Globalisation and the Impact on Health
A Third World View

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'Man's struggle against oppression is a struggle between memory and forgetfulness'
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Introduction

The *Human Development Report 1999* notes the following trends in this era of globalisation:

- More than 80 countries still have per capita incomes lower than they were a decade or more ago
- Inequality has been rising in many countries since the early 1980s
- The income gap between the world's richest fifth and its poorest fifth has more than doubled to 74 to 1 over the past three decades.
- Sustained economic growth has not reduced unemployment in Europe at 11% for a decade affecting 35 million.
- One person in eight in the richest countries of the world is affected by poverty, long term unemployment, a life shorter than 60 years, an income below the poverty line or a lack of literacy needed to cope in society.
- State provided care is suffering cutbacks
- Public services have deteriorated markedly the result of economic stagnation, structural adjustment programmes or dismantling of state services
- Debt servicing for the 41 poorest countries amounted to $11.1 billion in 1996
- Some 50 million migrants are women, 30 million in the Third World
- AIDS is now a poor people's epidemic with 95% of all HIV infected victims in the Third World
- Some 1.3 billion people do not have access to clean water
- About 840 million are malnourished
- One in seven children of primary school age is out of school
- About 1.3 billion people live on incomes of less than US$1 a day
- Mergers and acquisitions are concentrating power in megacorporations
- Transnationals dominate global markets. They account for some $9.5 trillion in sales in 1997. US based TNCs account for more than a quarter of US GDP - $2 trillion of $7.3 trillion. Capital is becoming more and more concentrated.

Clearly we are witnessing a social crisis both between and within countries of the North and the South. This crisis has its roots in the market economy, which took hold with the development of western industrial society. This model was based on a pattern of production and consumption, which was unsustainable and benefited a minority. It was exported worldwide first during the colonial era and further intensified in the post-war 'Development Decades' that followed.

The Colonial Enterprise

The global social crisis and in particular the health crisis that afflicts the South today can be traced to the European colonisation of South America, Africa and Asia. Beginning with the first wave of European expansion when Columbus landed in the New World, the historical record of this encounter was replete with instances of wholesale plunder, genocide and oppression.

Fifty years after Columbus' arrival, the indigenous populations were decimated by death, enslavement, malnutrition and diseases the white man brought like the common cold, measles, chickenpox, typhus and syphilis as they had no resistance to combat these diseases. In fact, smallpox epidemics were instrumental to the success of the Spanish Conquest. The final solution arrived with the deliberate extermination of populations and the sense of powerlessness, loss of security and identity which followed, took its toll in the psychological and cultural breakdown of the original inhabitants of the New World resulting in mass suicide occurrences.

Hand in hand with colonial conquest, the slave trade, which spanned some four centuries, fuelled the prosperity of the New World, Western Europe and the institutions that participated in it. Sixty million Africans were kidnapped and shipped to the Americas and the Caribbean to work in the mines, coffee, cocoa and sugar plantations. Millions died at sea from over-crowding, hunger, diseases and the inhuman conditions meted out to them. Others were killed during insurrections against their captors; yet others threw themselves overboard. Over two hundred million slaves died in the middle passage across the Atlantic. The slave trade also brought along with it yellow fever, leprosy, yaws and hookworm from West Africa to the Americas.

The slave trade had a deadly impact on African society. Societies disintegrated and the loss of Africa's population bled the continent to death and led to its underdevelopment, which persists to this day. With the second wave of European colonisation sometime in the 1800s, Africa was left with a legacy of massive poverty, economic stagnation, crippling indebtedness, wars and conflicts.

The slave trade was the cornerstone on which colonisation developed and grew. Britain, which took the lead, became the most powerful colonial power by the 19th century. European colonial expansion was accompanied by wars and military campaigns, which adversely affected the local populations. Uprisings against colonial rule were brutally crushed; villages and farmlands were destroyed resulting in death, disease and famine. This was the experience in East Africa in the late 19th and early 20th century where it became the focus for imperialist rivalry between the English and the Germans (Doyal 1979:102-103).

Apart from the importation of new deadly diseases and the deleterious effects of warfare, colonial penetration and unequal treaties led to the social and economic disintegration of native societies as well as their integration with the global market economy. This had a major lasting impact on health conditions in the Third World.

Integration into the Market

To feed the global market economy, new crops mainly for export were introduced in the colonies; new laws and social structures were imposed; new technologies and consumption patterns, which were totally alien, took hold. Subsistence food production gave way to commercial crops and raw materials to feed Europe's industrialisation. Agrarian societies in the colonies were profoundly transformed. Fertile lands were given to grow cash crops with less land to grow food to feed the local population. Food scarcity became a permanent feature and this affected the nutritional and health status of the people.

For example, Bengali peasants under East India Company (EIC) rule in India were forced to grow indigo and kept in extreme poverty as a result of very high land taxes imposed by the Company. Within a few years of Company rule, Bengal's economy was in ruins. Fertile agricultural lands became barren and useless and famine killed some ten million Bengalis. The frequency and

severity of famines which occurred under the rule of the EIC, accelerated under direct British rule when food production was increasingly displaced by commodities like jute, dyes, and cotton.

By the second half of the 19th century, India's industry and economy were in complete ruins. India became one huge plantation for the British to grow tea, indigo, and jute for export. Famine became endemic and reached epidemic proportions under British colonial rule. During this period, more than 20 million Indians died from famine.

All told, British exploitation of India, not only pauperized more than 90 percent of the Indian masses, it left behind a weakened population, susceptible to disease and destroyed indigenous coping mechanisms that had been developed over the course of centuries. This story was replayed in many Third World societies under colonial conquest.

In Java, the Dutch imposed the Culture System, which involved the compulsory use of land and labour for export crops and sugar contracts. Under this system, Java was exploited as one huge plantation owned by the Dutch. Javanese peasants were forced to pay two fifths of the crop they grew as land rent or the cultivation of one fifth of the rice fields in a cash crop. Sugar, coffee and indigo were grown on rice lands, which were expanded to include tea, tobacco, pepper, cinnamon, cinchona (quinine), oil palms, cassava, cotton and cochineal. Corporal punishment was inflicted to enforce compliance. Land and labour was concentrated on the export sector at the expense of rice cultivation.

The labour required for sugar and indigo was more than that required for the same acreage of rice so the peasants could not grow food. This was made worse by the fact that during the height of the Culture System, the population of Java increased by half.

Serious famines occurred, resulting in peasant unrest: starvation and famines became frequent and widespread with the worst in Central Java from 1848 to 1850. This haemorrhage of wealth from Java resulted in phenomenal profits for the colonial government. Over a 45-year period, the Netherlands treasury received some 900 million guilders from Java. It revived Dutch commerce and shipping and made Amsterdam a great entreport for tropical products. It paid off all Holland's public debts, saving it from bankruptcy and Netherlands' railroads and public works were built with these funds. The revenue extracted from Java under the Culture System contributed not less than one third to the annual budget of the Netherlands. In the space of 70 years from 1830-1900 some 2 billion guilders had been drained from Java. The Culture System was a form of semi slavery, which severely retarded Java's social and economic development (Cady 1964:359-367; Vlekke 1959:284-307).

Perhaps the most blatant form of the export of ill health and misery in modern colonial history was the Opium Wars perpetrated on China by Britain. The British wanted Chinese tea badly, which they had to pay in silver, but they had nothing to sell the Chinese in return. The Chinese Emperor in a letter to George III had this to say: 'As your ambassador can see for himself, we possess all things. I set no value on objects strange or ingenious, and have no use for your country's manufactures' (Whyte 1927). The British had only opium[1], which they were determined to trade, against China's laws, despite the fact that opium smoking was prohibited in England. In March 1839, the Chinese Imperial Commissioner burnt all stocks of opium at Canton (the only port opened to the West). War was declared and British naval vessels sank four

[1] The British East India company owned the monopoly to produce and market opium in Bengal which was openly and aggressively promoted throughout Southeast Asia under the protection of the Company by licensed country traders.

warships of the Chinese fleet. The Chinese suffered a humiliating defeat at this war, which was called the First Opium War. At the treaty of Nanking in 1842, the Chinese were forced to pay a large indemnity and had to open five treaty ports with British Consuls appointed in each; whilst Hongkong was ceded in perpetuity to the British. To further open up the Chinese market to the opium trade, the British again entered into another war, this time in collusion with the French in 1856. The Treaty of Tientsin concluded the Second Opium War in 1858, which led to the further opening of China to foreign trade. Opium became a scourge of the Chinese, and debilitated the Chinese Empire, which led to its dismemberment by the Western imperial powers.

Colonial conquest not only destroyed life sustaining societies and social relationships, it resulted in the breakdown of ecological systems and balances which had enabled people and communities to feed and sustain themselves and maintain good health.

For instance in India, colonial policies and administration had led to the neglect of Indian agriculture. As a result, arable land was laid waste, previously reclaimed areas reverted to swamp where malaria and other diseases spread. And soil productivity declined. This environmental degradation forced more people off the land, even as the agriculture sector had to support more people (which had been displaced by rising rents and the collapse of traditional industries). This led to a decline in the small producers and a rise in landless rural labour (Ross 1998:151).

British colonisation also made possible the spread of cholera from riverine areas (where it was initially confined) to the entire Indian subcontinent. The breakdown of local communities and livelihoods and the marginalisation of peoples contributed to the emergence of cholera in India in the 19th century.

Colonial policies, which undermined traditional methods of controlling the physical environment, were also responsible for the outbreak of disease. Until the arrival of the British in East Africa, sleeping sickness was endemic in the region. The tsetse fly, which carries the disease, is known to thrive in dense bush inhabited by wild animals. The African pastoralists were able to effectively control the disease through bush clearing and the control of game. These preventive measures were destroyed when colonial wars, famine and disease took a toll on the human and livestock population. With fewer people to till the land and fewer goats and cattle to graze and keep the bush at bay, coupled with British laws that prohibited burning and hunting, the bush advanced and wild animals moved in to graze. In their wake, the tsetse fly spread. Sleeping sickness affected local economies and the availability of protein in the African diet (Doyal 1979:108-109).

Although medical discoveries and breakthroughs were achieved under colonial rule, (which included the malarial parasite, yellow fever, the transmission of plague by fleas and rats, and sleeping sickness by the tsetse fly), improvements in health were largely determined by colonial economic interests and political expediency. Death and disease posed a constant threat to armies, white settlers and the European business community in the colonies. Thus, overcoming these scourges was vital to the colonial enterprise. It was with this objective that the London and Liverpool Schools of Tropical Medicine were established in 1899 to study tropical disease in furtherance of 'imperial policies' (*Ibid: 241*).

Post-Colonial Development Strategy

'Imperial policies' and the market enterprise did not end with colonialism; it was given a new name with 'Development'. With independence and the postwar 'development decades' that followed, Third World states became tied to the world system of trade, finance and investment with the TNCs in the forefront of this economic order. With the help of local elites, which the

colonial government had successfully nurtured, integration of postcolonial societies into the world economic system became entrenched. To enable the newly independent states to catch up with their former colonial masters, it was believed that economic development was the answer. This panacea for the major ills of the Third World was foisted on the latter in no time.

Aid programmes in the form of 'Development Aid' from the rich Northern countries and the World Bank (WB) and commercial banks, including foundations (like Ford and Rockefeller) and research institutions all played a major or significant role in the adoption of a development model imposed from the North. Cold War ideology played a significant role in development policy and population control was used as a key instrument to further that goal. Under the guidance of Rockefeller III the Population Council was established in 1952. Drawing support from the Ford Foundation and the World Bank, international birth control programmes targeted Third World women exposing them to dangerous technologies very often under dubious circumstances without their informed consent or against their will.

The WB-promoted post colonial model advised Third World nations to plant more commodities for export which led to oversupply, lower prices, falling terms of trade, environmental degradation and increasing poverty.

For instance, USAID, private banks and US led multilateral banks like the Inter-American Development Bank and the WB provided cheap loans to Guatemala to transform its 'backward' economy into an agro-export for the international market. Land concentration and commercialisation of agriculture led to increasing food insecurity among the peasants. In recent years with declining exports, Guatemalan peasants have switched to vegetables, fruits and flowers for Europe and North American markets. Extensive use of pesticides and chemical fertilisers have led to a severe impact on the health of the people and the fertility of the land. By the 1970s American corporate interests had opened up the country for cash crops like cotton, sugar and coffee and cattle production (which took away land for grazing), thus putting pressure on a land hungry rural population. Several generations of Guatemalans have suffered increasing material and nutritional deprivation. By the 1980s, more than 80 per cent of the rural peasantry lived in poverty and over 40 per cent of them lacked even a minimal diet. Some 81 per cent of all children below the age of five suffered from malnutrition and nearly a million peasants were suffering from extreme poverty. This has driven 200,000 Guatemalans to Mexico and the US to seek work. (Ross 1998:125-29)

One of the most significant developments in western development strategy in the postwar era was the commercialisation of Third World agriculture through the Green Revolution (GR). This Ford-Rockefeller inspired and WB backed scheme led to the transformation of Third World societies with effects, which were far-reaching and irreversible. The GR replaced indigenous agriculture with modern agriculture; it led to the use of high yielding seed varieties leading to a loss of indigenous rice and wheat varieties (many of them now only found in the genebanks of the North); the contamination of soils and water systems from the use of pesticides, chemical fertilisers and modern irrigation systems and dependence on modern machinery and technology. Monoculture promoted by the GR in wheat, maize and rice staples narrowed the basis of food security by displacing diverse nutritious food grains. In India alone, per capita pulse consumption dropped by 27 percent between 1964-69 (Wilson, D. 1973:129-144). According to the FAO, by 2000 the world would have lost some 95 percent of the genetic diversity used in agriculture at the beginning of the century.

In Mexico, modernisation of agriculture and the use of costly chemical inputs led to increased indebtedness and the collapse of the state cooperatives (*ejido* sector); concentration of land

holdings, landlessness and increased poverty. By the 1970s, half of the Mexican population was said to be malnourished. Export led growth fuelled a decline in domestic food production at the expense of the dietary needs of Mexico's rural and urban poor. Fodder production for livestock and meat products (which catered to the international market and the wealthy and middle class Mexicans) led to an increase in sorghum cultivation. By 1984, 50 percent more land was devoted to sorghum than wheat. In many areas, sorghum had displaced maize and wheat the staples of the Mexican working class. In fact other feed grains like oats and soybeans have displaced lands used for maize, wheat and beans. Meat (animal) production has gobbled up land from 5 per cent in 1960 to over 23 per cent in 1980; while feed grain had increased from 6 percent in 1960 to over 32 percent in 1980.

This led to the marginalisation of the rural peasantry creating an army of migrant and seasonal workers who led a tenuous existence. This widespread and growing rural unemployment produced a scale of migration to Mexican cities, which was 'unprecedented in the demographic development of Mexico'. (Ross 1998:173-74) This model of development resulted in Mexico becoming increasingly dependent on US food imports. When the debt crisis struck in 1982, food subsidies were cut by 80 per cent. This further intensified pressures on the Mexican rural poor and the rural exodus flooded Mexico City or else they risked life and limb to enter the US.

In India, Punjab was the jewel of the GR introduced in the mid 1960s. Within two decades, it became a cauldron of ethnic conflict and ecological crisis. Punjab was left with a legacy of pesticide poisonings, diseased soils, pest infested crops, destruction of genetic diversity, water logged deserts, indebted farmers increasing income disparities, and conflicts over water resources. Between 1985 and 1991, some 15,000 people had already lost their lives in the violence. The rapid commercialisation and transformation of the economy and society in Punjab precipitated a moral crisis. Traditional social relationships and norms broke down resulting in an epidemic of social diseases such as alcoholism, drug addiction, smoking, the spread of pornography and violence in the community especially towards women and children (Shiva 1991:185).

At the same time, dangerous and hazardous technologies were exported to the Third World. The case of Union Carbide's disaster in Bhopal, India, which killed almost 8000 people and maimed and blinded thousands more, is a telling reminder. Other projects most of which were instigated by the World Bank or TNCs include dams, nuclear power plants, and incinerators. Apart from the health concerns, all these involved many imported components which, the Third World countries had to pay for foreign technologies, inputs, tractors, machinery, materials and even consultancy fees. So to find the money to finance these projects they were forced to export more timber, fish, oil, minerals, cash crops, and a host of others; depleting their natural resources and contaminating their soils, waters and air in the process. This sucked them deeper and deeper into the world economic system. This model is now firmly internationalised. It has become the universal model especially with the collapse of the Eastern bloc.

From the above, it can be seen that colonial rule and post war development strategies played a significant role in the underdevelopment of the Third World. This resulted in serious social malaise and ill health for the majority of the people. This development model has led to increasing polarisation of the North and South (and within countries in the North and South as well). The net flow of wealth from the poor countries to the rich from the mid 80s especially in relation to the debt crisis was $418 billion or the equivalent of six Marshall Plans (Mihevc 1995:11).

The South not only inherited an economically unequal world tilted against their favour; political power relations between the North and the South were entrenched in the UN Security Council where the Allied nations (the US, UK, France, China and the Soviet Union) agreed among themselves just before the end of World War II, that they will have veto powers to police the world.

As global markets expanded, the rich Northern countries encouraged the independent Third World countries to borrow money to finance their development. As a result all manner of loans, aid and instruments were received by Third World governments with the WB playing a crucial role. This money flows to the South, was good for the economies of the rich countries as it expanded the North's markets for goods and the balance of trade was in their favour due to their control of the price of commodities. During 1985 and 1986 alone, Third World countries lost between $60 and $100 billion due to the fall in commodity prices. The Third World countries were faced with a situation where they were getting less and less for their exports but having to pay more and more for manufactured imports from the industrialised North.

At the same time the Third World was accumulating massive debts as a result of skyrocketting interest rates and the oil price hikes in late 1973. In the 1970s, a debt crisis was looming ahead; by 1977, Third World countries were spending 60-90 per cent of their lending just to service the interests on their debts (*Ibid*: 61). The other causes of debt were that monies were spent on armaments, mega projects and infrastructural development which initially were promoted by the IFIs (but now blamed for the crisis which emerged); and non-performing projects and white elephants; while other monies left the country as capital flight to land in the Swiss bank accounts of corrupt politicians and dictators. Over $30 billion left Africa in 1990 as flight capital (Mihevc 1995:130).

Free Market Reform

Meanwhile the post war economic boom was coming to an end. By the 1980s, the global economy was in a deep recession. Northern economic interests were driven to counter this economic slowdown. The governments in the US and the UK took the lead in economic reform and restructuring of their societies. The ascendancy of this economic reform model was consolidated with the fall of the Berlin Wall and the end of the Cold War, when a 'political consensus' on economic policy was spelt out and embraced by the governments in the North.

This economic reform gave new life to the global free market economy. Thus under the 'law of the market' the free market regulates itself. This calls for all power to the market, which actually means unfettered access to corporations to operate free of any institutionalised control. This free market was grounded in the doctrine that:

- the most rational and efficient allocation of resources can only take place without government interference
- economic growth is the measure of human progress
- economic globalisation in which trade in goods and capital can flow across national borders unimpeded in a single integrated market benefited everyone. It leads to growth, efficiency and spurs competition.
- Hence countries will benefit if they become internationally competitive and switch from domestic production for self-sufficiency.

This faith in the free market rests on the premise that human beings are motivated by self-interest and will seek to benefit themselves. Therefore this will yield the greatest benefit to individuals and society. It follows then that individuals will compete with each other to seek their interests. Thus competition among people (as against cooperation) is rational. As such, human progress and advancement is measured in terms of how much members of a society consume (Korten 1996b:184-5).

Under the free market, economic behaviour was deemed apart from social relationships and obligations; economic relationships were separate and independent from social rights and responsibilities that governed all social systems. Unlike in other non-European societies, economic institutions were embedded and dependent on the social system; economic behaviour was governed and regulated by social relationships; and economic activity was carried out to serve the values of society and secure its common interests. This gave rise to values, which affirmed the primacy of the collective good (Polanyi 1957).

The self-regulating free market was characterised by great social upheavals in England where it was first invented and it became the dominant force shaping European civilisation from the 19th century onwards. This international free market system has been shown to be highly unsustainable and destructive to human society.

The global free market has led to the concentration of economic power in the TNCs which is unaccountable to government; it has destroyed resources, the environment and viable social systems; it has created powerlessness and alienation eroding the functions and authority of states and fragmented society; it has increased poverty, and polarised societies; it has led to the breakdown of sociocultural systems and worldviews replacing, the common good, cooperation, the sense of community, spiritualism, respect for life, compassion, tolerance and love with crass economistic values that put a premium on individualism, competition, survival of the strongest, disdain for the weak and the losers, materialism, compulsive consumption, and arrogant secularism.

Free Market Rules

Under this new economic regime, governments privatised state enterprises such that industries, banks, hospitals, utilities like water, sewage and sanitation, railways, and toll highways were sold off to the private sector in the name of efficiency. Public expenditure for social services was cut. Government control and regulation was reduced, hence laws on food, food subsidies, taxes, workers' safety and welfare, environmental protection, and job security were lifted or whittled away to facilitate business (read profits). The role of government was to ease conditions for companies to invest and increase their profits. The free market was allowed to rule, meaning there should be no impediments to the free flow of money, goods, investments and services. Free enterprise also meant individual freedom and responsibility in place of the public good. People and individuals were responsible for their welfare, health and social security and well being.

The dismantling of the State began and the need to mask the benign face of the free market (as embodied in social democracy and the welfare state) was soon removed. In Europe (especially France, Germany and the UK) workers lost their jobs, poverty increased and income inequality especially in Sweden, the US and the UK rose. In the UK, the number of families below the poverty line rose by 60 per cent in the 1980s, and in the Netherlands by some 40 percent. In Canada, US, UK and Australia, at least half the single parent households with children have incomes below the poverty line. By the end of the 90s, economic and corporate restructuring, and dismantled social protection have made jobs and incomes more precarious. Flexible labour

policies, work arrangements with no long-term commitment between employer and employee are the norm. Belgium, France, Germany and the UK watered down their worker dismissal laws and Holland, Spain and UK have emasculated wage bargaining (*UNDP* 1999).

In the transition economies of Eastern Europe and the former Soviet Union, the effects of market reform were devastating. The dismantling and weakening of the welfare state have meant cuts and deterioration in health services and education leading to deteriorating human outcomes. Life expectancy was lower in 1995 than in 1989 in seven of 18 countries – falling as much as five years since 1987. Responsibility for pre-primary education was transferred from the state to parents with drastic consequences for mothers of children. Kindergarten enrollment between 1989 and 1995 plunged from 64 percent to 36 percent in Lithuania and from 69 percent to 54 percent in Russia (*Ibid*).

This shift in the political and economic climate in the North also led to the decline of aid budgets in the Third World, as the rich industrialised countries cut back on overseas aid. This development aggravated the already shrinking social budgets of Third World countries. Official development assistance (ODA) from the OECD's Development Assistance Committee (DAC) decreased by 17 percent between 1992 and 1997 (*OECD* 1997). In the 1980s, the percentage of (ODA) disbursed to countries available for the health sector stagnated in absolute terms and declined as a share of total aid. By the end of the decade barely six percent of total aid went to health (*UNDP* 1992). In 1986 the North spent over 20 times as much on the military as on development assistance (*UNICEF* 1986:72): the US spent over $250 billion annually on arms (Forsberg 1995) while arms spending worldwide is $750 billion each year (Renner 1994). Although bilateral aid was more significant for individual countries, only 25 percent of ODA go to the ten poorest countries, which represent three quarters of the world's poorest people (*UNDP* 1992). In 1998, DAC nations' commitment to health spending was $1.5 billion, the lowest since 1991. Within this total US$578 million was for basic health funding which accounted for 1.3 percent of all DAC nations' commitment to bilateral ODA (*International Federation of Red Cross and Red Crescent Societies* 2000:130). In terms of education, DAC funding totaled $4.4 billion in 1998, the lowest in the decade of which only $434 million was for basic education. These figures are mere commitments, actual disbursements would be less still (*Ibid*: 131). The amount of bilateral ODA disbursed in 1998 was $8.5 billion less than what DAC nations committed.

Since 1994, ODA has fallen from US$60 billion to $50 billion in 1997 (*UNDP* 1999). And whatever aid that is given goes to debt relief or rescheduling not development. Third World countries have a slim chance of receiving substantial foreign direct investment (FDI) so they have to depend entirely on aid for development.[2] Although private foreign investment is increasing, a disproportionate share goes to a few countries like Southeast Asia which despite rapid growth in the last two decades or so, have been overtaken by a severe financial crisis since 1997.[3] Whilst Africa, (where two thirds of the countries are defined by the UN as least developed, received less than five percent of the direct foreign investment in Third World countries in 1994 (Ross

[2] FDI fell from $173 billion in 1997 to $166 billion in 1998. This $7 billion drop was more than double the rise in ODA over the same period (IFRC and RCS 2000:133). Just five countries received 55 percent of FDI in 1998. All the 48 least developed countries received less than one percent of the FDI available.

[3] In fact FDI into the Asean region dropped by 21 percent in 1999 and 22 percent in 1998. (Wain, B Aug. 4-6 Aug. 2000)

1998:203).[4] Thus, the new wave of economic and political reform in the North, has led to a drastic decrease in overall aid to the South, a downward trend which is set to continue. More important, this economic reform model was transplanted on the Third World with adverse results on the population.

This model of economic reform and restructuring was carried out at the global level by the International Financial Institutions (IFIs), namely the WB-IMF and the WTO (World Trade Organisation). The economic reform policies are increasing the health crises in the Third World through instruments namely the WB-IMF imposed structural adjustment policies (SAPs); trade agreements in the WTO; and social and health policies implemented by the international institutions like the WB, WHO and UNICEF.

The Role of the World Bank in Global Economic Reform

The role of the World Bank was further enhanced with the debt crisis, which unraveled when Mexico declared in August 1982 that it was not able to service its crippling debt. This precipitated a financial crisis and jittery bankers were concerned that this could encourage the other debtor nations to default. The World Bank stepped into the breach and implemented Structural Adjustment Policies (SAPs). Through this mechanism, the World Bank played a crucial role in rescuing the private banks by pressuring the Third World to continue debt servicing and thus saving the system (Mihevc 1995:65)

The debt crisis benefited the banks and private creditors of the North enormously. Debts to banks continue to be serviced although no new money has been lent out. Throughout the 1980s, debt service payments grew. Between 1982-89, the total amount paid to banks was $615 billion in interest and amortisation: at the same time, the amount owed to commercial banks soared from $493 billion in 1982 to $629 billion in 1989. New lending from the WB-IMF has been used to pay debt servicing to banks under the guise of structural adjustment lending. From 1983-89, $32.7 billion in loans from multilateral sources went to service commercial bank debt, representing 17 percent of total debt service over the period (Ibid:67).

By the mid 1980s, Third World nations had become net exporters of money (capital) in favour of the rich North. This meant that the flow of actual debt servicing was more than the new inflows of capital (i.e. in the form of loans, foreign investments and foreign aid) (Chossudovsky 1997:51).

In the case of Africa, debt soared from US$204 billion to $272 billion between 1986-90. In 1990, the continent owed 46 percent of their export earnings on debt servicing alone, while financial flows to Africa fell from US$13 billion in 1986 to $8.7 billion in 1989 (Mihevc 1995:129-30). Africa's debt grew faster than that of any other region in the Third World. In 1970, it was US$6 billion, in 1993 it had grown to $300 billion. In 1997 the total Third World debt reached a staggering $2.2 trillion. Hardest hit have been the 41 heavily indebted poor countries (HIPC), 33 of them in Africa. Since 1980, the debt of HIPCs has more than tripled (*UNDP* 1999).

The debt burden has undermined growth, health and education. Debt service payments exceed annual expenditure on health and education in nine HIPCs, and they exceed health spending in 29, including 23 in Sub-Saharan Africa (SSA). Tanzania's debt service payments are nine times what it spends on primary health care and four times what it spends on primary education (*Ibid*).

[4] FDI recipients were Nigeria, South Africa and a few North African states which in 1998 received $8.3 billion in 1998 a fall of over $1 billion from 1997 (IFRC and RCS 2000: 133, 135).

