THE LONE PINE STATEMENT (DRAFT)[1]

1. The Health Crisis

The gap between the health standards of the North and the health of people of the South is widening. Despite claims of continuing health improvement, millions of people in the South suffer from preventable illness and disability and die prematurely.

The health gap between rich and poor countries has grown over the last forty years. While death rates under the age of five have decreased over this time (from 25% in 1950 to 9.6% in 1990), the gap between the death rates of the poor countries and those of the rich countries has widened over this time (from 3 fold to at least 8 fold)[2].

In Sub-Saharan Africa, the absolute numbers of people dying prematurely have increased, particularly among the young. The number of children dying before the age of five in Sub-Saharan Africa increased from 2.3 million in 1950 to 4.0 million in 1990[3]. In India there has been á 30% drop in the number of deaths before the age of five (from 4.4m to "only" 3.2m) but over the forty years, 1950-1990, there has been no change in the numbers of deaths in the 5-14 group (static at 600,000 deaths per year)[4].

Over recent years there has occurred an increasing polarisation of health status within many countries as well as between countries. The 'health gap' has widened in the rich

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1. This statement has been prepared as an outcome of a joint meeting of the International People's Health Council and the People's Health Network (an associate organisation of the Third World Network). A small group of health personnel from fourteen countries met for one week at the Lone Pine Hotel in Penang in Malaysia (28 November to 2 December 1994). The group included health practitioners involved in community based health care organisations and also writers and analysts from academic centres. The International People's Health Council (IPHC) is a developing network with links with community-based health organisations in 35 countries, principally in the Third World.
2. Calculated from Table A5, p203.
3. Table A.4 p202
4. ibid

countries as well as in the poor countries.

does any one have any data here?

Whilst the AIDS epidemic has affected people in all regions, the impact has been particularly devastating in the developing countries, such as India and Thailand and in particular in Sub-Saharan Africa. The rapid spread of HIV in the developing countries is directly linked to the economic pressures that these countries are under. In rural areas where subsistence farming is insufficient to keep their families fed it is common for men to move to the cities or the mines and they are often forced to live away from their families for months and years. Likewise women who are living alone in the cities (often because they have been bereaved through AIDS) are forced into exchange relationships involving sex, simply to survive. The deaths which flow from these circumstances are deaths from economic crisis, not simply from AIDS. Resources for the care of people suffering from AIDS in developing countries are grossly inadequate also.

AIDS/HIV is not the only epidemic disease on the move today. The TB epidemic in New York and the recurrence of plague and cholera in India all reflect the breakdown of public health protection and basic health services, in the North and in the South.

The Social Conditions Underpinning the Increasing Risks to Health

Health is created prior to the involvements of the 'health system'. The factors which produce good health include access to material resources (food, shelter, and a clean environment), safety from war and violence and the opportunity to contribute to one's community and be appreciated for that contribution.

The single most important threat to the health of poor people in Third World countries is their poverty. The minimum wage in Bolivia is so low that a family of five would need a total of seven full time wages simply to eat enough.

Other major threats to health in Third World countries are rapid and squalid urbanisation, social disruption and dislocation, war and conflict. There are more wars proceeding today than at any time in recorded history. Military exports constitute an

increasing proportion of export revenues of the UK and other rich countries.

In addition to these economic and political threats the deregulation of trade barriers has facilitated the penetration of tobacco and alcohol marketing into the most isolated parts of the Third World.

In sharp contrast to these social and economic threats to people's health in developing countries, investments in medical research globally are overwhelmingly focussed on treatment interventions, in particular drugs and diagnostic technologies, with the promise of high earnings to the manufacturers. In some respects these developments carry threats which could outweigh their benefits. Genetic engineering is now practised in small laboratories all over the world, primarily under 'self-regulation' arrangements. While the risks of catastrophe may be small, the impact of possible 'accidents' could be truly catastrophic.

