SFU SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

ENGAGING DIASPORA in development
Tapping Our Trans-Local Potential for Change

Report on Dialogue 2:
Improving Global Health

March 16, 2011, 6:30 - 9:00 PM
SFU Morris J. Wosk Centre for Dialogue, 580 West Hastings Street

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1: Overview

On March 16, 2011 the Engaging Diasporas in Development (EDD) convened the second in its series of five public dialogues. 115 participants attended the dialogue.

Agenda

The dialogue was entitled *Improving Global Health* and the agenda (see Appendix 1) covered three core themes:

(1) the unique skills and experiences of diasporas influencing health,

(2) how these experiences are transforming health practices and systems, and

(3) tapping the current potential impacts in Canada and beyond.

In order to frame the dialogue participants and members of the public were provided access to a background paper *Global Health – Issues and Concerns*--prepared for the dialogue, by James Busumtwi-Sam, associate professor in the Department of Political Science, and Director (acting) of the Development & Sustainability Program at SFU (see Appendix 2).

Media

The global health briefing paper also formed part of a series of six blogs that were posted on the Vancouver Observer site (see Appendix 3).

There were several members of the media present, including Kathleen Flaherty, who is recording all five sessions for the CBC Ideas series.

The event was a video recording of the event is available on the website – http://www.sfu.ca/diasporas/event_improving_global_health.htm. In addition, there was a live Twitter feed - @SFU_Diaspora

Summary of Proceedings

The dialogue was opened by Shaheen Nanji who welcomed the participants on behalf of the traditional First Nations territories. She gave an overview of the project and provided a working definition of the diaspora for the conversation: people who live in Metro Vancouver who retain a sense of identity with another place. In many cases, in addition to feeling an attachment to another home, diasporas feel a sense of attachment and belonging to Canada and may have been born here. This duality – or embodiment of diversity -- that diaspora possess is what gives them the empathy, cultural agility, and commitment to bring to bear on international development. Joanna Ashworth presented the evening's agenda and invited everyone to participate and provide their different perspectives. She introduced her co-moderator for the evening, Ajay Puri.

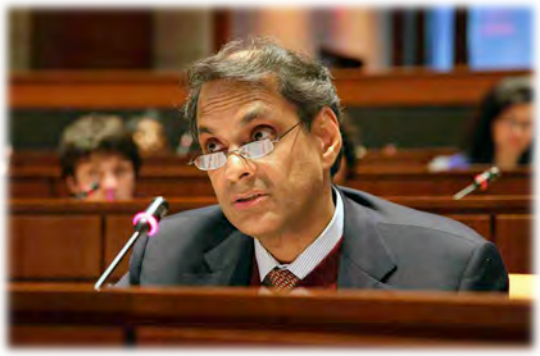
Back row: Marj Ratel, Ashok Mathur, Dr Shafique Pirani, Mohammad Zaman, Lyren Chiu, Derek Agyapong-Poku, Jerry Spiegel, Steven Pi
Front row: Shaheen Nanji, Ajay Puri, Dr. Kojo Assante, Joanna Ashworth

Dr. Jerry Spiegel provided an overview of global health, a term that is becoming more common in recent years. Dr. Spiegel explained that international health becomes global health when the causes and consequences of a health issue circumvent, undermine, or are oblivious to the boundaries of state and thus beyond the capacity of any one nation to address. He went on to say that we have to look not just a treating a case, but at the circumstances that allow that case to exist. We have to examine questions of context, and not privilege treatment to the exclusion of prevention. "When we look at distributions of need and capacity we find huge disparities. The majority of health care providers are in North America and Europe. The burden of disease is overwhelmingly in Africa and Asia. International and

national flows of health care professionals tend to exacerbate the problem rather address it."

After Dr. Spiegel's presentation, Ayumi Mathur guided the group through an exercise where participants considered what health meant to them as individuals by discussing it in small groups.

The dialogue then turned to the storytellers. The first was Dr. Shafique Pirani, who was born in Uganda and left at age 15 at the "invitation" of Idi Amin. He trained in Canada as a pediatric orthopedic surgeon and returned to Uganda 23 years later to see his old house. His remarkable story has been in the subject of numerous media interviews and articles.



The next storyteller was Steven Pi who talked of the May 2008 earthquake that struck Szechuan killing almost 100,000. He was then-president of the UBC Chinese Varsity Club that held a fundraising dinner to raise money for the earthquake victims. They were so successful that the group decided to continue their fundraising efforts. They also have been effective in the areas of drug rehabilitation. In 2009-10 Steven went to Yunnan to visit an atypical drug rehabilitation centre. This centre had a high success rate by using methods that worked with addicts rather than punishing them.

Next was Marj Ratel, who worked with her partners in Ghana and with a multinational team to make the Korle-Bu Neuroscience Foundation project successful. In 1999 a Ghanaian surgeon, in residency at a Vancouver hospital, invited Marj to go to Ghana to train nurses. She accepted and brought three nurses with her, where they initially provided nursing resources. The high commissioner from Ghana later came to Vancouver and she showed him all the beds being donated for the hospital in Ghana. He asked what was wrong with them and when told they were in good working order, he was astonished. The president of Ghana was instrumental in getting them going and establishing a sense of trust and legitimacy.

Derek Agyapong-Poku told the audience that being a part of Korle Bu has been a dream come true. He has been searching for a way to give back to Africa through the knowledge he has gained in administration and financial management. He is the president of Excellence in Africa, which is the active wing of the program in Ghana. His passion is to contribute to health care in Ghana and other African countries. He wanted to give back as he was given a scholarship to study in Ghana. He also wants to inspire the youth.

Finally Mohammad Zaman talked about arriving in Canada in 1980 as a graduate student at the University of Manitoba. He completed his dissertation in Bangladesh looking at flood displacement. Bangladesh is at the epicenter of climate disaster, where between 30-75 million people could be displaced. He said that when you talk about health you must talk about vulnerability, including that which is created by environmental factors. We must look at all of the social factors. There will be at least 200 million people displaced by climate change, something that we all must address.

2: Key themes and topics of discussion

What is unique about diasporas doing development?

Dr. Pirani: At the time of visiting Uganda, he was able to raise his own awareness and then raise the awareness of others. He was also able to tap his networks for support - there are many who want to help and don't know how. When he realized that the issue was something that he could address, there was a leap into actually getting personally involved.

Dr. Kojo Assante: After many years of working in Northern BC and Uganda he became interested in fetal alcohol syndrome He went South Africa, but he also wanted to get involved in Ghana. He became aware of Korle Bu and the people involved. They invited him to participate and he agreed that it was a good idea. He was aware that many people in Ghana were dying because a lack of services that we take for granted here. He was interested in the issue of education.

Steven Pi: He primarily sees himself as a connector. Seeing his peers and friends connect with people on the other side of the world, he understands the role that diasporas can play as connectors.

Dr. Zaman: He is part of a very vibrant Bangladeshi community in Vancouver, with many organizations. When the climate change issue became a global discussion and Bangladesh was identified as being on the brink of disaster, they though they should do something. After a series of discussions amongst themselves they created the Society for Bangladesh Climate Justice (SBCJ) primarily as an awareness-raising organization, but also to get involved in research and action. They are connecting with several researchers and professors. International migration cannot be the solution to climate displacement. There must be capacity building for adaptation and mitigation. The primary purpose of SBCJ is to network with sister organizations in support of developing local capacity in Bangladesh. They are in year three, undertaking a series of projects in Bangladesh on a voluntary basis to support capacity building.

Dr. Kojo Asante: As a physician who trained abroad and stayed abroad, he offers that young doctors must realize the need for change in their country. Going abroad is not a good option for that. Doctors need to stay in their country and push for change. Countries doing well can serve as templates for young people. It is not hopeless. Social change is necessary. It is difficult, but we need to find ways to make social change. Leaving the country is not a good option for achieving this.

Jean de Dieu: What excited him is to see educated people take global health seriously. It inspires him to see Western medicine, Western theories and thoughts about health. For thousands of years people have known how to heal each other. How do we address our indigenous knowledge? Why do we always place it in Western packages?

Dr. Pirani: Sustainability: in BC we spend 40% of our budget on health. The per capita health care budget in Uganda is $10/capita. How can we find sustainable approaches given these constraints? What can we do to bring forward sustainability?