Structural Adjustment Programmes (SAPs)

In 1989, no less than the UN Economic Commission for Africa (ECA) issued a document *African Alternatives Framework to Structural Adjustment (AAF-SAP)*. This was a comprehensive critique of the World Bank's SAP agenda for Africa. According to the ECA, SAPs have not achieved their macro-economic objectives. 'The World Bank was oblivious to the social costs of adjustment: increased poverty and unemployment: 'debt service obligations have become unbearable…starvation and malnutrition, abject poverty, and external dependence have worsened, while other structural weaknesses and deficiencies of the African economies have intensified' (Mihevc 1995:116-117).

The SAPs packages entailed sweeping economic and social changes designed to siphon the indebted country's resources and productive capacity into debt payments and to enhance international (TNCs) competition. They included massive deregulation, privatisation, currency devaluation, social spending cuts, lower corporate taxes, export driven strategies (ie export of agricultural products and natural resources) and removal of foreign investment restrictions. (Clarke 1995:301). In order to find the foreign exchange to pay the debts, countries were forced to export their timber, fisheries, wildlife, minerals, and oil and grow crops for the global market. In the absence of strict regulations in these countries, TNCs polluted water systems, destroyed forests, depleted fish stocks and wildlife, and dumped toxic wastes in the process. In fact, several African countries in June 1988 made the world newspaper headlines when it was revealed that toxic wastes were offered by the North and dumped in some African countries[5]: with soaring debts and the plunge in commodity prices, these cash strapped countries were in dire need of foreign currency.

SAPs was imposed to promote efficiency and a more rational allocation of productive resources based on the market mechanism. More important, through SAPs the WB-IMF set the development agenda of the Third World. Loans were given to debtor countries to 'help them adjust'. But these monies were tied to strict conditionalities. These loans were only granted when the countries agreed to the adoption of a comprehensive programme of macro-economic stabilisation and structural economic reform (Chossudovsky 1997:52) In fact these loans did not lead to the development of the local economy as the donors determined how the funds could be used. None of these monies were channeled into investment. Instead the adjustment loans diverted resources away from the domestic economy and encouraged countries to keep on importing large quantities of consumer goods and food staples from the North. So money granted in support for example, of the adjustment of agriculture was not meant for investment in agricultural projects. The loans could be spent freely for commodity imports including consumer durables and luxury goods. This resulted in the stagnation of the domestic economy, the increase in the balance of payments crisis and the ballooning of the debt burden. With decreasing commodity prices, earnings from the depressed export sector, the debtor countries find themselves unable to meet servicing obligations (*Ibid 52-53*). While commodity prices have tumbled since the early 1980s leading to a decline in the value of exports, an increasing larger share of export earnings had been earmarked for debt servicing.

[5] In 1991, World Bank economist, now Secretary of the US Treasury Lawrence Summers, in an internal memorandum advocated for the transfer of waste and dirty industries from the North to the Third World. Summers wrote: 'I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable … I've always thought that underpopulated countries in Africa are vastly underpolluted; their air quality is vastly inefficiently low compared to Los Angeles or Mexico City'.

In essence this meant that debtor countries will have to devalue their currencies, remove price controls and food subsidies, reduce spending on health care and education, reduce budget deficits, remove tariffs, and import quotas, privatise state assets, deregulate commercial banking systems, and liberalise foreign exchange movements (through electronic transfers). These measures eventually lead to inflation, price hikes in food, consumer durables, gasoline, fuel, farm inputs, equipment; governments curtailing spending; reducing real wages; laying off civil servant jobs; closing down schools, hospitals and clinics; collapse in public investments and domestic manufacturing.

While the IMF-WB dictates budget cuts for social spending, in the indebted countries, SAPs have not targeted military spending which in Third World countries are seven times higher than they were in 1960 (Sivard 1988). The US is the world's biggest arms dealer: in 1999 US contractors sold some $11.8 billion in weapons with $8.1 billion in sales to the Third World (Myers August 22, 2000). From 1972 to 1982 Third World countries' military expenditures rose from $7 billion to over $100 billion while spending on health and education fell. By 1986 the 43 countries with the highest infant mortality rates spent three times as much on defence as on health. By 1988, military spending in the Third World totaled $145 billion which is sufficient to end absolute poverty in the world within the next ten years, satisfy needs for food, clean water, health care and education for all. (*UNICEF* 1990). The Third World is the arms industry's fastest growing market: often promotion is expedited by US aid. Massive supply of arms is increasing armed violence and militarisation in the Third World which has an escalating impact on health.

Through SAPs Northern economic interests (which include the TNCs, banks, and governments) through the WB-IMF dictate economic policy reforms and facilitate globalisation in the Third World.

Impact of SAPs in the Third World

Increased Poverty

Since the 1980s, the social impact of SAPs has been recognised: poverty has increased both in the rural and urban areas; real salaried earnings in many countries have plummeted by more than 60 percent since the beginning of the 1980s; while the situation is much worse in the informal sector. In 1991, a university trained teacher in Hanoi received a monthly salary of less than US$15. In Peru after the IMF-WB sponsored reforms in 1990, fuel prices shot up 31 times overnight and the price of bread increased 12 times: the real minimum wage had declined by more than 90 percent compared to levels in the mid 70s (Chossudovsky 1997:38).

In South America, SAPs have rolled back the progress achieved in the 1960s and 70s. The number of people living in poverty rose from 130 million in 1980 to 180 million at the dawn of the 1990s. One decade of negative growth only worsened income inequalities, while the cost of adjustment fell on the middle and lower income groups, the top five percent retained and even increased their living standards. (Bello 1996:292). Income disparities widened with privatisation and deregulation as massive resources were concentrated in the hands of a few. In Mexico the richest 20 percent received more than 52 percent of the national income while the income of the poorest 20 percent had less than five percent. The number of billionaires rose from two to 24 while 17 million people subsisted on less than $350 per person per year during the Salinas administration (Heredia & Purcell 1996:283).

The shift from food production for domestic consumption to export needs under SAPs has affected nutritional levels. In Brazil, production of foodstuffs per capita like rice, black beans,

manioc and potatoes fell by 13 percent from 1977 to 1984. Per capita output of exports like soybeans, oranges, cotton, peanuts and tobacco shot up by 15 percent. As a result of these policies 50 percent of Brazilians suffer malnutrition (Morris 1996:223)

In Mexico the health budget in the 1980s fell from 4.7 percent to 2.7 percent. Between 1980 and 1992, infant deaths from nutritional deficiencies tripled to rates higher than those in the 1970s as a result of cutbacks in social and health spending (Heredia & Purcell 1996:277). In 1990, half of all Mexicans (42 million) were living in poverty, with 18 million living in conditions of extreme poverty and 'malnutrition has become the normal condition of society' (*Ibid*:282).

In Chile between 1980 and 1990, the proportion of families below 'the line of destitution' rose from 12 to 15 percent while those below 'the poverty line' (but above the destitution line) from 24 to 26 percent. Some 40 percent or 5.2 million people were classified as poor in a country that once boasted of a large middle class. (Bello 1996:291) This has led to increased hunger and malnutrition; for some 40 percent of Chileans the daily calorific intake dropped from 2,019 in 1970 to 1,751 in 1980 to 1,629 in 1990 (*Ibid*:291).

Corruption

Privatisation of public enterprises and downsizing of the civil services have engendered the spread of corruption in the Third World. A recent report reveals that Western business interests pay bribes worth $80 billion a year – about the amount the UN believes is needed to eradicate poverty. It 'is largely the result of the rapid privatisation (and associated practices of contracting out and concessions) of public enterprises worldwide: … this process has been pushed by Western creditors and governments and carried out in such a way as to allow multinationals to operate with increased impunity. Thus multinationals supported by Western governments and their agencies are engaging in corruption on a vast scale in North and South alike' (Hawley: 2000).

Efficient, accountable, adequately paid and well motivated civil services are essential for combating corruption. Civil service reform, a major plank of SAPs since the 1980s has meant downsizing. These cuts as the World Bank discovered produced neither efficiency or increased revenue: eight out of 15 countries in Africa actually increased their wage bills after downsizing from pay offs to retrenched workers. In 40 percent of cases laid off civil servants had to be rehired. An internal World Bank staff report noted in 1999, that civil service reforms were eroding governance (*Ibid*). SAPs induced decline in wages have resulted in lack of motivation, low morale and increased risks of petty corruption among civil servants who remain employed.

Bribery enables companies to gain contracts like public works and military equipment, or concessions, which they would not otherwise have won. In 1999, the US Commerce Department reported that in the last five years, bribery was a factor in 249 commercial contracts worth $145 billion. Yet corruption is increasingly cited as a reason for withholding foreign aid or debt relief for the South, despite the fact that it is through WB-IMF led deregulation, privatisation, and SAPs requiring civil service reform, and economic liberialisation policies, and their manner of implementation that have increased corruption (*Ibid*).

Social Dislocation & Unrest

There is a brain drain from the Third World countries to the North: as many as 30,000 African PhDs live abroad, while the continent itself is left with only one scientist and engineer per 10,000 people. At least 30 million women migrants are in the Third World: a large share of migrants

from the Philippines, Sri Lanka and Indonesia are women, many doing work that is dirty, dangerous and demeaning (*UNDP* 1999).

The situation in many Third World countries is desperate if not hopeless. Anti SAP riots have occurred in many countries as reported by Chossudovsky (1997:36) like the following:

- Venezuela: In 1989, the President declared a state of emergency to quell riots in Caracas sparked off by a 200 percent increase in the price of bread; men, women and children were fired upon and unofficial reports listed a thousand people were killed;
- Tunis, Tunisia: In January 1984, bread riots occurred as a result of the rise in food prices;
- Nigeria 1989: anti-SAP student riots led to the closing of six universities by the military government;
- Morocco 1990: There was a general strike and popular uprising against the government's IMF sponsored reforms;
- Mexico 1993: Economic polarisation and declaration of war by the Zapatista Army of National Liberation (EZLN) in Chiapas, and the assassination of a presidential candidate;
- Bolivia 2000: WB pressured the sale of Cochabamba's water to the US firm Bechtel: the company hiked water rates and citizens took to the streets. Martial law was declared (*The Ecologist* June 2000).

Social Conditions Worsen

Reforms in the social sector have had dramatic impact on the status of education, health, environment and women and children. The restructuring of the health sector had led to the collapse of both preventive and curative care due to the lack of medical equipment, supplies, poor working conditions, low pay of medical personnel and the resulting low morale. User fees in primary health care and education have led to the exclusion of large sectors of the population from health services as they are unable to pay.

In fact the utilisation of health centres by high risks groups dropped when cost recovery schemes and user financing were introduced. In Kenya, user fees at a centre for sexually transmitted diseases, caused a sharp decline in attendance leading to a likely increase in the number of untreated STDs in the population. In 1994, medical experts voiced fears that the introduction of user fees, along with SAPs may be contributing to the rapid spread of AIDs in Africa. In the Upper Volta region of Ghana, health care use plummented by 50 percent when cost recovery was introduced. In Dar es Salaam, Tanzania, the three public hospitals saw attendance drop by 53.4 percent in a matter of months in 1994 when user fees were introduced. In Niger, cost recovery measures implemented between 1986 and 1988 led to: a sharp decline in the use of preventive care services; increased exclusion of the most impoverished from care at Niamey Hospital, where outpatients who did not pay for care would wait some 24 days before seeking care while an outpatient who did have to pay for care would wait an average of 51 days; exemptions that were applied to the benefit of urban, military and civil service families and not for the intended beneficiaries (the most impoverished) led to a drop in already very low primary school enrolment rates: these went from 17 percent in 1978 to 28 percent in 1983 to 20 percent in 1988 (*50 Years is Enough* July 14, 2000).

In Nicaragua, about one quarter of primary school children have not enrolled in primary school since charges for registration and a monthly fee were introduced. However, when school fees and uniform requirements were eliminated in Malawi in 1994, UNICEF reported primary enrollment

increased by some 50 percent virtually overnight from 1.9 million to 2.9 million and the main beneficiaries were girls (*Ibid*).

In China, when user payment for tuberculosis treatment was introduced, some 1.5 million cases of TB remained untreated, leading to 10 million additional persons infected: many of the three million deaths from TB in China during the 1980s could have been prevented (Werner & Sanders 1997:103). Elsewhere, community involvement in health care amounts to replacing the government salaried nurse or medical assistant by an untrained and semi literate health volunteer. The shortage of funds for medical supplies like disposal syringes and pharmaceutical drugs as well as price hikes in electricity, water and fuel (required to sterilise equipment) have led to an increase in the incidence of infection (including AIDS) (Chossudovsky 1997:72). In Sub-Saharan Africa (SSA), the inability to pay for prescription drugs tends to reduce the levels of visits and the use of government health centres so that health infrastructure and personnel is no longer utilised cost-effectively (*Ibid*:72).

Cuts in public expenditure under SAPs have led to a drastic decline in control and prevention measures. As a result, diseases, once under control or eradicated have made a comeback. Sub-Saharan Africa records a resurgence of cholera, yellow fever and malaria. In South America the prevalence of malaria and dengue has worsened dramatically since the mid 80s. The outbreak of bubonic and pneumonic plague in India in 1994 has been seen 'as the direct consequence of a worsening urban sanitation and public health infrastructure which accompanied the compression of national and municipal budgets under the 1991 IMF-WB, sponsored structural adjustment programme' (*Ibid*: 72). The three country studies of the impact of SAPs on health outlined below are from Chossudovsky's research (1997).

SAPs Reform in Peru

Peru implemented SAPs at the outset of the debt crisis and by 1985 estimated food intake had fallen by 25 percent in the space of ten years since 1975: real earnings at the minimum wage level fell by more than 45 percent; the average decline in earnings of blue-collar workers and white-collar workers were 39.5 percent and 20 percent respectively. The annual rate of inflation for the same period was 225 percent. In 1990, a new government carried another round of economic reform under IMF tutelage. Since 1985, Peru had declared a moratorium on the payment of debt servicing obligations and the country was on the IMF blacklist. The new government unconditionally accepted to reimburse Peru's debt areas to the IFIs. This was through negotiations of 'new loans' earmarked 'to pay back old debts'. Peru was obliged to start servicing its debt immediately. As a direct result of these loans Peru's debt servicing obligations more than doubled in 1991 from US$ 60 million a month to over $150 million (*Ibid*:193).

The growing economic crisis led to another round of economic stabilisation, which entailed an 'economic shock treatment' as a condition for the renegotiation of its external debt. To solve Peru's hyperinflation, wages were further lowered and social expenditures cut further together with the massive lay-off of public sector workers. A few days before the 'Fuji shock' a state of emergency was declared in Peru on 8 August 1990. The IMF austerity measures led to a reduction of health and educational expenditure and the collapse of civil administration in the regions. The *Sendero Luminoso* (Shining Path) insurgency gained ground and under the Fujimori regime, controlling the insurgency became a pretext to systematically harass civilian opposition to the IMF programme like the peasant movements, trade union leaders, students, intellectuals and activists. The IMF programme had an immediate impact on the rural economy: domestic producers were displaced by cheap food staples imports; immediate and abrupt hikes in the prices of fuel farm inputs, fertilisers and agricultural credit; in many areas cost of production was more

than the farmgate price; many peasant communities could not sell their surplus in local markets and increased prices of fuel and transportation cut them off from the cash economy (*Ibid*: 205-207).

The cholera epidemic in 1991 received worldwide news coverage. News reports at that time quoted the President who blamed it on the debt crisis. With a thirty-fold increase in cooking oil prices, the population including the 'middle classes' could not afford to boil their water or cook their food. Some 200,000 declared cases of cholera were detected and 2000 deaths registered in a six-month period (*Ibid*: 201).

Since August 1990, tuberculosis had reached epidemic levels aggravated by malnutrition and the collapse of the state vaccination programme. The breakdown of the public health infrastructure had led to a resurgence of malaria, dengue and leishmaniasis. In July 1991, an indefinite strike by teachers and health workers had closed down schools, hospitals and universities as monthly wages were on average $45-$70 which was 40 times lower than wages in the US. In the-mid 90s, more than 83 percent of the population did not meet the minimum nutritional requirements. Peru had the second highest rate of child malnutrition in South America (*Ibid*: 201).

Famine in Somalia

Until IMF-WB intervention in the early 1980s, agriculture in this country was based on reciprocal exchange between nomadic herdsmen and traditional agriculturalists. In the 70s commercial livestock was developed and this affected the nomadic herdsmen. Until 1983, livestock contributed to 80 percent of export earnings. Despite recurrent droughts, Somalia was virtually self sufficient in food until the 1970s. From the-mid 1970s to mid 1980s, food aid increased fifteen fold at 31 percent per annum. The influx of cheap surplus wheat and rice in the domestic market soon displace local producers and caused a shift in food consumption patterns to the detriment of traditional maize and sorghum (*Ibid*:102).

The IMF led austerity reform to service Somalia's debt led to a dramatic decline in purchasing power, the deregulation of the grain market, and the influx of 'food aid' led to massive impoverishment of the farming communities. In June 1981, the devaluation of the Somali shilling led to hikes in the prices of fuel, fertiliser and farm inputs. This affected both the rainfed agriculturalists and irrigated farming communities. At the same time Somalia was encouraged to produce 'high value added' fruits, vegetables, oilseeds and cotton for export, on the best-irrigated lands.

Prices of livestock drugs increased with devaluation: user fees for veterinarian services and the vaccination of animals were introduced; the functions of the Ministry of Livestock were phased out and the Veterinary Laboratory services were to be fully financed on a cost-recovery basis. The privatisation of animal health together with the absence of emergency animal feed during drought periods, the commercialisation of water and the neglect of water and range land conservation led to the decimation of the herds and the pastoralists who represent 50 percent of the population. The World Bank had succeeded in wiping out the herdsmen and the traditional economy (*Ibid*:103).

Aid was increasingly given in the form of food aid. By the 1980s, ' the sale of food aid' (government would sell this on the local market) was the principal source of state revenue and the donors were thus in charge of the nation's budget determining what monies were spent where. When the herds' died and nomadic herdsmen were pushed into starvation, the small farmers could not barter or sell their grains for cattle. The entire social fabric of the pastoral economy

disintegrated. The collapse in foreign exchange earnings from declining cattle exports and remittances (from the Gulf) affected the balance of payments and led to a breakdown in the government's economic and social programmes (*Ibid*:105).

By 1989 health expenditure had declined by 78 percent in relation to its 1975 level. From 1981-1989 school enrolment dropped by 41percent. Nearly a quarter of primary schools closed down. By 1989 real public sector wages had declined by 90 percent as compared to the-mid 70s. Average wages in this sector had plunged to US$3 a month, leading to a breakdown in the civil service. Debt servicing obligations represented 194.6 percent of export earnings. IMF cancelled its loan because of outstanding areas. WB froze a structural adjustment loan for $70 million in June 1989 due to Somalia's poor macro-economic performance (*Ibid*:104). Somalia has not had a national government since faction leaders overthrew the 21 year dictatorship of Mohammed Siad Barre in January 1991.

Thus famine in Somalia and the collapse of civil society was not (due to a shortage of food) caused by drought, desertification and civil war which were the official causes and which led to US military intervention in 1993 in the guise of 'Operation Restore Hope'. It was the disintegration of the peasant economy and the destruction of its agriculture. US grain surplus destabilised domestic food production. Since the early 80s grain markets were deregulated under WB supervision (*Ibid*: 106). The nomadic and commercial livestock industry was destroyed by SAPs. Subsidised beef and dairy products from the European Union destroyed the pastoral economy. European beef imports to West Africa increased seven fold since 1984. EU beef sells at half the price of locally produced meat, and Sahelian farmers are finding that no one is prepared to buy their herds (*Ibid*: 106). Thus food aid leads to famine. Years of economic deprivation and conflict have swelled the capital Mogadishu with the influx of refugees and gunmen.

SAPs role in undermining food security has been repeated throughout Africa. Food aid to Sub-Saharan Africa since 1974 has increased by more than seven times and commercial grain imports have more than doubled. SAPs undermine all economic activities that do not serve the interests of the global market (*Ibid*: 106).

Economic Reform in Vietnam

The end of the Cold War and the demise of the Soviet Union affected the Vietnamese economy. In 1986 free market reforms under the guidance of the WB – IMF was launched. The same prescriptions were doled out; devaluation of the currency; the closure of state enterprises; downsizing the civil service; removal of tariff barriers, subsidies; deregulation; and restructuring of the Central Bank. One of the conditions for the normalisation of economic relations and the lifting of the US embargo was that Vietnam had to pay for the debt incurred by the US backed South Vietnamese regime during the liberation war. The effects of the economic reforms can be compared to a new phase of economic and social devastation in the aftermath of the Vietnam War, which ended in 1975 after 50 years of struggle (*Ibid*: 149).

By 1994, the free market reforms had contributed to the closing down of more than 5000 out of the 12,300 State owned enterprises. The most valuable state assets were transferred to joint venture companies. Through a series of deliberate manipulation of the market forces, and IMF intervention, the State economy collapsed. There was a hidden agenda to the economic reforms in Vietnam, namely to destabilise the country's industrial base such that all heavy industry, oil and gas, natural resources and mining, cement and steel production were restructured and taken over by foreign capital with Japanese conglomerates in the lead role (*Ibid*:152). In the agriculture

sector, Vietnamese farmers were encouraged to switch to 'high value' cash crops for export. The 'local level self sufficiency in food' policy which was devised to prevent regional food shortages was done away with under the guidance of the World Bank and the FAO. Thus overcropping of coffee, cassava, cashew nuts and cotton together with falling world commodity prices and the high cost of farm inputs have led to severe food shortages and outbreak of local level famines. In areas where rice growing had been abandoned following the policy of 'regional specification' food shortages struck (while rice was being exported below world market prices) (*Ibid*:159).

In 1994 famine occurred in a border province with China which affected 50,000 people. In the Mekong Delta, World Bank data revealed that more than a quarter of the adult population had a daily energy intake below 1800 calories. Fall in real earnings, massive unemployment and soaring food prices (due to the removal of food subsidies and price controls) also affected the urban population with lower levels of food intake and a deterioration in the nutritional status of children as a result (*Ibid*: 160). The deregulation of the grain market triggered famine and led to a high incidence of child malnutrition.

According to the World Bank: 'Vietnam has a higher proportion of underweight and stunted children (of the order of 50 percent) than in any other country in South and Southeast Asia with the exception of Bangladesh. The magnitude of stunting and wasting among children certainly appears to have increased significantly…. it is also possible that the worsening macro-economic crisis in the 1984 – 1986 period may have contributed to the deterioration in nutritional status'. A FAO nutrition study revealed that Vitamin A deficiency (which causes night blindness) is widespread among children in all regions of the country except Hanoi and the southeast. The FAO study also confirmed a situation of severe undernourishment, with the adult mean energy intake per capita per day for the country was 1,861 calories with 25 percent of the adult population below 1,800 calories. In nine percent of households, energy intake by adults was less than 1,500 calories (*Ibid*: 160-61).

Health System Collapse

Until 1989, the district hospitals and commune level health centres provided medical services and essential drugs free of charge. With reforms, a user fees system was introduced and cost recovery and the free market sale of drugs were applied. Consumption of essential drugs (through public distribution) declined by 89 percent. With complete deregulation of the pharmaceutical industry and the liberalisation of drug prices, imported branded drugs sold exclusively in the free market at enormous costs have displaced domestic drugs. By 1989 domestic production of pharmaceuticals had declined by over 98 percent compared to its 1980 level. A large number of drug companies closed down and Vietnam's pharmaceutical and medical supply industry was pushed into bankruptcy.

The government discontinued budget support to the health sector (under the guidance of the donors) which paralysed the public health system. There was no money for medical equipment and maintenance; salaries and working conditions declined. With the emergence of private practice, tens of thousands of doctors and health workers fled the public health sector. By 1991, commune level health centres were not working. There was no annual check-up for TB; no medicines, and farmers could not afford user fees at district hospitals.

With the public health system in shambles, there was a resurgence of infectious diseases like malaria, tuberculosis and diarrhoea. A WHO study revealed that malaria deaths increased threefold in the first four years of reforms with the collapse of curative health and soaring prices of anti-malarial drugs. In the words of the World Bank: 'despite its impressive performance in the

past, the Vietnamese health sector…there is a severe shortage of drugs, medical supplies and medical equipment and government clinics are vastly under utilised. The shortage of funds to the health centre is so acute; it is unclear where the grassroots facilities are going to find the inputs to continue functioning in the future' (*Ibid*: 168).

In the area of education, Vietnam had 90 percent literacy rates and school enrolments were among the highest in Southeast Asia. However economic reforms have resulted in shrinking the educational budget, depressing teachers' salaries, and commercialising secondary, vocational and higher education through the introduction of tuition fees. School enrolment declined and a high dropout rate in the final years of primary school has been recorded. The proportion of graduates from primary school who entered the four-year lower secondary education system declined from 92 percent in 1986 - 87 to 72 percent in 1989 - 90. A total of nearly three quarters of a million children were pushed out of the secondary school system during the first three years of the reforms. The economic reforms have systematically undone some 40 years of struggle and efforts of the Vietnamese people. This will have severe repercussions on health as education is an important determinant of health: where the mother's educational level is the single most important determinant of infant mortality among the poor.

According to the Ministry of Labour, War Invalids and Social affairs (MOLiSA) joblessness is becoming a major concern for this nation of 77 million people. Unemployment has risen from 6.8 percent in 1998 to 7.4 percent in 1999. With less land for cultivation and increasing unemployment, uncontrolled migration to the cities is now widespread. More than 30,000 Vietnamese have gone to work abroad. Vietnam has workers in some 38 countries and the numbers are expected to increase by about half a million in 2005 (Nguyen Nam Phuong July 11 2000).

Thus the World Bank and IMF through SAPs have successfully destroyed domestic economies, disintegrated societies; enhanced the integration of countries into the global free market; increased the dependence of indebted countries on the North for their survival; empowered the role of the TNCs in controlling their economies; facilitated the spread of corruption; and increased poverty and hunger and a deterioration in health in these societies.

The Global Assault on Health

In the wake of the freedom struggles against colonialism and repressive regimes, for self-determination and independence, many Third World societies in their attempts to create self-reliant models of development carried out people – centred national policies. In the area of health, many remarkable advances were made.

China's contribution to public health was the 'barefoot doctor' model which was based on community led health initiatives and the integration of traditional Chinese health systems in healthcare: its success in eradicating schistosomiasis through mass mobilisation inspired health workers the world over. China's success was the outcome of its liberation movement. Elsewhere, the experiences of Cuba, Vietnam and Tanzania in adopting people centred approaches and the growing emphasis on the socioeconomic causes of diseases and health was gaining attention.

Pioneering work in community based health initiatives were also carried out by individual health workers and community workers working on their own. In the 1960s and 70s, these grassroots programmes centred on participatory and awareness raising approaches, grew in India, South Africa, Bangladesh, the Philippines, Nicaragua, Mexico, Costa Rica, Honduras and Guatemala (Werner & Sanders 1997:16). In India, significant achievements were made in Primary Health

Care which became the basis of people driven manpower development, community health, research, public health services and the inclusion of indigenous health systems. India's pioneering work in TB research had a major impact on TB programmes all over the world including the North (Banerji 1999:235).

WHO under Attack

These developments help trigger major changes and a paradigm shift also occurred in the WHO and its policies. In 1978 WHO introduced an *Action Programme on Essential Drugs* and in 1981 the World Health Assembly passed the *International Code of Marketing of Breastmilk Substitutes*. This resulted in fierce opposition to WHO from the food and drugs industry. Both the pharmaceutical and baby food companies campaigned vigorously against these developments. When the *Code* was passed, the US was the single country to oppose it on the grounds that this would interfere with free trade. Shaken by this success, the pharmaceutical industry (many of which were also baby foods manufacturers) decided to kill any moves by WHO to frame an international code on the marketing of pharmaceuticals: the US leapt into action and withdrew its contribution to WHO in 1986 and 1987. Despite this, the WHA in 1988 approved the 'WHO Ethical Criteria for Medicinal Drug Promotion' but this was subverted by the International Federation of Pharmaceutical Manufacturers' Associations (IFPMA) which produced its own self regulatory marketing code (Hardon 1992). The IFPMA is the Secretariat for the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH). The ICH is the leading global regulatory regime on pharmaceuticals led by corporate interests. The world's twenty-five largest firms have adopted nearly all of the first set of guidelines. With the ICH, the pharmaceutical lobby together with the European Commission have disempowered the role of WHO in the regulation of the pharmaceutical trade (Braithwaite & Drahos 2000).

