and 84% in Gaza, the same level as last year. The direct impact of the continued high poverty levels is that poorer people are less healthy.

The Imposition of Poverty and the Deterioration of Health

It is very obvious that health has been the most affected area in the life of Palestinians. Because a majority of the population is unemployed— 74% in Gaza strip , 60% in West Bank— many Palestinian families are driven to depend totally on Humanitarian Aid for survival, or coping in other instances by, borrowing and selling their belongings or savings. This resulted in shifting priorities where even the basic needs are reduced. In a society where families have cut spending on food, spending precious income on health services has almost ceased.

By September 2000, The World Bank estimated that 21% of the Palestinian population lived under poverty line; by the end of 2002 it has reached 84% in Gaza Strip. This factor of economic decline, in particular, reflected itself on the deterioration of health conditions of Palestinians—ranging from the immediate impact on the nutritional status of children and women; to the impact on the health of elderly, those who suffer from chronic diseases, and all children, whom the youngest are at high risks of psychological trauma.

All the analysis of the current situation reveals that external humanitarian aid, although important at this difficult time, has proven to have limited potential to overcome the size of such socioeconomic complications. Assistance has not guaranteed growth or development for the Palestinian society it only prolongs Palestinians' capability to survive through such circumstances.. The level of humanitarian support that each Palestinian receives is an estimated 315\$ per capita, which is an unprecedented level of support. The World Bank calculated that even if this level of support continues for two years to come this only will reduce the amount of poverty by only 7%. However, the solution does not come from humanitarian aid, despite its importance, and the conflict will continue until the fundamentals of the conflict changes. What will influence the situation is political change through various actions that include lifting of the closures and ending the mass punishment of population. Despite its inability to eliminate the emergency situation in the OPT, humanitarian aid is necessary if only to decrease the speed of the society's collapse.

It is important to mention the poverty in Palestine has its particularities. It is a man made crisis, the direct result of Israeli aggression. Its very acute in character, has raised from 21% to 70% (average) during the last 3 years, and more importantly than the statistics is the coping strategies of families that will vanish and disappear due to the depletion of saving and belonging.

Health Services Under Occupation

Provision of services and reaching out to receive these services have become more and more difficult. In order to obtain PHC services in rural communities, the patient would have to overcome huge difficulties and obstacles (roadblocks, closures of areas, curfew, etc.) and restrictions of movement. And yet to reach out for secondary or tertiary health care is close to impossible, since most of these services are concentrated in cities and central areas and people's ability to get there is often limited if not eliminated by the current situation on the ground. One of their only options is to use authorized ambulances that are theoretically neutral vehicles, to try to bypass roadblocks and closures. 70% all Palestinians living in rural communities who need ambulance





service use back to back system , yet only 30% of them have been able to reach the hospitals directly from their place of residence. Ambulances are frequently searched and prevented passage, and as a result at least 96 people have lost their lives at check points before reaching hospital. Other people in need of emergency medical assistance use animals and carriages and many others are simply unable. The situation has isolated hundreds of communities and enabled them to receive the very basic necessity of health care.

Three years of the increasing need for emergency services in an environment of closure and collective punishment, is leading to the imminent crisis in health ranging from the provision of services, to sustaining existing regular programs of vaccination, antenatal care, well baby clinics, and school health.

Three Dimension to Health Problems in Palestine

In the fast moving world of today, factors of morbidity travel faster than money. It became rather impossible to separate the local health concerns from the global ones which needs not only to get through countries boundaries but also to interact and penetrate through the various aspects of human activities to improve health. Palestine in this respect is laying in the middle way to deal with diseases, problems that characterize underdevelopment, (infectious diseases, parasite infestation, malnutrition,) and at the same time faces the sharp increase of modern life disease. (coronary heart diseases, DM, Hypertension). In addition to these health problems, the continuous imposition of the siege and closure on 3.4 million Palestinians and the undeclared war accompanied with the highest level of violence, killing and destruction of Palestinian infrastructure, dictates another dimension on health concerns, focusing on the immediate emergency services needed.

This reality implies that the nature of services and type of planning for health and community concerns intersects with each other. The impact of globalization on health and its consequences, the Palestinian local health concerns and the continuous occupation and the measures imposed on us are three factors coinciding and perpetuating a system that continually represses the health of all Palestinians.

Health System, Reform and National Policies

A thorough assessment of our success since the Alma Ata reveals that there are some shortcomings in the improvement of the health care system. It is necessary to evaluate such problematic areas and seek to remedy them as soon as possible.

1. The deterioration of socioeconomic conditions, combined with disruption of health services, continued closure, siege, and bleak political future, all emphasize the focus on emergency services provision and weakens the development side of health sector.
2. Planning for health takes place at the highest level of uncertainty. This leads to a lot of assumptions and emphasis on responding only to the emerging needs. And forced the halt of the implementation of health plans or investing in health systems.
3. There is a strong common belief that the potential to improve health services provisions is possible, but the forced separation of areas, restriction on the movement of people, deprives the health sector from the possibility to strategically develop human resources, or put some focus on dissemination of PHC Protocols and guidelines this is the biggest challenge on the development of a comprehensive health system.
4. Finally, the achievement in the health sector, in the development of models of health service provision based on the principles and values of PHC, is at a high risk of collapse, due to the current situation much of what has been achieved in the promotion of the health of children, elderly and disabled might not be sustainable

We all know that, human dignity is in the heart of the legal understanding of human rights, through the last few decades Human rights movements gradually developed its understanding to be more comprehensive, after it





has been only focusing on the political and civil rights the international definition of human rights incorporated economic, social and cultural rights including the right for health education, food and shelter....etc. Not only that, but these became integral part off all humanitarian laws and conventions

From this perspective, we think that the humanitarian crisis in Palestine is the symptom of the imposition of such a dire situation and the solution is political. We view that supporting Palestinian people initiatives to achieve just and lasting peace and ending the occupation, which is one of the most destructive tools to human dignity, is the only solution.

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IRAN: THE PRESENT AND FUTURE OF PRIMARY HEALTH CARE

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PHC Networks have reached a considerable degree of expansion in Iran. Between 1985 and 1991, over 8,800 Health Houses, 600 Rural Health Centers, 430 Urban Health Centers and 147 Behvarz Training Centers have been built and has grown from 4,236 (in 1985) to 19,468 (in 1991). Today, over 94% (1997) of the population is covered by PHC services via the network. All these accomplishments (which have been achieved at a cost of 3,600 million rials to the National Budget from the Ministry of Health and Medical Education's allocation) still remain at a vulnerable and fragile stage. Their preservation and expansion requires continuing political commitment and support of the kind, which brought the networks into being in the first place.

The most prominent merits of Iran's Primary Health Care networks are:

- A firm and rational basis on which to found the stratification of services and the distribution of facilities (exemplified by the Master Plan for expansion of PHC networks).
- Assured easy accessibility of every health service facility.
- A strong programme of behvarz training, which produces efficient community health workers who have frequently been acclaimed for the quality of their work (The female behvraz and the male behdahst yar)
- Considerate behvarzes and enthusiastic instructors who have made it all possible.
- The valuable asset of a small number of experienced senior health workers who help sustain these efforts.
- Relatively good intra – sectoral coordination at the highest levels of planning and decision-making.
- Availability of reliable information and statistics regarding the rural areas of the country.
- Provision of a medium for health system research by scholars interested in the subject.

In addition, a few more relevant features were:

- Merging Medical Education with Executive health affairs so that the present Ministry of Health and Medical Education links the two
- Sectors educational and executive closely and effectively.
- Setting up a council for expansion of PHC networks.
- Active continuing education of personnel within the health network.
- Integration of vertical programme into the health system.
- Training medical students in the Health Network through Community Oriented Medical Education (COME) in universities of Medical Sciences.
- Potential for use of the health networks for the purpose of applied research, which has been effective in promoting a community – based style and methodology of research and learning-by-doing. Results of these studies have also been very helpful in identifying areas of weakness.

The PHC networks at the at the same time suffer from a number of weaknesses:

- Most of the credits gained so far have been by virtue of the outstanding efforts of Health Houses; other facilities are as yet lagging behind.
- Insufficient support of Health Houses by the Rural Health Centers has so far hindered implementation of an efficient referral system. While the cooperation of hospitals in accepting referrals from Rural Health Centers has been dismal. The prevailing attitude of indifference by hospitals to the networks has been depressing and detrimental.

- As mentioned before, in the absence of appropriately – trained managers (i.e., new Iranian medical graduates), Rural Health Centers have not yet acquired the capacity to support and guide Health Houses. Given this situation, health technicians have not lived-up to what is expected of them either. Frequently, lack of proper workspace and laboratory facilities further aggravate the problems.
- Urban Health Centers must tackle even more serious constraints. It is hard to see how the problem of limited building space in the cities can be overcome in the near future with the present amount of government support.

The structure of today's UHCs have essentially remained unchanged from yesterday's 'clinics' which they have replaced, and the exhausted staff usually have difficulty in coping with the new demands. Furthermore, the 'passive' method of delivering services at urban facilities cannot be expected to rival the striking accomplishments of the 'active' services, characteristically offered by the Health House. At the present time, even immunization and care of high-risk groups is handled in a passive manner at UHCs. To this must also be added the overwhelming presence of the private sector (with its complicated transactions), and frequent absence of basic lab and radiology facilities in many of today's UHCs.

- Higher levels of the PHC network are still very unfamiliar with the spirit of community participation and Inter – sectoral collaboration and little has been done to address this problem so far.
- In spite of all the efforts made at training and education, programs are running at Regional and District Health Centers, in which former advocates of this or that vertical project are apparently working together, but actually far apart!
- To this day, no organized attempt at training well-informed managers has approached the stage of implementation, and as long as this situation is unchanged, efficient and brilliant managers will come and go like brief flashes of fireworks in an otherwise bleak sky, with no guarantee of replacement.
- PHC networks must frequently rely on external aid (received on a case – by – case basis), for providing many of their needs, especially those materials, which must be obtained abroad. This liability too, shall persist until sustained and organized provisions are guaranteed.
- The PHC network – somewhat out of necessity – has so far operated outside of the policies of curative services; apart from the public insurance system and separate from the larger body of health services in our country. This situation is obviously unsustainable, and can only be replaced by a rational reunion of health services, which in turn calls for a greater degree of support and deeper consideration on the part of the national authorities.

FUTURE CHALLENGES

- Need for establishing efficient organizational structures and managerial systems for health development
- Increasing demand for improving the quality of care
- Prioritizing nutrition and food safety
- Weak referral support
- Matching community health needs and development of human resource
- Hosting a large number of refugees
- Increasing burden of non-communicable diseases due to epidemiological transition
- Ensuring the quality of essential drugs and rationalizing their use
- Ensuring the relevance of human resource development to the health needs of the community.
- Launching a broad based health system research (HSR) where health workers have a direct role in its implementation as a problem-solving tool.

PHC Coverage (%)

INDICATORS	YEAR	VALUE
Population with safe drinking water	1999	92
Population with adequate excreta disposalFacilities	1999	86
Population with local health care	1997	94
Women attended by trained personnel During pregnancy (atleast 2 times and over)	1997	77
Deliveries attended by trained personnel	1997	86
Infants attended by trained personnel	1997	62
Women of childbearing age using family Planning (Modern Methods)	1997	56
Infants fully immunized against: Tuberculosis (BCG)	2000	97.4
Polio (OPV3)	2000	99
DPT (DPT3)	2000	97
Measles	2000	99
Hepatitis (HBV3)	2000	82

Compilation: Global PHM Secretariat, Bangalore, INDIA.

Source:

1. King Maurice (Ed), 1983.
The Iranian Experiment in Primary Health Care: The West Azerbaijan Project (Principal investigations, Dr. Amni and Dr. M.A. Barzgar et al),
School of Public Health, Ministry of Health and Social Welfare, Teheran,
Oxford University Press, Oxford, UK.
2. Shadpour, (1994)
The PHC Experience in Iran
The Council for Expansion of PHC Networks, Ministry of Health and Medical Education,
UNICEF, Teheran
3. Ministry of Health and Medical Education, 2003.
Health Situation and Trend in the Islamic Republic of Iran, Teheran 2003

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“WHATEVER HAPPNED TO ALMA ATA?”

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Somehow or other the month of September seems to have recent significance for humankind. September the 11th and the World Trade Center are still fresh in our collective memory. What is barely in our memory is what happened on the 12th of September 1978 when the world was introduced to the concept of Primary Health Care and the Alma Ata Declaration was published. For us in the field of public health, Alma Ata was the defining moment but its stated objective of Health for All by the year 2000 came and went without creating a ripple since it was a mirage in the first place. As we mark the 25th Anniversary of Alma Ata in, again September 2003, it behooves us to examine the hopes and aspirations that Alma Ata generated, the paths we have traveled since, the gods that we worshipped which we subsequently found had feet of clay and the highly touted New International Economic order that was already dead when it was given a quiet burial in Cancun in September 2003. What holds great symbolism for us is the loss of the name of Alma Ata itself which has now become Almaty in Kazakhstan and where significantly the Infant Mortality Rate of 12 per thousand live births in 1978 is now 60/1000 live births, reflecting indeed the state of public health in much of the world.

Recently I had an occasion to talk to several recent medical graduates in Sri Lanka and India. Not a single person had heard of Alma Ata. No one knew the principles of Primary Health Care (PHC). Nothing about this had been part of their curriculum. Herein lies one of the reasons why Health for All by 2000 A.D. remained a mirage. It is easy for us to sit back in our arm chairs and discuss what has happened in the last twenty five years. We, as the chosen community of healers with a clear mandate to heal and a clearly defined 2000 year old focus on the poor, with an infrastructure best suited to respond to the challenges of PHC, have to admit to a collective failure. Wittingly or unwittingly, we became part of a cartel that sabotaged PHC. Let us for a moment stop and examine which of our institutions played a pioneering role in the spread of PHC? There are honourable exceptions of NGO programs predating Alma Ata, which indeed, gave some of the principles of Alma Ata, but collectively, as the NGO sector in general, we failed in promoting PHC with the zeal we should have exhibited. With our institutions and organisations, with dedicated and informed staff, with our reach in the community and focus on the poor, if we had stood unambiguously for PHC, the entire public health scenario would have been different. We did not. This is an opportunity to examine again our structures and systems to see why this has been so and how we can face these challenges better in future.

The Hope and The Promise

Health is a fundamental human right. This is built into the Indian Constitution. The Constitution directs the State to regard the improvement of public health as one of its primary duties. When J.P.Yadav, India's representative to the International Conference on Primary Health Care held in Alma Ata signed the Declaration, he very forcibly reiterated it saying "...the health scene in most countries in Asia and Africa suffers from severe distortions.... We are now laying greater emphasis on PHC in rural areas, on narrowing the gap between the village and the city, between the 'haves' and the 'have nots'. The new direction which we have given to our health programmes seeks to take basic health care to the doorsteps of the people in the villages". What has happened to this lofty promise of a *new direction* in the last twenty five years?