Dr. Spiegel: One thing he appreciated about Dr. Pirani's presentation was the question of building skills that would stay. The question of poaching – for people who choose to stay in difficult situations, being able to connect with a wider community can make the work environment more appropriate. When we have recruiting drives, we are not just allowing the tide to bring people here, but we are aiding and abetting it. It would be wise to look at professional interactions as a means of reinforcing people who stay in their homelands – bring them into a global community.

In what ways are global health initiatives leveraging the trans-local potential of the diaspora communities in Vancouver?

Mike Wilson (member of the audience): his work deals with identity and the problems of "us" and "them". Getting past this false distinction is key. At this time there are 20 global problems that defy national level identity (climate change etc.) Think globally and act locally doesn't work. We need to maintain local identity but also transcend it to think and act as a global person. Japan is an example of a global, trans-generational trans-species problem. The nature of the problems we now face demand getting beyond local identities. This is one of the most beautiful opportunities for our species and our evolution.

Marj Ratel: Communication technology allows us to interact internationally on a daily basis

Samson (member of the audience): He disagrees with some people saying that you can convince doctors to stay when they are so underpaid. Some soldiers make more than doctors. In Uganda the Uganda Virus Research Centre is the place where the first research was conducted showing that circumcision reduces the risk of HIV transmission. The Johns Hopkins hospital and others provide the research from this centre and private enterprise is involved. Doctors involved in this project in Uganda do not leave.

Dr. Pirani: There is a problem with private enterprise and NGOs. What happens when the NGO gets tired? What happens when the private enterprise decides to go elsewhere? The question of sustainability has to be addressed.

Miraj Khaled (member of the audience) – We can tap into the expertise of diasporas for things like emergency preparedness. Why should we focus on democratic institutions of government so much in international development when there are such problems of disease and health?

Dr. Lyren Chiu – Founder of the Canadian Research Institute of Spirituality and Healing (CRISH). She was born in Taiwan. She has 25 years of experience in mental health and spirituality. Spirituality is harmony, it is an evolving process, and it is living in the world while transcending the world. She joined the UBC faculty in 1999. She pursued her interest in alternative medicine at Harvard, but came to Vancouver because it was a hub of research in this area. In 2007-8 CRISH initiated a public forum in Vancouver to discuss making integrated health care a reality and introducing other concepts beyond western medicine into the community. They wanted to create a society called Beautiful Minds as a means of bringing people and minds together. They have successfully helped open numerous Chinese medicine centres across the city. They helped defeat bill C-51, which placed inappropriate standards on Traditional Chinese Medicine. TCM is very popular in Vancouver.

How are diaspora transcending boundaries and serving as a bridge between the Global North and South?

Jean de Dieu – when he looks at the question he thinks about two years ago when the EU was talking about diaspora. In Europe they have 50,000 African professionals working. Does the government take into consideration the value and ability of the diaspora? It is very easy for the Canadian government to support a project done by a white person. If the same project is done by a black person with a diaspora background, the government tends to turn them down. Many people in Diaspora groups have tried and the government put them down.

Dr. Zaman: This is a very important issue. The Canadian government and international development work should involve the diaspora more. That is something lacking. This does not mean excluding the non-diaspora population. The current bureaucratic model involves a few local people in its projects, but fails to engage with the diaspora. This is a policy issue that must be addressed.

Dr. Spiegel – it is fundamentally important to look at how you affect change. We need to relook at how we define knowledge. There is at least some rhetoric acknowledging this. It is time to walk the walk

Dr. Pirani: a question: What, then, constitutes an enabling environment for diasporas to become sustainably engaged. The enabling environment for his work is

CIDA. The diaspora have to make the case that they can be involved and they have to do it in a cohesive way.

Steven Pi – When his peers started their organization there was criticism and questions of why students would care. The enabling environment came from recruiting people to get involved.

The dialogue ended with a summary of key thoughts and themes by Ashok Mathur, who left the participants with a quotation to consider in the context of the evening's discussion. "All we want to do is get as far away as possible, but we can't" – from a Japanese woman who is stuck in the 30km radius of the Fukushima reactor. Dr. Mathur reminded us that although we might want to get away from issues of health, care, responsibility, we can't.

Appendix I: Agenda

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ENGAGING DIASPORA in development

Tapping Our Trans-local Potential for Change
www.sfu.ca/diasporas

Dialogue Program
Improving Global Health

Wednesday, March 16, 2011, 6:30 - 9:00 PM
SFU Morris J. Wosk Centre for Dialogue, 580 West Hastings Street

Project Co-Directors

Joanna Ashworth
Centre for Sustainable Community Development, SFU

Shaheen Nanji
International Development, SFU

Dialogue Planning Committee:

Shams Alibhai
BC Centre for International Cooperation

James Busumtwi-Sam
Department of Political Science, SFU

Kina Chenard
Department of Political Science, SFU

Angela Kaida
Faculty of Health Sciences, SFU

Joe Knockaert
Former Director of CIDA, Pacific Region

Ajay Puri
Ethno-Cultural Research Network

Umeeda Switlo
CUSO-VSO

Artistic Advisor: **Ayumi Mathur**
Graphic Design: **Franciska Hidayat**
Project Coordinator: **Mignon Alphonso**
Researcher: **Douglas Olthof**
CUSO-VSO Intern: **James Christopherson**

Dialogue Purpose

This dialogue is part of an ongoing public engagement series that examines the unique role of the diaspora resident in Vancouver who are committed financially and personally to development activities in the global south. Diaspora-driven development efforts have a powerful impact in the global south that reverberates here in Metro Vancouver. While often informal or grassroots, these initiatives demonstrate the benefits and unique strengths of the diaspora – cultural awareness of communities of origin and residence, fluency working in dual cultures, awareness of local issues and concerns (trans-local), and long-term personal commitment to projects and communities.

This dialogue foregrounds the many ways diaspora leaders and partners are transcending borders to improve health through innovations in research, clinical services, and population-based preventive health practices.

Dialogue questions include:

- What are the unique skills and experiences of diaspora in improving global health?
- In what ways are initiatives experiences transforming health practices, and systems in the Global South?
- What are the current and potential impacts on people, health systems and institutions in both Canada and trans-locally?

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Canadian International Development Agency | Agence canadienne de développement international | Canada
This project is undertaken with the financial support of the Government of Canada provided through the Canadian International Development Agency (CIDA).
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Project partners:
SFU SIMON FRASER UNIVERSITY | BCCIE | CUSO-VSO
with special thanks to Bruce and Lis Welch Community Fund.

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Program

6:30 pm Welcome

First Nations Welcome to the Territory
Shaheen Nanji, Project Co-Director and Director SFU International Development
Joanna Ashworth, Project Co-Director and Dialogue Co-Moderator
Ajay Puri, Coordinator, Ethno-Cultural Research Network and Dialogue Co-Moderator

Global Health Defined

Jerry Spiegel, Liu Institute for Global Issues and the School of Population and Public Health at UBC.

Dialogue:
- *What does health mean to you?*
- *What are the unique qualities that you bring to your understanding of health and how to improve global health?*

Global Health: Diaspora Stories

Shafique Pirani, MD, Royal Columbian Hospital
Steven Pi, President, Hands Across the World
Marj Ratel, Vancouver-based neuroscience nurse who founded Korle-Bu Neuroscience Foundation (KBNF) in 2000
Derek Agyapong-Poku, KBNF 's Vice President; President of Excellence in Africa Neuroscience and Health and the Canada-Ghana Liaison
Mohammad Zaman, Executive Director, Society for Bangladesh Climate Justice

Dialogue:
- *What excites, inspires, or surprises you about what you have heard? What questions do you have?*
- *In what ways are these global health initiatives leveraging the trans-local potential of the diaspora communities in Vancouver?*

Transcending North and South: The Potential of the Trans-Local

Lyren Chiu, Founder and President of the Canadian Research Institute of Spirituality and Healing

Dialogue:
- *How are diaspora transcending boundaries and serving as a bridge between the Global North and South?*
- *What impact do these "trans-local" interactions have in transforming health practices, systems, and understanding in Canada?*

Dialogue: *Final Reflections on the Dialogue*

Weaving: Parting Reflections and Implications for Practice and Research

Ashok Mathur, Director, Centre for Innovation in Culture and the Arts in Canada, Thompson Rivers University

9:00 pm Adjourn

Reception to follow in atrium

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Speakers

DEREK AGYAPONG-POKU is KBNF's Vice President; President of Excellence in Africa Neuroscience and Health, an operating charity, and the Canada-Ghana Liaison.

