

## news brief # 20

Nov. - July  
2007



# People's Health Movement

### EDITORIAL

In the life of any network or movement like what PHM is, four months are too long a period without the News Brief but we take heart from the fact that the PHM exchange on the world wide web has been a constant and unfailing resource on PHM and related matters thanks to the indefatigable efforts of Claudio Schuftan. The 20<sup>th</sup> edition of the News Brief is specifically aimed at the World Health Assembly. There has always been a PHM presence at the WHA. In fact three years back, PHM had the largest independent NGO presence there. WHA is an ideal occasion to lobby, meet important people in WHO and from the country delegations and raise queries of topical importance. Our Press Releases are widely circulated and reproduced. This time too, taking advantage of the presence of a large number PHM and PHM related participants, we are arranging a range of workshops listed elsewhere. Some of them are pre-WHA. Also, the Coordinating Committee of PHM will meet several times before and during the WHA.

Hopefully PHM will be given an appointment to meet the new Director General of WHO. Dr. Margaret Chan. Many of you may recollect that she was one of the people who responded to PHM's questionnaire during the election process. PHM is increasingly being looked upon as the global voice of civil society engaged in health action. WHA and the proposed meeting with the DG are processes that would strengthen our relationship with WHO even if PHM believes that ultimately only people's action can bring about a healthy society.

In this issue you will find a report on the activism of PHM partners in Brazil and a report on a role model known as GK from Bangladesh, all inspiring stuff indeed. The letter from Brazil is a wake up call for us to stand up and be counted. Hence it is given in its entirety. Also, Claudio Schuftan's note on RIH campaign is given in its entirety since we believe it aims at expanding PHM worldwide. Write to us so that people globally know that PHM is really making a difference.

Prem Chandran John  
Editor



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## PHM Events at the World Health Assembly, May 2007

1. A Workshop on "Health and Development in Preparation for the 60<sup>th</sup> World Health Assembly" ,11-12th May organised by Third World Network (TWN), People's Health Movement (PHM), Health Action International (HAI) and World Council for Churches (WCC). The objectives are: i. To identify and explore, collectively, the topics to be focused on in advocacy work during the WHA. We will try to identify which will be key topics and then try to reach consensus under each topic on key messages, demands and proposals to sharpen our impact during our participation at the WHA and beyond and ii. To agree on strategies for advocacy on these issues during the WHA including whom to negotiate with
2. A Seminar on "How to support the WHO to keep to its fundamental principles, 15th May 07, 2:00 – 5:00 PM, organised by Centre Europe-Tiers Monde (CETIM), PHM, and NGO Forum for Health. The agenda:
  - i People's Health Movement and Alma Ata Principles: Threats to Alma Ata Principles in terms of globalization in the neo-liberal era.
  - ii. Strategies today to support WHO in keeping to fundamental principles.
  - iii. Why WHO thinks GMO food is safe and why WHO has to review its analysis on this point.
  - iv. Why and how WHO has to amend its agreement with IAEA and why such an agreement is dangerous.
3. A Seminar on "Primary Health Care and Health Systems", 16th May 07, 3:30 – 5:00 PM organised by People's Health Movement (PHM) and World Council for Churches (WCC).
4. One more workshop is in the offing. Details shortly.

## PHM and Primary Health Care

The People's Health Movement (PHM) welcomes the World Health Organization's (WHO) renewed focus on primary health care (PHC), as signalled by Director-General Dr Margaret Chan's address at the Executive Board meeting in January 2007. In particular we are pleased that the theme of the 2008 World Health Report will be PHC, appropriately celebrating the 30th anniversary of the Declaration of Alma Ata and the 60th anniversary of WHO.

PHM believes that the comprehensive PHC approach articulated at Alma Ata remains highly relevant today. The world has changed greatly since 1978. The current era brings unprecedented resources to bear upon improving global health, but has also brought unprecedented inequalities and worsening health for many peoples. Given the widening inequalities in today's troubled world, any PHC approach must be comprehensive and equity oriented. If it is to substantially and sustainably improve the health of all peoples, it must broadly address the determinants of health – social, economic and environmental – from the micro to the macro level.

### Essential features and principles of PHC

PHM asserts that a renewed commitment to a reinvigorated comprehensive PHC approach is imperative to making the best use of available resources to improve health status and finally realise "health for all" in an equitable way. PHM has a comprehensive statement on the social, economic and environmental actions required to confront current health issues – the People's Charter for Health (available at [www.phmovement.org/resources/phcharter](http://www.phmovement.org/resources/phcharter)). In summary, PHM sees the main features of a comprehensive PHC approach as follows:

\* PHC is a comprehensive approach based on human rights based strategy to assure that the essential health needs of all people are met in a fair and enabling way. PHC has a participatory focus that mobilizes people to work together for the wellbeing of everyone, including the most vulnerable and disadvantaged. ("Health for All.") More than merely "primary level care," PHC is a systems-wide, universally accessible approach that includes curative and preventive services at all levels, fully backed up by a referral system for more specialized care at district hospitals and tertiary centres.