In 1993, fifteen years later, a critical analysis of the health data in India reports: "...the health scenario of the country is in an abysmal state notwithstanding the islands created by five star private hospitals and nursing homes. In spite of the Parliament adopting the National Health Policy in 1983, the health situation in the country today is a cause of deep concern". We will come to this later.



The Aspirations

When statesmen and international decision-makers gather in conferences much hot air is produced and rhetoric bandied about. But the Alma Ata Declaration was truly a path breaking one thanks to the indefatigable efforts of Dr. Hafdan Mahler and his team. It is well to recall at least the key phrases in the Declaration in order to assess how far we have strayed from it:

Article I : Health is a *fundamental human right* and the attainment of the *highest possible level of health is a most important world-wide social goal* whose realization requires the action of *many other social and economic sectors*.

Article II : The existing *gross inequality in the health status*.... Particularly between developed and developing countries as well as *within countries* is politically, socially and economically unacceptable and is therefore of *common concern to all countries*.

Article III : *Economic and social development based on a New International Economic Order is of basic importance* to the fullest attainment of health for all.

Article IV : The people have the right and duty to *participate individually and collectively* in the *planning and implementation* of their health care.

Article V : *Governments have the responsibility* for the health of their people - to lead *socially and economically productive lives*. PHC is the key to attaining this target as part of the *development of the spirit of social justice*.

Article VI : *Universally accessible, socially acceptable, full participation, self reliance, self determination*.

PHC forms an interface of the country's health system *of which it is the central function and main focus*.

Article VII: PHC

Reflects and evolves from the economic and socio-cultural and political characteristics of the country and its communities

Addresses the *main health problems* in the community Includes education or prevailing health problems, promotion of *food supply*, proper *nutrition*. Adequate and *safe water* supply, basic *sanitation*, MCH, immunization, prevention and control of endemic diseases, provision of essential drugs.

Involves *agriculture, animal husbandry, food, industry*, housing, public works *etc.*, and *demands coordinated efforts*

Mutually supportive *referral system* to those *most in need*

Uses various levels of health workers including *traditional practitioners*

Article VIII : *National policies* to sustain PHC....it will be necessary to *exercise political will*, to mobilize the *country's resources* and to use the available external resources *rationally*.

Article IX : All countries should cooperate to *ensure PHC for all people* since attainment of health by people in one country directly concerns and benefits every other country.

Article X : An acceptable level of health for all by 2000 can be attained *through a fuller and better use of world's resources*, a considerable part of which is spent on arms and military conflicts.

...Finally, the Conference calls on *all of the aforementioned* to support *national and international commitment* to PHC, collaborate in introducing, developing and maintaining PHC in accordance with the *spirit and content of the Declaration*.

What a beautifully comprehensive document whose centrality unambiguously is "*people*" and their health in their own hands! What has happened to this spirit in the last 25 years?



India's Health

19th century diseases such as Leishmaniasis (80% of the cases in three countries, including India), Plague and Leptospirosis (125 cases and 12 deaths in Surat alone have made a come back)

Malaria, reported to be eradicated by NMEP has returned in more virulent and resistant forms, with two and a half million cases with an SPR of 3%.

Tuberculosis has made a come back and at last count there being one fourth of the global cases - 3.5 million cases and 500,000 deaths annually, more than 1,200 deaths a day.

HIV-AIDS: By 2010 India will have 20-55 million cases, the official prevalence rate being 1%.

Typhoid, Infective Hepatitis, Childhood ARIs are widely prevalent with attendant mortality

At last count, there were 19 new viruses yet to be studied fully for which, of course, there is no treatment.

Causes of the Deplorable State of India's Health

It is a well known fact that despite being avowedly being disowned by the ruling structures, that *caste* and to a lesser extent *class*, which largely follows from it as well as *asset holding patterns* are at the root of the problem of poverty. Everything else derives from it. There has been only one basic cause of poverty throughout the history of humankind. It is the lack of access to the control and possession of resources. 80% of these assets are owned by 20% of the population. In a recent document, the World Bank states: "...absolute poverty in India is declining but slowly, and it remains widespread in 37% of the rural population which lives below the poverty line. India has the largest concentration of poor people in the world...". The report found that staggering as the overall numbers remain - 240 million rural poor - they do not tell the story. Social indicators of well being - health, education and nutrition - describe a country which has made substantial gains against widespread deprivation over 50 years of its independence *but* has not achieved the momentum needed to bring the great majority of the poor into the economic mainstream. ..."its death rate for infants under five remains one of the highest in the world...maternal mortality, which accounts for 12.5% of the annual deaths of rural women aged 15 to 45, causes about 470 deaths per 100,000 population. India's rate is *four times that of China's* and 2.5 times that of the world as a whole. Tuberculosis alone kills more than 500,000 people a year. Half the children under five are malnourished and one third of the babies are underweight. And fewer than half the children from poor households are in school, reducing their prospects of escaping poverty. Two thirds of all women and two fifths all men remain illiterate.....Among the most disadvantaged groups, the ratios are even worse: literacy rates of just 19% among scheduled caste women. The Report goes on to say that in general gender, literacy, land ownership, employment status and caste are closely associated with poverty.

What an indictment of a country that has:

- The second largest pool of scientifically trained people in the world, after the USA
- Exploded its own nuclear devises successfully
- Sent its own satellites into space
- Capacity to build its own aircraft, cars
- Some of the best heart, eye and kidney surgical facilities and specialists
- The seventh largest stock exchange
- A citizen who has the largest steel empire in the world (Mittal)
- The largest group of software engineers in the world





Also has produced

Wines that are equal to the best

More winners of Miss. World and Miss. Universe than any other country

Contrast this with a few basic anomalies:

The two-tumbler system that exists in many interior villages where dalits have a separate tumbler in tea shops

The spate of killings of those who dare to marry outside their caste

The ostracism of dalits who dare to win panchayat elections

High rate of infanticide in several districts

The sacrifice of children when beginning new projects in some areas

The brides that are burnt for dowry

And on and on. Where do the twain meet? Who makes plans and makes allocations? Who oversees their implementation? Therein lies the rub, even if it involves only health. A class of people from specific social groups and who suffer from a set of Euro-American diseases such as heart attacks, hypertension, diabetes, obesity and so on plan for, implement, oversee and monitor health plans for a class of people from an entirely different social background and suffer from an entirely different set of illnesses such as tuberculosis, malnutrition, anaemia, typhoid, infective hepatitis, diarrhoea, dysentery, cholera and so on.

Our health system was designed not to work. At independence we had the opportunity of choosing a community-based and people-oriented system but what we did was to exchange one set of rulers for another, only the colour of the skin being different. The results are plain to see and reflected in the health statistics that the Ministry of Health so kindly provides. Even without disaggregation, they are deplorable. But as the saying goes, our decision-makers have eyes that do not see, ears that do not hear and minds that refuse to acknowledge the obvious.

Along with our traditional burdens stated above, newer threats in the form of globalisation loom large along with privatization, further putting public health and other public services, inefficient as they are, beyond access to the vast majority of people who need them.

What is more surprising is not the absolute number of poor Indians but the disparity that exists between the haves and the have-nots.

Table I Estimated per capita GNP in US\$ of the poorest 20% and the richest 10% In South Asia

Country Average	National	Poorest 20%	Richest 10%	Ratio between Rich and poor
Bangladesh	210	69	490	1:7
India	380	90	910	1:10
Pakistan	400	138	840	1:6.8
Sri Lanka	470	139	1160	1:8.4

As an aside, it should be mentioned here that 30 million Americans, 25% of the country's work force, don't earn enough to stay out of poverty. It is also reported that more than 50 million Americans, one in five, do not have health coverage so that they end up as emergency cases. Of course the American poverty line is quite different from ours.



In The World

In the last 25 years considerable gains in the health status have been achieved worldwide. Globally life expectancy at birth has increased from 46 years in the 50s to approximately 65 years in 1995. Total number of young children dying has been restricted to approximately 12 million instead of the projected 17.5 million. Disaggregation of these data unfortunately reveals that the gap in mortality rates between and *within* countries has widened considerably. Further, in a number of countries IMR actually increased in the 1990's largely due to SAPs, the impact of HIV/AIDS, wars and unrest.

There has been, like in India, a resurgence and spread of older communicable diseases such as cholera, tuberculosis, malaria, yellow fever, trypanosomiasis, dengue etc., while HIV/AIDS threatens this century's health gains in developing countries, many of which are also experiencing a double disease burden with cardiovascular diseases, cancers, diabetes and other chronic conditions and violent trauma replacing communicable diseases in some social groups.

There has been some progress in improving access to water supply and sanitation, although *great differences* continue to exist between and within countries and social groups. Much greater immunization coverage, from 20% in 1980 to 80% in 1990 has been reported. That a great number of these children so protected will subsequently die of malnutrition is of grave concern. Even immunization coverage has declined since 1999, with difficult to reach, poor populations experiencing the burden of preventable disease; the reappearance of diphtheria in the newly independent states as a result of vaccine shortage and less than 50% coverage of pregnant women with tetanus toxoid is of concern. The nutrition situation remains serious with almost 200 million young children being malnourished and almost a billion people receiving less than their basic requirements of energy and protein.

Acute respiratory infection and diarrhoeal diseases are still widely prevalent and the leading causes of death of children under five globally, mainly as a result of minimally improved environmental hygiene and persistent malnutrition. Maternal mortality and morbidity from largely preventable causes remains unacceptably high.

Table II Maternal Mortality Rate

Countries	MMR per 100,000 lbs.	Number of Member States Studied
Developing countries	421	113
Least Developed countries	727	37
Eastern Europe	41	8
Developed Countries	34	25

Tuberculosis is not only a threat to India's health. It affects other developing countries also causing 25% of avoidable adult deaths worldwide with 95% of the cases in developing countries.

One of the main obstacles to improved health status has been the deplorable state of health systems in developing countries including in India. Health systems do not mean more buildings, personnel and infrastructure, which for example India, has plenty of. To use a current analogy, hardware is less important than software - what is needed is the spirit behind PHC that Alma Ata specifically called for. Health systems development also has been hampered greatly by austerity measures such as reduction and withdrawal of subsidies dictated by the fiscal policies of IMF/WB. As Sanders notes, one of the significant impediments to the successful implementation of PHC has been the substantial failure of medical colleges, to adapt their missions and activities to the challenges posed by Health for All. Where does this challenge leave our own institutions? Or are we merrily continuing with our business-as-usual approach?



Why Alma Ata Failed

Alma Ata was remarkably ahead of its time when it spoke of a comprehensive and progressive approach called PHC with an inclusive, equity oriented, participatory strategy since called “people-centered development”. As the Declaration states: “ the purpose of development is to permit people to lead economically productive and socially satisfying lives (*Article V*). This approach meant a structural change, a systemic overhaul in favour of the poor, in favour of those most in need which the ruling classes in most , if not all, countries were not about to allow. The Conference itself anticipated opposition to this revolutionary approach and warned: “It can be seen that the proper application of PHC will have far reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it will greatly influence community organisation in general. *“Resistance to such change is only to be expected”*.”

Quite simply stated, the ruling power structures in the world and within nations were simply not willing to accept this and thus the deliberate scuttling of PHC. The scuttling process started early enough, in fact in 1979 itself, when ‘experts’ at Johns Hopkins School of Public Health started advocating ‘selective PHC’ claiming that PHC was too complicated and too expensive for developing nations to handle. Therefore, instead the community-based, people-oriented participatory approach gave way to a top-down, reductionist, technological approach resulting in separate programs for selected aspects of PHC such as immunization, MCH, oral rehydration etc., with, as Banerji has pointed out, virtually no scientific data to support its implementation, people once again becoming recipients of pre-fabricated, market-driven, techno-centric, and scientifically questionable programmes *imposed* by international agencies. People’s participation became the first casualty that contributed significantly to the failure of PHC.

The second biggest obstacle was the structural adjustment programs (SAP) introduced by IMF and WB in the early 1980’s. The dominant models of development that liberated countries chose were patently inappropriate (Remember Nehru waxing eloquent on the steel factories being the temples of modern India?) and created a dependency on western ideas, western technology, and even western food (Remember PL 480 and the millions of tons of wheat that an entire generation of Indians grew up on?), not to speak of western money.

By the early 80’s most of the southern countries were deeply in debt to western banks and governments and were ripe for intervention in the name of SAP. The draconian policies of IMF/WB under SAP resulted in the net transfer of US\$178 billion to the west between 1984 and 1990 from poor developing countries to commercial banks in the north. The transfer was so outrageous that a former World Bank executive described it as follows: “not since the conquistadores plundered Latin America, has the world experienced a flow in the direction we see today”. Galbraith described the debt crisis as *“an astounding process of impoverishment of the poor for the sake of enrichment of the rich”*.

Reduction of public spending especially in public health, public distribution systems and in education had devastating effects, as already cited by Sanders above (22). Increase in IMR, MMR, and malnutrition rates right from Latin America to sub-Saharan Africa to Orissa in India is well documented, not to speak of the loss of sovereignty that made it impossible for Parliaments to enact laws in favour of their own citizens.

Privatisation of health services, charging of user fees, patent laws to protect western pharmaceutical companies and the General Agreement on Trades in Services (GATS) which may make it easy for the eventual take over of health services by foreign health maintenance corporations - all these have made already or will shortly make even the most basic of health services inaccessible to those who most need it.

Health as a Commodity

In January 2000, the Director General of WHO established the Commission on Macroeconomics and Health (CMH) to assess the place of health in global economic development. It is well to quote the fountainhead, Jeffrey Sachs himself in full; “Although health is widely understood to be both a central goal and an important





outcome of development, the importance of investing in health to promote economic development has been much less appreciated". Therefore, investing in health for economic development, especially in the world's poorest countries has become a prime strategy. Consider the paradigm shift in the way health is viewed. People and their health as the centrality at Alma Ata to investing in them so that they become economically productive in order to further strengthen neo-liberal economic policies.

This is actually the result of the active involvement of the World Bank in health matters that started in the early 1990's when the Bank discovered that poor health reduces worker productivity, thus impeding economic growth of big industry. By the late 90's the World Bank was spending on the health sector *three times as much as the entire WHO budget*.

The Corporatisation of Global Governance

When David Korten wrote "When Corporations Rule the World" he could not have foreseen how intensively and how soon this would become a reality. The presence of trans-national corporations in trade agreement meetings have been widespread and significant even since the Uruguay Round. They have played a crucial role in shaping international policies, not merely restricted to trade alone. Consider what happened to the Kyoto Protocol on Environment or the Doha Process. Their influence can be seen in the measures demanded by IMF/WB and the Western nations in SAP and after. These include:

- Cutbacks in government spending/subsidies to social sectors such as health and education
- Successive devaluation of local currencies in the name of achieving export efficiency while retail prices go up
- Rollback or containment of wages, retrenchment of workers
- Deregulation of the economy, free entry of foreign operators
- Elimination of protection to local markets
- Liberalization of trade, reduction of tariffs
- Removal of trade and exchange controls
- Abolition of price controls

Compare this with Alma Ata's call for economic and social development based on a New International Economic Order that is *basic* to the fullest attainment of health? (Article III)

Globalization of Poverty

Vardent advocates of growth-oriented development often refuse to look at history. The Human Development Report 1996 states: Recent decades show all too clearly that there is no automatic link between growth and development. Globally economic growth is declining in about 100 countries with almost a third of the world's population. Between 1990-1993 the average income fell by 20% or more in 21 countries.

