



## Networks

### **Médecine pour le Tiers Monde (M3M)**

Médecine pour le Tiers Monde (M3M) is a Belgian NGO defending the right to health for all through people's empowerment. To this aim M3M supports partner organizations in Cuba, the DR Congo, Latin America, Laos, Palestine and the Philippines. All of these partner organizations organize and mobilize the people to assert their right to health. Through alliances with people's organizations from different sectors they also try to build alliances on a national level. Besides their local and national activities they engage in international networking for solidarity and advocacy purposes.

In Belgium, Médecine pour le Tiers Monde has close ties with the solidarity movement intal, which is applying a similar empowerment strategy to arouse, organize and mobilize youth and social movements to globalize solidarity for the right to health by acting upon issues that are related to the economic, political and social determinants of health (e.g. actions against free trade agreements; against war, occupation and military interventions; against the repression of defenders of the right to health, actions on climate change and social justice...).

[www.m3m.be](http://www.m3m.be)

### **Medicus Mundi International Network (MMI)**

Medicus Mundi International is a Network of private not-for-profit organisations working in the field of international health cooperation and advocacy. MMI is an association according to German law, seated in Tönisvorst, Germany, and registered at the Amtsgericht Krefeld (VR 3655). Since 1974 the Medicus Mundi International Network maintains official relations with the World Health Organization (WHO EB 63 R.27).

The MMI Network aims to be a living community where members come together voluntarily to share and develop their knowledge, solve common problems and develop joint activities. The MMI Network does not impose leadership, coordination or representation on its members. The MMI members bear the overall responsibility for the MMI Network, its development and its activities.

#### **Shared vision of the Network members**

The MMI Network members share the vision of access to health and health care as a fundamental human right ("Health for All").

While recognizing that poverty, inequality, violence and injustice are at the root of ill health and death in many low-income countries, MMI Network members are convinced that

- accessible, equitable and affordable health care is essential to the improvement of global health, fighting diseases and reducing poverty;
- the major challenge is to keep basic health care sustainable and affordable;
- the key strategy is to strengthen the health system as a whole;
- the private not-for-profit health sector is an essential actor that needs to be considered while strengthening the health care system;
- users of health services should have the opportunity to contribute to the development, management and monitoring of health care policies and services.

### **Aim and mission of the Network**

The MMI Network aims at promoting access to health and health care, supporting the efforts undertaken in this respect by the Network members.

The Network supports its members' efforts to achieve the shared vision of Health for All through a set of specific contributions:

- undertaking advocacy and sensitization activities at an international level;
- enhancing communication and the exchange of knowledge and know-how between members;
- enhancing cooperation, coordination of activities and the development of joint activities;
- fostering the development of common policies and practices

[www.medicusmundi.org/en](http://www.medicusmundi.org/en)

## **Health Poverty Action**

Health Poverty Action's role is to strengthen poor and marginalised people in their struggle for health.

We have grassroots programmes in 13 countries in Asia, Africa and Latin America as well as seeking to influence policy and practice at all levels. Most of our roughly 500 staff are based locally and come from the populations they serve.

Health Poverty Action has a distinct approach, summarised as a combination of three factors:

1. **We emphasise the need for justice rather than charity.**  
We work to tackle not just the symptoms of poor health, but its root causes. In particular, we recognise the profound importance of the social and economic determinants of health – hence our name, Health Poverty Action.
2. **We prioritise those missed out by others.**  
Development initiatives exhibit a natural tendency to cluster together, the same factors leading numerous organisations to the same areas. This leaves large populations with almost

no support at all. They may be living in hard-to-reach areas, or are difficult to support for some other reason.

**3. We specialise in providing a holistic approach.**

This is especially important for the poorest and most marginalised with little support. They face so many threats to their health. Tackling one in isolation might give the appearance of success, while in reality doing little more than changing the cause of death. Tackling numerous factors together can bring lasting improvements – and also give rise to creative linkages and innovations.

Our work falls into four broad categories:

- 1) In-country development programmes
- 2) Influencing policy and practice
- 3) Responding to emergencies
- 4) Provide consultancy & other contracted services

Health Poverty Action sees itself as having been born out of the primary health care movement, a few years after Alma Ata. The People's Health Movement's history, analysis and positioning therefore strongly resonate with those of Health Poverty Action. Our growing role within PHM is now a fundamental part of our identity, and we see it as our primary global network.