The tobacco companies have not been idle either: their sustained undermining of WHO was recently uncovered. WHO has issued a report detailing the covert activities of the tobacco industry dating back to the 1980s, which included having ostensibly independent surrogates attack the credibility of international health organisations and spin the concern with smoking as a First World issue, not worthy of the Third World's attention. Based on tobacco company documents that surfaced in recent lawsuits, WHO reveals that the tobacco companies created bogus front groups, misrepresenting research, pitting other international organisations against the WHO and lobbying to cut its funding. The Report reveals that some consultants served both WHO and the tobacco industry. No one knows for certain the extent to which this industry campaign is still being waged. But the tobacco industry will gear itself up to fight the WHO in October when negotiations to frame the international tobacco control treaty starts: by diluting the treaty language that would leave Third World consumers unprotected (*IHT* Aug 4, 2000). There is too much at stake for the tobacco industry with an annual turnover of US$400 billion. By the year 2030, tobacco will kill 10 million worldwide; some 70 percent of tobacco related deaths will occur in the Third World unless current trends are reversed. The WHO Director General noted that: 'By 2020 the burden of disease due to tobacco is expected to outweigh that caused by any single disease'.

The Alma Ata Declaration

However, the real challenge to the global free market in the area of health, was the WHO – UNICEF Alma-Ata Declaration (AAD) in 1979. Alma-Ata was inspired by the changes and experiments in healthcare, which in turn was a result of the struggles and attempts at social

transformation, by societies in the Third World. The AAD was the culmination of this radical approach to health and health policies.

In this historic document, Primary Health Care (PHC) was the cornerstone of community self-reliance. It affirmed health as a fundamental human right; it called for: peoples' participation in health care; the responsibility of governments for the health of their people; community self reliance and self-determination; intersectoral approach to health; social control over health services; use of traditional health systems; provision of essential drugs and social justice and government commitment to health for all by 2000. In short, Alma Ata addressed the underlying social, economic and political causes of illness and disease.

The community based health initiatives which formed the basis of Primary Health Care in the AAD, were part of a larger struggle by the marginalised for their well being and rights. The emphasis on addressing the root causes of the poor health and efforts to put health in the hands of the people posed a threat to entrenched interests, namely the elites, governments and the medical establishment, who had the monopoly on knowledge and the power of healing (Werner & Sanders 1997:19). In some countries community health workers were harassed or arrested: in Latin America, anyone found in possession of David Werner's pathbreaking book, *Where There Is No Doctor* was either arrested, brutally dealt with or even shot.

The Alma Ata document posed a direct challenge to the economic and political thinking of the day. It was only a matter of time before a full-scale attack against its principles was launched.

Undermining Primary Health Care

The sustained attack against the AAD has also come from international public health 'experts' associated with the large donors of the North. The first salvo was fired with the invention of the concept of Selective Primary Health Care (SPHC). This was launched to strip PHC of its comprehensive and revolutionary characteristics and reduce it to a narrow technocentric approach (*Ibid*:20).

The justification for SPHC was that Primary Health Care (PHC) was too ambitious a project, therefore one should be selective in choosing areas that are cost effective. Led by the Rockefeller Foundation, PHC was considered 'costly and unrealistic: high risks groups need to be targeted with 'selective cost effective interventions.' SPHC was reduced to a few high priority technological interventions determined by international health experts with no role for the communities: the emphasis on socio economic development was removed, together with the need to include other areas that related to health in the focus of the programmes. The centrality of involving communities in the planning, implementation and control of PHC was done away with (*Ibid*:23).

Although, countries like Nicaragua and Mozambique did carry out PHC in the Alma Ata mould in the 1980s, and showed impressive health improvements; these successes were shortlived as they were destabilised by the US and apartheid South Africa respectively.

UNICEF's role in SPHC

In 1983, UNICEF adopted a new child survival strategy of health interventions called GOBI (growth monitoring, oral rehydration therapy and immunisation). This was expanded to include family planning, food supplements and female education (FFF). GOBI was an instant hit with donors and money poured in from the World Bank, USAID, the Vatican and Rotary International.

By the 1980s almost all Third World countries were promoting GOBI (*Ibid*:25). Many countries however limited their child survival campaigns to oral rehydration therapy and immunisation, which UNICEF called the twin engines of the 'Child Survival Revolution'. In India, GOBI was reduced to the distribution of oral rehydration solution packets and immunisation: in family planning, the focus was ante natal care namely registering pregnancies and nutrition (food supplements) meant the distribution of iodised salt, iron and Vitamin A supplements (*Jan Swasthya Sabha* 2000:21).

UNICEF's endorsement of SPHC through GOBI was a major shift in health policy, and had profound implications. SPHC and GOBI put paid to the ideals of Alma Ata and 'was a way for governments and health professionals to avoid dealing with the social and political causes of poor health and thus preserve the inequities of the status quo.' … UNICEF's policy 'was tantamount to accepting inequity and poverty as unalterable facts of life' (Werner & Sanders 1997:24-25).

Thus these 'vertical' 'top-down' programmes were claimed to be as good as the comprehensive local service model promoted under the name of Primary Health Care. Instead of local communities deciding their health priorities, these were instead set in some far off capital or by the World Bank and thrust on the entire population. It was not just selective health care: it was selection of health priorities by a distant medical burreacracy not even by local health officials, let alone the people. Thus if a particular area has a major disease like hepatitis or snakebite, there is no mechanism by which SPHC can respond to these problems let alone be aware of it *(Jan Swasthya Sabha* 2000). By the 1980s the WHO, UNICEF and WB had launched the global initiative for SPHC focusing on immunisation, AIDS and TB. Many concerned public health experts have questioned the scientific validity of the concept. The global initiative programmes were criticised for its 'inconsistencies, contradictions and was deemed scientifically flawed'. These programmes do not take into account the extreme variations among and within Third World countries under the 'prefabricated' global initiative (Banerji 1999:239).

Thus the claim that these global programmes are cost effective given the wide variations among and within countries was contradictory whilst the selection of the health problems targeted for action conformed to the special interests of the North. These international initiatives were highly technocratic and the very antithesis of community self-reliance promoted in the Alma-Ata.

The Indian Experience with SPHC

In the case of India, the Universal Programme of Immunisation/Expanded Programme of Immunisation (UPI/EPI) was revealed to be a failure. The EPI was launched by WHO in 1974 to immunise the world's children against six diseases namely measles, polio, diptheria, pertussis, tetanus and tuberculosis (TB). By the-mid 80s, Northern donors began to concentrate their resources for PHC in the EPI. Under the global objective set by WHO and UNICEF, 80 percent of the world's infants will be immunised by 1990. The EPI/UPI programme of India, which began in 1985, was the largest in the world. But it began to unravel when a joint Government of India, WHO UNICEF evaluation in 1989 showed immunisation coverage was less than a fifth in the two thirds of the population which accounts for the most poor and for most of the infant mortality in the country (*Ibid*: 247). The study revealed that reports of immunisation coverage had been exaggerated by 100 percent or more to please the national and international officers responsible for administrating the programme. The surveillance system was non-existent and no potency tests were carried out at the time of inoculation. At least 56 deaths were recorded due to the vaccination process (*Ibid*: 247).

The WHO Global Programme for AIDS (GPA) which was shaped in the US did not take into account the variations in the epidemiological behavior of the disease and its complex, social and cultural dimensions worldwide, which required a flexible approach to programme formulation. The first Union Budget (1992 – 1993) after India submitted to IMF conditionalities saw a 20 percent cut in the health allocation (including the TB programme). However, the WB and WHO assisted India in setting up the National AIDS Control Programme (NACP) which accounted for a quarter of the total allocation of the health budget in the same financial year (*Ibid*: 248). Because the NACP was designed on the US model, many of the basic assumptions have been questioned (*Ibid*: 248).

WHO's declaration of the tuberculosis problem as a 'Global Emergency' in the 1990s took the health community by surprise: the database to justify such a sweeping declaration was virtually non-existent (*Ibid*: 243). TB became a problem however in the US and the North when the AIDS epidemic activated TB in many AIDS victims and led to its spread. This TB outbreak was 'extrapolated to the entire world' and the Global Programme for Tuberculosis (GPT) was born. A campaign was launched in a massive effort to identify TB cases in entire populations in which DOTs (Directly Observed Treatment with Shortcourse Chemotherapy) was applied. DOTs entails regular monitoring of patients by health personnel to ensure that patients take their medication regularly. This was impractical and designed to fail. The option of involving the community in case detection of TB and monitoring compliance is not considered though the success of such an approach has been demonstrated. Increasingly, concerns have been raised among public health proponents that DOTs has been promoted as a single intervention worldwide, without taking into account the socioeconomic inequalities that underlie the resurgence of TB.

The prefabricated DOTs driven agenda of the GPT was hardly impressive. In India the major epidemiological, sociological, economic and administrative flaws in the GPT were highlighted by tuberculosis workers. India has had a distinguished record in tuberculosis research and control, which was acknowledged worldwide. But the 'overriding priority given to international initiatives all down the line have led to the neglect of other services provided at the grassroots level including TB work' (*Ibid*: 230). Thus the imposition of global initiatives under SPHC has led to in the words of Prof. Banerji, 'a frightening spectacle of distortion of the principles and practice of international public health by WHO, UNICEF and the World Bank… It has virtually decimated the somewhat promising growth of people oriented health services in a country such as India' (Ibid:250).

SPHC in Africa

In Africa, the story is no different. By the mid 1980s, donors were pouring large sums of money into the EPI. This initiative was carried out when the continent was reeling under the burden of SAPs. African governments were struggling with deficient budgets and coping under tremendous pressure in a situation where communication and transportation systems barely existed; communities were highly impoverished and poorly educated; and government health workers remain unpaid.

Donors concentrated their money on a single intervention i.e. immunisation. This purely technical topdown and fragmented approach used vertical systems, and highly selective assistance. The EPI took precedence and other health needs and services became neglected. While it did achieve short term and measurable results, it was not sustainable. There was no community involvement. It was increasingly clear that such global initiatives preclude national and local participation. As it was donor driven, quick and visible results were the desired objectives (Weeks: 2000).

The same problems surfaced with the 'eradication of polio by the year 2000' initiative under WHO. Large numbers of refrigerators, the backbone of the EPI programme, were sent to Africa despite the absence of effective equipment inventory and maintenance systems.[6] These global initiatives are highly visible, measurable and short-lived. Eradication strategy involves national mass immunisation campaigns, which are concentrated during only a few days of the year. According to a public health expert: 'Donor funded campaigns provide a carnival-like atmosphere. Banners with organisations' logos fly; T-shirts and caps are given away; celebrities make an appearance. Such big media events provide visible, evidence of action by governments and donors. Eliminating a disease from the planet appeals to the North's fast paced hi-tech culture…..diverts us from the more complex reality: the declining quality of life for millions in poverty, environmental degradation and the failures of our development projects.' WHO was involved with other donors in selling a product called 'eradication' (*Ibid*).

To date many countries in Africa have yet to achieve the global immunisation target of 1990. In 1998 only one of 21 countries in SSA managed to achieve the 80 percent global coverage target for more than one vaccine. None were able to sustain coverage of 80 percent or better for three consecutive years between 1995-1998. (*Ibid*) This global immunisation agenda is being carried out at the expense of malaria and HIV/AIDS, which are posing a more serious threat to Africa. In short the global initiatives for SPHC has undermined existing public health services, by creating conflicting priorities between the targets of donors and local community needs. It has led to the dismantling of primary health care approaches. Indeed, 'when a child has received ten or even more doses of oral polio vaccine, dies from measles, dehydration or malaria; or must grow up malnourished without parents because of the AIDS pandemic or in urban squalor, without hope' what has been achieved with polio eradication? (*Ibid*).

UNICEF and User Fees

In response to the crippling impact of SAPs, UNICEF announced the Bamako Initiative which promoted user-financing in rural health centres. Health cutbacks under SAPs had led to the closure of many rural health posts because of the lack of medicines: to keep them stocked and functioning, fees were charged for medicines. The Bamako Initiative was very well received by donors especially the US, as it shifts the cost of health care from governments to individuals. The drug companies were happy because it actively promotes and increases the sales of medicines to the poor. Thus cost recovery schemes through the Bamako Initiative have aggravated inequities, 'since the distinction between willingness and ability to pay has not been addressed'. It has resulted in the rapid expansion of the private sector and irrational and expensive drug use (*The Ukunda Declaration* 1990).

The Role of the World Bank

Despite the growing criticism leveled against the Bank for its indifference to the precipitous decline in living standards and the social conflicts that have resulted from its structural adjustment programmes, it released *Financing Health Services in Developing Countries: An Agenda for Reform.* With this 1987 publication, the World Bank gave notice that it intended to play a prominent role in global health reform. The thrust of *Agenda* was clearly the role of health financing as a conditionality in SAPs. Hence the promotion of the role of the market to finance and deliver health care. In 1993, the World Bank's *World Development Report: Investing in*

[6] In 1994, WHO reported that surveys carried out in four of six regions revealed that up to a third of immunisation injections were unsterile (Bland & Clements 1998:172).

Health outlined its agenda for health reform. This was a comprehensive policy document on market driven healthcare combining health sector financing and delivery.

The *Report* recognises that poverty is a threat to health but does not address the issue of economic inequality and poor health. It states that economic growth is a condition for good health, that is, economic growth will fuel good health and better population health will result in more secure economic growth, but does not tackle the health consequences of unbridled economic growth which has led to greater income disparities and wider health differentials in countries. In fact, under the guise of promoting cost-effective, decentralised and country appropriate health systems the *Report's* key recommendations follow from the same line of thinking and solutions in SAPs that have worsened poverty and lowered levels of health (Werner & Sanders 1997:104-106).

In this *Report*, health is evaluated in terms of the Global Burden of Disease measured in Disability Adjusted Life Years (DALYs). DALYs incorporate questionable assumptions about the value of life. The Bank assigns different values to years of life lost at different ages. The value for each year of life lost rises from zero at birth to peak at 25 years and then declines with increasing age. Thus the very young, the elderly and disabled people are less likely to contribute to society in economic terms hence considered less valuable: so, fewer DALYs will be saved by health interventions which address their ills. Therefore public money and support should not be wasted on interventions for these social groups. Thus resources allocated to the health sector is determined by interventions which address conditions with high disease burdens (as measured in DALYs) and priority will be given to interventions which are cost effective.

Two minimum packages are proposed based on resource allocation and the leading role for the private sector in health care delivery. The first deals with clinical services and the second with public health. The policy recommendations of the *Report* are recommended as the basis for a new 'health conditionality'. Thus guidelines are provided that SAPs will be implemented in ways that do not lead to the deterioration in health statistics for which the IFIs have been criticised in the past (*The Lone Pine Statement* 1994). The Bank's three pronged approach for governments is to:

- 'Foster an enabling environment for households to improve health'. In effect this means that disadvantaged families are required to cover the costs of their own health. In other words fee for service and cost recovery through user financing (user fee) and putting the burden of health costs on the poor.

- Improve government spending in health. This calls for trimming of government spending by reducing services from comprehensive coverage to a narrowly selective, cost-effective approach or a new brand of selective primary health care.

- 'Promote diversity and competition in health services'. This deals with the turning over to private doctors and businesses most of those government services that used to provide free or subsidised care to the poor. This implies privatisation of most medical and health services, thus pricing many medical interventions beyond the reach of those in greatest need (Khor 1994).

Privatisation and Profits

The *Report* affirms a wider role to the private sector and proposes a limited role for government in the financing and provision of health care. In fact, the State's role is to facilitate and strengthen private initiative since government is depicted (in the *Report*) as inefficient if not corrupt, and health care is too expensive to be paid for from State coffers, the private sector is the competent

authority to manage it for profits. Data for South America reveal that implementation of the WB proposal would release $38 billion for the private sector (Laurel & Arellano 1996: 14). Health care then becomes a commodity and the health sector becomes a place to accumulate wealth.

In many Third World countries, this process has been accelerating whereby the dismantling of the public health sector has spurred the corporatisation/privatisation of the health sector and the growth of private health insurance schemes. Privatisation in these countries is selective and confined to sectors, which are profitable. Thus the proposal to assign and essential health package to the public sector and reserve discretionary services for the private sector.

In Malaysia, where the public healthcare system is under threat, there has been an explosion of private healthcare services in the last two decades or more. In 1996 the Health Ministry privatised the five hospital support services at the University Hospital, namely cleaning, laundry, clinical wastes, maintenance of biomedical equipment and emergency power supply. Since then, costs have increased by 250 percent (*Malaysian Medical Association*: April 2000). Skimming was very much the order of the day. In one instance the Health Ministry awarded a RM100 million contract to a company which subsequently subcontracted it for RM 65 million to a second company. The first company earned RM35 million in profit for doing nothing. In another example, the Health Ministry tendered a separate contract to the same company mentioned above for RM60 million, which again subcontracted it to the same second company for RM 40 million. The second company in turn subcontracted it to a third company for RM20 million. Profits were made by all the companies through the subcontracting mechanism at the taxpayers expense (*Ibid*).

With the corporatisation of the University Hospital, the latter in March 2000, further increased charges by over 100 percent for many essential lifesaving procedures like the electrocardiogram (ECG) which saw a price hike from RM20 to RM40; exercise ECG from RM120 to RM240; angiogram from RM600 to RM1300; and emergency heart pacing which was free in the past, has been slapped with a fee of RM700 (*Ibid*). Patients who cannot afford these fees[7] are refused these essential procedures and referred to the welfare section. Poor patients cannot afford these fees and many feel humiliated going through the process of being refused and told to depend on kith and kin to foot the bill. Increasingly, public health services are being subsidised to cater for the middle class and the rich (*Ibid*).

The *World Bank Report's* proposal for increased health insurance coverage (for middle income countries) where consumers are given a choice between public and private insurance, in effect ensures the collection of funds (through compulsory savings) to the private sector. It provides a criterion (with the amount paid in premiums) which can be used to separate those who are profitable from those who are not. This will serve to redistribute funds from the public to the private sector. This means funds are not distributed according to need, as in the case of collective State funds but according to individual premiums, thus separating out the higher payers for the private sector. Complementing this is the growth of hospital corporations.

In South America, serious cutbacks in State health expenditure in the context of SAPs necessitates the use of private health funds, as public funds are insufficient to cover the cost of private services. Thus the growth of private insurance is crucial to the consolidation of a private health system provision and insurance, parallel to the State public system. Through this mechanism private health care gets access to a major portion of health resources covering the needs of a minority of the population, thus reducing the resources of the State system which is

[7] The mean monthly household income in Malaysia is about RM2000 (US$1=RM3.8) while the bottom 40 percent of households earn only RM672, which shows income disparity is increasing.

responsible for the majority. In Chile, the private system covers 20 percent of the population and concentrates over 40 percent of all resources used (Laurell & Arellano 1996:16).

Under this free market model, health is no longer considered an absolute human need: it is a private good, rather than an inalienable right. Health is subjected to the forces of the free market where free choice and competition is the golden rule. This means the dismantling of the state welfare system. The model acknowledges the laws of the market to determine whose health is profitable for investment and who should live or die. This approach can only lead to a growing health gap between private affluence for the rich minority and public scarcity for the majority. This exclusionary principle abolishes the concept of health for all (as enshrined in the Alma-Ata) and equity and social justice.

Because of its financial clout and political influence, the Bank *Report* has had an influential impact on Northern donors shaping their thinking about health. It is now subscribed to by aid agencies, other international organisations and Northern donors. Thus countries who are willing to implement these health policies can receive aid to finance the costs of these structural changes in the health sector.

Because of its financial leverage, the Bank can make Third World countries accept this blueprint for health as it has done with SAPs. In the words of a Bank economist 'Policy lending is where the bank really has power – I mean brute force. When countries really have their backs against the wall, they can be pushed into reforming things at a broad policy level normally, in the context of projects, they can't. The health sector can be caught up in this issue of conditionality' (Kamran, A. 1999).

The World Bank has taken over the role of international health policy formulation leaving the WHO on the sidelines. The Bank Report dealt the final blow to the Alma Ata Declaration.

The World Trade Organisation (WTO)

The WTO came into being on 1st January 1995 after the completion of the General Agreement on Tariffs and Trade (GATT) Uruguay Round in 1994. It is headed by its highest authority the Ministerial Conference comprising member states and meets at least every two years. The day to day operations notably dispute settlement procedures and trade policy review are overseen chiefly by the General Council which reports to the Ministerial Conference and a number of subsidiary bodies. The WTO is not a part of the UN, nor is it a specialised agency of the UN like the World Bank and the IMF. Although the WTO is a successor to GATT, it covers not only areas pertaining to trade in goods but includes trade in goods, services and ideas and knowledge systems. Unlike GATT which is only an Agreement the WTO has a formal identity as an intergovernmental organisation. It contains a framework for the enforcement of rights and obligations to Agreements.

The WTO is the body that governs international trade. It is the maker and enforcer of rules that limits every nation's ability to make its own laws and policies to protect its national interests. It is thus vested with immense power and authority over trade matters overriding nations and their right to sovereignty. The WTO administers and enforces more than 20 international trade agreements and its rules and agreements have an enormous impact on all facets of life affecting nations and societies namely, in the economic, political, social, environmental and cultural spheres.

WTO's central premise is that global free trade must not be impeded by national governments even if national laws have been put in place to protect the environment, vulnerable groups and social justice. National governments must apply the 'least trade restrictive measures' to achieve environmental and health protection. For example laws that allow a government to protect the environment, or workers and consumer health; subsidies to promote energy conservation or sustainable farming methods will be against free trade and WTO rules. Under 'nontariff barriers' any measure that is not a tariff but inhibits trade is forbidden by governments. In this manner, it becomes illegal when governments ban dangerous technologies, contaminated or toxic foods and products, and culturally unsuitable TV programmes and films. What is even more alarming is that the WTO requires that the future laws of all member states must also comply with WTO rules. Thus national governments when promulgating new laws or amending them must ensure that their national legislation conform to WTO rules. Under WTO, all corporations must be given 'national treatment' which means that national governments cannot give preference or favour domestic companies and their citizens.

Thus under the WTO, the rule of governments are weakened and the unfettered power of the transnational corporations are strengthened. It serves as the government of the world order for corporate interests. Although it is and inter-governmental body comprising member states, it is the TNCs that sit on the important advisory committees which decide policy and set the agenda. In the case of the US, members of the Advisory Committee for Trade Policy and Negotiations include IBM, AT&T, Bethlehem Steel, Time Warner, Corning, Bank of America, American Express, Dow Chemical, Scott Paper, Boeing, Mobil Oil, Amoco, Pfizer, Eastman Kodak, Hewlett-Packard, Weyhauser and General Motors (Clarke 1996: 301-02). The US proposal for an agricultural agreement was not only written by a Cargill senior executive, but Cargill (the largest agricultural corporation in the US) employees lead the US negotiations throughout the Reagan, Bush and Clinton presidencies (Koivusalo 1999). WTO trade agreements have been described as a bill of rights for corporate business.

The Dispute Settlement Body (DSB)

The WTO operates under rules of secrecy as the most important negotiations are held behind closed doors among the cabal of the most economically powerful nations from the North namely the US, the European Union, Canada and Japan (also known as the Quad). WTO control is carried out under the dispute settlement system. It is a very powerful instrument to pressure governments to fall in line. The dispute settlement is conducted by secret tribunals. Under the WTO Dispute Settlement Understanding (DSU), administered by the Dispute Settlement Body (DSB) the latter will establish a panel comprising normally three persons who sit in closed sessions. These persons are bureacrats (not elected officials) from member nations with expertise in trade policy and trade laws only. The panel members upon receiving written submissions from the parties in the dispute, will submit a report to the DSB. When a party makes an appeal, it will be referred to the Appellate body (AB) of seven members. The report of the AB has to be adopted by the DSB (Das 1998:133). The panel will hear only the trade representatives of the national government. Citizens groups, the press or other non-commercial interests are not allowed in.

Thus should a dispute arise or an issue with important health or environmental implications be challenged, the panel of three has the authority to define and determine what is considered a health or environmental issue in the context of competing trade interests. Decisions of the panels are thus not made on the basis of social and environmental judgements. For instance in the hormone beef case, concerns of carcinogenicity based on studies carried out by the International Agency on Research of Cancer (IARC) were dismissed as not sufficiently specific for the purpose

(WTO 1998). The WTO rules requires conclusive scientific evidence of a risk before a trade in food products can be restricted.

Once a ruling is made, the country which has lost its case can change its national laws to conform to WTO rules; pay permanent compensation; or face punitive trade sanctions from the other member country. The DSB has had a record of ruling against health, environmental and social concerns. These decisions invariably favour corporate interests. Thus commercial considerations are deemed higher than social and human rights and the laws of nations or international laws that are in the public interests. Little wonder then that the DSU is considered by no less than the WTO Director General as the 'jewel in the crown' of the WTO system.

For example, in 1997 the WTO dispute settlement panel sided with the US in its challenge to a European Union (EU) ban on beef treated with growth hormones that have been scientifically linked to cancer and other serious diseases. In a January 1998 appeal the WTO upheld its decision ruling that the EU law violated WTO rules. In July 1999, the US imposed WTO approved retaliatory sanctions on the EU for its refusal to accept US hormone – treated beef, slapping 100 percent tariffs on $116.8 million worth of European imports including fruit juices, mustard, pork, truffles and Roquefort cheese (Brown *et al* 2000a: 192).

The WTO Appellate Body had ruled that the EU ban was not based on adequate scientific evidence. The EU's defence was that the ban was justified by the Precautionary Principle - a basic tenet of international law.[8] The Precautionary Principle allows countries to protect their citizens based on scientific evidence of risk, but before the scientific proof of harm is conclusive (Goldman & Wagner 1999). The WTO's rejection of the Precautionary Principle opens the floodgates to public health and environmental threats and undermines the ability of states to protect the environment and the health of its citizens.

Recent developments have revealed that the DSU has been used to tilt the balance against the South in a system which was already highly skewed and imbalanced and unjust. Through a steady process of interpretations usurping the authority vested in the WTO Ministerial Conference and the General Council, the dispute settlement system and its panels have with single minded purpose eroded the rights of the South and increased their obligations. The interpretations of the panels and the Appellate Body have further enhanced the rights of the North especially the US. For example when the EC brought a case against the US S.301 in January 1999 (The S.301 family of laws include Special 301 and Super 301 refers to Sections 301-310 of the US Trade Act of 1974), the panel ruled that while the US law was in violation of the WTO, WTO members and the trading community could be satisfied with the US administration which has given an assurance to Congress (which was repeated before the panel) that in implementing the law it would do so in a manner that is not in violation of its WTO obligations.

The WTO rules that every member must bring its laws into conformity with the WTO. However instead of ruling that the S301 should be brought in line, the panel gives no finding or ruling on this basis instead says the DSB can in view of the US assurances, accept it and not make any recommendations to the US. This ruling is 'so blatantly based on politics rather than a legal interpretation of the rules that it strengthens the view that the WTO is basically a power based institution in terms of not only its negotiated agreements but also their administration' (Raghavan 2000:5)

[8] The Precautionary Principle is included in various multilateral environmental agreements eg Rio Declaration, Cartegena Protocol on Biosafety and the Treaty on European Union in the Treaty of Amsterdam.

The US had used a Special 301 Watch List to threaten South Africa in April 1998 concerning its Medicines Act which the former claimed had violated intellectual property rights; it also threatened Thailand with Super 301 to prise open the Thai tobacco market and to prevent the latter's production of AIDs related drugs.

Health Implications

It can be seen that the WTO has far reaching implications for health and health policy. Although broad public health concerns are deemed to have been dealt with in the clauses on public health, public order and slave labour set out in Article XX of the GATT and its consequent elaboration in relation to sanitary and phytosanitary measures (SPS) they are heavily biased towards trade considerations. The nature of these public health measures is not defined and in the process of dispute settlement, there is a danger that the decisions of the WTO DSB will prioritise the interests of trade and restrict definitions of what are considered public health measures, given the non-transparent nature of the DSB and its partisan views.