Between 1979 and 1985 the global GDP increased by 40% but the number of poor increased by 17%. OECD countries contain 28% of the world's population but account for 78% of the GDP. The ratios of the incomes of the poorest to the richest in the world was 1:30 in 1963 but in 1993, it was 1:60.

The dominant 'free market' paradigm of development is the main reason why primary health care as envisaged in Alma Ata did not work. It is undemocratic, unsustainable and promotes economic growth of the rich regardless of human and environmental costs.

Roadmap for the Future

To use a currently fashionable phrase, though it hasn't worked much in Palestine, is there a roadmap for the future of public health?





To quote Mahatma Gandhi, the world has enough for everyone's need but not for every one's greed. A small fraction of the annual profits of the tobacco and arms industries alone can provide clean water, food and basic health services to everyone who needs it. Do we see this happening?

Political Will

Article VIII of the Declaration calls for not just political will of the ruling structures in implementing PHC but goes beyond in spirit to call for political will of the people through their *conscious* and full participation. Making local governing structures including primary health centres be accountable to local communities through participatory grassroots democratic movements is one option for an alternative. There are growing movements across the globe that promote people's struggle for equity. In this age of information, sharing of information leads to solidarity building (Seattle, Genoa, Geneva, Evian, Cancun - can we ever forget the picture of a man stabbing himself in protest in Cancun?).

Some of the other hopeful initiatives are:

- Watchdog bodies that monitor the activities of trans-nationals (eg., Multinational Monitor)

- Voluntary groups that spread information, build up public awareness and support such as Oxfam

- Groups that monitor policies, dialogue with policy makers such as in WHO (People's Health Movement)

- Building public opinion against big business, oil cartels, arms merchants, tobacco industry

- Lobbying national and international policy makers

- Bringing all sorts of concerned people together and raising public awareness like in the World Social Forum, Asian Social Forum, People's Health Assembly

- Building effective, broad based coalitions such as the People's Health Movement

In Conclusion:

There is actually no pot of gold at the end of the rainbow, if a rainbow there is. Present will be only pain and grief for the large majority of people unless we make substantial changes in the way we look at the problem and at the solution.

There are two issues at stake. One is in the middle future, say around 10 years from now and involves building up people's movements. One recent example is the People's Health Assembly that took place in December 2000. PHA brought together 1,500 people from 91 countries - people concerned about the future of public health - academics, activists, practitioners, doctors, health workers, traditional midwives, teachers and students, arguably the biggest meetings of those concerned about health since Alma Ata and. This resulted in the People's Charter for Health, a more comprehensive and 'topical' one than the Alma Ata Charter itself. This meeting resulted in the formation of People's Health Movement that now has roots in most regions of the world. There has to be constant joint action by PHM and in concert with other movements such as the women's movement, oppressed people's movement, campaign against unfair trade, campaign for rational drugs and such in order to bring back the spirit of Alma Ata and keep alive the hope raised in Savar, Bangladesh in December 2000.

These plans should also include grassroots democratization and making local structures accountable to local people, a shift in power equations in favour of the majority. This will mean a coalition of people's organisations at the ground level, provision of relevant and topical information and training in advocacy and other people related action. NGOs in spite of their doubtful track record of the past few decades, still have an important role to play in this.

Secondly and more importantly, what do we, as the NGO sector do? The Alma Ata. Are our institutions - schools, colleges, nursing and medical colleges, service organisations, especially hospitals prepared to sacrifice their organisational and institutional priorities and staunchly set their agenda according to the priorities of the people? Can we take an unequivocal stand against unjust structures that breed and nurture inequality, especially





in health? It is easier said than done since most of our structures are mired in a milieu of self absorption from which one can come out only with difficulty.

In the history of humankind people's rights have never been handed over voluntarily by ruling structures, they have to be taken. This can only happen through solidarity building on a geographically significant scale which is now possible through the use of information technology. With us, without us or even in spite of us, people power is bound to rise. Where will we be - comfortable in our organisations or behind the barricades with them? There is hope yet that momentous changes are afoot and several people based initiatives around the world are beginning to grow in size and effectiveness giving hope that, indeed another world is possible and perhaps Health for All by 2020.

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WARS, CONFLICTS AND MILITARISATION ARE KILLING THE DREAM OF *HEALTH FOR ALL*

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Introduction:

Wars and conflicts, along with the military industry, has become the main barrier to achieve “*health for all*”. Health, lives and truth are the first casualties in wars and conflicts. Wars hit health services badly and cripple them. Governments and military leaders divert precious resources required to ensure *health for all* for military expenditure. Medical science is increasingly being misused to develop Weapons of Mass Destruction.

Ordinary health workers, a very few health and medical professionals and a very limited number of professional associations and civil society initiatives continue to resist the onslaught of wars, conflicts and the arms industry. However the majority of the medical professionals and international bodies (including some of the UN bodies) continue to remain Dr. Neros.

It is time to do a soul searching- a reality check. It is time to extend renewed solidarity to fight militarisation and occupation. Time to STOP wars and conflicts.

Medical, health and social impacts: devastation tripled:

We know from the experience of the last century that wars and conflicts wreck havoc. The People’s Charter for health, the largest consensus document on health in the world testifies that “ War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector”.

The impacts are multi dimensional and long lasting. As someone coming from health and humanitarian background, let me focus more on their killer impacts on health and life.

Immediate health concerns are conflict-related injuries. Today, live ammunition and heavy weaponry top the reason for death in Occupied Palestinian territories. Union of Palestinian Medical Relief Committees estimates that upto 81 percent of the lives are lost due to these factors.

As war progresses, the situation deteriorate fast resulting in public health crisis. Diseases in epidemic if not in pandemic proportions; cholera and dysentery and nutritional diseases, measles, meningitis and other preventable diseases (due to low vaccination rates) are some of the fallouts of wars.

Rapid increase in diarrhoeal diseases (when access to potable water is denied), rise in respiratory infections (when oil wells are hit) follow. Humanitarian workers like us never succeed, despite our best efforts, to provide basic humanitarian assistance in camp situations where refugees and Internally displaced people turn up in large numbers. Iraq is a case in point. MEDACT (an affiliate of International People’s health Council (IPHC) and PHM) and International Physicians for the prevention of Nuclear War (IPPNW), in a joint study titled ‘Collateral damage’ just before the US lead invasion in Iraq warned that there was a caseload of 5.2 million vulnerable people in Iraq, including 4.2 million children below the age of 5, 1 million pregnant and lactating women and 2 million internally displaced people (IDPs).

As we know from Rwanda and other conflict torn places, nutrition deficiency disorders and food crisis cripple refugees and IDPs and leave a long shadow of morbidity. Human sufferings due to wars have many dimensions. Psychosocial impacts, disability and long term morbidity are just some of the amplifying factors.





Rules of the war and their impacts also have changed. Wars have become increasingly biased against the poor and weaker. In the First World War, 5 % of the casualty was civilians. By the second world war, this went up to 50 %. In the 1990s, over 32 conflicts in barbaric ways demonstrated that 90 % of the casualty was civilians. Majority are innocent children and women.

Today there are more internal conflicts and less international conflicts. With privatization of wars and conflicts, military machine has degenerated into a killing machine, without any conscience. Violence, terrorism, state sponsored human rights abuse and structural violence add to the lot. Let me recall what an Iraqi family said about their plight to me when I met them in Baghdad in February, just before the latest round of bombing began: "When two big elephants fight, it is the grass that suffers".

To illustrate this further let me take you through some of the chilling images of the last two centuries. I would like to take you to visit Vietnam, Cambodia, Afghanistan, Iraq and Palestine.

Reminders from the past: warning signals for the future:

Vietnam: Firstly, let me take you to Vietnam, a laboratory of US armed forces invasion in the 1960s. Over 3 million people died in the hostilities. Most of them were innocent civilians. That was just a beginning. In the 1960s, the US sprayed much of South Vietnam, with 'Agent Orange' a code name for a cocktail of defoliant herbicides, including Dioxin. Dioxin is a poison and it caused foetal death, miscarriage, chromosomal damage, congenital defects and cancer. US Senator Gaylord Nelson, during a speech to the US Congress on Aug 25, 1970 admitted that "...US has dumped (on South Vietnam) a quantity of toxic chemical amounting to six pounds per head of population, including women and children". Today Vietnam is still struggling to cope with the terratogenic effects of Agent Orange and the impact of chemical warfare.

Cambodia: Let me take you to another Asian country- Cambodia. Two decades of genocide have left the country shattered. Between 1969 – 73, US bombers killed 750,000 Cambodian peasants. Between 1970 and 1973, US forces dropped more bombs on Cambodia than what was dropped on Germany in World War II. B-52 bombers dropped bombs equivalent of five Hiroshimas. In the 1970s, 2 million died in forced labour camps and interrogation centers. Renewed civil wars by Khmer rouge left 100,000 landmine victims. In the peak of the Khmer Rouge, 600-6000 amputations were recorded every month. Some say, this is an under estimate. "In Cambodia, 28.4 % of the survivors of war and mass violence suffer from Post Trauma Stress disorder" says a study in Journal of American Medical Association in 2001.

Afghanistan: Now let me take you to Afghanistan. 23 years of conflict has left a long trail of mortality and morbidity. Afghans have gone through generations of trauma. About 97 per cent of women interviewed in Kabul and refugee camps in Pakistan showed signs of depression, says a research study. The details of the study published in the prestigious *Journal of American Medical Association* added that 86 per cent of the women had significant anxiety symptoms.

But the study came out before the last round of bombing by the US and their allies. The bombings and the fighting that intensified have added to the suffering of people. Conflicts and war situations spawn psychosocial disorders. Women and children are the most vulnerable in conflict situations. Loss of family members, traumatic experiences, displacement and constant terror rewrite their biography into a nightmare. Worse is the situation of the people with other limitations. For example, people disabled due to landmines are doubly disadvantaged. Poverty, insecurity, uncertainties and other social factors complicate the plight of the war-affected.

I was in Afghanistan last month (Sep 2003) for work reasons. One of the bizarre items that I saw during a visit to the local shops is a shoe shop selling shoes for one leg- yes, shoes sold not in pairs. It may seem strange for people elsewhere to understand why this is so. But for the most land mine infested country in the world that has killed and crippled thousands of people and their families, this is just a user friendly (made to the actual need) item. The conflicts of last 23 years, types of weapons (including the Depleted Uranium weapons) have left a legacy- legacy of death, devastation and diseases.





Iraq: My work is to facilitate health and humanitarian assistance in wars, conflicts and disasters situations. This has taken me to several places. Perhaps the most haunting images I have seen during humanitarian missions are from Iraq. Let me tell you about one child we (my colleague from ActionAid and I) met in the over crowded, under equipped pediatric hospital in Baghdad. It was just a few days before the bombing this year.

Mariam Fahemi was among several hundred children with serious illnesses admitted in the prestigious paediatric hospital- awaiting an uncertain future. With its medical system crippled by the 1991 Gulf War and an unkind embargo that followed, for Fahemi and the other children in the hospital, the chances to celebrate their next birthday looked increasingly dim. With no medicines and equipments, Mariam's future was uncertain- she was diagnosed to have leukaemia.

Doctors treating her admitted that there has been a sharp increase in blood cancer caseload since the 1991 war. Rosalie Bertell, the world-renowned radiation expert, wrote in her recent book, *Planet Earth: The Latest Weapon of War*, referring to Iraq: "Cancer rates appear to be significantly higher than the world average... The suspected culprit is depleted uranium, a toxic and radioactive metal extensively used in the bombing by the US and their allies". Depleted Uranium is a killer. It kills those who are already born, would not spare even the children who weren't born when it was dropped.

Experts have documented that depleted-uranium-induced cancer has been increasing manifold in Iraq. The bombing campaign by the US forces and their allies has left a long trail of morbidity.

Lamia was another child I met at the same hospital. She had bloodstained cotton on her nose, a grim reminder of the seriousness of her condition. She was still bleeding, a bad omen for a leukaemia patient. We present her a weak smile. Lamia was too tired, perhaps the reason why she didn't smile back. Next day at the hospital, her bed was empty.

US initiated sanctions also deteriorated the plight of ordinary Iraqis, especially children like Mariam. In 1997, UNICEF estimated that 32 percent of children under five, some 960,000 children, were chronically malnourished—a rise of 72 percent since the imposition of sanctions in 1991. Of them 23 per cent were underweight - twice as high as the levels found in neighbouring Jordan or Turkey.

Sanctions-related reasons were behind the deaths of tens of thousands of children in Iraq, humanitarian agencies point out. Infant mortality rate went up from 47 per 1000 births before sanctions to over 108 after it. That is more than 100 per cent increase in ten years. A survey by UNICEF in 1999 showed that in places in south and central Iraq, children under five years were dying more than twice the rate before the depleted uranium bombing and imposition of sanctions. The silent funeral wiped out a good generation of Iraq children. Iraq had seen a mass murder in slow motion. The new war has just amplified it. During the peak of the bombing, hospitals and medical facilities were targeted. Members of Medical Aid for the Third world, a voluntary medical body, have documented this. They have filed a case against Tommy Franks for committing crimes against humanity, as 'coalition forces' allegedly 'targetted' hospitals.

Palestine: Talking about committing crimes against humanity and violation of Geneva conventions and International Humanitarian Laws brings me to the last place I would like you to visit. That is Palestine.

In May last week, I was in Geneva, attending the World Health Assembly and meetings of the People's Health Movement. Dr. Ghassan Hamdan, a good friend who works with UPMRC was with us in Geneva. UPMRC has been a lifeline for the civilians in the Occupied Palestinian territories. On May 24th, I was woken up by an emergency call from Ghassan. He informed, in breaking voice, that his emergency clinic in Nablus was destroyed in shelling by the Israeli forces. The attack brought this emergency clinic, the only medical facility for thousands of poor Palestinian people, into a grinding halt. Material loss alone was worth over US \$ 10,000.

The pictures of the devastated emergency clinic, spoke of terror- terror waged by a powerful army on a civilian hospital. During my regular humanitarian work, I have seen several hospitals destroyed in earthquake-hit areas. The pictures that Ghassan showed looked so similar- but this clinic was the victim of a PREVENTABLE political earthquake'.





Unfortunately, this was not an isolated act of terror. Let me try to narrate an 'incident' that Ghassan told me that afternoon (This is also documented in the website of UPMRC). On December 10th, 2002 (World Human Rights day) the following tragedy happened in Nabulus. Adla Abdel Jaber As-Sayyefi, 37 years old, developed labour pain at around 3am. Her husband spoke to the Red Crescent requesting for an ambulance, but the ambulance was unable to reach their village because of the trenches and checkpoints and suggested instead the ambulance and the family and Adla, meet at another checkpoint of Beit Eba.