The Crisis in Health Service Systems

The increasing risks to health in developing countries contrast sharply with the increasing technical capabilities of modern medicine. While the technical power of medical technology increases, the economic, political and institutional systems which should be delivering these benefits to people in developing countries are failing. (This is true also of the marginalised people of the rich countries. Around 40 million people in the US do not have access to basic health care.)

THE DEATH OF PRIMARY HEALTH CARE

The primary health care model which was announced at Alam-Ata in 1978 has been widely acknowledged as the most appropriate model so far for the development of basic health care and public health protection and improvement.

Notwithstanding the widespread support for primary health care among health workers in developing countries it has been under sustained attack from 'experts' associated with the large donors of the North since Alma-Ata. The first round of attack was under the slogan of 'selective primary health care' suggesting that 'vertical' 'top-down' programs were somehow the same as the

comprehensive local service model promoted under the name of primary health care. More recently, primary health care systems in developing countries have been under more sustained attack through the impact of structural adjustment packages forced on such countries through the IMF and more recently by the World Bank.

(can DW suggest modifications and/or a new para here please)

The most recent attack on comprehensive primary health care comes through the 1993 World Development Report of the World Bank. This recommendations of this report mention primary health care but in the context of delivering sharply defined vertically controlled 'basic' programs, selected on the grounds of 'cost-effectiveness'.

The impact of structural adjustment on health services has been documented in a number of countries. In Zimbabwe what was an effective primary health care system has been progressively dismantled as a consequence of policies mandated through structural adjustment.

(can DS write a paragraph about SAP here please)

the failures of marketisation (privatisation and user charges, etc)

turn down of immunisation rates

para from DW please

ATTACKS ON ESSENTIAL DRUGS POLICIES

The production, import and sales of medicinal drugs in the majority of Third World countries do not match the health needs of the people of those countries. Rather, they reflect the pressures of multinational interests and the vulnerability of economically pressed governments. When Bangladesh attempted to implement a courageous essential drugs policy in 1982 on the basis of the WHO guidelines they were subject to intense pressure from lobbyists working for the multinational pharmaceutical manufacturers supported by high level representatives of the governments of USA and Germany.

In spite of knowing what constitutes a rational drug policy (ensuring availability of essential drugs at affordable prices of adequate quality and with unbiased drug information) we find that Third World markets flooded with thousands of non-essential, irrational and hazardous drugs.

There have been numerous examples of drugs which are not allowed to be sold in the industrialised countries being dumped in Third World countries. One example from India was a high dose oestrogen/progestogen preparation recommended for use as a pregnancy test, inducing abortion and other indications despite the likely teratogenic risks. Large companies with deep pockets are able to stretch the resources of government regulators.

Even in relation to established drugs the withholding of consumer cautions and technical information from the prescribers is common. Since in most Third World countries there are no adverse drug reaction reporting systems and medical records are generally poor there is likely to be a serious morbidity burden which is not presently reported or acknowledged.

With increasing pressures on public health systems there are frequent and continuing shortages of essential and life saving drugs and with deregulation of price controls there have been steep price increases for many of these drugs. Increasing user charges means that many people cannot afford to commence or complete recommended treatment regimes. This is especially problematic in some of the diseases of poverty which require long term treatments such as TB and kala azar (leishmaniasis).

The current changes to the GATT are likely to lead to the dismantling of national pharmaceutical industries where such industries exist. This has serious consequences for achieving self-reliance. Increasing patent protection (TRIPS) are likely to lead to increasing prices and problems with availability of drugs under monopoly control.

FAILURE TO SUPPORT TRADITIONAL FORMS OF HEALTH CARE

For many people in the Third World, traditional systems of medicine and health care have met their health needs for many generations. Such systems are rooted in the world view and social life of the people and is readily available to the community. They rely on

local resources and local practitioners and hence contribute to self-reliance.