\* The policies and services of PHC deal directly with the social, political and economic determinants of health. To rectify the most entrenched societal and environmental obstacles to health, PHC requires inter-sectoral cooperation at all levels: global, national, district and community. In today's endangered world, health must be redefined as "complete and

# PHM Activities

sustainable physical, mental, social, and environmental wellbeing: both individually and collectively." Because health is a key measure of human and economic development, PHC systems have a co-coordinating role to implement action to improve wellbeing across the whole of society, giving special attention to those whose needs are greatest.

\* PHC promotes community empowerment to improve health, respecting the agency of the individual, their families and their communities to act towards improving their health and the conditions they live in. PHC practitioners thus work together with communities, fostering community organisation and clear accountability, to minimize exploitation of the weak by the strong. Involving communities in analysing their situation and collectively solving their problems for the common good is central to the Alma Ata declaration, but has been the principle least adhered to.

\* PHC is fundamentally aimed at achieving equity, or fairness, for all peoples with respect to their health. Therefore, PHC includes a universal system of healthcare as opposed to multi-tier systems whereby poor people receive so-called "basic" or "essential" packages inferior to those with more money. This requires health systems to respond to the needs of the most underserved and the underlying determinants of health rather than, as often occurs, providing more and better services to those who are more privileged.

\* PHC is more than medical care and involves providing care from providers with different skills (could list them) and working with people individually, in groups and across communities. Social mobilisation is important to increase understanding of the factors that create and detract from health and to take action on them.

\* PHC emphasises prevention as the most effective and efficient means to improve health. But this must be balanced with adequate curative services. Above all, a comprehensive approach is necessary, covering all sectors, is needed to address the underlying determinants of health. Equity-focused health impact assessment methodologies are an important modern tool to achieve this [although the language and methods need to be simplified for fuller community involvement.]

\* PHC is not monolithic but adapts to local challenges and the priorities []. PHC thus provides culturally appropriate care that integrates and respects traditional medicines and knowledge about health – while at the same time helping people learn to combine the best and reject to worst of both traditional and modern medicine.

## Modern Challenges to PHC

Implementation of comprehensive PHC approaches has led to impressive health outcomes in many contexts, including in China, Costa Rica and Cuba historically, and in Brazil and Thailand more recently. However, it is well documented that the principles of Alma Ata have not been implemented globally. Furthermore, new challenges to health have arisen in the thirty years since Alma Ata. Key threats to implementing comprehensive PHC include the following:

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Should we include reference to peace (Alma Ata did and sustainability which Alma Ata didn't but is crucial to our health at this point in time)

\* Selective PHC approaches have been promoted which ignore the broader social, political and economic determinants of health and focus on single issues through vertical programmes that are often divorced from (and even undermine) the broader health system. While there will always be a need for specialist programmes to address key issues, [such measures need to interact with and support comprehensive PHC systems, [] rather than competing with them for staff and [] resources.

\* Increasing privatisation, fragmentation and commercialisation of health systems has eroded decreased poor people's access to health services and demoralized health workers. And it has led to the segmentation of health systems according to socio-economic status, [] undermining equity and increasing health disparities [] within and between countries. This is not to say that non-government actors cannot play significant roles in health systems, but there is a need for strong government co-ordination and input to assure "health for all."

\* Globalisation presents opportunities for increased sharing of knowledge [] and greater co-ordination of efforts [] to address the major determinants of health. However, the accelerated globalisation of the health

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worker labour market ("brain drain") has seriously undermined the ability of many poor countries to support PHC systems. Furthermore, global inequalities have meant that many poor countries continue to lack sustainable domestic funding for their health systems and are thus reliant on foreign sources. This has led to a diminished accountability and funding for local priorities and further reinforcement of selective, vertical approaches that undermine comprehensive PHC.

\* While global public private partnerships bring unprecedented financial resources to address health challenges, [] these initiatives have tended to focus on technocratic solutions to single issues without addressing the determinants of health or adequately developing health systems to deliver these solutions. Such programmes often employ narrow cost-effectiveness analyses that ignore benefits to other sectors from measures that improve health [] (e.g. the claim that provision of safe water is not a cost-effective health measure [Report of Working Group 5, Commission on Macroeconomics and Health, 2002]). Partnership initiatives should enhance rather than undermine PHC systems. The challenges of meeting the 3x5 target for antiretroviral provision clearly show how vertical programmes need to at least develop health systems to deliver their interventions. There are also particular concerns about the sustainability and accountabilities of such vertical technocratic programmes and how their priorities often do not correspond to local needs.

\* While technology offers tremendous potential to improve health status, [] it is sobering to recall that many of the most useful interventions existing in 1978, at the time of Alma Ata, are still not available to all. Even in some places where progress has been made, basic measures such as [] vaccination still have poor and even regressive coverage. Technological interventions are useless without health systems to deliver them. To achieve sustainable progress, they need to be embedded in the socially inclusive and empowering process such as that promoted by comprehensive PHC.

\* There are also significant issues around equity in the current development of technology that are well set out in the recent WHO report on intellectual property, patents and public health.

The People's Health Movement calls on member states, WHO staff and other global health actors to consider these challenges, [] and to support WHO's global leadership and co-ordination in implementing solutions that advance toward "health for all." We suggest that this can be best done by implementing comprehensive equity-driven PHC systems that address the determinants of health, and by squarely addressing the contemporary challenges described above. Some of the member states have advanced toward solutions to these problems, and PHM is in the process of documenting these solutions as a contribution to WHO's upcoming work on the World Health report next year.