Adla's husband, her father in law, mother in law and her mother, went in a neighbour's car to catch the ambulance. However, when they came within sight of the checkpoint, a tank was blocking the path. So, in the dark and rain they tried to attract the attention of the soldiers in the tank. The lights of the ambulance were clear on the other side of the checkpoint and Muhammad beeped the horn, and the ambulance turned on its siren, but still the soldiers in the tank made no moves. Finally, Muhammad got out of the car and shouted to the soldiers that Adla needed to get to the hospital and to let them pass - but still the soldiers refused to respond. Too terrified to try to pass, 74-year-old Muhammad turned the car around and began to return to the village, but after only ten meters or so Adla gave birth; however the baby died.

Medical access denied is death assured- 2,575 Palestinians have been killed between Sep 28,2000 and June 3, 2003. Out of this, 326 (12.7 %) are children below the age of 15. 1,238 (48.1 %) are between the age group of 19 to 29 years. Can you see a whole generation of Palestinian youth disappearing in front of our eyes?

Live ammunition and heavy weaponry, the key two immediate causes of death have taken away 2104 lives (81.7 %). Prevention of medical treatment killed more than 79 Palestinian in checkpoints. Wars are not just about death, injury and diseases. 2002 witnessed steep decline in all economic indicators in Occupied Palestinian Territories. Unemployment is now reaching 53 per cent. Even the World Bank estimates that 60 % of the people are living below the poverty line. By the end of 2002, Real Gross National Income (GNI) had shrunk by 38 per cent from its 1999 level. UNRWA and World Bank estimates that real per capita incomes are now 46 per cent lower than in 1999. Combined with a 13 per cent population increase, these figures tell humane suffering. In September 2002, Palestine Monitor estimates that almost half of the Palestinian households live on 50 per cent of what their income was when the current *Intifada* began. 12,700 houses destroyed in Palestinian territory.

Let me quote the United Nations, the white dove agency that is increasingly failing in its duty to protect the people of the world. The agency, that has increasingly become a puppet in the hands of couple of rich and arrogant nations, said the following in June 2003. "The accelerated impoverishment is reflected in a significant drop in the real per capita food consumption of Palestinians, now estimated at 70 per cent of the pre-September 2000 levels". It added "Continued disrespect of the International humanitarian law was noted as the single largest cause of the growing humanitarian emergency".

Earlier I said that wars, conflicts and militarisation divert the scarce resources. Middle East explains this phenomenon in reality times. Middle East has become the most militarised region in the world. This exerted terrible financial and social costs in the 1980s and 1990s. In 1991- 13.9 % of the GNP in the Middle east was spend on arms. The world average at that time was 4.7 %. At the same time, expenditure on health was limited at 2 % of the GNP. The global average was 4.7 %.

Today, the annual arms expenditure is over US \$ 850 Billion. The world needs just 9 Billion US dollars to provide basic education and 11 Billion US dollars to provide water and sanitation to the people in the developing world. Remember, tomorrow by this time, wherever we are, over 30,000 children will die worldwide from preventable diseases. That is, every 24 hours, over 30,000 children die world wide from preventable disease. We know why they are dying, we know who are responsible for these deaths. We need to stop them. Let us begin our counter attack by targeting the military industry and Trans National Corporations that has destroyed the dream of *Health for All*.

Last month marked the 25 years of Alma Ata, perhaps the most important and progressive declaration that the WHO has ever conceptualised. Alma Ata declaration was issued during the International Conference on Primary Health care (Sep 6-12, 1978) at Alma Ata in the former USSR. WHO, UNICEF and others who facilitated Alma Ata promised health for all by 2000 AD. The declaration recognized the negative impact of militarisation and stated clearly that "An





acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts".

In December 2000, over 1500 people from nearly 100 countries came together at Savar, near Dhaka in Bangladesh for the historic People's Health Assembly. The venue rightly was *Gono Shasthaya Kendra* (People's Health Centre), a grass roots organization that was born during Bangladesh's struggle for independence. One of the key concerns that were raised by the participants at PHA 2000 was the increasing negative impact of wars, conflicts and militarisation. Testimonies from Palestine, Latin America, Africa and Asia reiterated the need to *give peace a chance to achieve health for all*. The people's Charter for health that was formulated during PHA 2000 is the largest consensus document on health today.

The Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms.
- Support people's initiatives to achieve a just and lasting peace.
- Demand the end of occupation.
- Oppose the militarisation of humanitarian relief interventions.

PHA and its collaborating agencies like IPHC have launched a series of activities and campaign to demand "*Health for ALL NOW!*" www.TheMillionSignatureCampaign.org launched in January 2003 during Asian Social Forum was a good starter. The Spanish version was launched at Porto Alegre during the World Social Forum. The campaign is growing, with more language versions and people signing it. Please extend your solidarity in this struggle for health for all NOW !

At this critical moment in history, let me reiterate our key needs and demands. This is also a call to join hands, ensure synergy and extend solidarity with others to work to achieve the following.

1. Stop the wars. Respect International Humanitarian Laws.
2. Stop the occupation of Iraq, Palestine and other places. Let the local people decide their future.
3. Give health a central role in the rebuilding efforts.
4. Put an immediate end to all research programmes that are being carried out to develop weapons of mass destruction (WMD). Possession as well as use of WMD is one of the greatest threats to public health.
5. Give health a chance. Divert the precious resources wasted for military and defence expenditure to public health programmes.

Let me stop this with an appeal we have just received from Palestinian friends. On November 9, 1989 the Berlin Wall – which became the symbol of shame of the politics of division of the 20th century - was torn down. 9th of November 2003 will be observed as the International Day of Solidarity with Palestinians against the Separation Wall. Let us observe November 9th as a worldwide Protest Day against the new 'Berlin' Wall currently being erected by Israel across the West Bank. Let us join hands with the Palestinians to make the wall fall. The wall must fall!

Watch out. Palestine is not the first place of occupation. It is not going to be the last either. It is time to Act.

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THE STRUGGLE FOR HEALTH: PROBLEMS AND SOLUTIONS – REFLECTIONS FROM THE SOUTH (Reprint)

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THE CONTINUING RELEVANCE OF ALMA-ATA

Maria Hamlin Zuniga (*International People's Health Council*)*

Mike Rowson (*Medact and Health Counts*)**

The year 2003 marks the 25th anniversary of one of the most important documents in international health, the Alma-Ata declaration on Health for All. The declaration set a deadline of the year 2000 for achieving a level of health that would enable all of the world's people to "lead a socially and economically productive life." The strategy to achieve the goal would be the implementation of primary health care, with its emphasis on community participation, and tackling the underlying causes of diseases, such as poverty, illiteracy, and poor sanitation. The declaration was drafted by WHO and UNICEF and signed by over 130 health ministers (including those from the developed countries) and called for a New International Economic Order to benefit the developing world, and the diversion of money spent on arms to investments in health. It seems slightly unbelievable today that rich nations and international agencies could have put their names to such a radical declaration. However, despite promises, very often the Declaration was not put into effect: Health for All by the year 2000 was patently not achieved.

But this does not mean we should throw away the Declaration. It has continuing, and even heightened relevance for the world today. Alma-Ata was an evidencebased Declaration, which sprung from the lessons learnt in the many communitybased projects working in health and from the performance of some of the high achieving developing countries such as Costa Rica, Malaysia, Cuba, China and Sri Lanka. The emphasis these countries placed on reducing social and economic inequalities and providing broad based education, health, water and social security services, showed that good health could be achieved in even very poor countries, if the political will was in place. Although these problems are challenging, experience shows that they cannot be ignored.

Challenges

Since Alma-Ata parts of the world have undergone a 'health reversal', and many of the contributions to this booklet show the consequences. Health systems have come under unprecedented stress, as Dr. Sanders shows in his analysis of the situation in sub-Saharan Africa. New diseases (and old ones) have flourished, and public health has deteriorated in many countries. Dr. Unnikrishnan highlights the intolerable burden that health care costs place on the poor: it is a perverse world in which the actual costs of health care can push people into poverty, but in many places they routinely do so.

Globalisation and the expanding role of the market have also frequently damaged health and health care. The new world of free trade in goods and capital has led to greater instability in the global economy, with dire consequences for health, as Dr. Monsalvo reveals in his analysis of the Argentinian situation. Global trade agreements, as Dr. Sanders shows, have prioritized trade concerns over public health. At a deeper level, the emphasis on introducing markets in health care has had an unhelpful influence on fundamental values such as co-operation and solidarity, and affected the ability of countries to re-distribute income from richer to poorer segments of society.





Alternatives

Dealing with these global problems, as well as those at the national and community level is a complex and tiring business for health activists. The experiences of the Council for Health and Development in the Philippines show how positive health interventions can be set back by the actions of governments and the military. However, even in dire situations bravery and tenacity can win through. In Latin America, Dr. Monsalvo describes the efforts of health professionals and others to envisage a new Argentina (and a new world!) through practical health interventions and policy debate. Dr. Quizpue shows how in Ecuador, health activists have composed their own 'Health Charter' with a list of demands to government. All such efforts bear testimony to the values encapsulate in the Alma-Ata Declaration.

All over the world, people concerned with health are trying to focus the attentions of governments and international agencies on the promises they signed up to 25 years ago in Alma-Ata. Recently, the People's Health Movement, with which International People's Health Council and Health Counts are closely involved, has been formed to focus attention on these goals and to mobilize activities. We hope that this booklet will be part of that process and that people concerned with health will join us in the ongoing struggle for 'Health for All'.

* IPHC is a worldwide coalition of people's health initiatives and socially progressive groups and movements committed to working for the health and rights of disadvantaged people - and ultimately of all people. The vision of the IPHC is to advance toward Health for All—viewing health in the broad sense of physical, mental, social, economic, and environmental well-being. The IPHC maintains that: Health for All can only be achieved through: **participatory democracy** - decision-making power by the people, **equity** - in terms of equal rights and everyone's basic needs, and **accountability** of government and industry, with strong input by ordinary people in the decisions that effect their lives. The International People's Health Council – IPHC - is one of the groups that helped to organize and coordinate the People's Health Assembly held in Bangladesh in December of 2000. If you want to learn more about the IPHC and the People's Health Movement as well as future plans for action, please contact:

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10 CRY MY BELOVED COUNTRY

Unnikrishnan PV, India

The cover picture of this book shows Endramaya (60), a migrant casual labourer carrying on his back his wife, Lakamma (50), her broken right leg in a plaster cast. Lakamma is also a migrant worker, and she was injured in an accident in the outskirts of Bangalore two weeks earlier. The couple came to the city from Raichur in the northern dry belt of Karnataka state, where a farm and market crisis make local people migrate in search of work elsewhere in the country. State capital Bangalore, one the best technology hubs in the world, "the Silicon Plateau of India", is a favourite destination for many migrants.

I was on my way to office when I spotted the couple. Endramaya had already walked for over two hours along the two km stretch of Mahatma Gandhi Road in the heart of the city, carrying Lakamma on his shoulder, occasionally resting on the roadside.





Endramaya made several attempts to get his wife medical treatment. His first stop was the government Primary Health Centre (PHC). But the PHC did not even have the basic facilities to take an X-ray or to put a plaster cast on the patient's leg. Endramaya then took his wife to several private hospitals and clinics, but they would not treat her. He did not have enough money to pay.

After several days, once he was able to mobilise some money, Endramaya took Lakamma to a private clinic for treatment. Needless to say, the couple ended up spending most of the money they had. They had just enough for the bus fare to Raichur. After treatment, they spent the night on the pavement and it was raining. Around midnight, Endramaya started walking towards the Central Bus Station located in the heart of the city. He walked over 7 km, almost unnoticed in a City that is home to six million people, thousands of them employees of top firms, including several Fortune 500 companies. He tried several times for a free lift, waving at cars, some of them latest models, four-wheel drives and auto rickshaws passing by. It did not work. Perhaps after several days on a hospital trail and a sleepless night he did not look quite presentable.

Endramaya would walk slowly, after every few yards letting his wife sit on the kerb, so that he could stretch his hands and try to flag down some vehicle. Moments later he would continue his journey.

It was morning peak hour. Several vehicles slowed down, those driving them staring at the couple in disbelief, but they proceeded to catch their deadlines as if nothing had happened. I was upset and angry. Running towards them, I pulled my camera out of my backpack. I paused and started clicking. Then they told me their story. I joined the duo, waving hands at vehicles. Two cars stopped, their occupants willing to help. We all pooled in some money and helped the couple get a taxi to the bus station.

That evening at the photo studio I was waiting for the prints to come. A curious clerk at the cash counter asked me about the photograph. I was still upset, so I talked a bit loud about it all. Overhearing our conversation, a gentleman patted me from behind. "It is a good shot, but you should have used a wide-angle lens," the professional photographer said, leaving me speechless. As a medical professional, I should have told him about the 'rigor mortis' of the private sector health care and the numbness of citizens in general. As a humanitarian professional, I should have told him that medical expense is the second largest contributing factor for rural indebtedness in India after dowry, an equally unacceptable social evil.

A leading national newspaper flashed my photograph of Endramaya's journey on the front page of their city edition the following morning. The caption said how callous the city could be towards its "guests" like migrant workers. They said it was "reality and not virtual," probably referring to the virtual reality shows at the city's annual international IT fare that concluded the previous day. It did not have space to discuss larger issues - mounting medical expenses and an insensitive health policy that denies even basic facilities to the poor. A day after the news report, I was giving a class on humanitarian action at a leading medical college in the city. I waved the newspaper featuring Endramaya's journey on the front page. One of the senior students said: "It is a multiple fracture of tibia and fibula." Quite a professional remark! By that evening I had one more professional remark, from a photographer: "It is a very good picture, but we missed the story." Sad.

These professional reactions are the signs of our times. The present health care system has become super-efficient, and it is going fast forward, at least in terms of technology and innovation. But it has lost touch with social realities, and it is losing its human element. By the time you finish reading this note more than 15 people in India will have died of tuberculosis (TB). Every minute one person dies in India because of TB. Treating TB is no rocket science. A nutritious diet, sanitation and basic public education can cut down TB toll. This year we have even seen reports of "alleged starvation deaths" from two belts in India, a country that has a surplus of food grains. In a country where a large percentage of women are anemic, this sounds like a riddle.

Around the same time Endramaya was walking his way of the cross in Bangalore, experts were discussing the proposed new Health Policy in New Delhi. The last National Health Policy was announced in 1983. Compared with that, the new policy draft looks like a sell out. "The new policy (draft) is more eloquent where





it is silent," says a critique. It omits the very basic concept of comprehensive and universal health care. For example, one of the salient features of the 1983 document was its commitment to the Alma Ata declaration. It said: "India is committed to attaining the goal of 'Health for all by the year 2000 AD' through the universal provision of primary health care services." The new policy (draft) is silent about it.

The new policy is also silent about the role of village health workers, the frontier guards of public health, who keep the pulse of this country ticking. The new policy has just a few lines about the women's health, without any specific plans to improve their health - a betrayal of half the population. The policy does not care about children. It does not even have a separate section for children's health in a country where 70 out of 1000 children die prematurely.