The DSB panel may seek information from any relevant source and consult experts and with respect to factual issues concerning a scientific or other technical matter, a panel may request an advisory report in writing from an expert review group. However, whilst expertise on health and social policy issues may be heard in the panel discussion, decisions of panels are not made on the basis of the judgements of these experts (Koivusalo:1999; Rowson:2000), as can be seen in the beef hormone case.

The WTO rules stipulates that in a trade dispute, products must be compared to 'like' products regardless of the methods or practices, which have produced them. Thus a country should not exclude a product from its imports, even if they deem that the production of that product involves risks to health, society or the environment. For example, foreign beef imports derive from cows fed with hormones or antibiotics must be treated as similar to beef without hormones or antibiotics in them even when domestic laws ban such practices. In the same manner, the US has argued that genetically modified (GM) products are technically 'like' non GM products especially in cases where GM organisms have been used in part of the production process, so member states have no grounds for imposing import restrictions. This was the reasoning behind the WTO dispute panel's decision when it initially found that France's ban on white asbestos violates Canada's right to access French markets. Since the latter according to the dispute panel, imported concrete containing asbestos which is 'like' or 'similar' to domestically produced concrete containing non toxic cellulose.[9] Similarly, products made by compromising labour rights and or safety measures are considered to be identical to those which have been produced with respect for these standards (*Ibid*).

The requirement to treat 'quite like' products as 'similar' even if they differ in fat, alcohol, salt, fibre, tar, nicotine or any content whose level is important for health will undermine government attempts to promote healthier diets and lifestyles. Similarly, if countries restricted market access, imposed higher taxes or set higher prices for products with negative health impacts eg alcohol and tobacco, problems of discrimination will arise. For instance the dispute between Japan and the European Commission on taxation of alcohol resulted in a ruling that the price and alcohol content could be considered as discriminatory if they set foreign producers at a disadvantage compared to domestic producers (Koivusalo 1999). In the case of the tobacco dispute concerning

[9] However, the panel decided that France had to prove that asbestos is toxic (under an exception clause which allows member states to prevent import of a product to protect public health).

the lifting of import restrictions on imports of foreign cigarettes, under GATT between the US and Thailand, the panel's definition of necessary measures gave way to trade principles instead of public health and required Thailand to abolish restrictions on cigarette imports (Kinnon 1998).

To date, the dispute settlement decisions have shown that 'least restrictive trade measures' should be applied to address public health and safety concerns. As a result, there appears to be pressure to use labelling as a guide to matters of health concern e.g. labelling of GMO foods in place of systematic regulatory mechanisms like taxation, banning of access, advertising or use (Koivusalo 1999; Rowson 2000).

Although labelling can improve consumer choice and address concerns about food allergens, its effectiveness remains questionable, as in mass food catering, which will affect the ability of consumers to make a choice and how labelled products will be dealt with; and how much data can be presented on labels; and how far this represents real and accurate information. Labelling puts the burden of responsibility to regulate and make decisions on health and safety issues on the individual thus undermining the responsibilities of public health and environmental authorities to provide sufficient safeguards covering production methods and processes used (*Ibid*).

The WTO has included many issues not pertaining to trade but which are crucial to the economic interests of the North; for example the Agreement on Agriculture (AOA); Trade Related Intellectual property Rights (TRIPs); the General Agreement on Trade in Services (GATs); and the Agreement on Technical Barriers to Trade (TBT). Although the Agreement on the Application of Sanitary and Pytosanitary Measures (SPS) relates to the protection of human, animal and plant health and life, all the above mentioned Agreements have important implications for public health and safety.

The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS)

The SPS Agreement has particular relevance to the trade in foods: it deals with issues related to food safety and animal and plant health laws. The Agreement recognises the rights of governments to protect human, animal or plant life or health based on sound principles and scientific evidence and that the measures are not used as a pretext for erecting technical barriers to protect domestic markets. It should not discriminate between member states with similar or identical conditions prevailing. The Agreement states that members must base their SPS measures on international standards, guidelines and recommendations if they exist.

While the WTO agreements are based on relevant international standards, it is not always defined who or what should be the body which sets the international standards, thus creating opportunities for industry led self regulation.

Though the SPS Agreement explicitly mentions some international benchmarks, there is a danger that commercially driven voluntary standards and codes of conduct which are lower than the standards of international regulatory agencies will be used (Koivusalo:1999) This will have serious implications for health.

The international standards used in WTO disputes and as the basis of international standards in food matters are the Codex Alimentarius (CA). The CA is defined by the Food and Agriculture Organisation (FAO) and the WHO and has acquired new importance with trade liberalisation under the WTO regime. However there are concerns that the CA has been dominated by commercial interest. Between 1989-91, 96 percent of the non-governmental participants or national delegations represented industry and Nestle sent 38 representatives to Codex committee

meetings, which is more than most countries. In the committee on pesticide residue levels, 33 percent of participants came from agro chemical and food corporations. This raises questions concerning the objectivity and impartiality of the Codex in scientific assessment (Koivusalo: 1999).

For example in the 1990s Codex allowed residues of DDT on numerous foods in sharp contrast to the US ban on DDT imposed in the 1970s (Goldman & Wagner 1999). Forty two percent of the Codex standards for pesticides are lower than US EPA & FDA standards and fifty times more DDT may be used on or left in residual amounts on peaches, bananas; and thirty three times more DDT may be applied on brocolli (Goldsmith 1996:90).

In the beef hormone case, the EU challenged the CA standard. The Joint FAO-WHO Expert Committee on Food Additives which is an advisory body to the CA Commission had concluded in 1988 that 'residues resulting from the use of (these substances) as growth promoters in accordance with good animal husbandry practice are unlikely to pose a hazard to human health' (WHO 1988). This evaluation had provided the basis for the relevant CA standard. The dispute settlement panel and the AP both found that the EU's ban was inconsistent with the relevant articles of the SPS Agreement. In other words, that the EU had not conducted appropriate risk assessment or provided scientific evidence to support its ban (Kinnon 1998).

We have seen how the guidelines of other international scientific bodies have been ignored for example in the beef hormone dispute, IARC studies were considered irrelevant. The beef hormone case clearly shows that risk assessment has been defined in highly quantitative and scientific terms measuring specific exposures generated by specific products and the effect on human health or mortality. This excludes low level exposures which are technically impossible to measure and does not allow scope for the application of the Precautionary Principle thus opening up areas for future disputes for instance in the recent dispute with the EU, Canada challenged the EU's standards for exposure to asbestos which are more stringent. While asbestos is acknowledged as a carcinogen, the carcinogenicity of asbestos at low exposure is very hard to show, even when a known risk exists.[10]

Narrowing the intepretation of risk assessment in such a manner ensures weak and loose regulatory standards (Koivusalo 1999). The fact that the DSB panels comprising individuals with competence in trade laws and policies are given the authority to judge the legitimacy of national regulations such as health in which they have no expertise; in the absence of any transparent or open process and public scrutiny goes against all rules of fairplay and justice. Even worse, the decisions made by the DSB can pose a threat to public health and safety.

Given that the overarching aim of the WTO is to facilitate trade, the guiding principles for food safety measures is towards 'downward harmonisation' of health and environmental standards, risks assessment supported by scientific evidence and equivalence. This will pose a major challenge to international standards in health protection currently being developed eg WHO's *International Framework Convention on Tobacco Control*; as well as others like the *International Code of Marketing of Breastmilk Substitutes* (Koivusalo 1999); *The Revised Drug Strategy* and *The Cartegena Protocol on Biosafety*.

[10] The WTO panel's interim report has rejected Canada's claim that the ban constitutes an obstacle to trade (*The Financial Times* 15 June 2000), upholding the French ban. This is the first case where the panel has upheld a trade-restrictive public health measure which will have implications on future disputes and the application of international health and environmental laws and standards in trade disputes.

There are other grey areas which hold the potential for future disputes. These are issues where scientific uncertainty is large or where regulatory measures currently in place are not geared to assessments of specific products, that is, they are not very exact in their assessments of the risks of specific products, but geared more to addressing risky or problematic practices, misuse or abuse. These could cover the following issues based on Koivusalo's (1999) research and analysis:

- Implementing precautionary measures in cases where scientific evidence does not exist or is problematic due to minor risks of widespread exposure which has potentially serious long-term implications, e.g.:
  - substances with potential hormonal or carcinogenic impacts; bioaccumulative substances;
  - substances with population-level associations with chronic diseases;
  - substances in relation to which prior knowledge of related substances suggests caution e.g stabile organo-chlorine compounds or hormone derivatives.

- Regulating new or newly developed products where scientific evidence and risk assessment procedures may remain confidential and protected due to their commercial nature, e.g.:
  - GM foods, bio- and genetechnology products;
  - newly developed pharmaceuticals;
  - pesticides and other chemical products;
  - food additives.

- Implementing regulatory measures to deal with inappropriate measures in production methods which have broader health implications than simply those related to consumption or use of the end product, e.g.:
  - GM foods and 'terminator seeds' which may give only one crop;
  - Use of antibiotics and hormones in cattle breeding.

- Implementing regulatory measures where the product as such may not be dangerous to health but where regulatory measures may be the least costly and easiest way of avoiding inappropiate use in the local context, e.g.:
  - breast milk substitute marketing and marketing products for children;
  - any products for which health impacts are related to inappropriate use e.g. medicines.

The Agreement on Technical Barriers to Trade (TBT)

The TBT Agreement also has a bearing on the production, labelling, packaging and quality standards of pharmaceuticals, biologicals, foodstuffs and other technology assessments (Koivusalo 1999). It deals with various aspects of food labelling, and with claims relating to health and nutrition, which are made for food products. The Agreement also covers other health related commodities, medicinal products and medical devices.

The TBT Agreement encourages member states to apply internationally agreed standards as a basis for their technical regulations, but unlike the SPS Agreement it does not identify them. As the TBT covers a very broad range of products, the Agreement does not specify the international standards to be taken as a reference. Should a trade dispute arise involving biologicals, the dispute settlement panel might have to take a decision on which standards should apply to that case. They could be WHO's guidelines and requirements for good manufacturing practices for biological substances (e.g. vaccines and blood products) or the norms of another standardizing body. This will bring on uncertainty as to what might happen in a dispute e.g. like vaccines; for which manufacturers have differing, yet equally valid standards. It might raise the issue of

whether to apply WHO's standard or those of industry, both of which are recognised under the TBT Agreement (Kinnon 1998). These concerns have far reaching implications for health.

The Agreement on Trade Related Aspects of Intellectual Property (TRIPs)

TRIPs came into effect in 1995. It imposes minimum standards in seven areas of intellectual property i.e. patents, copyright, trademarks, geographical indication, industrial design, and undisclosed information (trade secrets) and covers diverse areas as computer programming and circuit design, pharmaceuticals and transgenic crops. TRIPs was devised based on standards of the North and conflicts with the national interests and needs of the Third World countries. For instance most Third World countries previously exempted medicines, agriculture and other products from national patent laws but with TRIPs almost all knowledge-based production is subject to tight intellectual property protection. Third World nations have to adjust their laws to conform with TRIPs by 2000 while the least developed countries by 2016. The latter will be confronted with severe financial and administrative constraints (*UNCTAD* 1996:2-3).

Negative Impact

TRIPs ignores the profound differences in economic and technological capabilities between the North and the South, and is an instrument of 'technological protectionism' aimed at consolidating an international division of labour where the North generates the innovations and the South will be the market for the resulting products and services. It is a move by US corporate interests to establish global rules to counter their declining competitive market edge in world markets (Correa 2000:5).

TRIPs will affect the Third World by increasing the knowledge gap; and by shifting bargaining power towards the producers of knowledge most of whom are in the industrialised North (Koivusalo 1999). This will be most strongly felt in the area of patents and its effects on the prices of medicines.

Although the positive effects of TRIPs on the South, have been touted by the North, in terms of technology transfer, foreign direct investment (FDI) and research and development (R&D) innovation, there is scant evidence of this taking place. In fact the strengthening and expansion of intellectual property rights (IPRs) will affect the access to and use of technology and the Third World's prospect for industrial and technological development; stronger IPRs means higher costs in terms of royalties and other payments and reduce resources available for local R&D; scientific and technological protectionism is a growing problem as the increasing economic relevance of scientific research limits the free dissemination of research results and constrains the traditional openness of university laboratories where most basic research is conducted in the North – this will reduce the Third World's prospects of improving their social and economic conditions (Correa 2000:33).

In terms of domestic innovation, most Third World countries (with the exception of the East Asian 'Tigers', India and Brazil which have built up their R&D) are not likely to improve their innovative performance on the basis of a stronger and expanded IPRs regime: Third World countries' share in world R&D expenditure is negligible declining from some six percent in 1980 to about four percent in 1990, they are thus overwhelmingly dependent upon innovations made in the North (*Ibid*:5, 38). As for FDI, the UN concluded that companies in the North will rather sell their products and services that incorporate innovations than transfer the technology through FDI and licensing agreements which would result in more exports by the developed North and less opportunities for transfer of technology to the Third World (*Ibid*:27).

The North's dominance of intellectual property can be seen from the following data: 97 percent of all patents worldwide is concentrated in a handful of countries; in 1993, ten countries accounted for 84 percent of global R&D; 95 percent of patents granted in the US over the past two decades were conferred on applications from ten countries which captured more than 90 percent of cross-border royalties and licensing fees; 70 percent of global royalty and licensing fee payments were between parent and affiliate in TNCs; and more than 80 percent of the patents that have been granted in the Third World countries belong to residents of industrial nations. (UNDP 1999:68) The TRIPs Agreement represented a major victory for the North and their industrial lobbies. It provides an enabling environment for the TNCs to tighten their dominance over the ownership and control of technology and impede and increase the cost of transfer to the Third World (Correa 2000:21; UNDP 1999:34).

Although Article 27.3(a) of TRIPs allows member states to exclude from patentability diagnostic, therapeutic and surgical methods used for the treatment of humans and animals, pressure is expected from industry to expand their rights further to exploit the innovations emanating from the health care industry. As such, concerns have been raised regarding moves to broaden the scope of (IPRs) to include medical and health technologies and issues such as surgical, diagnostic and therapeutic methods, especially with the development of gene therapies in the health care industry.

Privatising Knowledge

In the area of medicine and health, stronger and wider IPR protection will affect the practice of medicine and the spread of medical knowledge. This will lead to the privatisation of medical knowledge, restricting its access and removing the free flow of scientific exchange for the public good. Protectionism of medical knowledge and medical practice commodifies medicine further and threatens well being and public health.

This is already happening in the US where patents have been registered for a number of medical technologies which will affect the practice of medicine with implications on human health and welfare. Some example cited from Coleman include:

- A US surgeon patented a particular type of cataract operation and warned other surgeons that they have to pay a royalty for the use of the procedure;
- A doctor owns the rights to a basic suturing technique;
- A doctor own the rights to the technique of making a slit in a skin graft in order to expand it;
- A doctor has patented the practice of applying the anaesthetic lidocaine to the skin to treat nerve pain associated with shingles;
- A doctor has the right to the idea of treating a nosebleed with a catheter wrapped in gauze;
- A doctor has a patent on a technique to treat piles;
- A radiologist owns a patent covering the technique for determining the sex of a foetus aged 12 to 14 weeks with ultrasound – which relies upon the radiologist's ability to distinguish male genitalia from female genitalia;
- A Swiss drug firm owns a patent on all *ex vivo* human gene therapy, due to its ownership of a patent to treat a rare genetic disorder – such broad patent rights prohibits any scientist from repeating the patent owner's experiment to check results and verify them;
- US courts have stopped doctors prescribing life saving treatments when rival companies claim to own part of the underlying technology;

- Cancer patients in the US have been refused treatment with a drug made by one company because a second company claimed its rights were being infringed (Coleman April 2000).

Article 39 of TRIPs obligates member states to protect data and undisclosed information of commercial value. In the case of pharmacueticals and new chemicals, strict data confidentiality may hinder or prohibit prompt action especially when there is a reason to doubt the decision made (e.g. adverse drug reactions of the drug) and there is a need to re evaluate the licensing decision that have been made. This problem may arise in relation to medical research and the assessment of health technology, as much clinical research is funded by the private sector and research could be corporate driven. Further protection of IPRs will shift research and innovation from the public sphere of scientific exchange towards the corporate sector (Koivusalo 1999).

Protection of commercial information could pose a problem to governments in terms of their ability to regulate contracted out services in health care. In terms of public health, lack of access to information can compromise or threaten health for instance when data or information is necessary to ensure the quality and cost of contracted services or products that have been purchased by the health service in areas like pharmaceuticals, blood and tissue products and medication, waste disposal methods, and food preparation and processes. Strengthening IPRs can further limit access to information and the citizen's right to know the basis of decisions made which can have a lasting impact on public health and safety.

Trade Marks

TRIPs protection of 'well known' trademarks even if they are known on the basis of publicity and not of effective use in a country was a major achievement for the TNCs (Correa 2000:13). Trademarks are increasingly used by the TNCs to promote their products. These have an impact on public health especially when toxic and unhealthy products are advertised: companies are resorting to indirect advertising i.e. through the placement of a logo in tobacco, alcohol and infant formulas to circumvent national bans on advertising. For instance, *Camel* is placed on cigarette lighters, clothes and accessories like wallets, caps and boots; *Malborough* is found on torchlights and cigarette lighters, and caps, *Benson & Hedges* runs a coffee place in Kuala Lumpur and promotes sporting activities and 'Golden Dreams'; *Salem* is selling holidays and music for a new generation on this *Cool Planet*; *Mild Seven* offers a sporting spirit and fine leisure; *Dunhill* brand of watches and clothes are sold; and *McDonald's* appears on giveaway toys.

In some countries like Finland, legislation forbids indirect advertising of tobacco products through the use of similar trade marks in other products. However, this may cause problems for member states who initiate public health measures to curb the use of such trade marks or logos as in the case of tobacco, alcohol; infant formula, and junk foods. It can be construed as discriminatory measures, which support local industries to the detriment of foreign producers. Although disputes over such hazardous products have not made their way to the DSB, the mere hint of a threat of trade sanctions may be enough for Third World member states to allow foreign companies better representation of their products; which has been one of the most important methods used by tobacco companies to avoid government bans and restriction of tobacco (Koivusalo 1999).

One of the most crucial area of IPs in the TRIPs is patents. Under TRIPs, patents must be granted and the conferred rights will be exercised without discrimination as to the place of invention, the field of technology or whether the protected product is locally produced or imported. This limitation clearly indicates the internationalisation of the patent system and the move by the industrialised nations to push for a legal system that facilitates global trade rather than the local

working of inventions (Correa 2000:15-16). The US pharmaceutical industry was primarily responsible for this expansion and strengthening of patent protection and a major beneficiary (*Ibid*:15).

Price Increase on Medicines

TRIPs will have the greatest impact on the pharmaceutical industry and the Third World's access to medicines. With the introduction of the TRIPs patent regime 'prices will be a regular feature and not an accident': Third World countries are going to suffer from substantial price increases and other costs (*Ibid*:36). World Bank studies show that the minimum welfare loss to Argentina, Brazil, India, Mexico, Korea and Taiwan due to the impact of patents on the prices of medicines, would be no less than US$3.5 billion and a maximum of $10.8 billion; while the income gains by foreign patent owners would be between $2.1 billion and $14.4 billion (Nogues 1990).

Welfare and price effects were found to be negative for Asian countries: price increases estimated for patented drugs ranged from five to 67 percent. Drug prices in Malaysia where patent protection existed were 20 to 760 percent higher than in India, reflecting a profit maximising behaviour based on 'what the market can bear' (Subramaniam 1990).

One study in Argentina estimated that the introduction of pharmaceutical patents would imply an annual additional expenditure of US$194 million with a reduction of 45.5 percent in the consumption of medicines, as a result of a price increase of some 270 percent: the increase in remittances of foreign firms abroad would reach $367 million. Fiscal expenditures would have to increase by about US$200 million annually in order not to affect the current public health level (Challu 1991).

Annual welfare losses for India (the biggest market) ranged between $162 million and $1,261 million and annual profit transfer to foreign firms between $101 million and $839 million (Subramaniam 1995 a&b). A 'national health disaster' has been anticipated by the Indian Drug Manufacturers' Association as a result of the implementation of TRIPs where only 30 percent of the population can afford modern medicines in spite of the fact that drug prices in India are one of the lowest in the world (Correa 2000:35).

Thus TRIPs will lead to draining further the resources of the Third World as a result of the outflow of foreign exchange; increased costs in medical and health care; as well as undermine countries' self reliance in drugs as is the case in India where both public sector and small drug firms have been forced to close down or taken over by the TNCs (*Jan Swasthya Sabha* 2000:40).

Lack of Access to Essential Medicines

Except for China, no Third World country is self sufficient in essential drugs. Some 2.5 billion people have little or no access to essential drugs (*UNDP* 1991). WHO estimates that some countries pay 150-250 percent more than the world market prices for essential drugs while others are faced with unreliable suppliers and poor quality drugs. In the Third World, a full course of antibiotics for pneumonia can cost a month's wages. The standard triple treatment for HIV costs some US$10,000 per year, while the per capita expenditure on drugs in SSA is only $8. Treatment that can save lives for people with HIV/AIDS is beyond the reach of many in the poor countries. Medicines for other life threatening diseases like TB, malaria and meningitis are equally out of reach. For example, most of the 100,000 TB patients suffering from multi-drug resistant strains cannot afford the new standard combination therapy which is estimated at US$15,000 per course.

Apart from the prohibitive costs of drugs, many drugs, which are essential for the treatment of tropical diseases, have disappeared from the market because they are not profitable. Take the case of eflornithine (DFMO) used in the treatment of sleeping sickness, which is caused by a parasite transmitted by the tsetse fly. DFMO is the only treatment for advanced sleeping sickness. If left untreated the disease leads to death. It affects some 30,000 people a year. DFMO was developed by Merrell Dow (MD) in the mid 1970s for cancer. In 1985 WHO in cooperation with MD made the drug available when it proved to be effective against sleeping sickness. In the early 1990s, drug production ceased, as it was no longer commercially profitable. In 1995, Hoechst Marion Roussel (HMR) which took over MD offered the technology and patent rights of DFMO to WHO, but the latter could not get any company interested to produce the drug. HMR offered the remaining bulk product for free but is no longer able to put the product in vials. The only existing DFMO vials in the MSF (*Medecins Sans Frontieres*) drug store in Kampala expired by July 1999 (t Hoen: 2000).

Thus medical R&D in drugs today are geared towards increasing share holder value and profits and not the public interest. It is highly concentrated in favour of diseases that afflicts the North and the concerns of the affluent in the South. There is thus a lucrative market for developing cures to deal with impotence (viagra), obesity, ageing, jetlag and baldness (Koivusalo 1999). Almost nothing goes to tropical diseases. While pneumonia, diarrhoea, TB and malaria account for more than 20 percent of the disease burden of the world, they receive less than one percent of health research funds; less than 10 percent of the US$56 billion spent yearly on research is aimed at the health problems affecting 90 percent of the world's people (The Corner House 1999). With biotechnology, a new generation of expensive genetics based medicines will hit the market in the future.

It can be seen that pharmaceuticals account for a sizable part of the health budgets of Third World governments. Although essential drugs are outside patents and part of the public domain, drugs like HIV are not, and diminishing access of Third World countries to essential drugs is becoming a major health problem. These concerns and the implications of TRIPs were raised by the WHO which passed a Resolution on essential drugs in 1998 at the World Health Assembly. This was strongly opposed and the WHO gave in to US pressure with a revised version which was unanimously accepted at the 1999 WHO Executive Board and the subsequent World Health Assembly (see p42 on South Africa).

The EDL (essential drugs list) comprises some 306 mainly generic drugs (about 15 or so are patented products) which are safe, efficacious and available at reasonable prices. Other Third World countries produce the medicines themselves eg. India, China, Brazil and Egypt allow patents on pharmaceutical processes but not the final products. That means they can produce the drug legally using a different process from the original used. This supported the development of national domestic industries to produce generic drugs, which were cheaper than the branded originals. For instance when Glaxo Wellcome launched AZT as an AIDS inhibitor, it initially cost US$10,000 per patient each year (although with increased sales the cost for treatment fell to US$ 239 per month) which was still unaffordable for many in the Third World. An Indian company then produced the generic Zidovir 100 reducing cost to US$239 per month. India then exported it to Tanzania, Uganda and Belgium at less than half the price sold by Glaxo Wellcome.

TRIPs sanctions 20-year patents protection on both processes and products. Thus the company holding the patent has exclusive rights to manufacture, sell and distribute the drug. Others can copy the generic only 20 years later. TRIPs protects the power of the TNCs to further increase and tighten their dominant ownership of technology and impede the transfer of technology to the

Third World. The implementation of TRIPs will have serious implications on the access to drugs and health care in the Third World. TRIPs will undermine domestic production of medicines and deprive countries of a source of innovative quality drugs. This will further widen the gap of access between the North and the South: Third World countries cannot afford to wait 20 years before they can make life-threatening drugs for their people as the HIV/AIDS pandemic clearly illustrates the magnitude of the public health crises in many nations.

However, under TRIPs countries can still gain access to drugs and protect public health under 'compulsory drugs licensing'. Article 31 of TRIPs states that member states 'may use the subject of a patent without the authorisation of a right holder including use by the government' in the public interest. It also says that 'the right holders shall be paid adequate remuneration taking into account the economic value of the authorisation'. Thus governments can grant a licence to make copies of patented drugs without the approval of the patent owner and pay a royalty to the latter. 'Compulsory licensing' is part of the patent law of many countries. This option has been used by countries to restrict the monopoly rights of companies (the patent holders) in the interest of the public good. The US has applied it domestically in hundreds of cases. Licences on patent have been granted in areas including biotechnology, pharmaceuticals, aerospace, military technology, air pollution, computers and nuclear energy. In many cases, the rights have been granted free of royalty payments.

TRIPs also allow for the import of medicines from countries other than the country of manufacture without the permission of the manufacturer. This is called parallel importing and is provided in article 6, Exhaustion of Rights. Countries resort to parallel imports when there are price differences for the same product in different markets. For example, a retail drug prices study for Glaxo Wellcome's Zantac (Zinetac) tablets in 11 Asian countries shows the following variations: US$9 in Bangladesh; $2 in India; $41 in Indonesia; $55 in Malaysia; $183 in Mongolia; $3 in Nepal; $22 in Pakistan; $63 in Philippines; $61 in Sri Lanka; $37 in Thailand and $30 in Vietnam. (*HAI News*, April 1998). Malaysia could save a considerable sum of money if it buys Zantac from India instead of in Malaysia. Parallel importing is common in the EU pharmaceutical retail trade.

Despite this, Third World countries have been pressured not to use these measures to the detriment of public health.

US Bullies Thailand

Thailand has a million HIV victims out of a total population of 61 million. Since 1993, the Thai government had supplied the HIV antiviral zidovidine, which resulted in a drastic drop in price from $324 in 1992 to $87 in 1995. Meanwhile under threat from the US to limit its textile imports, Thailand passed a law on product patent protection in 1992. As a safeguard however, the Thai authorities created the Pharmaceutical Patent Review Board (PPRB) to collect economic data including the production cost of medicines. This move was not viewed favourably by the US either (Wilson *et al* 1999). Trade pressure was again applied on Thailand when the latter attempted to produce generic didanosine. This drug which is used in triple combination therapy for HIV was developed by the US National Institute of Health with taxpayers money and patented as DDI. The US government gave the exclusive licence to Bristol-Myers Squibb (BMS) to make and market DDI in return for a royalty of five to six percent of net sales. BMS is the sole supplier of the drug in Thailand and sells it at a monthly cost of US $136. Thailand wanted to produce the drug thus enabling AIDS patients to receive one low-tech double therapy combination (AZT/DDI) at an affordable price. Since July 1997 as a result of the financial crisis, the daily minimum wage in Thailand had stagnated at $4.50.