We have agreed at Board level that (unless a specific decision is made otherwise), Health Poverty Action's policy analysis and positions will be guided by those of the PHM and Global Health Watch. We will contribute to the latter's formulation in return.

[www.healthpovertyaction.org](http://www.healthpovertyaction.org)

## **Latin American Association of Social Medicine – ALAMES<sup>1</sup> [www.alames.org](http://www.alames.org)**

### **The creation of ALAMES**

During the 1960's and 1970's in Latin America the principles of social medicine gained wide acceptance and the discipline matured. In a number of countries there was a critique of the over medicalized training of human resources in health as well as of health practices which focused on biological parameters without adequately considering the impact of social, political, economic and cultural factors on the health-illness continuum of populations.

There were many voices which joined this critique of the biomedical model and proposed a new social medicine model. Among those voices, that of the Argentinean sociologist and physician, Juan Cesar García stands out. Juan Cesar García drew upon the postulates that had been developed in

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<sup>1</sup> Taken from: Torres Tovar Mauricio. ALAMES: Organizational Expression of Social Medicine in Latin America Journal Social Medicine. 2007, Jul; 2(3): 125-130. Available at:

<http://www.socialmedicine.info/index.php/socialmedicine/article/view/142/252>

France and England in the mid nineteenth century by such notable figures as Rudolph Virchow, recognized as the father of social medicine, and developed them with the theoretical tools of historical materialism.

During the 1970s, in his role at PAHO's Human Resources Department, Juan Cesar García continued his work on the training of health personnel on the continent. At the same time he helped coordinate the diverse social and academic players who agreed on the need to transform the then-current model human resources development in order that the health needs of the continent could be better met, with a clear political commitment to social transformation at the service of marginalized sectors of society.

Garcia promoted two key gatherings in the development of a blueprint for a political proposal in this field; these were both held in the city of Cuenca (Ecuador) and are known as Cuenca I (1972) and Cuenca II (1974). During these gatherings the lack of training in medical sociology in the formation of health professional was criticized as promoting a static conception of health problems and a rigid description of the relationship between health problems and other spheres of productive processes in general. These meetings stated the necessity of developing new models for organizing knowledge, models that would center analysis on change and include theoretical training of research that would start from the internal contradictions of a given phenomenon and be able to incorporate not only the elements specific to that phenomenon, but also the structural factors, as well as the relationship between the two.

From these principles the gatherings at Cuenca proposed the development of post-graduate academic programs in social medicine. These were seen as the context for changing both the training and the praxis of public health. This initiative resulted in the appearance of post-graduate programs in various countries. The first among these were the Masters in Social Medicine at the Metropolitan Autonomous University in Xochimilco, Mexico (1975), and the Social Medicine program of the Rio de Janeiro State University (1976).

After these developments the need arose for some way to coordinate the people and initiatives that were working from a social medicine perspective. This led in 1984 to the formation of the Latin American Association of Social Medicine (ALAMES) during the third conference on the development of human resources in health in Ouro Preto, Brasil.

### **ALAMES' accomplishments**

During its years of existence, ALAMES has managed to coordinate the activities of diverse social actors. Initially, these were the academic institutions, which made possible the theoretical and methodological development of social medicine. Later, health care providers joined these efforts by putting into practice the wealth of technical and methodological knowledge on social medicine.

Since the 90s organizations and social movements that advocate for the right to health in the region have joined these efforts.

Over the almost three decades, ALAMES has contributed to the transformation of the training of health care professionals, to the development of practices in health designed to affect the social determinants of health and to overcome the biomedical model. ALAMES' members hold positions in governmental health programs from which they have been involved in the design and implementation of public policy geared towards overcoming health inequality. ALAMES has supported social movements that seek the guarantee of the right to health on the continent.

## What are the guiding principles of ALAMES?

A founding principle of ALAMES has been political action. Since the mid 90s ALAMES has defined itself as a social, political and academic movement involved in concrete activities at the regional level to fight for health as a civil right and a public good. With this perspective ALAMES has proposed and defended these fundamental principles:

- Health is a prized asset of human beings; for health to be a reality requires a radical defense of life and wellbeing;
- Health is a human and social right and a public good; this places a duty on the State to guarantee it and on society the responsibility to demand it;
- Health, as a public good and human right, must be detached from the logic of the marketplace;
- Addressing health inequities is an ethical imperative; it involves changes in the social, economic, political, environmental and cultural determinants of health as well as the recognition that the diversity of health needs must be considered in the design of social and institutional responses.