Traditional healing covers a very wide range of activities, ranging from religious rituals to bone setting to herbalism. In some countries the role of traditional birth attendants has been very important in midwifery. However, there are also harmful practices in traditional, as in western medicine. The professional politics which characterise Western medicine are sometimes manifest also in traditional systems. Western and traditional medicines share some of the same advantages and dangers. For example, in the Philipines there has been a fad, particularly among the rich, to use 'traditional' medicines including expensive 'honey therapies'. This kind of traditional medicine can be confused with "real" traditional medicines.

The hegemony of Western medicine in Third World countries has over recent decades has led to the neglect and disregard of many traditional practices. There is an urgent need to revive rediscover and conserve traditional medicine as a viable system of health care. It is clear that modern allopathic medicine will not be able to meet the health needs of the majority for a long time to come.

Traditional health systems must be preserved, promoted and allowed to flourish primarily because it is a basic human right of peoples to preserve their culture and traditions. Indigenous health and healing practices are sources of wisdom and learning that may guide scientists in developing health technology that harmonises with nature and the environment. Indigenous health practitioners provide significant amount of health services. Their skills and potentials must be developed and their important role in the health care systems must be recognised and supported.

2. The Political Economy of the Health Crisis

The deteriorating conditions for health in many Third World countries and the damage wreaked upon health systems reflect health hazards of an economic and political kind. Most of the x million people who die of malaria today are victims of poverty and

powerlessness and of economic policies which are implemented without regard to their impact on people's health.

dw - how many people die each year from malaria?

Economic trends trends at the global and national levels are exacerbating this situation. Chief among these are:

- the long range slow down in global economic growth from the mid 1970s;
- the net flow of wealth from the poor countries to rich countries from the mid 1980s, especially in association with the debt crisis;
- increasing polarisation between and within countries of the North and South;
- unemployment and under-employment; and
- continuing environmental degradation.

The dominant policy strategies which are being put in place globally to counter the effects of the global slow down are making the health situation in the developing countries worse. The policy instruments which constitute the new health hazards include:

- structural adjustment programs (SAPs) imposed by the IMF and the World Bank;
- the provisions of the new GATT;
- the policies of WDR93; and
- debt discipline.

Structural Adjustment

Structural Adjustment Programs (SAPs) are the conditions imposed by the IMF as a condition for bailing out heavily indebted less developed countries who have run out of credit. In recent years the World Bank has directed an increasing proportion of its lending to budgetary support in the context of IMF negotiated SAPs. (This funds are thus redirected away from the previously accepted purpose of the World Bank which was to support development focussed projects.)

The indebtedness of many of the poorer countries is understood as being due to failed import substitution policies, grandiose development projects, irresponsible borrowing, inefficiency and corruption, military adventurism, etc. SAPs usually comprise: cuts in public sector programs, user charges for public services and programs, payment of overseas debts, export development, devaluation and the dismantling of national economic

controls.

It is hard to disentangle the impact of structural adjustment from the stresses associated with the economic pressures which have forced the country to accept a structural adjustment package in the first place. Nonetheless there is an accumulating body of evidence testifying to damage to people's health chances and to health systems which are clearly the direct consequence of the policies which have been imposed through structural adjustment.

DS - could you please provide a para or page or so?

The Provisions of the New GATT

The new provisions of GATT will have the effect of increasing the exposure of vulnerable economies to 'free trade'. The effect of this will be different in different kinds of economies, most damaging in the least developed group and in countries which are largely import dependent.

MK - could you please provide a para or two about GATT

The New Health Role of the World Bank

The 1993 World Development Report of the World Bank marks a new move by the World Bank to establish a dominant role for itself in the shaping of world health policies. The 1993 Report is cast in terms of the health needs of poor and middle income countries and but it is clear that the sharp edge of the report will be in the context of structural adjustment programs.

The Report ("Investing in Health") comprises: an overview of world health; an analysis of the conditions for better health; and a set of policy recommendations for health development (with the focus on the health of developing countries).