In 1998 under threat of increased tariffs on imports of wood products and jewellery by the US, Thailand dropped the DDI plan. The threat came at a time when the Thai economy was crippled by the Asian economic crisis. Under the urging of US trade officials, Thailand disbanded the PPRB and enacted a law to restrict its rights to issue compulsory licensing to medicines. This law ironically, is more restrictive than the rules set out in the TRIPs agreement (Wilson *et al* 1999; Bond 1999).

US Threatens South Africa

South Africa was threatened with US trade sanctions unless the nation amended its *Medicines and Related Substances Control Amendment Act 1997*. This law would enable South Africa to seek the cheapest world price for a drug through parallel importing; and to grant rights to make copies of patented drugs without the approval of the patent holder by imposing compulsory drugs licensing. This law would make life saving medicines affordable to South Africans. Under compulsory licensing South Africa can reduce the price of drugs by as much as 90 percent. (Bond 1999).

South Africa has the world's fastest growing HIV infection rates. Some 16 percent of the population, 20 percent of pregnant women, and 45 percent of the armed forces test HIV positive and black people have the highest risk of dying early from AIDS (*Ibid*). An estimated one million people have already died. The standard multidrug AIDS therapy that cost more than $12,000 a year is out of reach of almost all South Africans whose average annual income is less than $3000 (*Ibid*). The reaction to South Africa's new law came first from the 40 pharmaceutical companies which jointly filed a suit in the African High Court barring the law from taking effect, claiming that it violates intellectual property rights and was thus unconstitutional. By 1998, the drug companies had brought their campaign against South Africa to the White House. In October 1998, US Congress out off foreign aid to South Africa in an effort to force its hand.

The US Trade Representative Charlene Barshefsky, denied South Africa tariff breaks on exports to the US worth more than $3 billion in 1998 and placed it on its 'watch list' for unfair trade practices. Pressure was brought to bear on Pretoria by the Commerce Secretary, the US Embassy and the Clinton administration tried to kill a WHO resolution that urged member nations to 'ensure that public health interests are paramount in pharmaceutical and health policies'. In a report dated 5 February 1999, to Congress from the US Trade Representative: 'All relevant agencies of the US government have been engaged in an assiduous concerted campaign' to get South Africa to capitulate (L J Davis: 2000). Even the European Commission lent its weight to the US attack: Sir Leon Brittan, the Trade Commissioner at the time issued a warning to South Africa's Vice President in a letter in March 1998, that Pretoria's drug law was 'at variance with South Africa's obligations under the WTO and its implementation would negatively affect the interests of the European pharmaceutical industry' (Taylor: 2000).

US Double Standards

All these measures[11] were taken by the US to prevent South Africa from exercising its rights under TRIPs. The US charge that South Africa was violating WTO rules was strongly condemned by AIDS activists, health and consumer groups, which accused the Clinton – Gore administration for practising double standards and hypocrisy. The US has liberally issued compulsory licences at

[11] However thanks to protests by US AIDs campaigners, the sanctions threat against South Africa was finally dropped.

home and countries like Britain and the Netherlands get eight to ten percent of their drugs through parallel imports, yet no trade sanctions are leveled against them. In fact US extensive use of compulsory licensing for governmental use has brought on complaints from the EU. In a report from the European Commission Article 31 of TRIPs introduces a requirement to inform promptly a rights holder about government use of his patent but no action has been taken by the US so far to bring their legislation into conformity with this provision' (Correa 2000:93).

Compulsory patent licensing has been used by the US in cases involving meprobamate; antibiotics like tetracycline and griseofulvin; synthetic steroids; and most recently, several basic biotechnology patents owned by Ciba-Geigy and Sandoz which merged to form Novartis. The latter would control Chiron, a biotechnology company and the US Federal Trade Commission (FTC) considered the merger a violation of its antitrust laws. The FTC required divestiture of several products and ordered compulsory licenses of IPRs for a number of healthcare inventions. Ciba-Geigy, Sandoz and Chiron were required to license a large portfolio of patents, data, and know how relating to HSV-tk products, haemophilia gene rights and others to Rhone-Poulenc Rorer. They were also required to grant non-exclusive licences to all requesters for patent and other rights to Cytokine products.

Similarly, when Dow Chemical acquired shares of the Rugby-Darby Group, FTC required Dow to license to a potential entrant intangible dicyclomine assets like formulations, patents, trade secrets, technology, designs, drawings, quality control data, software, management information systems, the Drug Master File, all information relating to USFDA Approvals that are not part of the acquired company's physical facilities or other tangible assets.

Upjohn was required to divest certain IP including patents or the FTC would appoint a trustee to issue an exclusive US licence and a non-exclusive rest of the world licence for Pharmacia's R&D assets related to 9-AC. These requirements would protect consumers from reduced competition and higher prices for topisomerase I-inhibitors (*Ibid*:92).

In contrast, the bullying tactics the US employs against Third World nations in relation to pharmaceutical patents is unlawful and hypocritical. It expects conformity and compliance from others while blatantly disregarding its obligations under TRIPs. Under TRIPs, Third World countries have a transitional period after the date of entry into force of the WTO Agreement to apply the obligations relating to IP protection. For countries, which are bound to introduce product patent protection in areas of technology not so protected in their country, the general transition period is further extended to nine years. This applies to pharmaceutical products in Argentina, India, Egypt and other Arab nations.

Transitional periods may provide the time necessary but not the resources, to introduce changes in legislation, develop the infrastructure for administration of IPRs and introduce other measures required to reduce any eventual economic losses derived from the new framework (*Ibid*:10).

However, the US is threatening several Third World countries with sanctions under Section 301 of its Trade Act. It requests among others not only the immediate introduction of the TRIPs standards for patents, but its retroactive application. Such unilateral actions to force a member state to adopt the TRIPs minimum standards are illegal under WTO rules. This has undermined the efforts of countries to amend IPRs laws before the expiration of the transitional periods and to provide protection beyond the requirements of the TRIPs Agreement as in the case of Argentina (*Ibid*: 10-11).

US Unilateral Action against Argentina

In May 1995, Argentina's Parliament approved a new patent law. During the legislative process, the US government repeatedly threatened Argentina with unilateral trade retaliations claiming the lack of retroactive (pipeline) protection for pharmaceutical patents, ignoring the transitional period that Argentina can apply in accordance with Article 65 of the Agreement. In December 1996, Argentina passed a law on 'confidential information'. In January 1997, the US government announced the partial withdrawal of Argentina's benefits under the GSP (Generalised System of Preferences) as a sanction based on the latter's failure to protect IPRs in accordance with 'international standards' (*Ibid*:12).

Under the direct influence of the powerful pharmaceutical lobby, the US disregards international binding rules and deprives Third World countries of their right to take the necessary time to introduce legal reforms and adopt measures that mitigate their eventual economic and social impact (*Ibid*:10).

The Thai, African and Argentinian experience confirms the fact that patent rights are used by the North as a protectionist measure to enable them to reap monopolistic profits while preventing the transfer of technology. The world sales in anti HIV drugs total some US$3 billion a year. In 1998 alone, the three major AIDS drug companies, Glaxo Wellcome, BMS and Pfizer made $4.43, $3.64 and $3,35 billion respectively (Bond 1999). Bristol-Myers Squibb which has monopoly rights to sell DDI and D4T anti HIV drugs at high prices have made enormous profits from these drugs which were developed through public funding. Drug companies will continue to pressure the US and other Northern governments to prohibit countries like Thailand and South Africa access to life saving drugs through compulsory licensing and parallel imports. These efforts by the North in collusion with their corporate interests have undermined the efforts of Third World governments to give their people better health care. In the wake of the Thai and South Africa episode there are moves afoot among the European pharmaceutical industry to lobby the EU on changes to TRIPs.

BioPiracy

Another impact on health concerns the patenting of life forms. TRIPs requires all member states to adopt a uniform regime of Intellectual Property Rights (IPRs) which recognises and protects the privatisation and exploitation of genetic resources for profit. Article 27.3(b) forces all countries to allow the patenting of all microorganisms invented and to accord protection to plant varieties by patents or some legal means. These enable the biotechnology lobby and Northern governments to exert private monopolistic rights over terrestrial biological resources.[12]

These measures will legitimise the private appropriation of community-based resources and knowledge and undermine indigenous and local communities. It gives the North legal right to plunder the biological heritage of the Third World. For instance, it will further the patentability of traditional medicines and crops which in the Third World have been in the public domain for millennia. The Third World is the source of some 90 percent of the world's store of biological resources. Bioprospectors have for many years stolen the plant knowledge of local people for profitable uses. For example the rosy periwinkle found in Madagascar contains anti-cancer

[12] This does not include newly discovered marine biodiversity within and or beyond national boundaries found in deep sea vents or seeps which hold great commercial value to biotech and pharmaceutical companies. Currently these areas are not adequately protected under international laws.

properties, Eli Lilly developed a drug from it making $100 million in annual sales but nothing for Madagascar (*UNDP* 1999).

The value of the trade in medicinal plants is currently estimated at US$43 billion a year; whilst the value of crops varieties improved and developed by traditional farmers to the seed industry amounts to US$15 billion. Other natural products so derived like sweeteners, perfumes, biopesticides, fabrics and cosmetics indicate the immense contribution and value of biological resources from the Third World (Gray 1991 & Brush 1999). In terms of the contribution to pharmacology, some three quarters of the plants that provide active ingredients for prescription drugs drew the attention of researchers because of their use in traditional medicine; of the 120 active compounds currently isolated from the higher plants and widely used in modern medicine, 75 percent show a positive correlation between their modern therapeutic use and the traditional use of the plant from which they were derived (Farnsworth *et al* 1985). Landmark discoveries were made of an important class of antihypertensive agents – ACE inhibitors from plant extracts collected from Malaysia, Ghana and Costa Rica (Howson, Fineburg & Bloom 1998).

What this amounts to is that the process of theft is now enshrined in international law and Third World countries are forced to buy back resources that were originally taken from them. Patenting of agricultural seeds and medicinal plants prevents farmers and local communities to freely use what belonged to the community originally. For example, the neem tree of India which has been used for thousands of years as a natural pesticide; a medicine for a wide range of diseases including leprosy, diabetes, constipation and contraception was patented by several Northern corporations[13]. Since 1985, there are over fifty US patents on neem. Others include kava, barbasco, endod, quinoa and tumeric[14] all of which are based on plants and knowledge developed and used by local and indigenous communities.

Health Threats from Biotechnology

Patenting of life forms and biological materials through genetic engineering, also raises adverse health and environmental concerns. Transgenic organisms have entered the food chain: they include bacteria, fungi, animals and fish. The potential for adverse effects of genetically engineered organisms on the environment and human health is becoming evident.[15] Genetically modified food can cause allergies, toxicity and antibiotic resistant organisms.

In one example, the US FDA in 1992 approved the use of Monsanto's genetically engineered bovine growth hormone (BgH) in cows to increase milk supply (BgH is a naturally occurring hormone that stimulates milk production in cows). Monsanto's BgH forces the animal to produce between 10 and 20 percent more milk. The use of this drug had adverse health effects on the dairy cows and the milk produced was contaminated with high levels of hormones and antibiotics which poses a threat to human health. The milk is sold unlabelled to countries the world over including India, Mexico and Russia.

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[13] However on 11 May, 2000, the European Patent Office revoked a patent given to the US government and WR Grace for a process to extract oil from the neem tree for use as a plant pesticide.

[14] A patent on tumeric granted to the University of Mississipi Medical Centre in December 1993 was invalidated in August 1997 by the US Patent Office on the request of India's Council for Scientific and Industrial Research (SUNS 8 Sept 1997).

[15] Although the Cartagena Protocol on Biosafety was set up to regulate the trade in genetically-modified (GM) products, it will not override rights and obligations under other international agreements including the WTO.

L-tryptophan, a natural bacteria was genetically engineered by Showa Denko, a Japanese company. The genetic manipulations caused the bacteria to produce a highly toxic substance in the tryptophan which was not detected until after the product was marketed in 1989. Consumers who took the product were severely afflicted with a painful and debilitating circulatory disorder called eosinophilia myalgia syndrome. As a result, 5000 people became ill, 1500 were permanently disabled and 37 people died (Mayeno & Gleich 1994). Similarly when a gene from the Brazil nut was inserted into soybeans to increase their protein levels, the transgenic soybeans also contained the nut's allergenic properties.

Genetically engineered crops use genes that are resistant to antibiotics to help identify whether the genes that have been introduced have been successfully inserted into the engineered crops. These marker genes can exacerbate the spread of antibiotic resistance among humans. The UK rejected Ciba-Geigy's transgenic maize, which contains the marker gene for ampicillin resistance (Ho 1997:108)

Many of the genes transferred into the genetic code of food crops come from plants, microorganisms and animals that have never before been part of the human diet. Such transgenic foods especially those that contain human DNA or the DNA of viruses that attack human beings can pose a danger to human health. For example, scientists have shown that the genetically engineered DNA of these foods can break down and enter the blood stream, when eaten. The human gut contains enzymes that can rapidly digest DNA. However, in a study designed to test the survival of viral DNA in the gut, mice fed DNA from a bacterial virus exhibited large fragments of it in the bloodstream. The DNA had survived in the gut and entered the blood of the mice. Further studies show that the DNA is present in spleen and liver cells and white blood cells (*Ibid*:110).

Thus, transgenic foods and the foreign DNA in them can be absorbed by gut bacteria, as well as gut cells and into the blood stream and other cells in the body. The presence of DNA in cells can lead to the regeneration of viruses or, if the DNA integrates into the cell's genome (i.e. all the genes in each cell of an organism), many harmful diseases can result including cancer (*Ibid*:111).

Transgenic crop plants are now engineered to be herbicide resistant, which means that, these crops can withstand heavy application of powerful herbicides e.g. Monsanto's Roundup, which is poisonous to most plants species, poisoning the soil, ground water, and affecting human health. The immediate danger of herbicide resistant crops is the spread of transgenes to wild relatives by cross-hybridisation creating superweeds. Herbicide-resistant transgenic oilseed rape, released in Europe has now hybridised with several wild relatives (*Ibid*:100).

Transgenic crops are engineered for resistance to viral diseases by incorporating the gene for the virus's coat protein. These viral genes can cause new disease by generating new and virulent strains. These are readily transmitted by many species of aphids and other insects that attack plants. These new broad range recombinant viruses could cause major epidemics (*Ibid*:109-10). Thus transgenic crops can become noxious weeds, affect wild ecosystems, and create new plant disease.

Farmers in the Third World have always relied on the diversity of crops in agriculture for sustenance. These crops were highly adapted to local conditions and possess a range of natural resistance to diseases and pests. This diversity of crops has enabled them to maintain a balanced nutrition. Genetically engineered crops threaten this biodiversity and the local ecosystem with superweeds, toxic pesticides, contamination of soils and water systems and new virulent viruses.

Patented seeds are expensive as all inputs like chemicals and the seeds have to be bought. These seeds cannot be saved (for the next planting season as in traditional agriculture) because these are genetically engineered not to reproduce themselves as in the case of the *Terminator Seed*.

In March 1998, a US patent was granted for TPS or Technology Protection System. TPS is now known as *Terminator Technology*. It is so called because it will produce plants that have in them seeds that will poison itself, or self-destruct. Thus, seeds of the next generation cannot be replanted because they are actually sterile, dead seeds or suicide seeds. *Terminator Technology* epitomizes the attempt by big companies to control and 'own' lives. The *Terminator* will threaten farmers and the food security of the South, as farmers cannot save their seeds to replant in the next season. Through the *Terminator*, companies load their proprietary genetics traits ie. patented genes for herbicide tolerance or insect resistance, and enslave farmers, who will be hooked on their seeds and caught in the chemical treadmill. *Terminator Technology* has serious implications for agriculture in the South. The company Delta and Pine that owns the joint patent with the US Department of Agriculture has been bought over by Monsanto whose track record for a clean environment, health and safety has been shocking to say the least.

Because the *Terminator* has the ability to switch off and on other transgenic traits, until the plant with the *Terminator Technology* is exposed to a specific outside stimulus be it a chemical, temperature extremes, or osmotic shock, the technology allows for crop diseases to be exported in the seeds. There is no gainsaying that the *Terminator* can be used by the powerful, to undermine the food security and economies of nation states. Already, the US military is preparing to use and apply biotechnology for military and security purposes. These are dangerous and dark trends in biotechnology and such assaults on Third World food security becomes evident when it is realised that some 1.4 billion rural people rely on farm-saved seed (*UNDP* 1999:68).

Thus corporate appropriation and patenting of the medicinal and agricultural knowledge of local, indigenous and farmer communities of the Third World have led to the theft of genetic resources from the South by the North, and threaten the food security and well being of farmers. Through TRIPs, pharmaceutical companies and agribusiness will gain monopoly rights over Third World resources.

The General Agreement on Trade in Services (GATS)

Historically trade agreements involved reducing tariffs, eliminating trade barriers like quotas on imports on goods produced in a country and sold elsewhere. However, this has changed drastically in recent years in the North as manufacturing has ceased to be profitable because of global competition. Presently, the services sectors have expanded and are growing in importance to the North. According to the EC 'The service sectors accounts for two thirds of the Union's economy and jobs, almost a quarter of the EU's total exports and a half of all foreign investment flowing from the Union to other parts of the world' (Price, Pollock, Shaoul 1999).

In the US, more than a third of economic growth over the past five years has been because of service exports. In the words of Charlene Barshefsky the importance of the services trade to the US in 1998 was '$265 billion in services exports supporting four million jobs…an indicator of how much we can achieve in an open market (Cohen 2000). The World Bank estimates that in less developed countries alone, infrastructure development involving some private backing rose from US$15.6 billion in 1990 to $120.0 billion in 1997. Some 15 percent were direct foreign investment in public schemes (Price, Pollock, Shaoul 1999).

As the service sectors of the First World economies grew, trade in various types of services were exported. The TNCs lobbied for new trading rules that will expand their share of the global market in services as governments everywhere spend a considerable amount of their budget on social services. For example, the OECD countries spend more than eight percent of GDP on health alone. In the mid 1990s, this amounted to some US$2,000 billion annually. In the Third World health expenditure was five percent of GDP, which included public and private spending on both goods and services and social or compulsory health insurance (WTO: Sept 1998).

According to the WTO, the GATS covers some 160 separate sectors including telecommunications, transport, distribution, postal services, insurance, environment, tourism, the construction industry, real estate, entertainment and leisure industries. The corporate lobby is bent on opening up every conceivable area that covers the trade in services; the US Coalition of Service Industries (CSI), which was responsible in getting the US to initiate a services agreement in the Uruguay Round, has advised the WTO to adopt a 'flexible' and 'innovative' negotiating strategy as they 'need flexibility to include some services which may not be captured by (existing) definitions' (Bertrand & Kalafatides 1999).

In the new round of negotiations which was to have begun in Seattle, the US specifically wanted to focus on the free trade in services in the professions, health and education as the US had a trade advantage because of the new technologies (Cohen 2000). The GATS covers all services including health and social services. 'It covers not just cross border trade but every possible means of supplying a service, including the right to set up a commercial presence in the export market' (*Ibid*). This agreement is so comprehensive that analysts consider it the 'world's first multilateral agreement on investment' as it covers 'the kinds of rights that corporations in general would have received through the Multilateral Agreement on Investment (MAI), (had it not failed as a result of international public action), can be granted to investors in services through the existing GATS' (*Ibid*). The framework of obligations that applies to all member states in the WTO is valid in GATS which provides for 'national treatment' i.e. no discrimination in favour of national providers; and the most favoured nation (MFN) principle which states that no discrimination between other member states is allowed.

GATs negotiations is being pushed and binding agreements set without countries being able to make proper assessment of costs and benefits because of the absence of data. Opening up the services sector will not benefit the Third World countries as most have hardly any supply capacity in the services sector for export to the North. The vast differential in this area makes the achievement of reciprocal benefits nearly impossible with the pattern of negotiations adopted in the Uruguay Round of trade talks (which resulted in the establishment of the WTO) (Das 2000).

The GATS as in all the other agreements contains provisions which allow further 'rollbacks' i.e. further deregulation of any national legislation which is seen to be hostile to free trade. This is referred to as a 'built-in agenda' to liberalise services and allows for the negotiations to be a continuous (on-going) process. GATS identify the specific commitments of member states that indicate on a sector by sector basis the extent foreigners' may supply services in the country. The negotiating process in GATS allows for countries to decide, through 'request offer' negotiations, which service sectors they will agree to cover under GATS rules. This refers to the extent to which member states want their services like health and education to be open up to free trade.

Selling Health

As GATS allows for negotiations in services in the various areas to be an ongoing process; the deliberations over free trade in these areas have received little public attention or debate. So far

agreements have been reached on information technology (1996), telecommunications (1997) and financial services (1997). The health services involves a handful of countries: only 27 percent of WTO members have agreed to open up hospital services to foreign suppliers and 35 percent have done so for medical and dental services (Kinnon 1995).

The new negotiations for services through the Council for Trade in Services began at the end of February 2000. These negotiations are to 'achieve a progressively higher level of liberalisation (which shall) be directed to the reduction or elimination of the adverse effects on trade in services ……as a means of providing effective market access'. (Cohen 2000). In many countries in the Third World and the North the health and social services sector is traditionally the responsibility of governments.

However, with the increasing trend towards deregulation and privatisation of services provided by the public sector together with the expansion of contractual arrangements (through World Bank policies and economic reform in the North), the role of private actors is set to expand with the inclusion of government procurement into the multilateral trade negotiations, the framework for broader GATs implementation will be provided which will further facilitate the trade in services. This will lead to competitive bidding for various public sector services and increased investments in health. The private insurance companies, managed care firms, health care technology companies and the pharmaceutical industry of the North will be looking for opportunities to expand health care markets. With the advances in telemedicine, surgery, consultation and patient (customer)-doctor services across borders will be easier, facilitating global health care operations and trade in health services (Koivusalo 1999).

Thus in the US, the CSI is calling for a majority foreign ownership to be allowed for all health facilities. 'We believe we can make much progress in the negotiations to allow the opportunity for US businesses to expand into foreign health care markets….public ownership of health care has made it difficult for US private sector health care providers to market in foreign countries' (Price, Pollock & Shaoul 1999). Already 'the US is of the view that commercial opportunities exist along the entire spectrum of health and social care facilities, including hospitals, outpatient facilities, clinics, nursing homes, assisted living arrangements and services provided in the home (Kuttner 1999). In the US the multibillion-dollar business of health maintenance organisations (HMOs) which rely heavily on public funding, private health insurance and user charges was achieved with the acquisition of non-profit hospitals in the country. It has tried to capture new markets abroad by acquiring publicly run facilities (Kuttner, R, 1996). The industry has received influential support for its foreign acquisitions policy from the US government, the World Bank and multilateral financial institutions like the Inter-American Development Bank. The IFIs are behind the move for 'managed care initiatives that convert public health care institutions and social insurance funds to private management, private ownership or both' (Stocker, Waitzkin & Iriart 1999). HMOs target the public funding behind foreign health care systems: multibillion-dollar social security or tax pools are effectively privatised when public health care is redirected through private sector organisations (Price, Pollock, Shaoul 1999).

In the Third World, private health services were by and large provided by nongovernmental organisations like charities, religious societies and community oriented associations which were not entirely profit driven. This will change when health services and investments in health expand and the corporate sector is poised to play a prominent role especially in countries where there is an affluent elite willing to pay or where there exists a private health service base: Latin America, Southeast Asia, China and the Pacific have been targeted as potential areas for growth (Koivusalo 1999). This move to open up the health and social sectors to allow for privatisation and

competition from the private sector will mean private corporations taking over the health and social services of countries for profit undermining the equitable distribution of health care.

Equity in health care can be defined as the provisions of services according to need and the financing of those services according to the ability to pay. Comparative studies suggests that progressive taxation and public provision is the least regressive approach; whereas financing through private insurance and out-of-pocket payments is the most regressive; whilst universal insurance systems fall somewhere in between (Koivusalo 1999).

The US, the world's richest nation has the highest health spending rate as a percentage of GDP, on earth. In 1990 the US consumed 41 percent of the global total spent on health care (World Bank 1993:4). The presence of strong private actors has meant that a large proportion of the population (44 million out of a total of 258 million) remains uninsured and have no access to healthcare; while another more than 20 million people have inadequate coverage (Sidel 1992). In a recent report from the US Consumers Union, the privately managed healthcare system imposes a heavy financial burden on millions of seriously ill patients and on middle and lower income families: a family earning $45,000 has to spend 6 percent of its income on healthcare, twice as much as a family earning $100,000. The present system forces the sickest ten percent of Americans to spend seven times more on medical costs than others (Aravind Adiga Aug. 11, 2000). The US health system dominated by the profit hungry private sector is not only the most expensive in the world: US health statistics are among the worst in the North. Washington D. C. has poorer child and maternal mortality rates than Jamaica (Werner 1992). The US has the highest mortality rate of children under five[16] of the 19 major industrial countries (Werner & Sanders 1997:109). In the US, between 21,000 to 10,000 children die of poverty related diseases yearly (*Ibid*). Wealth has never been more concentrated with the wealthiest one percent controlling 40 percent of the nation's wealth. Inequality has widened not only in access to health care and essential services; poverty and hunger have worsened dramatically in the US in the last 15 years (*Ibid*:109).

The US healthcare system is illustrative of what can develop when GATs is implemented: the global trade in health and social services and the privatisation of healthcare will lead to costlier and inequitable health systems which will adversely affect the health and well being of the majority of peoples everywhere.

Prise Open Markets

The GATs negotiations will be based on four modes or methods in which the service[17] is supplied namely cross border trade eg telemedicine, and internet services; consumption abroad which involves movement of consumers eg health resorts, spas and tourism; foreign commercial presence, eg international hospital and managed care chains; health insurance firms, and the presence of natural persons eg the movement of physicians, consultancy services, nurses etc. In all the modes of service supply, the obligations and commitments under the Agreement relate to the treatment accorded to the service or the service supplier and not to the consumer of the service (Das 1999: 334).

[16] UNICEF regards the mortality rate of children under five (U5MR) as a truer measure of a population's well being although infant mortality rate (IMR) i.e. the number of deaths per 1000 live births in children under one year of age, is widely used as an indicator of overall health level.

[17] The treatment of capital and labour in GATs is unbalanced, as it allows for unrestricted movement of capital but not the same treatment for movement of labour (Das 2000 No.238).

The market driven orientation of GATs will allow foreign health service providers legal protection to capture every aspect of the health sector under a wide range of trading activities. In all these areas of trading activities in health services, barriers to trade have been identified. Under the EC, the European Services Network of Transnational Industries has been set up to 'advise EC negotiators on the key barriers and countries on which they should focus' (*Ibid* 1999). All non-trade barriers will be scrutinised and whatever programmes and practices which are exempted will be targeted in subsequent rounds of negotiations. As the President of USCSI has declared, any minimal agreement in GATS that would at least get countries to list the areas they wanted protected under each service would be 'useful as a transparency exercise, forcing countries to demonstrate explicitly their laws and practices that are trade restrictive' (Vastine 1998).

Corporate moves to enlarge wider market access in services have been made advocating the adoption of the 'horizontal approach' to rule across all sectors; such that if a particular measure is conferred or agreed in one sector e.g. telecommunications, it is automatically applied to all other sectors including health. Thus in the case of telemedicine which involves patients (customers) consulting distant doctors and receiving prescriptions via videophone, this will be liberalised since member countries have already signed on the Agreement on Telecommunications (Bertrand & Kalafatides 1999: 367). Thus according to the CSI President, if 'national treatment' is applied across all sectors it works to the benefit of private service providers (Cohen 2000).

Under GATS rules government protection of health and social services was accorded by defining them as government services which 'is supplied neither on a commercial basis nor in competition with one or more service suppliers'. However, whenever there is a mixture of public and private funding as in user charge or public insurance, or subsidies for non-public infrastructure exists, such as private – public partnerships or competitive contracting for services, the service sector should be open to foreign corporations. What this means is that for governments to protect their health services it must be given free of charge. But if the treatment is free for the patient, but paid for by 'subsidies or other similar forms of financial advantages', then not only must the sector be opened to competition but the same 'subsidies' should be offered to competing commercial suppliers (Bertrand & Kalafatides 1999: 367).