JOANNA ASHWORTH is Associate Director for the Bolivia Community Economic Development project and advises community organizations throughout BC on multicultural dialogue planning. She is a senior research associate at the Centre for Sustainable Community Development. Joanna is also co-director of the Engaging Diaspora in Development: Tapping our Trans-local Potential for Change project.

LYREN CHIU is Founder and President of the Canadian Research Institute of Spirituality and Healing. He has 25 years experience and training in both mental health care and spirituality. http://www.beautifulmindsconsulting.com/specialists/dr-lyren-chiu/

ASHOK MATHUR was born in Bhopal, India, and immigrated to Canada with his family in 1962 when he was one year old. Journalism school followed high school, and by 1981 Ashok worked as a photojournalist and was active in Minquon Panchayat, an activist artist collective comprised of First Nations artists and artists of colour that addressed racism in the arts on a national level. Currently, he is the Director of the Centre for Innovation in Culture and the Arts in Canada at Thompson Rivers University in Kamloops, British Columbia.

SHAHEEN NANJI is Director of International Development and Faculty Engagement at SFU. She co-directs Engaging Diaspora in Development: Tapping our Trans-local Potential for Change and oversees CIDA projects in China and Kenya. Shaheen is working on a Master of Arts in International Studies, with a focus on diasporic influences on development. Born and raised in Nairobi, Kenya, Shaheen moved to Vancouver in 1989 and has firsthand understanding of the ways diaspora communities seek to give back to their birth nations.

STEVEN PI is the President of Hands Across the World a Vancouver-based non-profit organization started by a group of university students who strongly believe that the young adults within their communities can make a large difference in the world. They have raised money to support victims of the 2008 Szechuan Earthquake, where more than 90,000 victims have been declared dead or missing in the last seven months, 19,000 of which were students and to raise awareness about HIV-AIDs stigma abut to also impart knowledge and awareness of some of the serious issues that are plaguing this world today. http://www.handsaroundtheworld.ca/about-us/

SHAFIQUE PIRANI, MD has an Orthopaedics clinical practice at the Royal Columbian Hospital. His special interest is in Paediatric orthopaedics with an emphasis on clubfeet, paediatric hip abnormalities and the Ilizarov Method of treating musculoskeletal disorders. He is the principle organizer and driving force of the CAD $1.8 million Uganda Sustainable Clubfoot Care Project (USCCP) funded by the Canadian International Development Agency (CIDA) and Enable Canada. The USCCP Goal is to reduce the consequences of disability from neglected clubfeet in Uganda with a public health approach by making available sustainable, universal, effective, efficient, and safe treatment (by the Ponseti Method) of the congenital clubfoot deformity. http://www.ponseti.info/uganda/

AJAY PURI, Coordinator, Ethno-Cultural Research Network and Dialogue Co-Moderator. Ajay is a Principal at Masala Consulting Services, Co-Lead and Co-Founder at Coop Culture, Co-founder at RangiChangi Roots, Doctoral Student at the School of Population and Public Health, UBC, lead at the Canadian Ethno-cultural Health Network and Research Associate at the Centre for Addictions Research of BC.

MARJ RATEL is the Founder of the Korle-Bu Neuroscience Project. The non-profit Korle-Bu Neuroscience Foundation was established in 2003 and Marj was the President since inception. She is also President of Korle-Bu Foundation, a public charity, since inception. Korle-Bu Neuroscience Foundation provides medical support for brain injuries and diseases to the people of Ghana and West Africa. KBNF is committed to assisting the people of West Africa for the long-term through the development of a world-class regional hospital and network, by providing specialist training to the doctors, nurses and other health care professionals who will work in their homelands, and by establishment of a neurological research unit. KBNF is also supporting health care infrastructure development for the West African region. http://kbnf.org/

JERRY SPIEGEL, PhD is an associate professor at the Liu Institute for Global Issues and the School of Population and Public Health at the University of British Columbia. His research focus is on the strengthening of capacities to address determinants of health – and he currently leads active collaborative projects in Ecuador, Cuba, and South Africa focused on environmental and occupational health risks. He was founding President of the Canadian Coalition for Global Health Research.

MOHAMMAD ZAMAN, PhD is a Social Safeguard/Resettlement Specialist and Executive Director of the Society for Bangladesh Climate Justice – a voluntary, non-profit, advocacy group in Vancouver – dedicated to climate change awareness and global "climate justice". Dr. Zaman has published in many areas including climate change impacts, natural disasters, displacement, migration, and development.
http://www.bangladeshcalling.org/about_us.htm

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Photography

NARRATIVE 360 is a non-profit organization advancing the role of the documentary arts in civil society and supporting their development in the areas of photography, audio and literary journalism. The organization is committed to intellectual discourse regarding media representation of societies, cultures and communities, and supports work in the documentary arts as a way of understanding the social and cultural fabric of humanity. Narrative 360's last project was Kites, Guns and Dreams, a documentary photojournalism exhibition on Afghanistan that was exhibited in Vancouver, Toronto, Montreal and Halifax.

Suggestions?

Seeking stories of Trans-Local leaders

Are you or someone you know doing exemplary development work in the Global South while based in the Metro Vancouver area?

Please email us at ***diasporas-info@sfu.ca***

Next dialogue in the series:

Strategies for Education

Wednesday, May 18, 2011, 6:30 – 8:30 PM
SFU Morris J. Wosk Centre for Dialogue

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Appendix 2: Briefing

Global Health – Issues and Concerns

Backgrounder for the Dialogue on Diaspora and Global Health March 16, 2011 Simon Fraser University

James Busumtwi-Sam is an associate professor in the Department of Political Science, and Director (acting) of the Development & Sustainability Program at Simon Fraser University.

What is 'health'?

Today, there is widespread agreement that health is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO Constitution, 1946). When devising strategies, policies and programs to promote health, in addition to the important biomedical/technical elements (i.e., specific diseases, pathogens, etc) we should also be concerned with broader social determinants of health, which the WHO defines as the conditions in which people are born, grow, live, work and age, including available health-care systems. These conditions are shaped by the distribution of money, power and resources at global, national and local levels, which in turn are influenced by policy choices.[1]

Why do we need a broadened understanding of and approach to health?

The boundaries of public health policies and actions have been extended into other sectors that influence health opportunities and outcomes, reflecting increased awareness that health issues are affected by factors that traditionally were considered outside the health sector. These factors include population movements, environmental degradation, trade and investment flows, technological changes, patents and access to essential medicines, violence and conflict, and illicit/criminal activity.

The proliferation of non-governmental actors and institutions (public and private) including the activities of diasporic groups, strongly influence the ability of national and local authorities to protect and promote the health of populations around the world as well as the resources for addressing their consequences. Profound health disparities exist across the globe; and situating health within the context of broader social determinants provides a better understanding of the sources of health inequities.

What is health equity and why is it important?

Equity seeks to remedy a situation where an individual or group is artificially made unequal. This issue is important to the extent that the absence of equity in the provision of health services is considered to be one of the major impediments to achieving positive health outcomes (Chen and Berlinguer 2001). The WHO's 1998 World Health Report *Health for All*

[1] http://www.who.int/social_determinants/en/index.html accessed March 11, 2011

in the 21st Century, linked good health to the advancement of human rights, greater equity, and gender equality among other things. The social determinants of health generate health inequities -- the unfair and avoidable differences in health status within and between countries, and health equity requires the elimination of social barriers that produce disparities in health opportunities and outcomes (Janes 2006).

We can think of health equity as comprising three components: *vertical* -- requiring fair mobilization of resources to pay for everyone's health care; *horizontal* -- where the access to, use, and the quality and type of health services is based primarily on people's needs; and the *pooling of risk* such that everyone, especially the most vulnerable, are protected from the economic consequences of illness (Janes 2006; Chen and Berlinguer 2001).