## Global Health Watch 2007/2008

We have started receiving the first drafts of some of the Chapters and expect to continue receiving drafts over the next few months. After an internal editing process, the drafts will be forwarded to reviewers for input and suggestions. The comments will be sent back to the chapter authors for incorporation into the final draft.

We aim to get the final manuscript to the printers by November 1<sup>st</sup> 2007.

Still want to participate in the next edition of GHW?

- We are still looking for case studies and human interest stories for all the chapters. Please refer to the PHM website <http://www.phmovement.org/en/ghwatch> and GHW website [www.ghwatch.org](http://www.ghwatch.org) for criteria. The PHM website is listing chapter specific information and is being updated regularly! We cannot guarantee that all the case studies submitted will appear in the print edition, but we will put all stories up on the website. The stories should be written in a journalistic style - please avoid academic and scientific jargon. Submit the case studies to [ghw@hst.org.za](mailto:ghw@hst.org.za).
- We are still looking for reviewers for many chapters. If you are interested please let me know which chapter you are interested in reviewing and a brief background regarding your experience in this field.
- The next edition will be launched in the first half of next year. Please let us know if you would consider organising a launch.
- Advocacy: please help raise the profile of GHW! Refer to it in presentations and at meetings; give people the web address, etc. Please forward on newsletters and email requests for case studies and human interest stories to email lists and others in your region.
- Translations - we have not managed to get many translations of newsletters or GHW advocacy documents (Spanish and French). Please let us know if you are willing to assist with translations.
- Fundraising - we still need to obtain funding for G H W. If you have contacts or can help, please let us know.

We would really like to know how the GHW has been used - so if you have been using it for teaching purposes, studies, and advocacy or on projects, please let us know by sending an email to [ghw@hst.org.za](mailto:ghw@hst.org.za) (Bridget Lloyd)

TO RECEIVE PERIODICAL UPDATES E-MAIL  
GHWatch-newsletter-  
[subscribe@yahooogroups.com](mailto:subscribe@yahooogroups.com)

# PHM Activities

## LETTER FROM PHM Partners in BRAZIL about MINGA

A Lesson in People's Action to Reduce health  
inequity in the Americas

[ Minga is a word used by indigenous peoples and nations of the Andean region, referring to a social practice of collaboration, solidarity, and cooperation in which each person, according to ability, contributes resources for the benefit of the community as a whole ]

We are a coalition of social and popular movements and organizations of women, rural people, peoples of the forest, indigenous peoples and nations, communities of African descent, Rama and other nomadic peoples, gender identity and sexual orientation (GLBT) groups, territorial neighborhood organizations, union movements of workers, academics, housing activists, health service users, patients' leagues, professional guilds, and NGOs of various parts of the Americas, from Canada to Chile, through Central America and the Caribbean, gathering in Brasilia for the regional meeting of consultation on social determinants of health, convened by the Governments of Brazil and Chile, civil society organizations of the Americas, the OAS, PAHO, and the WHO, to discuss the multiple health-related issues we face and the need and importance of recognizing social determinants of health in order to overcome them.

This meeting reaffirms profound dissatisfaction with the prevailing approach to social and economic development in the Americas, an approach that, in recent decades, has gained strength through a set of neo-liberal policies associated with globalization, and that must be replaced. Based on market logic, it privatizes and medicates health to the detriment of the right to health, heightens human rights violations and inequalities that lead to health inequity, weakens and impairs health and living conditions, and is entirely avoidable and unfair.

We also reaffirm that this development approach reduces the role of the state as a promoter of health, fragmenting and privatizing health systems, shrinking public health resources, emphasizing a curative approach to individual diseases.

The growth of this approach in the Americas heightens inequalities and social exclusion, as evidenced by the concentration of wealth, land, and income and the improper use of natural resources. At the same time it heightens gender inequality and discrimination for reasons of ethnicity, race, religion, and sexual orientation and gender identity (GLBT), and increases all forms of violence in both rural and urban areas, both public and private places.

It is clear to the civil society movements and organizations present at the meeting that health is a universal human right, a duty of the state, which requires a set of factors like food safety and security; decent work and recognition of the value of childbearing; adequate income; land access, use, and tenancy; sustainable management of natural and renewable resources; decent housing in a healthy

environment; democratic civic participation; universal access to education and health services that are timely, humanized, of quality, and culturally appropriate; inclusive government social policies; social relations that are neither sexist nor racist; and cultural and religious tolerance. This means that health factors and the right to health are indivisible and interdependent.

It is clear that, in order to make progress in overcoming health inequities, it is essential to devise sustainable approaches to social and economic development that safeguard human, civil, political, economic, social, cultural, environmental, sexual, and reproductive rights; that government adopt an approach that guarantees those rights; to promote sovereignty and food security to eradicate hunger from the Hemisphere, promoting agrarian reform that ensures land access, use, and tenancy, makes possible sustainable agriculture, and preserves ownership of heritage seeds, in a context of rural family farming appropriate to the climatic diversity of the region; to have urban reform that promotes better distribution of urban land and the building of socially just and environmentally sustainable cities; to democratize human cultural capital through universal access to education; to bring about participatory democracy; and to develop government policies that are inter-sectoral, universal, integrated, equitable, and participatory.