The argument of the Report starts with the introduction of a new tool for measuring the "global disease burden", namely "disability-adjusted life years" (DALYs). The gobal burden of disease in 1990 measures the present value of the future stream of disability-free life lost as a result of a death, disease or injury in 1990.

The DALY is derived from an older indicator, 'years of life

lost' which is based on age-specific mortality rates and life expectancy. The DALY involves three additional methodological steps:

- future years of life (lost or gained) are given lesser value the further they lie in the future; this is achieved by applying a 3% discount rate for future years, compounding into the future;
- early adulthood is assigned greater 'value' than infancy and childhood and late middle and older ages; this is achieved through the application of a schedule of values of life at different ages;
- the value of future years of life (lost or gained) are adjusted downwards for disabling conditions; this is achieved by a schedule of reduced life year equivalents associated with a range of disabilities.

The DALY, as a unit for describing 'disease burden', is illustrated in the Report with estimates of the present total 'global disease burden'; comparisons of different disease burdens of different countries and regions; and estimations of the contribution to total disease burden of particular disease conditions and groups of conditions.

Having established the DALY as a method for measuring disease burden, a further method is introduced for determining the 'cost-effectiveness' of therapeutic and preventive interventions. This is based on the cost (per intervention or intervention-year) of each DALY achieved (or loss of DALYs averted).

On the basis of the DALY two principles are proposed for resource allocation in the health sector: first, that priority be assigned to interventions which address conditions with high disease burdens (as measured by DALYs) and second, that priority be assigned to interventions which are 'cost effective' (in terms of DALYs achieved for resources outlayed).

The report proposes a very limited role for government in the financing and provision of health care. Government is depicted in the Report as uniformly and inevitably inefficient if not corrupt. In contrast a very wide role is affirmed for private sector. This is based on a very one sided account of the strengths and weaknesses of these two pathways.

Two minimal health care "packages" are proposed based on the above resource allocation principle and the leading role proposed

for the private sector in health care delivery. One package deals with clinical services and one concerns public health.

The public health package includes:

- augmentation of the Expanded Programme on Immunisation, including micronutrient supplementation;
- school health programs to treat worm infections and micronutrient deficiencies and to provide health education;
- programs to increase public knowledge about family planning and nutrition, about self-care or indications for seeking care, and about vector control and disease surveillance activities;
- programs to reduce consumption of tobacco, alcohol and other drugs
- AIDS prevention programs with a strong STD component.

The clinical package includes:

- tuberculosis treatment
- management of the sick child
- prenatal and delivery care
- family planning
- STD treatment
- treatment of infection and minor trauma
- assessment, advice and pain alleviation

These packages are put together in somewhat different forms for the low income countries, middle income countries and for the formerly socialist economies.

The policy recommendations of the Report are proposed as the basis for a new 'health conditionality'. In other words they will provide guidelines to ensure that, at least in the future, structural adjustment packages will be implemented in ways that do not lead to the deterioration in health statistics for which the Bank and the Fund have been so criticised in the past.

Our question is, what effect will this Report have?

The most important place where this report will have its impact is in the context of structural adjustment and accordingly this is where we have focused our analysis.

The first finding of our analysis is that the policy recommendations are highly individualist and are inconsistent and contradictory. There is a strongly individualist emphasis in the public health recommendations:

- mass treatment for worms but no subsidy for sanitation
- micronutrient supplementation but deregulate food markets and land reform not acceptable

There are big contradictions in the health service development recommendations:

- in health financing there is a circular argument about the need for health insurance to support private sector activity;
- in relation to health service development the report urges that vertical programs can be implemented through primary health care.

In the course of trying to work our way through these contradictions we found ourselves increasingly concerned about biases in both the presentation and the underlying analysis. The report provides a very positive account of global health improvement over recent decades. It focuses on absolute aggregate improvements but fails to mention the increasing gap (from 3 fold to 8 fold over the last 40 years in the <5s)

Age Group	1950	1980	1990
Mortality rate ratios:			
< 5	3.4	6.4	8.8
5-14	3.8	6.5	7.0
15-59	2.2	1.8	1.7
60+	1.3	1.4	1.4

Mortality rate ratios across the ages indicated (DDG/(FSE+EME) [Demographically Developing Group/ (Former Socialist Economies+ Established Market Economies)]

The account of the roles of government and the market are very biased including a doctrinaire condemnation of government and special pleading for private enterprise and competition.