An emphasis on health equity, then, implies that *need* -- not income/wealth, power and privilege -- should be the major determinant of health-care access and ultimately of health outcomes. The WHO's constitution declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. The notion of health care as a universal human entitlement the access to which should not be determined by particular economic circumstances was cemented in the 1978 Alma Ata Declaration. [2]

The profound disparities in health opportunities and outcomes across the world today, however, indicate quite a divergence between recognizing a 'right to health' in principle and in practice. Globally, the disparities are most acute between the North and South. As Kofi Annan, the then UN Secretary-General noted in an address to the World Health Assembly in 2001, "the biggest enemy of health in the developing world is poverty." In countries classified as 'least developed' or 'low income', for example, life expectancy is just 49 years, and one in ten children does not reach their first birthday. In high-income countries, by contrast, the average life expectancy is 77 years and the infant mortality rate is six per 1000 live births.

There is a 'vicious cycle' in the relationship between poverty and ill-health -- poverty contributes to ill-health and ill-health leads to poverty. A recent report by the WHO and World Bank *Dying for Change: Poor People's Experience of Health and Ill-Health*, notes that poverty creates ill-health because poor people tend to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Poverty creates hunger, which in turn leaves people vulnerable to disease. Poverty denies people access to reliable health services and affordable medicines, and the illiteracy associated with poverty leaves people poorly informed about health risks.

It is within this context that the deprivations, exclusions and inequities associated with poverty and inequalities globally have been highlighted as one of the biggest obstacles to promoting health globally.

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[2] WHO 1978, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

What are some of the main challenges to achieving more equitable healthcare?

The 1978 Alma-Ata Declaration sought to achieve 'health for all by the year 2000' through participatory, community-focused comprehensive primary health care (PHC) within the broader context of multi-sectoral development (WHO 1978; Thomas & Weber 2000). Needless to say, the goals of PHC have not been achieved. As the WHO itself acknowledges, while there have been improvements in areas such as childhood immunization, there have been setbacks to providing equitable access to essential health care worldwide. Health system constraints including financial barriers and health worker shortages, combined with challenges such as the HIV epidemic, have hampered progress towards achieving health for all. [3]

The reality is that in the 30 plus years since the Alma Ata declaration, the equity and community-based (bottom-up) emphasis of PHC has been eroded in favour of 'efficiency' cost-utility (top-down) reforms based on neoliberal market economic principles (the so-called 'Washington Consensus' favouring privatization, deregulation, etc). The original framework for this neoliberal approach was outlined in the World Bank's 1993 World Health Report *Investing in Health*, and embraced by other major Multilateral Financial Institutions (MFIs) including the IMF, and bilateral donors (Thomas and Weber 2004). The new approach, 'Health Sector Reform', made little use of PHC principles and focused on the reduction of government services in favour of private sector delivery of healthcare services. User fees, cost recovery, private health insurance, and public–private partnership became the focus for healthcare service delivery. Overall, healthcare was seen in terms of economic benefits that improved health delivers (i.e., human capital for development), rather than as a consequence and fruit of development.

To be sure, the major MFIs and bilateral donors have made some modifications to this model. Some analysts talk of a 'socially-inclusive' neo-liberalism (the so-called 'post-Washington Consensus') emerging at the end of the 1990s and into the new millennium, entailing increased attention to poverty and improving other social variables especially health and education (Porter and Craig 2004). This new version sought to soften (but not eliminate) the emphasis on market-driven economic growth in the original Washington Consensus. The MFIs and bilateral donors made 'poverty reduction' a cornerstone of their lending programs, and created new lending programs to accommodate higher pro-poor public expenditure in the South. It was within the context of this new agenda that the Millennium Development Goals (MDGs) were adopted in 2000.

What do the Millennium Development Goals say about health?

The United Nations Millennium Declaration was signed in September 2000, which led to the adoption of the MDGs -- a set of eight goals and a number of numerical targets to be

[3] http://www.who.int/bulletin/primary_health_care_series/en/index.html accessed March 11, 2011).

achieved by 2015 or earlier.

MDG 1: eradicate extreme poverty and hunger
MDG 2: achieve universal primary education
MDG 3: promote gender equality and empower women
MDG 4: reduce child mortality
MDG 5: improve maternal health
MDG 6: combat HIV/AIDS, malaria and other diseases
MDG 7: ensure environmental sustainability
MDG 8: develop a global partnership for development

Health is at the heart of the MDGs – recognition that health is central to the global agenda of reducing poverty as well as an important measure of human well-being. Health is the explicit focus of three of the eight goals, and health issues are acknowledged as central to the attainment of other key goals including eradicating extreme poverty and hunger, gender equality, and environmental sustainability.

The MDGs provide important benchmarks for measuring global progress on key development outcomes and focus attention on the enormous challenges in the poorest countries. The global financial and economic crisis that began in 2008 has had a negative impact on progress towards achieving the MDGs, and the ability to recover will vary across countries and regions. According to the World Bank (2010), while the longer-term effects of the global economic crisis are unknown, by the end of 2010 – just five years to the target year of 2015 – lack of progress was evident in several key MDG indicators in poorer countries including health, nutrition, and poverty-reduction indicators.

Some key shortcomings and challenges to achieving the health-related goals of the MDGs include:

Maternal mortality has shown the least progress of all the health-related MDGs, declining by only 6 per cent in the developing regions (from 480 maternal deaths per 100,000 births in 1990 to 450 deaths in 2005) (United Nations 2009).

Child mortality declined in the developing regions from 103 deaths per 1,000 live births in 1990 to 74 in 2007, but even the faster annual decline now underway is insufficient to reach the goal of a two-thirds reduction by 2015 (United Nations 2009).

Shortage of health workers*:* The shortage of health workers reached 4.3 million in 2006, including 2.4 million doctors, nurses and midwives. Among the 57 countries facing a critical shortage of doctors and nurses, 36 were in sub-Saharan Africa (WHO 2006). Shortages are more critical in rural areas. Nearly half of the world population lives in rural areas, but only 38 per cent of the world's nurses and less than 25 per cent of doctors work in rural areas (WHO 2009).

Emigration of health professionals affects health service delivery and is contributing to the shortages of health workers in some developing countries. Small developing countries are disproportionally affected by emigration of health workers. (OECD 2006).
Donor funding for reproductive health on a per woman basis has fallen by over 50 per cent in 42 of the 49 least developed countries since the mid-1990s. This decline has contributed to shortages in supplies and services, which in turn keep unmet need high (United Nations 2010).

What can diaspora do to improve health opportunities and outcomes?
Diasporic contributions to health can be situated within the context of debates over health equity and the challenges to realizing the health-related MDGs. The World Health Organization has sought to renew the emphasis on primary health care in its 2008 Report *Primary Health Care: Now More Than Ever*[4]

Five key elements are central to achieving this goal:
reducing exclusion and social disparities in health (universal coverage reforms);
organizing health services around people's needs and expectations (service delivery reforms);
integrating health into all sectors (public policy reforms);
pursuing collaborative models of policy dialogue (leadership reforms); and
increasing stakeholder participation.[5]

Questions for further exploration:
In what ways can the diaspora help achieve these goals?
What are the main areas in which the diaspora have a comparative advantage or unique opportunity to engage with communities in their places of origin/attachment to help in the 'development' process, and how can they organize to increase the impact they will have (conversely, what are the constraints they face)?
What are the opportunities/insights for successive generations to participate in the development process in their places of origin/attachment?
Do subsequent diasporic generations lose some of the socio-cultural context that might provide them greater or lesser insight into their places of origin/attachment? Is the perspective they bring significantly different and if so, how?
How do diaspora bring about positive 'systemic' changes in their places of origin/attachment?

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[4] http://www.who.int/whr/2008/en/index.html
[5] (http://www.who.int/topics/primary_health_care/en/ accessed March 11, 2011)

How might the diaspora accelerate more substantive or fundamental changes than are associated with small, discrete projects such as improving sanitation and access to safe drinking water in a single village?

What opportunities are there for diaspora to engage in advocacy work, knowledge creation, and capacity building? Are there any positive changes that diasporic researchers bring about through their studies and proposals?

In what ways are these experiences and interchanges transforming health practices and understandings in the North? (i.e., what is the looping effect?)

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Appendix 3: Blogs

SFU SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

ENGAGING DIASPORA in development
Tapping Our Trans-Local Potential for Change

Global health through the diaspora lens

Author: Douglas Olthof **Posted:** Mar 7th, 2011

What does health mean to you? The question might sound simple, but only until you try to answer it. Is health simply a matter of a disease-free mind and body, or are there social, cultural, spiritual or environmental dimensions to be considered? How does our cultural, social and community background influence our understanding of 'health'? These are just a few of the questions we will ponder when the "Engaging Diasporas in Development" project convenes its second public dialogue: Improving Global Health.