Accordingly, we civil society organizations meeting in Brasilia believe it is advisable to promote a common agenda concerning determinants of health that strengthens and broadens activism, autonomy, and social mobilization—at the national and hemispheric levels—to orient government and public policies toward this integrated perspective on health factors.

Therefore, we call for a civil society alliance based on the ancestral principles and knowledge of indigenous peoples and traditional communities (Minga), to restore a social practice in which we all will feel invited and committed to contribute our experience so as to strengthen action to transform determinants of health and enforce demands for health-related rights. At the same time we call upon national governments and international organizations to respect the autonomy of social organizations—according to those same principles—and to commit their initiative, action, and resources to this transformation.

As organizations present in multiple social sectors, we pledge to publicize this discussion among popular organizations and social movements in the Hemisphere, to broaden it to include their viewpoints and contributions, and to enlist their active participation in the debate and in realizing the shared agenda, building a hemispheric movement that will continue to grow.

We also call upon the region's governments and the international organizations to commit themselves to this process, which began with the establishment of the Commission on Social Determinants of Health, in 2005, and to move forward, together with civil society, in firming up policies and programs that will affect and transform those determinants. The WHO, PAHO, and the OAS, along with the region's governments, must continue to support and broaden this process, facilitating broad and influential participation by the region's civil society organizations. (Brasilia, April 14, 2007)

## Coordinator's Corner



Dear Friends,

Warmest greetings from the PHM Global Secretariat in Cairo!

An exciting and busy year has passed since the PHM Global Secretariat moved from Bangalore, India to Cairo, Egypt. During this period, the Global Secretariat has been involved in the struggle of all PHM partners and networks across the globe in their struggle for "Health for All". The following activities, among others, took place:

- The Global Secretariat office has been established and has gradually worked on increasing its capacity and efficiency in enabling the PHM global structures and networks to address issues in a manner that would bring tangible impacts
- The global PHM structures were revisited and restructured for better internal governance. A Steering Council representing geographical areas as well as areas of competence was formed and is now the Governing Body of PHM. A smaller, functional Coordinating Commission was established as an executive body to work more closely with the Global Secretariat. A new model of the Global Secretariat in which three countries, Egypt, Palestine and Lebanon shared the responsibility of overseeing the Global Secretariat was established.
- PHM participated in several regional and international events to support the struggle for human dignity and the right to health all over the globe. Among these events the most significant were the World Social Forum - Nairobi, Kenya, January 07 (WSF07); The Second National Health Assembly - Bhopal, India, March 07 (NHA07); the 60<sup>th</sup> World Health Assembly - Geneva, Switzerland, May 07 (WHA07); the First US Social Form - Atlanta, USA, June 07 (USSF07).
- The PHM International People's Health University (IPHU) continued coordinating the process of creating a younger and more informed leadership for PHM as well as for people's struggles. During the year, IPHU implemented three leadership workshops held around major events namely; the NHA07 (Bhopal, India); Vancouver07 (Vancouver, Canada); USSF07 (Atlanta, USA). In each of these, 25-40 health activists participated, shared experiences and coordinated their struggle for "Health for All". Two more workshops are planned during the second half of the year, one in Bangladesh and the other in Lebanon.
- Global Health Watch (GHW) continues with widening its ownership through participation by all by asking for case studies, life stories, testimonies, etc., from the regions.

The second GHW would be completed and published during the second half of the 2008.

- PHM continues to support and 'push' the WHO to be re-commit itself to being the sole body responsible for coordinating efforts for people's health. May be the most significant event during the last year was PHM's engagement with the Commission on Social Determinants of Health (CSDH). PHM is also closely involved in the final report of the Commission through the Civil Society report that we have prepared. This was well received at the meeting of the Commission in Vancouver recently.

During the coming year, the global secretariat will continue coordinating the struggles of different PHM constituencies towards "Health for All". The focus will be on movement and network building by strengthening country and grass roots involvement. In addition, the Global Secretariat will work on:

- Further institutionalization and strengthening of the PHM projects such as issue and geographical circles. This means enabling different PHM geographical and thematic circles to have the necessary institutional capacity for more efficient work and sharper impact.
- Assisting the geographical spread of the PHM through helping establish and strengthen new country circles.
- Further developing of the linkages and mutual feed back between the geographical and thematic PHM circles. Global PHM projects like the GHW, the Civil Society report on the Social Determinants of Health and others would be built on contributions from countries and local communities that the PHM is active in. To widen the ownership of these reports that will reflect different realities all over the world and in the process, provide the geographical circles with an advocacy tool to support people's struggle for health.
- Enhancing communication among different PHM constituencies and between PHM and other stakeholders including governments, international organizations as well as other civil society and people's organizations at local, regional and international levels.
- Enhancing and democratizing PHM internal governance by enabling the participation of local and country circles to participate in the PHM global decision making process.

To convert the People's Charter for Health to a global agenda for the right to health for all has become an achievable objective. It is no longer a dream. This has been made possible through the active involvement of PHM constituents across the globe for which I am very grateful.