More than this, the inclusion of public procurement under WTO rules would enable the release of massive amounts of government spending e.g. in health infrastructure and in social security contributions to the private sector.

The 'Agreement' On Government Procurement

Under the proposed 'Agreement on Government Procurement Policy' the North wants to introduce a process in the WTO whereby their companies are able to obtain a large share of the lucrative business of providing supplies to and winning contracts for projects of the public sector in the Third World. Presently, such government expenditure is outside the scope of the WTO unless a member state voluntarily joins the plurilateral agreement on government procurement. This means that states are free to set up their own rules on procurement and project awards and most Third World countries give preferences to locals in such awards.

The aim of the North is to bring government spending policies, decisions and procedures of all member countries under the umbrella of the WTO, where the principle of 'national treatment' will apply. Under this principle, governments in their procurement and contracts for projects (as well as privatisation deals) would no longer be able to give preferences or advantages to citizens or local firms. The bids for supplies, contracts and projects would have to be opened up to

foreigners, who should be given the same (or better) chances as locals.(Khor 1999). Thus the EU in its reform proposals focus on 'unlocking new potential market by extension of private firms' involvement with public services and by creation of contracting rules to ensure acceptable returns for investors. (European Commission: 1996) It was further proposed that foreign firms that are unhappy with the government's decision could bring the matter to the dispute settlement body in the WTO.

Since government procurement expenditure in some countries is bigger in value than imports, such an agreement to bring procurement under the WTO rules would tremendously enlarge the scope of the WTO and its rules. As most Third World countries would object to having their public sector spending policies changed so drastically, the rich North have a two – stage plan for this issue: firstly, have an agreement only to bring in greater transparency in government procurement; secondly, to have a broader agreement that would cover the national treatment principle. On the agenda at Seattle, the North wanted to wrap up an agreement on 'transparency in government procurement'. Governments need not apply the 'national treatment' principle and can still favour locals. But they must make public (to the world) what they are purchasing and the projects they are opening up for awards, who are eligible for the bids and what the terms are. After such an agreements is obtained, the North would then push for an expansion of the agreement so that it incorporates the market access element i.e. that foreign firms be given national treatment (Khor 1999:10).

Should the Third World countries agree to negotiations for a transparency agreement, they would put themselves on the road to a full-scale procurement agreement incorporating national treatment. At stake is the right of governments to reserve some of their business for local firms. With the removal of this right, a very important instrument for national development and for socio economic engineering would be removed (*Ibid*). Through the government procurement issue, the North will enable its corporate bodies to tap the vast public resources available in the health and social services sector and dismantle the public provision of health care. Public procurement will be the golden goose providing the crucial link to open up the services sector.

The 'Agreement' on Competition Policy

Privatisation of health care will also be facilitated under the proposed 'Agreement on Competition Policy'. The competition issue focuses on establishing 'constraining principles' and 'disciplines' that will affect market access. Member states 'will have to consider making reforms to their regulatory regimes' such that national regulations should have four central attributes: adequacy, impartiality, least intrusiveness and transparency', towards corporate interests. (Bertrand & Kalafatides 1999: 367). In this regard, the EU is advocating a new agreement that would look unfavourably on domestic laws or practices in Third World countries that favour local firms on the basis that it is against free competition. The EU has argued that WTO obligations (national treatment and non-discrimination) should be applied through a WTO agreement on competition policy.

Under such an agreement, Third World countries would be forced to establish domestic competition policies and certain type of laws. Distinctions that favour local firms and investors would not be allowed. For example, if there are policies that give importing or distribution rights (or more favourable rights) to local pharmaceutical companies (including government agencies or enterprises), or if there are practices among local firms that give them superior marketing channels, these are likely to be targeted and even banned. The North is arguing that such policies or practices create a barrier to foreign products or firms, which should be allowed competition. If smaller Third World enterprises were treated on par with the large foreign conglomerates, they

would not be able to survive. The North will insist that their giant firms be provided a 'level playing field' to compete equally with smaller domestic companies. Competition of this type will invariably lead to foreign monopolisation of Third World markets (Khor 1999:10).

The 'Agreement' on Investment

Similarly on the investment issue, the Northern governments want to introduce new rules that make it legal to give foreign investors the right to enter and establish themselves with 100 percent ownership. Governments then will lose the right to regulate investment to achieve and protect social, environmental and health well being in the national interest both long term and short term. Under the principle of 'national treatment' foreigners and foreign companies should be treated like locals and restrictions on the free flow of capital into and out of the country would be prohibited. 'Performance requirements' that host governments now place on foreign companies (like technology transfers, the use of local professionals, reinvestments of profits) would be banned (*Ibid*). With regards to public health protection laws, to protect public health and environment could be challenged if they prevent a foreign company from investing eg a cigarette company could then claim compensation for 'expropriation of trade mark rights' if advertising or sponsorship was restricted or 'expropriation by taxation' for losses from raised taxes. Similarly junk foods like KFC, & McDonalds, must be allowed to operate freely.

Discussions on the three issues on government procurement, competition and investment had been planned for the WTO Ministerial Round in Seattle which would have been the basis for new WTO agreements in the 'Millenium Round'. Despite the shutdown of the WTO at Seattle by democratic forces there is no gainsaying the WTO will push to widen the coverage of GATS to create wider market access for global corporations. This can be done once any minimal agreement is agreed upon, as it will allow the North to launch an attack in subsequent rounds of negotiations.

Corporations Shape Health

We have seen how WB – IMF SAPs and conditionalities have created the conditions for the expansion of privatised health care and the dismantling of public health services in the Third World. It's bias toward privatised health care is explicitly stressed even 'if market monopolies in public services cannot be avoided then regulated private ownership is preferable to public ownership' (Stocker, Waitzkin & Iriart 1999). With the GATS instrument, countries will be forced to remove all barriers to foreign participation in their health and social services sector; with implications for redistributive health and social services. These policies conflict with the principles of universal health care and public responsibility. Commercialised health services will lead to a growing health gap in society, between those who can afford and the vulnerable groups who cannot.

Already the privatisation of health in many countries in the North have revealed disturbing trends. Privatised health care has resulted in state-of-the art hospitals (also in the South) with the most sophisticated technologies that cater to the wealthy few. Health care is dominated by insurance companies, pharmaceutical firms and enterprises involved in technologies for treatment and diagnosis. This will lead to emphasis on private insurance within health systems and the promotion of curative technical fixes rather than preventive measures. New health technologies also raises ethical and political concerns eg genetics.

Public hospitals operating under tight cutbacks suffer shortages of equipment, deteriorating health care services, longer hours and less pay for health workers, and longer patient queues and waiting

lists. Health reform in France will lead to the closure of 100 hospitals in the Paris region alone in the next five years (Bertrand & Kalafatides 1999: 366). In the UK, competition in the health services from autonomous health providers has destabilised the provision of health care and diverted planning and service priorities away from local community needs. The goals of universality and equity are being replaced by consumer sovereignty (Price, Pollock, & Shaoul 1999:1892). In South America, public and voluntary hospitals have to compete with commercial providers for per-person public funds, private insurance and co payments. Unlike previous tax-funded or social insurance funded health system which provided universal coverage and community shared risks, changes in the financing and delivery of health care provide insurers and private health providers to make maximum profit the incentive to engineer favourable risk pools. This has left the public sector to bear the risk for more vulnerable populations but with diminished risk pools (or pooled funding) to finance health care (Stocker, Waitzkin & Iriart 1999).

If Third World countries commit to fully cover health services under the existing GATS rules, this will lead to irreversible changes in the financing and delivery of health and social services. Governments will have to open up their health sectors to foreign health service providers. Foreign health suppliers are guaranteed access to the health services market, which includes the right to invest, to provide health services from abroad and to send health professionals to practise. Any preferential treatment for local hospitals, nursing and handicapped homes, etc. will have to be eliminated or given to foreign service providers. Requirements that first preference be given to locals will be eliminated. Conditions must be created for the private health sector to provide or supply any service (like resorts, spas, exotic therapies, laundry, food catering, cleaning, health management consultancies, etc.); the private sector will effectively tap funds that the government spends on health by directing government spending towards the private sector in this way funding the privatised health services. This is already happening in the North where private prison and welfare service providers rely on government funding to buy their services (Cohen: 2000). Public grants or tax incentives for health research and development must also be made available to foreigners and foreign health research institutions.

The dismantling of the public health service means public funds will be siphoned to cater for a minority; private health insurance will make profits at the expense of the most vulnerable groups in the community; universal and equitable health care will be replaced by commodity based health. The welfare state health system will be a thing of the past. This assault on public health will severely undermine the health and well being of the majority in the Third World.

The Agreement on Agriculture (AOA)

Trade in agriculture came under GATT discipline after the Uruguay Round ended in 1994, when GATT was replaced with the WTO and the liberalisation of agriculture became known as the Agreement on Agriculture (AOA). There are three main areas of commitments namely market access; domestic support ie support by governments to domestic producers; and export subsidies ie support by governments to exports.

The AOA while pushing free trade on the South actually promotes monopoly for the North; the GATT agreement instead of dismantling the structure of subsidies in the North had left them intact as the US and EU agreed among themselves that direct income payments to farmers will be exempted from GATT rules. Direct income payments are payments e.g. made to farmers to withdraw land from farming ie to keep it fallow. For example, farmers in England are paid some one million pounds every year for not growing any thing. These direct payments account for a growing proportion of subsidies provided under the EU's Common Agricultural Policy (CAP).

Direct payments have generated new investment to farmers and have raised EU cereals output by some 30 million tons which is more than the average total of EU cereal exports for the second half of the 1980s (Watkins: Dec '98 – Jan '99). Through this, the EU & US have maintained and even increased their subsidies to their farmers thus allowing them to export more of their subsidised products to the Third World.

In this situation, where massive subsidies allows the North to maintain their mountains of foods which will be disposed through exports; against the South which have to open their markets to the North's agricultural products, free trade is used to regulate monopolistic competition to prise open the markets of the South.

Under the AOA, Third World countries have to reduce their domestic support and their export subsidies to their farmers over a 10 year period; they have to open up their markets to the agricultural products and services of other nations as well. Although the AOA offers concessions like the lifting of quotas and tariff reduction on Third World exports, these will only benefit the large scale commercial exporters of coffee, sugar, cocoa and oilpalm.

These measures namely import liberalisation, reduction of domestic support and export subsidies will have serious implications as Third World countries have used tariff walls and quotas to protect their farmers against competition from the food products of the North especially the EU and the US. We have seen how under SAPs US grain imports and cheap EU exports of subsidised beef[18] into Africa had destroyed the pastoral economy including small scale cattle growers in SS Africa. The reduction of domestic subsidies and the removal of non-tariff controls on agricultural products will expose Third World farmers to global competition.

Third World farmers comprise the majority in many countries where agricultural is the main economic activity. They will not be able to compete with cheaper imports and this would endanger the livelihoods of millions in the Third World. In fact FAO in a recent study of 16 developing countries implementing the Uruguay Round Agriculture Agreement concluded that: 'A common reported concern was with a general trend towards the concentration of farms. In the virtual absence of safety nets, the process also marginalised small producers and added to unemployment and poverty. Similarly most studies pointed to continued problems of adjustment. As an example, the rice and sugar sectors in Senegal were facing difficulties in coping with import competition despite the substantive devaluation in 1994' (FAO: 1999).

In several Third World countries, agriculture is not so much a matter of commerce: it is intimately interwoven with the pattern of rural life. Many farmers cultivate their land, not as a commercial venture but as part of a family tradition which goes back to several generations and those cultivating it have no other source of income to support their families. As a result of the division of holdings many farmers possess small parcels of land which are not commercially viable. These small and marginal household farmers will face great difficulty when faced with world competition (Das 1999:228).

Under the WTO rules, India has to reduce all import barriers on over 27,000 items, of which over 800 are agricultural items including milk, milk products, wheat, rice, pulses, livestock, agricultural chemicals, tea, rubber and others. Over 700 items have gone off all quantitative restrictions in 2000. This has already created a crisis in the tea and rubber industry where millions

[18] BSE – infected (mad cow) beef has been made available to Third World countries since 1996 when the EU lifted its ban on the export of UK, BSE beef and bovine products. Recently scientists say that BSE infection is now global. Germany, Italy and Spain officially BSE-free are likely to be infected; and it cannot be excluded in six more European countries as well as Canada, Australia and the US (Mackenzie, D., 10 June 2000).

of workers are unemployed as the plantations could not withstand the competition from cheaper imports (*Jan Swasthya Sabha* 2000: 44). The loss to livelihoods will spread to milk and milk products where millions of women earn their livelihood as well as to those growing cereals like wheat and rice (*Ibid*: 45).

The reduction of direct subsidies which also include sales from stocks by government at a lower price than the domestic market; and subsidized exports means that there is a pressure to lower government procurement and support price policies. The subsidy on fertilizers is sought to be lowered greatly. Indian farmers do not get direct export subsidy unlike the farmers in the North with whom they have to compete. (*Ibid*: 45).

Food consumption is the single most important determinant of good health. In India, as in many countries, food security has been one of the most important and central objectives of economic planning since the country's independence. It is considered the cornerstone of India's economic and political independence and food security is therefore a question of national sovereignty.

This is all the more crucial as chronic hunger and malnutrition is widespread in India. There are some 320 million poor people in India. For almost 90 percent of Indians, the share of income that goes to buy food is more than 50 percent. For the poorest 50 percent of the population, expenditure on food is over 70 percent of income. Thus, any food scarcity or a rise of food prices will have a grave impact on food consumption; similarly any fall in wages will have adverse consequences on food intake. Food scarcity affects women more and threats to food security will have a grave and immediate impact on women's health (*Ibid*: 43-44).

On the other hand, there are some Third World countries who are net importers of food; as subsidies for food production are progressively reduced in the North, this could result in a price increase in their food exports and poor countries who rely on food imports may face rising import bills, especially when many of the Third World countries suffer from lack of foreign exchange problems. This would threaten their food security which is made worse by the fact that food aid to the poor countries have seen a steady decline; between 1987 and 1997 food aid shipments were halved from 12.7 million tons to 5.43 million tons (Raghavan C. December '98 – January '99).
With the implementation of AOA, the adverse social impacts which resulted with the first round of liberalisation under SAPs will only worsen. Allowing the free forces of the market to operate in agriculture will threaten the food security of farmers in the Third World. Cheap subsidised food imports will destroy farmers livelihoods, displace communities and create rural unemployment; increased reliance on food imports undermines a nation's food security; and poverty, hunger and starvation can only worsen for the majority of small farmers.

The Globalisation of Culture

Trade agreements have removed all obstacles and resistance to corporate invasion and control of the Third World. With the liberalisation of telecommunications under GATS, corporate culture is set to rule the world. Today the whole world is wired and plugged into the TV programmes, movies, news, music, lifestyles and entertainment of the North. Satellite cables, phones, walkmans, VCDs, DVDs and retail giants and other marvels and wonders of entertainment technology are creating the mass marketing of culture. Through these channels and networks corporations homogenise the consumer culture of the North.

All over the world people of all ages are exposed to the same music, the same sporting events, the same news, sitcoms, soap operas and the same glamorous lifestyle. US corporate culture is available everywhere. Satellite TV has made available viewing anytime of the night and day.

More than 75 percent of the world's population have access to daily TV reception. In South America and Asia, US films and TV programmes dominate the screens. Every week viewers in Malaysia, click with 'Ally McBeal', her angst in her quest for true happiness and love. Young people the world over aspire for the kind of adult relationships found in 'Friends'.

Young people in Third World countries are the largest consumers of the global culture and global corporations are racing to get a piece of the market, even children are not spared. Sony has developed its range of toy-like radios, kids music label and videos for this age group. With MTV, global entertainment reached its apex; today it beams daily to over 200 million households in over seventy countries. The biggest growth potential for pop music is in South America and Asia. Foreign pop brands and local versions and renditions of the same synthesised beat is imitated every where. Local artistes belt out songs popularised by the 'Spice Girls', and 'West Life' with the same stage sets, manoeuvres and costumes.

The penetration of global music has resulted in the marginalisation of traditional music among cultures the world over. Today, pop music and its local variations can be heard in all social settings from weddings to religious festivals and birthday celebrations. Young people have lost touch with traditional harmonies and traditional tunes; songs and dances which are specific to regions or villages in Third World countries, are no longer heard. Transnational sound has destroyed cultural diversity every where. Ironically, as Third World artistes consciously imitate their western counterparts, indigenous music and genres have been hijacked by western musicians and pop bands as free global commodities. Global entertainment is addictive to the young because it is selling an experience and an image. It gives the illusion that we are all connected in this global world. That is why the World Cup fever is such a seismic global event sweeping everyone into its megapresence. In Malaysia, giant screens are installed outdoors and hundreds of fans rave, rant and weep (and get drunk) on the fortunes of their favourite teams. Deaths have also been reported as a result of heart attacks brought on by watching the matches.

TV offers not only entertainment, it embodies the sheer power and influence of global corporate culture. It has become the most powerful and insidious tool of mass education in the Third World; like an immovable juggernaut it shapes lifestyles and values and fills the vacuum emptied by the pervasive collapse of traditional institutions, communities, clans, family, life, and authority. Through Hollywood movies, programmes and global advertising we learn, cultivate and internalise values and lifestyles.

TV not only creates artificial needs, it undermines the meaning of community, wealth and the notion of self. The effects have been particularly devastating among indigenous communities. When TV was introduced among the Dene Indians and Inuit peoples in the Arctic, children lost interest in the native language, they wanted to learn Canadian English; they refuse to learn how to fish on the ice or go hunting. It has ended the tradition of story telling through which the old handed their experience, Indian culture, traditions, oral history and way of life to the young who had a sense of place and their roots. TV makes the young important and the old redundant. 'Young people did not want to be Indians, in fact they hate being Indians - they want to be Canadians and Americans'. The old were silently witnessing the death of their culture (Mander 1996c: 352). American values as encapsulated in 'Dallas' are eloquently captured in the words of an *Dene* Indian: 'People are sitting in their log houses, alongside their frozen lakes with dog teams tied up outside, watching a bunch of white people in Dallas, standing around their swimming pools, drinking martinis, and plotting to destroy each other or steal from each other or get their partners' wives into bed. Then after that comes a show about a man turning into a machine… The effect has been to glamorise behaviours and values that are poisonous to life up here. Our traditions have a lot to do with survival. Community co-operation, sharing, and non

materialism are the only ways that people can live here. But TV always presents values opposite to those.' (*Ibid*: 351-52). It is life and soul destroying and obliterates the richness and diversity of life.

In the Third World TV serves to heighten the stark contrasts between the poor majority and the rich few. An Indian social scientist has tried to explain the recent suicide epidemic sweeping the sub-continent as a result of social breakdown and culture induced stress. According to him, 'economic liberalisation has further widened the gulf between the rich and the poor'. The opening up of the economy has benefited the elite further; while 'traditional bonds of extended families have snapped, leading to the disintegration of old family support structures. Increasing westernisation of the Indian elite, the rat race for personal wealth and glory has contributed to the loss of equilibrium. The stress on material values rather than moral or spiritual values, increasing consumerism, fuelled by myriad satellite TV channels' so that the rich now 'drive around in foreign cars, wear branded clothes and patronise expensive discos and five star hotels have contributed to the suicide frenzy in the economically deprived communities. Dazzled by the riches of the Indian elite, the poor take increasingly to crime. When this short cut to riches fails, as in most cases it must, the poor commit suicide'. (Coomi Kapoor, 10 July, 2000). Seventy percent of Indians do not have access to sanitation; 53 percent of children under five are underweight; almost 16 percent of the total population cannot hope to survive beyond the age of 40. Some 44 percent of the population is under the international poverty line of US$ 1 per day (*Ibid*). In the midst of this, corporate food chains vie to capture a dedicated following among the rich and the young, for the new tastes and lifestyles that Pepsi, Coke, Pizza Hut and Kentucky Fried Chicken offer.

In this theatre of life, corporations dominate and shape our perceptions of how life should be lived. In the US, some 75 percent of commercial network TV time is paid for by the hundred largest corporations meaning these entitles determine what goes on TV, hence deciding what viewers should watch. The average viewer watches 22,000 commercials every year. Thus 'twenty two thousand times, corporations place images in our brains to suggest that there is something great about buying commodities. Some advertise cars, others drugs … but all commercials agree that you should buy something and that human life is most satisfying when inundated with commodities. Between commercials there are programs, also created by corporations, that espouse values consistent with the ads… It is the pathbreaker for cars, paved roads, western franchise foods, frantic and stressful lifestyles, loss of traditional skills, immersion in computers, walkmans, CD ROMs' (Mander 1996a: 3,11).

TV has become the agent for the new global corporate vision. In this manner, a whole new generation has been schooled and future generations will be taught. It packages vicarious experience and synthesised canned consciousness severing people from human connections and the real world around them. In like manner, the computer age is inflicting the same subtle damages. Adults and kids alike spend hours surfing or chatting on-line. Like video and film and global entertainment, the computer becomes the substitute for human interactions, community and civic life. Little by little the machine conditions our lives, our consciousness and we lose the sense of inter-connectedness, human sensitivity and understanding that is vital for survival in the web of life on this planet.

The Culture of Violence

Globalisation has left in its wake a trail of bloodshed and violence. Armed conflicts have been occurring world-wide; from 1989 to 1998, data from the University of Uppsala, Sweden showed that there were 108 armed conflicts in 73 different locations. The majority of these i.e. 92 of the

108 took place within the boundaries of a single country. With the exception of Kosovo, all armed conflicts during 1999 took place in the Third World: Asia and Africa were the two regions with the highest number of armed conflicts. Wars in Sudan and Afghanistan have left millions dead. They are followed by Rwanda (500,000 – 1,000,000 million), Angola (more than half a million), Algeria, Burundi, Congo (Zaire) and Sri Lanka (100, 000 – 200,000 each). (Sollenburg 1998). Since 1990, these conflicts have claimed civilian lives which comprised 90 percent of deaths (*WorldWatch*, March/April 2000a) as a result of war induced famine, genocide, and social upheaval. Today's wars are fought between warlords, ethnic militias, private armies, and criminal organisations, and some 300,000 child soldiers (in at least 20 countries) are conscripted as cannon fodder world-wide. According to Canadian research, the violence and social chaos which results is an indication of the breakdown of state institutions and its failure 'to create or maintain conditions conducive to the welfare of their populations'. (Project Ploughshares 1999).

In Africa, the reasons for this breakdown has its roots in the economic crisis; SAPs, mounting deficits, debt servicing, and corrupt regimes have led to social breakdown, political instability, conflict over resources, hopelessness and despair; whilst the fall out from the Cold War has helped to fuel the civil wars that beset the continent. In a recent Conference on African Conflicts, analysts attributed the role SAPs played in destroying the political patronage system used by the elite to keep themselves in power. With the end of the Cold War and super power rivalry (as client governments and proxies were not needed), these regimes lost their source of protection and largese and corporate interests (especially mining) filled the vacuum.

When ethnic and religions conflicts flared in the region, it spawned a lucrative private security industry; and the major powers today contract their foreign military policy to military advisory and training companies. The end of the apartheid regime and the disbandment of its special forces have helped swell the ranks of mercenary groups. These military companies are involved in the armed conflicts in Angola, Sierra Leone, Somalia, Congo (Zaire), Namibia, Rwanda, Sudan and the People's Republic of Congo. Mercenaries and militias, have become the alternative in law and order situations as governments no longer have state monopoly over coercive violence. In fact the prevailing view in the North is that the solution to the security problem in Africa is to use mercenaries. Military companies are sponsored and funded by the mining corporations especially the $42 billion diamond trade. In fact these companies operate in areas where they target at reclaiming strategic resources and service the commercial interests of mining companies (Koomson Jan/Feb 2000).

The economic and human costs of these wars have been devastating. Its main victims are the weak and the vulnerable and the burden of war invariably falls on women who lose husbands, sons, children and family support on top of being the specific targets as victims of rape, sexual abuse, coercion and as war booty. In Mozambique the 16 year armed conflict that ended in 1992, killed one million Mozambicans, 60 percent of them children. Some 120,000 child soldiers are believed to be fighting in Africa: in Mozambique, children were kidnapped from their homes, given basic training and sent to fight against the Frelimo government. In Sierra Leone the more than eight year civil war (1991-8) saw thousands of children's lives irreparably damaged: many were forced to take up arms and to commit atrocities; others had their hands hacked off by soldiers (Lee 2000). Antipersonnel mines have made daily tasks like fetching food and water a mortal hazard; thousands of civilians including children have been killed, maimed and blinded. Some 280 million people are at risk. In Angola alone the number of antipersonnel mines in existence is said to be 12 million (*World Health Forum*, Vol 19, 1998). Conflicts in Mozambique and Angola are responsible for 50,000 and 20,000 amputees respectively, largely civilians (Werner & Sanders 1997:100). Landmines kill or maim more than 24,000 persons each year

(*UNDP* 1998), many children; yet mines are laid 25 times faster than they are removed with up to 2 million new mines planted each year (Renner 1994).

Ever since the financial crisis struck, Indonesia has been plagued with ethnic and religious violence. Some 4000 people have died in 18 months of violence in the Malukus and the violence has been spreading to other islands like Sulawesi (*Associated Press* 17 July, 2000).

Women for Sale

Economic reforms and SAPs have been responsible for the disintegration of civil society in Russia and the dismemberment of Yugoslavia. Economic growth has stagnated; between1989 – 96 inequality doubled, wages fell by 48 percent and serious human deprivation has resulted. Homicides, illegal drug trafficking has increased, and illegal human trafficking is a major social problem; some 500,000 women are trafficked each year for sexual exploitation from Eastern Europe and the Commonwealth of Independent States to Western Europe; an estimated 15,000 Russians and Eastern Europeans work in Germany's red light districts; in the Netherlands 57 percent of the trafficked women are under 21 years of age.

UN data reveal that some four million people are tricked or forced and smuggled into foreign countries each year by criminal syndicates. Women (and children) are trafficked from low-income countries to high-income countries in Asia and Europe. Women from Central and Eastern Europe are forced into the sex trade, which is growing. The slave trade in women is run by organised crime syndicates; their global enterprises have been estimated to be worth $1.5 trillion a year. With their power and money they have been able to influence politics and government. Economic collapse and war have created the victims, which are readily exploited by the criminal syndicate (*UNDP* 1999:43,85). The European Parliament blames 'the growing scale' of the problem on 'the inequalities of the world economic order' (Bebbington August 2000).

According to the International Organisation of Migration (IOM), Nigerian women are sold into sexual slavery in West Asia, Asian women are trafficked to Australia, and Latin Americans land up in US brothels. Nigerian girls were also brought to Britain and then sent to Italy to work as prostitutes. The victims usually poor, are promised jobs as waitresses, hotel domestics, and nannies, then forced into prostitution once they are out of the safety of their home regions. The UN Special Rapporteur on Violence Against Women, Radhika Coomaraswamy informed the UN Commission on Human Rights that 'The current era of trafficking has been described as the "bloom period" a particularly aggressive period where women and children are being trafficked for the purpose of prostitution (*Ibid*).

UN Complicity

In the fledgling state of Bosnia, which has become the biggest slave market in Europe, former warlords turned crime bosses buy and sell women, most of them from Eastern Europe. Some of the worst human rights violations are perpetrated by the international peacekeeping and reconstruction forces. The presence of the international community creates the market for prostitution (in 1993 the presence of UNPROFOR – UN Protection Force – presently SFOR – Stabilisation Force), which includes not only the soldiers of SFOR but, UN personnel and staff from the 400 or so nongovernmental organisation in Bosnia which either use the trafficked women or in a significant minority of cases are actually the traffickers themselves. According to Madeleine Rees, head of the Office of the UN High Commissioner for Human Rights in Bosnia, who has gathered evidence which include:

- an unpublished UN report of compelling evidence of complicity of local and international police and SFOR in 14 cases;
- four cases, one involving SFOR and three the International Police Task Force (IPTF) where men had trafficked women;
- in one IPTF base two officers admitted regularly visiting brothels where they knew trafficked women were held;
- five IPTF officers were caught in raids on brothels and recently sent home ;
- a number of staff (unconfirmed reports say six), from the Office of High Representative- the most senior UN body in Bosnia – were also caught in a brothel raid;
- saw and filmed European Union vehicles parked outside a well known Sarajevo brothel and saw UN vehicles outside other brothels;
- filmed a senior US member of the international community in a brothel boasting how easy it was to buy a woman 'as property'. (McGhie August 2000).