After completing a successful dialogue on poverty reduction and economic growth in January of this year, we at the Engaging Diasporas in Development project are steering the conversation in the direction of global health. Our goal is to address not only how diasporas living in the Vancouver area affect health in the countries and regions of the world with which they identify, but also how those same individuals draw upon their international connections and their appreciation of diverse paradigms to influence health and health care in Canada.

We will begin the dialogue with a framing discussion by asking the "*what does health mean to you?*" Here, we hope to access alternative conceptions of health that draw on various cultural, spiritual and intellectual traditions. We will then ask: "*what are the unique qualities that*

Posted Mar 7, 2011 on the Vancouver Observer website
http://www.vancouverobserver.com/blogs/engagingdiasporas/2011/03/07/global-health-through-diaspora-lens

diaspora bring to improving global health?" Our conversations thus far have led us to recognize a plurality of insights and abilities that inhere in members of the diaspora. Our hope is to focus specifically on how these insights and abilities can be brought to bear on issues of global health.

Following an open and inclusive discussion intended to "define" global health, the conversation will shift toward exploring specific examples of diaspora health initiatives. To this end, we have assembled a distinguished panel including professor of paediatric orthopedics Dr. Shafique Pirani, HIV/AIDS campaigner Steven Pi, neuroscience nurse and NGO founder Marj Ratel, international neurological healthcare organizer Derek Agyapong-Poku and climate activist Dr. Mohammed Zaman. The panel will describe the initiatives and their impacts, their unique contributions as diasporas and the potential for more active and effective diaspora involvement. This will be followed by an open discussion drawing in reactions, perspectives and experiences from dialogue participants.

The Engaging Diasporas in Development project has identified "translocality" as a key component of the diaspora experience. "Translocality" refers to simultaneously being and acting in multiple localities across and within national boundaries. The "Improving Global Health" dialogue will address translocality by asking how diasporas transcend boundaries to serve as a bridge between the 'Global North' and 'Global South.' Distinguished speakers will address this question with reference to their own experiences working in the area of health in various settings. They will also address the impacts trans-local interactions have on transforming health practices, systems and understanding here in Canada.

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This will be followed by an open discussion exploring existing diaspora efforts to address global health issues and the as yet unrealized potential for further engagement.

Engaging Diasporas in Development project Co-directors Joanna Ashworth (left) and Shaheen Nanji
Photo: Greg Ehlers

The "Improving Global Health" dialogue is the second in a series of 5 dialogues organized by the Engaging Diasporas in Development Project. Those interested in joining in the discussion can register for the dialogue.

For more information on the Engaging Diasporas in Development project, please visit the project website.

We look forward to seeing you at the dialogue and hearing your stories.

In health,

Joanna Ashworth and Shaheen Nanji
Co-Directors
SFU's Engaging Diasporas in Development project

Posted Mar 7, 2011 on the Vancouver Observer website
http://www.vancouverobserver.com/blogs/engagingdiasporas/2011/03/07/global-health-through-diaspora-lens

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THINKING OF THE WORLD

ENGAGING DIASPORA in development
Tapping Our Trans-Local Potential for Change

A Vancouver doctor brings a cure for clubfoot to children in Uganda

Authors: Douglas Olthof **Posted:** Mar 8th, 2011

In 1998 Dr. Shafique Pirani returned to Uganda to visit his birthplace and childhood school. A member of the Ismaili diaspora, Dr. Pirani had been among those expelled from Uganda by Idi Amin's government in 1972. In making preparations to visit the country of his birth, he had not intended to tackle problems of Ugandan public health, but while on that visit he bore witness to a problem that he was uniquely qualified to diagnose and address.

Years before his fateful trip to Uganda, Dr. Priani had taken a research interest in a congenital musculoskeletal disorder known commonly as clubfoot. This disorder occurs in roughly 1 in 1000 children and, if untreated, leads to deformation of the feet. This can leave the sufferer walking on the sensitive dorsum (top) of the foot, resulting in chronic pain, immobility, ulcerations, infection and, often, stigmatization. At the time of Dr. Pirani's visit, the most commonly practiced treatment for clubfoot around the world was corrective surgery.

Surgical treatment for clubfoot in Uganda was not an option. In a country of 28 million with a birth rate of 3.5% annually, approximately 1500 Ugandan children are born with clubfoot every year. As late as 2008 the country had 20 practicing orthopedic surgeons, most of whom were concentrated in

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Kampala and focused on trauma. Dr. Pirani recognized a dire need for alternative treatments for clubfoot in Uganda that could be economically and socially feasible.

A Ugnandan baby born with the potenitally crippling congeatal disorder know as "clubfoot." Photo: USCCP

In the late 1940s, a doctor at the University of Iowa named Ignacio Ponseti was investigating the long-term results of clubfoot surgeries. The results he observed were not encouraging and he soon began work on a nonsurgical method to correct the disorder. The resulting "Ponseti Method" proved far superior to surgical treatment, but failed to catch on with the medical community for another 50 years. In 1997 Dr. Pirani had begun using the Ponseti method in his Vancouver practice, with promising results. In Uganda, Dr. Pirani saw the life altering implications of the Ponseti Method for thousands of children.

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Soon after his 1998 visit, Dr. Pirani began working on how the Ponseti Method could be brought to Uganda, bearing in mind the limited number of surgeons. The solution was to train paramedical health care professionals in the method, so that they would treat the children. Dr. Pirani developed training materials, and set about organizing Ponseti Method workshops and seminars for paramedicals in Uganda, sponsored by the Rotary Clubs of Burnaby and New Westminster Royal City. Dr. Pirani's pilot studies showed that children born with clubfeet could have the clubfeet corrected by paramedicals trained in the Ponseti Method.

Dr. Pirani was then successful in securing $1 million in funding from the Canadian International Development Agency for the Uganda Sustainable Clubfoot Care Project. Through partnerships with several organizations including Uganda's Makerere University and the Uganda Ministry of Health, the project has built capacity within the Ugandan healthcare system to screen for, diagnose and treat clubfoot using the Ponseti Method. Dr. Pirani and his partners have worked to adapt the Ponseti Method to make the treatment socially and economically feasible for Uganda. The estimated cost for treatment is less than $150 per child, with benefits potentially lasting an entire lifetime. The ultimate objectives are to develop treatment and training capacity in Uganda such that project's like the USCCP are no longer required.

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Paramedicals in Uganda trained by the USCCP apply a locally-appropriate adaptation of the "Ponseti Method" to treat clubfoot. Photo: USCCP

Throughout its years of operation, the Ugandan Sustainable Clubfoot Care Project has encountered some challenges. For example, as with many development projects spanning international boundaries, the project initially struggled to develop a truly inclusive and participatory approach. On the whole, however, the project has been tremendously successful. The model pioneered by the Dr. Pirani and the USCCP has already been expanded to Malawi, Rwanda, Kenya, Tanzania, Zimbabwe, and Bangladesh. Health care practitioners and officials in Brazil, Honduras, India and Nepal are also drawing lessons from the UCSSP in Uganda. The project stands as a shining example of how members of the diaspora can build international connections that foster significant and sustainable improvements in health.

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Dr. Pirani will share his experiences and insights at the Engaging Diasporas in Development project's "Improving Global Health" dialogue on March 16, 2011. Those interested in joining in the discussion can register for the dialogue. For more information on the Engaging Diasporas in Development project, please visit the project website.

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THINKING OF THE WORLD

ENGAGING DIASPORA in development
Tapping Our Trans-Local Potential for Change

Panos Network provides a new lens for international development

Authors: Douglas Olthof **Posted:** Mar 11th, 2011

Faced with complexity, it is often prudent to simplify. To that end, we have invented concepts like "left" and "right" as tools to better understand politics, and use broad categories like "middle class" or "below the poverty line" to build manageable categories out of unwieldy continuums. In some instances, these simplifications help us to make sense of the context in which our busy lives unfold. In other cases, they obscure important dimensions of reality, generate unrealistic perceptions of the world and throw up barriers to achieving a more equitable, just and sustainable global society. The portrayal of the world in terms of a "global north" and a "global south" is a case in point.