The account of the relations between economics and health is quite one-sided. In such a context it is frankly misleading to fail to mention:

- the historical creation of capital out of health;
- competitive pressures on countries to deregulate (eg export of toxic waste);
- links between inequality and health (Wilkinson)

There are also methodological biases built into the in the method of cost-effectiveness calculations. These methodological biases appear to have determined certain important findings and

recommendations. These are the:

- rendering of caring as discretionary and ineffective (because interventions which do not affect the future stream of illness, disability or death are rendered as infinitely ineffective or infinitely costly); and
- determining that investment in water supply and sanitation is not cost-effective (by assigning the full cost of infrastructure development to the health benefits alone).

The report states that, if the costs of an investment in water supply and sanitation are to be justified in terms of improved health then it would be cheaper to the pay for recurrent mass drug administration. This comparison ignores the productivity and amenity benefits in other sectors of social activity. If the costs of the investment were partitioned across a range of other beneficial outcomes the result might be very different.

The key impact of this Report will be in providing guidelines for health policies imposed under structural adjustment programs.

The Report concludes that:

- it is possible to target funding to 'cost-effective' interventions;
- cutting public expenditure is not necessarily bad for people's health;
- governments are notoriously and inevitably inefficient;
- public subsidy for water supply, sanitation and garbage removal are generally not cost-effective and an inappropriate use of public sector health budgets;
- much hospital care is not cost-effective and therefore can be cut without damage to people's health;
- structural adjustment lending can be consistent with health improvement if implemented in association with the recommended health policy packages.

The influence of the Report is direct (in the context of World Bank staff negotiating structural adjustment loans) and indirect through the influence that the Report has had on other donors in their thinking about health. The Report makes it clear that the Bank is well placed to encourage other donors to make the new health conditionality part of their negotiations also.

3. The Links between the Objectives of Current Economic Policies and their Health Effects

Why are the dominant policy movements at the global level so strongly running against the peoples of the South, in the health sector and in other sectors?

The policy directions which are presently being implemented globally will have the effect of protecting the living standards of people in the North (threatened by the limits imposed by environmental degradation and the long run slow down of the global economic system).

The consequences of these policies are having very bad effects on the health of poor people in the South and North

3.1 Maintaining the conditions for rapid economic growth

One of the key policy themes affecting all social sectors including the health sector is directed at the reduction of the tax burden on companies and investors, through reducing company taxation and moving to more regressive tax regimes (eg through reduced income tax and a heavier reliance on indirect taxation). These taxation changes are believed to have the effect of reducing the costs of production and provide the basis for different tax jurisdictions to compete for investment on the grounds of 'tax competitiveness'. The pressure to reduce taxation and the decreased revenue which follows are having dramatic effects on health systems through: the privatisation of service delivery and reducing public expenditure on service delivery and imposing user charges.

DS - can we have a few paras here about the ways in which privatisation, reduced public sector involvement and user charges are affecting health

Another theme of economic policy orthodoxy is the creation of increasing economic inequality through the deregulation of the market sector and the progressive removal of public sector programs. The exacerbation of economic inequality is clearly reflected all over the world in a widening health gap, from New York to Sub-Saharan Africa.

The deregulation of the institutional systems which are necessary for better health is another theme of current policy

orthodoxy. Stark examples of the health impact of the deregulation of health protection is in the field of - environmental protection (eg the toxic waste trade).