Hani Serag  
PHM Global Coordinator  
July 2007



# PHM Activities

## A Report on PHM - IPHU Leadership Workshop in Bhopal, 23-24 March, 2007

By Hripsime Nazaretyan, NGO "Future Generation Union"  
Focal Point of the PHM in Armenia Was it useful + What to  
do after Bhopal (A perspective to initiating a PHM Country  
Based Circle In Armenia)

"DIVIDED WE BEG, UNITED WE DEMAND"

It was my pleasure to participate in a leadership workshop  
for PHM "old" and "young" activists in Bhopal, India, on 23-  
24 March on behalf of the Armenian NGO, "Future Generation  
Union" (FGU).

Around 38 participants from 24 different countries came  
together to get more familiar with the history, development,  
structures, campaigns, strategies and processes of PHM  
in all its various manifestations. More experienced activists  
shared their expertise, lessons learnt with less experienced  
ones and newcomers. I was one of the newcomers, and I  
was inspired by the enthusiasm and motivation of the  
participants, who were telling about the campaigns in their  
countries, about their struggle and achievements. Claudio  
Schuftan from Vietnam was advocating that "Divided we beg,  
united we demand," and that only joint efforts can bring us  
to a better world. Thelma Narayan from India called PHM to  
address broader social and political determinants of health,  
as those issues do not have national borders.

We went deep into Alma-Ata and Cuenca Declarations,  
People's Health Charter (PHC) and tried to find answers to  
not very easy questions. During the workshop the participants  
shared their experience on various PHM campaigns. PHM-  
USA Water Rights Coordinator Jeff Conant introduced PHM  
USA's experience on Right to Water, which include opposing  
privatization of water systems, advocating for social control  
of water supplies, etc. The PHM Right to Health Campaign  
(RIH) was of more interest to me, as it reflects the priorities  
and advocacy strategies of Armenian NGOs. I learned that  
PHM perspective is Right to Health - Health for All. The  
right to health includes the right to a range of social  
determinants of health (clean water, food security and  
nutrition, education, housing and safe environment, etc),  
as well as, the Right to Healthcare.

Enriched with new ideas, new strategies, new skills, I was  
inspired with the idea of building a PHM country circle in  
Armenia. There are civil society networks and NGO coalitions  
that are trying to solve health related issues in Armenia.  
The plan is to translate People's Health Charter and other  
PHM documents into Armenian and distribute among partner  
organizations and all other interested stakeholders. Read  
and discuss Alma Ata and Mumbai Declarations. Next,  
discuss possibilities to join Million Signature and Right to  
Health campaigns.

Last year Armenian NGOs launched "Health for All"  
campaign aiming at highlighting the desperate lack of basic  
health care facilities for poor people across the country.  
NGOs are calling on the Government of Armenia to  
incorporate a community based Revolving Drug Fund (RDF)  
model into the national health insurance strategy. The other  
campaign, that FGU is actively involved in, is advocating  
the concept of "Health-Promoting Schools".

I hope that with your assistance PHM Country circle in  
Armenia will become a reality.

## A Note from PHM, USA

PHM - USA is organizing for the US Social Forum  
(June 27 - July 1 in Atlanta, Georgia)! PHM will  
hold a health activists training - the International  
People's Health University - in conjunction with the  
US Social Forum. We hope to enroll 60 activists to  
participate in the 4-day training and to work on  
developing campaign proposals for expanding PHM's  
work in the United States. PHM has also organized a  
number of health justice sessions and activities to be  
held in the US Social Forum. We are working in  
coordination many health activist organizations,  
including: Healthcare Now!, Physicians for a National  
Health Plan, American Medical Students Association,  
Poor People's Economic and Human Rights  
Campaign, Center for Policy Analysis on Health and  
Trade, Partners in Health, Universities Allied for  
Essential Medicines, Student Global AIDS Campaign,  
Physicians for Social Responsibility, Doctors for  
Global Health, Hesperian Foundation and many others.  
As a part of PHM's Right to Water Campaign we have  
also formed a coalition of organizations including  
Corporate Accountability International and Women's  
International League of Peace and Freedom to organize  
a series of sessions and activities related to  
privatization of water to be held at the US Social Forum.  
If you are interested in participating in health justice  
events at the US Social Forum, please contact us at  
iphu.atlanta@gmail.com or phm@hesperian.org.

Another upcoming event is a workshop May 30 on  
"Renewing Primary Health Care in the Americas  
and Globally" to be held in Washington D.C.,  
organized by the PHM-affiliated Spirit of Alma Ata  
Caucus. Contact Connie Gates (connie@jamkhed.org)  
or Jean Mouch (mouchjf@yahoo.com) for questions  
and to register for the event.

# PHM Activities

## PHM's Right to Health Campaign An Explanatory Note from Claudio Schuftan

This was prepared as a response to concerns and questions raised by the PHM Steering Council at its last meeting in Bhopal, March 2007