According to Jon Tinker, founder of the Panos Network and Executive Director of the Panos Institute of Canada, the concept of a global "north" and "south" is a relic of a bygone era. In the wake of the Second Word War, as communism spread and the powers of Western Europe and North America moved to check its expansion, it became useful to think in terms of a world divided between the First World West, the Second World East and the Third World South. After the fall of the Berlin Wall and the Warsaw Pact, the Second World was dropped and a simplistic two-part vision of the world remained.

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http://www.vancouverobserver.com/blogs/engagingdiasporas/2011/03/10/panos-network-provides-new-lens-international-development

Jon Tinker thinks it's high time this conceptual hand-me-down is tossed in the dustbin of history. He points out that the "North and South are no longer broadly distinct and homogeneous groups. Today, they are overlapping and heterogeneous categories, with at best only an historical validity " He argues that, while the "North/South lens" was sometimes useful to the social justice and development movements, ultimately "using [it] is not just lazy. It's dangerous. It hinders us from seeing, let alone addressing, today's unjust and socially unsustainable imbalances of power and wealth."

The Panos Institute of Canada is part of the global Panos Network consisting of eight independent institutes. The network's members in London, Paris, East Africa, Southern Africa, West Africa, South Asia, the Caribbean and Canada engage in programmes with a strong focus on economically and socially disadvantaged people around the World. The Panos Institute of Canada, of which Jon Tinker is Executive Director, makes HIV-AIDS its primary area of focus.

One of the most powerful methodologies they bring to bear on the immense problem of HIV-AIDS is the commonalities lens: an explicit rejection of the notion that there exists a "North" characterized by economic prosperity, technical ability and expertise and a "South" that is "poor, ill-informed, technologically backward, badly-trained and politically naive." Instead of fixating on differences between countries and cultures, the commonalities lens focuses on what we have in common. It "helps us

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realize what we share, and provides a basis for solidarity, and for learning from one another as equals."

In 2007 the Panos Institute of Canada teamed up with public health specialist and photographer Pieter de Vos to produce AIDS in Two Cities: a photography project highlighting the common elements of HIV/AIDS issues in Port-au-Prince and Vancouver. Photos: Pieter de Vos - AIDS in Two Cities

A recent initiative of Panos Canada illustrated vividly the power of the commonalities lens. In November 2008 the Panos Institute of Canada brought 10 Haitian AIDS experts to Vancouver. The Haitian delegation did not come to Canada to receive training; they were not invited to play the part of recipients; nor was the aim of the exchange to 'build their capacity.' The goal of the project was to provide an opportunity for the experts from Haiti to share their insights with their Canadian counterparts. In the context of the dominant development paradigm, this was a radical initiative.

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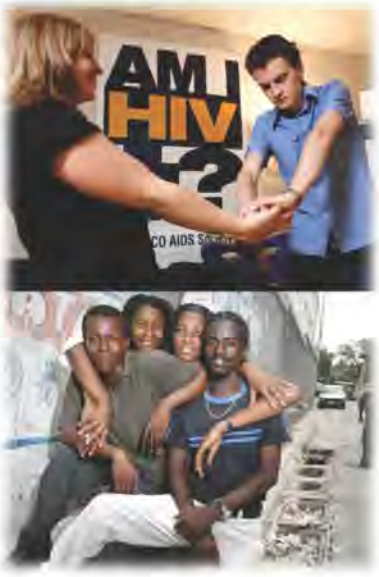
The project evolved as a follow up to The Panos Institute of Canada's 2007 collaboration with public health specialist and photographer Pieter de Vos: *AIDS in Two Cities.* This captivating photo essay juxtaposed images from Port-au-Prince and Vancouver not as means of pointing out differences, but of highlighting commonalities. What emerged from AIDS in Two Cities is the understanding that the problems surrounding HIV/AIDS in Port-au-Prince and Vancouver are characterized by differences of degree, but commonalities of type. What emerged form the Haiti Exchange was that AIDS experts charged with addressing these problems in Port-au-Prince could teach a great deal to their counterparts in Vancouver.



Youth Speak to Youth: The AIDS in Two Cities portrays the common experiences of youth-driven theatrical groups working to educate their peers to the dangers of HIV/AIDS in Vancouver and Port-au-Prince. Photos: Pieter de Vos - AIDS in Two Cities

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The sad history of "development" in the latter half of the 20th century has exposed as folly the notion that having achieved advanced economic development is the only necessary and sufficient condition for knowing how others should do the same. We now understand and acknowledge that underdevelopment is not simply a result of 'insufficient local capacity'; reality is a much more complex picture. The "North/South lens" reinforces that discredited perspective. By recognizing the diversity that exists within countries and the commonalities that exist between them, the commonalities lens suggests how a more equitable exchange might be possible and how we might begin to redress the power asymmetries that have for 60 years rendered the "North/South" development relationship impotent.

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Tapping Our Trans-Local Potential for Change

Climate refugees: diaspora response to a human health crisis

Author: Douglas Olthof **Posted:** Mar 13th, 2011

Bangladeshi women try to adapt their livelihood strategies to a landscape changing rapidly due to climate change. Photo: Mohammad Zaman

Over the next 30 years, some 30-40 million Bangladeshis will take what they can from their homes and move to higher ground. They will pour into Dhaka and other Bangladeshi cities, overflowing the already expansive slums and bastees; they will cross international borders into India, Myanmar and other countries looking for livelihoods, homes and some semblance of security for their families. This mass of humanity, at least equal in size to the entire population of Canada, will not be pulled to the cities by the promise of a better future. Theirs will not be an economic migration associated with new opportunities, but instead a forced exodus driven by an unprecedented environmental calamity that they have played virtually no part in causing. They will make up the largest group of climate refugees this world has ever seen.

Bangladesh is the world's most densely populated deltaic country. More than half of the country's 160 million inhabitants make their homes on a massive delta formed by the confluence of the Ganges, Brahmaputra and Meghna rivers. A one-meter rise in the sea level – as is predicted by some of the most conservative climate change models –

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would inundate roughly a third of Bangladesh's land and trigger a forced migration unprecedented in its scale.

The Ganges (locally called Padma), one of the three major rivers, is eating away valuable agricultural lands every year, making thousands homeless and landless destitute. Photo: Mohammad Zaman

Vancouver is home to some 6000 Bangladeshis who are all too aware of the disaster facing their home country. Over the past 8-10 years the impending humanitarian crisis facing Bangladesh has grown from a topic of conversation to a focal point of organization within Vancouver's Bangladeshi community. In 2009 the Society for Bangladesh Climate Justice was formed as a unified effort to enhance awareness of climate change, promote the cause of Bangladesh internationally, support action research in the areas of climate change mitigation and adaptation, and to work with the Canadian government to help Bangladesh manage what is sure to be an overwhelming humanitarian catastrophe.

Dr. Mohammad Zaman is Executive Director of the Society for Bangladesh Climate Justice. He points out that the community of South Asian states (SAARC) has established mechanisms for sharing climate change data, but has done nothing to address the issue of climate refugees and migration. Indeed, the international community in general has yet to devise a framework for handling the estimated 200 million people around the world who will become permanent climate refugees by 2050. Such a framework will be

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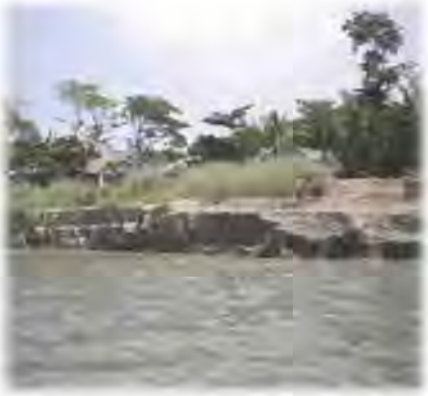
necessary to manage the inevitable international migration of people displaced by flooding, drought, coastal erosion and other climate induced crises. According to Dr. Zaman, however, the solutions to these problems must also include strengthening the capacity of countries like Bangladesh to mitigate and adapt to them.

Climate refugees face a set of problems distinct from those affecting other migrant groups. Unlike those who uproot to the cities in search of economic opportunities, climate-induced migrants often lack preparation for the journeys they embark on. They leave their homes in a state of distress and may be unable or unprepared to establish new livelihoods. They experience ongoing trauma with lasting effects on their physical and mental health. In this context, Dr. Zaman points to the need for a holistic approach to health incorporating community building, livelihood development and trauma counseling – in addition to medicine and treatment for the physical body.