3.2 Maintaining the flow of wealth from South to North

A range of policies are being implemented which have the effect of maintaining the flow of wealth from South to North. These include:

- Third World debt (refusing forgiveness; preventing repudiation through the discipline of the WB and IMF and Paris Club);
- introduction of 'free trade' through GATT, whilst denying the effects of declining terms of trade and removing certain arrangements which were previously in place providing positive discrimination with respect to trade for countries of the South

These policies are damaging to the health of people in developing countries.

3.3 Legitimating the Present Global Regime in relation to Health

The interest of the World Bank in health policy is cast in terms of a concern to ameliorate the health conditions of Third World peoples although the need to stoke economic growth is not ignored. We find that the claim to have reconciled the Bank's preferred economic policies with the health needs of Third World peoples is simply not credible.

Nonetheless the Report is superficially impressive and clearly backed by a willingness to spend large amounts of money (on focussed efforts to reduce key mortality statistics and to control population growth). The gloss and the cash will undoubtedly have the effect of creating an appearance of legitimacy around the Bank's involvement in health.

A huge investment is presently being directed at population control, operationalised through very technologically oriented and women-focussed programs (to the neglect of issues such as poverty, social security and gender relations). These programs do not address the institutional and structural factors underlying population growth. However, they do have the effect of directing the attention of environmentally concerned people in the countries of the North to Population as 'the problem' underlying environmental degradation. This was clearly evident at the recent

Cairo population conference. If they are successful (in achieving population control) these programs will also have the effect of reducing the demand from the South on a larger share of global resources (including pollution absorption capacity).

4. Addressing People's Immediate Health Needs in Ways that also Contribute to Redressing the Underlying Structural Conditions

As health workers who seek to address the health problems of our communities we need strategies and models of practice which address the immediate health needs of people in the South in ways which also contribute to opposing the economic and policy trends which are making things worse.

We cannot continue to implement health programs and deliver services to our communities without having regard to such damaging policy directions being introduced at the macro economic and policy levels.

On the basis of the analysis outlined above we have identified a small number of strategic objectives which we believe will enable us contribute to resisting the damaging effects these policies are having on the people of the South.

Objective I. We will work with health workers in Third World countries, developing actions in solidarity and working to develop our shared understandings of the relations between the conditions for health in each country and global economic movements. Actions:

We will strengthen our networks, extending our links within the regions and countries.

We will develop systems to facilitate wider access to information resources (see item 9 below).

We will continue with our work producing resource materials ("Questioing the Solution" and "Water, Food and Solidarity"; a publication analysing and criticising the 1993 World Development Report; the forthcoming health and development bibliography; the report of the Jerusalem Conference).

We will bring together existing materials on the health impact of structural adjustment and collect further more systematic data (see Item 8 below).

Objective II. We will work the popular movements in Third World countries, developing actions in solidarity and and working to develop our shared understandings of the relations between the social conditions in each country, the possibilities for health and global economic movements. Actions:

We will work to increase the circulation of TWR among the popular movements, in particular, by providing TWR with mailing lists of local popular organizations.

We will contribute to strengthening the health input to TWR and the dossiers series by contributing materials and assisting in other ways.

We will participate in campaigns on specific issues (see Item 4 below)

We will develop an "Urgent Actions" alert capacity and network in relation to human rights issues. This will be based on the IPHC network but will develop links with other human rights organisations such as Amnesty and the Boston-based Institute for Health and Human Rights. As an immediate action we will forward a Message of Support to the people commemorating the 10th anniversary of the Bhopal disaster.

We will invite activists from local and regional popular organizations to IPHC/PHN conferences.

Objective III. We will work to contribute to a deeper understanding among the peoples of the North about the relations between the social and economic problems that they are facing; the economic policies they are supporting and the impact these policies are having on the health of the people of the South. Actions:

We will participate in conferences in the North around health and development. We will put forward our analysis of the issues and raise the profile of IPHC. In the immediate term we will be represented by D Sanders at the Bali meeting of the World Federation of Public Health Associations.