1. As originally designed, the RTHHC campaign uses a participatory process to inform people about their right to health and actually involves them in preparing the assessment of the right to health care in their country – at the same time that it builds and mobilizes a sustainable PHM network. The idea is that information gained during the mobilization and assessment processes leads to the development of active lobbying strategies aimed at improving government health policies
2. Collecting the data that brings out the evidence of the violations of the RIHHC does not, by itself, mobilize the sufferers of such violations into action. They must be present when the important issues to include in the assessment are defined, when doing the assessment itself, when selecting the concrete cases to be looked into, and when the data are analyzed. By going through this process, they themselves will learn about what the right to health and health care is all about and will thus meaningfully contribute to its operationalisation.
3. The national PHM RIHHC campaign committees will also work to plan and carry out international level actions that will further pressure national governments by influencing international/multinational organizations and institutions that currently play a major role in health policy.
4. Country-level activities are the heart of the campaign, and need to be developed with flexibility and context-specific innovation. How the RIHHC campaign is organized in Country X is up to the campaign committee in that country. PHM's overall concerns are that the process involves as many people from different sectors and tendencies as possible, and that the final assessment report, as closely as possible, covers the different parameters described in the campaign's RTHHC Assessment Guide. As written, the Guide provides a step-by-step explanation of the reasoning process to be followed to identify violations of the right to health. Therefore, regardless of how country circles end up using the Guide, it is recommended they consider its five steps in reporting their findings.
5. The most important goal of this campaign is to empower and involve ordinary people to represent their own interests in a political process/movement that has the power to influence both the national and international level of decision making. Because PHM as an organization is seen as representing the interests of hundreds of thousands of people [what we call the (lower-case) people's health movement], we have achieved a certain level of recognition and access at the international level. We want to bring people's claims for their health rights to that level in a way that cannot be ignored.
6. The point of this campaign is not to produce RIHHC reports. It is not a "desk exercise." The reporting process is a strategy to find evidence, to educate people about their rights and about key principles of public health, as well as to bring them together behind shared, common goals. This is what is needed to make effective demands on governments. The final report should preferably include documentation of testimonies of denial of health care, and participatory case studies of health care facilities or health-related services carried out by participating organizations. Such activities simultaneously build evidence and generate involvement. Holding of dialogues between groups of health activists and health authorities, public hearings, workshops on the Right to Health, and/or carrying out symbolic protest actions of various types can be important features of the campaign –keeping in mind the situation prevailing in each country. These actions can be carried out right from the beginning. (The campaign coordination team can give interested PHM circles referrals to other PHM circles or affiliates that have carried out such actions and can offer support).
7. For the above reasons, we think that before engaging in the actual assessment, it is crucial to set up a credible network of strategic allies. Country focal points for the campaign are thus to contact such allies (individuals and institutions) at the same time that they identify potential opponents to the campaign (and work out means to neutralize their opposition). The local political scenario has to be analyzed by the PHM circle so that committed strategic allies can be aligned and given concrete responsibilities, as part of an ad-hoc plan for the whole campaign. The question also has to be asked, then, whether the timing for launching the campaign is right given the concrete local political realities.

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8. Establishing such a critical-size network to get started is more important than following the campaign coordinators' originally proposed timetable (i.e., March to October 2007 for phase I of the campaign). Participating countries are to build-up their own initial mobilization momentum to go ahead with the assessment. To arrive at a point when the time is right, they ought to take as many weeks or months as needed to insure success. The original timetable recently circulated to all interested countries and through pha-exchange is thus now considered to be too rushed. As we now see it, countries do not have to do their assessments at the same time or finish at the same time. But there does have to be a certain critical mass of countries in a region that have gone through the assessment process and the national strategic action planning before it makes sense to have a regional meeting (phase II). Each of the regional meetings should also happen within a reasonable period of time so that an international momentum can be generated.

9. Consequently, the criteria for proof of social mobilization preceding the launching of the actual phase I of the campaign are being tightened and now are:

- a. Organizing at least two national level meetings to discuss the campaign, involving participants from various organizational backgrounds, preferably including some from different regions of the country.
- b. Formation of a first campaign coordination group which will take collective responsibility for expanding and developing the campaign.
- c. A formal agreement on the provisional decision-making mechanisms for the development of the campaign.
- d. Existence of a functional e-group/listserver or other means of communication among the participating organizations/individuals to facilitate campaign communications.

10. The campaign will require that, early-on, the national PHM circle develops the capacity to reliably review and monitor intermediate results and outcomes so as to be successful in institutionalizing the campaign in the years to come.

11. The small funding available on a first-come-first-serve basis will be released for two purposes: a) to allow for organization and mobilization activities to go ahead, and b) to launch the actual assessment (phase I) of the RIHHC. Modalities of the release of these funds will be kept flexible to fit specific cases.

12. The first countries to succeed in completing the mobilization and assessment process will be asked to

mentor countries just joining or countries that have had a weak performance of their campaign.

13. The regional traveling 'organizers' to be trained by the campaign coordinators (to help setting up national PHM circles and to help in the launching of the actual campaign) will have previous social mobilization experience. With the change in time line we will re-open recruitment of organizers, since some people were interested in the position but were unable to fit it into their schedules.

14. Some countries may center their mobilization around already strongly felt needs in the population and, as an entry point to the campaign, address these issues as they relate to the RIHHC, e.g., in Central American countries the negative health effects of the FTA they are locked-in into; in Palestine the unnecessary deaths caused by the occupation, etc. Connecting the campaign to ongoing national popular struggles is a good idea. Moreover, building alliances with related campaigns, such as groups or networks working on social sector issues, i.e., the right to water, to food, to education, to a safe environment, to housing, as well as with the existing struggles against privatization in its various forms should be actively considered.

15. The campaign will not attempt to be confrontational, unless needed. The lobbying strategies outlined in the Assessment Guide show ways to work with duty bearers in a constructive manner.