Endramaya's desperate walk in one of the fastest growing cities in Asia is symptomatic of the sickness of the health systems in a large part of the developing world where they fail to cater to the needs of the poor. India's experience of dealing with the health needs of its majority, especially the poor, has not been very impressive. In fact, the health care system has worsened in the last decade, which has seen comparatively good economic growth.

Critics argue that neo-liberal policies related to trade and commerce, as part of the World Bank- and IMF-imposed Structural Adjustment Programmes, have left a long trail of ill health. The cost of medicine, including that of essential drugs, has shot up. In the last 10 years, the price of drugs used even for killer diseases like malaria and TB have been decontrolled to boost the health of the pharmaceutical industry at the cost of human lives.

Public health investment in India is one of the lowest in the world and it fell from 1.3 per cent of the GDP to 0.9 per cent during the 1990s. The new policy recommends an increase to 2.0 per cent by the 2010. This still falls much short of the 5.0 per cent benchmark demanded by the People's Health Movement, several health and social groups and the WHO long back.

The new draft policy projects that by 2010 public expenditure will be 33 per cent of the total health expenditure. But even 33 per cent will be lower than the government expenditure of some of the most privatised health systems in the world. At present India spends an average of around Rs.160 (less than US \$ 4) per person per annum on health care. That is roughly the price of three hamburgers, going by the standards of the new economy. No wonder that Lakamma had to go from pillar to post before finding place in a private clinic.

In contrast to the cut in health care sector, the defence budget has shot up. This is an insult to the people of India, where 200 million people (1/5th of the total population) do not have access to safe drinking water and 600 million who do not have access to basic sanitation. Moreover, India pays a huge amount every year to the World Bank by way of debt servicing - much more than what the country receives every year. "Our programmes are like medicine. Some of the medicine has harmful side-effects, and there are real questions about what the dosage ought to be," says Michael Mussa, Chief Economist at the International Monetary Fund. "The best that can be hoped for is that we are prescribing more or less the right medicine in more or less the right dosage." The bitter pills prescribed by the World Bank have worsened health problems in many countries. For example, Bank loans for agriculture, dams, mines and power plants often cause health problems as a side effect of environmental devastation. Bank-financed dams around the world have increased the incidence of waterborne diseases like malaria and schistosomiasis because the stagnant pools of water in dam reservoirs breed vectors such as mosquitoes and snails- an additional burden on the already crippled health system. Further, structural adjustment programmes have often meant drastic cuts of social safety measures. Often poor people have ended up paying more for products and services, further cutting their limited food budget.

As a health and humanitarian worker, my attitude should be positive. I should explore the possibility of saving and rebuilding lives in disaster, war and epidemic situations. This note may sound pessimistic. But it reflects the mood of our times.





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11 GLOBALISATION, HEALTH AND HEALTH SERVICES IN SUB-SAHARAN AFRICA

David Sanders, South Africa

Health is in a state of crisis in Sub-Saharan Africa (SSA). While at an aggregate level health status has improved in SSA over the last fifty years, these improvements have been slower in SSA than in other regions of the world. For example, between 1981 and 1999 IMR has decreased in SSA from 126 to 107 as compared with 78 to 57 for the world as a whole. The respective percentages of decline for this period are 15.1% and 26.9%. Furthermore, in 1999, seven of the 48 SSA countries had a lower life expectancy (LE) than in 1970, while eight countries have seen an increase in infant mortality rate (IMR) between 1981 and 1999. Life expectancy in 17 of 48 countries has declined between 1981 and 1999^{1,2,3}. In addition, young child malnutrition has worsened significantly over the past decade in SSA⁴.

In the past two decades there has been an alarming resurgence and spread of "old" communicable diseases once thought to be well controlled, for example cholera, tuberculosis, malaria, yellow fever and trypanosomiasis, while "new" epidemics, notably HIV/AIDS, threaten last century's health gains⁵.

To aggravate matters, a number of African countries are experiencing an "epidemiological transition", with cardiovascular diseases, cancers, diabetes, other chronic conditions and trauma, replacing communicable diseases in some social groups, but in others, co-existing with them⁶.

Access to health services improved considerably during the period 1980 – 1990, but has worsened since then as shown by Expanded Programme on Immunisation (EPI) coverage data. EPI coverage data for SSA in 1999 show declines in coverage of all routinely administered antigens⁷. This occurred despite the intensive polio vaccination campaigns and the regular measles vaccination campaigns.

The above declines in health status and health sector performance are the result of the combined impact of economic decline and adjustment, the HIV/AIDS epidemic which now affects 28 million Africans, approximately 70% of the total of HIV infected people globally⁸, and conflict and violence which involves 13 of 48 SSA countries.

The serious economic situation is summed up by the startling statistic that 28 of 48 countries had an average per capita income of less than \$1 per day in 1999 compared to 19 of 36 countries in 1981⁹. Furthermore, there is evidence that the income gap between rich and poor within countries has increased dramatically over the past decade. In addition, most SSA countries still spend less than an average of US\$10 per person per year on health care, an amount that is 20-40% below even that required to cover the basic package of health services advocated by the World Bank¹⁰.

The above situation is the result of a number of factors, some historical and others contemporary, the latter being ultimately linked to various aspects and instruments of globalisation.

In Africa, amongst the most important components of the recent phase of globalisation have been Structural Adjustment Programmes (SAPs), which have had the effect of further integrating countries into the global economy through the imposition of stringent debt repayments and liberalization of trade. SAPs have also resulted in significant macro-economic policy changes and public sector restructuring and reduced social provisioning, with negative effects on education, health and social services for the poor. A recent review of available studies on structural



adjustment and health for a WHO commission states: 'The majority of studies in Africa, whether theoretical or empirical, are negative towards structural adjustment and its effects on health outcomes'¹¹.

More recently, other instruments of globalisation have further undermined the ability of developing country governments to provide health care for their populations. For example, the development of agreements under the World Trade Organisation (WTO), notably Trade-related Intellectual Property Rights (TRIPS) and its interpretation by powerful corporate interests and governments, have already threatened to circumscribe countries' health policy options. The best known case relates to the recent legal battle around the attempt by South Africa to secure pharmaceuticals, especially for HIV/AIDS, at a reduced cost. In 1997 Nelson Mandela signed into legislation a law aimed at lowering drug prices through "parallel importing" – that is importing drugs from countries where they are sold at lower prices – and "compulsory licensing", which would allow local companies to manufacture certain drugs, in exchange for royalties. Both provisions are legal under the TRIPS agreement as all sides agreed that HIV/AIDS is an emergency. This was confirmed during the WTO meeting in Doha in 2001. The USA administration did not bring its case to the WTO but instead, acting in concert with the multinational pharmaceutical corporations, brought a number of pressures (e.g. threats of trade sanctions and legal action) to bear on the South African Government to rescind the legislation. This followed similar successful threats against Thailand and Bangladesh¹². However, an uncompromising South African Government, together with a vigorous campaign mounted by local and international AIDS activists and progressive health NGOs, forced a climb-down by both the US Government and the multinational pharmaceutical companies¹³.

Notwithstanding this important victory, the provisions of the WTO, particularly TRIPS and the General Agreement on Trade in Services (GATS) hold many threats for the health and health services of developing countries¹⁴.

Accompanying neoliberal reforms of the macro-economy have been health sector reforms (H.S.R.). Key components of HSR include decentralisation of management responsibility and/or provision of health care to local level, improvement of national ministry of health's functioning, broadening health financing options through, for example, user fees, insurance schemes and introduction of managed competition; and rationing of health care through the identification of public health and clinical "packages", comprising a set of (often limited) interventions.

The combined effect of the above interventions together with the impact of HIV/ AIDS on the health workforce has resulted in a significant reduction in public provision of social (including health) services in SSA, and there is mounting evidence of a general decline in access to health services, affecting particularly the poor. This is starkly illustrated by immunization coverage, a sensitive marker of health service coverage, which has fallen during the 1990s.¹⁵

In recognition of the growing global health divide between North and South, the crisis imposed by HIV/AIDS and the resurgence of TB and malaria, as well as the inability of both for governments and increasingly cash-strapped multilateral (UN) agencies to invest in health services, a number of Joint Public - Private Initiatives (JPPIs) have been recently launched. The best-known of these in health are GAVI (Global Alliance for Vaccines and Immunisation) and the GFATM (Global Fund Against Aids, Tuberculosis and Malaria).

The first disbursements of the GFATM have still to be made, but those for GAVI, made for 2000/2001, totaled USD 150 million from initial commitments totaling USD 1.03 billion. Of this initial disbursement 90% was allocated for the introduction of new vaccines and single use injection materials, while only 10% went to strengthen immunization services. Anita Hardon has commented: *"The emphasis on the introduction of new and under-used vaccines in GAVI reflects a more general shift away from equity towards technological innovation and disease eradication in global health programmes. This appears to indicate a fundamental move in vaccine policy from the values of the Post-Alma Ata (PHC) era."*¹⁶.





Further, it is emblematic of the current emphasis of health policy and the influence of the private sector partners, that, notwithstanding the clear inability of health systems – particularly in Africa – to sustain “delivery” of robust, effective and tested technologies, such as the standard six vaccines, that the focus is on the pursuit of new technologies, rather than the resuscitation of delivery systems. Without a shift in currently dominant neoliberal thinking and a consequent change in macroeconomic policy and its reflection within the health sector, the future for Africa’s health is bleak.

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REFERENCES

- 1 UNICEF. State of the World’s Children. 1984. Oxford: Oxford University Press, 1983.
- 2 UNICEF. State of the World’s Children. 1994. Oxford: Oxford University Press, 1993.
- 3 UNICEF. The State of the World’s Children. 2001. Oxford: Oxford University Press, 2000.
- 4 ACC/SCN, Nutrition Throughout the Life Cycle, 4th Report on the World Nutrition Situation, Geneva, 2000
- 5 Sanders D, Primary Health Care 21: “Everybody’s Business”, Commissioned Directional Paper for an International Meeting to celebrate 20 years after Alma-Ata, Almaty, Kazakhstan, 27-28 November 1998, Jointly organised by WHO Headquarters, Geneva, Switzerland and the WHO Regional Office for Europe, Copenhagen, Denmark, WHO EIP/OSD/00.7,
- 6 Frenk J, Bobadilla JL, Sepulveda J, Lopez Cervantes M. Health Transition in Middle-income Countries: New Challenges for Health Care. Health Pol Planning 1989; 4: 29-39.
- 7 UNICEF. State of the World’s Children, Reports 1984, 1994, 2001 op.cit
- 8 Collins J, Rau B. AIDS in the Context of Development. Programme on Social Policy and Development, Paper number 4. Geneva: UNRISD, 2000.
- 9 UNICEF. The State of the World’s Children. 2001. Oxford: Oxford University Press, 2000.
- 10 Simms C, Rowson M, Peattie S. The Bitterest Pill of All. The collapse of Africa’s health systems. London: Medact/Save the Children Briefing report, 2001.
- 11 Breman A, Shelton C. Structural adjustment and health: A literature review of the debate, its role players and the presented empirical evidence. WHO Commission on Macroeconomics and Health Working Paper WG 6:6. Geneva: WHO, 2001.
- 12 Bond P. Globalisation, pharmaceutical pricing, and South African health policy: Managing confrontation with U.S. firms and politicians. Int J Health Services 1999; 29: 765-92
- 13 Hong E. Globalisation and the impact on health: A third world view. Third World Network, 2000. Available at <http://www.twinside.org.sg/health.htm>
- 14 See <http://www.preamble.org>.
- 15 UNICEF. State of the World’s Children, Reports 1984, 1994, 2001 op.cit
- 16 Hardon A. 2001 Immunisation for All? HAI Europe, 2001: 6 (1).

12 TAKE TIME GIRLS

Fortunate Kahari

Mwanza Secondary school Zimbabwe

Let me take this opportunity
 To warn you my fellow sisters, teenage girls.
 Before attempting to do anything
 Think of the four Ps first
 That is Purpose, Plan, Perseverance and Price





Nowadays, there is AIDS.
 Do not rush to be parents
 Those boyfriends lovers of your are liars
 They tell you that they have cars
 Where as they are fathers
 They tell you that you are as sweet as sugar
 But imagine girls can you be put into tea
 They tell you that your eyes are stars
 But do you really know what exactly a star is like
 They can even tell you that you are a rose of Sharon.
 But why did not they plant you in their gardens.
 Take time to know the one you desire in life
 Do not rush
 And you girls are sometimes foolish
 When you hear that, you think that they genuinely love you
 But no they are only after your bodies
 They are only there to vacate you
 You agree to the proposal and have sex with them
 After that, they spit you like unsweet bubble gum.
 Take time to know what you are doing
 Do not rush
 Some young girls are involved in such activities
 Just because they are blessed at a young age.
 Some even, wear cloth that attracts boys
 But I tell you; you do not need to show off your body to catch a boy's eyes.
 Their eyes dance every time a boy whistles.
 Girls are stopped in streets like commuters.
 Girls why not wait like a boutique;
 These are not like flea markets
 For many people enter in a flea market and a few in a boutique.
 Wait until the right time comes and the right one takes you.
 Some of you girls have vanished and come are regretting.
 Ignore those silly boys and concentrate with school first, lastly boys

13 DEVELOPING SELF RELIANCE IN HEALTH

Nang Vicky's story

When the *Community Based Health Program (CBHP) of Tandag* reached *Nang Vicky's* community in Camamanon, San Isidro, she was among those chosen by her community members to be trained as a *community health worker (CHW)*. With the existence of *CBHP Tandag*, the training and developing of CHWs in Surigao del Sur has been a community effort. Normally, one per 10-15 families is chosen to be trained as a CHW.

Aside from training CHWs, the health program undertakes community organizing and health services delivery, which includes assisting referral patients and conducting medical missions. The trained CHWs are deeply involved in such activities not only in their communities, but also in nearby communities as needed.

Attending health skills training was never simple for any CHW. This would mean leaving their children at home, foregoing a day's work in the farm and finding extra food to bring and extra money for transportation.





When the CHWs of San Isidro had a 6-day training on Anatomy, Parasitism and Tuberculosis, *Nang Vicky* resolved to attend the training at any cost. Only at that time, the challenge was even harder for her. For three weeks, her husband then had been suffering from a kidney infection with occasional bouts of vomiting and fever. The situation made her think twice. She presented her problem to her family groups, which had offered to look after her husband and children while she was training.

The importance of community health services

Nang Vicky finished the scheduled training and went on to serve her community as a health worker. She belongs to the over 3,000 CHWs of the 57 CBHP members of the *Council for Health and Development* (CHD). The CBHPs directly serve marginalized sectors in Philippine society, namely, the peasants, farmers, fisher folk, workers and indigenous peoples in 2,000 villages spread out in 67 provinces in the Philippines. (The country is comprised of 75 provinces).

Most CHWs like *Nang Vicky* now recall common experiences of carrying sick members of their communities in hammocks down the mountain trails for a day or two to reach help. Most of them suffered from tuberculosis, malaria or diarrhea. The children were malnourished. People died as they were being brought to the nearest doctor. These deaths happened because health services were inaccessible and unaffordable.