Poverty and Sex Trade

In South Asia, rampant poverty has spurred the slave traffic both within states and across countries; women and children have been trafficked for forced prostitution, forced marriage, bonded labour and the organ trade. Children end up as camel jockeys in circuses, in the slave trade, in the organ trade and prostitution (Akhter 1999). A UN report states that child prostitution is a global business. 'Chidlren are abducted, drugged, coerced by gangs and syndicates into prostitution both locally and across frontiers. They may be killed or maimed in the process. The tragedy is aggravated by AIDS' (Lee 2000). Globalisation and the economic crises have increased prostitution, pornography and mail order brides. In the Third World, sex tourism is a major component of the global sex industry where Third World women and children are used as recreation for Western men.

As can be seen globalisation and its effects have led to violence, crime and armed conflict in many Third World societies. A free market system that concentrates power and wealth and operates according to its own laws can only yield values like unaccountability and contempt of life.

This in turn has bred violence in all its myriad forms and violence in the world today is pandemic and a major public health concern. Corporate crime and violence is perpetrated against Third World communities and indigenous peoples in the form of toxic dumping; pollution of their lands, waters and other resources; poisoning of their children and future generations with chemicals and nuclear wastes; hazardous products and technologies at the workplace e.g. the electronics industry which is endangering the lives of thousands especially women in the Third World; defective cars promoted as speed machines that kill and maim; and tobacco which kills four million people annually world-wide. Through the corporate global media, Third World children are exposed to a culture that glamorises and glorifies killing and crime and denigrates women. Globalised culture desensitises and conditions viewers to accept violence against the weak, the old, women, people of colour and other cultures and religions. Even animals are not spared: they are tortured and killed for experimental purposes and testing procedures in the production of weapons, chemicals, cosmetics, and the like, while commercial farming inflicts cruelty on poultry, cows, pigs and others.

The US-UN Sanctions on Iraq

August 6th, 2000 will mark the tenth anniversary of the US-UN economic sanctions imposed on Iraq. These sanctions unleashed a human catastrophe that is unparalleled in history. Since the end of the Gulf War in 1991, the regime of sanctions imposed by the Security Council on the people of Iraq constitute the most punitive measures ever to have been devised and inflicted on a member State of the United Nations. They are unprecedented and transgress the acceptable norms of international law.

The cumulative effects of the more than nine-year sanctions on the Iraqi people have been devastating. Nine years of economic, financial and intellectual isolation have caused enormous human suffering especially among the young, women, and the elderly. It has resulted in death and disease, broken lives, lost skills, violent crimes, prostitution, divorce, family desertion, and rampant corruption which has undermined the entire social and moral fabric of Iraqi society. The collapse of educational institutions have led to levels of illiteracy that are harming an entire generation of children.

The six-week long Gulf War in 1991 killed some 250,000 people and devastated all facilities essential to civilian life and economic productivity throughout Iraq. Electricity generating plants, water treatment facilities, sewage treatment plants, communication systems and transportation networks, hospitals, schools and museums, and agricultural fields were all systematically destroyed. Iraq was bombed back to the 'Stone Age'.

Because of the sanctions, Iraq has not been able to repair or replace these facilities which have a direct impact on the health and well being of its 22 million citizens. More than 1.5 million people have perished in the last nine and half years as a direct result of the sanctions.

Yet, in contrast to the Gulf War event and many other series of conflicts and catastrophes occurring the world over, this silent war virtually garners no interest from the mainstream western media; leaving many sadly unaware of the unspeakable human suffering that is unravelling in Iraq.

Infant and Child Deaths

Last August, Iraq UNICEF Executive Director, Ms. Carol Bellamy said the findings in the latest UNICEF survey entitled Child and Maternal Mortality Survey 1999 (released for the first time since 1991) reveal an ongoing humanitarian emergency; highlighting a staggering increase in the death tolls of infants and children. The key findings of the Survey, (conducted in central and southern Iraq which comprise 85 per cent of the country's population) reveal:

- Under 5-mortality more than doubled from 56 deaths per 1000 live births before sanctions were imposed (1984 - 1989) to 131 deaths per 1000 live births between 1994 - 1999.

- Infant mortality increased from 47 per 1000 live births to 108 per 1000 live births within the same time frame.

- Maternal mortality ratio was 294 deaths per 100,000 live births over the ten year period 1989 to 1999. The Survey also states that 'the proportion of maternal deaths (31%) shows that maternal mortality is a leading cause of deaths in the last ten years among women of reproductive age'.

The comprehensive survey conservatively estimates that half a million children have died because of the sanctions during the eight-year period 1991-1998. This means that more than 5000 Iraqi children die every month from the impact of sanctions on Iraq's water and sewage treatment facilities, food and nutritional needs, and health care and delivery system.

Access to potable water is currently 50 per cent of the 1990 level in urban areas and 33 per cent in the rural areas. The April 1998 UNICEF Report stated: 'the increase in mortality reported in public hospitals for children under five years of age is mainly due to diarrhoea; pneumonia and malnutrition.' Many of the children who survive death suffer severe physical and mental injury from the cumulative effects of the sanctions. Apart from diarrhoea, there are also threats of outbreak from other communicable diseases such as cholera and typhoid due to the lack of access to safe water and sanitation.

Malnutrition

From 1991 - 1996, acute malnutrition among under fives increased from three percent to 11 per cent while chronic malnutrition increased at a higher rate from 18 per cent to 31 per cent within the same time frame. ('Situation Analysis of Children and Women in Iraq', UNICEF, April 1998). Malnutrition among children has stunted the physical, mental and emotional development of an entire generation of children; leading to long term health problems.

Low infant birth weight (under 2.5 kg) rose from five percent in 1991 to 22 percent in 1996 due mainly to maternal malnutrition. About 70 per cent of Iraqi women are anaemic. This will affect the health of the children concerned. Many will have underdeveloped organs, mental retardation, remain smaller and weaker than average and be more vulnerable to sickness, malnutrition and bad water.

Prior to the war, Iraq depended on imported food for almost 70 per cent of all its requirements. Today, under the sanctions regime, its food security and agricultural activities are severely threatened. Agricultural inputs such as seeds, fertilizers, pesticides, farm machineries and other necessary items for food production are not available under the dual-use policy thus undermining food availability. Earlier in September 1995, FAO had reported a famine.

Under the dual-use policy, basic humanitarian items such as chlorine for water purification and sanitation, pencil graphites, papers, and vaccines which have potential military use are blocked by the UN Sanctions Committee. With hardly any supply of vaccines and the lack of testing facilities, it is impossible to detect new strains and control the widespread outbreak of animal diseases. The 1998 - 1999 'foot-and-mouth' outbreak ravaged thousands of Iraq's livestock, devastating the Iraqi economy and food supply.

Cancer Epidemic

The US led coalition forces exploded more than one million depleted uranium (DU) encased shells over Iraq during the war. No one knows how much of the discarded shell casings and other radioactive material still remain in Iraq, but several investigators who have traveled to the area report that shell casings containing depleted uranium are scattered all over the ground in many areas, including in school yards and other similar civilian locales.

According to Professor Siegwart-Horst Gunther, who was one of the first to reveal that DU had been used in the Gulf War, 'many DU projectiles spread over the battlefields have been collected by children and used as toys with possibly devastating consequences'. He said that documents

released under the US Freedom of Information Act indicate that the Allied Forces would have left more than 300 tons of DU on the battlefields between Kuwait and Iraq mostly in the form of toxic and radioactive dust. Much of the uranium dust has been scattered about thousands of square miles of desert. Entire regions have been contaminated as radioactive DU has seeped into the subsoil and water table. Professor Gunther added that: 'It is feared that uranium particles get into the ground water and finally reach the food chain. Highly toxic uranium dust if inhaled can result in lung cancer'.

DU is responsible for the ten-fold increase in cancers in the country. Startling increase in the incidence of congenital malformation cases such as phocomelia, achondroplasia and mongolism as well as bone dysplasia, central nervous system disorders and anencephaly have been recorded. Myloid, lymphatic and undifferentiated leukaemia and increase in the incidence of relapses have all been attributed to the Gulf War. If cancers continue on their present upward trend, experts say 44 percent of the population will develop cancer within ten years. DU contamination of the food chain will continue for generations. The devastating long-term effect of radiation (the radioactive half-life of DU is 4.5 billion years) has an adverse effect on both the current population and many generations to come; the genetically deformed newborn and the environment.

Emerging Diseases

Many diseases, which had been virtually eradicated in Iraq before the war is making a comeback in this once-medically advanced country. Poliomyelitis has increased by a multiple ranging from 2 to 18.6 times since 1989, as contracts for vaccines are not approved by the Security Council. Cholera rose from zero cases in 1989 to 2560 cases in 1998 and scabies increased every year from zero cases in 1989 to 43,580 in 1998. Health conditions and diseases such as malnutrition, diphtheria, and cholera are posing a big challenge to the highly specialised Iraqi doctors as they were not previously trained to treat these typical third world health problems (ICRC Report, December, 1999)

Health System Collapse

Under the sanctions restricted conditions, the public health care system has eroded at every level. Basic supplies in the hospitals such as clean bed linen, proper lighting, soap, sterilisation equipment, oxygen, catheters, gauze, x-ray films, writing materials and the like are lacking. Life-saving medical supplies such as chemotherapy drugs, antibiotics, vaccines etc., are either banned or delayed under the dual-use policy. Limited medicines and medical supplies which are allowed in cannot be efficiently distributed or administered because other complementary equipment are vetoed or delayed for more than a year; due to the lack of transportation; communication breakdown; dilapidated bridges and roads; and erratic electrical supply which affects refrigerated storage capacity. Poor hospital conditions such as overcrowding and inadequate ventilation as well as the lack of access to many basic medical supplies increasingly frustrate the efforts of doctors. Many of their young patients are dying from diseases, which are easily treatable under normal conditions. Not only are they unable to save lives, doctors cannot even relive pain without painkillers.

It is evident that the US-UN imposed sanctions have taken a genocidal toll on the civilian population. The UN sanctions against Iraq that continue to be imposed at the insistence of the US (with the UK in full support) are a gross violation of international laws and the UN Charter. Sanctions in Iraq violate the right to life and the full range of economic and social rights including the right to health, education, food and an adequate standard of living, all guaranteed by the Universal Declaration of Human Rights, the International Covenant on Economic, Social and

Cultural Rights, The Convention on the Rights of the Child, and other international treaties including the Geneva Convention.

The fact that this crime against humanity is perpetrated in the name of the United Nations is an affront to human morality and decency. It clearly shows that the Security Council has abandoned its legal and moral responsibilities towards the Iraqi peoples. That the Security Council has been used by the US and the UK to pursue their political interests is a sign of the times – globalisation of a new world order.

Since 1991, the US led UN Security Council has instituted ten sanctions regimes. Following its military debacle in Somalia, the US has often opted for sanctions rather than military intervention. Indeed between 1993 and 1996, 35 new sanctions regimes were initiated by the US (Garfield Nov 1999): by 1997, US sanctions of some kind were in force against more than 50 countries containing 68 percent of the world's peoples (Meyers April 20, 1997). The cost of sanctions are born by the civilian populations, just as in economic globalisation, sanctions are almost exclusively employed by the rich market economies of the North, against weaker and more dependent states. They are 'part of a general assault on states that resist the cultural, political or economic penetration of the US led post cold war world order' (Garfield Nov 1999).

The Asian Financial Crisis

The total deregulation of the banking and financial markets aided by the revolution in communications technology has facilitated instantaneous money transfers worldwide. This has enabled currency speculators to move immense resources electronically at a blink across countries. In this cybertech globalised economy, money has become a product in itself that money buys and sells. It has been estimated that for every $1 circulating in the productive economy, $20 to $50 circulates in the pure world of finance. Since these transactions take place through unmonitored computer networks, no one knows how much is really involved (Korten 1996b: 28). This financial system is beyond the control of governments, which cannot ensure the stability of markets or currency values in the face of the tremendous acceleration of speculation (Barnet and Cavanagh 1996: 361). The result is that the world financial system has become extremely vulnerable to technological breakdown, short term speculation and freelance decision making (*Ibid*: 361).

In fact, global financial gamblers have been responsible for many of the financial crises that have caused devastating effects worldwide; large institutional players such as speculative hedge funds, the investment banks and the mutual and pension funds have led to short term capital flows across national borders in search of quick and high returns amounting to US$2 trillion changing hands everyday. In 1997, Thailand was forced to devalue its currency after it came under sustained speculative attack; this spread to the rest of Southeast Asia and South Korea. The huge inflows turned to sudden massive outflows as speculators acted like a herd, rushed out in panic. Roughly $22 billion and $30 billion flowed out of Asia in 1997 and 1998 respectively (Lester *et al* 2000: 194). Banks failed and stock markets collapsed; the economies of the region went into a tailspin. The cost of the crisis to the region in 1998 alone was said to be some $260 billion or one percent of global output, equivalent to the annual income of SS Africa (*UNCTAD* 1998).

The social fallout was severe and are likely to persist long after economic recovery. The immediate effects were political chaos mass unemployment, food shortages, spiraling food prices, riots and millions became impoverished overnight. Many local businesses went bankrupt due to high interest rates, currency devaluation and credit squeeze. A total of 435 Malaysian firms were declared bankrupt in the nine months from July 1997 to March 1998. Livelihoods were lost for

employers and employees, as they did not receive rescue packages unlike the large conglomerates.

Poverty increased markedly in Indonesia where 20 percent or 40 million were affected. In Korea and Thailand poverty is expected to rise to 12 percent: 5.5 million and 6.7 million, respectively. Unemployment rose in all the affected countries. More than 13 million people lost their jobs. Real wages in Korea fell by nearly 10 percent in the 12 months following April 1997. Social budgets were under tremendous strain.

In Philippines health expenditures declined by 10 percent with 6 percent reductions in family health and nutrition and 10 percent in communicable disease control; while in Malaysia the cut was initially 18-12 percent but a stimulus package was later introduced (*UNDP* 1999:42).

The increased social social stress and fragmentation was evident: rising domestic violence, street crime and suicides were reported in all countries. The worst affected countries were Indonesia, Thailand and Korea. (*Ibid*).

In Indonesia, the collapse of the rupiah and the spiraling inflation estimated at over 80 percent in 1998, have sapped purchasing power and eroded savings; unemployment was forecasted at 15 million in 1998 or 17 percent of the work force; wages fell by some 40-60 percent and poverty would increased by 50 percent by the end of 1998 (*UNCTAD* 1998: 73; *UNDP* 1999:40). The financial turmoil was followed by social upheavals that affected all sectors of society: the military dictatorship collapsed; ethnic tensions emerged; the Chinese were targeted, shops were looted and burnt, pogroms were conducted and Chinese women were raped. In the aftermath, many left to set up homes in Malaysia and Singapore. Ethnic and religious tensions have continued unabated in the outer islands of the Republic and thousands have died as a result.

In Korea workers took to the streets in droves; unemployment seriously deteriorated and was estimated at 10 percent by the end of 1998. The crisis hit women, the young and unskilled workers hardest. Unemployment declined by 7.1% among women between April 1997 and April 1998, compared with 3.8 percent for men. Migrant workers were also hardest hit, many were sent back. School enrollments declined but drop outs registered increases of 36 percent in 1998. Women suffered increased domestic violence – seven times more in 1999 as compared to 1998. Suicides increased from 620 a month in 1996 to more than 900 a month in mid 1998 (*UNDP* 1999:40).

In Thailand unemployment almost doubled to 8.8 percent between 1997 and Feb 1998. Since the onset of the crisis three years ago, some 1.8 million workers with primary and less than primary education lost their jobs and aggregate wage earnings of this group fell by 13 to 20 percent *(The Nation*, 22 July 2000). Poverty increased by one third by the end of 1998 as a result of job losses in augmenting rural and urban under-employment and in reducing urban worker remittances to rural families. With the drop in household incomes parents could not afford to send their children to school; as a result elementary school dropouts almost tripled from 1997 to 1998 (*UNCTAD* 1998: 74). In one study nearly 100,000 students are not in either primary or secondary education (*UNDP* 1999:40); the public health budget was reduced by 10 percent while the community and social services took a cut of 7.6 percent. Most Thais from the construction industry (which was hardest hit with 1.1 million laid off), returned to the rural areas to eke out a living. Since the 1997 crisis income disparity in Thailand has widened. The poorest saw their annual household income reduced to 3.8 percent from 4.2 percent in 1997 while the richest group were two percent richer at 58.5 percent in the same period. After the crisis, 3.1 million 'new poor' were added to the 11.4 percent of the population considered poor (Yuwadee T., 1 Aug. 2000).

The IMF medicine meted out to these economies which included high interest rates, tight monetary policies, cutback in government spending and the closure of banks, worsened the crisis further.

The economic crisis has made child sex tourism worse. The number of foreigners coming to Asia for child sex is rising sharply, says the organisation End Child Prostitution in Asian Tourism (ECPAT) at a UN sponsored regional conference on child sex tourism held in Manila recently. As a result of the economic crisis, prices for children have gone down, more children are living on the margins of society and more foreign paedophiles are streaming into the region (*The Sun* Aug 27, 2000).

Socio Economic Causes of Ill Health

It can be seen that the new economic reforms that have been imposed on the Third World and the changes in the global economy which have led to increased export led growth, privatisation, deregulation and free trade have had drastic consequences on the social fabric. It has led to the collapse of social systems; increased social inequities, resulted in conflicts; displaced populations; and increased migration. It has created a development model of production and consumption with far reaching impact on the physical environment worldwide. The environmental crises can be seen from the following indicators:

Threat to life support systems

- Carbon dioxide ($C0_2$) emissions have quadrupled over the past 50 years. The North with one fifth of the world's population account for 53 percent of the $C0_2$ emissions which is projected to rise between 30 and 40 percent by 2010;

- Global temperatures have risen especially in the last three decades – the period when $C0_2$ levels have been rising most rapidly. $C0_2$ concentrations are projected to double pre-industrial levels this century leading to global temperature increase by at least one degree Celsius and four degrees (two-seven degrees Fahrenheit);

- Climate change from global warning will reduce crop yields in Africa, South Asia and South America. Harvests will drop by more than 30 percent in India and Pakistan by 2050;

- Sea level is projected to rise from a minimum of 17 centimeters to as much as one meter by 2100;

- The above developments will alter every ecosystem on Earth;

- A sixth of the world's land area, some two billion hectares is now degraded (from erosion, compaction, salination, water logging and chemicalisation): by 2050 more than two billion people will live in regions facing land scarcity with extensive and increasing desertification in SS Africa and South Asia;

- Some one billion people in 40 Third World countries risk losing access to their main source of protein as overfishing driven by export demand for animal feed and oils puts pressure on fish stocks;

- A growing number of synthetic chemicals are endocrine disruptors: they are linked to male and female reproductive disorders, immune system disorders, neurological toxicity, low birth rates, slowed foetal development and male infertility among others. They amass in body fat and are carried up the food chain from prey to predator, bioaccumulating at higher concentrations; working their way into innocent species and distant ecosystems; migrating through the atmosphere, condense and deposit in soil or water and evaporate again spreading to all corners of the globe;

- The 132 million people in water stressed areas are in Africa and the Arab world: by 2050, the number may rise to 1-2.5 billion;

- Over the last two decades South America and the Caribbean lost seven million hectares (ha) of tropical forest, Asia and SS Africa four million ha each;

- Biodiversity loss will mean loss of food, medicines, energy, fibres, translated into destroyed livelihoods and human needs deprivation for two thirds of humanity;

- Sulphur emissions in the US alone were 20 million metric tons in 1993 compared with 38 million metric tons for 20 Asian countries. Acid rain is a major problem in Southeast China, Northeast India, Korea, Thailand;

- Ozone layer depletion is fast depleting thinning by some ten percent in the temperate regions: ultra violet light induced cataracts claim the sight of 17 million people a year;

- By the year 2023 the number of cars now more than 500 million may top one billion;

- Lead emissions (most of them in the Third World) could increase fivefold between 1990 and 2030: leaded petrol is crippling human health permanently impairing the development of children's brains. In Bangkok up to 70,000 children are at risk of losing four or more IQ points because of high lead emissions: in South America around 15 million children under two years of age are at similar risk (*UNDP* 1998; Brown *et al* 2000a; *WorldWatch* March/April 2000b).

Thus, the deterioration of the global environment and the ecological crises manifested as climate change, ozone depletion, degradation of food producing systems, depletion of fresh water sources, loss of biodiversity, the spread of invasive species, and chemical pollutants are threatening the biosphere and its capacity to sustain healthy human life.

Global warming from $C0_2$ emissions affects the entire world and represents one of the most serious environmental threats in the new century. The UN Intergovernmental Panel on Climate Change estimates that it will require 60-70 percent reduction in emissions to halt the rise in atmospheric concentrations of the greenhouse gases. Burning of fossil fuels and the emissions of green house gases have increased global warming. The US, which is the world's largest emitter of greenhouse gases will see average temperature increases by three to six degrees Celsius by 2100 (*AFP* 14 June 2000).

Extreme weather conditions linked to global warming have resulted in extremes of temperatures, fiercer winds, deadlier floods, longer droughts (the El Nino effect), increasing dust storms, tsunamis, tornadoes, hurricanes and cyclones. It has raised sea levels in the Pacific. In 1997 and 1998 El Nino and La Nina brought wild swings in temperature and rainfall. El Nino is estimated to have displaced nearly 5 million people, injured 118 million and caused almost 22,000 deaths.

Worldwide costs of the El Nino disaster were judged to be as high as $33 billion. The storms have ruined harvests and fuelled fires from Indonesia to Brazil (*UNDP* 1999:43). Weather related disasters are costing the world economy some $50 billion per year. They have caused suffering to more than two billion people since 1965 and three million have lost their lives (Smith 2000:36). For example, in China, the clearing of thousands of forests for economic and urban development around the Yangtze had stripped 85 percent of its forest cover. The monsoon in 1998 resulted in flooding of the Yangtze river which destroyed huge swathes of territory and made 223 million people homeless and $30 billion in damages (Brown *et al* 2000b: 24).

Debt-Induced Disasters

In Central America, socio-economic policies over the last three decades marginalised and impoverished the rural peasantry, who were forced off their agricultural lands onto degraded hillsides and shanty towns on floodplains, which were prone to floods and mudslides. When Hurricane Mitch struck in 1998, thousands lost their lives. The governments of Nicaragua and Honduras paralysed by a decade of structural adjustment did not have the resources to evacuate people. With the health system and social infrastructure destroyed, there was no money for vehicles, for vaccines, no staff, no petrol, no ability to stockpile drinking water. Honduras could not put the country on alert as it could not muster sandbags, plan evacuations, and organise back-up power supplies. Structural adjustment made it incapable to prepare for disaster-readiness. The country suffered $1 billion worth of damage to infrastructure and received $16 million of aid in return (Cockburn, St. Clair & Silverstein 1999: 459-462). In 1997, over half of state revenue in Nicaragua went to service the $6 billion debt: the amount it repaid on loans (over $600,000 per day) although it has consistently failed to service its debts in full, was more than double that spent on health and education combined. Over 40 percent of Nicaraguans do not have access to safe water and sanitation: 84 percent of Nicaraguan children live in poverty. In October 1999, hundreds of people outside Managua were struck by leptospirosis, a disease caused by rats, following heavy rains and flooding: by mid-November some 2500 had become ill (*IFRC & RCS* 2000: 13). The natural disaster in Central America was a man made catastrophe. La Nina killed some 9,000 people and left more than a million homeless in Nicaragua and Honduras (*UNDP* 1999:43).

A replay of this disaster struck Venezuela in December 1999. Two weeks of unprecedented rainstorms caused by La Nina swept hundreds of bodies and entire buildings into the sea. Fifteen metre waves inundated coastal areas destroying entire communities. Unofficial estimates put the death toll at 30,000 making it South America's worst natural disaster of the 20th century: 23,200 houses were destroyed and over 110,000 people made homeless. Some 85 percent of Venezuela's 22 million people live in urban areas, mostly shantytowns on degraded hilltops from two decades of rural urban migration due to unemployment and poverty. Some one quarter of a million jobs were lost in Vargas state alone, nearly 30 percent of the health infrastructure was damaged or destroyed (*IFRC & RCS* 2000:10).

In 1997 Southeast Asia was enveloped in a haze which was considered a global environmental disaster. Coupled with the dry season (related to the El Nino phenomenon) the massive uncontrolled burning of tropical forests in Kalimantan and Sumatra for plantation agriculture reduced visibility all over the region: haze affected the Philippines, Malaysia, Brunei, and Singapore. The State of Sarawak in Malaysia declared a State of Emergency because of the hazardous pollution and almost zero visibility. Air traffic grounded to a halt, deaths from traffic accidents due to poor visibility resulted. Acute respiratory problems among the young and asthmatics were reported. Those who could afford left the region with their families for fear of the long-term effects on health and safety. Experts estimated that the loss due to the fires in terms

of biodiversity was incalculable and irreversible. The Indonesia fires cause the deaths of more than 1000 people and more than 20 million suffered smoke related respiratory problems (*UNDP* 1998).

Over 80 percent of the fires were caused by private companies: conservative estimates have put the damage caused by the fires and haze at $4.4 billion which is 2.5 percent of Indonesia's GDP at the time. The losses does not include malnutrition due to crop destruction, deaths and diseases and loss of livelihoods to millions of indigenous peoples. (*Down to Earth* 2 Aug 1999). On 14th July, 2000, the Malaysian government warned that the haze had returned to the region. The air pollution Index (API) in Singapore reported unhealthy to hazardous levels of air pollution in July. For fear of the economic repercussions and negative image the haze was creating worldwide, the Malaysian Government decided to withhold the API readings from the public (Ritikos 19 July 2000).

The forest fires are linked to the IMF-World Bank prescriptions to deal with Indonesia's crippling debt, which currently stands at $150 billion; and worsening economic crisis. Indonesia was the hardest hit by the Asian financial crash in 1997. In that year, IMF disbursed $43 billion: since then $5.9 billion had been pledged (*Down to Earth* 2 Aug 1999). Export led growth and the development of oil palm plantations via the IMF-World Bank model has been the driving force for the destruction of Indonesia's forests.

Diseases Out of Control

Global economic forces have given rise to a situation where exposure to pathogenic microorganisms has increased and human resistance has been weakened. It has led to new emerging diseases and old diseases have staged a comeback.

In 1993, WHO estimated 14.4 million people died of infectious diseases. In the US, TB rose by 18 percent between 1985 and 1992. One third of the world's population is said to be carrying the infection. The spread of the HIV virus, which destroys the immune cells that keep the TB germ under control in the body, will cause many to die of the disease. With several strains of the TB bacterium now resistant to all anti-TB drugs, the WHO admits that the disease 'is out of control in many parts of the world'. Diptheria has reemerged as a major killer of adults in Russia. Plague has resurfaced in India, while malaria has returned to regions which it had been eliminated and is spreading to previously unaffected areas. Cholera has re-emerged as a major killer in South America. Epidemics of dengue fever transmitted by the *Aedes Aegypti* mosquito have swept parts of Venezuela, Brazil, India and Australia the first time ever. Yellow fever is on the increase in Africa.

Chemicalised and commercialised farming and food preservation have resulted in salmonella and listeria epidemics; transference of antibiotic resistance to humans from livestock and poultry; hormone or endocrine disrupters in agricultural pesticides, which affect foetal development, sperm counts and cause cancer; mad cow disease arising from modern large-scale methods of breeding and feeding livestock; and mad sheep disease which now can be transferred to humans and make them mad as well.

According to the Harvard Working Group on New and Resurgent Diseases, the major economic strategies of privatisation, export agriculture, deregulation and free trade, and economic growth have altered the epidemiology of our species through multiple pathways. Some of the factors or pathways that have affected human health include the global microbial traffic, altered ecosystems, and climate change (Harvard Working Group 1996:160).