ALAMES seeks to collaborate with a broad spectrum of social actors and movements throughout the continent in a joint effort to promote the right to health and life. Among the key components of that political agenda are to:

- Demand social policies that affect the structural determinants of health;
- Demand the consolidation and construction of universal and free health systems;
- Advance the right to health for everyone without regard to gender, sexual and ethnic origin;
- Protect the right to health in the context of environmental degradation;
- Insure the health of workers, defending and building upon the rights they have already acquired;
- Defend the right to health in the face of war, militarization and violence;
- Fight for the development of primary health services and for health systems of high quality, efficiency and sustainability;
- Demand the revision of intellectual property legislation *imposed by developing countries*, so that they do not affect the guarantee of the right to health;
- Promote the integration of traditional and academic health knowledge within a framework of respect and cooperation, for the purpose of rescuing traditional health practices;
- Demand that health inequality be eliminated with urgent and diverse public programs which would include prevention, protection, education, curative and rehabilitative assistance, as well as the organization and management of health services in such a way as to expand organized social participation and the effective control of the State by society.
- Promote alliances for a radical defense of life among movements working for the rights to health, to water, food security and land, the environment, gender rights, and the rights of indigenous and Afro-American populations, among others.

## The International People's Health Council

“The struggle for health is a struggle for liberation from poverty, hunger and unfair socio-economic structures”

IPHC, 1991

The International People's Health Council (IPHC) was established in 1991 as a worldwide coalition of people's health initiatives and socially progressive groups and movements committed to working for the health and rights of disadvantaged people – and ultimately of all people.

The vision of the IPHC is to advance toward 'Health for All', viewing health in the broad sense of physical, mental, social, economic and environmental well being.

The inaugural meeting in Nicaragua in December 1991 was planned with a view to exploring concepts of health in “societies in transition”, where ‘transition’ was used in a positive sense, in terms of change toward healthier, people empowering social structures. The participants were mostly from countries in socio-political turmoil, if not always transition. All were leaders in community health work among disadvantaged groups, many in the struggle for liberation or for far reaching social and political (structural) change. They were from El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, the Dominican Republic, the USA, India, Bangladesh, the West Bank and South Africa.

At the end of the meeting a public statement was issued, announcing the name of the newly formed IPHC, its proposed structure and objectives.

### ***IPHC Objective***

***To foster among local, national and international agencies the formulation of economic and health policies that respect equity and the right to health, with an emphasis on primary health care, community-based health and health as a broad crosscutting issue.1***

The second international gathering was held in Palestine in February 1995 around the theme of ‘The concept of health under national democratic struggle’<sup>2</sup>. The third gathering in Cape Town in January 1997 was co-sponsored by IPHC, the National Progressive Primary Health Care Network (of South Africa) and the South African Health and Social Services Organisation. The proceedings of this conference were published under the title, ‘Lighten the burden of third world health: the new world order: a challenge to health for all by the year 2000’<sup>3</sup>.

The networks and connections from which IPHC participants drew their experiences and into which they, in turn, fed IPHC analyses was impressive. It was well placed to strengthen the link between political analysis and grassroots work and to extend the network's efforts to promote the political understanding of health as a global issue

The planning and management of the first People's Health Assembly out of which emerged the People's Health Movement was a crucial achievement towards which the IPHC made a very significant contribution.

As PHM evolved, IPHC, as a loose network of activists, continued to play an important role in steering PHM, in organizing subsequent PHAs and in sustaining the work of PHM at the local, regional and global levels. However, many of the objectives which IPHC had set itself in the early years are now being carried by PHM including promoting a structural analysis of health politics, promoting the importance of grass roots mobilization and building global solidarity.

As a consequence of the commitment to PHM by IPHC activists and the success of PHM as a growing global movement, activism under the IPHC banner subsided in the new millennium.

IPHC was one of the founding networks of PHM since 2000 and as such has had a representative on the PHM Steering Council. However, with the PHM governance reforms currently being put in place IPHC has been required to review its position vis a vis PHM.

In terms of the future of IPHC a range of scenarios are possible, ranging from revitalization with a focus on political and economic analysis of global health issues; through hibernation; to disbandment. One practical consideration which is worth some weight is that IPHC has legal status as a Stichting registered in the Netherlands.

Pending finalization of current discussions regarding the future of IPHC it would be appropriate for the network to be included in the PHM college of networks (however named) but not to put forward a person for election to the Steering Council.