16. Particularly in the health sector, health professionals' stated aim to conform to ethical and quality of care standards of practice can be used to engage them in the campaign. With claim holders mobilized and front line health providers appropriately motivated, chances of a positive response from duty bearers is much more likely.

17. Because of this, the campaign highly encourages the early involvement of health workers and their unions. They are, at the same time, claim holders and duty bearers (i.e., claim holders of decisions made at higher-up levels), and their involvement will give the campaign access to valuable information, as well as greater depth and additional credibility. The endorsement of the campaign by well known personalities and prestigious institutions is also invaluable.

18. Finally, to reiterate, the campaign's Assessment Guide does give a very good comprehensive overview of what needs to be done to assess the RIHHC. It does emphasize the needed mobilization. It is quite user friendly – given the complexity of some of the issues to be covered. It takes the user(s) by the hand, in a step-by-step manner, to cover all aspects that will result in a good,

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standardized diagnosis of the state of the RIHHC in each country. As stated in the Guide, it should be applied with flexibility to adapt it to the different national realities. Key in this flexibility is to skip those sections or questions for which there are no data available or for which data would be extremely difficult to get; on top of giving space to address additional issues of particular local concern. Each country will decide for itself how to use the assessment process as a tool for additional mobilization. For example, certain questions or areas of interest can be assigned to particular groups with a connection to those issues – with the national campaign coordinating committee then combining the work of those groups into the final report.

19. The two main campaign co-coordinators have asked for at least two more PHM members to join them to help them lighten their heavy workload. Dr. Ghassan Issa from Lebanon has volunteered to join and is being incorporated. – We want to have information about the campaign in every participating country on the PHM website. We will be including contact information for each country so people can get in touch with you if they want to join. Without photos the site will be very boring. When you send photos, please identify the organizations present by their full names – no acronyms please! Take pictures of your kick-off meeting or of any events you hold and send them to Pacome Tometissi at [tometissi1@yahoo.fr](mailto:tometissi1@yahoo.fr), and Ghassan Issa at [arcgi@mawared.org](mailto:arcgi@mawared.org).

## New PHM Circles and Campaign committees being formed

Congratulations to Benin, Congo Brazzaville, and South Korea – they have formed new PHM circles and RIHCC committees. Campaign organizing meetings have been held recently in Uruguay, Nigeria, Kenya, Peru, Mexico, Morocco, Australia, Argentina and we have had inquiries from many other countries. The response has been truly exciting. Concern about privatization of health care and inadequate health systems is global. Working together our demand for health for ALL cannot be ignored!

## How you can help the Campaign (besides mobilizing in your country)

- \* Sign up as a translator
- \* Join the web site team

- \* Create a resources page for the web site (The papers, web sites, organizations have been identified. You would organize and annotate the links)

- \* Help with data entry into a spreadsheet (boring, but necessary and important!)

- \* Work on grant writing and fundraising on either a regional or global level.

Tell us about any potential funders you know.

## Campaign organizer update

As mentioned in the campaign clarification above, the timeline of the campaign has been extended and so we are reopening our request for volunteers to be campaign organizers. The organizers will travel to participating countries to assist them in their mobilization and provide training on the use of the Assessment Guide. They will receive training about the campaign and their duties. We need people who speak/write English and at least one other language spoken in region where they will work. They must have time and schedule flexibility to be able to travel and to communicate with the countries they are working with between trips. We anticipate that the traveling will be more intermittent than originally planned. The positions are voluntary but all expenses (flights, buses, food, lodging, incidentals) will be paid by the campaign while traveling. In particular we need a French-speaking African to work in the francophone countries now joining the campaign, but people from any region are invited to apply. We thank those who have already submitted their applications.

To apply please send to [p hm@turiano.org](mailto:p hm@turiano.org) and [claudio@hcmc.netnam.vn](mailto:claudio@hcmc.netnam.vn):

- \* a CV or summary of your related experience (in health, human rights, community organizing and mobilization, etc) and the organizations you are affiliated with (full names please – no acronyms)

- \* 2-3 references (preferably including one from someone known to PHM)

- \* your contact information

- \* a brief statement about why you want to do this work and what you would bring to it.

# PHM Activities

## A Personal Note from Dr. Ravi Narayan, immediate past Coordinator of PHM on his Mission to Geneva on 26<sup>th</sup> and 27<sup>th</sup> April

I just returned from a very significant PHM mission in Geneva (26/27<sup>th</sup> April) which was undertaken on behalf of Hani, the secretariat and all of you, using the strategic opportunity of a Global Forum for Health Research foundation council meeting 23<sup>rd</sup> to 25<sup>th</sup> April at Vevey. Some of this was formal and some of it was through informal discussions. It was an opportunity to assess the situation and make some head way on certain fronts. The main points to help the planning for WHA and the next CoCo meeting are as follows:

### 1. Lunch Time Seminar on 26<sup>th</sup> April 2007

The invitation to be the main speak at the seminar was from the new cluster of Information Evidence and Research, headed by Tim Evans. The theme 'Primary Health Care today-How can we get it right?' The two special guests and respondents were Halfdan and Paul Hunt. There was great synergy between us and the seminar was oversubscribed with more than half the numbers standing (100+) including staff of WHO, Unit heads and team members. Dr.Asamoah - Baaha (AB for short) the DDG who was recently appointed to head a Primary Health Care working group along with Mirta Roses (PAHO) was the chairperson. He initially planned to chair till 12.30 and then attend a donors meeting but he changed his mind and stayed on to conduct an interactive discussion till 2.15pm. We were frank and as politically incorrect as possible and received a great and enthusiastic reception and lots of questions.