We will challenge the Northern donor agencies to take responsibility for developing a wider understanding in the North of the links between the social problems seen as priorities in Northern countries, the macro economic policy choices they are facing and the perpetuation of the conditions of under-development in the South. (See Item 5 below.)

We will develop links with immigrant communities from the South living in the North with a view to working together to represent in Northern political debate the need for different macro economic policies.

Objective IV. We will work with activist networks organizing around specific issues such as arms control, human rights, the control of baby foods, alcohol and tobacco and the influence of the various elements of the narcotics industry. Actions:

We will continue to participate in these networks at the national, regional and global levels (e.g. IBFAN, HAI). Where they are inactive we will seek to activate them if possible.

We will send the statements from IPHC to these groups inour own regions. IPHC in Nicaragua will send to central bodies.

We will liaise with IPPNW and PSR in relation to the arms industry and narcotics with a view to encouraging them to continue to take a more active role in these areas.

Objective V. We will seek to challenge the hegemony of the World Bank's analysis of the conditions for better health in Third World countries and its policy recommendations among the donor agencies and UN agencies. Actions:

We will undertake a campaign in relation to the donor agencies, focussed in the first instance on the Social Summit in Copenhagen. This will involve developing basic resources including a detailed critique of the World Development Report, of the effects of structural adjustment on health, the neglect by the Bank of public sector health service models, such as the UK NHS, the study of ORT as a case study of vertical and technicist interventions. We will prepare a signed Statement (the Penang Statement?) as the focus for the campaign and materials. We will send the Statement to the main donor agencies in the North with an appropriate covering letter.

We will organise a conference in Europe with a view to bringing together European donors, IPHC, critics and community based health organizations from the Third World. This will be directed partly at challenging the hegemony of the World Bank's health policy analysis and partly at challenging the European NGOs to take responsibility for the attitude change in the North. (See Item 3 above.)

We will seek to participate in (or at least make an input into) country-specific working groups and consortia of donor organisations. In the immediate term we will use the the Statement from this meeting to convey our views to the forthcoming meeting of the India consortium of donors.

We will document and disseminate positive examples of health development projects with a view to guiding donor agencies towards providing support for community based health programs. For example: contraception as part of comprehensive women's health care, rather than a vertical program;

comprehensive food and nutrition programs rather than a total reliance on micronutrient supplementation.

Our 'Line': Good policies for health are possible but the present economic policy environment places impossible constraints on implementing these. The policies which are being implemented are damaging to people's health.'

We will make contact also with the forums and networks where alternative macroeconomic policy options are being discussed so that they can take into consideration the health issues and we can develop the economic aspects of our analyses.

We will organise regional workshops involving NGOs, health organizations and popular organizations.

Objective VI. We will collect, study and disseminate case studies of good models of practice which illustrate the principle of addressing the immediate health issues of communities in ways that also contribute to redressing the structural conditions. Actions:

We will develop an inventory of cases studies already documented or published and incorporate these into the bibliography of health and development.

We will invite participants to present case studies at the next IPHC conference in South Africa.

Objective VII. We will document the impact of structural adjustment on people's health and publish widely the results. Action:

This research program will be coordinated through the Institute for Health and Social Justice. The IPHC/PHN networks will provide assistance in identifing reports; in finding the names of people who have been researching the field and identifying possible research partners.

The results of this program will be discussed at the next conference of IPHC scheduled for early 1996 in South Africa.

Objective VIII. Setting up Systems to provide for wider access to information bearing on the current trends and policies on the health of the people in the South. Actions:

We will develop our existing Resource Centers (PRODUSSEP, TWN, HealthWrights and CISAS).

We will continue to develop, maintain and disseminate the "Health and development annotated bibliography". We will prepare and maintain short reading lists on questions of widespread interest.

We will produce packets of reading materials around particular topics available at discounted prices.

Objective IX. We will support the health struggles of indigenous Peoples. Actions:

We will maintain and develop our existing links with the health movements of the indigenous peoples in our regions and countries and seek to develop actions in solidarity with them.