There should be no doubt that IPHC as an organization and as a loose network of activists is fully supportive of PHM and the direction that PHM is presently taking including the governance reform.

## References

1. International People's Health Council. Health care in societies in transition: a report on a small international meeting held in Managua, Nicaragua, December 4-9, 1991. Palo Alto, Hesperian Foundation, 1992.
2. International People's Health Council. The concept of health under national democratic struggle:. Jerusalem, Union of Palestinian Medical Relief Committees, 1995.
3. International People's Health Council. Lighten the burden of third world health: the new world order: a challenge to health for all by the year 2000. Durban, Health Systems Trust, 1997.

## **Gonoshasthaya Kendra (GK) Peoples Health Centre**

GK emerged from the field hospital of Bangladesh Liberation War. On March 25, 1971, the liberation war of Bangladesh began in response to an oppressive Pakistani rule, marked by brutal genocidal attacks by the Pakistan army. During this time, news of the armed struggle of Bengalis led a group of expatriate doctors working in London to organise the Bangladesh Medical Association. Two of the doctors, Dr. Zafrullah Chowdhury and Dr. M.A. Mobin visited the frontlines of the war and began treating wounded soldiers, known as "Freedom Fighters," who were fighting a guerrilla war against the Pakistan army. With the help of the Bangladesh exile government in Calcutta, they established a field hospital on the eastern border of Bangladesh, near the Tripura and Comilla districts.

After independence, the lessons learned in treating the Freedom Fighters and refugees proved invaluable in developing the character of today's Gonoshasthaya Kendra (GK).

### **Strategy:**

GK's overall strategy is to use primary health care as an entry point to work with the people, for the people, to develop a self-reliant, equitable a social just society

### **The Major Objectives of GK:**

1. To find ways and means for providing complete and comprehensive health care delivery system.
2. To sponsor projects for the social and economical development for poor people and particularly to restore control by women and attempt to preserve the rights and privileges of the majority population.
3. To launch some exemplary activities for the upliftment of the fate of the general public which would influence on all public or private future development planning.
4. To promote more self-reliance to reduce the tendency to depend on others.
8. Create social awareness against fundamentalist, fight communal violence to restore peace and security with protection interest of the minorities.

### **[Ongoing Projects](#)**

- Health Care
- Education
- Nari Kendra – Women Empowerment
- Disaster Management
- Seasonal Credit
- Agriculture Cooperatives
- Research and Publications

During the last almost four decades, GK has increased its coverage from 50,000 people in 50 villages in 1972 to almost 1.2 million rural population with 39 Primary Health Care centres with 5 Referral hospitals two Tertiary Hospital, -covering 608 villages, 38 unions in 40 locations under 17 districts across the country in 2010 making GK as one of the largest health care service providers outside the government of Bangladesh

[www.gkbd.org](http://www.gkbd.org)



## Health Action International (HAI)

Stichting Health Action International is a Dutch civil society Non-Government Organisation (NGO), with a coordinating office (HAI Global) in Amsterdam and partner regional offices Africa (Nairobi), Asia Pacific (Penang), Latin America (Lima) and Europe (Amsterdam). Although primarily a Dutch organization, HAI is recognised for its global medicines policy expertise and as a non-profit, independent, worldwide network of over 200 members including consumer groups, public interest NGOs, health care providers, academics, media and individuals in more than 70 countries.

HAI works to increase access and improve the rational use of essential medicines.

HAI is working towards a world where all people, especially the poor and disadvantaged are able to exercise their human right to health, which requires equitable access to affordable quality health care and essential medicines.

HAI and its global partners recognize that poverty and social injustice are the greatest barriers to health and sustainable development. Partners are working for just societies where people can participate equitably in all decision making that affects their health and well being, including the allocation of resources.

HAI's strength is to enable consumers, health care providers, public interest NGOs and policy makers to collaborate based on mutual interests and common positions to advocate for policy changes and improved health for all.

Partners work together to respond rapidly to priority issues by sharing information and expertise. Collaboration creates a broad base of support and ensures that the concerns of diverse communities are communicated at local, regional and international levels.

Globally HAI works:

- to promote the essential medicines concept, that fewer than 350 medicines are necessary to treat more than 90% of health problems requiring medicines.
- to increase access to these essential medicines and ensuring that they are available at affordable prices when treatment is needed, especially for the poor
- for greater transparency in all aspects of decision making around pharmaceuticals, for example, by reducing industry secrecy and control over important clinical data
- to promote the rational use of medicines: that all medicines marketed should meet real medical needs, have therapeutic advantages, be acceptably safe and offer value for money
- for better controls on drug promotion and the provision of balanced, independent information for prescribers and consumers.