### 2. Meetings with Dr. Ian Smith and with Dr. Tim Evans of WHO

The move to strengthen PHC is strong and consistent. They welcomed PHM's strong advocacy for PHC and would do their best to get us as involved as possible.

### 3. Meeting with Mental Health Unit on 27<sup>th</sup> April 2007

They need PHM's support on the report on Evidence based strategies and interventions to reduce alcohol related harm (A60/14 document - WHA agenda item 12.7) This document lists out all the approaches that have worked mostly tackling the alcohol industry directly not just through health promotion ( indirect) This is being opposed by UK/USA/ Australia and other industry friendly economics and civil society advocacy is urgently needed and is in line with our peoples charter. (They will be invited by TWN to the PHM orientation session on 12<sup>th</sup> May 2007 to dialogue with us)

### 4. Meeting with PHM partners Geneva- John Knox on 27<sup>th</sup> April 4.30 to 6.00pm

The Meeting was attended by representatives from NGO Forum for Health (Alan), CEIIM( Julie/Alison), TWN ( Martin, Sangeeta, Riaz and Yvonne); the infants of Chernobyl group ( Vladimir & Emmanuela); WCC ( Manoj & Anna) ; NGO Advisory group of Health Promotion ( Gabriella); World Federation of Mental Health ( Myrna); Global Forum for Health Research ( Sylvie Olifson); Geneveive Jourdan, and others.

## Ordinariness and People's involvement

In my analysis, ordinariness and involvement of the common human being, especially women have been the hallmark of Gonosasthaya Kendra, universally recognised as (GK) which celebrated its 35<sup>th</sup> anniversary this week. The common understanding of the word ordinariness does not apply here. GK, deliberately "branded" itself as ordinary in order to identify itself with the common people whose struggle it was identifying itself with. With a beginning like that, involvement of ordinary people was logical. I believe that these two processes have made what GK is today - an acknowledged leader, innovator whose cost-effectiveness is to be seen to be believed. They have achieved extraordinary goals within a generation, on the way, enthusing the current generation and setting standards for future generations.

GK grew out of the blood, sweat and tears of the independence struggle and started as a medical facility for treating wounded freedom fighters in 1972 by a team of then young doctors led by Zafruallah Chowdhury and Qasem Chowdhury.

I was privileged to have been a part of the 35<sup>th</sup> Anniversary celebrations held 28 April- 1 May 2007 in Savar, Bangladesh. Not content with merely celebrating this as a chronological event, GK organised a series of workshops which were well attended, moderated and ended up being very productive. The workshops started with a homage to their heroes, martyred and living. A group of 35 living heroes were honored

with several military commanders, poets, sculptors, teachers, agricultural innovators, a poor widow who risked her life by passing information from sector to sector about enemy troop movements among them - was honored, given mementos and invited to participate in the ensuing workshops. Themes close to GK's (and PHM's) hearts such as the NGO Movement in Bangladesh, Traditional Birth Attendants, the Alma Ata Declaration - Mirage or Reality, the Role of the Physicians as health workers as well as Diagnosis and Treatment of Cancer at the Community level, Agriculture and People's Health, Education as a tool of empowerment, access to Essential Drugs (GK being a pioneer in this sector globally), Disaster Management (after all this is a country of unlimited disasters and most importantly Gender and Health.

Every evening, acknowledging the crucial role that the community around has played in GK's plans, programs and perspectives through the years, everyone from all around was invited making the PHA Auditorium burst its seams to colorful and skillfully executed cultural events. I left GK with a heart full of gratitude for the fortitude of these innovators who have, in the first place, made and continue to make a remarkable difference in the lives of over a million and a half people in the country and secondly, have set a role model that every NGO worldwide should and will try to emulate. Extraordinary achievements indeed! (PCJ)

FOR ADDITIONAL INFORMATION....

### PLEASE VISIT PHM RELATED WEBSITES AROUND THE WORLD

- 1) [www.phmovement.org](http://www.phmovement.org)
- 2) [www.health-now.org](http://www.health-now.org)
- 3) [www.iphcglobal.org/iphu.org](http://www.iphcglobal.org/iphu.org) (International People's Health University)
- 4) [www.ghwatch.org](http://www.ghwatch.org) (Global Health Watch)
- 5) [www.saveunicef.org](http://www.saveunicef.org)
- 6) [www.righttowater.net](http://www.righttowater.net)
- 7) [www.phmoz.org](http://www.phmoz.org) (Australia)
- 8) [www.phm-usa.org](http://www.phm-usa.org) (USA)
- 9) [www.phm-india.org](http://www.phm-india.org) (India)
- 10) [www.aifo.it/english/alliances/phm.htm](http://www.aifo.it/english/alliances/phm.htm) (Italy)
- 11) [www.thenetwork.org.pk/phm-htm](http://www.thenetwork.org.pk/phm-htm) (Pakistan)

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