Riverbank erosion alone displaces over 100,000 people every year. People displaced are poor and need urgent support and assistance. Photo: Mohammad Zaman

The crisis facing Bangladesh is not a potential consequence of climate change; it is catastrophe that is unfolding at this very moment. Already 100,000 Bangladeshis are displaced by climate-induced erosion along riverbanks and coastal areas every year. Nor is it a problem peculiar to Bangladesh. Upwards of 50 million Indians face the prospect

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of forced migration as rising sea levels subsume coastal areas in that country. Meanwhile, island nations like the Maldives could be completely submerged in mere decades.

For most people living in the high-consumption countries responsible for the vast majority of green house gas emissions, climate change represents an amorphous threat lurking somewhere in the uncertain future. For Dr. Mohammad Zaman and the Society for Bangladesh Climate Justice, climate change is an immediate and dire threat to the lives, livelihoods and health of their loved ones and countrymen. Their objective is to convince the public and the government of Canada that concrete actions must be taken not only out of compassion for Bangladeshis, but out of recognition that the scale of the humanitarian crisis facing Bangladesh and its neighbouring countries is of grave consequence to the entire world.

Dr. Mohammad Zaman is part of a distinguished panel of speakers participating in the Engaging Diasporas in Development project's "Improving Global Health" dialogue. Dr. Zaman will share experiences and insights from his work with the Society for Bangladesh Climate Justice and will highlight the environmental, economic and social determinants of health. Those interested in joining in the discussion can register for the dialogue here. For more information on the Engaging Diasporas in Development project, please visit the project website here: https://www.sfu.ca/diasporas/.

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ENGAGING DIASPORA in development
Tapping Our Trans-Local Potential for Change

Diasporas and global health

Author: James Busumtwi-Sam **Posted:** Mar 15th, 2011

Professor James Busumtwi-sam speaks at the Engaging Diasporas in Development dialogue "Poverty reduction and economic Growth" Photo: Greg Ehlers

What is health? According to the 1946 WHO constitution it is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*" Today this definition is widely accepted, as is the notion that, in addition to its biomedical and technical elements, we should be concerned with the broader social determinants of health as shaped by the distribution of money, power and resources at global, national and local levels. This broadened understanding of and approach to health reflects increased awareness that health issues are affected by factors traditionally considered outside the health sector. Globalization and the proliferation of non-governmental actors and institutions (public and private) strongly influence the ability of national and local authorities to protect and promote public health, but profound health disparities exist across the globe. Situating health within the context of broader social determinants provides a better understanding of the sources of health inequities.

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The absence of equity in the provision of health services is considered to be one of the major impediments to achieving positive health outcomes. The WHO's 1998 World Health Report *Health for All in the 21st Century*, linked good health to the advancement of human rights, greater equity, and gender equality among other things. Social determinant of health generate health inequalities. An emphasis on health equity implies that *need* -- not income/wealth, power and privilege -- should be the major determinant of health-care access and ultimately of health outcomes. This notion was embodied in the 1978 Alma Ata Declaration. However, the profound disparities in health opportunities and outcomes across the world today, indicate quite a divergence between recognizing a 'right to health' in principle and in practice.

There is a stark relationship between poverty and poor health -- in countries classified as 'least developed' or 'low income', life expectancy is just 49 years, and one in ten children do not reach their first birthday. In high-income countries, by contrast, the average life expectancy is 77 years and the infant mortality rate is six per 1000 live births. There appears to be a 'vicious cycle' in the relationship between poverty and ill health -- poverty contributes to ill-health and ill-health leads to poverty. A recent report by the WHO and World Bank *Dying for Change: Poor People's Experience of Health and Ill-Health*, notes that poverty creates ill-health because poor people tend to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. It is within this context that the deprivations, exclusions and inequities associated with poverty and inequality have been highlighted as one of the biggest obstacles to promoting health globally.

The goal of achieving more equitable healthcare around the world faces serious challenges. As the WHO itself acknowledges, while there have been improvements in areas such as childhood immunization, there have been setbacks to providing equitable access to essential health care worldwide. Health system constraints including financial barriers and health worker shortages, combined with challenges such as the HIV epidemic, have hampered progress towards achieving health for all. In the 30 plus years since the Alma Ata Declaration, the equity and community-based (bottom-up) emphasis

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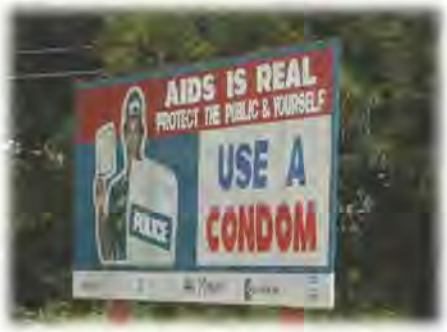
it espoused has been eroded in favour of 'efficiency' cost-utility (top-down) reforms based on neoliberal market economic principles (the so-called 'Washington Consensus' favouring privatization, deregulation, etc). User fees, cost recovery, private health insurance, and public–private partnership became the focus for healthcare service delivery. Overall, healthcare was seen in terms of economic benefits that improved health delivers (i.e., human capital for development), rather than as a consequence and fruit of development.



Aids warning sign as part of a USAID campaign with the Ghana police (photo: Shaheen Nanji)

More recently, the major MFIs and bilateral donors have made some modifications to this model. Some analysts talk of a 'socially-inclusive' neoliberalism (the so-called 'post-Washington Consensus') emerging at the end of the 1990s and into the new millennium. The MFIs and bilateral donors made 'poverty reduction' a cornerstone of their lending programs, and created new lending programs to accommodate higher pro-poor public expenditure in the South. It was within the context of this new agenda that the Millennium Development Goals (MDGs) were adopted in 2000.

The United Nations Millennium Declaration signed in September 2000 led to the adoption of the MDGs -- a set of eight goals and a number of numerical targets to be achieved by 2015 or earlier. At the heart of the MDGs is the recognition that health is

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central to the global agenda of reducing poverty as well as an important measure of human well-being. Health is the explicit focus of three of the eight goals, and health issues are acknowledged as central to the attainment of other key goals including eradicating extreme poverty and hunger, gender equality, and environmental sustainability.

The global financial and economic crisis that began in 2008, however, has had a negative impact on progress towards achieving the MDGs. By the end of 2010 – just five years to the target year of 2015 – the World Bank was reporting lack of progress in several key MDG indicators in poorer countries including health, nutrition, and poverty-reduction indicators. Maternal mortality has shown the least progress of all the health-related MDGs, the annual decline in child mortality is insufficient, and the global shortage of health workers reached 4.3 million in 2006. Small developing countries are disproportionally affected by emigration of health workers and donor funding for reproductive health on a per woman basis has fallen by over 50 per cent in 42 of the 49 least developed countries since the mid-1990s.

The contributions members of the diaspora make to global health can be situated within the context of debates over health equity and the challenges to realizing the health-related MDGs. In 2008 the WHO placed renewed emphasis on primary health care in its report *Primary Health Care: Now More than Ever*. Achieving this goal will require reducing exclusion and social disparities in health, reorganization of health services around people's needs and expectations, integration of health into all other sectors, pursuing collaborative models of policy dialogue and increasing stakeholder participation. In addressing diaspora contributions to improving global health we might ask:

- In what ways can the diaspora help achieve these goals?
- What are the main areas in which the diaspora have a comparative advantage or unique opportunity to engage with communities in their places of origin/attachment to help in the 'development' process, and how can they organize to increase the impact they will have (conversely, what are the constraints they face)?

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- What are the opportunities/insights for successive generations to participate in the development process in their places of origin/attachment?
- Do subsequent diasporic generations lose some of the socio-cultural context that might provide them greater or lesser insight into their places of origin/attachment? Is the perspective they bring significantly different and if so, how?
- How do diaspora bring about positive 'systemic' changes in their places of origin/attachment?
- How might the diaspora accelerate more substantive or fundamental changes than are associated with small, discrete projects such as improving sanitation and access to safe drinking water in a single village?
- What opportunities are there for diaspora to engage in advocacy work, knowledge creation, and capacity building? Are there any positive changes that diasporic researchers bring about through their studies and proposals?
- In what ways are these experiences and interchanges transforming health practices and understandings in the North? (i.e., what is the looping effect?)