They are one in saying that “We have learned so much since that time”. As products of CBHP training programs, the CHWs have been trained in basic health skills such as prevention and treatment of common diseases, first aid, use of herbal medicine, dental hygiene and tooth extraction. And from the basic line of prevention, the knowledge and skills of the CHWs were raised to a higher level. They were given trainings on basic anatomy and physiology, history-taking and physical examination, acupuncture and acupressure. The trained CHWs multiplied themselves by training new CHWs.

In undertaking such trainings, *Nang Vicky*, as well as many of her co-community health workers, are able to find new directions in life after being introduced to the CBHPs. With limited education and seemingly no hope in the communities to be employed decently, many of them regain their confidence because they realize that they can acquire skills that can be of productive use.

Military threats

Many communities of *CBHP Tandag* were never before visited by government health care providers. When the whole province was put under massive military operations against insurgency, soldiers were everywhere in the province—the town hall, the plaza, the market place and in the fields. People were driven away from homes and from their sources of livelihood. Women and children alike were caught in the crossfire.

The CBHP communities, including San Isidro where *Nang Vicky* lives, became the subject of undue suspicion from the military and were subjected to tactical interrogations. The CHWs were also favorite targets for intimidation and harassment, just like leaders of people's organizations. The intense military harassment demoralized many CBHP communities, forcing the program to cease its operations.

A decade after, *CBHP-Tandag* was back on its feet again, working closely with the diocese of the catholic church. Because of the CBHP's long and effective history, there was much work that needed to be done. Memories of the turbulent period were still poignantly vivid for the communities. However, the tremendous help the communities have gained from the CBHP outweighed the fear they had for themselves.

Although, *Nang Vicky* and the other CHWs of San Isidro like *Nang Dolor* were met with malicious suspicions and even threats from the military, they were never afraid to let the military know that they were CHWs. In the case of *Nang Dolor*, her regular visitors during those days were not her family groups asking medical help,





but the military looking for subversive documents like her training manuals in acupuncture, herbal medicines and the likes. Thus, before any military personnel could rummage through her belongings, she would hide her training manuals at the back of her house.

After a painstaking period of recovery, *CBHP Tandag* continues to operate in 33 villages from different municipalities, making people aware of their capacity to help alleviate their situation by working together as one community. And the likes of *Nang Vicky*, *Nang Dolor* and the rest of the CHWs have once again proven their worth as many times before in contributing their share in developing self reliance for an alternative health care system that CBHPs promote.

The story of *Nang Vicky* and *CBHP Tandag* that she worked with is only reflective of what is now 29 years experience of CBHPs in the Philippines. Evolving from the first mobile-paramedic training health team in the 1970s to actually laying the foundation for an alternative health care system, CBHPs continue to survive and thrive because they are rooted in a very strong and solid foundation—the people of the community who struggle unceasingly to defend their lives and rights, and to develop their own appropriate health programs. — [Council for Health and Development, 04 November 2002, Quezon City, Philippines].

Nang Vicky Undangan is a peasant woman from a mountain village in Surigao del Sur, which is home to landless farmers in this northwest province of Mindanao in the Philippines.

14 PROPOSALS FROM DAILY LIFE

Argentina 2002, Endemic Injustice and Silent

Julio Mousalvo, Argentina

“Microbes are insignificant as a cause of disease compared to the illnesses that cause poverty, the social despair, anguish and misfortune of peoples.”

Ramón Carrillo (first Minister of Public Health of the Argentine Nation, 1945-52)

The growth of hunger

Angela lives in a poor neighborhood in one of Argentina’s large cities. She is 39 years old, mother of four children. In the “Health Center,” a young doctor, Alejandra, diagnoses that Angela has anemia. The cause is quite clear. She lacks access to adequate nutrition. Angela is one of nine women over age 35 who have been diagnosed with anemia this week, all due to the same cause. A simple test shows that Angela barely has 8 grams of hemoglobin, as well as low levels of red cells.

In this Health Center, as in most Argentine hospitals, medications with iron supplements have not been supplied for quite some time. This is happening throughout the country, anemia is being detected in all age groups due to a lack of access to food. Numbers are growing of malnourished and anemic children (particularly under age 5), anemic pregnant women, anemic children with low birth weight, and malnourished elderly people. In one province alone, official 2001 data showed 71 deaths from malnutrition, of which 44 were children under age 5 (62%) and 21 people over age 50 (30%).

But our young doctor does not become discouraged. She researches what local plants may be a source of iron and discovers “nettle” (*Urticaria urens* L.) She prepares a nettle tincture in the Health Center and gives Angela this natural treatment for three weeks. The test results improve and Angela feels much better. This encourages Alejandra and other health workers to treat the other women with nettle tincture. The results were successful and the word of the solution spreads. It’s an uphill struggle, but also heroic and hopeful. Bit by bit, spread from mouth to mouth, people begin to talk about this possible treatment.





An abundance of food

Argentina annually produces, according to official data, 68 million tons of food. With a population of 35 million, there would be an abundance of food if this were deemed a social good and the production of food was aimed at feeding people instead of increasing the profits of a few corporations. Each person would have 2 tons of food per year, five and a half kilograms per day. Even part of that food would take care of the country's needs, and the system could keep exporting the rest. Instead, over half of the population is living in poverty or outright indigence.

In addition, there are concerns about food quality. Argentina is one of the countries with a large area dedicated to growing genetically modified foods. The use of agrochemicals not only contaminates food sources and soil, but also leads to poisoning and deaths. Animals are subjected to cruelty, fed unnaturally to be fattened quicker, in order to produce "increased economic benefits." The industry uses an abundance of chemicals for coloring, as preservatives, and "authorized" flavoring. On top of the injustice that the great majority is denied the right to feed themselves, we now have food insecurity in a country that has lost its food sovereignty among its many other losses.

Another Argentina, another world

Alejandra, the young doctor in our story, is one of thousands of health workers in this country who silently struggle every day to provide humanitarian answers to pain and misery. At the same time proposals are being made to build a different Argentina!

For many years in cities there has been a food production for consumption program called "Prohuerta." The State provides seeds for vegetables and fruit and farm animals, in addition to training for organic-style production (no agrochemicals or chemical fertilizers are used). Between large cities and smaller communities, up to 400,000 family, school and community garden plots have been registered. These produce about 80,000 tons of food per year for 2.5 million people. It is estimated that the country has 7.5 million indigent people. Instead of supporting and broadening this program, the budget allocated for it has been reduced by 7%. Other State and NGO programs also help people feed themselves. However, these efforts are not encouraged or supported by the State.

Here and there, throughout the country, small groups of women and men farmers produce events with incredible political and transformational voltage: fairs to exchange seeds from local production and establishing local markets with organic products. There are many examples of healthy food production systems, social and economic organizations based on respect for all forms of life, which translates into healthy relations with the ecosystem that have a positive impact on health.

A change in paradigm and in consumption patterns is urgently needed to roll back the endemic social injustice and immediately bring an end to all cruelty and the denial of access to foods and healthy foods.

Over 50 years ago Ramón Carrillo pointed out that social injustice was the cause of illness. Today in Argentina those social injustices have deepened and spread, and have become ecological injustices in the form of soil deterioration, the disappearance of forests, contamination of rivers and the air. For many years in this country, women farmers, professionals and students committed to health and life have been proving that it is possible to create another Argentina, and another world as well.

Dr. Julio Monsalvo is a doctor and activist of the Peoples Health Movement and International Peoples' Health Council



15 HEALTH FOR ALL: ESSENCE OF A GOOD GOVERNMENT

Mandate to the new Government

Arturo Quizhpe, Ecuador

“Equity, ecologically sustainable development and peace, are the central focus of our vision of a better world. A world in which a healthy life for all becomes a reality; a world that respects, appreciates and celebrates all life and diversity; a world that allows the flourishing of talents and abilities to enrich all of us; a world in which the voices of the people guide the decisions that affect our lives. More than enough resources are available to achieve this vision.” (1)

A sick society

The neoliberal development model in effect is not sustainable; its failure has been extensively proven in countries like Argentina. It cannot even be considered as a model of development, as it is designed to perpetuate underdevelopment and strengthen dependency. We survive in a sick society in which humans have been sacrificed for the market, where nature is profaned and attacked by the greedy interests of large transnational corporations, where the abuse of power, corruption, intolerance, segregation and injustice rule.

We cannot go on with more deceit and white lies. Health is intimately connected to development, and development in turn, produces health. One cannot speak of health policies for the majority if this does not go hand in hand with an integral reform of the State aimed at the well being of the majority. As Dr. Roses, the new Director of PAHO, has stated: health programs are a reflection of a country's ethical decisions, they reflect the value given to life and human development in general, and even more specifically, the value of the life of each human being, of women and children, of the disabled and elderly.

Poverty must be eradicated

In Ecuador and the other countries of Latin America, poverty constitutes the main cause of illness and death, and therefore its roots are found in the economic and social policies imposed upon us.

Poverty arises from the inequitable distribution of wealth, the society's organizational structure, the unequal trade between nations, the exaggerated power of transnational corporations, and the policies they impose to increase their profits.

As stated in the People's Charter for Health: “economic globalization and privatization have deeply disrupted communities, families and cultures. Public institutions have been undermined and weakened; many of their responsibilities have been transferred to the private sectors, to corporations or other national and international institutions that rarely take on responsibility before the people.”

Poverty must be eradicated, not lessened. Attempting to lessen poverty means treating the symptoms instead of the disease. Fighting poverty means redistributing wealth, working for more just rules of trade, generating employment, allocating resources, responsibility and power to the people.

All the countries in the region have included health in their constitutions as a right of all people. However, expenditures on health have been determined and subjected to economic calculations, the decisions of transnational corporations, and market interests, sacrificing the life of millions of men, women, children, and elders.

Human development indicators reflect a degrading reality for human beings: 80% of Ecuadorian homes are poor; 20% are indigent, with no access to education, social security, or basic sanitary infrastructure; maternal mortality (160 to 300 for 100,000 live births) and infant mortality (39 out of 1000) are high and result from preventable causes, the persistence of illnesses associated with poverty such as dengue fever, malaria, yellow fever, tuberculosis, and others.





A variety of organizations and groups from towns in Ecuador working in this area and committed to the struggle for the respect and full effectiveness of this primordial human right, appropriate as our own the points of the People's Charter for Health and set forth the following:

Basic Principles for a Program of Health for all

- Guarantee the universal access to high quality integrated Primary Health Care, according to the needs of the population, not their ability to pay.
- Elimination of cost-effectiveness criteria as a defining factor for the implementation of health care programs and the abolition of cost recovery projects because they generate inequity and obstacles to access to services.
- Stop privatization of public health and social security services, ensuring the effective regulation of the private medical sector including medical charities and NGOs.
- Increase public investment to at least 70% of the national expenditure on health.
- Emphasize the promotion of health, primarily in community organization and participation.
- Strengthen and legally support social participation, intersectoral work, and a multidisciplinary approach to health problems.
- Promote health programs aimed at women, the eradication of domestic violence and fulfillment of the Law of Free Maternity.
- Establish promotion and prevention programs for the health of young people, particularly related to sexual and reproductive rights.
- Adopt measures to ensure occupational health and safety that include oversight of working conditions, particularly for high-risk sectors (for example: assembly plants, flower growing companies, the informal sector and others).
- Regulation of the use of technologies, production and issue of medications, to assure they are subordinate to the needs of the population.
- That research on health – including genetic research and the development of reproductive medicines and technologies – be oriented towards people and public health and respect universal ethical principles.
- To defend harmony with the environment and the protection of ecosystems.
- Invest more, invest better and begin to pay the social debt, giving priority to health and education, reducing military expenditures and payment on the foreign debt.
- Submit economic policies to assessment regarding their health, equity, gender and environmental impact and include regulatory measures to follow-up on their fulfillment.

Health is a fundamental human right, and this is why we tell, beg, and demand that the new government make a serious commitment to Health for All.

Cuenca, November 2002

(1) People's Charter for Health. IPHC. December 2000.

*1 * This Policy Brief draws heavily upon: Sanders D., D. Dovlo, W. Meeus, U. Lehmann, "Public Health in Africa" in Global Public Health, R. Beaglehole (ed.), O.U.P. (forthcoming)*

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DECLARATION OF ALMA-ATA

**International Conference on Primary Health Care,
Alma-Ata, USSR, 6-12 September 1978**

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

- I The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.
- II The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
- III Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.
- IV The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.
- V Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.
- VI Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.
- VII Primary health care:
 1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;



2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

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

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.



PEOPLE'S CHARTER FOR HEALTH

People's Health Assembly, 4-8th December 2000,
(GK-Savar, Dhaka, Bangladesh)

INTRODUCTION

In 1978, at the Alma-Ata Conference, ministers from 134 members countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of Third world populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterized by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalisation which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata, has significantly aggravated the global health crisis. Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of Health for All to its rightful place on the development agenda. Genuine, people-centred initiatives must therefore be strengthened in order to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organisations and civil society movements, NGOs and women's groups decided to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organised the "People's Health Assembly" which took place from 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthaya Kendra or GK (People's Health Centre).

1453 participants from 92 countries came to the Assembly which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The Plenary Sessions at the Assembly covered five main themes: Health, Life and Well-Being; Inequality, Poverty and Health; Health care and Health Services; Environment and Survival; and The Ways Forward. People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organisation. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five days event gave participants the shape to express themselves in their own idiom. They put forward the failures of their respective governments and international organisations and decided to fight together so that health and equitable development become top priorities in the policy makers agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The Charter from now on will be the common tool of a worldwide citizen's movement committed to make the Alma Ata dream a reality. We encourage and invite everyone who shares our concerns and aims to join us by endorsing the Charter.





PEOPLE'S CHARTER FOR HEALTH

PREAMBLE

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalized people. Health for all means that powerful interests have to be challenged, that globalization has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organizations and corporations.

VISION

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world — 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 that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

THE HEALTH CRISIS

"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."

(A voice from Central America)

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks 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.

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The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximize their private profit. Neo-liberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade



Organization. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

PRINCIPLES OF THE PEOPLE'S CHARTER FOR HEALTH

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and inter-sectoral approach to health and health care is needed.
- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors. The demands presented below provide a basis for action.

HEALTH AS A HUMAN RIGHT

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.





Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- Demand the cancellation of Third World debt. – Demand radical transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.
- Demand the control and taxation of speculative international capital flows.
- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.



- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalized communities and encourage solutions that minimize waste production.
- Reduce over-consumption and non-sustainable lifestyles — both in the North and the South. Pressure wealthy industrialized countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centered monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.





- Develop people-centered, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarization of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A PEOPLE-Centered HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drug policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.





- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures inter-sectoral work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
- Support, recognize and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD

Strong people's organizations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

- Build and strengthen people's organizations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organizations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centered solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a *People's Charter for Health*.

The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000.





The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health movement can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the *People's Charter for Health*.

PHA Secretariat, e-mail: secretariat@phmovement.org

Web site: www.phmovement.org

Mailing address: PHM Secretariat, CHC, # 367, Srinivasa Nilaya, Jakkasandra I Main, I Block Koramangala, Bangalore – 560034

Amendment

After the endorsement of the PCH on December 8, 2000 it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neo-liberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading systems, the two paragraphs were merged and amended.