Global Microbial Traffic

Modern transportation has made possible the large scale movement of goods and people rapidly. This increases the probability of vectors and non human carriers of disease being introduced into areas where they did not exist, often with fatal results. For instance the reintroduction of cholera to South America in the 1990s is thought to have resulted from a freighter discharging ballast water from China into Peruvian coastal waters. The water carried the cholera germ which flourished in algae which are eaten by seashells, fish, prawns and other marine life which in turn are eaten by people. Once it entered South America, the infection spread rapidly encouraged by urbanisation and IMF-WB SAPs cutbacks in sanitation and public health programmes. As of December 1994, millions of South Americans had become ill and thousands had died.

Migration as a result of rural displacement has contributed to the resurgence in malaria. In Malaysia, *P. falciparum* malaria in urban centres has been traced to Indonesian migrant workers. The same concern regarding yellow fever has been generated: its increase in Africa could be carried over to the urban areas from the savannah and forest fringes through migrants seeking work in the towns thus spawning an epidemic.

Altered Ecosystems

Environmental degradation and disturbed habitats can eliminate predators and competitors creating opportunities for new species to take up residence. For example, Oceania has been devastated by the colonisation of rats, goats, or weeds as the few native species could not compete with the intruders. The spread of water hyacinths in East Africa's Lake Victoria from Brazil is now a breeding ground for the water snail that transmits schistosomiasis and for the proliferation of diarrhoeal disease organisms (Epstein, PR 1998).

There is a major threat of new epidemics of malaria as a result of changes in land use associated with development activities. In Thailand, the removal of forest cover and the cultivation of commercial tree crops like rubber led to malarial epidemics. Malaria which was endemic in natural forest disappeared when clearing took place but reappeared in plantations which offered suitable habitats and hosts for mosquitoes. In Vietnam, people from the North were relocated in the south to work in plantations. Thirteen years after the stands were created, the country recorded its highest death rates from malaria, a significant proportion in rubber plantations, where the trees had reached the age at which they provide highly favourable conditions for the *anopheles dirus* which transmits *P. falciparam* malaria (Gomes, M., 1998).

Infrastructure development, poverty and pollution have combined to create new niches for pathogens (disease causing agents). Sewage and fertilisers draining into marine ecosystems, the over-harvesting of fish and shellfish, the loss of wetlands and myriad climatic changes have caused massive algal blooms in coastal areas worldwide providing a rich environment for diverse communities of microorganisms. High sea surface temperatures foster the growth of more toxic forms of pathogens among them a new variant of the cholera germ *V.cholerae 0139*. Antibodies that react to other known cholera variants do not recognise this new variant which is now present in at least ten Asian nations. There are fears that this environmentally hardy new form of disease could easily be the agent of a global cholera epidemic.

As the affluent urban environment becomes increasingly engineered through the impoundment, treatment and distribution of water and design of closed buildings in which air circulates, organisms that can survive in disinfected and 'hygienic' environments prosper. Disease like legionellosis, cryptosporidiosis and 'sick building syndrome' are the result. Institutions like

prisons, nursing homes, and hospitals, where residents are more prone to infection, have been the sites for the transmission of TB and antibiotic-resistant infections.

Climate Change

Global climate changes have severe implications for human health. Not only does it change global patterns of temperature, precipitation and climatic variability, exposing populations to thermal extremes and regional variable increases in weather disasters; substantial risks to human health occurs as a result of the disruption of complex ecological systems that determine the geography of vector-borne infections (such as malaria, dengue fever, and leishmaniasis); and the range, seasonality, and incidence of various food borne and water borne infections; the yield of agricultural crops; the range of plant and livestock pests and pathogens; the salination of coastal lands and freshwater supplies due to rising sea levels; and the climactically related production of photochemical air pollutants, spores and pollens (McMichael, & Beaglehole 2000).

Changes in global temperatures carry with them, changes in wind and precipitation patterns, ocean currents, humidity, soil composition and vegetation. These affect human activity and movement, vector redistribution, and new breeding sites for diseases. In Zimbabwe and western Mozambique, periods of drought associated with El Nino affect, have regularly led to major infestation of rats, which are carries for a number of diseases. In India and Colombia, a warmer climate is believed to be responsible for the spread of *Aedes aegypti* mosquitoes at altitudes above 2,000 metres; previously they were confined by temperature to altitudes below 1000 metres.

According to Paul R Epstein, Associate Director of the Centre for Health and Global Environment at Harvard Medical School, global warming influences health through several routes: more directly, it can generate more, stronger and hotter heat waves; in some places the number of deaths related to heat waves is projected to double by 2020. Prolonged heat can enhance the production of smog and the dispersal of allergens both effects have been linked to respiratory symptoms. Heating of the atmosphere increases the frequency and intensity of droughts and floods, which promote by various, means the emergence, resurgence and spread of infectious disease.

Global Warming Spreads Diseases

Diseases carried by mosquitoes such as malaria, dengue fever, yellow fever and several kinds of encephalitis are among those causing the greatest concern as the world warms. Malaria is reappearing north and south of the tropics: it has returned to the Korean peninsula, parts of Southern Europe and the former Soviet Union, to the coast of South Africa along the Indian Ocean. Dengue has broadened its range in the Americas in the last ten years and reached down to Buenos Aires by the end of the 1990s: it has also found it its way to Northern Australia.

The incidence of vector borne and water borne diseases climbs during El Nino and La Nina years, especially in areas hit by floods or droughts. Longterm studies in Colombia, Venezuela, India and Pakistan reveal, that malaria surges in the wake of El Ninos: regions stricken by flooding or drought during the El Nino of 1997-1998 (the strongest of the century) often experience a convergence of diseases borne by mosquitoes, rodents and water. Additionally, in many dry areas, fires raged out of control, polluting the air for miles around.

According to Dr. Epstein, several climate models predict that as the atmosphere and oceans heat up, El Nino will become more common and severe which means weather disasters they produce and diseases they promote could become more prevalent. Since 1976 the intensity, duration and

pace of El Ninos have increased: during the 1990s every year was marked by an El Nino or La Nina extreme. These trends bode ill for human health in the 21st century. Increased climate variability accompanying warming fuels outbreaks of certain vector-borne diseases for eg. warm winters followed by hot dry summers favour the transmission of St. Loius encephalitis and other infections that cycle among birds, urban mosquitoes and humans.

This was the pattern that led to the emergence of the West Nile virus in New York City last year. The persistence and spread of the virus was aided by mosquitoes, which was responsible for the transmission of the disease. The mild winter of 1998-99 enabled mosquitoes to survive into the spring, which arrived early. The drought in spring and summer allowed them to breed better while killing off mosquito predators, and encouraged birds to congregate more, many of them sharing the water holes frequented by mosquitoes. Once the mosquitoes acquired the virus, the heat wave speeds up the rate at which the virus inside the insects reproduces and mature.

In 1997, 527 people in Bucharest, Romania were struck with West Nile virus and 50 died. In 1999, the virus killed seven in New York and by 2000, scientists have warned that it has spread all over the Americas. The infection is endemic to Africa, Asia and Europe where it resides harmlessly in many bird species but kills others. The virus is transmitted to humans from the *culex mosquito*, which is infected by birds. Migratory birds congregating on mosquito infested wetlands will spread the disease far and wide (Mackenzie, 8 July 2000).

If increased warming and weather extremes result in more ecosystem disturbance, that disruption may foster the growth of opportunist populations and enhance the spread of disease.

Rains brought by a warmed Indian Ocean to the Horn of Africa in 1997 and 1998 led to flooding, setting off epidemics of cholera and two mosquito born infections: malaria and Rift Valley fever fatal to both livestock and people. In the aftermath of Hurricane Mitch, Honduras reported thousands of cases of cholera, malaria, and dengue fever. In February 2000, unprecedented rains and a series of cyclones inundated large parts of Southern Africa. Floods in Madagascar and Mozambique killed hundreds, displaced thousands and spread both cholera and malaria.

New diseases are triggered by climatic disruption in the form of floods. In late 1993, a new disease emerged in the Four Corners region of the US. A 37 year old farmer died after experiencing flu like symptoms for several days including fever, nausea and vomiting which progressed to coughing and shortness of breath. An X-ray showed fluid in both lungs, the farmer developed respiratory distress and died. The Centres for Disease Control in Atlanta, linked the mysterious disease to a new strain of Hanta virus – one of a group of viruses that have been associated with haemorrhagic fevers and kidney disease in Europe and Asia. Studies linked the emergence of the disease to a sudden increase of deer mice, which are carriers of the Hanta virus, following the end of a six year drought in the spring of 1992. Heavy rains flooded the area, producing an explosion of pinon nuts and grasshoppers - the food for mice. Deer mice flourished, but the drought had eliminated all of their predators. Between May 1992 and May 1993, the numbers of deer mice increased ten fold. As of February 1995, 102 cases of Hanta virus pulmonary syndrome had been reported mostly in the Southwest. Fifty-two percent were fatal. The hanta virus pulmonary syndrome has appeared in South America, where some ominous evidence suggests that it may be passed from one person to another.

In Malaysia in 1999, the Nipah virus led to the deaths of millions of pigs, in Penang, Selangor, Negri Sembilan and Melaka, virtually wiping out the pig industry in some regions. One hundred and five people succumbed to the disease while others were totally incapacitated with coma. Farmers lost millions of dollars, some almost their entire families. The new virus emerged again

in June 2000, hundreds of thousands of pigs were culled although no humans have been affected at the time of writing. The Nipah virus is assumed to be transmitted by direct contact with infected individuals and their body fluids or urine. It is not known whether the Nipah virus is highly infectious or whether it is transmitted from person to person. Scientists say that the virus is not indigenous to pigs or humans: it must have reservoirs and circulate naturally among some unknown wildlife animal species like birds or rodents. As long as the ecology, reservoirs and natural transmission cycles of the Nipah virus in Malaysia are unknown, real preventive measures are not within reach (Third World Network 1999). Unless an interdisciplinary and integrated study is conducted to understand the Nipah virus ecology, the Nipah viral epidemic will remain a constant threat to the pig and human population.

Today, with increased international commerce and travel, an infectious disorder that appears in one part of the world can quickly become a problem continents away if the pathogen finds itself in a hospitable environment. According to a WHO report, between 1969 and 1999, 89 cases of malaria were reported among people living close to airports in countries where malaria is not endemic. They included France (26 cases); Belgium (17 cases); Britain (14 cases); North America (4) and at least five deaths recorded (*The Financial Times* Aug 22, 2000).

Disease cannot be understood and tackled in isolation from the social, ecological, epidemiological and evolutionary contexts in which it emerges. Disease cannot be reduced to a single cause. Thus the network of factors that lead to a disease is complex and conventional classification of diseases as infections, environmental, psychosomatic, autoimmune, genetic and degenerative is applicable only to a few diseases where one factor overwhelms all others (Harvard Working Group 1996:169).

Failure to address this remains the hallmark of the institutions that govern global health policy. Technological, quick fix approaches do not address the multiple causes of diseases; it does not help to create new social and ecological processes and conditions that would minimise the disease burden in Third World countries. With increasing globalisation that further undermines the environmental and social wellbeing of societies everywhere, we can envisage further threats to health. Large-scale technological solutions promoted by the WB and the global health institutions like the WHO-UNICEF further masks the social and environmental causes of ill health (*Ibid*).

Conclusion

Globalisation has led to increased environmental threats; the marginalisation of local communities; increased migration; urbanisation; land use patterns which affect the soil, deforestation, monoculture, soil depletion, and loss of biodiversity; pollution of the seas and farmlands from chemicalised agriculture; resource depletion; malnutrition; and the curative emphasis in health care and public health with increased reliance on technologies like drugs, vaccines, and chemicals. Integration of markets has resulted in new products and new lifestyles especially toxic products like tobacco, alcohol, contaminated foods, irradiated foods, junk foods, dangerous medicines, the trafficking in drugs, organ trade, antipersonal landmines, light weapons, pornographic materials and the like. These developments have far reaching implications on the spread of disease and public health.

Clearly the effects of the global economy have been devastating for societies everywhere. Globalisation as institutionalised in the WTO, IMF-WB acting on the pressures of the TNCs and their governments has led to the disempowerment of nation states and the collapse of their economies. Governments especially in the Third World are burdened with debt, economic decline and environmental disasters: this makes it almost impossible to achieve any meaningful social

development for their peoples. Poverty has increased and the gap between the rich and poor have widened; unemployment is a fact of life; communities have disintegrated; traditional family structures have broken down, there is more homelessness and destitution, violence in all forms is escalating; environmental problems and diseases are beyond control.

Increasingly peoples have come to recognise that this system is not working; where people are devalued and life has no social meaning; where institutions are given unbridled powers to facilitate corporations to accumulate and concentrate wealth and immiserate the lives of the majority. They are reacting against this system demanding changes and seeking alternatives: that foster justice and equity; happiness and fulfillment; promote ecological principles, values of cooperation, community, love, caring, and respect for life and diversity.

Many citizen groups and individuals are now working together in various networks and coalitions to bring about change at different levels.

Global Level Initiatives

Reform of the WTO

Seattle and its aftermath have inspired and encouraged social movements that the process has begun to meet the challenges of the next century. There is now an international call to 'roll back the power and authority of the WTO' which demands include:

- opposition to a New Round and to bring in new issues such as investment, competition, government procurement, and biotechnology;

- a full review of the WTO Agreements and their impact on social, environmental and health policies;

- removal of all critical issues that affect the environment, public health, safety, and the rights, welfare and basic needs of people from the WTO. Thus WTO rules must not apply to issues like food security, water resources, basic social services, health and safety, and animal protection;

- national governments should be sufficiently informed about the impacts and have capacities to analyse and give inputs as part of democratic governance. National interests is more than just economic and trade interests;

- disputes on issues concerning health and public safety, labour rights and environmental concerns should be shifted to appropriate fora like the specialised UN agencies, ILO, WHO, FAO rather than being dealt behind the closed door dispute settlement body of the WTO;

- removal of TRIPs from WTO as intellectual property rights is not related to trade and should not be in a trade agreement that leads to the private appropriation of knowledge, undermines biodiversity, deprives people of essential medicines, threatens food security and sustainable agriculture, and keeps the South from developing their technological capacity. Patenting of life forms must be prohibited from all national and international laws;

- Third World countries should enhance their domestic legal capability to deal with the dispute settlement process instead of relying on the law firms of the North which charge heavy fees

eg. regional cooperation to set up a legal centre to prepare and defend cases should be considered;

- given the fact that the WTO is the single institution which will have the largest impact on health, there is a need for WHO to play a major role in international health policies especially in the WTO negotiations. This is all the more necessary when the WTO provides the potential for the development of corporate self-regulatory measures eg. the pharmaceutical industry has set the agenda in the International Conference on Harmonisation (ICH) of Technical Requirements for Registration of Pharmaceuticals for Human Use which was set outside the WHO (in fact WHO was sidelined to observer status). This is of crucial importance as the WTO makes reference in the TBT Agreement to international standards, which will be exploited by corporate interests. Since the WTO calls for the least restrictive trade practices, and the downward harmonising of laws, environmental, social and health standards will be subordinated leading to the use of the lowest standards.

Debt Cancellation

This campaign has successfully brought together groups of every political stripe including secular and religious groups. Debt has been defined as **illegitimate** because it was contracted by dictatorships and corrupt governments; **immoral** as governments to pay their debt have to sacrifice the health of their peoples, reduce education, worker wages, damage the environment and threatens the survival of present and future generations.

The Jubilee 2000 is calling for:

- The cancellation of all Multilateral (owed to the IFIs) Bilateral (owed to individual governments) and Commercial (owed to international commercial banks) debts;

- An international court or tribunal to judge these odious, immoral debts and order their cancellation. The Brazilian Jubilee 2000 has called for an international mobilisation to propose to the UN General Assembly that a joint suit be brought before the International Court of justice at The Hague; to seek a judgement on the processes that give rise to foreign debt, and factors that cause it to grow, such as unilateral decisions by creditor nations to raise interest rates;

Others have called for:

- The control of the process dealing with debt be removed from the IMF, WB and the Paris Club. (The Paris Club is the name given to the regular gatherings of creditor nations who meet with debtor countries to discuss terms of rescheduling, refinancing and writing down of debts);

- The use of structural adjustment conditionality to force trade liberalisation in the Third World must be halted;

- Northern governments must honour their commitment to give 0.7 percent of GNP to AID: donors only allocate $55 billion or 0.25 percent of their total GNP of $22 trillion. Only four of the 21 donor countries have met the UN target namely Denmark 0.99 percent; Norway 0.91 percent; the Netherlands 0.8 percent; and Sweden 0.72 percent. The USA remained at the bottom at 0.1 percent of GNP. For most third World countries aid is the only source for national development especially for social development in health and education;

- All multilateral and bilateral aid, grants, projects and programmes must have social, environmental and health audits eg the World Bank is exporting hazardous incinerators as part of its aid programme to the Third World;

- The North must honour the 20:20 Compact under the Social Summit that requires Northern States to allocate 20 percent of ODA to basic social programmes with mutual Third World Partners who will do the same from national budgets;

- The North must reverse the transfer of resources from the South to the North (already made worse by debt servicing and SAPs, rising military expenditures and poor returns on investment) with fair terms of trade, eg better market access and fair prices for the Third World's primary commodities;

- Northern governments must stem the corrupt practices of transnational corporations, the bribe givers in the South. These practices undermine national development, increase debt, disadvantage smaller domestic firms, manipulate contracts for projects that benefit the elite few and the company and increasing inequality and poverty; bypass the domestic process, damage the environment and circumvent laws;

- Nothern governments must facilitate and ensure that the ill gotten gains of corrupt regimes must be exposed and repatriated from private banks in the North.

Democratisation of the UN

At the Havana Summit some 40 Ministers from the South have called for a fair share in the UN's decision making process if they are to improve their lot. They called for:

- Permanent membership in the Security Council for the South and the elimination of the veto;

- Transparency in the Security Council and an early warning system to prevent emerging conflicts;

- Reaffirming the UN Charter's provisions on respect for sovereignty, sovereign equality, non-intervention in internal affairs and self-determination;

- The primacy of the UN General Assembly and the reform of the Bretton Woods Institutions to allow the South to participate in the decision making process given the major impact of their policies on those nations' economies;

- Many groups have also made the same call for full democratic participation of member States in the UN system;

- An end to the sanctions on Iraq;

- The WHO, ILO, FAO, UNICEF, UNESCO must be provided adequate resources and support; shrinking funds have made them rely on extra budgetary funds (voluntary funding) eg more than half of WHO's (and FAO's) budget is from this source for special programmes like AIDs and essential drugs; these funds should not be used by donors to influence policy and decision making in the special agencies thus undermining their work;

- Reevaluation of UN corporate partnerships. In July 2000, an international coalition of NGOs wrote letters to the UN Secretary General and heads of UN agencies who are associated with the Global Compact to reevaluate their partnerships with the corporate sector (with tarnished records on human rights, labour and the environment) which include Nike, Shell, BP Amoco, Rio Tinto Plc and Novartis. The NGOs charge that the Global Compact which includes the UNHCHR, ILO, UNEP UNDP and UNICEF is promoting a vision of corporate-driven globalisation that threatens the mission and integrity of the UN (Third World Network 31 July 2000). In 1999 UNDP was found to have solicited funds from corporations under the Global Sustainable Development Facility. The corporate sponsors include Rio Tinto Plc, Asea, Brown Boveri, Dow Chemical, Citibank and Stat Oil Norway. WHO should not renew its ties with Ciba Geigy and Galactina S.A. or forged partnerships and alliances with corporations;

- The US government must fulfil its commitments and pay up the $1.8 billion it owes to the UN, to allow the latter to carry out its functions instead of seeking money from the corporate sector.

Stengthening the Role of WHO

It has been shown that all socioeconomic activities impinge on health. Health can only improve if there is a serious commitment to address the real issues that affect its enhancement namely the global economic forces that have led to inequality, poverty, and poor quality of life from environmental degradation. Clearly poverty is the most important factor affecting health. Health is more important than to be simply dealt by the Ministry of Health in each country. Today's health problems are more complex and challenging. In the light of this, social movements, and concerned peoples should call on their governments that WHO, deal with member States not at the level of their Health Ministries alone. With this in mind WHO should:

- Call for an international meeting or Forum to discuss the impacts of Globalisation on Health; or for the UN General Assembly to convene such a meeting;

- Call on governments to support and strengthen the efforts of WHO which is under threat from both corporate lobbies and their Northern governments who are trying to roll back WHO's initiatives for better health namely, in The Revised Drug Strategy and the Framework Convention on Tobacco Control. Even the Code on Baby Food has been under attack and, Third World governments have come under pressure to abandon it;

- Affirm and promote the spirit of Alma Ata: primary health care continues to be undermined by 'new health approaches', 'new public health' more 'Round Tables' and more renewal strategies for Health for All. Despite the subversion of Alma Ata 'Health for all through primary health care' is imperative for the Third World and especially relevant in the face of the global economic threats that we are confronted with today;

- With the help of member States and social movements ensure that all health regulations and treaties eg. Cartegena Protocol, Convention on Biological Diversity and the Basel Convention, to protect the health of peoples are not superseded by international rules and regulations which destroy government's attempts to protect peoples' livelihoods, health and environment;

- Cooperate with other UN agencies to study, assess and monitor the environmental and health impact of climate change, liberalisation, SAPs, and the WTO Agreements e.g. TRIPs, GATs and the AOA;

- Assist governments to formulate policies, programmes and provide expertise to help formulate and strengthen laws relating to the environment, health and social well being, and women eg GMOs, use of genetic technologies in diagnostic procedures and therapy;

- Be provided with adequate resources and support by the members to be effective in global health work. WHO' grants have stagnated at around $900 million a year, compared to the World Bank which is now the single largest source of funds for health with an active portfolio of $9.2 billion by the end of 1996. WHO must take back its leadership role as the directing and coordinating authority on world health, which has been usurped by the World Bank. This is crucial as the World Bank's health policies promoted in the name of health reforms driven by economic outcomes are opposed to WHO's health for all strategy and emphasis on health outcomes;

- Ensure and enforce its independence and integrity from corporate and donor interests and the pressure of Northern governments in its work.

National Level Initiatives

Role of Government

The current free market model is weakening public institutions and governments' responsibility and capacity to ensure equity, democracy, security and well being: increasingly functions of government are hijacked by the TNCs and the WTO which are undemocratic, unaccountable and non-transparent in their activities. In this era of globalisation, good governance is of first imperative: **Third World** governments must:

- promote self reliance and support traditional and indigenous health systems (including homebased healing traditions) and the recognition of women's crucial role as healthcare providers;

- promote self-reliance in agriculture and support traditional and local sustainable farming practices and organic agriculture. For example countries like Cuba have proven that organic farming is not only sustainable; it has increased yields of small farmers: it has successfully developed a biological pest control programme and established 173 vermicompost centres across the country producing 93,000 tons of natural compost yearly;

- honour their commitment to Alma Alta and Health for All; they have a fundamental responsibility to provide universal access to human needs and services according to peoples' needs not means: health (including mental and social well-being) services must be universal, comprehensive and people centred not market driven;

- be allowed to implement the Essential Drugs List to foster safer, efficacious and cheaper medicines use without being threatened and pressured by the pharmaceutical lobby and their Nothern governments. In 1982 when Bangladesh banned over 1600 drugs which were useless, ineffective or harmful under a new Drug Control Ordinance, led by the US, UK, Fance , Germany and the Netherlands threw its weight behind the drug TNCs and threatened to cut off foreign aid to Bangladesh. Even the World Bank pressured the government to make

changes to its National Drug Policy deemed restrictive to free trade. The progressive drug and health policies of Bangladesh were partly responsible for the removal of President Ershad from office in 1990. Similarly when Sri Lanka introduced an essential drugs policy, the American Pharmaceutical Manufacturers' Association responded swiftly by halting drug sales forcing Sri Lanka to water down the policy. In many countries public spending on drugs take up some 40 percent of the annual health budget: over 70 percent of the drugs that the TNCs sell to the Third World are non essential: out of some 270,000 pharmaceutical products on the global market, WHO has compiled a list of about 300 or so essential drugs that are needed to treat virtually all human ailments; in all Third World countries, irrational and hazardous medicines proliferate the market; some $7 billion can be saved with the EDL that could be spent on better health measures when EDL is used;

- assure drugs should not benefit only the rich minority. Governments whose countries are burdened with AIDs eg SS Africa, Brazil, Thailand and Haiti, should be allowed to obtain cheaper drugs through compulsory licensing and parallel importing without being threatened and bullied by the US. If the US and the North are sincere they should pressure their drug companies to reduce the prices of these life saving medicines instead of the former offering $1 billion loans to SS Africa which would further increase their debt problems, to buy drugs at world market prices (Swarns, Aug 23, 2000). The high prices of AIDs drugs cannot be justified: most of them were discovered in public laboratories and developed in clinical trials supported by public funds. Ninety five percent of HIV afflicted people are in the Third World: WHO estimates that by 2000, there will be 40 million living with AIDs in 2000 and some 16 million children orphaned (who lost their mother or parents to AIDs);

- reform the medical and health curriculum to make them socially relevant and people centred. Third World countries inherited the colonial medical model which is urban centred; based on curative care in large hospitals and 'Western trained' specialists who are ignorant or ignore the underlying socioeconomic causes of illness and poor health. They are often arrogant, gender insensitive and incapable of identifying with the needs of the common people (most doctors come from a higher social class background) and invariably align themselves with commercial medical interests;

- upgrade, improve, foster and give equal importance, recognition and support to the development of indigenous systems of health through training, education, research and development, documentation and so on;

- cooperate together eg South-South initiatives and regional cooperation in areas like agriculture and health and pharmaceuticals.

Northern Governments must:

- stop the manufacture and sale of light arms, antipersonnel landmines, and the like to Third World countries. Although the 1997 Mine Ban Treaty (Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction) came into force in March 1999, and has been signed by at least 138 countries, the US, Russia, and China have not signed the Treaty. These countries must honour their global responsibility as veto wielding permanent members of the UN Security Council;

- stop the dumping of hazardous technologies and products eg incinerators, nuclear irradiators for food and microwave ovens which threaten public health and safety;

- regulate the financial sector and lobby the G8 to act; a new financial architecture must be people oriented and socially inclusive and deal with global inequities and poverty that affect more than four billion people; the role of the nation state must be accorded a primary role to control global finance and the active participation of the Third World countries which have been currently marginalised and ignored.

- seriously tackle the global traffic in women and children with tougher laws. The international community is part of the problem in the trafficking of women (and girls) in Bosnia and must show urgency and a sense of responsibility in combating this outrage. Many groups are calling for international laws against the sexual exploitation of women and children to deal with the abuse of prostitution, as the 1949 Trafficking convention does not recognise prostitution as sexually exploitative, nor does it include forced marriages and forced labour.

Local Level Initiatives

Peoples movements should:

- Monitor the activities of their governments as to whether they are keeping their global commitments to treaties and agreements;

- Meet with Northern donors and ask for transparency in their aid policies;

- Network with groups and individuals which are working across sectors on North-South and South-South cooperation to campaign, plan strategy, share information, tactics, lobby governments and citizens;

- Monitor the activities of TNCs, the IFIs and donors in their respective countries;

- Lobby governments for better national legislation to foster peoples' participation in nation building, protection of women, children, workers etc. For example Thailand has a provision that allows for constitutional review when the views of 50,000 citizens' and their signatures are presented to parliament;

- Foster, support and highlight local initiatives towards sustainable, ecological and self-reliant community development models. For example there are movements everywhere which are encouraging and developing the growth of local economies, protecting rural and urban communities and family life. In the North, farmers are now directly linking with urban consumers and farmers' markets in Japan, UK and the US to benefit local economies and the environment. In the South communities are also developing alternatives, going back to organic agriculture, promoting village self-reliance and rehabilitation of degraded habitats (terrestrial and marine) for survival and livelihood;

- Actively and sincerely build second generation leadership (with gender balance); we all grow old and cannot live forever and the process of change is a long-term effort.

Finally, changes are not going to happen overnight. It needs a long-term plan and health activists and social movements need to prepare for a protracted struggle. For this to happen there must be a programme to nurture and groom new blood and leadership among the young. We must constantly seek cooperation and solidarity with other networks and forge links with these forces.

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