James Busumtwi-Sam is Associate Professor of Political Science and (acting) Development & Sustainability program at Simon Fraser University. He will participate in the Engaging Diasporas in Development project's March 16 dialogue "Improving Global Health." Those interested in participated can register here.

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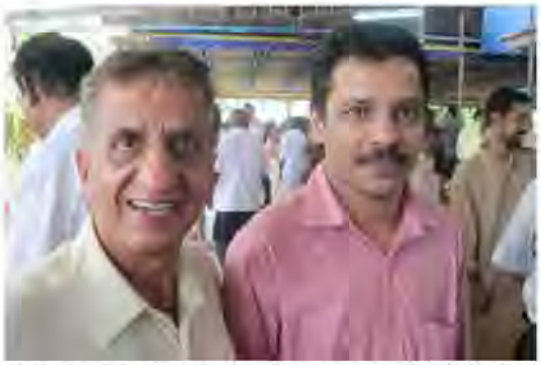
THINKING OF THE WORLD

ENGAGING DIASPORA in development
Tapping Our Trans-Local Potential for Change

Eyes healed by Ayurvedic treatment

Author: Ashok Puri **Posted:** Mar 22nd, 2011



Ashok Puri poses with the head doctor at the Sreedhareeyam eye clinic in Kerela, India Ayurvedic eye treatment helped heal my eyes, after Western doctors declared my condition 'untreatable.'

Some years ago, I had a cataract operation. At the time, I was overly anxious and excited to have my vision improved. Cataract operations are so routine and quick that I couldn't wait for the results. After the operation, I opened my right eye, expecting 20/20 vision.

Unfortunately, this was not the case. My sight went unchanged and remained at 20/60. I was diagnosed with idiopathic perifoveal telangiectasia shortly after. This is a rare, irreversible condition in which there is leakage of fluid from extra blood vessels around the fovea, a part of the eye that allows sharp vision for reading and watching television. The worst part was not just that this condition can lead to blindness, but that there is no known cure in the allopathic system of conventional medicine.

I was given one option, an expensive non FDA-approved injection called Avastin, which had no guaranteed results.

While I was still contemplating whether I should go for the injection or not, my job brought me to India. I went door-to-door looking for answers, exploring everything from homoeopathy, naturopathic doctors, eye specialists, to mystic men with healing powers and quacks with claims of magic cures. Finally, I ended up in an eye clinic in Kerala, southern India. The clinic, called Sreedhareeyam, practiced Ayurveda --a system ancient Indian medicine, developed over thousands of years of trial and error.

The head ayurvedic doctor assured me with confidence that the clinic could definitely arrest the leakage and further deterioration of my eye, but could not guarantee restoration of the already deleterious effects of the damage already done.

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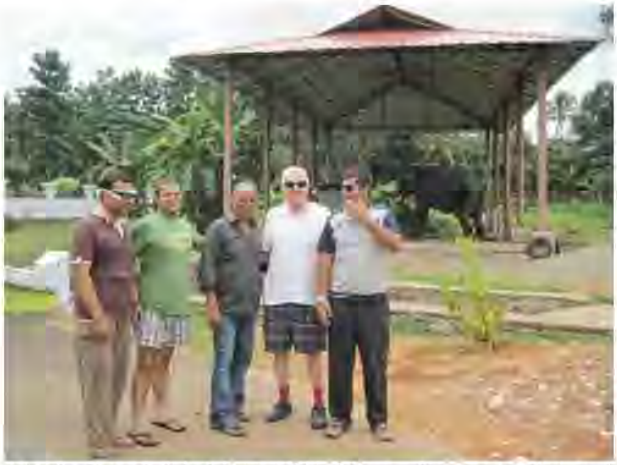
http://www.vancouverobserver.com/blogs/engagingdiasporas/2011/03/22/eyes-healed-ayurvedic-treatment

This news was very reassuring. After three weeks of intense treatment in the clinic, I returned to Vancouver. My total expenses, including lodging, fees, treatments, a four-month supply of medicine and all meals, was only $800 CAD. None of this, of course, was covered by the Medical Service Plan (MSP).

How did this ayurvedic treatment work? My typical day started daily at 5:30 am, with freshly prepared mixture of herbal extracts called *kashayam*. At 7 am, I was off to the massage centre where two strong masseurs were ready to tone me with specially prepared oil mixtures. They work on you in the such synchronized time that you would think only one person is massaging you. At around 9:30 am, I would begin the *netra dhara*, a special cleansing technique of pouring of herbal extracts in a stream over the eyes for 15 – 20 minutes.



After receiving treatment, Ashok Puri and his fellow patients enjoy their surroundings.

After lunch, I went through *shirodhara*, which involves gently pouring of liquids over the forehead -- the third eye, in Hindu religion. Of all the treatments, I loved the *shirodhara* the most, during which I felt completely stress-free.

I was also treated with *khizi*, a massage given through heat which essentially involves very hot oil being applied through a technique similar to the energetic strokes of a wire brush.

All the above treatments are essentially preparing the patient for the final treatment, which is performed for the last full week. *Tharpanam* means retention of medicines over the eyes for 30 minutes or more a day. Big wells of dough are put onto your eyes, and are poured on with warm herbalated *ghee* (clarified butter). The frequency and dosage depends on the extent of the problem. You are kept blind folded for almost three hours with the most refreshing bandage I have ever felt. Imagine petals of cooling flowers being used, instead of cotton.

Evenings are free time, so people gather in the front of the old home of the family to share their stories and experiences. Some sing hymns, Bollywood songs, and people from different

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regions tell a variety of jokes. Many people go to the evening congregation at the temple. It is a delightful sight to see all the walls of the temple lit with thousands of *diyas* (oil filled lamps). The place is filled with high energy. Everybody has a positive attitude and is in good spirits. Dejected people who had previous failed treatments feel once again full of hope after hearing the success stories of others.

Most of the medicines used in the clinic are prepared from the herbs grown on-site. *Panchkarama*, herbal massages, *shirodhara*, *basti*, *netra dhara* and *tharpanam* are the main treatments. The most common treatments are for near-sightedness, glaucoma, diabetic retinitis, retinitis pigmentosa, age-related degeneration and diseases related to the optic nerve.

When I came back, my ophthalmologist in Vancouver was surprised to find that there was no leakage and that my eye site had become 20/20 in both eyes. He taunted me as to why I was still wearing glasses. Since the appointment, I only wear glasses while reading.

The Sreedhareeyam eye clinic is operated by a team of highly trained and experienced ayurveds (doctors). The business has been running in the family for many generations. The premises is set up in a resort-like facility away from the hustle of big cities and located near a small village. It has a capacity for over 300 patients and escorts, and contains a gorgeous kitchen which prepares all fresh vegetarian meals, as well as a canteen with internet facilities. It has a large research and development department and modern factories where the clinic's medications are manufactured. About 10% of the patients are from abroad, 35% are from the city of Kerala, and the rest come from from all parts of India.

The dedication, sincerity of purpose, and a belief in the Hindu Goddess Badri Maa are quoted as the main reasons for the successful treatments of all the patients. Morning and evening prayers are performed daily by most patients and the doctors.

Ayurvedic ophthalmology, or *Netra Chikitsa*, is a well-documented branch of Ayurveda, the ancient holistic medical science. Numerous Ayurvedic documents cover treatments for 70 to 90 eye ailments. Ophthalmology is taught up to the post graduate level, which takes up to eight and a half years to complete.

Most eye-patients reach this treatment centre after exhausting all other options available to them. Presently, ayurvedic medicine is said to be the last hope for people who suffer from blindness. The specialists and doctors I have seen in Canada cannot believe that this ayurvedic treatment is working, nor can they explain to me why my condition is not worsening.

Richard Dawkins, a renowned British ethologist, once said "there is no alternative medicine, there is only medicine that works and medicine that doesn't work." It makes me wonder why the mainstream medical profession does not open its doors and gain some insight into the magic of these so-called alternatives, complementary systems. Most of these alternatives practitioners are finding it hard to compete with the mainstream system, as their treatment is not recognized by our government.

Regardless, I go to my clinic in India for annual checkups and treatments. I do not know what brings me back every year. It may be the faith in the doctors, the medicines or the Goddess.

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