The section on War, Violence, and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.

The People's Health Charter is now available in the following languages:

01 Arabic	11 Greek	21 Portuguese	Now in Progress
02 Bangla	12 Hindi	22 Russian	31 Cambodian
03 Chinese	13 Indonesian	23 Shona	32 Creole
04 Danish	14 Italian	24 Sinhala	33 Dhari
05 English	15 Japanese	25 Spanish	34 Lithuanian
06 Farsi	16 Kannada	26 Swahili	35 Norwegian
07 Finnish	17 Malayalam	27 Swedish	36 Pastun
08 Flemish	18 Ndebele	28 Tamil	37 Thai
09 French	19 Nepalese	29 Urdu	38 Tonga
10 German	20 Philippine	30 Ukrainian	39 Vietnamese
			40 Welsh

Also Audio in English and in English with Braille Titles.

You can get these either at the website www.phmovement.org

Or

Get in touch with

pamzinkin@gn.apc.org or

communications@phmovement.org.

If you have translated into any other language, please get in touch with the above addresses immediately with an electronic copy.



STATEMENT ON PRIMARY HEALTH CARE AT WORLD HEALTH ASSEMBLY, MAY 2003

People's Health Movement in collaboration with Churches Action for Health

People's Health Movement Response to *International Conference on Primary Health Care, Alma Ata : Twenty-fifth anniversary Report, by the WHO Secretariat*

Comments on introductory sections

PHM believes that WHO has progressively withdrawn from the true spirit of the Alma Ata vision of PHC. Increasingly selective and disease focused, donor driven initiatives have been supported at the expense of people centered comprehensive approaches that both provide basic care and tackle the underlying causes of disease and seek to promote positive health. PHM calls on WHO to return to the original vision.

The document states that PHC is about the health of the disadvantaged but ignores the following:

- Inequities are increasing – the gap between developing and developed countries is growing.
- Inequities within many countries are also increasing, despite, in some cases, overall increases in life expectancy.
- In many African countries life expectancy is declining rapidly (HIV / AIDS has offered new challenges for PHC and this is not acknowledged in the resolution).
- The absolute number of people living in poverty has increased worldwide and sharply in some regions.

The analysis of the People's Health Movement indicates that the major cause of the growing inequities is the increasingly unipolar world economic order and its impact on the lives and livelihoods of people around the world. Neither the global report nor the resolutions acknowledges this impact. Until the world is characterized by FAIR economic and trade relationships, Health for All can not be achieved.

Greater pluralism in funding has meant less access for the poor to health services as a result of:

Introduction of user fees

Privatization of health services

Privatization and contracting out of services provided within the public health system

The imposition of health sector reform with its dominant focus on efficiency and cost effectiveness has further resulted in:

Decentralization without adequate resources leading to a decline in health system capacity as evidenced inter-alia by sharp reductions in basic vaccination coverage globally since 1990.

Lack of investment in publicly funded primary health care systems and no attention to leadership and management development for PHC.

Although many countries see PHC as a policy corner stone and a framework for health care delivery, this commitment has not been reflected in a reallocation of resources away from the hospital sector. The PHM considers that States should be responsible for the funding, organization and delivery of PHC. Many NGOs provide services to marginalized communities in the absence of government funded services. PHM believes that governments should support public funding for PHC, adapted to local need and based on comprehensive models stressing community participation and encouraging community development, social action, popular education and direct service delivery.



Amendments to resolutions

Requests Member States:

- i. To ensure the development of PHC is adequately resourced through a targeted reallocation of resources to non-hospital care and local community based health initiatives involving other sectors. Member States should demonstrate this by setting specific targets to allocate extra funding to community based services and monitor the impact on reducing health inequalities.
- ii. To accelerate long term improvement of human resource capability through increasing resources and activities for capacity for implementing comprehensive PHC systems (rather than selective PHC focused on donor driven disease specific initiatives) within both government and non-government services.
- iii. To enhance the potential of PHC to tackle the rising burden of chronic conditions through health promotion including illness prevention and disease management but not at the expense of comprehensive initiatives to tackle the increasing burden imposed particularly on the poor by communicable diseases including HIV / AIDS, TB, Malaria.
- iv. To create mechanism, including the allocation of resources and training, for the active involvement of communities and NGOs for PHC.
- v. To support research in order to identify effective methods for strengthening PHC and linking it to overall improvement of the health system and to the reduction of health inequalities.

Requests the Director – General

1. To re-affirm the principles of the comprehensive PHC approach as enriched in Alma Ata into the activities of all programmes.
2. To review the Millennium Development Goals and the recommendations of the Commission on Macroeconomics and Health in terms of their compatibility with the principles of PHC as enshrined in Alma Ata, especially health as a human right rather than primarily as an input to economic development.
3. To evaluate different approaches to PHC by both government and NGOs and to identify and disseminate information on best practices to government and community actors in PHC in order to improve implementation.
4. To instruct WHO personnel in Geneva, Regional and Country Officers to engage more proactively with both government and NGO PHC initiatives to determine the capacities they require in order to meet new demographic, epidemiological and socio-economic challenges.
5. To continue to provide support to countries for improving the quality and quantity of health personnel in order to enhance access to comprehensive services, especially for the poor.
6. To lay renewed emphasis on support for the implementation of locally determined models of PHC that are flexible and adaptable.
7. To organize a series of meeting on future strategic directions for PHC that capture grass roots experiences of PHC and involve the People's Health Movement.

A shorter, edited version of this statement was presented at the Committee A Session (discussion on Primary Health Care)



PEOPLE'S HEALTH MOVEMENT

PRESS RELEASE

Primary Health Care: More Action Less Words please!

Revive the spirit of Alma Ata !

Geneva, May 21: The People's Health Movement welcomes the proposed adoption of a resolution affirming the Alma Ata vision of Primary Health Care (PHC) as the cornerstone of national health systems by member states of the World Health Organization.

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

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

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

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

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

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

- Increasing global inequities - the gap between developing and developed countries is growing
- Increasing inequities within countries
- Declining life expectancy in many African countries where HIV/AIDS offers new challenges for PHC which are not acknowledged in the resolution
- The absolute number of people living in poverty has increased world wide and sharply in some regions.

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

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

- Privatisation of public health services



- The introduction of user fees for patients
- Lack of public investment in state-run primary health care systems
- Lack of attention to leadership and management development for PHC

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

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

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

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

Dr Ravi Narayan

Co-ordinator- PHM Secretariat

Prof. David Sanders

International People's Health Council & PHM

Dr. Armando De Negri

ALAMES (Latin American Association for Social Medicine) & PHM

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PEOPLE'S HEALTH MOVEMENT

PRESS RELEASE

War on health is killing the dream of “Health for all”

Geneva, May 16th, 2003: 25 years since the historic promise by the WHO and the international community to ensure *“health for all”*, the idea is a distant dream. Wars, along with conflicts and the military establishment, have become one of the key hindrances in making the dream of *health for all* a reality.

People's Health Movement (PHM) is holding a parallel process to the upcoming World Health Assembly that is expected to begin at Geneva, next week. PHM came down heavily on the failure of the WHO to protect the health rights and meet the health needs of the war affected in Iraq.

People's Health Movement is a people-oriented global initiative that evolved out of the **People's Health Assembly** (PHA), a historic summit that was held in December 2000 in Bangladesh. Over 1453 participants from 92 countries met for the PHA that was the culmination of 18 months of preparatory action around the globe.

Testimonies of grass roots health workers and medical professionals working in humanitarian agencies give a chilling account of the disastrous impacts of the wars and conflicts on the lives of civilians in general and their health in particular. Research concludes that wars have reversed the limited developments that were achieved in the field of health.

“The humanity is not able to cope with the devastating impacts of the depleted uranium weapons that were used on Iraq and Kuwait. Generations will pay a heavy price for reasons they were not responsible for” said Dr. Rosalie Bertell, a well-known international expert on radiation and militarisation. “Unfortunately Iraq, Kosovo and Afghanistan are not cases in isolation,” she said.

“Firstly, wars and conflicts destroy the health systems. Secondly, health is not a central theme while post-war rebuilding and post-conflict reconstruction work happens. Humanitarian agencies and health movements need to work together to ensure synergy,” testified Dr. Unnikrishnan PV of PHM and *International People's Health Council* who was in Iraq recently. Wars along with its fallouts have killed over 750,000 children in Iraq between 1991 and 1997 and destroyed the health infrastructure. The recent war in Iraq has amplified the suffering of Iraqi children and people.

Political insensitivity and absence of resources have made the plight of millions of refugees, internally displaced people and civilians a continuing nightmare. Their health is one of the worst affected and there has been a sharp decline in the quality of assistance and their health status.

“What illegal occupation has done in the Palestinian territory is to kill the dream of health for all. Occupation today ensures hell for all” said Dr. Ghassan Hamdan, a spokesperson for the Union of Palestinian Medical Commissions (UPMRC). UPMRC has been a lifeline for the millions of Palestinians caught in the unending crossfire. There has been an increased incidence of deaths and deliveries happening at checkpoints because Israeli forces denied access to hospitals.

“Spending on public health has been falling. Even the available limited resources are cleverly and increasingly diverted to a new privatisation process deceptively called as private-public partnership. The trend of US forces to occupy more and more countries will further amplify the military expenditure at the cost of health and other social sectors. This is an assault on the poor and this trend must be reversed,” said Dr. Zafrullah Chowdhury of *Gonoshsthaya Kendra*, Bangladesh. It is estimated that the global annual military expenditure is more than US \$ 780 billion per year. The UN agencies estimate that US \$ 11 billion will help to fetch safe drinking water and basic sanitation for the people of the developing world.



“PHM as a people-based mass movement has been putting efforts to address the issue of war and conflicts. Efforts will be put to amplify the efforts at the grass roots level as well as in international forums,” said Dr. Ravi Narayan, co-coordinator for the PHM secretariat.

“PHM is picking energy in Switzerland,” said Ms. Garance Upham, the president of the newly formed PHM-Geneva International (PHM-GI), the local body of the PHM. PHM-GI, because of its strategic positioning at Geneva, the seat for WHO and several UN organisations, is expected to play a major role in PHM’s advocacy and lobbying efforts.

While demanding the WHO to be more pro-active, assertive and sensitive to the health needs of war-hit people, PHM calls for synergy between antiwar movements, peace groups and humanitarian agencies.

“Today, the attack is on Earth and Nature- the foundations of life and humanity. This has already resulted in irreversible damages that will last for generations to come. This assault must be stopped” added Dr. Rosalie Bertell.

At a time when disturbing reports continue to pour in from Iraq about the deteriorating health of the civilians and internally displaced people, PHM places five key demands on the international community:

1. Stop the wars. Respect International Humanitarian Laws.
2. Stop the occupation of Iraq, Palestine and other places. Let the local people decide their future. “We urge the US, UK and Israel to show the courage to withdraw from occupied countries and territories and thus lead a genuine, lasting and just peace process”.
3. Give health a central role in the rebuilding efforts. Governments and humanitarian agencies that dominate the initial rebuilding process need to be more imaginative and sensitive to short term medical needs as well as long term health needs.
4. Put an immediate end to all research programmes that are being carried out to develop weapons of mass destruction (WMD). Possession as well as use of WMD is one of the greatest threats to public health. Irrespective of the economic status, no country can legitimise the development and preservation of WMD.
5. Give health a chance. Divert the precious resources wasted for military and defence expenditure to public health programmes.

People's Charter for Health, the guiding spirit of the PHM is the largest consensus document on health. “Wars, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector,” says the People's Charter for Health.

Dr. Ravi Narayan
Co-ordinator, PHM Secretariat

Ms. Garance Upham
President, PHM- Geneva International



MILLION SIGNATURES ON THE INTERNET TO DEMAND "HEALTH FOR ALL NOW"

**PEOPLE'S HEALTH MOVEMENT and INTERNATIONAL PEOPLE'S HEALTH COUNCIL
PRESS RELEASE**

January 2003: Hyderabad, Managua and London

"In the next 24 hours, over 30,000 children will die from preventable diseases on our planet earth. Today, while the world is writing a collective obituary of the future generation, we know why they are dying; we know who are responsible for these deaths. We know how these deaths can be stopped... Join 'The Million Signature Campaign', - a march demanding health for all."

These are not just statistics, but precious lives that the World Health Organisation promised to save 25 years ago. In 1978, World Health Organisation, the apex UN body dealing with health, promised Health for all by 2000 through a historic moment, the Alma Ata declaration.

"Since the Alma Ata declaration in 1978, responses were promising. However, the spirit of Alma Ata and the idea of Health For All has been under attack by anti-health, anti-poor policies, reemerging and new diseases, new challenges and above all by efforts to put private profit over public health. In the current international health crisis, it is more essential to reaffirm and implement the principles and strategies of Alma Ata" says www.TheMillionSignatureCampaign.org, the home page for this-web based campaign. The Million Signature campaign was officially launched today simultaneously from Bangladesh, Nicaragua and India. Thousands of people participating in the Asian Social Forum at Hyderabad, India, are expected to extend their solidarity on the opening day of this web campaign. People's Health Movement is at Asian Social Forum to extend the solidarity of the global health movement.

25 years since the Alma Ata declaration, health for all by 2000 is not a reality. This signature campaign, initiated by the People's Health Movement and the International People's Health Council, is being endorsed by ordinary people from various walks of life and organisations, institutions, people's associations and others working for a just world.

Ms. Parven Akhter, a 22- years old health worker from Souther, a village located in the Faridpur district of Bangladesh is the first signatory. "Let us work together, make other people aware of their health rights and ensure basic health care for all. I hope everybody will join this campaign", said Ms. Akter.

Some of the first signatories include ordinary health workers, former UN officials and architects of the Alma Ata declaration, medical professionals, journalists, writers, policy-makers, academics, Nobel Prize and Right Livelihood award (alternate Nobel prize) winners, ministers and former heads of nations, politicians, celebrities, leading organisations, students and mass movements.

"The campaign is conceptualised and designed to catch the attention of the WHO, UNICEF, other UN bodies, social and political organisations, policy-makers, governments and others. It is one more step towards making health for all a reality," said Dr. Qasem Choudhury, the outgoing facilitator for the People's Health movement (PHM) secretariat. PHM was launched in Dec 2000 through the People's Health Assembly, a historic summit in Bangladesh that had participation of over 1500 representatives from nearly 100 countries. The goal of the People's Health Movement is to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities.

PHM aims to draw on and support people's movements in their struggles to build long-term and sustainable solutions to health problems. One of the outcomes of the PHA 2000 is the People's Charter for Health, the largest consensus document on health.





“Last 25 years have seen several experiments in the health sector. Some of them met with success in the initial stages. Of late, corporate and private interests have defeated public health. The negative impacts of unregulated globalisation and privatisation are neutralising the achievements we had in making health for all a reality,” said Ms. Maria Hamlin Zuniga, Co-ordinator of the International People’s Health Council (IPHC). IPHC, a constituent of the PHM, is a worldwide coalition of people’s health initiatives and progressive groups and movements committed to working for the health and rights of disadvantaged people. “Primary Health care works where there is a political commitment,” she said.