[www.haiweb.org](http://www.haiweb.org)

## Third World Network:

Third World Network (TWN) is an independent non-profit international network of organisations and individuals involved in issues relating to development, developing countries and North-South affairs.

TWN was formed in November 1984 in Penang, Malaysia at the concluding session of an International Conference on "The Third World: Development or Crisis?" organised by the Consumers' Association of Penang and attended by over a hundred participants from 21 countries. At this conference, TWN was formed to especially strengthen cooperation among development and environment groups in the South.

Its mission is to bring about a greater articulation of the needs and rights of peoples in the South, a fair distribution of world resources, and forms of development which are ecologically sustainable and fulfil human needs.

TWN's objectives are to deepen the understanding of the development dilemmas and challenges facing developing countries and to contribute to policy changes in pursuit of just, equitable and ecologically sustainable development.

To achieve these objectives TWN conducts research on economic, social and environmental issues pertaining to the South; publishes books and magazines; organises and participates in conferences, seminars and workshops; and provides a platform representing broadly Third World interests and perspectives at international fora such as United Nations agencies, conferences and processes, WTO, the World Bank and IMF.

The [TWN website](#) contains information on economics, environment and other issues from a development perspective. There is also a dedicated website for [biosafety](#), [finance and development](#) and [bilateral free trade agreements](#). Selected Mandarin Chinese translations of TWN's web materials are available at <http://twinchinese.net>.

TWN's International Secretariat is in Penang (Malaysia) with offices in Kuala Lumpur (Malaysia), Geneva (Switzerland) and Goa (India). There are researchers based in Beijing, Delhi, Jakarta and Manila. The Latin America Regional Secretariat is located in Montevideo (Uruguay) and the African Regional Secretariat is in Accra (Ghana).

### TWN PUBLICATIONS

[Third World Resurgence](#) – a monthly magazine on development, ecology, economics, health, alternatives and South-North relations.

[Third World Economics](#) – a bi-monthly economics magazine focussing on the GATT/WTO, the World Bank/IMF, etc.

[SUNS bulletin](#) – the daily South-North Development bulletin published from Geneva, Switzerland.

[TWN Features Service](#) – a service to the media providing three features a week.

For more information, a publications catalogue and subscriptions details, please write to or e-mail TWN publications department.

## **HAI-Asia Pacific**

Health Action International Asia-Pacific (HAIAP) is part of an independent global network, working to increase access to essential medicines and improve their rational use through research excellence and evidence-based advocacy. HAIAP is an informal network of non-governmental organisations and individuals in the Asia-Pacific Region committed to strive for health for all now.

HAI AP News is the organ of Health Action International – Asia Pacific and presents the happenings in the regional campaigns for more rational and fairer health policies and carries material in support of participants' work.

## **International Baby Food Action Network (IBFAN)\**

The International Baby Food Action Network, **IBFAN**, consists of public interest groups working around the world to reduce infant and young child morbidity and mortality. IBFAN aims to improve the health and well-being of babies and young children, their mothers and their families through the protection, promotion and support of breastfeeding and optimal infant feeding practices. IBFAN works for universal and full implementation of the [International Code](#) and Resolutions.

### **The International Code**

The groups that formed IBFAN were instrumental in putting the marketing of baby foods onto the health agenda, resulting in the 1979 meeting referred to above. IBFAN then campaigned for a strong and effective marketing code. The [International Code of Marketing of Breastmilk Substitutes](#) was adopted by the World Health Assembly in 1981. Through continued vigilance, new marketing strategies and developments in thinking on infant nutrition have been brought to the attention of delegates at the World Health Assembly leading to the adoption of further Resolutions which aim to protect infant health and mothers rights.

### **A global action network**

IBFAN is an International Network. Structured like a net, it encompasses the Earth. Groups are diverse: they may work on infant feeding issues alone, or they may be mother support groups, consumer associations, development organisations or citizens rights groups. Some are staffed by volunteers, some have full time staff. What all groups have in common is they take Action to bring about implementation of the International Code and the subsequent, relevant Resolutions of the World Health Assembly. These are the main tools that IBFAN uses with the aim of ensuring that the marketing of baby food does not have a negative impact on health.

<http://www.ibfan.org/>