“People’s Health Movement will observe 2003 as the year of Alma Ata. A series of activities are being planned to remind and revive the key principles of Alma Ata,” said Dr. Ravi Narayan, the new facilitator for the PHM secretariat.

“The struggle for justice and health for all needs to be fought at different levels. We are aware of the digital divide. Concerted efforts will be put to take this campaign and spread the struggle for health for all also to people who are below the digital line. Using media apart from the Internet will be one of the methods to popularize this Internet based campaign,” said Dr. Unnikrishnan PV of IPHC, facilitator for this web-based campaign.

Dr. Qasem Choudhury, Outgoing facilitator: PHM secretariat

Maria Hamlin Zuniga, Co-ordinator: IPHC

Dr. Ravi Narayan, Facilitator: PHM Secretariat.

To access the campaign website and sign up, go to www.TheMillionSignatureCampaign.org



'GOVERNMENTS: TAKE RESPONSIBILITY FOR WOMEN'S HEALTH !'

**Primary Health Care and Women's Reproductive and Sexual Rights:
Where are we today?**

**16th International Day of Action for Women's Health
May 28th 2003, A Call For Action**

Women's Access to Health Campaign:

Health For All – Health For Women!

From 2003 to 2005 the Coordination Office will coordinate the Women's Access to Health Campaign, in close collaboration with the People's Health Movement. The 3-year core demand is that primary health care be provided for all people and peoples everywhere, taking into account, in theory and practice, women's reproductive and sexual health needs.

Contact us if you would like more information or would like to get involved.

See pages 16 and 17 for more ideas on what you can do!

The Call for Action is supported by

People's Health MOVement

Boston Women's Book Collective, USA

CHETNA, India

Civil Liberties and Public Policy Program, Hampshire College, USA

Committee on Women, Population and the Environment, USA

EDUC Actions, Cameroon

ISIS, Uganda

Latin American and Caribbean Women's Health Network, Chile

Likhaan, Philippines

PREPARE, India

WIPHN, Women's International Public Health Network, USA

Women in Black, Yugoslavia

Women Living Under Muslim Laws, United Kingdom

SAMA, India

MASUM, India

Forum for Women's Health, India

Get in touch

We would appreciate receiving your reports, pictures, posters, newspaper clippings etc. for inclusion in our report on the Day of Action in the WGNRR Newsletter. You can also request more copies of the Call in English, Spanish and French from our office.

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SOME SUGGESTIONS FOR THE CELEBRATION (An A to Z of ideas)

Organize an event to include one or more of these

- A. DISCUSS** the Alma Ata Declaration and the People's Charter for Health
- B. SIGN** the million signature campaign for Health for All Now
- C. TRANSLATE** the signature campaign note into your own language and release a vernacular language website version on this day (Contact Dr. Unnikrishnan, PHM Media person for further details)
- D. REVIEW** the primary health care experience in your state or country and present it at this meeting
- E. IDENTIFY** case studies of primary health care projects by government or NGO/civil society initiative in your state or country and invite project leaders to share their experiences. Using a SWOT approach learn from the Strengths, Weaknesses, Opportunities and Threats of each of these initiatives.
- F. RELEASE** a press statement or media brief for the occasion and release it through a press conference (try and reach all language media in your country/region)
- G. CELEBRATE** your Country's Health Policy if it has been Primary Health Care oriented or has tried to reach Health for All in your country context.
- H. HONOUR** Primary Health Care workers in your state or country.
- I. ORGANIZE** a small exhibition on Alma Ata Declaration principles and the action points of the People's Charter for Health.
- J. ORGANIZE** a convention of Primary Health Care workers and community level PHC volunteers. Listen to their experiences. Endorse their work.
- K. WRITE** articles in bulletins and journals on the Health for All / Primary Health Care and People's Health Movement Themes in the September 2003 issue or in the months thereafter.
- L. ORGANIZE** a street event, a public march; a candle light vigil; a human chain; a children's rally; a cycle rally; a walkathon; a run for health; to express solidarity with the Health for All Now campaign.
- M. ORGANIZE** street theatre or folk culture events that express solidarity with the theme through skits and songs and other forms of cultural expressions [Themes : Explore how the Primary Health Care needs and philosophy has been distorted by the market economy; celebrate how the people have resisted these distortions or how they have taken health in their own hands].
- N. ORGANIZE** talks in schools on the theme – People's Health in People's Hands. Thereby inspiring the next generation to the Health for All challenges.
- O. ORGANIZE** a Radio talk on the theme.
- P. ORGANIZE** a Television show – an interview or a panel discussion with Primary Health Care activists in your area.
- Q. WRITE** a letter from your PHM Circle to the Government of your country (Health Ministry and other related ministries, i.e., women, child, labour, rural development, environment, etc., and share your concerns about Primary Health Care and the concerns of the Charter.
- R. TRANSLATE** the Charter into your own language and release it at the anniversary celebration.



- S. DISTRIBUTE** the Charter or translated version actively on this occasion and or present it to key health officials.
- T. ORGANIZE** a rewriting of the Charter into a simpler local language version with examples, drawings and case sheet and release it / distribute it at the meeting to members of the community.
- U. ORGANIZE** a public signing of the Charter and the Million Signature Campaign in the town square or town hall or some central point in the bulletin.
- V. ORGANISE** Alma Ata Anniversary meetings in Schools of medicine, nursing schools, health worker schools and sensitise the next generation of health professionals to the Health for All Now campaign.
- W. ORGANISE** a musical evening or cultural programme. Have a few health and development songs to endorse the HFA campaign.
- X. LAUNCH** a PHM Circle in your institution / local area / state / country – do so as part of the celebration.
- Y. INNOVATE** other ideas that are more creative, more collective, more in solidarity with the theme.
- Z. FINALLY, SEND** us a report, copy of invitation, programme, poster, photographs, video clippings, press releases, background paper/s, educational materials or any other handouts about your event (whatever you do for the Alma Ata Anniversary) – so that we can put it on the PHM exchange or Website.

**JOIN THE ALMA ATA ANNIVERSARY CELEBRATION
JOIN US IN ENSURING HEALTH FOR ALL, NOW!**

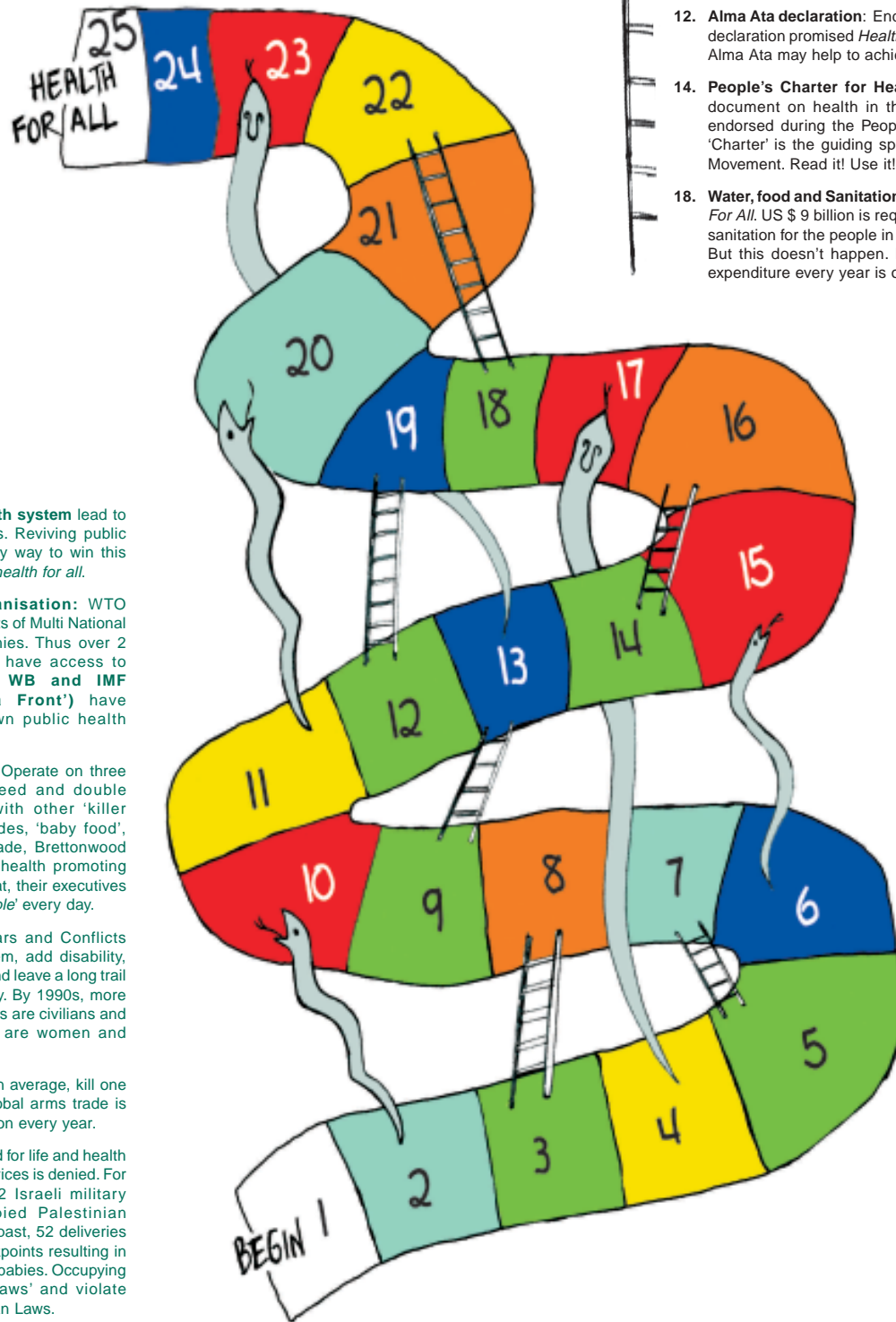
SNAKES & LADDERS

- A REALITY GAME -

In the next 24 hours, over 30,000 children will die worldwide from preventable diseases – lives that can be saved. This 'reality game' takes you through some of the key reasons why they die and what may help to stop these deaths. The race is to reach *health for all*. The stakes are high in this 'life and death' game.

Winning this game is not easy so is attaining *health for all*, with so many blocks.

TRY IT!



3. **Primary health care:** is the best way forward.
5. **Health and education:** Perhaps the best concoction to attain *Health For All*.
9. **Good governance and democracy:** Ensure say for people in making decisions that affect their lives and health.
12. **Alma Ata declaration:** Endorsed in 1978, this historic declaration promised *Health For All* by 2000. Reviving Alma Ata may help to achieve *Health For All*.
14. **People's Charter for Health:** Largest consensus document on health in the world. Developed and endorsed during the People's Health Assembly, the 'Charter' is the guiding spirit of the People's Health Movement. Read it! Use it! Circulate it!
18. **Water, food and Sanitation:** Crucial to achieve *Health For All*. US \$ 9 billion is required to provide water and sanitation for the people in poor countries every year. But this doesn't happen. However the global arms expenditure every year is over US \$ 800 billion!

10. **Collapse of public health system** lead to resurgence of epidemics. Reviving public health system is the only way to win this game – that is attaining *health for all*.

15. **World 'Trouble' Organisation:** WTO protects the profit interests of Multi National pharmaceutical Companies. Thus over 2 billion people do NOT have access to essential medicines. **WB and IMF (international 'Mafia Front')** have systematically cut down public health expenditure.

17. **MNC drug companies:** Operate on three principles – profit, greed and double standards. Together with other 'killer industries' (like pesticides, 'baby food', tobacco, liquor, arms trade, Brettonwood Institutions) they are ill-health promoting factories. Rumour is it that, their executives chant '*profits before people*' every day.

20. **War and conflicts:** Wars and Conflicts destroy the health system, add disability, psychosocial problems and leave a long trail of mortality and morbidity. By 1990s, more than 90% of the casualties are civilians and majority of the victims are women and children.

Conventional arms, on an average, kill one person every minute. Global arms trade is worth over US \$ 800 billion every year.

23. **Military occupation:** Bad for life and health as access to medical services is denied. For example, there are 482 Israeli military checkpoints in Occupied Palestinian Territories. In the recent past, 52 deliveries happened at these checkpoints resulting in the death of 17 newborn babies. Occupying forces rule by 'jungle-laws' and violate International Humanitarian Laws.

Facts and figures are from authentic sources. You can locate them at www.propagandafactory.info.

Download a copy of this from : www.propagandafactory.info

- a march demanding health for all

In the next 24 hours, over 30,000 children will die from preventable diseases on our planet earth. Today, while the world is writing a collective obituary of the future generation, we know why they are dying; we know who are responsible for these deaths. We know how these deaths can be stopped...

join "the million signature campaign"

health for all NOW

English Version | [La Versin.espaola](#) | [Deutsche Ausfuehrung](#) | [La Versione italiana](#)

Want to take a print-out? Print the [friendly version](#)
[View](#) the list of entries so far

About Us

This signature campaign, initiated by the People's Health Movement and the International People's Health Council, is being endorsed by ordinary people from various walks of life and organisations, institutions, peoples associations and others working for a just world. We hope this campaign will catch the attention of the WHO, UNICEF, other UN bodies, social and political organisations, policy makers, governments and others. It is one more step towards making health for all a reality.

(For more details mail unni@phmovement.org)



People's Health Movement



International People's Health Council

Join NOW!

Name/ Institution

Email Address

*Your e-mail address will not be disclosed

Country

clear form

add your signature

I/ We join THE MILLION SIGNATURE CAMPAIGN and demand HEALTH FOR ALL NOW!
I/ We demand the WHO, UNICEF, other UN organizations, governments, the international community and others reaffirm and implement the principles and strategies of Alma Ata.
I/ We endorse the Peoples Charter for Health.

25 years ago, World Health Organisation, the apex UN body dealing with health, promised Health for all by 2000 through a historic moment - [The Alma Ata declaration](#).

Since the Alma Ata declaration in 1978, responses were promising. However, the spirit of Alma Ata and the idea of Health For All has been under attack by anti-health, anti-poor policies, reemerging and new diseases, new challenges and above all by efforts to put private profit over public health.

25 years since the Alma Ata declaration, health for all by 2000 is not a reality.

In the current international health crisis, it is more essential to reaffirm and implement the principles and strategies of Alma Ata.

Join this march on the Internet - THE MILLION SIGNATURE CAMPAIGN- to revive the principles and strategies of ALMA ATA.

Join this march to endorse the [PEOPLES CHARTER FOR HEALTH](#), the largest consensus document on health (since Alma Ata and building on its foundations), endorsed during the PEOPLES HEALTH ASSEMBLY, a historic summit held in 2000.

www.TheMillionSignatureCampaign.org

No copyrights. Please feel free to spread the message.



www.phmovement.org



www.sochara.org



www.wgnrr.org



The International People's Health Council

www.iphcglobal.org



www.booksforchange.net



www.wemos.nl



www.medact.org